THE DISCLOSURE DILEMMA: THE INFLUENCE OF DISABILITY IDENTITY DEVELOPMENT ON DISCLOSURE AT WORK FOR EMPLOYEES WITH DISABILITIES

by

ANNA LUNSFORD HULETT

(Under the Direction of Karl W. Kuhnert)

ABSTRACT

Recently the disability community celebrated the milestone 25th year of the passing of the Americans with Disabilities Act (ADA, 1990). Though there is much to celebrate, there is yet still far more to go in terms of what we know about individuals with a disability, especially in the context of the workplace. The present study sought to specifically explore the process of disclosing one’s disability status in the workplace, and how these behaviors may be shaped by his or her disability identity. Utilizing a population of employees with disabilities from various organizations and industries, relationships were explored through Structural Equation Modeling (SEM) and results indicated nuanced evidence based on the level of disability visibility.

INDEX WORDS: Employees with Disabilities; Identity Management; Disclosure; Stigma.

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DEDICATION

Dedicated to the 56.7 million.

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CHAPTER 1

INTRODUCTION

The Americans with Disabilities Act (ADA) recently celebrated 25 years as active legislation protecting the civil rights of the largest minority group of Americans (Rutigliano & O'Connell, 2013). In its lifetime of 25 year thus far, the ADA has become one of the greatest allies for the 56.7 million, or nearly 20% of Americans with a disability (Erickson, Lee, & von Shrader, 2016; United States Census Bureau, 2012). The ADA has markedly increased access for individuals with disabilities within the realms of employment, education, public transportation, housing, and communication. Beyond these areas that were specifically outlined in the ADA, individuals with disabilities have been able to access and integrate even further into American society. Rosemarie Garland-Thomson (2015), disability rights activist and co-director of the Emory University Disability Studies Initiative, describes these successes and issues a challenge for the future,

> "As disabled people, we are everywhere now, included in the fabric of social life and public engagement made possible by the A.D.A. However, many of us remain hidden, and barriers – despite the proliferation of ramps – remain. The first generation under the A.D.A. was literally about getting in the door; now we must seek fuller inclusion."

Garland-Thomson's challenge to action astutely acknowledges the progress the ADA has allowed over the past 25 years, yet she is also keen to point out that there is further work to be done within the space of advocacy for individuals with disabilities. For example, individuals with a disability are twice as likely to be unemployed as an individual without a disability, which is supported by the most recent numbers from the September 2016 report from the United States Department of Labor, indicating that the unemployment rate for individuals with a disability is approximately 8.7%, while for non-disabled individuals the unemployment rate is 4.7% (United States Department of Labor, 2016; United States Census Bureau, 2012). Further, among employed individuals with a disability, the median monthly income is nearly 2/3 of the median monthly income for employed individuals without a disability (United States Census Bureau, 2012). In the present study I sought to understand, as Garland-Thomson describes, the many individuals "with disabilities who remain hidden," and further what organizational scholars know about the nuanced process of deciding to remain hidden or to openly share one's disability status. These efforts are aligned with the calls of other organizational scholars, (Santuzzi, Waltz, Finkelstein, & Rupp, 2014; Jones & King, 2013), to continue to move forward toward inclusion for individuals with disabilities, specifically by seeking to understand the relationship between an individual's disability identity development and the likelihood of disclosing his or her disability within the realm of employment.

Garland-Thompson's words also echo some of the most recent legislative changes in the United States related to individuals with disabilities. The ADA has been the backbone for over 25 years, however, just recently revisions to Section 503 of the Rehabilitation Act of 1973 (referred to as Section 503 Revisions onward) have dramatically changed the landscape for individuals with disabilities and for the organizations in which they are employed. The present study specifically addresses the legal and practical changes surrounding disability status disclosure that the Section 503 Revisions have put into motion, all with the goal of, as Garland-Thompson says, seeking fuller inclusion for individuals with disabilities in the workplace and beyond.

Americans with disabilities became a legally protected class in 1990 when the ADA was passed into law. The ADA made it illegal for employers to discriminate against qualified individuals on the basis of any qualifying diagnosis, the perception of such a diagnosis, or the association with another individual who has a qualifying diagnosis, like a spouse or dependent. What constitutes a qualifying condition for ADA protection is in fact rather broad, sometimes even subjective, but must meet the terms laid out by the ADA: “a physical or mental impairment that substantially limits one or more life activities of such individual,” (ADA, 2008). The major life activities mentioned in the definition of a disability is a rather long list of activities like caring for oneself, hearing, seeing, sleeping, learning, working, communicating, and the operation of any bodily function (ADA, 2008). From these definitions, we can see that there is a broad range of what may be considered a disability, thus providing the individuals affected with legal protection against discrimination. Examples include conditions such as Muscular Dystrophy, Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, diabetes, cancer, as well as impairments such as missing limbs, blindness, deafness, and paralysis. This is not an exhaustive list, but it does begin to illustrate the broad nature of coverage provided by the ADA.

Beyond defining coverage and providing protection against discrimination for qualified individuals, the ADA also lays out some very specific regulations about an individual with a disability’s rights regarding disclosure of their disability status in the workplace. The ADA prohibits employers from asking both applicants and current employee about the nature of their potential disability. However, employers may ask questions related to performance of the necessary job tasks. For example, if an employer is interviewing someone for a forklift driver positions who appears to be deaf, the employer cannot ask the applicant if he or she is deaf, but the employer can ask questions like “Please describe how you would you be able to tell if your forklift horn is working properly or not?” If an individual chooses to disclose their disability status however, then the employer can directly acknowledge that employee’s disability. Thus, many individuals with seemingly obvious disabilities may never formally disclose their status to their employers, and thus the employer is unable to discuss the disability with the employee.

For individuals with disabilities, having the ownership of their disclosure decision over the past 25 years has allowed a certain sense of empowerment. An individual with a disability is not typically able to control much of what happens to them as a result of their disability, yet in terms of disclosure at work, individuals with disabilities have had complete control. Some actively choose not to disclose, while others may happily decide to disclose.

One significant benefit for those who disclose also comes from the ADA. Once a disability has been disclosed to an organization, the organization is legally required to provide that individual with reasonable accommodation. Again, we see broad and subjective language in the ADA, but in reality reasonable accommodations are things like allowing noise cancelling headphones, a quiet office space, making changes in lighting, making the physical environment more accessible, or providing an interpreter. Accommodations can be as simple as a one-time adjustment, like building a ramp, or can be a continuous effort, like allowing an employee to audio record instructions and meetings (Wyld, 1997).

Podratz and Tetrick (2004) make a solid case for the potential benefits for the organization associated with implementing accommodations. For example, implementing accommodations is one a way to attract and retain top talent, and once accommodations for an employee are in place, it is likely for that employee to have increased productivity (Podratz & Tetrick, 2004). There are costs associated with implementing accommodations for employees with disabilities, however, researchers have noted that this cost may not be as great as one would expect. For instance, 80% of the accommodations for psychiatric disabilities cost $0 (Meltsner, 1998), and that more than 2/3 of accommodations for individuals with mental or physical disabilities are less than $500 (Zuckerman, 1993). More recently, the Job Accommodation Network (JAN) has been conducting an ongoing study on the costs and benefits associated with accommodations. JAN reports that 58% of employers had zero cost associated with the accommodations they implemented, while 37% experienced just a onetime cost, an average of $500 (Loy, 2015). Not only does JAN report information about the costs involved with accommodations, they also report benefits that organizations experience. The majority (75%) of employers report that the accommodations implemented were either very or extremely effective (Loy, 2015). Additionally, employers reported several indirect benefits associated with implementing accommodations such as improving interactions between coworkers, increasing morale, and increasing overall company productivity (Loy, 2015). Finally, there are federal tax incentives available for businesses who implement accommodation (ADA, 2008).

It would seem that accommodations would be implemented in great volumes based on their generally low cost and high benefits. However, an employer is only able to do so after the employee has disclosed their disability to the employer, and has requested such accommodations. Thus, where there may be many opportunities for accommodations to be implemented for the benefit of all, many individuals with disabilities choose not to disclose their disability status to their employer, and thus, no accommodations are made. For over 25 years, individuals with disabilities in the workplace have owned the process of disclosure and requesting accommodations. Yet in 2013 the 25 year- long script was totally flipped.

The Rehabilitation Act of 1973 served as an important precursor to the ADA, and in Section 503, provided a requirement for equal employment opportunity and affirmative action for federal contractors (Pryor, Dunleavy, & Cohen, 2014). However, Section 503 was updated in August 2013 to incorporate a number of revisions, revisions that went into practice in March 2014 (United States Department of Labor (DOL), Office of Federal Contract Compliance Programs (OFCCP), 2013). The Section 503 Revisions apply to federal contractors and subcontractors and now require these employers to adapt a hiring goal that 7% of the employees in each job group be qualified employees with a disability (DOL OFCCP, 2013). To obtain information about whether an employee has a disability, these organizations must solicit disability status multiple times from all applicants and employees (Pryor, Dunleavy, & Cohen, 2014), a sharp departure from the 25 years of the ADA preventing employers to ask individuals about any potential disability unless the individual made the decision to disclose. The organizations must solicit disclosure from all applicants, all individuals that are extended an offer of employment, and then from the organization's current body of employees, which will then be repeated every 5 years for updated records. An individual may be asked to disclose their disability status when they apply for a position, again when they are extended an offer of employment, and finally if they accept the offer, at some point they will be solicited again as part of the five- year evaluation of general population of employees. From the perspective of an individual with a disability, this is a major change in the 25 years of status quo. Organizations are also facing major changes here as well- beyond creating the systematic resources needed to obtain and maintain this data confidentially, if the organization does not have 7% of a job group that is qualified individuals with a disability, there may be consequences, the severity of which are still unclear in many ways (Pryor, Dunleavy, & Cohen, 2014). To clarify, the organizations are not charged with making sure that each job group includes 7% of qualified employees with a disability, but rather each job group should have 7% of qualified employees who have disclosed their disability status. For example, in large organization, the job group of accountants, there are likely already over 7% of these qualified accountants who have a disability, especially since almost 20% of Americans have a disability (Erickson, Lee, & von Shrader, 2016; United States Census Bureau, 2012). Yet the goal for the organization is to have 7% of those qualified accountants voluntarily disclose that they have a disability. Thinking about it this way, the task becomes quite the tall order for organizations with serious financial outcomes- in the past ten years the United States federal government has spent between $450-612 billion annually in federal contracts with organizations (National Contract Management Associate, 2015).

The present study investigated this very chasm in policy and practical execution by examining the nature of disclosure for employees with a disability. Specifically of interest was the role that an individual’s own disability identity may play in his or her disclosure decision. The present study answers various calls to action and to research in the realm of disabilities at work (Santuzzi et al., 2014) and stigmatized identity management, both visible (Jones & King, 2013) and concealable (Roberts, 2005). In the chapters that follow, a review of relevant literature will be put forth, leading to the development of several hypotheses and research questions, which then guide the design and execution of an empirical study to determine whether these hypotheses will be supported.

CHAPTER 2

LITERATURE REVIEW, HYPOTHESES, & RESEARCH QUESTIONS

Disabilities as a Minority: Unique Features for Scholarly Consideration

The literature regarding employees with disabilities is perhaps a bit more unique than that of typical areas of Industrial Organizational (IO) Psychology. First, employees with disabilities are people, not a process like performance appraisal or a construct, like job satisfaction. The IO and management literature largely focuses on such topics of processes and constructs and less so on specific groups of people. The diversity literature is a noteworthy exception; incorporating research on how specific groups of people interact within the processes and constructs that largely makes up the IO and management literatures. Yet even within the niche of diversity literature, there is far less research on individuals with disabilities compared to the scores of research on race, gender, and even sexual orientation. This is partly a function of the times- it seems in our society we have followed the same pattern, first coming to terms legally and socially with the equality of gender, and then race. Within the past 10-15 years, we have seen tremendous effort to bring the same civil rights protections to individuals based on sexual orientation, and with that, so has the literature grown on LGBT employees. Curiously, individuals with disabilities were legally granted civil rights protection in the aforementioned timeline, specifically with the ADA in 1990, but there was no boon of societal acceptance or prioritization, and thus the IO literature on employees with disabilities remained few and far between. As an example, from the year that the ADA went into effect, 1990, and the year 2014, a nearly 25 year range, Colella, Hebl, and King (2017) reported that in the premier Journal of

Applied Psychology (JAP), just 3 articles were published regarding individuals with disabilities at work. In contrast, Colella et al. (2017) report that 39% of JAP articles published between 1990-2014 were regarding gender in the workplace, while 27% were with respect to race in the workplace.

Disability is the underrepresented of all underrepresented groups. The progress made in our understanding of gender, race, and sexual orientation has been tremendous, especially in such a relatively short period of time. But now is the time to bring disability to the table, to deepen our understanding of what it means to be an individual with a disability, and for organizational scholars, what it means to be an employer of, and an employee with a disability.

There is good news: though the organizational literature has not been very fruitful in this content area, many other fields have (Colella & Bruyere, 2011). In fact, there has been a great deal of scholarship related to individuals with disabilities in the fields of vocational rehabilitation, occupational rehabilitation, education, counseling, and developmental and social psychology, Thus, the literature review that follows will be a diverse representation of many fields of scholarship, yet will weave these insights together to build a coherent representation of individuals with disabilities.

To begin, it is also important to note that there are some distinct elements of disability that make it unique from other minority groups, especially in terms of how this group is studied. As discussed in the introduction, the definition of a disability is very broad, allowing for a seemingly unending list of what should qualify for the label of disability. Race, gender and sexual orientation can be fairly easily defined as consisting of a definite number of groups, for example, gender can be seen as male or female, race can be defined as White, Black, Asian, or Hispanic, and sexual orientation can be defined as heterosexual, homosexual, and bisexual. Now practically speaking, it is certainly true that the reality is that these dichotomous and categorical groupings of gender, race, and sexual orientation, are not all encompassing. Yet from the perspective of a researcher, even including more inclusive additional options for, say sexual orientation (Gay, Lesbian, Straight, Bisexual, Queer, Questioning) and gender identity (Male, Female, Transgender, Questioning, Non-Gendered), these are still relatively short lists compared to the hundreds of conditions and experiences that qualify someone as an individual with a disability. Thus, the literature reviewed will cover very specific disabilities at times, like muscular dystrophy or Attention Deficit Hyperactivity Disorder (ADHD), or it will include larger groups, like mental disabilities, physical disabilities, or even all disabilities. For the purpose of the present study, disability will be defined as according to the law (ADA, 1990, 2008), which allows for the broadest interpretation of the definition, and will include any and all subgroups.

Another unique feature of disability as a minority group is that it is dynamic membership, as someone with a disability may not always have a disability and someone without a disability may come to have a disability. For example, a woman may be disabled right now, with lung cancer. However, after three years of treatment, she may no longer have lung cancer and thus is no longer disabled. Or, in the inverse scenario, there may be a non-disabled man right now, but tomorrow he is involved in an auto accident and no longer has the use of his right arm. One will likely always have a race, a gender, and a sexual orientation, and though their identity around those three statuses may vary, one will still have a race, a gender, and a sexual orientation. This changing nature of disability makes it challenging to study from a research perspective.

There is also great diversity within experiences of individuals with even the same disability. One man with depression may have a greater degree of severity of and frequency of symptoms compared to another man with depression. Each individual has a unique set of parameters regarding their own disability in terms of what the disability is, which symptoms manifest, how frequently and severely these symptoms do manifest, and to what degree the individual is able to conceal their disability. The present study integrates all the different features of understanding disability, especially within the context of the workplace, and utilized study design and analyses to account for the aforementioned challenging but integral parts of understanding disability.

Disabilities in the Workplace

Up until 2013, when the Section 503 Revisions were made, there were not substantial efforts to recruit individuals with disabilities, largely because the ADA did not include any affirmative action directives. (ADA, 1990, 2008; Colella & Bruyere, 2011). However, in the past few years we have seen the legislation change, now requiring federal contractors to have a specific aspirational goal for the percent of employees who are disabled. Thus, one would predict that there will be a significant increase in the level of recruitment efforts by organizations, as well as an increase in the recruitment literature focusing on employees with disabilities. However one study regarding recruitment of individuals with disabilities, (Bruyere, Erikson, & VanLooy, 2005) examined the use of online web-based application processes through both wide reaching job boards with job postings, as well as individual organizations' recruitment sites. Results indicated that because of the poor accessibility and usability characteristics, over 2/3 of the sites were deemed as inaccessible for individuals to successfully submit an application (Bruyere, Erikson, & VanLooy, 2005; Colella & Bruyere, 2011). This study illustrates an important part of the disability experience, and one that has received a great deal of attention in the literature, and that is the notion of accommodation.

Providing reasonable accommodations for an applicant or employee with a disability is mandated by the ADA (ADA 1990, 2008), yet in practice it may not always be as straightforward as the legal document presents. Noteworthy, to receive an accommodation, one must disclose his or her disability status to their employer, so the very act of requesting accommodation is linked in tandem with disclosure. Baldridge and Veiga (2001) began to take a nuanced look at the accommodation process, and found that requesting an accommodation is anything but easy, is often withheld, and when one does disclose, it often comes at a personal cost. The researchers developed a framework for the accommodation process, which David Baldridge and colleagues have continued to build upon as a program of research (Baldridge & Veiga, 2001; Baldridge & Veiga, 2006; Baldridge & Swift, 2011). The framework developed in the earliest work considers the process which an individual would experience as they make a decision to request an accommodation or not. Situational characteristics such as workplace attributes, accommodation attributes, and attributes of the disability itself lead an individual to assess in a cost benefit style whether they should or should not make a request (Baldridge & Veiga, 2001). Empirical testing of this framework has found notable results. In a study of 251 hearing impaired adults, Baldridge and Veiga (2006) found support for influencing factors on the decision to request accommodations such as anticipated social consequences, level of imposition on others, and whether the accommodation would be a single instance or a recurring action. Monetary costs, were also an influencing factor, however results indicated that the social costs associated with the perceived imposition and burdening of others were a greater influence than monetary costs. In this study, the researchers found evidence that though practical elements were a factor, such as monetary costs and logistical implementation, what really influenced these individuals' decision to request an accommodation was the perceived level of the social costs and consequences that may occur. In an additional empirical study, Baldridge & Swift (2011) tested for various factors that would perhaps serve as boundary conditions for the decision to request an accommodation, such as gender, age, age of onset, and disability severity. The researchers found that when the nature of the disability was more severe, the effects of age and gender on frequency of request withholding were weaker, and thus suggest that gender and age related norms are not as salient for these individuals (Baldridge & Swift, 2011). As quoted from the original theoretical piece, "There is nothing simple about the decision to make such a request [for accommodation]" (Baldridge & Veiga, 2001, p.95).

The accommodation decision-making process often begins at the beginning of an individual's employment life-cycle, during the selection process, as several works by Mikki Hebl and colleagues have demonstrated (Hebl & Skorinko, 2005; Wang, Barron, & Hebl, 2010; Martinez, White, Shapiro, & Hebl, 2016) . The selection process is, for many, the point at which it may be natural for one to disclose disability status and request accommodations, and as Hebl and Skorinko (2005) found, the decision to disclose during selection may even be beneficial. In a web-based experimental study, Hebl and Skorinko (2005) found that when confederates with a physical disability disclosed his or her disability status in the beginning or middle of an interview, the candidate was rated as having a more favorable impression on the evaluator than those who disclosed at the end of the interview or not at all. Further, applicants who disclosed at the beginning of the interview received higher ratings on happiness and capability (Hebl, & Skorinko, 2005). In another experimental study, Wang, Barron, & Hebl (2010) found that visually impaired applicants received lower ratings of hire-ability among human resource managers because the nature of their disability often does not allow them to prepare a resume that meets the visual presentation standards required, and thus they are penalized in the selection process.

