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THE HEALTH ISSUE DISCLOSURE PROCESS IN ORGANIZATIONAL CONTEXTS

UNVEILING THE DISCLOSURE DYNAMICS OF HEALTH ISSUES AT WORK

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Abstract

Organizations and employees have a reciprocal relationship in terms of well-being, which means they share a mutual interest in optimization. Nevertheless, the topic of health issue disclosure in organizational contexts is ignored by scientists. This study is an initial attempt to reveal the dynamics of the disclosure process of health issues in work environments. Components drawn from academic literature provided insights that constituted the basis of this study. Qualitative data from 58 semi-structured interviews with working citizens who disclosed or concealed

health issues were retrieved and recorded. Based on the results, a comprehensive framework that comprises three disclosure process phases was developed: 1. the 'pre-disclosure phase' provides insights into why and how workers make disclosure decisions and presents three questions considered and three factors that affect these considerations in the decision to disclose or conceal a health issue at work; 2. the 'disclosure event' shows components of the disclosure and represents a variety of situations, reactions and feelings that occur during the disclosure event; and 3. the possible outcomes, ranging from positive to negative, are captured in 'the post-disclosure phase' on individual, dyadic and organizational level. Moreover this phase includes a learning curve, the feedback loop. This study constitutes an exploration of a neglected field of research and provides a more versatile framework for scientific and organizational use. The findings of the study contribute to a better understanding of various conditions, questions and factors that occur in the disclosure process within organizational contexts. Next to that, the results can assist organizations on both strategic and operational level. Thus the results provide insights into how organizations can use the framework to lower their costs by improving the work atmosphere and (open) culture in terms of generating people´s openness and trust. The investment will pay off because it will: a. make employees go the extra mile; b. positively affect job satisfaction, involvement and productivity; and c. reduce absence (e.g. calling in sick), job insecurity and intention to leave.

Key Words: Disclosure; Process; Work; Communication; Conceal; Reveal; Organization; Health Issue; Employee; Qualitative research

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1. Introduction

Employees, referred to as "human capital", represent the organization they work for and comprise a significant portion of its investment. Wages and absence due to illness cost organizations effort and money. Health issues raise organizational costs due to absenteeism (i.e. not able to be present at work) and presenteeism (i.e. present at work although feeling unwell, which negatively influences their work performance and productivity) (Barnes, Buck, Williams, Webb, & Aylward, 2008; Danna & Griffin, 1999; Mann, 1996). Thus employees' well-being and health can affect organizational overheads (Danna & Griffin, 1999), which means that the employer benefits from the good health of the employee. The advantages for organizations to invest in an employee's health are established in the literature, which indicates that this investment pays off.

Turning to the employees themselves, one could argue that being confronted with a health issue is mundane; people are diagnosed with or face health complaints daily. However, whether it concerns a palpable issue such as a stroke at work or a less discernable matter such as a burnout, dealing with physical or mental deterioration is renowned to elicit both cognitive and somatic challenges and uncertainties for the person concerned (Greene, Magsamen-Conrad, Venetis, Checton, Bagdasarov, & Banerjee, 2012; Jones & King, 2013).

Besides the fact that he or she has to deal with the health issue, one is confronted with the difficult decision of whether or not to inform others when the health issue is not visibly apparent (Petronio, 2002). Disclosure is, in essence, perceived as a way to (verbally) share personal information through social interaction with a particular recipient (confidant), both of whom are entwined within particular social contexts. Thus the sharing of a health issue with co-workers is a type of interaction strategy.

The disclosure of health issues in the workplace could be relevant for employees' physical and mental wellbeing. Concealment of issues equates to keeping a secret (Afifi & Steuber, 2009), which does not contribute to the authentic self or promote open relationships (at work). Disclosure is associated with a reduction of distress, whereas keeping secrets relates to increased distress via intrusive thoughts and suppression (Major & Gramzow, 1999). In this study the disclosure process of health issues in organizational contexts will be examined.

The importance of this study will be apparent after the existing body of disclosure research has been explicated. First of all, health disclosure research is largely explored from a social and/or psychological angle (e.g. disclosing the health issue to family or friends); in other words, in private conditions rather than in a business contexts (Afifi & Steuber, 2009; Greene et al., 2012; Jones & King, 2013; Major & Gramzow, 1999). Considering the different interests and functions of these social settings, studies conducted from the perspective of the private arena

are insufficient to build upon for future organizational health disclosure science. Secondly, the organizational scholars that studied disclosure focused on specific, highly stigmatized non-normative issues, such as: depression (Garcia & Crocker, 2008), abortion (Major & Gramzow, 1999), LGB workers (Griffith & Hebl, 2002; Ragins & Cornwell, 2001; Trau, 2015) and HIV infections (Chaudoir & Fisher, 2010).

These stigmatized samples form a marginalized or minority group within organizations (Trau, 2015). Furthermore in contrast to being diagnosed with a health issue, which is something that could happen to anyone, these topics comprise a higher degree of devalued, invisible, identity-related disclosures (Clair, Beatty, & MacLean, 2005). This means that there is a higher perceived degree of responsibility in the acquisition of the condition, which implies a higher "own choice" association, which, in turn, results in an increased risk of stigmatization as a corresponding effect. For example, the disclosure of a heart attack or infertility is less dependent on personal choices compared to an abortion or HIV-diagnosis due to unsafe sexual intercourse.

To date, very little is known about the disclosure process of health issues in organizational contexts (Greene et al., 2012), nor there is a specifically applied model or comprehensive framework based on fundamental research. This deficiency indicates a need to scientifically inquire into the process of disclosing health issues. In this research an attempt is made to understand the underlying processes of health issue disclosure in the work environment. The aim of this study is to unveil the dynamics of the disclosure process regarding health issues in organizational contexts.

Due to a lack of theory on health issue disclosure in the organizational contexts, various affiliated theoretical constructs are used as foundation for exploration. In this study an attempt will be made to predict and understand the cycle that employees encounter when confronted with a health issue. For example, what considerations and factors affect the decision to disclose or conceal a health issue at work. To this end, the research question this study will attempt to address is the following:

To what extent are available disclosure models, in particular the DPM, applicable to the disclosure of health issues in organizational contexts?

Firstly, in the literature study scientifically-drawn components that are already established in related literature are examined, this section will also include the explanation for selecting the DPM as foundation. Secondly, in order to determine whether the recognized components are applicable to the phenomenon of health issue disclosure in organizational contexts, an empirical qualitative study will be conducted to ascertain the applicability of the components to the workplace context. This study does not deal with the question of whether employees should

disclose or not. The disclosure process will simply be exposed and an endeavor will be made to demonstrate that the final disclosure decision is contingent on particular components.

The urgent need to develop a specifically applied model for the disclosure of health issues in organizational contexts was poignantly demonstrated by the tragedy of 24 March 2015, when 149 people, who were traveling from Barcelona to Dusseldorf, lost their lives when the airplane they were travelling in crashed into the French Alps. The co-pilot, who had been alone in the cockpit at the time, was held responsible by the French Bureau of Enquiry and Analysis for Civil Aviation Safety (BEA) for the rapid descent of the plane. They claimed that the co-pilot deliberately caused this tragedy. This claim was, in the weeks that followed, supported by impressive evidence that the co-pilots' mental health was the reason for his actions; he had ignored the sick note from his doctor and had previously been treated for depression and suicidal tendencies. This might be an exceptional example in a high-sensitive job environment dealing with many factors (e.g. enclosed workplace? serious mental disorder?) and extreme consequences (death of 150 people); however it shows that the study of health issue disclosure in organizational contexts is relevant for science and organizations, since we can suppose that if this co-pilot had decided to disclose the truth of his 'doubtful psychological health' timeously, this could have potentially prevented the deaths of the 150 people.

The findings of this qualitative study extend the current body of disclosure literature and contribute to an augmented understanding of the different questions and factors that relate to a disclosure process in organizational contexts. This study will increase the current knowledge by delineating components of the disclosure process with respect to health issues within work environments. The results will contribute to the further development of disclosure theory, as well as providing empirically based insights for practitioners. For example, a disclosure model could fortify strategic proposals for guidelines for the enforcement of disease disclosure in order to reduce the costs accrued due to presenteeism and absenteeism.

2. Theoretical framework

Although various disclosure theories and models will be reviewed in this study, the prominent Disclosure Processes Model (DPM) of Chaudoir and Fisher (2010) has been adopted as fundamental. The DPM was drawn from extensive literature research and exposes the entire disclosure process of concealable stigmatized identities. Thus the DPM is comprehensive, whereas other studies were largely focused on individual, separate stages of the process, such as solely the antecedents or motivations of decision making (Afifi & Steuber, 2009; Garcia & Crocker, 2008; Greene et al., 2012; Omarzu, 2000; Ragins, 2008), as in the Disclosure Decision-Making Model (DD-MM) of Greene et al. (2012). This model addresses health diagnosis disclosures, but only in terms of the narrow scope of the decision-making part, while ignoring

the outcome process. The current study deals with the entire health issue disclosure process in organizational contexts, including the decision-making and outcomes processes, as in the DPM. The latter is depicted in Figure 1.

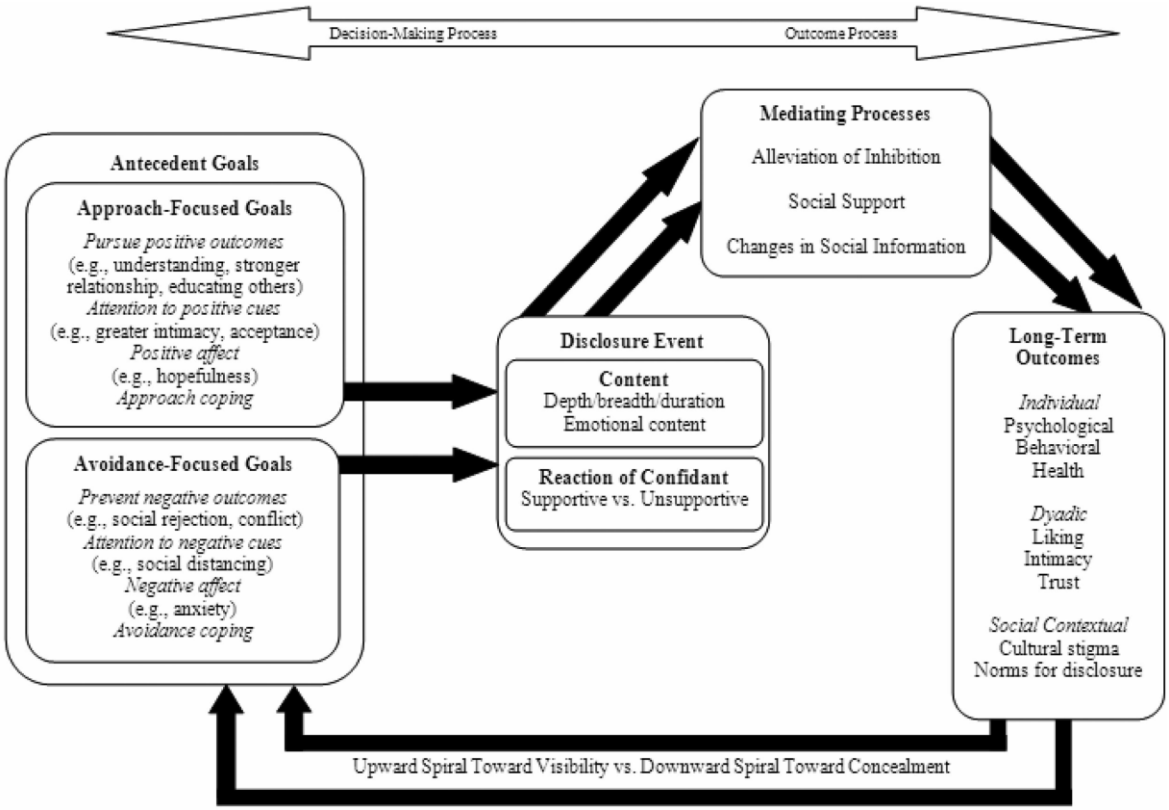

Figure 1: The DPM of Chaudoir and Fisher (2010)

Derived from the DPM, the disclosure process in this study is subdivided into three consecutive phases: 1. the pre-disclosure phase; 2. the disclosure event; and 3. the post-disclosure phase. In the pre-disclosure phase the decision to disclose (or not) is analyzed, including the utility (e.g. goals) and the risk assessment. The next phase is called "the disclosure event", although it also includes the moment of concealment. The final post-disclosure phase represents a range of probabilities and outcomes. To provide uniformity, the various disclosure components, drawn from existing disclosure literature, will be merged into these three consecutive phases.

2.1 Pre-disclosure phase

The pre-disclosure phase in this model is an attempt to identify and describe the components leading to a disclosure decision, which comprises considerations and evaluations. Although decision making is almost an indescribable process due to the elusive nature of human decision making (see prospect theory of Amos Tversky and Daniel Kahneman) and related cognitive functioning, an attempt will be made to outline the established assumptions in the decision-making process.

This area of science remains weak, as Mengov (2015, p. 17) noted: “Decision analysis has suffered from the chronic problem of not being able to develop a set of stable fundamental principles that can guide its further evolution”. Furthermore, it is advocated that daily decisions and evaluations are often automatic and largely controlled by unconscious mechanisms (Omarzu, 2000), which makes decision making difficult to clarify.

More specifically, with respect to this study, the decision to disclose a health issue (or not) at work is not processed routinely, which makes it even harder and more complicated (Mengov, 2015). However, it could be due to the abovementioned challenging reasons that the majority of disclosure scholars focused on this first phase of the disclosure process, that is, to grasp why and how people make disclosure decisions.

Disclosure researchers have widely acknowledged that individuals evaluate the **risks and benefits** of disclosure in the decision-making phase (Afifi & Steuber, 2009; Chaudoir & Fisher, 2010; Clair et al., 2005; Garcia & Crocker, 2008; Greene et al., 2012; Jones & King, 2013; Omarzu, 2000; Petronio, 2002; Ragins, 2008). Before sharing a health issue, employees try to make an estimation of the perceived outcomes during and after disclosure. Consequently, they take that estimated risk-benefit analysis into account in their decision to disclose or not. This implies that the risk-benefit analysis determines if one is ready and/or willing to disclose or not.

Risk-related outcomes are negative reactions, such as negative judgments. More concrete risks relevant to the workplace are, for example, job loss, isolation or truncated career paths (Afifi & Steuber, 2009; Chaudoir & Fisher, 2010; Clair et al., 2005; Ragins, 2008). Outcomes perceived positive are beneficial and rewarding, such as understanding, positive feedback or support in the form of adjustments at work (Chaudoir & Fisher, 2010). Disclosure is perceived as positive or rewarding when the benefits outweigh the costs (Chaudoir & Fisher, 2010; Garcia & Crocker, 2008; Griffith & Hebl, 2002, Jones & King, 2013). If the perceived risk is higher than the expected benefits, it is likely that a decision will be made to conceal the issue. For example, if an employee is convinced that his job will be compromised if he discloses a visual impairment, his most likely decision would be to conceal the health issue if possible. On the other hand, when one is expected to receive more advantages (e.g. support and the needed adjustments) than disadvantages, the inclination to disclose is higher.

A major component of the risk-benefit analysis is an estimation of the expected (positive or negative) feedback of the confidant and the associated envisioned consequences (in the short and long term) (Afifi & Steuber, 2009; Ragins, 2008). Fear of negative reactions is already sufficient to influence the risk-benefit analysis and thus the disclosure decision. The expectation of receiving negative judgments or reactions from the confidant is likely to contribute to a higher perceived risk, which will lead to a higher probability of concealing. People facing a health issue could, for example, expect to receive unsympathetic or stereotyped reactions and to

risk being criticized, (socially) disapproved of or discriminated against. Anger, shame and threat to an employee's identity are examples of types of responses that could occur after disclosure. Expectations of support, on the other hand, strengthen the evaluated perceived benefits, which increases the willingness to disclose (Afifi & Steuber, 2009; Ragins & Cornwell, 2001). For example, if an employee with a mental or physical health issue expects, based on previous experiences, to receive support of any kind (e.g. flexible work hours or understanding), he or she is more likely to be inclined to disclose compared to when a lack of support or discrimination is expected.

Previous studies referred to this part of the cost-benefit analysis in various ways. Ragins (2008) speaks of 'the anticipated consequences', whereas Green et al. (2012) made a distinction between anticipated response (the immediate feedback after disclosure) and the anticipated outcome (consequences or results of the disclosure). Munir, Leka, and Griffiths (2005) emphasized the importance of perceived organizational support and Ragins and Cornwell (2001) noted the importance of perceived discrimination. However, to avoid ambiguity and confusion, this study refers to this evaluative element with the umbrella term **'the expected reaction'** (Chaudoir & Fisher, 2010; Clair et al., 2005), which includes the estimation of the immediate feedback shortly after the disclosure itself and the expected reaction, outcomes and consequences after disclosure in the long run. Also, the expected reactions could vary in range from positive to negative.

Another irrefutable part of the evaluation of whether to disclose or conceal are the **disclosure goals** (Chaudoir & Fisher, 2010). The goals are indicated as the first step prior to the risk-benefit analysis (Omarzu, 2000). Putting the sequence discussion aside, in this study the disclosure goals are considered to be part of the pre-disclosure phase. Omarzu (2000) refers in his Disclosure Decision Model (DDM) to the following motives for (self) disclosure: 1. Social approval, to obtain affection and affirmation from the environment, which releases stress and enhances well-being (Munir et al., 2005). 2. Intimacy, to achieve closer relationships. 3. Relief from distress by expressing emotions. This is described by various scholars as catharsis (Afifi & Steuber, 2009). 4. Social control is about who is in charge of the information, and 5. Identity clarification represents the need to be liked by others and how one presents the self or explains behavior to achieve that. Other researchers added pressure from others (e.g. family, friends or doctor) to disclose or the feeling that others have the need or right to know (e.g. duty or education) despite the knowledge of possible negative outcomes (Afifi & Steuber, 2009; Munir et al., 2005). Also, more practically-oriented examples of supportive goals to disclose to receive support at work were defined by Munir et al. (2005), such as: working fewer hours or days, permission to leave for treatments, a reduction of the work, and other adjustments to the work or its environment.

What can be concluded is that disclosure has the positive potential to: strengthen relationships, to realize positive work-related outcomes, to influence the environment (e.g. educate others / increase awareness), receive positive benefits such as understanding and help, and to protect the confidant from worry. At the same time, disclosure has a negative potential to: provoke social rejection or isolation, disapproval, job loss, (job) discrimination and other negative work-related outcomes, as well as both physical and verbal violence or aggression (Afifi & Steuber, 2009; Clair et al., 2005; Munir et al., 2005; Pachankis, 2007; Ragins, 2008). These contradictory consequences of disclosure indicate that, within the risk-benefit analysis, potential disclosers balance personal interests and needs (e.g. keeping information private, protecting others from worry, avoiding social rejection) with the needs of others (e.g. safety reasons, education) (Chaudoir & Fisher, 2010; Garcia & Crocker, 2008). The RRM (Afifi & Steuber, 2009) suggested indeed that the assessment of risks and benefits involves an evaluation of motives for the self, the other and the relation.

Of course the risk and benefit consideration is subjective. Questions that arise are, for example, how employees determine a "too high" disclosure risk and what factors influence this risk-benefit analysis. Within the “disclosure dilemma”, people struggle, for example, with the tension between authenticity and self-protection or self-preservation (Clair et al., 2005). Authenticity means being open and honest (i.e. real) in public and represents the part of a person that wants to disclose. Contrary to this is the decision to conceal for protection of the self and maintaining social identity against negative outcomes, such as discrimination and stigmatization. Scientific studies found that various components contribute to the answer to these questions. Omarzu (2000) mentioned that a. individual differences, such as the degree of extroversion or social desirability, are related to disclosure rates but that b. these influences are found to be questionable in a variety of situations. He quoted the example that women tend to disclose more often than men. However, there are situational exceptions (when the situation is not blurred and there are clear goals) when men do disclose as much or even more than women. Ragins (2008) complemented this by defining three different factors that influence the ‘expected reaction’: 1. the individual, 2. the environment and 3. the stigma.

The individual factor indicates that a person’s own characteristics, motivations and experiences influence the disclosure decision in the risk-benefit analysis (Omarzu, 2000). Greene et al. (2012, p. 366) noted: “Overall, how patients frame the information is a foundational component of how they process disclosure decisions, view others’ potential responses, and perceive their efficacy for sharing.” Various scientific studies have confirmed that individual factors contribute to the decision to disclose or conceal, such as: internal motivations, needs and (eco/ego) systems (Garcia and Crocker, 2008; Ragins, 2008), personal frames (Clair et al., 2005), the belief in own skills and abilities (i.e. communication efficacy*)*

(Afifi & Steuber, 2009; Bandura, 1977; Greene et al., 2012), and the degree of identification with the health issue or the self (Griffith & Hebl, 2002; Pachankis, 2007; Ragins, 2008).

Omarzu (2000, p. 182) added the following to interpret these individual factors: "Thus, individual difference variables may be examined, not to determine who generally discloses more or less than whom, but to explain variation in how different individuals react to the same situational cues and in how they use disclosure strategically."

The environment factor refers in this study to the presence of organizational components that influence disclosure decisions (Clair et al., 2005; Ragins, 2008; Ragins & Cornwell, 2001; Trau, 2015). The organizational context emits various signs and symbolic indications, which are interpreted and taken into account within the risk-benefit analysis (Clair et al., 2005). Ragins (2008) defined three relevant environmental antecedents that support disclosure, namely: 1. the presence of similar others; 2. the presence of supportive and ally relationships; and 3. institutional support. The probability of disclosure will increase if all three are present; however, one of the three can serve as appropriate encouragement to reveal as well.

1. The outcomes of earlier cases (i.e. the presence of similar others) set the example for others, forming cues that can help to shape the expected reaction (Clair et al., 2005). Furthermore, the presence of similar others provide acceptance, affirmation, and emotional support, leading to more self-confidence (Ragins, 2008). Besides that, disclosure is more likely when people have demographical similarities, such as gender, race and sexual preferences (Clair et al., 2005; Ragins, 2008). For example, higher rates of gay co-workers (both supervisors and colleagues) are associated by gay employees in an organizational context with lower perceptions of discrimination (Ragins & Cornwell, 2001).

2. The presence of supportive and ally relationships decreases negative risk, since social support, trust and positive feedback are present. Four functions of psychosocial support are: direction and guidance, affirmation of ideas, role modeling and mutuality, and trust; hence, the presence of these functions affects the disclosure-decision positively (Trau, 2015). For example the inclination to reveal information is higher when closeness and trust is felt in a relationship (Clair et al., 2005). On top of that, these relationships can accommodate instruments for support such as protective and intervening actions by powerful individuals. Greene et al. (2012) found that the higher the perceived quality of the relationship, the more positive and supportive the expected reaction, which in turn increases the likelihood of disclosure. Afifi and Steuber (2009) also found that a lack of closeness in the relationship will increase the perceived risks and lower the willingness to disclose.

3. Institutional support involves the degree to which the environment is perceived as a "safe haven". People adapt to their environment to be part of it and to fit in (Clair et al., 2005). As applied to organizations, the culture, norms, values, policies, treatments, practices and

symbolisms of the organization are indicators of institutional support. These institutional factors represent the accountability and support of the organization (Clair et al., 2005), which can be cues for the disclosure-decision (Munir et al., 2005; Ragins & Cornwell, 2001). Evaluations of the climate (e.g. discriminatory environments) that organizations radiate give employees signs and indications for their identity management, career developments and work-related attitudes (Trau, 2015). In positive climates (e.g. nondiscriminatory), employees are more likely to disclose their issues and expect to receive more support (Trau, 2015). Ragins and Cornwell (2001) found that laws, policies and practices influence gay workers' perceived workplace discrimination and directly influence turnover intention, organizational commitment and career commitment. In organizations, the contexts and the type of industry or job are also relevant (Clair et al., 2005). For example, in masculine environments such as the army, people are less likely to reveal weaknesses than in more feminine environments, such as healthcare.

The Stigma in this pre-disclosure phase encompasses feelings of embarrassment, fear or anxiety to disclose due to the perceived stigma attached to the health issue (i.e. self-stigma). Several studies (e.g. Garcia & Crocker, 2008; Kelly & McKillop, 1996) emphasize the risks of possible stigmatization attached to disclosure (e.g. rejection, discrimination and stereotyping). Stigmatized groups are prejudiced and subordinated by "less inferior" groups regarded (by themselves) as "normal" (Ragins & Cornwell, 2001). Stigmatization is a judgmental aspect that can be developed only in social environments (Ragins, 2008) and is therefore relevant in organizational interaction.

Furthermore, this social aspect implies that components of the sender (e.g. the expected reaction of the confidant, the individual factor and perceived goals) and the receiver (factors of the environment) exert a significant influence on whether a health issue is perceived as stigmatizing.

Caution about stigmas at work is legitimate; they can damage employees' identity, strain social interaction and often result in discrimination, intolerance and loss of (social) value (Ragins, 2008). These effects hamper professional relationships and networks and suppress development opportunities at work (Clair et al., 2005; Ragins, 2008), which in turn has reciprocal effects on job-related outcomes such as productivity. The perceived stigma can elicit various feelings about social interaction, such as discomfort, uncertainty and unpredictability, and is indicated as a barrier to disclose (Garcia & Crocker, 2008; Ragins & Cornwell, 2001).