More recently, Martinez, White, Shapiro, & Hebl (2016), examined the process of disclosure for individuals with a history of cancer. The researchers found that individuals with a history of cancer often did decide to disclose this disability status to interviewers, and that they were consequently rated as higher in warmth than in competence. In the second study of the paper, the researchers found that individuals that disclosed his or her status as having a history with cancer received fewer callbacks and were treated with more negative interpersonal reactions than those who did not disclose a history with cancer (Martinez et al., 2016). From just these two studies we can see that depending on the nature of a disability (physical disability vs. cancer), one can expect very different outcomes if he or she chooses to disclose during the interview process.

Practically speaking, there are a number of challenges for the organization in the process of accommodating individuals with disabilities during the selection process. For example, in testing and assessment, the most common accommodations granted are modification to equipment, altering the location or situation, providing assistance (i.e. an interpreter), and altering the period of time required for the individual to finish (Ashworth, 2014). Yet the question remains, where is the line between providing accommodation and altering the nature of the construct being measured? Practitioners must act on a case- by- case basis to make such determinations (Ashworth, 2014).

As an individual with a disability does become an employee with a disability by completing the selection process, they too must navigate the experiences of an average employee in the workplace. Performance and performance appraisal represent a hefty subset of the IO literature, and there have been several studies examining these constructs within and regarding employees with a disability. Another researcher who has contributed significantly to the literature on employees with disabilities is Adrienne Colella, and along with her colleagues, she has conducted a number of studies examining disability and performance (Colella, DeNisi, & Varma, 1998; Colella & Varma, 1999) among other significant contributions that will be discussed in later sections. Colella, DeNisi, & Varma (1998) found that participants in an experiment demonstrated a negative bias when given the choice to select a partner with or without a disability for the task at hand, but only when the nature of the task (i.e. dependent on words in a sentence vs. building origami) was expected to be a poor fit for the partner with a disability (i.e. dyslexia vs. no dyslexia). Results support the notion that there are stereotypes for what may or may not be the right job for an individual with a disability to perform as well as a non-disabled individual.

Moving this conclusion along further, Colella and Varma (1999) utilized a lab study in which participants evaluated the videotaped performance of individuals, and found that there was no difference in the performance ratings given to individuals with a physical or mental disability as compared to those who did not have any disability. However, in terms of future performance ratings of the videotaped individuals, participants' ratings were dependent on whether the individual with a disability was performing in a job that the participants stereotypically expected would be a good fit (i.e. a business manager), or stereotypically would be a poor fit (i.e. a bus driver) (Colella & Varma, 1999). These results, along with other findings from this study, led the researchers to conclude that while employees with disabilities may have fair evaluations, they may also be excluded from developmental opportunities based on the biased belief that based on the occupation; a poor job fit would not indicate the employee is capable of performing well in the future. This is a troubling finding suggesting that despite fair treatment in the present, there are still barriers for individuals with disabilities to have a meaningful career path.

Other researchers have examined individuals with disabilities in the context of performance, including a positive rating bias for individuals with an emotional disability, such that these individuals receive higher ratings than those who did not have an emotional disability, across all levels of performance (Czajka & DeNisi, 1988). These results point to the notion that employees with disabilities are somehow less than in the context of performance, and raters believe they must overrate to compensate, which is also known as the norm-to-be-kind (Czajka & DeNisi, 1988; Colella & Varma, 1999). Reported in Martin and Fisher (2014), several studies from the medical field have examined the impact of depression in the workplace. For example, researchers have found that among all health conditions, depression has the greatest negative impact on an individual’s performance (Kessler et al., 2008). Other medical researchers give specific estimates of productivity- 28-30 days annually per individual with mood disorders such as depression (Tsuchiya et al. 2012), and others support this by presenting that this effect can compound as one’s symptoms of depression increase or become more severe (Jain, Roy, Harikrishnan, Yu, Dabbous, & Lawrence, 2013). Martin and Fisher (2014) also discuss negative consequences for employees with depression, such as loss of reputation. As discussed above, an employee with depression is likely to experience decreased performance as a result of his or her depression; however coworkers may attribute this change to the individual’s lack of interest or effort. Depression is considered less stable and more blame is assigned to the individual than physical illnesses, thus coworkers are likely to experience negative attitudes toward said employee (Monteith & Petit, 2011; Martin & Fisher, 2014)

Related to performance is often the relationship an employee has with their supervisor, as the supervisor is the most likely to conduct any formal performance evaluations. Colella and Varma (2001) conducted an experimental and field study on the relationships between employees with disabilities and supervisors, uncovering an interaction between an individual having a disability and engaging in ingratiating behavior toward the supervisor. Across both studies, ingratiation had a greater effect on supervisor's ratings of Leader-Member Exchange (LMX) ratings than employees who were not disabled. These findings suggest that in order to reach an ideal state of relationship with one's supervisor (i.ie. high in LMX), employees with disabilities have to work harder and more frequently engage in ingratiation than non-disabled counterparts. Taken all together, these findings regarding performance paint a complicated picture of how employees with disabilities are perceived as compared to non-disabled employees.

Consequently, individuals with disabilities may have a difficult time integrating into the workplace as an employee. Feldman (2004) discusses barriers for employees with disabilities in two categories; objective and subjective constraints. Objective constraints are the concrete, physical limitations that may hinder an employee with a disability's career transition, for example being unable to access the corporate cafeteria where many informal networking and mentorship relationships are being formed. Subjective constraints on the other hand are socially constructed and intangible limitations, such as biases, social discomfort, and low self-efficacy (Feldman, 2004). The presence of both objective and subjective constraints at work can impact the degree to which the employee feels accepted and integrated into the fabric of the workplace. One way to secure acceptance is through impression management tactics (Roberts, 2005). In a study of over 300 disabled college students, Kaiser, Wingate, Freeman, & Chandler (1987) found that depending on the level of salience the employee personally assigns to his or her disability, they will be more of less likely to engage in impression management strategies. Results indicate that the greater salience one's disability is to oneself, the more likely they were to engage in impression management strategies. Further, the researchers found very specifically that the way an employee with a disability dressed was used as a tool for deflection of attention from his or her disability (Kaiser, Wingate, Freeman, & Chandler, 1987), a finding that is reinforced by more recent work suggesting employees with disabilities (and their HR managers) prefer to focus on ability and being part of the mainstream at work, rather than being set apart (Kulkarni & Valk, 2010).

With integration into the larger workplace, we see research include not just the individual with a disability, but also those surrounding the individual, such as supervisors and coworkers. Much of this literature can be found exploring the factors influencing coworkers' attitudes and behaviors toward employees with disabilities, with generally less favorable perceptions of disabled employees (Czajka & DeNisi, 1988). For example, in a theoretical paper, Stone & Colella (1996) develop a model of factors influencing the way that coworkers treat individuals with a disability. Here the researchers classify supervisors and coworkers as "observers" who employ a variety of psychological processes, like categorization or stereotyping, in their evaluation of, and ultimately behavioral treatment of coworkers with a disability. Stone and Colella (1996) assert that this observation and subsequent psychological evaluation of their disabled coworkers "exerts a powerful influence over their feelings and behaviors toward [disabled individuals]," (p. 357).

Colella (2001) takes this framework of coworker treatment of individuals with disabilities a step further into the construct of perceived organizational justice, specifically distributive justice regarding the provision of accommodations for their colleagues with a disability. She proposes that the perceived fairness of an accommodation will be impacted by factors such as coworkers' concern for others, empathy, liking toward the person receiving the accommodation, scarcity of resources, and the level of interdependence between the coworkers and the accommodated individual. In a second theoretical model, Colella and colleagues develop a model specific to procedural justice (Colella, Paetzold, & Belliveau, 2004). Empirical testing of these theoretical frameworks has provided support for the observations and perceptions of coworkers as an important factor in determining that coworker's response to an individual with a disability. In an experimental laboratory study, Paetzold, Garcia, Colella, Ren, Triana, and Ziebro (2008), the researchers manipulated whether an accommodation request was granted or denied, whether the participants were in competition with one another on the task or charged with completing the task cooperating as a group, and finally whether the confederate with a disability was the top performer or the top performer was another participant. Results indicated that accommodation was thought to be unfair in conditions when the manipulation was such that an accommodation was granted to the confederate with a disability and that confederate was then deemed the top performer (Paetzold et al., 2008). Thus, in support of Colella (2001) and Colella, Paetzold, & Belliveau (2004), when the accommodation is perceived to provide an advantage for performance, the individual's coworkers are more likely to find this accommodation as less fair.

Ren, Paetzold, and Colella (2008) conducted a meta-analysis of 23 published experimental studies examining the effects of disability on human resource judgements (i.e. hiring, promotion, performance appraisal, etc.). The researchers found positive effects of disability on performance evaluations, paired with a negative effect of disability on performance expectations. This finding reflects the perception that an individual with a disability is somehow less capable of performing job duties, thus there are both lower expectations for performance, and that there is a leniency bias among those who do rate the performance of employees with a disability (Ren, Paetzold, & Colella, 2008). Some have posited that the seemingly positive biases uncovered toward individuals with a disability may be rooted in paternal instinct, or essentially equating the skills and capabilities of an individual with a disability to that of a child (Jones, Farina, Hastorf, Markus, Miller, & Scott, 1984). In terms of hiring decisions, there was an overall negative effect of disability on hiring, while this relationship was stronger for mental disabilities than for physical disabilities, indicating that though it is undesirable to hire individuals with disabilities, it is somewhat more desirable to hire individuals with a physical disability than a mental disability. In general, the authors found that type of disability was the strongest moderator they tested, such that mental disabilities were shown to have a more negative effect than physical disabilities on performance expectations and hiring decisions (Ren, Paetzold, & Colella, 2008). These findings reinforce the reality that as a protected class, there is much variability in the presentation of disability, and subsequently, there is variability in how each disability is perceived.

Disparate treatment of individuals with a disability is unfortunately a part of the workplace experience. In an examination of harassment of individuals with disabilities in the workplace, Shaw, Chan, & McMahon (2012), found that the influence of the disabled individual’s other minority group memberships increased the likelihood of harassment. The authors created 34 subgroups in their analyses, which represented all the categorical permutations possible from the variables gender, age, race, and type of disability. Results indicated that the greatest likelihood of harassment would be for Hispanic or American Indian women over the age of 35 with a behavioral disorder (Shaw, Chan, & McMahon, 2012). The authors found that the intersectionality of gender, age, race, and type of disability indicated higher risks of harassment for females, being older, being a person of color, and having a behavioral disorder disability (Shaw, Chan, & McMahon, 2012). Results here also support the results of Ren, Paetzold, & Colella (2008), as individuals with physical disabilities were less likely to be harassed as compared to other types of disabilities (i.e. behavioral, neurological).

Findings here are important to note because disability does not exist in a vacuum- an individual with a disability also has a gender, race, and age, allowing for the possibility that one may be a member of multiple minority groups. Being a member of more than one minority group has been found to increase the likelihood for one to experience negative outcomes (Berdahl & Moore, 2006; Buchanan, Bergman, Bruce, Woods, & Lichty, 2009; Shaw, Chan, & McMahon, 2012). Further, as the impact of intersectionality effects how the outside world perceives an individual, it also is a factor impacting the individual internally. For example, Johnson and Joshi (2016) examined a sample of autistic individuals, and found that age of diagnosis was a strong indicator of workplace well-being, specifically, that when diagnosed at an older age, employees had greater levels of perceived discrimination. These findings are also consistent with the results from Tenenbaum, Byrne, and Dahling (2014), which indicate that age of onset was a strong moderator in the relationship between disability severity and self-efficacy, such that the individuals who became disabled later in life had a much more negative impact of the severity of their disability on self-efficacy.

Another noteworthy study on workplace attitudes is that of Miller and Werner's (2007) examination of helping behaviors as related to individuals with a disability. To test part of Stone and Colella's (1996) previously discussed framework for treatment of employees with disabilities, Miller and Werner (2007) executed an experimental lab study focused on helping behavior. Results indicated that the participants' own equity preferences impacted the degree of helping behavior such that those with high levels of benevolent equity orientation would be more likely to exhibit helping behaviors toward an employee with a disability. Further, consistent with multiple previously discussed findings (Ren, Paetzold, & Colella, 2008; Shaw, Chan, & McMahon, 2012), Miller and Werner (2007) found support for the hypothesis that coworkers would provide more help to an employee with a physical disability than to an employee with a mental disability.

Identity and Social Identity Theory

Several of the above mentioned theoretical and empirical works on disability in the workplace begin to indicate that an important variable, especially as a boundary condition, is the degree to which an individual incorporates disability into his or her identity. Santuzzi & Waltz (2016) discuss lack of research exploring the complex role that one's own perceptions of disability serve in the larger process of organizational action. In other words, though an organization has several legal standards requiring protection, accommodation, and advocacy for an employee with a disability, these efforts can only go so far as the employee perceives to have a disability. For example, an individual born with a missing limb meets the legal standards to be considered an individual with a disability, yet he or she may not actually consider themselves to be disabled at all. Organizational efforts to engage this individual as a member of a protected class by expecting disclosure or accommodations meet a dead end when an individual meets the legal definition of disabled, yet does not believe they have a disability.

The perceptions and beliefs one holds about oneself is what Erikson (1968) refers to as an individual's identity. One's identity is multifaceted, and is malleable over certain periods of development across the lifespan. As one moves through this process, he or she will build an understanding of one’s self that “serves to integrate or bring into a meaningful pattern many different things such as one’s skills, values, goals, and roles into a coherent whole,” (McAdams, 1990, p. 403). Primarily, the process of identity development occurs in adolescence and early adulthood, and as Erikson (1968) theorized, takes shape across time via the processes of exploration and commitment. Exploration is the process in which an individual begins to question his or her assumptions about the self, and challenge the norms created in childhood, including the views of his or her parents, schools, religious bodies, and other authority figures and institutions (Erikson, 1968; McAdams, 1990). Through the experiences of exploration, an individual will begin to resolve the questions and doubting, and make commitments to the identity features that define how the individual sees oneself as part of the larger adult world (Erikson, 1968; McAdams, 1990). The extent to which an individual has explored and made commitments regarding various identity options is one’s identity status (Marcia, 1966). Some features of one’s identity will be more salient than others, and these features are typically important to the individual across time and environments (Hogg & Terry, 2000; Ragins 2008).

An individual will have multiple facets of identity, and when any of those facets reflect membership in a social group, it is then a social identity (Tajfel, 1981). For example, an individual’s identity may include their talent in the arts, being a parent, being a fan of a particular sports team, and being part of a particular minority community. Being a sports team fan and part of a minority community are both social identities, as they reflect group membership beyond what the individual finds personally meaningful about his or her life. The present study focused specifically on the social identity that comes from being a member of the minority group of having a disability. Hypotheses and study design were grounded in Social Identity Theory (Tajfel & Turner, 1986), which expands the understanding of social identity in numerous ways. In

Social Identity Theory (SIT), Tajfel and Turner (1986) posit that even with minimal association with a particular group, it is natural to find differences and discriminate based on group status. A group consists of individuals who perceive themselves and each other to be members of a particularly salient social category- like race, class, or sports fan allegiance (Clair, Beatty, & MacLean, 2005; Tajfel & Turner, 1986). The process of social categorization is the cognitive grouping of these like individuals as a group, essentially assigning individuals to their respective place in society. One can view his or her social identity as either positive or negative, typically determined by internal comparison of the individual's group membership to other groups, as well as the way that others externally evaluate the individual's group. Whether positively or negatively evaluated, one's group membership becomes internalized as part of his or her self-concept and larger identity and it becomes a source of self-esteem, psychological attachment, self-image, and one's need for belonging (Tajfel & Turner, 1986). There is the possibility of changing groups or changing how one's group is perceived, yet for underprivileged or stigmatized groups, this is very difficult, if not improbable to accomplish, and thus the negative social evaluations of a stigmatized social identity group adversely affect each of the psychological outcomes listed above (Tajfel & Turner, 1986).

Stigma

The theory provided by Tajfel and Turner (1986) allows for the understanding of how each individual's identity is multifaceted, and potentially largely defined by social group membership. Yet not all groups are created equal- as referenced above, some social identities can be stigmatized. For a group to bear this distinction, the common attribute among members that brings them together is in fact one which is seen as less desirable, even discrediting the value of these individuals in some way (Goffman, 1963). Further, Goffman (1963) observed that stigma can be conceptualized as a relationship between an attribute and a stereotype (Jones et al., 1984; Link & Phelan, 2001). People first distinguish a noticeable difference, and then, informed by larger societal and cultural beliefs, they label this difference as an undesirable characteristic which immediately reduces the status of anyone who possesses such characteristics (Link & Phelan, 2001). When individuals are perceived to be of a lesser status, they are then more likely to experience negative outcomes from stereotyping and discrimination. For example, Clair et al. (2005) cites a number of negative outcomes that a stigmatized individual is more likely to experience in the workplace such as reduced advancement and personal development opportunities, social isolation, lack of networking, difficulty in being hired and maintaining a job, job loss, and ultimately poorer job performance stemming from any of the above issues. Further, Herek (2009) reported that when others learned of an individual's sexual minority status, 50% of participants experienced verbal harassment and 20% of participants experienced criminal, personal, or property violations. Negative attitudes, discrimination, lack of opportunities, and even violence can be very salient parts of the lived experience of an individual belonging to a stigmatized group.

Stigma is a culturally relative phenomenon; what is stigmatizing in one culture may not be so in a different culture (Clair, Beatty, & MacLean, 2005). In the United States, culturally there is stigma associated with virtually any minority group, whether based on gender, race, age, or disability. There is also stigma associated with certain experiences like unemployment, the mental healthcare industry, or being a victim of assault. The list of stigmatized identities and experiences could be nearly endless, but in the present study we focused on the largely stigmatized experience and group membership of disability. Although positive features do exist for members of a particular stigmatized group, because the stigma is assigned to that group based on the belief of the larger culture in which one exists, it is often unpleasant to be the bearer of stigma, subject to stereotyping, status loss, and discrimination (Clair, Beatty, & MacLean, 2005; Crocker, Major, & Steele, 1998; Link & Phelan, 2001). Even just the anticipation of effects from stigmatization has been supported as a predictor of psychological distress (Quinn et. al, 2014).

Reactions toward a stigmatized individual are relative, depending on a variety of factors, commonly conceptualized by the following six attributes: disruptiveness, origin, aesthetic qualities, course, concealability, and peril (Jones et al., 1984). Disruptiveness refers to the effect of the stigmatized characteristic on social interactions, while origin refers to the degree to which the individual may be responsible for his or her stigmatized attribute. Aesthetic qualities reflect the degree to which the stigmatized attribute makes the individual physically unattractive, while course refers to the level of permanence of the stigmatized feature. Concealability is the extent to which the stigmatized attribute is visible to the naked eye, and peril refers to the extent to which the stigmatized attribute may cause danger to other people (Jones et al., 1984; McLaughlin, Bell, & Stringer, 2004). Each individual with a stigmatized feature will have varying degrees of each of these six factors, which impact the way he or she is perceived themselves and by others. For example, in a study of autistic adults, Johnson and Joshi (2016) found a direct relationship between severity of the disorder and workplace well-being.