Although the degree of stigma is not inferior to the other factors (thus the individual and the environment), this researcher perceives this focus as being too narrow. Greene et al. (2012) mentioned stigma as part of **information assessment** and referred to four other characteristics of information assessment, besides stigma:

1. **Stigma** (dealt with above).
2. **Prognosis** relates to the progress of the diagnosis and associated uncertainties. Is the health issue curable, treatable, temporary, chronic or terminal? For example, medication or treatments during work hours demand (visible) actions that influence the disclosure decision (Munir et al., 2005).
3. **Symptoms** affect the degree of visibility and disease progression. The degree of visibility forms a crucial component of the disclosure decision (Clair et al., 2005; Pachankis, 2007) because visible health issues are less easy to conceal and could lead to stigmatization during social interactions. However, facing a non-apparent health issue includes managing psychological considerations (e.g. if, how and at what time to disclose) prior to interaction. Also, some health issues are more disruptive than others (Ragins, 2008), which implies that the degree of interference in social interaction differs. Peril or threat associated with the issue (e.g. whether it is contagious) increases the risk of negative feedback (Ragins, 2008).
4. **Preparation** is to do with the fact that the option to anticipate is in some cases higher (e.g. a certain cancer type in family) than other unexpected cases. Thus the extent to which this 'happens to' someone is explained here. Ragins (2008) mentioned this as the controllability of the stigma, which means that the degree of own responsibility for the health issue is likely to be weighed in the disclosure decision.
5. **Relevance** means that the information could be, to some extent, (not) relevant to others. Higher relevance for others is, for example, when the health issue is transmissible within the environment (air) or genes and is related to higher disclosure rates.

Thus, this third factor information assessment relates to the assessment of the consequences of the contextual influence, not about the sensitivity of the information itself. By adopting this latter categorization, a broader vision for this study is endorsed, which makes it possible to explain other relevant information: a. information assessment includes other elements (prognosis, symptoms, preparation and relevance) that refer to the health issue diagnosis instead of stigma as the only focus and b. this study addresses, as in the Greene et al. (2012) study, more general health issues, including those with a visible impact, whereas Ragins (2008) had a specific focus on non-apparent stigmatized identities.

A related question at the end of this phase is why people decide not to disclose. The reason for concealment, according to this study, depends on (negative) considerations made in the pre-disclosure phase of evaluating the risks and benefits of disclosure. This comes down to negative evaluated disclosure goals or expected reactions. For example, the relevance for others to know is absent (the other), the willingness to disclose is absent due to a lack of belief in one's own communication ability (the self) or one has learnt from earlier experiences that disclosing a

health issue can cause job loss (the relationship). The next phase will anticipate the disclosure event itself and its relevant components.

2.2 Disclosure event

Previous research indicates that disclosure can vary on a continuum of strategies that ranges from concealed to disclosed (Afifi & Steuber, 2009; Munir et al., 2005; Omarzu, 2000; Ragins, 2008; Ragins & Cornwell, 2001). These scientists convey that people could use a variety of strategies to disclose, from indirect to direct strategies (Afifi & Steuber, 2009). Furthermore, scientists approached the disclosure event as an ongoing process accounting for any interaction at work (Jones & King, 2013; Ragins, 2008). In this study, however, disclosure is approached as a dependent variable and two dichotomous options that could arise after the pre-disclosure phase, namely disclosure or concealment, are explored.

Thus, a static yes/no view (i.e. the health issue is disclosed at work or not), as in the vision of Chaudoir and Fisher (2010), is adopted for this study. This view concentrates on one (disclosure) question specifically applied to the workplace: has the health issue been disclosed at work or not? This "disclosed at work or not" view is a simplified perspective of the event but makes it possible to measure an open discussion afterwards and leaves more room for the considered situation, why and to whom employees disclosed (or not). Defining the key components before, during and after disclosure seems for now a more relevant investigation than to find out the degree of revelation or the analysis of the order of every disclosure interaction at work.

The non-disclosure (i.e. conceal) option simply means the health issue is not disclosed at work. Based on Chaudoir and Fisher (2010, p. 6), we refer to the disclosure event as "the verbal communication that occurs between a discloser and a confidant at work regarding the discloser's possession of a health issue". Thus it is the interaction moment itself, a one-time situation in which the health issue disclosure took place and which concerned the ailing person communicating the issue to his or her supervisor or colleague(s).

In this phase the DPM indicates emotional content, depth, breath and duration during the event as relevant additional communicational attributions. Several disclosure model studies (e.g. Chaudoir & Fisher, 2010; Omarzu, 2000) noted that these dimensions are shaped by the expected reaction of the confidant and influence confidant's reaction. Without questioning their value, this study puts less emphasis on the abovementioned content due to the chosen method for this study.

Confidant's reaction, as presented in the DPM, indicates a separate dimension of the event phase and is also included in the event phase of this study because: 1. Disclosures are only beneficial if responses are supportive and accepting (Chaudoir & Fisher, 2010; Griffith & Hebl,

2002, Jones & King, 2013). 2. It is part of the risk-benefit analysis in the pre-disclosure phase, in which the expected reaction is already examined (Afifi & Steuber, 2009) in order to assess or even prevent negative reactions (Griffith & Hebl, 2002) and 3. The confidant's reaction is considered to affect not only physical and psychological health but also organizational outcomes (Jones & King, 2013; Trau, 2015). Griffith and Hebl (2002) found a mediating role for the confidant's reaction between disclosure and job satisfaction, and disclosure and job anxiety.

This phase automatically leads to the third phase, which will illustrate the consequences that stem from the disclose-decision.

2.3 Post-disclosure phase

This phase represents the results (outcomes and the evaluation) that emanate from the earlier phases. That is, in this phase the outcomes are judged and evaluated on the basis of the risk-benefit analysis (e.g. the goals and confidants' reaction).

Antithetical to the pre-disclosure literature, there is not much disclosure-outcome literature available. Chaudoir and Fisher (2010) recognized three contextual disclosure outcomes: 1. **individual outcomes**, such as psychological benefits (a decrease of stress and intrusive ideas of identity) and behavioral outcomes; 2. **dyadic results,** such as increased interpersonal liking, intimacy and trust; and 3. broader **social outcomes** such as the education of others.

Furthermore, resources provided by the organization such as institutional support (see pre-disclosure phase) influence **work-related outcomes**. Several studies associated work-related attitudes and behaviors in direct or indirect relation with disclosure. For example, Griffith and Hebl (2002) found that LGB-disclosure at work induces higher rates of job satisfaction and lowers job anxiety. Additional scientists found that the expected reaction (i.e. perceived workplace discrimination and perceived support) mediated between disclosure and the following job-related positive outcomes: 1. turnover intention; 2. organizational commitment; 3. career commitment and satisfaction; 4. organizational self-esteem; 5. job satisfaction; 6. opportunities for promotion (Ragins & Cornwell, 2001; Trau, 2015); and, in the negative sense, job tension (McGonagle & Hamblin, 2014).

Thus, in this post-disclosure phase, cues and expectations from the pre-disclosure phase are evaluated after experiencing the disclosure-event phase. For example, Trau (2015) found the following evidence regarding the organization's climate: "Those who perceived a nondiscriminatory climate in their organization were more likely to disclose stigmatized identity and receive higher psychosocial support from their developmental network […] psychosocial support was found to be positively related to job and career satisfaction" (p. 345).

An indispensable component that coincides with or follows this phase is the **feedback loop**. This component is established in several disclosure models (Chaudoir & Fisher, 2010; Clair et

al., 2005; Jones & King, 2013; Ragins, 2008) and is likewise inserted into the framework presented in this paper. It indicates that the outcomes (phase three) of the event (phase two) have shaping effects on the next disclosure decision (phase one). This experience of a disclosure process is applicable within various social environments and has also been found to be relevant to organizational contexts (Jones & King, 2013). This shows the relevance of including the feedback loop in this study.

To summarize briefly, in the pre-disclosure phase the disclosure decision is made and contains a risk-benefit analysis. Within this risk-benefit analysis the self, the others and the relationship between the two are taken into account. Note that in this phase the discloser can only estimate reactions, feelings and outcomes of a disclosure. The direction of the evaluation of whether to disclose largely depends on: 1. the expected reaction of the confidant; and 2. the disclosure goals. Furthermore, the outcome of the risk-benefit analysis and the decision to disclose or conceal is influenced by three factors: 1. the individual; 2. the environment; and 3. information assessment.

The disclosure event phase deals with disclosure as a static event with dichotomous outcomes, namely disclosure or concealment, and takes the confidant's reaction into account.

In the post-disclosure phase individual, dyadic and work-related outcomes ranging from negative to positive could be recognized, irrespective of disclosure or concealment. Furthermore, this is the end of the process, however, since the disclosure process forms an experience in itself, the full process will be taken into consideration in a (possible) next disclosure process; this experience is depicted in the feedback loop.

In addition, it must be mentioned that the disclose decision (event phase) cannot be categorized as a good versus bad decision, but rather as a cause and effect explanation (Ragins, 2008). This means that the perceived outcomes of the decision to disclose a health issue in an organizational context are fundamental. Whatever the decision is (to disclose or not), there are always consequences attached to the choice. The risk-benefit analysis serves to make an estimation of the outcomes and consequences. For example, the disclosure of a health issue will lead to differing outcomes and experiences depending on whether it takes place within a non-supportive or supporting environment.

Furthermore, this study does not constitute an attempt to address or visualize the contribution of each factor; they are assumed to be relevant parts of the disclosure decision and are unlikely to operate autonomously. Greene et al. (2012), for example, found that information assessment influences disclosure efficacy (an individual factor) and is related to the expected reaction and the environment. Ragins (2008) also mentioned that the individual factor not only has a direct influence in the disclosure decision but also indirectly controls the disclosure decision through the expected reaction.

The abovementioned components were retrieved from established disclosure and organizational literature. An attempt will be made to discern their applicability to health issue disclosure in organizational contexts in the current study.

3. Method

In this exploratory study, semi-structured interviews were held with 58 working participants who suffer(ed) a health issue. This methodology facilitated the retrieval of insights into the disclosure process in organizational contexts for the purpose of theoretical development, by means of the collection of reports of personal experiences, thoughts and attitudes. Furthermore, the method provided structure in the form of specifically formulated questions while allowing the researcher to retrieve more detailed information whenever it was considered necessary. This method was preferred over a focus group due to the sensitivity of the topic and the ability to delve deeper into the matter on a personal level.

3.1 Sample selection and population

The selection criteria were far-reaching due to the aim of the study (e.g. to determine components of the disclosure process of health issues in work environments). This resulted in a diverse sample of the working population who have (had) a health issue.

For efficiency reasons, the data was retrieved from two different sources. Firstly, the sample consisted of received data: the University of Twente provided a database that consisted of 49 useful interviews submitted by students in 2013 for obtaining pre-master credits. Their assignment and interview guide is attached in Appendix A. Secondly, the researcher added personally collected data consisting of nine similarly executed interviews, which were held in May 2015. Since the University of Twente provided a readymade sample, selected using the same population criteria, the researcher continued with the same sampling strategy. Irvine (2011, p. 182) used similar selection criteria, which gave the researcher confidence concerning the suitability of the criteria used by the university.

Due to the sensitive topic of the study (i.e. discrimination could be involved), a sampling technique in the form of purposive sampling was used: the researcher(s) approached respondents via their private network and after that via snowball sampling within that network. The idea behind purposive sampling is that people who fit selected criteria are more relevant "information-rich cases" for the purpose of the study (Patton, 2002). Thus, first of all, the selection technique can be justified by the research goals: the intention was not to draw objective statistical conclusions but to get insights, via people's perspectives (e.g. feelings, opinions and motivations), into the complexity of the disclosure process in organizational

contexts. Furthermore, the use of individuals' social network is used by researchers to: "access 'hard to reach' and 'sensitive' populations" (Browne, 2005, p. 48).

The sample was interviewed face to face and consisted of 26 females and 15 males, while the gender was unknown for 17 interviews.[1] The interviews lasted 15:14 minutes on average, ranging from 05:45 minutes to 24:00 minutes, with a total of 05:19:46 hours.[2] This average time is not very long because the interview comes down to one event (disclosed or not) and the considerations and outcomes. Nevertheless, it fitted the study goal, which was considered more important than to extend the duration of the interviews.

Forty-eight respondents (82,76%) had concealed their issues (23 female, 11 male, 14 unknown; 42 stated that the issue affected work, and 6 denied this), versus 10 respondents (17,24%) who had disclosed the health issue (3 female, 4 male, 3 unknown; 6 stated the issue affected work, 4 denied this).

3.2 Procedure

Prior to the interview, the researcher started with a short screening to make sure the attendee matched the criteria. Furthermore, relevant information was provided: a brief explanation with a relevant example, the aim and relevance of the study and the expected interview length. Permission to record the session was granted prior to each interview. The interviewer verified the voluntary participation (with the right to withdraw) and explained that there were no good or bad answers. Finally, before starting, the researcher assured the respondents of their anonymity and the confidentiality of their replies.

This pre-interview procedure covered mainly the respondents' rights and assurances; however, during the interview discomfort could have arisen because the issues concerned private and sensitive information (i.e. health issues with a possible stigma). In order to reduce possible uneasiness, the interviews were executed in a private setting chosen by the respondents themselves in order to create a safe and comfortable setting (most of the respondents chose their own homes). Apart from that, the interviewees knew the interviewer via their private network, which should also have contributed to a more comfortable feeling (Patton, 2002).

All the interviews were audiotaped and transcribed. The study was approved by the Ethics Committee of the University of Twente.

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[1] The development and collection of data was partly out of the authors' hands, which explains the incompleteness of some demographics (e.g. education, gender, length of interview and marital stage). However, collecting demographics was not the aim of the study. From the collected data (N=9) the respondents had an average age of 40 ranging between 22 and 66.

[2] Based on 21 interviews. Of received data (N=49), 37 students did not note the recording time. The tapes recorded by the students were, due to privacy considerations, not available.

3.3 The interview guide

A list with example questions was developed and provided by the University of Twente (see appendix A). The researcher chose to supplement the existing body of data in the same way as the students had done. The procedure for both samples was consequently similar: to enter into a dialogue with the respondents, a semi-structured design provided by the University of Twente was used as basis.

The interviews started out by gathering some job- and issue-related information via open questions (e.g. Can you tell something about your daily occupation?). The respondents were given the opportunity to speak about their jobs, the health issues they faced and the degree to which the issue affected their jobs. After that the question regarding the disclosure process, based on the content of the DPM (Chaudoir & Fisher, 2010), came up. First the event phase was covered. Did the interviewee disclose the issue or not? Furthermore, they were invited to explain the disclosure event in-depth by being asked how exactly the event happened (to whom it was disclosed) and to describe the actual reaction of the confidant. Then for the pre-disclosure phase the participants' decisions were discussed. Why did they choose to disclose or conceal? What were the considerations? Also, what (reaction) was expected by them? Finally the post-disclosure phase was measured by asking whether the experience had positive or negative consequences and if they would decide to do the same the next time. Thus the interview was divided into relevant topics, including: the employment of the interviewee, the experienced health issue(s), the disclosure itself, considerations and motives, the perceived outcomes, and finally future intentions. For the nine interviews conducted by the researcher; the template was translated into Dutch, with slight adjustments. This protocol with the questions can be found in Appendix B.

At the end or before starting the interview, some demographic information was gathered (age, living arrangements, gender and education).

3.4 Analysis

The interviews were transcribed verbatim, leaving out only redundant details (e.g. stutter, thinking expressions, repetitions, pauses and colloquialisms) to maintain an overview and display the respondents' words as accurately as possible. This was to focus on the meaning and perception regarding the disclosure and not the dynamics of the interview itself (Oliver, Serovich, & Mason, 2005). For analyzing the collected data MAXQDA 12, analysis software that supports the encoding of data, was used. The overview of the variables can be found in appendix C.

The data analysis was not executed purely inductively. However, to prevent becoming deductive, a coding style other than coding only in terms of the three phases was executed, as will be described below. To maintain structure, three steps were used to code. In step 1 the author used the three phases of the disclosure process (i.e. pre-disclosure phase, disclosure event, post-disclosure phase); thus all the interview quotations were assigned to one of these three phases. In step 2 the researcher looked for central recurring themes in the quotations assigned to the three phases. This resulted in: a. confirmation of the three predicted influential factors of the pre-disclosure phase (1. the individual; 2. the environment; and 3. information assessment); b. the recognition of three given reasons to disclose (i.e. no choice, benefits and rights); and three mentioned reasons to conceal (i.e. discrimination, unwilling, unaware/unable) in the pre-disclosure phase; c. four labels that belong to the disclosure-event (i.e. disclosing to manager/colleagues, confidant's reaction and experienced feelings); and d. the identification of outcomes that belong to the post-disclosure phase (i.e. positive, negative, image of the organization), including the feedback loop. Finally, in step 3, each individual case (i.e. interview) was cross-checked to discover possible patterns; for example, whether similarities in the pre-disclosure led to corresponding results in the post-disclosure phase. The final code structure and associated numbers of coding can be found in Appendix D.

3.5 Inter-coder reliability

To increase the reliability of the study, an inter-coder reliability was executed. Apart from the code structure, a protocol for grouping and sorting the citations was written (see the codebook in Appendix E). Armed with this codebook, a second experienced and independent coder allocated the quotations of 10 randomly selected interviews (17%).[3] This resulted in a Cohen's *K* of .778 (quotations were appointed to the three phases) with an observed agreement percentage of 83/97 = 85,57% (see the calculation attached in appendix F).

Some ambiguous labels were found in this phase, mainly in the pre-disclosure phase. It turned out that two of the mentioned reason labels, namely: 1. 'benefits' as a reason to disclose and 2. 'discrimination' as a reason to conceal, could also be regarded as a positive or negative 'expected reaction', which were labeled elsewhere. This is plausible since the expected reaction could vary in range from positive to negative. The mentioned reasons to disclose (benefits) or conceal (discrimination) are thus perceived as examples of the label 'expected reaction'.

Furthermore, an overlay was found in the other reasons to disclose or conceal; some respondents had mentioned that they had 'no choice' but to conceal, whereas others mentioned that they had been 'unaware or unable' to disclose. Both labels contained the possibility that the decision to disclose or conceal was beyond their control.

[3] *Excel was used for the random selection (#4, #14, #15, #19, #27, #31, #43, #48, #56, and #58).*

To solve this indistinctness, there were, apart from the three confirmed factors (i.e. the individual, the environment and information assessment), three overarching questions (Qs) that covered the formulated labels in the pre-disclosure: 1. is it possible to ignore the health issue at work? 2. Is it possible to hide the health issue at work? 3. What was the expected reaction of the confidant? Thus these Qs replaced the seven labels (i.e. the expected reaction, three reasons to disclose and three to conceal). In the results section the study findings will be presented.

4. Results

This study endeavors to unveil the dynamics of the disclosure process (pre-disclosure, disclosure event and post-disclosure) regarding health issues in organizational contexts. In a broad sense this includes the three phases defined in the literature study: pre-disclosure, the disclosure event including the option to conceal and post-disclosure. The subsequent paragraphs will outline the findings of this study.

4.1 Pre-disclosure phase

The pre-disclosure phase is about expectations and considerations. In this phase people basically evaluate the risks and benefits that contribute to the decision to disclose or conceal. This first disclosure-decision phase should not be seen as a literal roadmap but rather as a mental process.

It was found in this study that working people who face a health issue consider three questions within the pre-disclosure phase: Q1. Is it possible to ignore the health issue at work? Q2. Is it possible to hide the health issue at work? Q3. What is the expected reaction of the confidant? Q1 relates to the possibility of ignorance, which implies that the disclosure-decision might be influenced by denial (which automatically leads to concealment). Thus, to begin with, a person needs to be aware of the health issue before disclosure is an option. Q2 relates to the evaluation of a person's ability to hide the health issue. Q3 has to do with the assessment of (the expected) confidant's reactions, including direct reactions to the event and possible outcomes (i.e. negative thus risky or positive thus beneficial).

Furthermore the pre-disclosure phase comprehends the following three factors (Fs) that influence the evaluation and answers to the abovementioned Qs: the individual (F1), the environment (F2) and information assessment (F3). These factors provide an explanation for the differences in how and when people process these Qs (internally).

In paragraph 4.1.1 the three Fs will be roughly explained to provide clarity about what they include and to pave the way to a more specific application within the explanation of the three Qs. This will be followed in paragraph 4.1.2 with an explanation of the three Qs and an

elucidation of how the Fs are influential. Both are illustrated with relevant quotations from the interviews.

4.1.1 The three influencing factors in the pre-disclosure phase

As mentioned above, there are three differentiated Fs that influence the disclosure decision: 1. the individual, 2. the environment, and 3. information assessment.

The individual factor refers to the fact that several personal characteristics distinguish individual decision making. This relates to the pre-disclosure phase. People differ, for example, in their openness and willingness to share experiences with others.

The factor (work) environment is divided into: the presence of similar others (1), the presence of supportive and ally relationships (2) and institutional support (3). These three antecedents can be evaluated as positive or negative, which contributes to the risk-benefit analysis and thus the overall disclosure-decision. Negative cues are associated with concealment, whereas positive or supportive cues lead to disclosure via the risk-benefit analysis.

The information assessment factor explains how the variation of different antecedents of information (of the health issue) influences the disclosure decision. Firstly, health issue-related antecedents within this factor explain that the nature of the health issue is variable and relevant within the risk-benefit analysis. There are statements regarding: the development of the health issue, the visibility of the symptoms, the treatability (medication, healing, etc.) and the stigma associated with it. It is, for example, more awkward and risky to talk about a vaginal infection than an otitis. Secondly, job-related variables were found influential in this study. These job related antecedents influence the risk-benefit analysis in the disclosure decision. Differences could be found in: whether the job tends to physical or mental labor, the job position within the organization, the degree of independency to complete tasks or to work in relation to colleagues, mobility, the workplace environment and accountability in terms of the number of working hours, and status of tenure (from job candidate to someone nearing retirement).

In the next paragraph the three questions (Qs) will be outlined and it will be explained how the abovementioned factors could be of influence. All the components will be briefly explicated and illustrated by citations from the interviews.

4.1.2 Three questions belonging to the pre-disclosure phase

Three Qs that employees with health issues consider when formulating a (un)conscious disclosure decision in the pre-disclosure phase were proposed for this study. The results from the three Qs will now be described.

Question 1: Is it possible to ignore the health issue at work?

Table 1: Q1 and influencing factors in the pre-disclosure phase

Category	Definition	Sample quotes	Translated from
Q1: Is it possible to ignore the health issue at work?			
Yes, concealed by denial or unawareness	There is denial, unawareness or ignorance of the health issue. If the issue is ignored (by the person) this means it is automatically concealed (at that time) because one was not aware of it or unable to disclose the issue.	"Because the boutique was doing well, I ignored the symptoms; I was not aware that there could be something wrong" (#18,§16)	"Doordat de salon zo goed liep, negeerde ik de klachten en was ik mij er niet van bewust dat er iets mis zou zijn"
No, the next question (Q2) is considered	No option to deny or ignore the health issue is perceived or considered.	"Well you have to disclose if you receive sickness benefits and you will have to undergo surgery" (#33, §6)	"Nou je moet wel, als je in de ziektewet gaat en ze vragen wat je hebt en je moet geopereerd worden"
F1: The Individual	Factors of the personality that play a role in the perceived option to ignore the health issue at work. Less health issue (disclosure) experience could lead to more reluctance to disclose or later recognition of the symptoms.	"Often, at the moment I wanted to disclose, something intervened, which made me think: 'Well, never mind'" (#07,§28)	"Vaak was het echter zo dat op het moment dat ik het wilde vertellen er weer iets tussenkwam waardoor ik dacht: ach, laat ook maar"
F2: The Environment	Factors of the (work) environment that play a role in the option to ignore the issue at work.	"We are in a reorganization at the moment and I would therefore not want to take the risk to become unemployed" (#46,§53)	"We zitten midden in een reorganisatie en ik wil dus geen enkel risico lopen dat ik zonder werk kom te zitten"
3: Information Assessment	Factors of the work or health issue that play a role in the option to ignore the issue at work. For example, having a contract focusing on work or not having much contact with colleagues simplifies the possibility to ignore the issue at work.	"I was able to uphold appearances. My father (business partner) is building foreman; he left the building at a quarter past six and arrived back at five in the evening" (#03,§51)	"Ik kon mooi weer spelen. Mijn vader is uitvoerder; ging 's ochtends om kwart over zes naar de bouw en kwam 's avonds om vijf uur weer thuis. Hij had dat totaal niet door"

This first question endorses the contribution of awareness. Before a decision can be consciously made; there must have been a within-person confrontation that makes the sufferer aware of having to deal with a health issue.

In line with this finding, denial and unawareness was mentioned by the interviewees as an important reason to conceal. This will inevitably lead to concealment because denial or unawareness of the health issue implies that (internally) there is no available information about the health issue. Informing others is, for that reason, out of the question as well; one is not (or does not want to be) aware of the health issue and is therefore unable to disclose.

Indeed, some interviewees mentioned that the health issue was concealed because they perceived themselves (at that time) to be unaware or unable to disclose. They mentioned that they were unaware (at first) since they were unable to link the symptoms to the health issue: "*Well, I think I was not able to make clear that something was bothering me since I did not have a clue that the symptoms were related to the robbery*"[4] (#07,§20-§30). Thus this study shows that denial, unawareness or avoidance directly lead to concealment. However, when there is awareness and the answer to Q1 is NO, the next question (Q2) arises.

The three factors are found to be influential in relation to Q1. The individual (F1): "*It will take four months to figure out who you are and what happens to you*"[5] (#03,§39), the environment (F2) "*I knew a colleague who mentioned one should just find another job if suffering from those symptoms continues. I think that I took this, unconsciously, into consideration*"[6] (#07,§39) and information assessment (F3): "*It is also a bit of a taboo subject; a broken leg is naturally easier to discuss. Furthermore, because the problem was with my boyfriend, I did not want to disclose since he was the one who was 'out of order'. If this had been on my site it would have been easier, because than it would have been more my thing to disclose*"[7] (#15,§35).