Goffman (1963) made an important observation about stigma as an inherently socially constructed construct- by definition there must be at least two parties to classify something as a stigma. Mikolon, Kreiner, and Wieseke (2016) have designed a unique empirical study to capture perspectives from both the stigmatized and the stigmatizer. Their results support a phenomenon which they term “stigma magnification effect,” which refers to the notion that stigmatized individual may actually reinforce the negative reactions of others. The authors posit that stigmatized individuals create “metastereotypes,” a shared belief of what non-stigmatized others believe to be true about members of the same stigmatized group (Mikolon, Kreiner, & Wieseke, 2016). For example, a disabled individual may believe that most non-disabled people view disabled people as lazy. Here this individual has developed their own stereotype regarding the types of stereotypes made by non-disabled individuals. This metastereotype may actually serve to reinforce the negative views of non-disabled individuals, and the authors found support that these negative views are co-produced in this way (Mikolon, Kreiner, & Wieseke, 2016). However, there may be a silver lining for those who expect negative stereotypes to be held about them- Crocker and Major (1989; 2003) posit that when an individual can attribute the negative reactions to larger held stereotypes or discrimination instead of personal, internal causes, they are able to protect their self-esteem.

An important feature of stigma as mentioned earlier from Jones et al., (1984) is the degree to which the stigma is visible to others. Visibility plays a large role in dictating the ways that individuals interact with the world and the people in it. Stigmatized statuses that are not readily visible to the naked eye are often referred to as “invisible stigma” (Clair et al., 2005). Goffman (1963) was one of the first to differentiate between visible and invisible stigma, as he discusses the human tendency to assign group membership based on visual cues. Through this logic, humans can typically see physical features of certain stigma- race, gender, pregnancy, and some physical disabilities. Yet, other stigma, like HIV/AIDS status, sexual orientation, chronic illnesses, and various physical and mental disabilities, are not able to be visually detected by an observer, thus they are “invisible” stigma. An individual with an invisible stigma then has a choice – they are able to decide when and where they would like others to learn about their disability status. Or on the other hand, they are able to decide to hide their stigma from others.

The only way that the stigmatized identity becomes known is through the act of disclosure by the individual. The disclosure process for employees with a disability is not a cut and dry experience- it is dynamic, just as the experience of having a disability is dynamic. The decision making process surrounding disclosure is a complex system of cost/benefit analysis, which will be detailed in later sections of this paper. In general, depending on the visibility of one's stigmatized identity, it can dictate very different experiences for the individual in the workplace (Clair et al., 2005, Ren, Paetzold, & Colella, 2008; Stone & Colella, 1996) and the process of managing this presentation of one's stigmatized identity can put one at conflict with their authentic self-presentation (Creed & Scully, 2000) and causes stress and anxiety for individuals (Clair et al., 2005). Some have argued that having an invisible stigma is "better," however there is a psychological burden that comes with the responsibility of constantly managing the degree to which people know about one's stigma (Clair et al., 2005; Pachankis, 2007; Ragins, 2008). In the realm of disabilities, there are both visible and invisible disabilities, and the present study explored how the visibility of one's disability may impact other factors regarding identity and disclosure.

The stigmatization of disability is difficult to tease apart, especially in the context of the workplace. Though stereotypes due to race or gender sustain negative performance beliefs, it is logically plausible that an individual with a disability would actually face challenges to performance (Santuzzi & Waltz, 2016). There is some validity here, as there are individuals with disabilities who do not have the capabilities needed to function in the workplace. However, these individuals are at the lowest end of the functioning spectrum and would not likely be in the workplace to begin with. Yet this group of extremely low functioning represents a small percentage of the entire range of capability that individuals with disabilities exhibit. Still, even in high functioning cases, individuals with disabilities may be assumed to be unable to perform as well as an individual without a disability (McLaughlin, Bell, & Stringer, 2004). Employers concerns about hiring individuals with mental disabilities include symptom concerns such as the potential to be dangerous to themselves and others, having a reduced ability to handle stress, or perhaps engaging in strange and unpredictable behavior. They also include concerns about impaired job performance, absenteeism, the level of monitoring the employee may need, and the negative attitudes that may arise from other employees (Brohan & Thornicraft, 2010).

Disability is very much a stigmatized status, thus individuals with a disability must not just come to terms with their own personal identity via exploration and commitment, a challenging process for anyone (Erikson, 1968), but they must in addition reconcile the stigmatized existence of their disability. Individuals with a disability will have a myriad of personal values, experiences, and social group memberships from which to develop an identity, but depending on features of their disability mentioned above, such as age of onset (Johnson & Joshi, 2016), severity, disruptiveness, origin, aesthetic qualities, course, concealability, and peril (Jones et al., 1984), the salience of their disability will become part of their larger identity. Bogart (2014) defines disability identity as the part of an individual’s self-concept defined by having a disability. Unfortunately, disability identity is understudied, with little research attention or quantitative work done (Bogart, 2014; Santuzzi & Waltz, 2016). The present study answers to various calls for further research on disability identity experiences. What has been explored in the literature on disability identity has produced mixed results. Martinez, White, Shaprio, and Hebl (2016) found that many individuals with a history of cancer have incorporated this as a central component of their identity. Others have found that having a strong level of disability identity has been linked to positive outcomes such as decreased anxiety and depression

(Bogart, 2015), and increased self-esteem and satisfaction with life (Bogart, 2014; Nario-Redmond, Noel, & Fern, 2013). However, Bogart (2014) found that these desirable outcomes were more likely to occur in individuals with a congenital onset, as opposed to those who had acquired a disability at some point in life. Crocker and Major (1989) assert that members of stigmatized groups are actually at risk for a poor self-concept and low self-esteem. And finally, Santuzzi & Waltz posit that failing to have a disability identity at all "may impose serious psychological and physical health risks," (2016, p. 1126).

Aside from mixed results regarding the outcomes associated with developing a disability identity, there have been additional challenges in developing a disability identity. Unlike ethnicity or gender, an individual with a disability is often the only person in their family or even his or her community to be disabled, especially with the specific features of that individual's disability (Santuzzi & Waltz, 2016). Thus the process of charting their own identity may be very difficult without role models, mentors, or even just the opportunity to know others who are similar. There are nationally recognized and celebrated societal subcultures for other minority groups (i.e. "Black is Beautiful", LGBT Pride), yet there is no such equivalent for the disabled (Bogart, 2014; Hahn & Belt, 2004). Thus, the process of exploration and commitment for individuals with disabilities can be a very challenging, isolating, and potentially negative experience.

A notably distinct feature of disability identity development is the notion that societally we understand disability through what is termed a "medical model" of disability as impairment, a condition which the individual should want to improve or eliminate. The medical model of disability inherently deems disability to be a negative, undesirable quality, which does not readily allow for an individual to develop a positive identity surrounding their disability

(Weeber, 2004). In fact, there are segments of the disability population who intentionally do not seek medical treatment for their disability, as they do not perceive the need for treatment or a cure (Hahn & Belt, 2004). Hahn and Belt (2004) found that the medical model poses as a threat to positive disability identity, as individuals who have integrated disability into their self-concept perceive the idea of a cure as an invalidation of who they are as a person. A notable example has been gaining traction in the autism spectrum disorder community, coined the “Autism Rights Movement.” Advocates seek to advance the acceptance of neurodiversity, just as society accepts other differences in demographic features like race and gender as simply variations from the dominant group (Saner, 2007). Noted autism expert and clinical psychologist Simon Baron-Cohen says,

> “To talk about a 'cure for autism' is a sledge-hammer approach and the fear would be that in the process of alleviating the areas of difficulty, the qualities that are special - such as the remarkable attention to detail, and the ability to concentrate for long periods on a small topic in depth - would be lost. Autism is both a disability and a difference. We need to find ways of alleviating the disability while respecting and valuing the difference," (Saner, 2007).

Other minority groups are not approached from a medical model of treatment and cures, like race, gender, and, depending on your politics, sexual orientation (though in the past sexual orientation has been conceptualized from a medical model approach, see Fassinger, 1991). We approach these minority groups from what is termed a “social model” or “minority model,” where social, legal, and environmental factors are considered barriers, rather than the minority classification itself (Bogart, 2014; Hahn & Belt, 2004; Olkin, 1999; Santuzzi & Waltz, 2016;

Weeber, 2004). Thus, the present study serves as a departure from the medical model of disability, and rather will utilize the social model as preferred in the disabilities studies literature.

Stigmatized Identity Development

With a lack of substantive research on the internal experiences of individuals with a disability (Santuzzi & Waltz, 2016), one must look to the literature on the identity development of other marginalized and stigmatized social identities. In fact, various researchers note the parallels between the experiences of an individual with a disability and individuals who have minority status in a different realm. For example, both the stigmatized groups of individuals with a disability and other stigmatized groups, like racial minorities, must navigate the dominant versus non-dominant dynamics of prejudice, discrimination, and systematic disparities in health care, education, and employment (Olkin, 1999; Sciarra, Chang, McLean, & Wong, 2005), thus allowing disability researchers to draw from the larger literature on stigmatized social identities (Bogart, 2014, Dunn & Burcaw, 2013). Thus, as has been common practice in the diversity literature (Button, 2001, 2004; Walters & Simoni, 1993), the present study draws from the established literature on minority identity development.

Using the scaffolding from Erikson's (1968) framework, many researchers have created their own models for the development of specific social identities that are most often very salient to individuals (Roberts, Phinney, Masse, Chen, Roberts, & Romero,1999) such as race (Cross, 1971; Helms, 1990, 1993; Phinney 1989) or sexual orientation (Button 1996; Walters & Simoni, 1993). The earliest models of minority identity development were focused on racial and ethnic minorities, specifically the development of Black identity. William E. Cross, Jr. developed one of the earliest, and most influential, models of identity development (Cross, 1971, 1978, 1991; Vandiver, Fhagen-Smith, Cokley, Cross, & Worell, 2001). Cross's model of identity development for Black individuals included 5 stages: pre-encounter, encounter, immersion/emersion, internalization, and internalization-commitment (Cross, 1971).

The pre-encounter stage is described as the beginning of the identity journey, when the individual is not yet aware, or at least not aware of the significance of his or her “othered” identity. In this stage the individual believes that the dominant group (in this particular model, white individuals), is the desired state of existence- the individual may look up to members of this dominant group as role models who exhibit the ideals in terms of dominant culture, lifestyles, beauty standards, and customs. Eventually, the individual will experience the second stage, encounter, oftentimes through a specific event or experience that increases the salience of his or her “otherness.” In the encounter stage, the individual must face the truth about their own membership in a non-dominant group, as well as navigate the dissonance between what he or she had previously believed regarding the value of the majority group and the reality that he or she is not a member. This stage can be difficult emotionally, as many individuals will struggle with anger, disengagement, and opposition against the dominant group. The individual begins to shift assigned value from the majority culture to elements of his or her own minority culture. As the individual has begun to place more value on their own race, they begin to explore what this identity may mean to them. This includes learning more about the history of identity, exploring customs and foods, and displaying symbols representing the “othered” identity, while also becoming less hostile and more indifferent toward the majority. It is here that the individual is able to begin constructing a positive sense of self. As this positive self-concept is further solidified, the individual has entered the internalization phase, which brings with it a sense of security in the “othered” identity, along with a willingness to create meaningful relationships across the boundaries of social group, including with the majority. And finally, the individual arrives at the internalization-commitment stage, where he or she may incorporate the established identity into ongoing action expressing commitment to the group of individuals who share this “othered” identity (Cross, 1971, 1978; Tatum, 1997).

Cross’s model for Black identity development has since been altered, refined, and expanded, even by Cross himself (Cross, 1991; Vandiver et al., 2001). Originally 5 stages, now the model contains just 4, with the elimination of the internalization-commitment stage. Notable revisions came from the work of Janet Helms and Thomas Parham, separately and together as collaborators. Parham noted that Cross’s original framework has some limitations as a stage model that occurs in adolescence, and thus he proposed that identity development may be revisited at different points in one’s life cycle (Parham, 1989; Tatum, 1997). Helms renamed and reconceptualized Cross’s model, such that the pre-encounter stage was labeled as “conformity,” and the encounter stage was labeled as “dissonance.” Immersion/emersion and internalization remained the same, while instead of internalization-commitment, the fifth stage was labeled “integrative awareness (Helms & Piper, 1994). This model also was conceptualized to be a “circumplex” in which one likely moves through the stages sequentially, but one will likely move throughout the process multiple times across age and experience (Helms & Piper, 1994). Helms also developed a framework for White identity development based on Cross’s original scale, yet with the following six stages: contact, disintegration, reintegration, pseudo-independent, immersion/emersion, and autonomy (Helms, 1984, 1990, 1993; Tatum, 1997). The White identity development model follows a similar trajectory, yet the nature of the reality a White individual must grow to accept involves rejection of individual and institutional racism, while maintaining a positive sense of Whiteness that is not based in superiority (Helms, 1990; Tatum, 1997).

Together, Parham and Helms (1981) developed a scale measure based on Cross's (1971) model, called the Racial Identity Attitudes Scale (RIAS, Parham & Helms, 1981, 1996). Walters and Simoni (1993) then took Parham and Helms' RIAS scale and adapted the model and scale for lesbian and gay identity development, instead of race. In this study, Walters and Simoni (1993) had effectively brought the work of Cross, Helms, and Parham together to apply to a new population of sexual minorities and found support for the parallel application. Scott Button (1996, 2001, 2004) refined the sexual minority identity development scale developed by Walters and Simoni (1993) and further collapsed Cross's original stage structure to reflect three developmental stages: pre-encounter, immersion/emersion, and internalization. Button (1996, 2001, 2004) who was influenced by the work of Walters and Simoni (1993), as well as the model of homosexual identity development from Cass (1979), conducted a series of factor analyses to test this three stage model, with results strongly supporting the three distinct constructs among a population of gay men and lesbian women as had been supported in Walters and Simoni (1993). Thus, via the work of Walters and Simoni (1993) and Button (1996, 2001, 2004), the minority racial identity development model was successfully adapted to a different population, sexual orientation minorities. The present study follows suit by applying the past 40 years of research on ethnic identity development to a different minority population: individuals with disabilities.

Around the same time that Parham and Helms were adapting Cross's model of Black identity development, Jean Phinney was also developing an identity model based on the works of Erickson (1968), Marcia (1966) and Tajfel and Turner (1986). Phinney (1989) formulated four ethnic identity development stages passed on the four personal identity development stages created by Marcia (1980); diffusion indicated that the individual had not begun the exploration process of their ethnic identity; foreclosure occurred when individuals made commitments without exploration (i.e. committing to the values of their parents); moratorium indicated that the individual was in the process of exploration of their ethnic identity; and finally, ethnic identity achieved reflected individuals who had completed the exploration process and were now committed to an ethnic identity. In an empirical examination of these three stages, Phinney and Alipuria (1990) found support for the relationship between identity and self-esteem, as put forth by Tajfel and Turner (1986). Eventually, Phinney (1992) developed the Multi-group Ethnic Identity Measure (MEIM), a measure designed to capture responses from multiple groups of ethnic minorities in one sample. Previously, models such as Cross's & Helms's were developed to assess one specific race or ethnicity, such as White, Black, or Hispanic. Yet Phinney built her model to reflect the common shared experiences that an ethnic minority member would experience regardless of their actual group membership. As the model and subsequent measure developed by Phinney are based in developmental theory of identity (Erikson, 1968; Marcia, 1966) and the theory of social identity (Tajfel & Turner, 1986), as well as has been designed to reach a diverse population, the present study utilized Phinney's conceptualization of identity development adapted, as per Walters and Simoni (1993) and Button (1996, 2001, 2004), to the identity development of individuals with disabilities.

Disclosure of a Stigmatized Identity

The lived experience of a stigmatized identity is anything but straightforward, and the same is true for individuals with a disability. There has been a great body of literature regarding the process of identity management, or the behavioral strategies and patterns used by individuals to manage the potential negative outcomes associated with their stigmatized identity (Button 1996, 2001, 2004; Chaudoir & Fisher, 2010; Chrobot-Mason, Button, & DiClementi, 2001; Clair et al., 2005; Herek, 1996; Jones & King, 2013; Pachankis, 2007; Ragins, 2008; Roberts, 2005;

Shallenberger, 1994; Woods, 1993). In the process of identity management, the central conflict surrounds the notion of disclosure, telling someone in the context of the workplace about one's stigmatized identity. Disclosure is also a dynamic process, as the individual can make choices about to whom, how much information, and when he or she may disclose. There can be full disclosure, also called revealing, partial disclosure, called signaling, or no disclosure at all, referred to as concealing or passing (Clair et al., 2005; Herek, 1996; Jones & King, 2013). Even among these three disclosure options there are even more nuances, for example, for an individual who conceals his or her identity, do they conceal by avoiding the topic or perhaps they conceal by actively fabricating an alternate identity, or counterfeiting (Button 1996, 2001, 2004; Chrobot-Mason, Button, & DiClementi, 2001; Clair et al, 2005; Woods, 1993). Utilizing the literature reviewed above, along with Tajfel and Turner's (1986) Social Identity Theory and the developmental findings of Erikson (1968) and Marcia (1966), the present study hypothesized the following relationship:

Hypothesis 1: The development of a disability identity in an individual with a disability will increase the likelihood for that individual to disclose his or her disability status at work.

The process of disclosure of one's stigmatized identity, regardless of strategy, is an extremely significant decision for an employee (Johnson & Joshi, 2016), one that Clair et al. (2005) describes as "central and significant in interpersonal interactions at work," (p. 81). The process of disclosure carries an inherent risk- what if the individual is not accepted, penalized, or discriminated against based on the disclosed stigma? Thus, there is great variation among individuals and the identity management strategies they will use to manage their stigmatized identity. For example, von Schrader, Malzer, & Bruyere (2014) found that 80.3% of participants with a variety of disabilities chose to disclose their disability at work, with the need for an accommodation as the most common reason for disclosure (as a reminder, an individual with a disability cannot be granted accommodation until he or she discloses that they have a disability). Brohan and Thornicraft (2010) found similar rates of disclosure of mental illness disclosure at work (87%), while the most common reasons for disclosure in this study were due to a time of crisis in which the employee is no longer able to conceal, or when the employee felt valued and secure enough in the workplace to disclose. There are also differences in disclosure trends depending on the features of the disability. Baldridge and Swift (2013) found that those with congenital disabilities disclosed more often than those with acquired disabilities, while those with concealable disabilities do not disclose as frequently as individuals with a visible disability (Colella & Stone, 2005; Santuzzi & Waltz, 2016).

There are a number of reasons for employees to choose to disclose or conceal a stigmatized identity. Ellison, Russinova, MacDonald-Wilson, and Lyass (2003) report that individuals who did not disclose their disability status chose not to disclose because they believed it would lead to discrimination from colleagues. Johnson and Joshi (2016) found that disclosure acted as a moderator strengthening the negative relationship between age of onset of autism and indicators of well-being, such that individuals diagnosed later in life who disclosed this diagnosis were more likely to have decreased organizational-based self-esteem. These are two undesirable outcomes associated with disclosure; however there are also negative outcomes associated with concealment, or not disclosing a stigmatized identity. For example, Madera, King, and Hebl, (2012) found that participants who concealed their stigmatized identity had higher perceptions of perceived discrimination, which then significantly predicted job satisfaction and turnover intentions. Concealing one’s stigmatized identity involves considerable cognitive resources (Baumeister, 1989), and from the perspective of the job-demands-resources model, when an employee engages in the higher levels of self-regulation needed to conceal, he or she will have less available resources to devote to the job tasks at hand (Demourati, Bakker, Nachreiner, & Schaufeli, 2001; Jones & King, 2013). With fewer resources available, individuals who conceal a stigmatized identity have decreased levels of employee engagement (Jones & King, 2013).