Question 2: Is it possible to hide the health issue at work?

Table 2: Q2 and influencing factors in the pre-disclosure phase

Category	Definition	Sample quotes	Translated from
Q2: Is it possible to hide the health issue at work?			
Yes, the health issue is concealed or the next question (Q3) is considered	This means it is possible to hide the health issue at the workplace. At this time, both concealment and disclosure are possible. The consideration with the option to conceal (hide) will be explained in relation to the next question (Q3).		
No, disclosed by confrontation	Obligated disclosures lack the feeling of having a choice. Forced disclosure: the health issue could occur by their own body letting them down, a direct confrontation with others or being forced by others to disclose. The awareness of the issue by the afflicted person is a prerequisite for the disclosure.		
	** Forced by their own body*	"Yes, because if I had not told them they would have seen it; I walked crooked but I	"Ja, want als ik het niet had verteld dan hadden ze het wel gezien, ik liep een

[4] *"Ik denk dat ik ook heel slecht duidelijk kon maken dat mij iets dwars zat omdat ik zelf nog niet helemaal door had dat de ziekteverschijnselen gerelateerd waren aan de overval"*
[5] *"Voordat je in de gaten hebt hoe je in elkaar steekt en wat er met je gebeurt, ben je ook al vier maanden verder"*
[6] *"Ik weet dat er wel eens een collega is geweest die heeft gezegd dat je gewoon ander werk moet zoeken als je van zulk soort dingen last blijft houden. Ik denk dat dit onbewust wel mee heeft gespeeld"*
[7] *"Het is ook een beetje een taboe onderwerp, een gebroken been praat je makkelijker over natuurlijk. En, ook omdat het probleem bij mijn vriend lag, wilde ik het niet aan iedereen vertellen; hij is stuk en ik ben heel. Als het aan mij had gelegen dan was het makkelijker, dan was het meer mijn ding om te vertellen"*

		informed them immediately." (#11,§24)	beetje krom, maar ik heb het wel gelijk gezegd"
	** Forced by others (doctor, for example)*	"The doctor also said that I should talk about it" (#05,§65)	"De dokter heeft ook gezegd dat ik er over moest praten"
	** Forced direct confrontation*	"The situation came up during a meeting, where I needed to ask for a repetition. I then thought to myself: 'I am just going to tell them'" (#04,§55)	
F1: The Individual	Factors of the personality that play a role in the option to hide the issue at work, for example a person's personal preference to be open (or not)	"I am not a person who immediately rings a big bell" (#45,§63)	"Ik ben geen persoon die het direct aan de grote klok gaat hangen"
F2: The Environment	Factors in the (work) environment that play a role in the option to hide the issue at work.	"I know many bosses; they are more often sick than I am and they hide it" (#41,§55)	
F3: Information Assessment	Factors of the work or the issue that play a role in the option to hide the issue at work.	"If it affects your daily routine then I believe colleagues have the right to know" (#26)	

If it is not possible to ignore the health issue (Q1), the second question (Q2) arises. When the answer to this Q2 is "yes", this means it is possible to hide the health issue. This leaves people with the choice to disclose (after question Q3) or to conceal. The "yes" outcome of this question can lead to a. concealment or b. to the next considered question (Q3). The latter will be explained in more detail when we get to the results related to Q3.

However, the participants often mentioned in the interviews that they felt forced to disclose the issue at work or the confidant(s) would have found out anyway. In this case they did not feel they had the ignorance option available, so the answer to Q2 was "no". The sense of being compelled in this element was prompted in three ways, namely: 1. By their own bodies: "*The fact that you have had a stroke is just not something you can hide. You'll see it, especially the first few weeks at my walk and my actions*"[8] (#40,§17), 2. By others: *"The doctor told me that I had to call my father to inform him I was not coming to work for a year*"[9] (#03,§55), and 3. By direct confrontation: "*At one point I was working alone with her and she gave me well-intentioned tips on how to deal with children. Then tears came into my eyes, so I decided to disclose my whole*

[8] *"Het feit dat je een beroerte hebt gehad, valt gewoon niet te verbergen. Dat zie je gewoon, vooral de eerste weken aan mijn lopen en mijn handelen"*
[9] *"Wat mij heeft bewogen, is dat de dokter vertelde dat ik mijn vader moest gaan bellen en hem vertellen dat ik het komende jaar niet meer kwam werken"*

story"[10] (#15,§31). This study thus confirms that lying about the health issue, when one is directly confronted, for example, is avoided in order to remain credible and trustworthy.

The three factors were also found to influence this second question. The individual (F1): "*Both physically and mentally, I found it very nice to communicate openly with my boss and the people surrounding me*"[11] (#30,§44), the environment (F2): "*It is not the culture of the organization to conceal those issues; it is very open*"[12] (#11,§27) and information assessment (F3): "*I was not able to work because it is physically demanding; I have to walk all day and lift things, which is very annoying then… You will get a cure which works the same day, meaning you can usually get rid of the worst symptoms within a day. It happened to me a few times*"[13] (#55, §20-21).

Question 3: What is the expected reaction of the confidant?

Table 3: Q3 and influencing factors in the pre-disclosure phase

Category	Definition	Sample quotes	Translated from
Q3: What is the expected reaction of the confidant?			
The expected reaction and related outcomes	The expected reaction is often described in the form of positive versus negative outcomes that are taken into consideration in this phase. Positive expected reactions are perceived as the expectation to receive mental and/or physical benefits. Negative expected reactions (and outcomes) are mentioned as discrimination.		
	** Concealed; for the self*	"They could degrade me for being sick more often or show me a lot of pity" (#34,§60)	
	** Concealed; for the other*	I did not "burden" my colleagues with feeling sorry for myself; that's not helpful. Nor did I feel that they should do some of my work since they had enough to do themselves (#38)	
	** Concealed; for the relationship*	"I believe that this is a problem that affects only me, as an individual, and not the whole team. Therefore I see no reason to reveal this issue" (#19,§48)	

[10] *"Op een gegeven moment was ik 's avonds alleen met haar nog op het werk en ze gaf me goed bedoelde tips om hoe ik later om moest gaan met kinderen en toen sprongen de tranen in mijn ogen; dus toen heb ik mijn hele verhaal maar gedaan"*
[11] *"Zowel lichamelijk als mentaal vind ik het erg prettig om een open communicatie te kunnen en mogen hebben met mijn werkgever en de mensen om mij heen"*
[12] *"Bij ons is niet de cultuur dat je dat soort dingen niet zegt. Het is heel open"*
[13] *"Ik kon niet werken vooral omdat het werk ook fysiek belastend is en ik de hele dag moet lopen en tillen en dat is dan heel vervelend. Je krijgt bij deze klachten een kuurtje. Dat werkt goed altijd, dan ben je binnen een dag meestal wel van de ergste klachten af. Het is mij een paar keer gebeurd"*

	** Disclosed; for the self*	"My only reason to tell was to receive benefits. Firstly, I was hoping for understanding, because I have had an exhausting morning before arriving at the office. Secondly, I wanted to visit the hospital during work hours, to keep my holidays" (#01,§33)	"Mijn enige reden om het wel te vertellen was ook dat ik zelf voordeel uit zou krijgen. Ten eerste, hoopte ik op een beetje begrip. Ik heb tenslotte al een vermoeiende ochtend achter de rug voordat ik op kantoor ben. Ten tweede wilde ik ziekenhuisbezoeken onder werktijd kunnen doen, zodat mijn vrije dagen ook echt 'vrij' blijven"
	** Disclosed; for the other (safety or protection)*	"It is better to tell them, just to protect them somehow" (#37,§39)	
	** Disclosed; for the relationship*	"Your credibility disappears when you are not honest" (#05,§23)	
F1: The Individual	Factors of the personality that play a role in the expected reaction of the confidant	"I was the person with whom nothing was ever wrong. Everything went fine and perfect, always, or so people thought. In my perfectionism I preferred not to disclose issues out of shame" (#09,§119)	"Ik was altijd het persoon waar niets mee aan de hand was. Alles ging prima en perfect, althans dat dachten mensen. In mijn perfectionisme zit dus ook dat ik het liever niet wilde delen omdat ik mij ervoor schaamde"
F2: The Environment	Factors of the (work) environment that play a role in the expected reaction	"I expected to receive understanding for the situation. This is also in proportion to the relationship I had with my direct manager" (#06,§41)	"Ik had wel verwacht dat ze begrip zouden tonen voor de situatie. Dit staat ook in verhouding tot de relatie die ik met mijn directe manager had"
F3: Information Assessment	Factors of the situation (work or the issue) that play a role in the expected reaction	"I expected some pressure due to budget cuts and a shortage of labour force. Plus, we live in an era with much sickness because there is less thought given to the interests of workers" (#53,§31)	"Ik verwachte wel enigszins druk omdat er door bezuinigingen en dergelijke weinig mankracht is waardoor ze graag willen dat je werkt. Plus, we leven in een tijdperk waarin heel veel ziekteverzuim is omdat er gewoon minder gedacht wordt aan het belang van werknemers"

People consider this last question only if there is no possibility to ignore the issue at work and when there is an option to hide it. This last question (Q3) takes cognizance of two important components of evaluation for the disclosure decision: 1. the expected reaction and 2. the goals. The expected feedback from a confidant can differ from positive to negative and can vary from mental to physical. Positive expected reactions lead to the idea of receiving benefits, whereas negative evaluations lead to the expectation of not receiving cooperation. Both expected reactions were mentioned as important reasons for (fear of) disclosure during the interview.

The final disclosure decision can also be viewed from the perspective of three interrelated motives, which also partly belong or relate to the three Fs: 1. the self, 2. the other and 3. the relationship.

1. For the self. Positive for the self in this phase mean the expectation to receive benefits in any kind of support, in this case from the organization (supervisor) or colleague(s). For example: days or time off for purpose, adjusting work pattern, arranging backup or financial support for treatment and/or receive understanding and attention. One participant even mentioned disclosing only for personal benefits (exaggerated the condition to leave early to watch football, #44,§49). Be aware that in this phase only benefits could be expected.

The opposite evaluation in this phase means that the person with the health issue is afraid for negative outcomes. Most of the interviewees mentioned anxiety about discrimination as a reason to conceal since they were afraid others would condemn them (or their issue), resulting in various (perceived) negative behavior or thoughts towards or about them. Examples of discrimination are: dismissal, a disadvantage in job applications or a reduced risk of a (temporary) contract extension (e.g. a truncated career path), incomprehension, negative feelings, receiving pity, and thoughts of weakness.

2. *For the other* relates to the importance of considering "the other". This includes a perceived necessity or right of the other(s) to know. This works both ways, for both disclosure and concealment. Health issues are concealed because the risk is considered too high and for the reason that there is no need for others to know. When disclosed, the reason within the consideration "for the other" was, for example, others' protection or safety. It was mentioned that the confidant would be more aware of the reasons for abnormal behavior and would probably know better how to handle it in the case of an emergency: *"People need to know what is going on. If I fall, then they know and understand what is happening. When you conceal, they are not aware and, moreover, do not know how to handle it. That is way too dangerous."*[14] *(#05,§23).*

3. For the relationship (quality), there is another consideration in this final question. An open familial relationship makes it hard to keep secrets. Some interviewees almost felt morally obligated or duty bound to disclose the health issue: "*If you sit together in one room the morning until the evening, then you actually spend more time with them than your own family members at home … because if you sit there for like eight hours and longer in one office, then you also share worries and needs … this is inevitable … at least it should be like this, right?*" (#12,§1).

The three influential factors were also present and influenced the answers to this question: F1, the individuals (F1): "*If I disclosed, everyone would always worry about me and ask me how I am doing. I really did not need that; I just wanted not to think about it and feel comfortable at*

[14] *"Mensen moeten wel weten wat er aan de hand is als ik wat krijg. Als ik val, dan weten en begrijpen ze wat er gebeurt. Als je niks zegt dan weten ze ook niet hoe en wat. Dat is veel te gevaarlijk. De geloofwaardigheid valt dan ook weg, als je niet eerlijk bent"*

work"[15] (#18,§27); F2, the environment: "*I did trust my manager to keep the information to herself, but the situation has changed. It does not feel like she has the heart for the business. Perhaps heart for the people, but she's not often present and problems are not resolved (regarding the work)*"[16] (#50,§41); and F3, information assessment: "*If I was a different age or at a different work stage, then disclosing the issue could have had more unfavorable effects I think. For example, when I should have had to go abroad*"[17] (#25,§90).

4.3 Disclosure event

Table 4: Analysis of the disclosure event

Category	Definition	Sample quotes	Translated from
Resource	The "chosen" resource to disclose a health issue at work		
	** Face to face (1 to 1)*	"I informed my director at an early stage face to face" (#05,§56-71)	"Ik heb het vroegtijdig verteld, bij de directeur destijds 1-op-1"
	** During a meeting (1 > ? (more than 1)*	"I convoked my colleagues and explained my situation" (#16,§69)	"Ik heb mijn collega's bij elkaar geroepen en mijn situatie uitgelegd"
	** By phone*	"When I had a diagnosis, I called my manager and explained the story" (#27,§40)	"Toen ik de diagnose kreeg, heb ik mijn leidinggevende gebeld en het verhaal uitgelegd"
	** Via trusted others (partner, colleague/manager)*	"My wife informed others, I believe. Honestly, I do not know anymore. It was a very vague period in my life those first few months" (#03,§49)	"Mijn vrouw heeft dat verteld volgens mij, ik weet het eerlijk gezegd niet eens meer. Dat was een hele, hele vage periode in mijn leven die eerste paar maanden"
Person	There is a difference in disclosing to a manager and disclosing to a colleague due to the horizontal/vertical relationship	"I make a distinction between direct colleagues whom I consider to be friends and the management. I am more cautious about adopting an open attitude towards the management because they will determine one's severance… not my colleagues, whom I trust as friends"(#46,§61)	"Ik heb wel het gevoel dat ik een onderscheid maak tussen mijn direct collega's die ik beschouw als mijn vrienden en het management. Ik ben veel voorzichtiger in het geven van een open houding richting mijn management dan mijn collega's. Het management bepaalt immers wie er ontslag krijgt, mijn collega's niet"
Feelings	Before or during the disclosure of a health issue at work there are feelings involved		

[15] *"Als ik het zou vertellen, zou iedereen zich telkens zorgen maken om mij en vragen hoe het met mij gaat. Ik had daar echt geen behoefte aan. Ik wilde er juist niet aan denken en lekker aan het werk zijn"*

[16] *"Ik heb wel het vertrouwen in mijn leidinggevende dat ze het voor zich houdt, daar gaat het niet om, maar de situatie is wel veranderd. Het voelt niet alsof ze hart voor de zaak heeft. Misschien wel hart voor de mensen maar ze is er niet vaak en problemen worden niet opgelost (met betrekking op het werk) waar dat wel zou moeten"*

[17] *"Als ik een andere leeftijd had gehad en op een ander stadium in mijn werk zat dan had het nog nadeligere gevolgen kunnen hebben denk ik. Bijvoorbeeld als ik naar het buitenland zou moeten"*

	** Degree of nervousness*	"I was nervous, of course" (#05,§71)	Ik was wel zenuwachtig, natuurlijk wel.
	** Shame*	"Yes, you will have a feeling of shame" (#05,§90)	"Ja, dan heb je toch iets van schaamtegevoel"
	** Relief*	"I was not ashamed about it. Actually, I felt relieved, because now they could understand why I wasn't performing the way I always did" (#43,§33)	
	** Gratitude / appreciation*	"I felt cared about" (#26)	
Reactions from confidant	After or during the disclosure the confidant gives a reaction that can be divided into positive or negative reactions (as mentioned in the pre-disclosure phase).		
	Positive		
	** Understanding*	"Very compassionate and understanding" (#06,§44)	
	** Sympathetic*	"They showed me sympathy" (#41,§43)	
	** Shocked*	"He was startled" (#10,§33)	"Hij was geschrokken"
	** Amazed / worried*	"They never thought that something bad would happen to me" (#26)	
	** Feelings of guilt*	My father felt very guilty about it. He had a strong feeling it was his fault" (#03,§69)	"Mijn vader heeft zich daar heel erg schuldig over gevoeld, die had heel sterk het gevoel dat het zijn schuld was"
	Negative		
	** Pressure (to proceed)*	"My supervisor was a bit laconic about it, in the sense of: we all have these periods, you should just persevere and it will pass by" (#27,§40)	"Er werd door mijn leidinggevende een beetje laconiek over gedaan, in de zin van we hebben allemaal wel eens zo een periode en dan moet je gewoon even doorzetten want dan gaat het vanzelf weer over"
	** Underestimated*	"I remember my supervisor responding to my two-days-off question: that it was not necessary and I should do the work just a little in between" (#21,§50)	"Ik weet nog hoe mijn leidinggevende reageerde op mijn verzoek: nou, dat lijkt me niet nodig, doe dat maar een beetje tussendoor"

This event phase mainly focusses on disclosure, nevertheless keep in mind that this phase includes the option to conceal. When the issue is concealed, this automatically deprives the confidant of his or her ability or right to respond. This means a confidant's reaction is only

possible when the health issue is disclosed at work. This phase included the analysis to indicate a variety of situations, reactions and feelings that occur during the disclosure event.

The first phase is somehow related to this second disclosure phase since the event itself could also influence the disclosure decision. For example, disclosing a health issue after direct confrontation (by others) means that the discloser decided on the spot to inform the confidant and thus evaluated that the health issue was no longer ignorable or concealable, even though he or she had made an earlier choice to conceal. The confidant's direct question during the event thus changed the disclosure decision made earlier in the pre-disclosure phase. This, for example, limits the degree of freedom of resources (e.g. media).

The disclosure can take place via various resources. In the interview analysis, the next four were found: 1. Face to face: "*I went straight to my brother (and business partner) to inform him what was going on*"[18] (#48,§19); 2. By phone: "*I informed my manager via the telephone after he came back from a holiday*"[19] (#10,§27); 3. During a meeting: "*The situation came up during a meeting, where I needed to ask for a repetition. I then thought to myself: 'I am just going to tell them'*" (#04,§55) and 4. Via trusted others: *"Through a friend, also a colleague, of mine who was with me at the gym when it happened. She also went with me to the hospital. I agreed with her that she should inform a board member*"[20] (#13,§53). Most striking is that no written resources (letter or email) were mentioned as the first means of disclosure. The degree of sharing information can vary from disclosing information in detail to a conscious decision to conceal.

From analyzing this phase, it can be concluded that dealing with a health issue disclosure also includes a choice about to whom to disclose, which involves a different emotional feeling per type of coworker. A difference in hierarchical levels brings with it a different emotional and social situation than when it concerns peers. This is due to the legal and emotional contract and dependency. This can lead to differing outcomes of the disclosure decision. Factually, the interviewees mentioned making a distinction between disclosing to a supervisor versus to a direct colleague. This makes sense, since a supervisor has a higher rank in the formal vertical organizational structure and therefore has more influence than a colleague, who is more equal on the formal horizontal line: "*For your supervisor you want to perform correctly since she is finally assessing the internship. You want her to have a good picture of you as a stable and strong teacher. Colleagues are more equal, so with them you do not have to maintain a certain reputatio*n"[21] (#32,§40).

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[18] *"Ik ging meteen naar mijn broer (en ook mijn zakenpartner) om te vertellen wat er aan de hand was"*
[19] *" Ik heb het door de telefoon verteld nadat mijn werkgever terug was van vakantie"*
[20] *"Via een vriendin, en tevens collega van mij, die ook op de sportschool was op dat moment. Zij is ook met mij mee gegaan naar het ziekenhuis. Ik heb met haar afgesproken dat zij één van de directieleden zou inlichten"*
[21] *"Je begeleidster daar wil je het natuurlijk goed voor doen. Uiteindelijk moest zij mijn stage ook beoordelen en wil je gewoon dat ze een goed beeld van jou heeft als leerkracht. Dat je een stabiele, sterke leerkracht bent. Betreft collega's, daar ben je meer gelijk aan of zo. Dus daar hoef je niet per se een bepaalde reputatie hoog te houden"*

Feelings involved with the disclosure varied; from nervousness: "*Nervous because I did not know how they would react or the consequences*" (#04,§57) to shame: "*I actually felt ashamed that it had happened to me. But, as I said, I was disrupted too much to conceal*"[22] (#20,§45) and statements of relief: "*relieved because it was no longer baggage (that I would have to) to carry (alone) anymore*" (#04,§57), gratitude: "*I was happy and grateful to my employer*" (#10,§35) and appreciation: "*I felt very appreciated and loved*" (#26).

Confidants' reaction

Reactions during this (and partly the next) phase were, in essence, from genuinely positive (understanding and sympathetic): "*She was understanding and supportive and assured me that I could go and have my surgery and recovery anytime and made sure that I got healthy before thinking of going back to work*" (#43,§39) to shocked: "*They were all as shocked as I was*"[23] (#17,§49), amazed: "*They did not believe me. The fact that I was literally fallen hit like a bomb"[24] (#20,§51)* and worried: *"Most were really mad at me because I was on a stupid diet again. They were right; 20 kilos in three weeks is simply absurd*"[25] (#17,§53). Feelings of guilt were also reported: "*Perhaps he felt some regret*"[26] (#10,§35). These reactions are ought to report positive feelings and outcomes.

However, a few disclosers also reported no or less positive reactions, such as: pressure: "*They were not so happy that I was leaving, because with us there are not many people that can be called*"[27] (#24,§2) and underestimation of the issue: "*They didn't regard is as a medical problem… they thought of it as a headache everybody has, so they started to tell me that they experienced the same problem and told me that's not a big deal. I should go on and keep working*" (#23,§12). One participant even mentioned being accused of transmitting the health problem: "*After that, the whole office was sick and they accused me of spreading the flu. So, yeah, it is not a good idea in general to tell people. The best idea is to just stay at home*" (#37). In turn these types of reactions leaded to a more negative evaluation of feelings and outcomes.

The reactions of a confidant are related to and overlap with the post-disclosure phase since the confidant´s reaction but also the decision to conceal: a. in this phase represents the short-

[22] *"Ik schaamde me er eigenlijk voor dat het mij was overkomen. Maar zoals gezegd; ik was te sterk ontwricht om het allemaal te kunnen verbloemen"*
[23] *"Iedereen was net zo geschrokken ervan als ikzelf"*
[24] *"Men geloofde mij niet. Het feit dat ik letterlijk was omgevallen sloeg in als een bom"*
[25] *"De meeste waren ook echt boos op mij, omdat ik weer met een stom dieet bezig was. Ze hadden gelijk, binnen 3 weken 20 kilo afvallen is ook gewoon absurd"*
[26] *"Hij voelde misschien een soort van spijt"*
[27] *"Ze waren er niet zo blij mee bij mij op de afdeling, want bij ons zijn er niet zoveel mensen die opgeroepen kunnen worden"*

term results and b. forms a basis for the long term outcomes, which will be described in the post-disclosure phase.

4.4 Post-disclosure phase

This phase leaves mainly two options, receiving support or not, which could vary from positive to negative and from physical to mental support.

In this phase it is time to experience the outcomes of the reactions due to decisions made in the pre-disclosure phase. Table 5 below presents the positive and negative outcomes of disclosure and concealment on the individual, dyadic and organizational levels.

Table 5: Results and outcomes of the post-disclosure phase

Category	Definition	Sample quotes	Translated from
Individual	Possible outcomes for the person with the health issue, ranging from positive to negative. For example, perceived (lack of) benefits		
	** Positive outcomes of disclosure*	"I received the freedom to leave work when I was not able to perform anymore" (#11,§35)	"Ik had de vrijheid om, als het om twaalf uur niet meer ging, naar huis te gaan"
	** Negative outcomes of disclosure*	"Sometimes you will feel like 'I hope they do not think I am some idiot" (#50,§37)	Je hebt soms wel t gevoel van... als ze mij maar niet zien als een of andere idioot"
	** Negative outcomes of concealment*	"I sometimes have to bite through. If I need to go to an address where there is a lot of work or for five hours or so, that is a disadvantage" (#51,§50)	"Dat ik soms op mijn tanden moet bijten. Als ik naar een adres moet waar heel veel moet gebeuren enzo... een adres voor 5 uur ofzo. Dat is dan weer een nadeel"
Dyadic	Outcomes that are affecting the relationship at work between the discloser/concealer and possible confidant, which can vary from positive to negative. For example, if one feels (the inclination to) trust		
	** Positive outcomes of disclosure*	"They offered to work at my own pace, and gave me space. No sense of obligation whatsoever, which opened up the conversation for the rest of the time to inform them how I was doing. I never had the feeling I could not	"Dat ik op mijn eigen tempo kon opbouwen dat gaf me ruimte. Geen verplichtingsgevoel ofzo. Dat bood ook voor de rest van de tijd een open gesprek over om te vertellen hoe het met mij ging. Ik heb nooit t gevoel

		tell" (#54,§36)	gehad dat kan ik iets niet kon vertellen"
	** Negative outcomes of disclosure*	"My colleagues were disappointed I had not been honest to them from the beginning" (#18,§31)	"Mijn collega's vonden het jammer dat ik niet eerlijk ben geweest vanaf het begin"
	** Positive outcomes of concealment*	"Well, I was there for all my employees and that gave them confidence. That is the positive thing" (#41,§51)	
	** Negative outcomes of concealment*	"Well, there is less understanding sometimes. But if you look at it professionally, that would not have to be a limitation" (#53,§50)	"Dat je kan rekenen op minder begrip soms. Maar als je professioneel ernaar zou kijken, zou dat geen beperking hoeven te betekenen"
Organizational	Potential outcomes for the organization, which vary from positive to negative evaluations. This could lead to work motivation, job satisfaction, intention to leave, etc.		
	** Positive outcomes of disclosure*	"It resulted in the fact that I will not easily leave. Since I received so much freedom it is hard to imagine that another employer would provide or react in the same way" (#01,§42)	"Ja, de positiviteit heeft ervoor gezorgd dat ik hier niet snel meer weg ga. Omdat ik hier zo veel vrijheden heb ik gekregen waarvan ik verwacht dat ik die elders niet snel zal krijgen."
	** Negative outcomes of disclosure*	"Due to how it went, there is less motivation and confidence in the organization" (#58,§48)	"Doordat het zo gegaan is, ben je minder gemotiveerd en heb je wel minder vertrouwen in het bedrijf"
	** Negative outcomes of concealment*	"Well, as a result of having to work too long without taking care, I have left the organization" (#27,§51)	"Nou, het gevolg is geweest dat ik dus zo lang door heb gewerkt dat ik nu dus uiteindelijk niet meer bij de firma werk"

The outcomes depended heavily on the confidant's reaction in the previous phase and the interpretation of the reaction. Positive reactions were explained in the form of receiving benefits, more specifically: receiving advice and (physical or financial) help, sharing experiences or feeling no pressure from the organization, which spared the discloser: "*All the costs not covered by my insurance were paid by them; they really did everything. I never even had a*

conversation in which it was discussed that management wanted me back at work as soon as possible"[28] (#03,§67).