Aside from negative job-related outcomes from concealment, there are also undesirable psychological outcomes such as anxiety, depression, and lower self-esteem (Santuzzi & Waltz, 2016; Quinn & Earnshaw, 2011). The disclosure dilemma deepens when considering the results from Waldo's (1999) results indicating that both employees who disclosed their stigmatized identity and employees who did not faced the same stress and adverse effects (Chrobot-Mason, Button, & DiClementi, 2001).

Though there are risks of negative outcomes for both sides of the disclosure dilemma, there has also been support for positive outcomes. Individuals who disclose their stigmatized identity are able to truly be themselves in the workplace and present an authentic version of themselves (Clair et al., 2005). Others have purported that disclosing one's stigmatized identity could in fact be the impetus for positive social change to reduce stigmatization, both in that specific organization and society as a whole (Creed & Scully, 2000; Nittrouer, Trump, O'Brien, & Hebl, 2014). Revealing one's stigmatized identity has been linked with positive organizational outcomes like increased job satisfaction, increased job commitment, and higher quality relationships with coworkers (Button, 2004; Chaudoir & Quinn, 2010; Jones & King, 2013; Madera, King, & Hebl, 2012).

The outcomes associated with disclosure are varied, and the literature supports both positive and negative outcomes associated with both concealment and disclosure of a stigmatized identity. The present study explores additional evidence to determine the nature of the relationships among several of the most impactful personal and professional outcomes associated with disclosure. Theoretically, researchers have long purported the potentially negative personal and psychological outcomes associated with concealment of a stigmatized identity (Clair et al., 2005; Goffman, 1963; Jones & King, 2013; Ragins, 2008), however one also runs the risk of backlash or differential treatment once the identity is disclosed (Baldridge & Veiga, 2006; Clair et al, 2005; Colella & Bruyere, 2011; Herek, 2009). Numerous researchers have examined how concealment or disclosure may impact an individual's self-esteem (Corrigan & Matthews, 2003; Ilic et al., 2012; Jones & King, 2013; Santuzzi & Waltz, 2016; Shallenberger, 1994; Ragins, 2008; Quinn & Earnshaw, 2011) well-being and satisfaction with life (Chrobot-Mason, Button, & DiClementi, 2001; Fassinger, 1996; Ibarra, 1999; Uysal, Lin, & Knee, 2009). Another important personal outcome that is likely to be affected by one's disclosure decisions is the individual's level of self-efficacy in managing his or her disability (Hahn & Belt, 2004). If one chooses to conceal his or her disability at work, it could be more difficult to engage in behaviors required for healthy treatment and maintenance of the condition. Thus, the present study includes the following research question:

> *Research Question 1: Will the disclosure of one's disability status be positively related to the personal outcomes of self-esteem, life satisfaction, and health management self-efficacy?*

In addition to personal outcomes associated with disclosure, the individual is also likely to incur impact on professional outcomes, which contribute to the organization as a whole. For example, employee engagement is a construct linked to financial outcomes in an organization (Xanthopoulou, Bakker, Demourati, & Schaufeli, 2009). However, the National Organization on Disability reports data which indicate that employees with disabilities have lower levels of employee engagement than non-disabled employees (Rutigliano & O’Connell, 2013). This data does not include information regarding disclosure or concealment, which, along with other research (Baumeister, 1989; Demourati et al., 2001; Jones & King 2013), suggests that further study is warranted regarding the relationship with employee engagement. Two additional organizational outcomes, job satisfaction and turnover intentions, have been heavily investigated in the stigma literature as connected to an individual’s decision to conceal or disclose (Abraham, 1999; Button, 2004; Chaudoir & Quinn, 2010; Cote & Morgan, 2002; Day & Schoenrade, 1997; Griffith & Hebl; 2002; Hochschild, 1983; Jones & King, 2013; Madera, King & Hebl, 2012; Morris & Feldman, 1996; Ragins & Cornwell, 2001; Ragins, Singh & Cornwell, 2007; Roberts, 2005; Wrzesniewski, Dutton, & Debebe, 2003). Employee engagement, job satisfaction, and turnover intentions are each critical components of organizational success, yet could manifest very differently depending on the nature of an employee’s disclosure decisions. Thus, the present study includes the following research question:

> *Research Question 2: Will the disclosure of one’s disability status be related to the professional outcomes of employee engagement, job satisfaction, and turnover intentions?*

Stigmatized Identity Management

As evidenced above, disclosure (or lack of disclosure) is a nuanced and dynamic process, one of which there has been a great deal of organizational literature. At the most basic level of disclosure, an individual with a stigmatized identity such as disability can either choose to disclose or to conceal his or her identity (Button, 2004). Disclosure, or revealing, can manifest in a number of behavioral patterns. Woods (1993) termed full disclosure as integration, where the individual fully reveals his or her stigmatized identity and attempts to manage the consequences (Button, 2004). Shallenberger (1994) took integration one step further, and posited that integration can occur in one of two strategies, acknowledging or advocating. Acknowledgment is simply when an individual has disclosed via integration tactics, and they simply acknowledge their identity in the process (Shallenberger, 1994). It is considered to be a relatively passive method of disclosure; the individual may make telling remarks, or openly discuss aspects of the identity when asked (Button, 2004). Advocating, on the other hand, occurs when an individual takes a more active approach toward disclosure (Shallenberger, 2004), such as intentionally engaging in conversations about his or her stigmatized identity, creating opportunities to reveal his or her identity to coworkers, and actively seek opportunities to contribute to conversations that would be relevant to the stigmatized group of which they belong (Button, 2004).

Another set of revealing strategies are proposed by Clair et al. (2005) as signaling, normalizing, and differentiating. Signaling is considered a form of revealing, though not completely revealing one’s stigmatized identity. Behaviorally, involves dropping subtle hints, giving clues, or using specific language to imply membership in a stigmatized group, which in turn allow for speculation among coworkers (Clair et al., 2005; Woods, 1993). Signaling is especially advantageous for individuals who may be entering a new environment and are unsure of how that particular environment would react to his or her stigma identity. Signaling allows an individual to test the waters with smaller, lower risk hints or clues that are not entirely transparent, thus still allowing some self-protection until they are confident that the context is safe to reveal more explicitly (Clair et al., 2005). Normalizing is a disclosure strategy in which one reveals his or her identity, and strives to blend in to the organization as much as possible, perhaps insisting that the stigmatized identity is not abnormal, but in fact commonplace (Clair et al., 2005). Benefits for normalizing include the preservation of emotional balance and to reduce alienation or being set apart because of one's differences (Royer, 1998). And finally, the third strategy for disclosing one's stigmatized identity from Clair et al. (2005) is differentiating, which is essentially the opposite of normalizing- here individuals strive to highlight their stigmatized identity in a positive way, illustrating how it sets them apart from others, and even engaging in efforts to reduce the negative attitudes associated with the particular stigma.

As there are multiple behavioral strategies for how one reveals a stigmatized identity, there are several different behavioral strategies that one may use to conceal this identity. Also called passing, concealment allows individuals to be classified as a member of the dominant social group, without others knowing of the true devalued stigmatized identity (Clair et al., 2005). The first type of concealment strategy is counterfeiting (Button, 2004; Woods, 1993), also known as fabrication (Clair et al., 2005; Herek, 1996). In this strategy an individual not only conceals his or her stigmatized identity, but actively creates and maintains a false non-stigmatized identity. For example, a homosexual man may counterfeit by discussing his weekend plans to take a trip with his girlfriend, which indicates that he is heterosexual. The next concealment strategy is known as avoiding (Button, 2004; Woods, 1993), or discretion (Clair et al., 2005; Herek, 1996). When an individual conceals their stigmatized identity by avoiding, they are not actively hiding personal information, but rather striving to remain neutral by eluding conversation topics, changing the subject when asked, or avoiding personal questions in general (Chrobot-Mason et al., 2001; Clair et al., 2005; Woods, 1993). Individuals with stigmatized identities are faced with the disclosure dilemma nearly every day, across social contexts, and thus they must make decisions about disclosure constantly (Clair et al., 2005; Friskopp & Silverstein, 1987; Schneider, 1987). Each of these strategies for disclosure, whether one is revealing or concealing, are likely to be employed by different people at different times, based on the context, ultimately indicating that stigmatized individuals will utilize a combination of the listed strategies instead of one single strategy at all times (Button, 2004).

Aside from serving as the medium for which an employee can navigate the degree of disclosure they feel comfortable with, identity management strategies can also be utilized as tools for professional image construction, which has important implications for social approval, organizational advancement, power, and career success (Ibarra, 1999; Leary & Kowalski, 1990; Roberts, 2005). Employees often desire to obtain a certain self-presentation which allows them to be perceived as a competent professional (Baumeister, 1989), resulting in what Roberts (2005) refers to as one's desired professional image. Societally, the prototype for professional success is often an individual who is a member of dominant social identities- a heterosexual, white, non-disabled, male. Thus, individuals who are members of minority groups may choose to decrease the emphasis on the parts of their identity that differ from those of this prototype for success (Roberts, 2005). When stigmatized individuals are seeking a specific desired professional image, they will engage in identity management strategies to achieve that perception. These strategies are similar to those previously discussed with some overlap, but are distinct in that they are used based on the specific motivation to construct a professional image which is believed to lead to career success.

Roberts (2005) elucidates a framework of professional image construction strategies employed by stigmatized individuals, called social identity-based impression management (SIM). Roberts (2005) formulated this framework based on impression management theory, which holds that an individual strategically shapes the perceptions of others' perceptions of the individual to portray his or her desired professional image. The process of impression management involves monitoring others perceptions, a motivation to change those perceptions, and the construction of a persona designed to alter the perceptions of others (Leary & Kowalski, 1990; Roberts, 2005). In Roberts's (2005) model, there are two options, each with two sub-strategies, for employees to engage in SIM. The two strategies mirror the previously discussed elements of disclosure, revealing or concealing, whereas Roberts's (2005) model uses the terms positive distinctiveness strategies (revealing) and social recategorization (concealing). Despite the overlap between models in this way, the sub-strategies within positive distinctiveness and social recategorization reflect various motivations for achieving one's desired professional image. Positive distinctiveness strategies reflect the notion that although one's social identity may be stigmatized and socially devalued, not all individuals will want to reduce the salience of this identity (Bell & Nkomo, 2001), thus the individual will engage in strategies to increase the positive perceptions of the social identity. One way individuals engage in this process is through integration (not to be confused with the same term used previously in Woods (1993) and Button (2004)), where an employee will actively play up positive aspects of their identity, whether it is based on truth or stereotype. Roberts's (2005) integration also includes challenging the negative perceptions and stereotypes of the social identity held by others. The second positive distinctiveness strategy is called confirmation, which involves an individual capitalizing on his or her stigmatized identity to gain desired rewards and outcomes (Roberts, 2005). Confirmation involves active leverage of a particular social identity, such as a woman appearing motherly to gain desired outcomes.

While positive distinctiveness strategies involve an inherent disclosure of one’s stigmatized identity, social recategorization involves an inherent concealment of the identity. In this option, individuals use either decategorization or assimilation to apparently change the social identity group to which they belong by reducing its salience (Roberts, 2005). Decategorization occurs when an individual avoids being classified in any particular group, rather the individual deemphasizes any social identity groups they belong to and focuses on the ways they are unique as an individual (Roberts, 2005). Assimilation, on the other hand, involves reducing the salience of one’s stigmatized social identity and attempting to be categorized as a member of the dominant, non-stigmatized social identity group (similar to previously discussed counterfeiting or fabrication) (Roberts, 2005).

Hypothesis 2: The development of a disability identity in an individual with a disability will increase the likelihood for that individual to use stigmatized identity management strategies.

Hypothesis 3: The use of stigmatized identity management strategies will partially mediate the relationship between disability identity and disability disclosure.

Hypothesis 4: The use of stigmatized identity management strategies mediates the relationship between disability identity and disability disclosure; however, this mediated relationship is moderated such that high levels of disability visibility will strengthen the direct and indirect effects.

CHAPTER 3

METHOD

Sample

The present study includes participants recruited from an online crowdsourcing participant pool called Mechanical Turk, or MTurk. Convenience sampling via MTurk has been suggested by diversity researchers as a unique and effective way to sample special populations, like minority groups (Smith, Sabat, Martinez, Weaver, & Xu, 2015). For inclusion in the study, adults must have been 18 years of age or older and they must be employed full-time or part-time at the time of the study or within the previous six months. Employment is described to participants as a paid position with a company, held presently or within the past 6 months. To aid in the understanding of the experiences of individuals with disabilities, prior researchers have called for additional study directly within samples of individuals with a disability (Feldman, 2004; Link & Phelan, 2001). The present study advances the understanding of the unique experiences of individuals with disabilities, and thus to be included in the study participants must have self- identified as an individual with a disability. This was accomplished via a brief initial screening survey, with approximately 10 broad demographic items. Participants were instructed that their participation in the larger study will depend on whether they meet certain qualifications as determined by this screening survey. Therefore, this screen included items to determine if participants have a disability, as well as items that are not of interest in the present study, but served the purpose of concealing the desired variables within the screening survey.

All participants were paid, regardless of their inclusion in the present study. Any participant who took the initial screening survey were paid 10 cents, yet if they were identified as an individual with a disability through the screen, they were paid an additional $1.50 for participation in the larger survey. Over the course of data collection, 1,653 individuals participated in the screening survey, with 600 of these individuals indicating that they had a disability. Several cases were removed due to lack of consent, lack of qualifying employment, and failure to correctly respond to the attention check items throughout the full survey, resulting in a final sample size of n = 541.

Demographic characteristics for the final sample were as follows. Participants were 63.2% female, and 79.7% Caucasian or White , 6.8% African American or Black, 6.3% Multiracial, 3.7% Asian American, Asian, or East Indian, 3.1% Hispanic or Latino, and .4% American Indian or Alaska Native. The majority of the sample (57.1%) was between the ages of 18-34. The highest completed level of education was a Bachelor’s Degree (38.6%), followed by some college but no degree (27.5%), Master’s Degree (13.7%), Associate’s Degree (10.7%), High School or equivalent degree (6.5%), Professional Degree (i.e., J.D., M.D.) (1.5%), and Ph.D. (1.5%). Among the participants, 7.2% were United States Military Veterans.

Several job related demographic variables were obtained, indicating that 75% of the sample were employed full-time, reporting a wide range of annual income from less than $10,000-$39,999 (53.8%), to $40,000-$79,999 (34.4%), and $80,000 to over $150,000 (11.8%). Participants had relatively short tenure at their current organizations, with 48.6% indicating that they had been employed for less than 2 years at their current organization. An additional 25% indicated their organizational tenure as 3-5 years, followed by 15.5% at 6-10 years, 8.7% at 11-20 years, and 2.2% at over 20 years. A variety of industries were represented in the sample, with the most individuals reporting that their organizations were in Healthcare or Social Assistance (13.7%), Educational Services (13.3%), and Retail Trade (11.1%). The full list of industries represented may be found in Table 1, located in Appendix A. Regarding leadership status of participants, 33.5% reported that they held a formal leadership position within their organization.

Procedure

All measures were completed through an online survey created using Qualtrics survey building software, which the participants accessed through the MTurk system. Participants were given the opportunity to read and sign statements of informed consent, as were approved by the Institutional Review Board. With their informed consent, participants were administered an electronic survey containing the demographic variables discussed above. They were instructed that this is a screening survey, and that if they were to meet the conditions of participation, they will automatically advance to the larger study survey. Participants who did not meet the conditions for participation were debriefed, thanked for their participation, and paid the 10 cents for completing the survey screen.

Participants moving on to the larger study took a series of measures reflecting the study variables, each of which is detailed below. Once complete, these participants were debriefed, thanked for their participation, and paid $1.50 in addition to the 10 cents for completing the screen and the larger survey.

Measures

Disability. The present study used the legal definition of disability as designated in the ADA to determine participants' disability status. However, as previously discussed, many individuals who meet the qualifications for legal protection may not realize that they do in fact qualify, or even if they are aware, they may not perceive their condition to be a disability. Thus, the present study asked participants about their disability status in a number of ways to ensure a representative sample. Participants answered the following items, “Do you consider yourself to have, or have ever had, a physical or mental disability?” and, “Do you have, or have ever had, a physical or mental condition in which you would be legally and/or medically considered to have a disability?” If individuals with a disability were still unaware that they were legally considered to be an individual with a disability, the final item listed several specific conditions that meet the qualifications for ADA protection that are not often thought to be a disability, “Are you under the care of a medical professional and/or are taking medications for any of the following conditions: depression, diabetes, cancer, epilepsy, attention deficit hyperactivity disorder (ADHD/ADD), or anxiety?” If answered affirmatively, participants then read an informational paragraph explaining that the present study used the legal definition of a disability, which includes the condition they indicated, regardless of the participants’ own categorization. Of the 541 individuals with a disability in the final sample, only 171 (31.6%) answered the first disability screening question as affirmative, indicating that they have a disability, while the remaining 370 (68.4%) had initially answered this question as “No,” indicating that they did not have a disability. This demographic breakdown provides an interesting insight- only 1/3 of the individuals with a disability in the study initially identified themselves as such. The nature of the screen being framed as a qualifying survey for the larger study could have caused the remaining 2/3 of participants to answer inaccurately when asked directly about disability status, as they may have believed an affirmative answer may disqualify them from the main study. However, it is also likely that many of these individuals simply did not know that the mental or physical health condition they experience is in fact considered to be a disability. Thus, when these 370 participants were asked if they had one of the listed health conditions, these individuals answered affirmatively. Asking participants about disability in a number of ways maximized the number of participants who indicate that they have a disability, and thus were able to advance beyond the demographic screen to participate in the larger study.

The above items resulted in 30 different specific disabilities represented. The sample largely consisted of individuals with Depression (27.9%), Anxiety Disorders (22.4%), and ADHD/ADD (9.6%). The remaining 40% of individuals indicated a variety of other disabilities such as Post-Traumatic Stress Disorder (PTSD), Diabetes, Cancer, Bipolar Disorder, Paraplegia or Quadriplegia, and Epilepsy, among various others. A full list of the disabilities represented by the sample participants may be found in Table 2, located in Appendix B.

Once it was affirmed that the individual had a qualifying disability, they were asked a series of items regarding the nature of the disability. The length of time one has experienced the disability was assessed with the item, “How many years have you had this impairment?” followed by response options in years. Frequency of symptoms was assessed with, “Generally, how often do you experience symptoms?” with response options on a 5-point Likert scale (*1= Never*, *5=Daily*). Severity of symptoms was assessed with, “Generally, how severe are your symptoms?” followed with a 5-point Likert scale response format (*1= Mild*, *5=Severe*).

A majority of participants indicated that their disability is permanent (52.3%), with the remaining participants indicating that their disability is considered intermittent (24.6%), situational (16.5%), or temporary (6.7%). Among reports of length of time since diagnosis, the most frequent response was that the participants had been diagnosed for their entire lifetime (19.2%), followed by a diagnosis for 2-4 years (17.4%), 5-7 years (14.4%), and 8-10 years (13.3%). Regarding the frequency of symptoms experienced, the largest number of participants indicated that they experience symptoms daily (35.1%), followed by several times a week

(24.6%), and several times a month (19.6%), while the severity of symptoms experienced were most frequently considered moderate (56.9%) or severe (24%).