Furthermore, organizations often provide the discloser with help from a company doctor (according to procedure). This is evaluated as a benefit, since the lack of offering professional help is indicated and experienced as negative: "*The organization reacted pleasantly. The company doctor was accommodating and was not only giving information but was also informed about me. He never forced anything but guided me. I thought he was a nice man*"[29].

Receiving benefits can create bonds and generate trust and familial feelings: *"My colleagues are a sort of extended family to me. I know that they are there to help me; it is not only work. I know I've got real friends that care genuinely about my well-being. I've got a lot of appreciation for my boss and my colleagues because of the way they treated me before, during and after my surgery"* (#43, §45). Furthermore, positive reactions during and after the disclosure event and the related benefits (described above) influenced the work atmosphere: "*Openness to colleagues facilitates a good working atmosphere*"[30] (#07,§44). Openness elicits openness; being open and sharing information (embedded in culture) provokes other people's openness and trust: "*I know now who to trust and I would inform those colleagues directly. They also began to see me as more human, also sharing private information with me. This creates a bond*"[31] (#09,§135). A better atmosphere + positive examples in the surrounding (organization) + earlier positive experiences are relevant factors in the disclosure decision, underpinning the power of a positive (or negative) spiral.

Besides, providing benefits has another advantage for organizations. Disclosers experiencing (mental or physical) support in this phase feel grateful and satisfied with the supportive situation. In return they label this positive feedback (e.g. benefits) as a positive characteristic of the organization: "*When there is understanding and acceptance you for who you are, I find that a very positive attribute of the organization*"[32] (#45,§79). This makes employees go the extra mile: "*I think it also influenced me to do a great deal extra; a kind of compensating. Just perform better than the others, so it is not so bad when you are sick again*"[33] (#34,§49). This compensating behavior is also because employees are satisfied with the outcomes and because they do not want to be inferior to colleagues who do not have a health issue.

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[28] "Alle psychologische hulp die niet in mijn verzekering zat is door hen betaald, ze hebben er echt alles aan gedaan. Ik heb ook nooit een gesprek gehad waarin mij werd gezegd: ja, je leidinggevende wil toch wel graag dat je weer zo snel mogelijk aan het werk gaat"
[29] "Ik heb het traject vanuit de organisatie als prettig ervaren. De bedrijfsarts was zeer meedenkend en stuurde niet. Hij heeft mij nergens toe gedwongen maar overal in begeleidt en in meegenomen. Ik vond het een fijne man"
[30] "Openheid naar collega's toe beïnvloedt de goede werksfeer alleen maar"
[31] "Ik weet nu wie ik kan vertrouwen en die collega's zou ik het direct eerlijk vertellen. Ze zijn mij nu ook meer gaan zien als "mens" en delen nu ook privé dingen met mij. Dat schept wel een band"
[32] "Wanneer dan blijkt dat hier ook begrip voor wordt getoond en dat je wordt geaccepteerd zoals je bent, vindt ik dat een hele positieve eigenschap van de organisatie"
[33] "Ik denk dat ik hierdoor net een tandje extra doe. Me een soort van bewijzen en je hebt het gevoel dat je moet compenseren. Dus dat je net wat meer doet dan de rest, zodat als je dan een keer ziek bent, het niet zo erg is"

Negative post-disclosure outcomes were also mentioned. For example, interviewees asked themselves what others would think about the issue or them, which could be seen as being sensitive to discrimination: "*I feel disappointment and I also feel fear about future situations when I'll have migraine*" (#23,§12). Furthermore, conflicts and disappointments arise due to a lack of understanding or support: "*I was a bit disappointed that they responded so late because they knew exactly when I had surgery*"[34] (#24,§23). This shows that interest and compassion (i.e. emotional benefits) and adjustments to the work (i.e. physical benefits) after the disclosure are considered relevant. Ten interviewees mentioned having perceived a lack of benefits and evaluating this negatively, leading to resignation or disappointment: "*Well-equipped and professional help would have given me a boost, which I did not receive at that time*"[35] (#20,§63). Also, people do not want to admit they are having troubles due to the issue, which makes the issue more demanding: "*There is more, of course, but I do not let them notice, not at work at least. At home I am often tired after a long day, really tired. And of course I do extra to stay healthy. But a lot of people do not know that*"[36] (#01,§28).

So far the outcomes regarding a disclosure have been discussed. If the issue was concealed, a lack of (sometimes practical) benefits was experienced. Negative elements from concealing (at first) in this post-phase entails inconvenience due to increased pressure (to perform) on the person: "*Every now and then you have to make choices. Change the position to the whiteboard because you cannot read it. You are then asking yourself if others wonder why you do that*"[37] (#22,§28). Furthermore, people who conceal are less entitled to receive benefits; to keep the secret they offer their own free time (a day or a few hours) for resting or treatment: "*I often need to take days off to recover from running long shifts a couple of days. Especially in hard times when I suffer from inflammations*"[38] (#46,§59). Thus, sometimes the health issue bothers non-disclosers, which makes them (or they prefer to) work harder to hide symptoms with compensating behavior. By doing so they are not only harming themselves and their recovery but also misleading colleagues. They often invent excuses for behavior: "*In the beginning I did not say anything, but my colleagues, of course, noticed that there was something wrong. They asked me several times if all was well and I said that nothing was wrong and that it is just a temporary phenomenon*"[39] (#18,§22). When colleagues find out or are told later on they might feel disappointed for not being trusted, or/and might feel that they had the right to know. It

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[34] "Ik was wel een beetje teleurgesteld dat er zo laat pas een reactie kwam, want ze wisten precies wanneer ik geopereerd werd"
[35] "Goed ingerichte en professionele hulp zou me wel een duw in de juiste richting hebben gegeven; die heb ik toentertijd niet gehad"
[36] "Er is natuurlijk nog wel meer, maar dat laat ik niet merken. Tenminste op mijn werk niet. Thuis ben ik vaak moe na een lange dag, echt moe. Daarnaast moet ik natuurlijk van alles extra doen om gezond te blijven, maar dat weten een hoop mensen niet"
[37] "Zo nu en dan moet je zelf keuzes maken. Bijvoorbeeld verplaatsten voor het whiteboard omdat je het niet kan lezen en je dan een plek gaat opzoeken zodat je het wel kunt lezen. Je gaat je dan afvragen of andere mensen zich afvragen waarom je dat doet"
[38] "Dat ik vaak vrije dagen opneem om bij te komen van een paar dagen lange diensten draaien, vooral in slechtere tijden wanneer ik erg last heb van mijn ontstekingen"
[39] "In het begin zei ik er niets over, maar mijn collega's merkten natuurlijk wel dat er iets mis was. Ze vroegen mij meerdere malen of het goed ging met mij en dan zei ik dat er niets aan de hand was en dat dit een tijdelijk verschijnsel is"

then also affects the relationship: "*When I kept being irritated, they indulged me in certain conversations. I noticed that they no longer came to me with questions, for example*"[40] (#07,§42).

Interviewees who concealed first and, due to situational factors (the issue gets worse), disclosed later, described feeling too nervous to tell because they did not know what the confidants' reaction would be, but that they also felt relieved that they no longer had to carry the baggage (alone) anymore. Although they found it hard to tell, they decided to disclose because the benefits overweighed the negative counterpart. A few mentioned organizational consequences in the form of reassignment after a burn-out. However, before receiving benefits the person had to discuss the issue at work, which made it a kind of disclosure: "*My new job suited me better; I found more rest in it*"[41] (#31,§25).

The feedback loop

The feedback loop is a consequent element of the whole (disclosure) process. The loop is presented in this post-disclosure phase, since it starts where the post-disclosure (results and outcomes) ends and has high potential to provide new evaluative input for a subsequent disclosure processes, in particular in the pre-disclosure phase.

The personal evaluation of earlier experience, such as the results or outcomes after concealment or disclosure, is relevant for the evaluation made in the disclosure decision. Earlier experiences are not perceived, estimated or expected outcomes; they represent true (negative or positive) feelings based on previous situations and outcomes.

In other words, the whole disclosure process will be saved in the mind and can pop up next time as consideration in the (pre)disclosure phase. For example, if the experience of a previous disclosure to colleague A had been beneficial and resulted in support, it could be expected that this evaluation will positively influence the confidence of the discloser in the decision to reveal to colleague B. Furthermore, it could be that the discloser has, due to the positive (disclosure) experience, an increased trust in colleague A, which facilitates future revelations.

The majority of the interviewees confirmed that they would decide to do or act in the same way when they had to make the disclosure decision again: "*Definitely! For me it was a happy ending. So of course I would share my experience*" (#43,§47). Three interviewees mentioned that they would make different decisions. They stated that they would disclose at an earlier stage a. for benefit reasons and b. because they estimated that they would more easily recognize the symptoms of the health issue: "*No, I have learned that honesty is the best policy. The longer you conceal, the more it will gnaw. It would have been better to inform my team from the start, to devise a plan together so that the salon would not suffer*" (#18,§33).

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[40] *"Toen ik maar prikkelbaar bleef, gingen ze me misschien wel een klein beetje ontwijken in bepaalde gesprekken. Ik merkte wel dat ze niet meer zo snel bij me kwamen met bijvoorbeeld vragen of iets dergelijks, terwijl ze dat eerder wel deden"*

[41] *"Mijn nieuwe baan paste meer bij mij; hier kon ik meer rust in vinden"*

5. Discussion and conclusion

The aim of this study was to unveil the dynamics of the disclosure process regarding health issues in organizational contexts. With this study the researcher was able to ascertain the applicability of already established scientifically proven disclosure components to the workplace context. In this section a conceptual framework (figure 2) that fits the study findings will be presented and offers useful insights for researchers and practitioners.

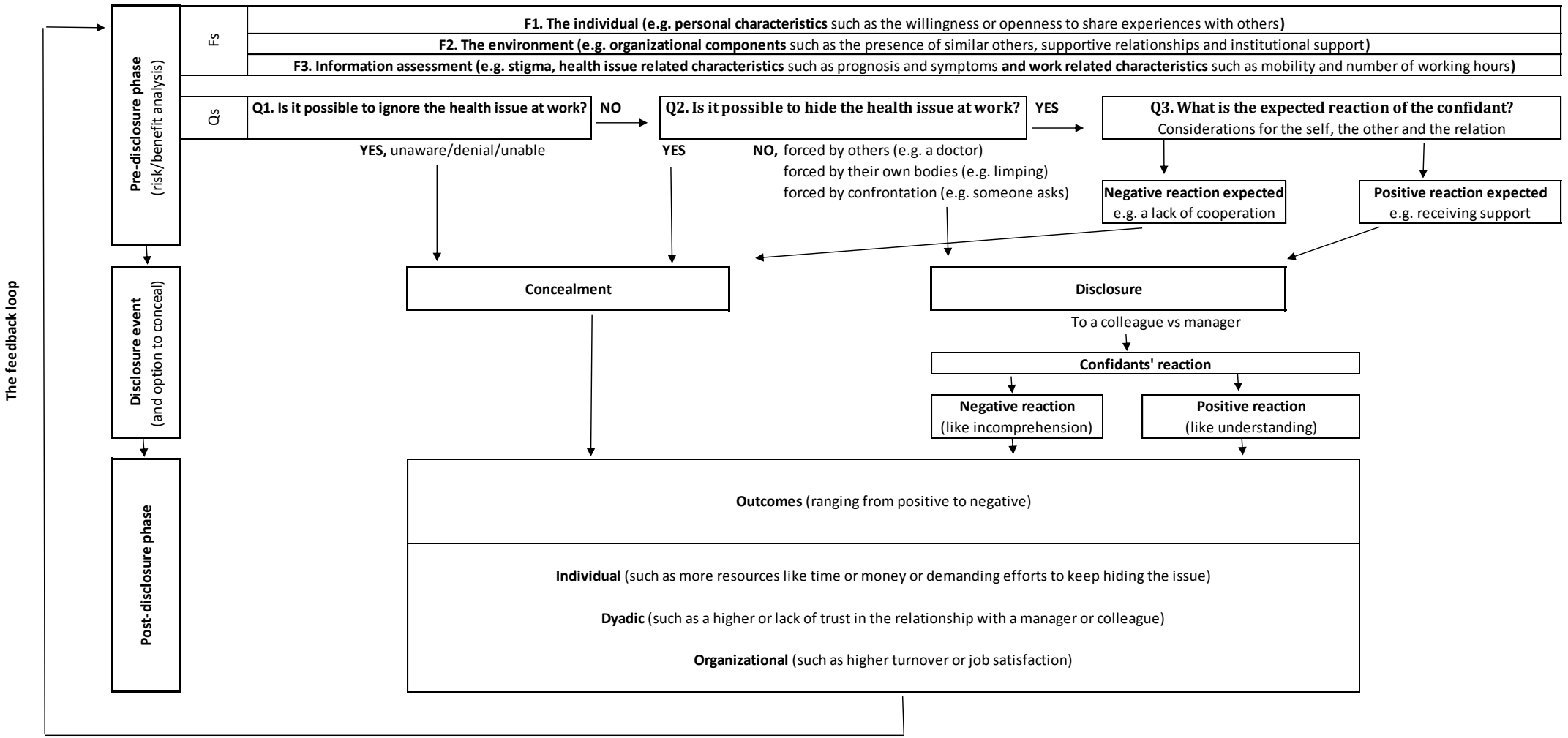

Figure 2: Conceptual framework of the health issue disclosure process in organizational contexts