Identity Development. Identity development was measured using an adapted version of the Multigroup Ethnic Identity Measure (MEIM; α = .93), developed by Phinney (1992). The most recent iteration of the measure includes 12 items corresponding with two scales: Affirmation/Belonging/Commitment (7 items; α = .92) and Exploration (5 items; α = .79) (Roberts et al., 1999; Yap, et al., 2014). These items were adapted to be used within a population of individuals with a disability by replacing terms such as "ethnicity" or "ethnic background" with terms like "disability" or "disability status." Sample items include, "I have a clear sense of my disability and what it means for me," (Affirmation/Belonging/Commitment), and, "To learn more about my own membership in the disability community, I have often talked to other people about my disability," (Exploration). The full scale can be found in Appendix C.

Identity Management Strategies. Based on the theoretical framework of Roberts (2005) regarding concealable stigma, Lynch and Rodell (2015) developed a Stigmatized Identity Stages Scale (α = .85). The present study used this measure to assess the behavioral practices of disclosure among participants. Consistent with Roberts (2005), the 16-item scale reflects four categories of stigmatized identity management, assimilating (α = .88), decategorizing (α = .90), integrating (α = ..93), and confirming (α =.87), with 4 items representing each area. In the present study, items were modified to anchor the items as referring to the participants' disability, as opposed to the more general terminology used in the original measure (e.g. "my disability," instead of, "this concealable identity"). Sample items include, "I display strengths consistent with more positively regarded groups over my identity as an individual with a disability. (Assimilating)," "I emphasize my unique traits over any group identity. (Decategorizing)," "I portray the favorable attributes of my identity as an individual with a disability. (Integrating)," and, "I try to profit from the qualities related to this identity (Confirming)." The full scale can be found in Appendix C. Responses were obtained using a 5-point Likert scale where participants will indicate the level of agreement with each statement (1= *Strongly Disagree*, 5= *Strongly Agree*).

Disclosure. In organizations in which the Section 503 regulations apply, disclosure is considered to be an affirmative response ("Yes, I have a disability") on the OFCCP's Form CC-305 (Voluntary Self-Identification of Disability; United States Department of Labor, Office of Federal Contract Compliance Programs, 2016), which can be found as Figure 1 in Appendix D. Thus, in the present study, disclosure was operationalized as the likelihood of future disclosure on Form CC-305, which was assessed with 4 items (α = .72). Participants viewed Form CC-305 and were asked to indicate the likelihood that they would respond to each of the form's three response options, ("Yes, I have a disability (or previously had a disability)," "No, I do not have a disability," and "I don't wish to answer"), as well as the likelihood that they would not respond to the form at all. Response options for each of these four items were 5-point Likert scale format (*1= Not at all likely, 5=Extremely likely*). The full list of items can be found in Appendix C.

Boundary Conditions

A number of variables were collected for use as boundary conditions for the proposed model, as well as to be utilized as potential controls. For example, the decision to disclose or conceal may be influenced by one's personality, such that individuals higher in openness to experience may be more likely to disclose a stigmatized identity than those with lower levels (Clair et al., 2005). Therefore, personality, along with several other variables listed below, were collected to be used if necessary to statistically control for the degree of variance for which they may be responsible.

Visibility. The degree to which one's disability is detected by the naked eye was measured with an adapted version of Button's (1996) identifiability scale ($\alpha = .69$). The scale was created for gay and lesbian populations, so where the items referenced the individual's sexual orientation, the words "individual with a disability" were substituted. The 3-item scale follows a 5-point Likert response scale format (1= *Strongly Disagree,* 5= *Strongly Agree*). The adapted items are as follows, "People usually identify me as an individual with a disability right away.," "People never realize that I am an individual with a disability unless I tell them.," and, "It is not hard for others to tell that I am an individual with a disability." The items are reproduced in Appendix C.

Personality. To address the possibility that one's inherent personality traits and preferences may be a factor that influences their decisions regarding disclosure, a measure of personality was used as a control variable. The Ten Item Personality Inventory (TIPI; Gosling, Renfrow, & Swann, 2003) was used to assess participants' personality traits from the Big Five personality typology. Thus, the TIPI includes items assessing each of the Big Five personality traits, Extraversion ($\alpha = .744$), Agreeableness ($\alpha =.45$), Emotional Stability (sometimes denoted as Neuroticism; $\alpha =.79$), Openness to Experience ($\alpha =.46$), and Conscientiousness ($\alpha =.60$). Gosling, Renfrow, and Swann (2003) encourage users to consider the sub-scale coefficient alphas with caution, as there are only two items per subscale, but offer that researchers should utilize test-retest reliability correlations as an additional source of reliability. However, since the present study only consisted of a single data collection time point, this was not an option. The ten-item scale presented participants with statements such as "I see myself as extraverted, enthusiastic.," and "I see myself as conventional, uncreative." The full scale may be found in Appendix C. Response options were obtained on a 5-point Likert scale based upon the participants' level of agreement with each statement (1= *Strongly Disagree*, 5= *Strongly Agree*).

Social Desirability. As is best practice among researchers exploring sensitive subjects (Ones & Viswesvaran, 1998), a measure of social desirability was included as a control measure in the present study. Having a disability is highly stigmatized, and thus participants may be reluctant to share information that they perceive may be socially undesirable. Utilizing a short version (13 items, α =.299) of the Marlowe-Crowne Social Desirability Scale (Reynolds, 1982), the present study was able to control for social desirability in responses. Sample items include, "I sometimes feel resentful when I don't get my way." and, "I am sometimes irritated by people who ask favors of me." Participants responded to each item by indicating whether the statement is true or false. The full scale may be found in Appendix C. Despite the sub-optimal reliability coefficient, consistent with previous research, (e.g., Aquino, Lewis, & Bradfield, 1999), a social desirability scale composite was created and correlated with all other survey items. If a correlation between the social desirability composite and any one item is at or above .30, this item should be dropped. Following this procedure, no items were found to be correlated with the social desirability composite at a level that warranted removal. This procedure, along with the poor internal consistency of the measure attributed to the removal of this scale from additional analyses.

Demographics

Various demographic variables were measured as is standard in psychological study; age, gender, race/ethnicity, employment status (full or part-time), industry, leadership role, salary, tenure, education, marital status, and veteran status were measured in the initial screening survey for use as potential control variables.

Associated Disclosure Outcomes

Though disclosure was the primary outcome of interest in the present study, there were also additional outcomes that are likely associated with an individual's disclosure decisions. The following variables are considered to be important, but less proximal, outcomes of study. They have been incorporated in the study as elements in the research questions, as there has been limited or mixed evidence in the extant research regarding the exact nature of these relationships.

Self-Esteem. Self-esteem were be measured by using the 10-item Self-Esteem Scale (α = .93) by Rosenberg (1965). Sample items include, "I feel that I have a number of good qualities.," and, "One the whole, I am satisfied with myself." A complete list of items can be found in Appendix C. Responses were in a 5-point Likert scale format, where participants indicated the level of agreement with each statement. (1= *Strongly Disagree*, 5= *Strongly Agree*).

Life Satisfaction. As an overall indicator of satisfaction in multiple facets of life, participants completed the Satisfaction With Life Scale (SWLS; α =.92) from Diener, Emmons, Larsen, and Griffin (1985), which has previously been utilized in disability research (see Bogart, 2014). The 5-item scale consists of items such as, "I am satisfied with my life.," and, "In most ways, my life is close to my ideal." A complete listing of items can be found in Appendix C. Participants indicated the level of agreement with each statement by using a 5-point Likert scale response format (1= *Strongly Disagree*, 5= *Strongly Agree*).

Health Management Self -Efficacy. The degree to which individuals feel a sense of agency about the management of their disability was measured using an adapted scale created by Lorig, et al., (2001; Lorig, 1996) for the Stanford Chronic Disease Self-Management Study. The scale includes 6 items (α =.87), presented by asking the participant to indicate how confident he or she is in executing each items. The scale was developed to measure a broad range of chronic illnesses and diseases, so where the item referenced the participant's "disease", the word "disability" was substituted. Responses will be in a 5-point Likert scale format (1= *Not at all Confident*, 5= *Extremely Confident*). Sample item statements include, "You can keep the fatigue caused by your disability from interfering with the things you want to do," and, "You can do all the tasks and activities needed to manage your disability so as to reduce your need to see a doctor." The full scale of items can be found presented in Appendix C.

Employee Engagement. The level of employee engagement experienced by participants was measured using the Utrecht Work Engagement Scale (U-WES; Schaufeli & Bakker, 2003). Employee engagement is operationalized with three facets, dedication, vigor, and absorption. The 15-item U-WES has 5 items per each of these three facets. Sample items from each of the three facets include, "I am proud of the work that I do. (Dedication)," "When I get up in the morning, I feel like going to work. (Vigor)," and, "Time flies when I am working. (Absorption)." A complete list of items can be found in Appendix C. All responses are on a 5-point Likert scale, where participants indicated the level of agreement with each statement (1= *Strongly Disagree*, 5= *Strongly Agree*). Reliability estimates are as follows, α = .90 (Dedication), α = .85 (Vigor), α = .79 (Absorption), and α = .93 as an entire 15-iem measure.

Turnover Intentions. To measure the participants' level of intention to leave the organization, the present study utilized the Turnover Intentions Scale developed by Adams and Beehr (1998). This scale consists of the following three items (α = .92), "It is likely that I will actively look for a new job in the next year," "I often think about quitting my job," and, "I will probably look for a new job in the next year." Items are reproduced in Appendix C. Responses will be collected using a 5-point Likert scale where participants indicated the level of agreement for each item (1= *Strongly Disagree*, 5= *Strongly Agree*).

Job Satisfaction. The participants' level of job satisfaction was assessed using a five item scale (α = .91) developed by Brayfield & Rothe (1951). Sample items include, "I feel fairly satisfied with my present work," and, "I find real enjoyment in my work." The full scale can be found in Appendix C. A 5-point Likert scale was the response format in which participants indicated the level of agreement with each item (1= *Strongly Disagree*, 5= *Strongly Agree*). Coefficient alpha is estimated at .87 (Brayfield & Rothe, 1951).

CHAPTER 4

ANALYSES & RESULTS

Descriptive Statistics

Descriptive statistics including variable means, standard deviations, intercorrelations, and coefficients alpha for the primary study variables were calculated in IBM SPSS Statistics software version 19.0 (IBM Corps, 2010) and are displayed in Table 3. Utilizing recommendations from Carlson & Wu (2012) and Neter & Wasserman (1990), all potential control variables were correlated with the outcome variable, disclosure. From the proposed boundary conditions, neither personality nor social desirability was found to be significantly correlated with the outcome variable disclosure. Of the demographic variables, organizational tenure and age were significantly correlated with disclosure. Thus, age was retained as a control variable in subsequent hypothesis testing analyses.

Confirmatory Analyses

Confirmatory factor analyses (CFA; Anderson & Gerbing, 1988; Lance & Vandenberg, 2002) were used to examine the latent factor structures and assess the fit of the measurement model for each of the study variables. An important distinction between CFA and other types of factor analyses is that the models are determined a prioi and thus procedures are largely guided by theory (Lance & Vandenberg, 2002; Little, Lindenberger, & Nesselrode, 1999; James, Mulaik, & Brett, 1982). All CFAs were completed in M*plus* statistical software (Muthén & Muthén, 2007).

Table 3

Means, standard deviations, and correlations of primary study variables

	Variable	M	SD	1	2	3	4	5	6	7	8	9	10	11
1	Disability Identity	2.62	.89	(.93)										
2	ID MGMT Strategies	3.24	.64	0.34**	(.85)									
3	Visibility	1.82	.87	0.25**	.07	(.67)								
4	Disclosure	3.24	.97	0.22**	0.13**	0.2**	(.72)							
5	Age	2.54	1.13	-.01	.03	.00	0.13**	n/a						
6	Employee Engagement	3.29	.83	0.2**	0.29**	.02	.04	0.16**	(.93)					
7	Job Satisfaction	3.37	1.11	0.12**	0.25**	-.04	.06	0.12**	0.81**	(.91)				
8	Turnover Intentions	2.89	1.38	-.08	-0.11**	.02	-0.13**	-0.15**	-0.52**	-0.66**	(.92)			
9	Self-Esteem	3.44	.97	0.1*	0.17**	-0.14**	-0.09*	0.24**	0.44**	0.46**	-0.31**	(.93)		
10	Life Satisfaction	2.87	1.12	0.21**	0.21**	-.07	-.07	-.02	0.49**	0.49**	-0.38**	0.63**	(.92)	
11	Health MGMT	3.34	.92	.02	0.19**	-0.13**	-0.09*	0.14**	0.44**	0.42**	-0.27**	0.53**	0.44**	(.87)

Note. N=541; * indicates p <.05; ** indicates p<.001. Coefficient alpha are reported in parentheses on the diagonal.

Best practice recommends the use of several types of fit indices to evaluate model fit (Lance & Vandenberg, 2002; Tanaka, 1993; Hu & Bentler, 1999; Marsh, Balla, & McDonald,1988), thus the following indices were utilized to determine model fit: the chi-square (χ^2) goodness of fit statistic, the comparative fit index (CFI; Bentler, 1990), the Tucker-Lewis index (TLI; Tucker & Lewis, 1973), the root mean square error of approximation (RMSEA; Steiger, 1990), and the standardized root mean square residual (SRMR; Bentler, 1995). For a model to demonstrate adequate fit, the CFI and TLI values should be greater than .90, the RMSEA value should be less than .08, and the SRMR value should be less than .10. For the model fit to be considered good, a more stringent set of cut off values should be met; CFI and TLI values should be greater than or equal to .95, the RMSEA value should be at .06 or lower, and the SRMR value should be at .08 or below (Hu & Bentler, 1999).

CFAs were conducted on all latent variables utilized in the study; however, three of these variables are of greater interest for discussion: disability identity development (DID), stigmatized identity management strategies (IDST), and likelihood of disclosure. Regarding DID, the present study has adapted a pre-existing scale of identity development, originally designed for use among ethnic minorities (Phinney, 1992) to be used in a different minority population, individuals with disabilities. Some minor semantic changes were made among the original measure's items (see the Measures section above for review), thus its measurement model was tested along with additional alternative models (Vandenberg & Grelle, 2009) to confirm the validity of the latent construct and its dimensions within this adapted format and new population. First, a single factor solution was tested (χ^2 (66) =355.093, $p<.05$; CFI = .86, TLI = .83, RMSEA= .11, SRMR= .06), followed by a 2-factor solution, which resulted in better model fit than the single factor model (χ^2 (53) =316.361, $p<.05$; CFI = .87, TLI = .85, RMSEA= .09, SRMR= .06; $\Delta\chi^2(13)= 40.177$, $p <.001$). Though the 2-factor model did fit the data better (as was expected based on previous research from Phinney, 1992), the fit indices still do not indicate an adequate model fit. Thus, standardized factor loadings were examined, and one item on each of the two dimensions were found to have with very low factor loadings (.22 and .395) relative to the other factor loadings within each dimension (ranges of .58-.881 and .546-.685 respectively). Once each of these items had been removed from the model, the 2-factor solution was retested and determined to have much improved and acceptable fit (χ^2 (34) =131.909, $p<.05$; CFI = .95, TLI = .93, RMSEA= .07, SRMR= .04; $\Delta\chi^2(19)= 201.79$, $p <.05$). Thus, a 10-item scale was used for future analyses. All CFA results for DID as well as chi-square difference tests can be found in Table 4.

The stigmatized identity management scale was developed relatively recently (Lynch & Rodell, 2015), thus it was of interest to provide additional evidence for its construct validity. As with DID, the first model tested was a single factor or global model solution (χ^2 (104) =2510.298, $p<.05$; CFI = .37, TLI = .28, RMSEA= .20, SRMR= .22). The results indicated poor fit, thus based on theory (Roberts, 2005), a 2-factor model representing the dimensions of "revealing" behaviors and "concealing" behaviors. This 2-factor model improved the fit and represented a significant difference in the chi square statistic, however the model still did not meet acceptable fit indices standards (χ^2 (103) =1475.099, $p<.05$; CFI = .64, TLI = .58, RMSEA= .15, SRMR= .13; $\Delta\chi^2(5)= 163.64$, $p <.05$). Finally, as per Roberts (2005) and Lynch and Rodell's (2015) model of stigmatized identity management behaviors, a 4-factor model was tested, representing the four dimensions of affirming, decategorizing, confirming, and integrating.

Table 4

Goodness of fit indices and difference tests for DID model comparisons

Model	χ^2	df	CFI	TLI	RMSEA	SRMR
1. 1-Factor (Global)	355.093*	66	0.86	0.83	0.1	0.06
2. 2-Factor (Exploration & Affirmation/Belonging)	316.361*	53	0.87	0.85	0.09	0.06
3. 2-Factor (Exploration & Affirmation/Belonging; Reduced Items)	131.909*	34	0.95	0.93	0.07	0.04

Model Comparison	$\Delta\chi^2$	Δdf
Model 1 vs Model 2	40.177**	13
Model 2 vs Model 3	201.79*	19
Model 1 vs Model 3	230.586*	32

Note. N= 541; *indicates p<.05;** indicates p<.001

Table 5

Goodness of fit indices and difference tests for IDST model comparisons

Model	χ2	df	CFI	TLI	RMSEA	SRMR
1. 1-Factor (Global)	2510.298*	104	0.37	0.28	0.20	0.22
2. 2-Factor (Reveal (Confirm, Integrate)/Conceal (Assimilate, Decategorize))	1475.099*	103	0.64	0.58	0.15	0.13
3. 4-Factor (Assimilate, Decategorize, Confirm, Integrate)	251.679*	98	0.96	0.95	0.05	0.04

Model Comparison	Δχ2	Δdf
Model 1 vs Model 2	163.64*	1
Model 2 vs Model 3	705.92*	5
Model 3 vs Model 1	908.2*	6

Note. N= 541; *indicates p<.05

Results indicated that this 4-factor solution provided greatly improved and quite good model fit (χ^2 (98) =251.679, p<.05; CFI = .96, TLI = .95, RMSEA= .05, SRMR= .04; $\Delta\chi^2(5)$= 705.92, p <.05). All CFA results for IDST as well as chi-square difference tests can be found in Table 5.

The third and final construct of heightened interest for this stage of the analyses was the scale developed by the researcher to operationalize the action of an employee disclosing disability status to an employer. For review of the operationalization process, see above in the Measures section. The disclosure scale consisted of 4 items, with model fit to be considered adequate by some of the goodness of fit indices (χ^2 (2) =26.156, $p<.05$; CFI = .89, TLI = .66, RMSEA= .14, SRMR= .05). There are no theoretically meaningful alternate models to be tested using the existing 4 item scale, and the removal of one item or more items (based on low factor loadings) would simply create a just-identified model or an under-identified model, neither of which would provide additional information about model fit. Thus, the present research using this scale should be interpreted with caution. The CFA results for disclosure can be found in Table 6.

Table 6

Goodness of fit indices for disclosure

Model	χ2	df	CFI	TLI	RMSEA	SRMR
1. 1-Factor (all 4 items)	26.156**	2	0.89	0.66	0.14	0.05

Note. N= 541; **indicates $p<.001$

The CFA results for the remaining variables used as boundary conditions or downstream outcomes were consistent with previous research and use of these scales in many varied applications over time. A table containing the CFA results for these variables can be found in Table 7 located in Appendix E.

Research Questions

Based on the vaired previous research regarding associated outcomes of the disclsoure of a stigmatized identity at work, the present study sought to investigate additonal information about the nature of these potential outcomes. Since the data collection was concurrent and not separated temporally by different time points, the present data do not allow for causal relationships to be tested. Research questions were evaluated by examining the zero-order correlations between disclosure and each of the associated outcomes of interest. Research Question 1 directed examination of the relationship between disclosure of one's disability and the potential personal outcomes of self-esteem, life satisfaction, and health management self-efficacy. Likelihood of disclosure was negatively related to self-esteem (r = -.09, p < .05) and health management self-efficacy (r = -.13, p < .05), but not found to be significantly related to life satisfaction (r = -.07, p = .11). Research Question 2 sought to increase understanding of the likelihood of disclosure and the three professional outcomes of employee engagement, job satisfaction, and turnover intentions. Of these three relationships, there was only support for the negative relationship between likelihood of disclosure and turnover intentions(r = -.13, p < .05; employee engagement r = .04, p =.367; job satisfaction r = .06, p = .192). These results specify that there is a negative relationship between disclosure and self-esteem, health management self-efficacy, and turnover intentions. As the present study is not longitudinal in design, causal order cannot be established, but these significant relationships are early indications of likely antecedents and/or outcomes of disclosure.

Hypothesis Testing

All hypotheses were tested via the M*plus* statistical software (Muthén & Muthén, 2007). Within the M*plus* software, the researcher created scale level composites based on the results of the confirmatory factor analyses and then mean centered these composite variables. The theoretical and analytical framework provided by Edwards and Lambert (2007), which combines regression and traditional path analysis, provides a method for testing moderated mediation hypotheses that avoids pitfalls associated with other approaches, and allows for testing and interpretation of the model's direct, indirect, and total effects at varying levels of the moderator variable using simple slopes analysis (Aiken & West, 1991; Stolzenberg, 1980; Tate, 1998). The present study hypothesized a total effects moderation model, indicating that visibility would moderate the relationship between DID and likelihood of disclosure at the 1st stage, 2nd stage, and direct effect of the mediation model. A total effects moderation model is considered to be the most conservative evaluation of moderated mediation (Edwards & Lambert, 2007; Preacher, Rucker, & Hayes, 2007). Analyses that contain a latent product term (the theoretical multiplication of the effects of an independent variable and moderator variable on a dependent variable) violate assumptions of normality (Edwards 2009; Edwards & Lambert, 2007), thus, a robust maximum likelihood estimator was used to account for this non-normality. Structural equation modeling (SEM) techniques were used to test the moderated mediation model, which consist of combining both the measurement model of the latent factors (determined by the CFAs) with the structural model containing hypothesized relationships among these latent variables represented by the observed variables (Bollen, 1989; Hancock & Mueller, 2013; Kline, 2005; Millsap, 2001). Compared to regression based approaches, SEM has several advantages such as the capability to test models with multiple dependent variables, models containing both latent and manifest variables, simultaneously estimate multiple path equations, estimate the full model fit in addition to individual parameters, and finally, SEM procedures account for measurement error (LeBreton, Wu, & Bing, 2009; B. Vandenberg, personal communication, 2013).

Support for hypotheses varied, and though not all as expected, the resulting relationships provide interesting and valuable insight. Hypothesis 1 predicted that disability identity development would positively predict an individual’s future likelihood of disclosure. In the subsequent hypothesis testing, Hypothesis 1 was only supported as predicted under conditions of low disability visibility (b= .279, SE=.106, $p < .05$). In the overall model and under conditions of high disability visibility, though non-significant, the direct effect of DID on disclosure was found to be *negatively* related to disclosure (*b*= -.122, SE=.114, *p* = .283; *b*= -.027, SE=.083, *p* = .744), suggesting that for some individuals with a disability, having a greater level of disability identity development may deter these individuals from disclosure.

Hypothesis 2 was found to have more consistent results, following the predicted relationships. Disability identity development positively predicted an individual's use of identity management strategies in the overall model (*b*= .226, SE=.114, *p* < .05), under conditions of low disability visibility (*b*= .259, SE=.085, *p* < .05), and under conditions of high disability visibility (*b*= .234, SE=.077, *p* < .05). These results suggest that individuals with a more developed disability identity are also engaging in greater levels of strategies to manage this stigmatized identity, thus Hypothesis 2 is supported.

The mediation model proposed in Hypothesis 3 posited that the effect of DID on disclosure would be partially mediated by identity development strategies. Despite a significant direct effect (*b*= .279, SE=.106, *p* < .05) and total effects (*b*= .19, SE=.084, *p* < .05), the total indirect effect of DID on disclosure through identity management strategies was not significant under conditions of low visibility (*b*= -.089, SE=.057, *p* = .119). Under conditions of high visibility, the direct, the indirect, and the total effects of DID on disclosure were all non-significant (*b*= -.027, SE=.083, *p* =.744; *b*= .061, SE=.042, *p* =.169; *b*= .034, SE=.084, *p* =.665). Taken together, these results fail to support the proposed mediating role of identity strategy management in the relationship between DID and disclosure (Hypothesis 3).

Despite the lack of support for the role of identity management strategies as a mediator in the hypothesized model, tests for conditional indirect effects were still examined for further insight; a summarization of the simple effects can be found in Table 8, and estimated unstandardized coefficients for the full structural model can be found in Figure 2. The unstandardized coefficient estimates indicate that visibility did not moderate the 1st stage mediation path from DID to IDST (b = -.023, SE = .122, p = .852), however, it did moderate the 2nd stage mediation path from IDST to likelihood of disclosure (b = .540, SE = .235, p <.05) and the direct effect path from DID to likelihood of disclosure (b = -.274, SE = .123, p <.05). Further analyses of the simple effects at both high and low levels of the moderator, visibility, can provide a more nuanced understanding of these results. Beginning with conditions in which visibility was low, the first stage path of the indirect effect of DID on likelihood of disclosure through identity management strategies (IDST) was significant (b = .259, SE = .085, p <.05), as was the second stage of the indirect effect (b = -.343, SE = .156, p <.05) along with the direct path (b = .279, SE = .106, p <.05). Though both of the 1st and 2nd stage paths of the indirect effect are significant in conditions of low visibility, their combined total indirect effects were not significant (b = -.089, SE = .057, p =.119). In conditions in which visibility was high, the first stage path of the indirect effect of DID on likelihood of disclosure was significant (b = .234, SE = .077, p <.05), but neither the second stage of the indirect effect (b = .260, SE = .177, p = .142) nor the direct path (b = -.027, SE = .083, p = .744) were significant. The total indirect effects for conditions of high visibility were not significant (b = .034, SE = .077, p = .665).

Table 8

Analysis of simple effects

Moderator	Stage		Effect		
Visibility	1st	2nd	Direct	Indirect	Total
Low	.259*	-.343*	.279*	-.089 ns	.190*
Hi	.234*	.260 ns	-.027ns	.061 ns	.034 ns
Differences	.025 ns	-.603*	.306*	-.150*	.157ns

Note. N= 541; * indicates $p < .05$

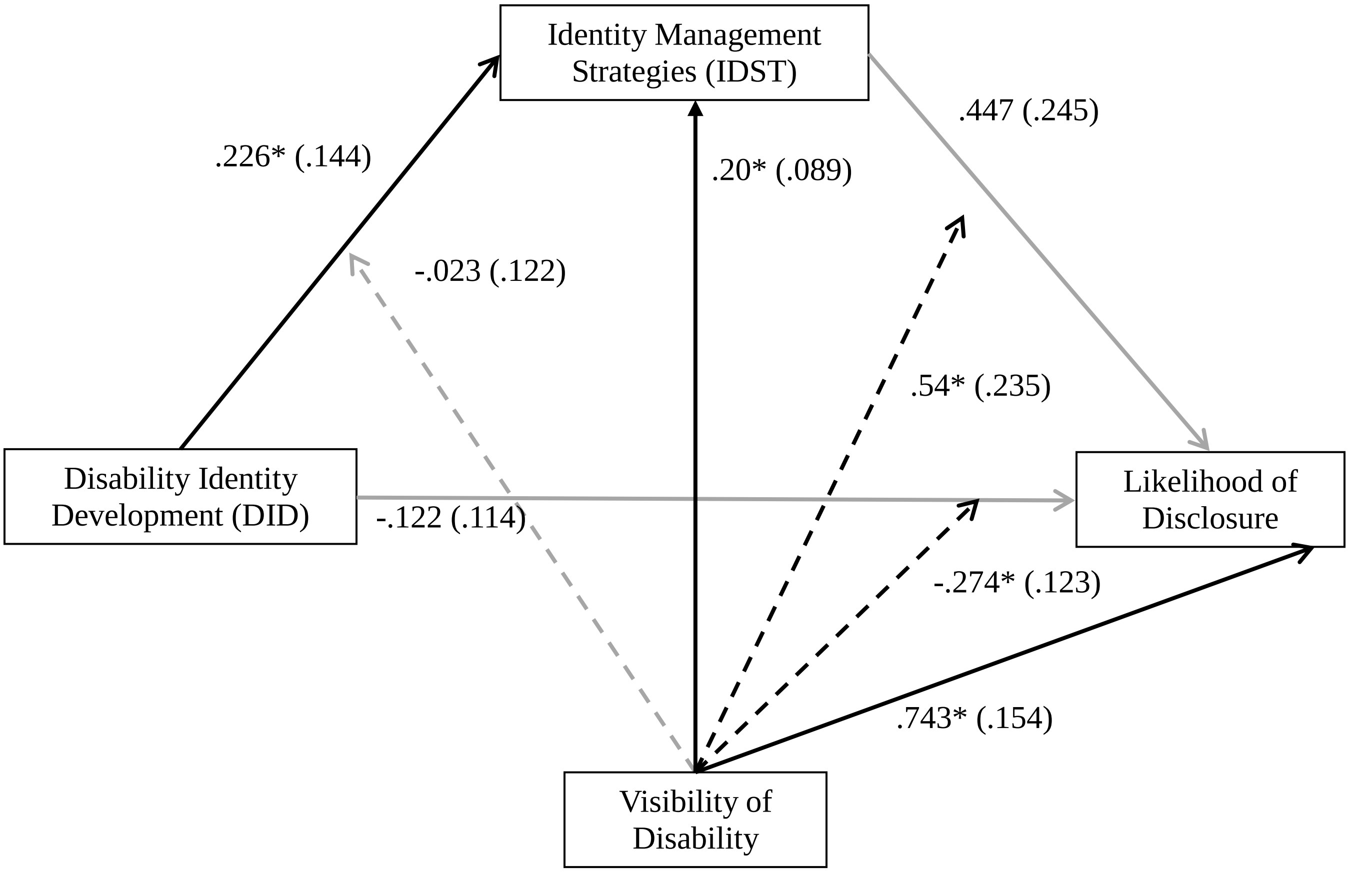

Figure 2. Full path model. Unstandardized path coefficients.

The above results indicate moderation effects may be present due to the significant paths occurring in different conditions of visibility, but to determine support for moderated mediation of both the indirect and direct effects of the hypothesized model, the differences between each of these low and high level effects must be tested for significance. Despite the significance of both of the 1st stage moderation effects, the difference between these effects is not found to be significant ($\Delta b = .025$, SE = .136, $p = .852$), which can be visually represented by plotting the simple slopes, as can be seen in Figure 3. This result suggests that there is a significant positive relationship between DID and identity management strategies across *all* levels of disability. This finding reinforces the previous support for Hypothesis 2, but does not support the predicted 1st stage moderated mediation effect from DID to disclosure through disability identity management.

The difference between the 2nd stage effects, however, was found to be statistically significant ($\Delta b = -.603$, SE = .267, $p < .05$), and this significant difference is confirmed by the simple slopes plot for the 2nd stage effects (Figure 4). In other words, the 2nd stage effect of identity management strategies on disclosure was significantly stronger (although in the negative direction) for individuals with low disability visibility than those with high disability visibility.

Though individually not significant, the difference between the indirect effects was significant ($\Delta b = -.150$, SE = .073, $p < .05$; Figure 5), indicating a stronger (but not statistically significant) indirect effect for individuals with low disability visibility compared to individuals with high levels of disability visibility. The difference between the two direct effects were also found to be significant ($\Delta b = .306$, SE = .141, $p < .05$; Figure 6), providing evidence that the effect of DID on disclosure is significantly stronger for individuals with a low level of disability visibility. Finally, despite significant differences between 2nd stage, direct, and indirect effects, the difference between the total effects was not statistically significant (Δ*b* = .157, SE = .113, *p* = .167; Figure 7). Thus, taken together, there is mixed support for Hypothesis 4. Support was found for the moderating effect of visibility on the relationship between identity management strategies and disclosure, however under the *opposite* conditions and direction from what was predicted, indicating that in fact this *negative* relationship is stronger when individuals have *low* levels of disability visibility rather than high levels. Support was also found for the moderating effect of visibility on the relationship between DID and disclosure, but again, under the opposite moderator conditions from what was predicted- individuals with higher levels of DID are more likely to disclose in conditions of *low* visibility rather than high visibility. However, the results fail to support the hypothesized moderation effect on the relationship between DID and identity management, as well as on the indirect and total effects of the mediation model. Explanations for the lack of support for the 1st stage effects are addressed in the discussion section. The failure to support the full moderated mediation hypothesis can likely be attributed to the lack of support for the mediating role of identity management strategies, along with the strong positive direct effects of the moderator variable (visibility) on both identity management strategies (*b* = .20, SE = .089 *p* <.05) and disclosure (*b* = .743, SE = .154, *p* <.05).

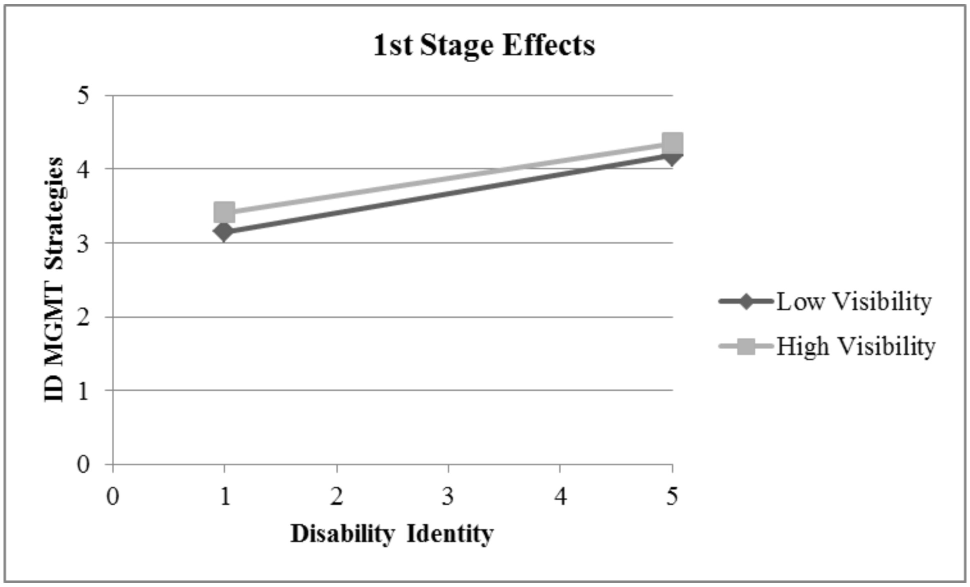

Figure 3: Effects of disability identity on identity management strategies at high and low levels of disability visibility.

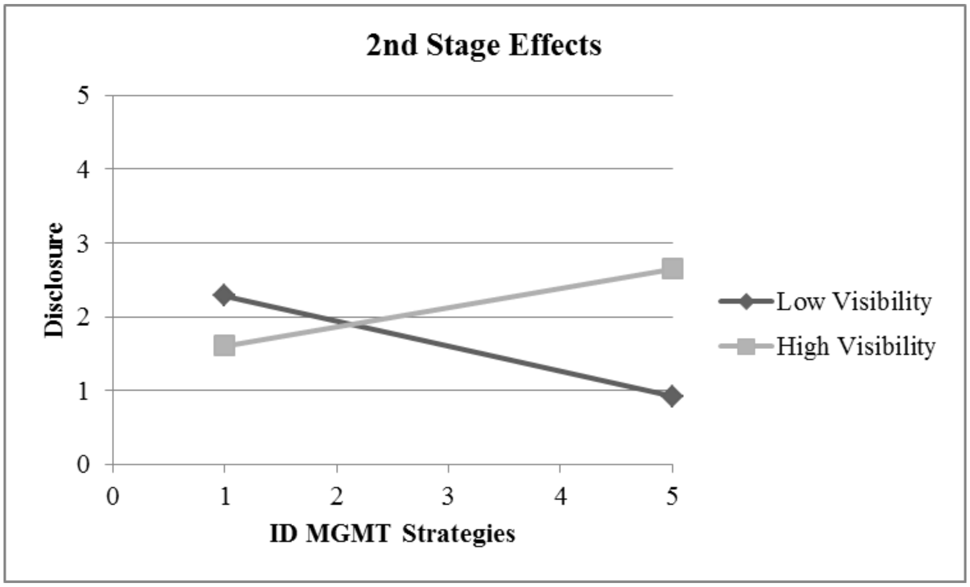

Figure 4. Effects of identity management strategies on likelihood of disclosure at high and low levels of disability visibility.

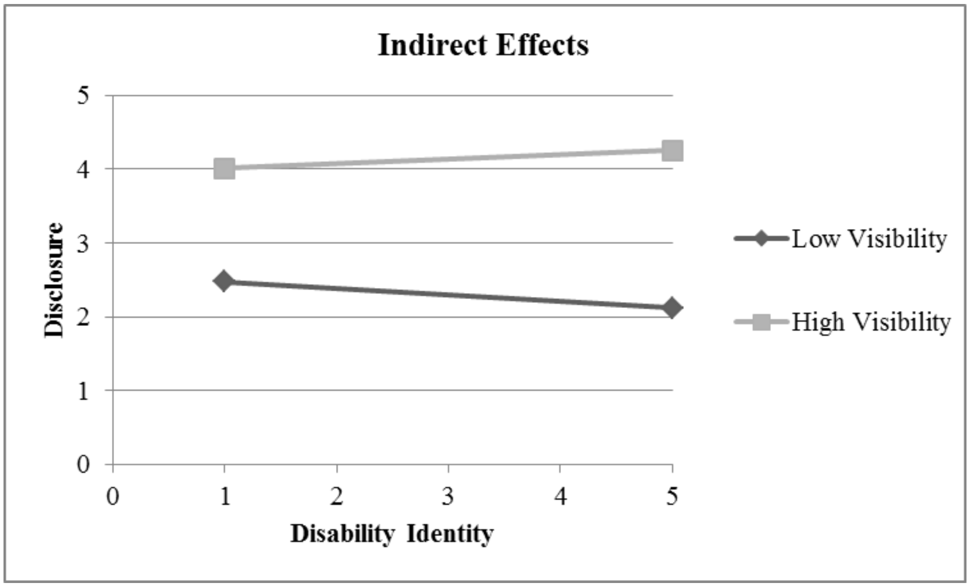

Figure 5. Indirect effects of disability identity development on likelihood of disclosure at high and low levels of disability visibility.

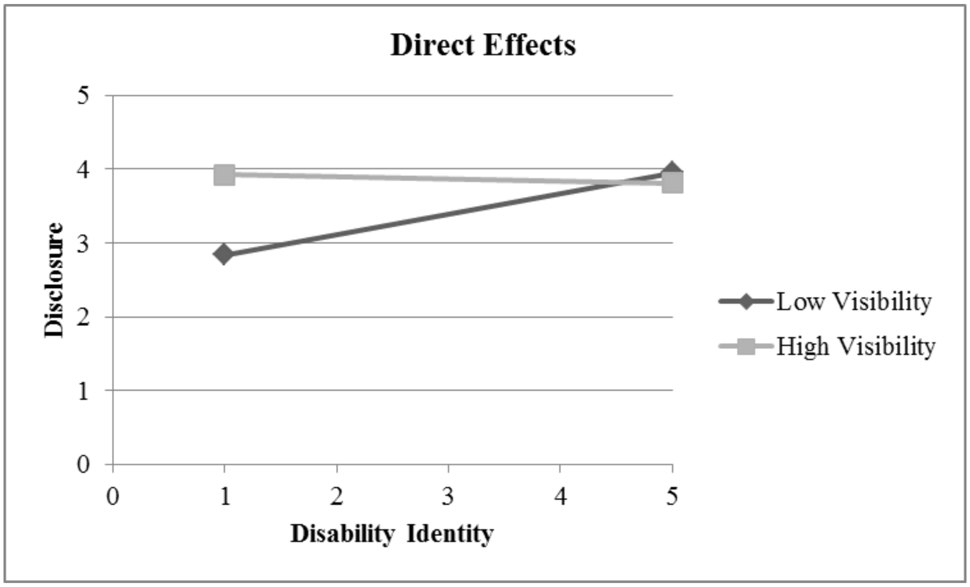

Figure 6. Direct effects of disability identity development on likelihood of disclosure at high and low levels of disability visibility.

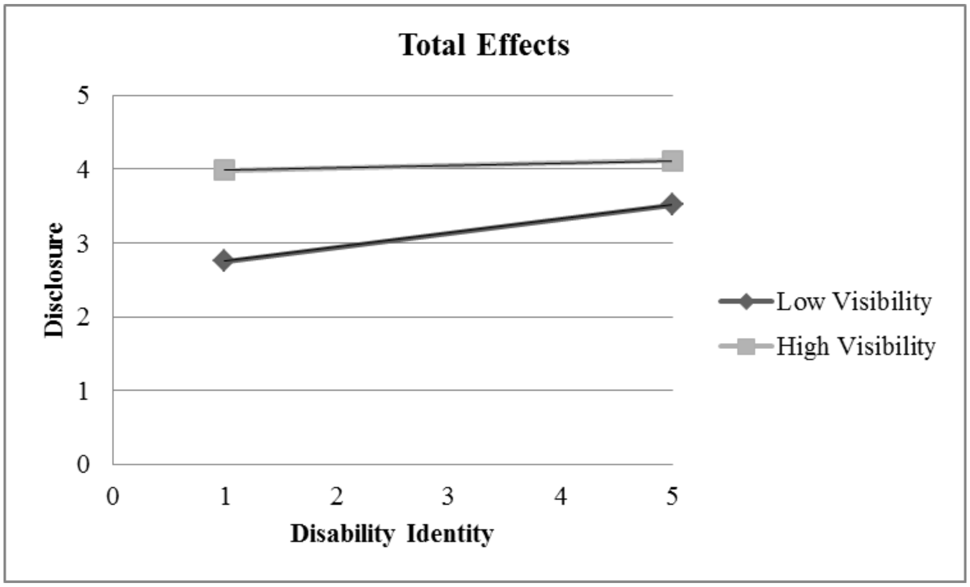

Figure 7. Total effects of disability identity development on likelihood of disclosure at high and low levels of disability visibility.

CHAPTER 5

DISCUSSION

The goals of the present study were threefold: to conduct scientific organizational research on individuals with disabilities, the largest (but severely understudied; Colella, Hebl, & King, 2017) protected minority class in the United States (besides gender), to extend previous stigmatized identity theory and practice by studying these concepts among this under researched population, and to provide context and insight for employees and organizations regarding the implications of recent legislative changes surrounding disability disclosure at work. In seeking to accomplish these goals, validity of adapted versions of stigmatized identity measures was confirmed, and a complex structural model representing the latent variables and the hypothesized relationships among them was tested. Conclusions from these procedures provide valuable evidence for understanding the unique experience of employees with disabilities and the complicated process of disclosing one's disability at work. Discussion of empirical results follows, along with the associated theoretical and practical implications, as well as study limitations and considerations for future research.

Main Findings

One of the contributions of this study was the successful adaptation of existing measures of identity related constructs for the population of individuals with disabilities. The support for reliability and construct validity demonstrated in the factor analyses allows researchers to reinforce parallels in the identity development and management experiences between more widely studied minority groups (race/ethnicity, sexual orientation, etc.) and individuals with disabilities. Though there are certainly features of the identity development and management experiences that are unique to individuals with a disability, this research is an early indication that many of the same psychological processes are occurring within all individuals with one or more stigmatized identity.

Probing of research questions directed at understanding the nomological network of disclosure among other variables of organizational research revealed three significant relationships. Likelihood of disclosure was negatively associated with self-esteem, health management self-efficacy, and turnover intentions, yet unexpectedly, disclosure was *not* found to be related to employee engagement, job satisfaction, or life satisfaction. These results indicate that the employees with the greatest likelihood of disclosing their disabilities are those who are likely to have lower self-esteem and lower self-efficacy regarding the management of their disability, but they are less likely to leave their current organization. The lack of relationships between likelihood of disclosure and employee engagement, job satisfaction, and life satisfaction indicate that these three variables may not exist with the nomological network of disclosure. Mixed support for understanding the relationships between disclosure and other organizational variables has been supported by previous research, with some support for positive outcomes (Clair et al., 2005; Corrigan & Matthews, 2003; Creed & Scully, 2000; Nittrouer et al., 2014; Ragins, 2008), but others finding support for negative outcomes of disclosure (Chaudoir & Quinn, 2010; Chrobot-Masonet al., 2001; Ellison, Russinova, MacDonald-Wilson, & Lyass, 2003; Johnson & Joshi, 2016; Quinn & Earnshaw, 2011; Santuzzi & Waltz, 2016; Waldo, 1999). Because the present study design is concurrent as opposed to longitudinal, conclusions regarding causal order cannot be made with the current results. However, establishing significant correlations between self-esteem, health management self-efficacy, and turnover intentions is an important contribution to the greater depth of knowledge surrounding disability disclosure at work.

Regarding the specific relationships among these identity-related constructs and outcomes of interest, a number of findings can be supported. Disability identity development was found to predict the use of identity management strategies across all conditions of visibility, however, results suggest that the use of these strategies are only significantly related to disclosure when an individual has a low degree of disability visibility, like PTSD or Depression. Though not explicitly hypothesized, this relationship was expected to be positive, thus the negative relationship supported by the analyses is of particular interest. One possibility for this result is that when an individual's disability is able to be concealed to some degree, identity management strategies are used as a protective behavior because of the negative outcomes one perceives may come from disclosure (Clair et al., 2005; Griffin, 1992; Jones & King, 2013). The direct effect of DID on likelihood of disclosure was also only significant for individuals with low levels of visibility. Taken together, these findings paint a very nuanced and complicated picture of the different experiences of identity and disclosure depending on the visibility of one's disability.

For example, a man with cancer who may be able to largely conceal his symptoms and a man with complete blindness will equally experience a positive relationship between their own levels of disability identity development and the degree to which they use identity management strategies regarding their respective disabilities. However, neither the level of disability identity development nor the degree to which the blind man uses identity management strategies will impact his decision to formally disclose his blindness at work. Conversely, the man with cancer *will* be influenced by his own identity as an individual with cancer and the way he manages this identity as he decides whether to disclose this disability at work or not. Contrary to what was hypothesized, the more this man with cancer engages in identity management strategies, the *less* likely he will chose to formally disclose, perhaps because he engages in such strategies as a means to protect himself from being identified as a member of a stigmatized group (Clair et al., 2005; Griffin, 1992; Jones & King, 2013).

As mentioned above, in conditions of high disability visibility, like immobility requiring the use of a wheelchair, neither disability identity development nor identity management strategies contributed to likelihood of disclosure. Although non-significant, in this condition the relationship between DID and disclosure was actually negative, suggesting that for some individuals with a high degree of disability visibility, greater disability identity may even deter one from disclosing his or her disability. Ultimately, due to lack of significance, results indicate that when disability visibility is high, identity and identity management aren't strong enough factors to predict disclosure. What really impacts the disclosure decision-making process for these individuals is simply the degree of visibility of their disability present. An individual with a missing limb may or may not have a strong sense of disability identity or employ varying levels of stigmatized identity management strategies, but her disclosure decision will not be driven by these factors. Instead, the degree to which her missing limb is physically visible will be a stronger indication of disclosure.

Understanding the differences (or lack thereof) between conditions of low and high disability visibility is critical for advancing knowledge about employees with disabilities. In the present study there was no significant difference in the relationship between disability identity and identity management strategies for individuals with high levels of disability visibility and individuals with low levels of disability. Though this lack of difference was not predicted, it can be meaningful because it suggests that individuals with a disability, regardless of the degree of visibility, experience the same relationship between understanding one's own sense of identity regarding this stigmatized status and the behavioral choices he or she makes as an attempt to manage such a stigmatized identity. As illustrated in a previous example, the man who is able to conceal his cancer symptoms and the man who is completely blind will have no difference in the way that their respective disability identity development predicts their use of identity management strategies. Because disability is so stigmatized across all levels of visibility, as one develops a stronger disability identity, he or she will also be more likely to develop strategies to manage the perceptions others may have about him or her based on his or her disability.

There are also meaningful differences among individuals with high and low levels of disability visibility. The relationship between identity management strategy use and disclosure *is* influenced by visibility, specifically for individuals with low visibility. Though individuals with high visibility engage in identity management strategies at the same rate as those with low visibility, evidence suggests the disclosure process diverges after this point. Perhaps because visibility is high, these individuals do not have as many contributing factors in the decision-making process to disclose. These individuals may have a sense that "the jig is up," so to speak, thus it is a simpler decision with less influencing factors than someone who does have concealment (low visibility) as an option. The same concept is supported regarding the direct effect of DID on disclosure; when visibility is high, it does not matter how developed one's DID may be, visibility is still the most impactful influencing factor in the disclosure decision. However, because an individual with a less visible disability may have concealment as an option, there were more factors significantly predicting disclosure, namely disability identity development and stigmatized identity management strategies.

Across all participants, there were some findings not affected by the level of disability visibility. For all individuals with a disability, the relationship between DID and disclosure was *not* mediated by identity management strategies as originally hypothesized. Further, visibility did not impact the relationship between disability identity and identity management strategies, however, it did significantly interact with both DID (negatively) and identity management to predict disclosure. With lack of support for the mediating role of identity management strategies, the moderated effect of the 2nd stage and direct mediation paths can likely be attributed to the strength of visibility on its own as a predictor of disclosure. Due to the strength of the direct relationships between visibility and both identity management and disclosure, it may be advised to use visibility as a simple predictor in future models.

Broadly speaking, the findings from the present research can be summarized as follows:

- Stigmatized identity development specific to disability occurs in individuals with a disability in similar patterns as other stigmatized groups (i.e., race/ethnicity; Cross, 1971, 1978, 1991; Helms, 1984, 1990, 1993; Helms & Parham, 1996; Phinney, 1989, 1992; and sexual identity; Cass, 1979; Woods, 1993; Walters & Simoni, 1993; Button 1995, 2001)
- Management of the stigmatized disability identity with specific impression management strategies also occurs in similar patters as other stigmatized groups (i.e. gender; Kaiser & Miller, 2001; race/ethnicity; Bell & Nkomo, 2001; Steele & Aronson, 1995; sexual identity; Chrobot- Mason, Button, & DiClementi, 2001Button, 2004; Shallenberger, 1994; Woods, 1993)

These two findings indicate that the identity development and management experiences for members of a stigmatized group contain elements that can be thought of as consistent across stigmatized characteristics, supporting assertions by previous researchers (Bogart, 2014; Dunn &

Burcaw, 2013; Sciarra et al., 2005; Olkin, 1999). For example, a Muslim man experiences some of the same psychological and behavioral processes related to his identity as a Muslim as would a man with bipolar disorder regarding this identity. These findings also indicate that the antecedents and outcomes associated with stigmatized identity development and management established by previous research may be mirrored for individuals with disabilities. Specifically, though not part of the present study's hypotheses, correlations between DID and life satisfaction, self-esteem, job satisfaction, and employee engagement were all found to be positive and significant. The correlations between identity management strategies were also positive and significantly related to the four previous variables, as well as positively related to health management self-efficacy and negatively related to turnover intentions. Though merely correlational evidence, it does provide early indications that these constructs play an integral role in the disclosure process for individuals with disabilities in the same way they do for members of other stigmatized groups (Chaudoir & Quinn, 2010; Jones & King, 2013; Madera, King, & Hebl, 2012; Rutigliano & O'Connell, 2013; Santuzzi & Walsh, 2016; Uysal, Lin, & Knee, 2009).

- The development of a disability identity predicted the use of stigmatized identity management strategies across all conditions of visibility

The more an individual has developed an identity regarding his or her disability, the more likely this individual will engage in specific strategies to manage others' perceptions of this disability. This finding seems to indicate that the greater sense of awareness one has about his or her disability identity, the more this individual feels the need to manage the way they present this disability to others in the workplace. In the larger scheme of society and culture, this finding indicates that disability, no matter how visible or concealable, is a highly stigmatized identity, so much that the more one understands his or her identity as an individual with a disability, the more this person also understands that this identity is undesirable.

- The use of such identity management strategies did not mediate the relationship between disability identity development and disclosure under any condition

Though identity management strategy use was not found to be the process by which disability identity development influences the likelihood of disclosure at work, there are likely other constructs that may in fact serve in this mediating role. Ellison et al., (2003) found that disclosure was related to the level of confidence in the security of the workplace, while Jones and King (2013) similarly posit that anticipated acceptance is the primary predictor of disclosure of a stigmatized identity. The extent to which coworkers displayed comfort, fairness, inclusiveness, and acceptance toward LGB employees was found to mediate the relationship between disclosure and positive job attitudes (Griffith & Hebl, 2002; Jones & King, 2013). Each of these previous researchers points to the viability of one's own perceptions of reactions to disclosure as a potential mediator in the relationship between disability identity development and disclosure. Possibly related may also be the specific employment context in which the employee is facing the decision to formally disclose at work- either as a job applicant, after receiving a job offer, or as a current employee of an organization. Each of these stages of the employment life cycle allows the individual to understand different levels of organizational knowledge, trust, and consequently, perceptions of disclosure acceptance.

- Disability identity and identity management strategies only predicted disclosure in conditions of low visibility. In fact, identity management strategy use was actually *negatively* related to likelihood of disclosure for individuals with low disability visibility.

- For individuals with high levels of disability visibility, no support was found for these relationships at all.

Likelihood of disclosure was only predicted by disability identity development when individuals indicated low levels of disability visibility. These findings indicate that a woman with diabetes is more likely to be influenced by her identity as a diabetic in her decision to disclose this disability than a woman with paraplegia. In fact, the woman with paraplegia's decision to formally disclose her disability status at work may not be influenced at all by her identity as a paraplegic. For this woman, the strong degree of visibility (i.e. permanent use of a wheelchair) will be the strongest factor in her disclosure decision. Similarly, likelihood of formal disclosure was only predicted by stigmatized identity development when individuals indicated low levels of disability visibility. However, this relationship was actually found to be negative, suggesting that for the woman with diabetes, the greater degree to which she uses strategies to manage the presentation of her diabetes to others, the less likely she will choose to disclose this disability at work. Yet again, for the woman with paraplegia, the degree to which she utilizes strategies to manage the presentation of her paraplegia to others is not likely to influence her disclosure decision. So, the more easily detected one's disability status is to coworkers, the less likely that her disability identity and management of perceptions of that disability will predict formal disclosure at work. With less disability visibility, it is more likely that both of these constructs will predict formal disclosure at work.

Theoretical and Practical Implications

Based on the contributions of the present study, a number of theoretical and practical implications exist. To the best of the researcher's knowledge, this is the first theoretical application and empirical study of identity development among individuals with disabilities.

Previous research has focused on the development of identity based on race and sexual orientation (Button 1996, 2001, 2004; Cass, 1979; Chrobot-Mason et al., 2001; Cross, 1971, 1978, 1991; Helms, 1984, 1990, 1993; Helms & Parham 1996; Phinney 1989,1992; Tatum, 1997; Walters & Simoni, 1993; Woods, 1993; Vandiver et al, 2001), but not disability. Thus, the theoretical implications are large and important. For the first time, the work of stigmatized identity researchers has been applied to and tested among a population of individuals with disabilities. Jean Phinney's (1992) measure of ethnic identity development was successfully adapted for individuals with disabilities and found to contain the same latent factor structure in this new population. Further, the measure developed by Lynch and Rodell(2015) operationalizing Roberts' (2005) theoretical framework for stigmatized identity management was also successfully adapted for individuals with disabilities with excellent evidence for validity of the latent factor structure. These results provide additional strength to the present literature on these two constructs and provide new avenues for researchers to understand the specific experience of stigma as an individual with a disability. Results from the present study also speak to the universality of stigmatized identity; though there are certainly unique elements based on the particular stigmatized group, individuals living as a member of a stigmatized group share some of the same psychological and behavioral processes.

More specifically, the present study also contributes to the literature regarding the impact of the visibility of one's stigma and disclosure (Chrobot-Mason et al., 2001; McLaughlin et al. 2004; Quinn et al., 2014). Results indicated a clear difference between the disclosure decision-making processes of individuals with low visibility as compared to those with high visibility. Previous research indicates that these differences make a key distinction (Clair et al., 2005; Goffman, 1963; Jones et al., 1984; Ren, Paetzold, & Colella, 2008; Stone & Colella, 1996), and the present results confirm that the disclosure decision for individuals with low levels of disability visibility may involve multiple factors, whereas the decision for an individual with a visible disability is most strongly impacted by that visibility. Of importance to note is that regarding the relationship between disability identity development and the use of identity management strategies, there was no meaningful difference between individuals with low and high visibility. This suggests that the psychological process of identity development and the behavioral manifestation of stigmatized identity management strategies are not different for an individual with PTSD compared to an individual with a missing limb. The key difference occurs when each of these individuals decides whether to disclose his or her disability or not.

Practically speaking, the results from the present study also carry important implications for both employees with disabilities and the organizations in which they are employed. For employees with low disability visibility, the disclosure decision process appears to be influenced by more factors (disability identity development, identity management strategies, along with degree of visibility) than individuals with higher levels of visibility. The more complex disclosure decision making process for these employees may contribute to increased use of cognitive and emotional resources, ultimately culminating in increased psychological strain (Clair et al., 2005; Goffman, 1963) and stress for the employee. In one stark example, Ragins and Cornwell (2001) found that the fear and anxiety surrounding the disclosure decision had a far more detrimental impact on job attitudes and psychological well-being than did the actual disclosure itself (Clair et al., 2005). Employee stress can be a significant issue for organizations to contend with; some researchers estimate that in the United States, the absenteeism and reduced productivity from employee stress costs organizations from $200-$350 billion annually (Miree, 2007; Nixon Mazzola, Bauer, Krueger, & Spector, 2011). Further, increased employee stress has been linked to other undesirable organizational outcomes such as increased counterproductive workplace behavior, lower organizational commitment, higher turnover rates, and in some cases even increased absenteeism (Sonnentag & Frese, 2013). Thus, organizations should seek to engage in policy and practice to reduce sources of workplace stress for their employees, in general, but also specific to the disclosure process. This could include methods to increase employee trust in the disclosure process, via education, communication, and encouragement from affinity groups. For example, in one large organization, a video was created that showcases employees at all levels, including executives, disclosing their disability status as an effort to normalize the process of disclosure.

Efforts such as this can increase transparency around the very specific process of obtaining formal disclosure (via OFCCP 503 Forms), why it is important, and how the information will be used. The present study indicates that the decision to formally disclose one's disability to an organization may be more complicated for individuals with low levels of disability visibility compared to employees with high levels of disability visibility. This would suggest that organizations may already have employees with a highly visible disability choosing to formally disclose, but not as many employees with low levels of disability are making the same choice. To meet the OFCCP's mandated aspirational guideline of 7% voluntary disability disclosure per job group, these results indicate that organizations are going to need to specifically focus on how to make the disclosure decision less taxing for individuals with low levels of disability visibility.

Limitations and Future Research

Aside from the strengths and contributions of the present study, there are of course a number of limitations that should not be ignored when drawing conclusions from the results.

Though the factor analyses did provide evidence for consistency of identity constructs through measures developed for populations other than individuals with disabilities, future research should test this conclusion with more stringent methods. One sufficient strategy would be to collect data from two different populations (i.e., racial minorities and individuals with a disability) using the same measures and conduct tests of measurement equivalence/invariance (ME/I) to confirm that measures are yielding the same results under different conditions of observation (Horn & McArdle, 1992). Researchers caution others that before inferring meaning from structural models linking latent constructs, one should ensure that their measurement is in fact understood and interpreted in the same way among individuals in multiple groups (Anderson & Gerbing, 1988; Vandenberg & Lance, 2000). Conducting statistical tests of ME/I would provide even stronger evidence for the parallels between populations in terms of stigmatized identity development and management.

Another limitation of the present study involves the data sampling approach. Data collection was conducted in one single time point. Without temporal distinction among constructs, conclusions about causality and causal order must be approached with caution. This is especially problematic in the research question investigation of potential outcomes associated with disclosure. Because the data regarding these supposed outcomes was collected at the same time point as the supposed predictors, no causal links can be established between disclosure and employee engagement, job satisfaction, turnover intentions, self-esteem, life satisfaction, and health management self-efficacy. Though significant correlations were found to exist between likelihood of disclosure and turnover intentions, self-esteem, and health management self-efficacy, there is no way to draw conclusions about the causal order of these variables; the constructs could be either antecedents or outcomes of disclosure. Future research should employ a longitudinal study design, collecting data from at least three time points, which would allow for both antecedents and outcomes related to disclosure to be examined more conclusively.

The actual method of obtaining the sample may also pose various limitations. Although the use of MTurk supported as a viable option for sampling hard to reach populations (Smith et al., 2015), this practice also creates range restriction for things like access to the internet, possibly socio-economic status, level of computer skills, and high functioning levels of disability. Future research could increase generalizability by incorporating sampling methods that allow for more variation in these areas, for example collecting data from national and local disability resource groups to incorporate a wider range of functionality. Though not explicitly due to the study design, the present sample largely consisted of individuals with depression and anxiety disorders. In seeking to find participants representing a broader range of disability functioning, future researchers should also employ strategies to ensure a wider range of specific disabilities experienced are represented. With more representation of different types of disabilities, future research could investigate additional hypotheses, like whether there are differences in which identity management strategies are used by individuals based on the specific type of disability.

At present, the operationalization of disclosure is very difficult for several reasons. First, there is no commonly accepted and psychometrically validated measure of disability disclosure in the extant literature, forcing researchers to determine their own operationalization of disclosure. Up until 2013, there has been no legal method for organizations to formally ask and keep record of disability disclosure, which has certainly impacted the lack of available measures in the organizational literature. Further complications arise as unlike many other constructs common in organizational research, formal disclosure in an organization is a very specific behavioral procedure and one that cannot be measured directly at the time of disclosure. Researchers must approximate this behavior by either asking employees if they have disclosed in the past, which poses issues of memory and accuracy, or assess the likelihood of formal disclosure in the future, as the present study has done. This operationalization must be interpreted with caution, as it does not represent actual disclosure, but the participants' reported likelihood of formal disclosure in the future. In the future, researchers should conduct a psychometric scale development to create a reliable and valid measure of disclosure (i.e., Hinkin & Tracey, 1999).

Conclusion

The present study sought to expand scientific knowledge regarding the experiences of individuals with disabilities in the workplace, to extend theory from Tajfel and Turner's (1986) social identity model to specifically investigate disability identity development and management, and finally to conduct one of the first empirical studies focused on the newly mandated disability disclosure process in organizations with federal contracts. Each of these goals was accomplished through innovative hypotheses and study design, providing nuanced conclusions about the complicated process of disability disclosure and the impactful role of disability visibility in such decision-making.

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APPENDIX A

Table 1

Frequencies of industry

Industry	Frequency	Percent
Healthcare or social assistance	74	13.7
Educational Services	72	13.3
Retail Trade	60	11.1
Professional, scientific or technical services	46	8.5
Other Services not Listed	43	7.9
Finance or Insurance	40	7.4
Arts, entertainment or recreation	34	6.3
Government	29	5.4
Accommodation or Food Services	26	4.8
Manufacturing	24	4.4
Transportation or Warehousing	23	4.3
Information	20	3.7
Construction	11	2.0
Admin, support, waste management or remediation services	10	1.8
Utilities	6	1.1
Management of companies or enterprises	6	1.1
Real estate or rental and leasing	5	.9
Wholesale Trade	5	.9
Forestry, fishing, hunting, or agricultural	3	.6
Mining	2	.4
Unclassified Establishments	2	.4
Total	541	100.0

APPENDIX B

Table 2

Frequencies of disability type

Disability Type	Frequency	Percent
Depression	151	27.9
Anxiety Disorder	121	22.4
ADHD/ADD	52	9.6
Diabetes	33	6.1
PTSD	32	5.9
Bipolar Disorder	23	4.3
Cancer	16	3.0
General Disability (Not otherwise specified)	16	3.0
Chronic Pain Disorder	15	2.8
OCD	11	2.0
Fibromyalgia	9	1.7
Autism Spectrum Disorder	7	1.3
Epilepsy or Seizure Disorder	7	1.3
Personality Disorder	6	1.1
Eating Disorder	5	.9
Lupus	5	.9
Cerebral Palsy	4	.7
Blindness	3	.6
Deafness	3	.6
Multiple Sclerosis	3	.6
Traumatic Brain Injury	3	.6
Stroke	3	.6
Dyslexia	2	.4
Muscular Dystrophy	2	.4
Missing or Partially Missing Limbs	2	.4
Paraplegia or Quadriplegia	2	.4
Tourette's Syndrome	2	.4
Parkinson's Disorder	1	.2
Schizophrenia	1	.2
Spina Bifida	1	.2
Total	541	100.0

APPENDIX C

Disability Identity Development Scale (Adapted from the Multi-group Ethnic Identity Measure, Phinney, 1992)

1. I have spent time trying to find out more about people who have XXX, such as their history, accomplishments, and culture.
2. I am active in organizations or social groups that include mostly members who also experience XXX.
3. I have a clear sense of my XXX and what it means for me.*
4. I think a lot about how my life will be affected by my XXX.*
5. I am happy that I am part of the larger group of people who have XXX.
6. I have a strong sense of belonging to the group of people who have also experienced XXX.
7. I understand pretty well what being part of the group of people who also have XXX means to me.
8. To learn more about my XXX, I have often talked to other people about my XXX.
9. I have a lot of pride in the XXX community and its accomplishments.
10. I feel a strong attachment toward my own XXX community as a group.
11. I feel good about my identity as an individual with XXX.
12. I think a lot about how my life will be affected as someone in the broader disability community.

Note. All items were answered on a 5-point Likert scale (1= *Strongly Disagree*, 5=*Strongly Agree*). * indicates an item dropped via the confirmatory factor analysis process. Each participant's previously indicated disability was piped in to the items where there is "XXX."

Identity Management Strategies Scale (Adapted from Lynch & Rodell, 2015)

Assimilating

1. I emphasize my similarities with more favorably viewed group identities over my identity as an individual with a disability.
2. I highlight my characteristics associated with more positively regarded group identities rather than my identity as an individual with a disability.
3. I play up things I have in common with more favorably viewed group identities rather than my identity as an individual with a disability.
4. I display strengths consistent with more positively regarded group identities over my identity as an individual with a disability.

Decategorizing

5. I emphasize my unique traits over any group identity.
6. I play up my individual attributes rather than any group identity.
7. I highlight my distinctive strengths instead of any group identity.
8. I display my own qualities over any group identity.

Integrating

9. I portray the favorable attributes of my identity as an individual with a disability.
10. I present the best qualities associated with my identity as an individual with a disability.
11. I express the positive aspects of my identity as an individual with a disability.
12. I embody the good characteristics of my identity as an individual with a disability.

Confirming

13. I attempt to benefit from the things I have in common with others who share an identity as an individual with a disability
14. I try to gain from the characteristics associated with this identity.
15. I take advantage of attributes affiliated with this identity.
16. I try to profit from the qualities related to this identity.

Note. All items were answered on a 5-point Likert scale (1= *Strongly Disagree*, 5=*Strongly Agree*).

Likelihood of Formal Disability Disclosure Scale
(Adapted from OFCCP Form CC-305, see Appendix D)

What is the likelihood that you would select each of the following options as your response to this form in the future?

1. "Yes, I have a disability (or previously had a disability)"
2. "No, I do not have a disability"
3. "I do not wish to answer"
4. I would not respond to this form

Note. All items were answered on a 5-point Likert scale (1= *Never*, 5=*Extremely Likely*).

Degree of Disability Visibility (Adapted from Button, 1996)

1. People usually identify me as an individual with a disability right away.
2. People never realize that I am an individual with a disability, unless I tell them. (R)
3. It is not hard for others to tell that I am an individual with a disability.

Note. All items were answered on a 5-point Likert scale (1= *Strongly Disagree* 5=*Strongly Agree*). Reverse coded items are indicated with "(R)" following the item.

Ten Item Personality Inventory (Gosling, Rentfrow, & Swann, 2003)

I see myself as:

1. Extraverted, enthusiastic. (E)
2. Critical, quarrelsome. (R) (A)
3. Dependable, self-disciplined. (C)
4. Anxious, easily upset. (R) (ES)
5. Open to new experiences, complex. (O)
6. Reserved, quiet. (R) (E)
7. Sympathetic, warm. (A)
8. Disorganized, careless. (R) (C)
9. Calm, emotionally stable. (ES)
10. Conventional, uncreative. (R) (O)

Note. All items were answered on a 5-point Likert scale (1= *Strongly Disagree* 5=*Strongly Agree*). Reverse coded items are indicated with "(R)" following the item. (E) = Extraversion. (A)= Agreeableness. (C)= Conscientiousness, (ES)= Emotional Stability. (O)= Openness to Experience.

Crowne-Marlowe Social Desirability Scale (Form-C, Reynolds, 1982)

1. It is sometimes hard for me to go on with my work if I am not encouraged.
2. I sometimes feel resentful when I don't get my way.
3. On a few occasions, I have given up doing something because I thought too little of my ability.
4. There have been times when I felt like rebelling against people in authority even though I knew they were right.
5. No matter who I'm talking to, I'm always a good listener.
6. There have been occasions when I took advantage of someone.
7. I'm always willing to admit it when I make a mistake.
8. I sometimes try to get even rather than forgive and forget.
9. I am always courteous, even to people who are disagreeable.
10. I have never been irked when people expressed ideas very different from my own.
11. There have been times when I was quite jealous of the good fortune of others.
12. I am sometimes irritated by people who ask favors of me.
13. I have never deliberately said something that hurt someone's feelings.

Note. All items were answered as *True* or *False*.

Self-Esteem Scale (Rosenberg, 1965)

1. I feel that I am a person of worth, at least on an equal plane with others.
2. I feel that I have a number of good qualities.
3. All in all, I am inclined to feel that I am a failure. (R)
4. I am able to do things as well as most other people.
5. I feel I do not have much to be proud of. (R)
6. I take a positive attitude toward myself.
7. On the whole, I am satisfied with myself.
8. I wish I could have more respect for myself. (R)
9. I certainly feel useless at times. (R)
10. At times I think I am no good at all. (R)

Note. All items were answered on a 5-point Likert scale (1= *Strongly Disagree*, 5=*Strongly Agree*). Reverse coded items are indicated with "(R)" following the item.

Life Satisfaction (Diener, Emmons, Larsen, & Griffin, 1985)

1. In most ways, my life is close to my ideal.
2. The conditions of my life are excellent.
3. I am satisfied with my life.
4. So far I have gotten the important things I want in life.
5. If I could live my life over, I would change almost nothing.

Note. All items were answered on a 5-point Likert scale (1= *Strongly Disagree*, 5=*Strongly Agree*).

Health Management Self-Efficacy (Lorig et al., 2001; Lorig, 1996)

1. I can keep the fatigue caused by my XXX from interfering with the things I want to do.
2. I can keep the physical discomfort or pain of my XXX from interfering with the things I want to do.
3. I can keep the emotional distress caused by my XXX from interfering with the things I want to do.
4. I can keep any other symptoms or health problems related to my XXX from interfering with things I want to do.
5. I can do all the tasks and activities needed to manage my XXX so as to reduce my need to see a doctor.
6. I can do things other than just take medication to reduce how much my XXX affects your everyday life.

Note. All items were answered on a 5-point Likert scale (1= *Strongly Disagree*, 5=*Strongly Agree*). Each participant's previously indicated disability was piped in to the items where there is "XXX."

Employee Engagement (Schaufeli & Bakker, 2003)

Dedication

1. I find the work that I do full of meaning and purpose.
2. I am proud of the work that I do.
3. My job inspires me.
4. I am enthusiastic about my job.
5. To me, my job is challenging.

Vigor

6. When I get up in the morning, I feel like going to work.
7. At my job, I feel strong and vigorous.
8. At my job, I am very resilient, mentally.
9. I can continue working for very long periods at a time.
10. At my work, I feel that I am bursting with energy.

Absorption

11. Time flies when I am working.
12. Performing my job is so absorbing that I forget about everything else.
13. I feel happy when I am working intensely.
14. At my work, I always persevere, even when things do not go well.
15. It is difficult to detach myself from my job.
16. I get carried away when I am working.

Note. All items were answered on a 5-point Likert scale (1= *Strongly Disagree*, 5=*Strongly Agree*).

Turnover Intentions (Adams & Beehr, 1998)

1. It is likely that I will actively look for a new job in the next year.
2. I often think about quitting my job.
3. I will probably look for a new job in the next year.

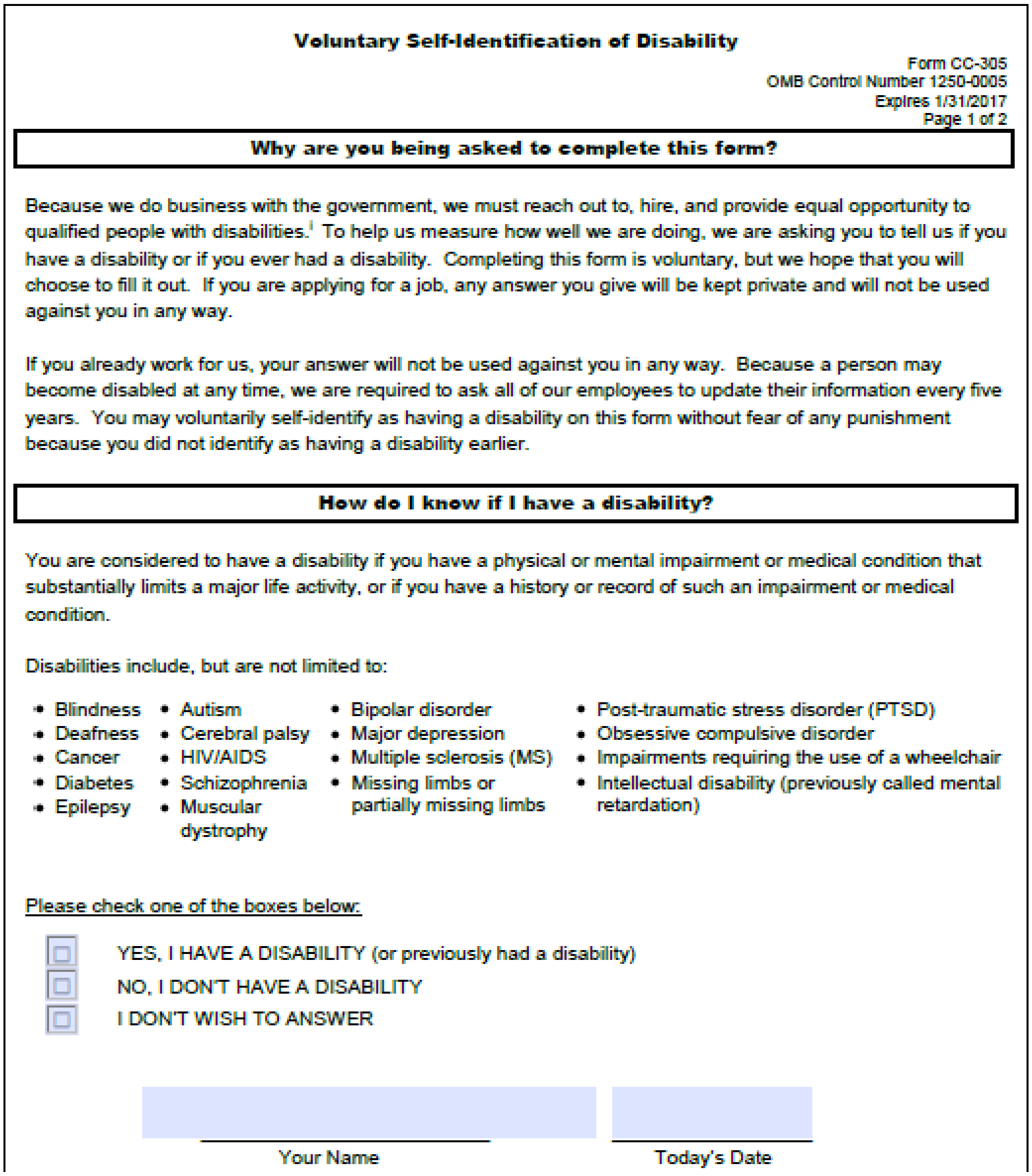
Note. All items were answered on a 5-point Likert scale (1= *Strongly Disagree*, 5=*Strongly Agree*).

Job Satisfaction (Brayfield & Roth, 1951)

1. I feel fairly satisfied with my present job.
2. Most days I am enthusiastic about my work.
3. I find real enjoyment in my work.
4. Each day of work seems like it will never end. (R)
5. I consider my job to be rather unpleasant.(R)

Note. All items were answered on a 5-point Likert scale (1= *Strongly Disagree*, 5=*Strongly Agree*). Reverse coded items are indicated with “(R)” following the item.

APPENDIX D



Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2017
Page 1 of 2

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[i] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

☐ YES, I HAVE A DISABILITY (or previously had a disability)
☐ NO, I DON'T HAVE A DISABILITY
☐ I DON'T WISH TO ANSWER

Your Name

Today's Date

Figure 1. Office of Federal Contract Compliance Programs (OFCCP) official voluntary disclosure form (Form CC-305).

APPENDIX E

Table 7

Confirmatory Factor Analysis (CFA) results for additional study variables

Variable	$\chi 2$	df	CFI	TLI	RMSEA	SRMR
Visibility (Just-Identified)	0.00	0.00	1.00	1.00	0.00	0.00
Job Satisfaction	26.83	5	0.98	0.95	0.09	0.03
Employee Engagement	517.992	101	0.92	0.9	0.08	0.04
Turnover Intentions (Just-Identified)	0.00	0.00	1.00	1.00	0.00	0.00
Life Satisfaction	28.959	5	0.99	0.97	0.09	0.02
Self-Esteem	3545.98	45	0.88	0.85	0.149	0.06
Health Management	1507.5	15	0.98	0.97	0.07	0.02

Note. N=541