The results of this qualitative study show that for the phenomenon of health issue disclosure, scientifically-drawn components from related literature, in particular the DPM to a large extend are applicable to the workplace context.

The findings of the study led to the development of a comprehensive framework containing three phases: 1. the pre-disclosure phase; 2. the disclosure event; and 3. the post-disclosure phase and a feedback loop, derived from the DPM.

The first phase includes: 1. three questions a working citizen considers when making a decision whether to disclose a health issue, a contribution of this study; and 2. three factors influencing the possible answers to these questions, adopted from Greene et al. (2012) and Ragins (2008). The second disclosure event phase provides an analysis of different disclosure components, such as situations, reactions and feelings belonging to the disclosure event. Also this phase includes the decision to conceal. Finally, the third phase presents the possible outcomes of the disclosure process on individual, dyadic and organizational level and includes a learning curve, the feedback loop which was drawn from several disclosure models.

To revert to the co-pilot example in the introduction that caused the deaths of 150 people who were travelling to Dusseldorf. We know that he had not informed his employer after a doctor's visit, with disastrous consequences. This studies' framework supposes three possible options with regard to the reasons for this. The first one is that the co-pilot was unable to disclose his health issue; he was in denial about the (impact of the) health issue or perhaps physically or mentally unable to disclose. The second option is that he could have concealed the issue because he thought it would not influence his ability to do his job or was not relevant enough to divulge to those in his work environment. Pilots work per flight with various peers, so his relationships with his colleagues might not have been close. At the same time, the issue was mental and therefore less visible than physical issues. These components of the information assessment (job and health issue) made it easier to hide. Thirdly, it is proposed that he concealed because he was afraid of negative outcomes, such as discrimination or dismissal from work.

Among others, Chaudoir and Fisher (2010) declared that people evaluate the risks and benefits before making a disclosure-decision. The results of this study are in agreement with this; however, the formulated framework shows that there is not always a (conscious) evaluation when making the disclosure decision. Sometimes people are not aware of having to deal with a health issue, which makes them unable to disclose. Also, it could be that people are no longer able to hide the issue, which makes them unable to conceal. This means concealing the issue is not always due to a negative evaluation but can also occur because people are unaware that they are dealing with a health issue. Some studies (Clair et al., 2005; Jones & King, 2013) indicated that revealing behavior is cognitively less challenging (emotionally consuming) than

concealing behavior, indicating that concealment therefore leads to negative organizational outcomes (decrease of work performance). The findings of this study are thus partly congruent with this, taking the cases that were unaware or unable to disclose into consideration.

As in Omarzu (2000) and Ragins (2008), the consideration of possible results (e.g. the expected reaction) was also dealt with in this study. These are included in Q3 with positive versus negative expected reactions. Also, the findings confirm that when these perceived reactions (and results) are positively evaluated, people are more inclined to disclose than when they are negatively evaluated. However, the 'catharsis reason' to disclose (Afifi & Steuber, 2009) is not found to relate to the pre-disclosure phase, since the respondents mentioned that they experienced relief during or after the disclosure event. This means that this study evaluates catharsis not as reason to disclose but rather perceives it as an experienced emotion during or after the disclosure event.

Ragins (2008) acknowledged three influential factors. He mentioned: 1. the individual; 2. the environment; and 3. the stigma. This study confirms the first two factors, but located 'the stigma' as a part of 'Information Assessment', which was based on Greene et al. (2012). Although the study findings demonstrate the existence of these overall influencing factors (Fs), one should be careful when interpreting them since they are used as an explanation for the various interpretations and outcomes of the three questions (Qs). What is lacking in this study is the degree of influence these factors exert on the defined questions.

Clair et al. (2005) defined three personal characteristics that are plausible influencers of the questions due to individual differences: propensity towards risk taking (1), self-monitoring (2) and the developmental stage (3). Although they were not clearly present in the results, these seem important. In their statements interviewees mentioned their degree of openness and perfectionism as influential. It is due to the design of the study that these personal characteristics were hard to identify, since it is difficult to attribute these kinds of personality characteristics to oneself.

The study findings validated the presence of the three supportive environmental antecedents for revelation defined by Ragins (2008): 1. the presence of similar others, 2. the presence of supportive and ally relationships, and 3. institutional support. The five measures of Greene et al., (2012), grouped within Information Assessment: 1. stigma, 2. prognosis, 3. symptoms, 4. preparation, and 5. relevance, were found influential.

Furthermore, the results for Q3 of this study conform to the findings of other disclosure studies (Ragins & Cornwell, 2001; Trau, 2015) that perceived discrimination within the organization elicits concealment, whereas an environment with no (or less) discrimination evokes disclosure. According to this study, abnormal behavior is perceived to elicit negativity (e.g. what would the work environment think about me?). This means that by disclosing the

health issue, negativity could be prevented (which is also a benefit, of course). If the issue was disclosed, despite anxiety about negative reactions (e.g. discrimination), the goal to receive positive reactions (e.g. benefits) outweighed the negatives in the decision to disclose. They probably decided they had more to win than to lose. Disclosure permits the environment to be supportive, whereas receiving support was associated with positive personal, relational and organizational outcomes. Furthermore, it was found that positive reactions by the confidant (organization) with beneficial outcomes in practice (e.g. providing benefits and support) would lead to a more open culture with a higher chance of people feeling safe to disclose their health issues to others within the organization. However, a distinction should be made between disclosures to a manager and disclosures to a colleague.

Regarding the disclosure event, the findings of this study are in agreement with Ragins (2008) that the outcome of the disclosure-decision in the pre-disclosure phase is not a good versus bad decision but should rather be interpreted as a cause and effect. Furthermore, the outcomes support the claim of others (Chaudoir & Fisher, 2010; Jones & King, 2013) that the disclosure is beneficial only if the confidants' reaction is supportive and accepting. Thus the confidants' reaction (at the disclosure event moment and afterwards) influences the outcomes.

This study shows that receiving benefits and positive feedback encourage an open culture and atmosphere, which delivers positive examples and stories. This makes disclosers feel content; they label the reaction as a positive characteristic of the organization that makes them work harder. Thus we can conclude that a positive reaction to a health disclosure influences work-related outcomes positively and vice versa; a negative reaction leads to negative work-related outcomes.

The findings of this study are in partial agreement with the three contextual disclosure outcomes (individual, dyadic and social) defined by Chaudoir and Fisher (2010). This researcher adapted the context of individual and dyadic and added organizational outcomes to this list. These different levels of outcomes were confirmed in the results in both cases, disclosed or concealed.

Finally, the framework supports the existence of the feedback loop mentioned in most disclosure models (Chaudoir & Fisher, 2010; Clair et al., 2005; Jones & King, 2013; Ragin, 2008). The loop demonstrates the whole experience depicted in the disclosure model, which is taken into consideration in a next occurrence. Also, people unaware of the issue (first) stated that they had learned from the situation and would be able to recognize symptoms of the issue earlier the next time and would then be able to handle it differently.

The final results are shown in figure 2 and complement the existing literature in two ways. Firstly, the disclosure-models in previous studies were either not restricted to health issues or lacked organizational context (Afifi & Steuber, 2009; Greene et al., 2012). Secondly, the papers

that presented a model or study conducted in organizational contexts (Griffith & Hebl, 2002; Ragins & Cornwell, 2001; Trau, 2015) were focused on highly stigmatized issues (e.g. HIV, sexual orientation). Thus, this study constitutes an exploration of a neglected field of research and provides a more versatile framework for organizational use. Furthermore, there was no literature or model that provided questions that people consider in the decision-making phase. The presented framework makes a clear distinction between what people consider (with the Qs) and the factors influencing these considerations (the Fs). Also, the option of non-disclosure and underlying reasons was ignored in other models. The results thus provide more insight into the full disclosure process, including the option to conceal. Hence, the study adds a significant contribution in complement the existing body of disclosure literature and provides empirically based insights for practitioners.

5.1 Practical implications and recommendations

There are some practical implications related to this study. First of all, the developed framework could be used by organizations to gain insight into how a more open and positive culture that stimulates the disclosure of health issues can be created. Clair et al. (2005) mentioned that institutional factors represent the accountability and support of the organization, which function as cues for disclosure. Indeed, this framework shows that the environment is taken into consideration in the pre-disclosure phase. This means people scan their environs, which therefore constitute an important influential factor to keep in mind for organizations. Culture, rules and regulations are part of this, so organizations could, for example, add and evaluate open-culture elements to their company policies.

Furthermore, organizations could provide specific rules and regulations for their managers on how to react during or after a health issue disclosure. Providing benefits and reacting with compassion have immense value for the discloser, the organization and their environment in the short- and long-term. Offering not only mental support but also help in the form off a company doctor or additional coverage of the costs outside the insurance are helpful examples.

It is not only the environment and associated facilities that are important; the people working within the organization in higher vertical positions (indirect or direct managers, presidents, directors, board members etc.) are also included in the range of people facing health issues. Since managers have much more power, their behavior and decisions are an important example with respect to the prevention of discrimination. Managers should be able to generate trust and to radiate empathy and support in order to develop an open culture within organizations. In return, this should make employees feel safer to disclose. Also, more openness and attention being paid to how the organization deals with the disclosure of health issues in communication will, if positive, stimulate the disclosure. Organizations, in particular HR-professionals, could for

example include these relevant values (communication skills and the ability for empathy) in their selection criteria in hiring managers.

In this way, the framework might serve to contribute on both strategic and operational levels by: enhancing the (open) culture regarding health issue disclosures, creating higher involvement and productivity within the workplace, and providing a safe environment with supportive facilities. In the short term, this will improve the employees' job satisfaction and lower their insecurity, since people will attribute positive characteristics to the organization. In return, this results in a reduction of people wanting to leave the organization. Furthermore, this has the potential to lower the absence (e.g. calling in sick) of employees, which directly means a reduction of organizational costs in the long term.

General education about symptoms can help employees to identify health issue at an earlier stage. For example the account of somebody in the organization who faced a burn-out. Communicate, for example in storytelling form, about the background and symptoms of the health issue and how the organization was able to help. This kind of communication could provide cues for the employee about the confidant's reaction on the one hand and can help them to recognize the symptoms on the other hand, which both positively contribute to the decision in the pre-disclosure phase. Other, more general, initiatives could stimulate the communication of health issues within the organization, such as: health scans or checks (for example based on Maslachs' Burnout Inventory) and the organization of sporting activities (running or bicycling groups; hiking during work time, shower facilities, discounts for gym membership, offering massages, etc.).

5.2 Future research and limitations

This study is the first one that presents a comprehensive framework for health issue disclosure in organizational contexts. The findings are empirically drawn, but should be interpreted as subjective; the attendees gave their perception of the truth by means of self-reports. Therefore it should be mentioned that the framework in figure 2 does not display causal relationships, despite the fact that the presented framework supposes a causal order. This means that, in practice, the boundaries will be less structured. Some weaknesses of this retrospective measuring method are: socially desired answers, the failure of the mind to recall important information and making the issue less severe. These risks could be solved by executing a longitudinal study. To this end, the developed framework can be used as a tool for future studies regarding this topic and for organizational professionals to gain insight into the various components of the disclosure process.

Another limitation was incompleteness of demographic information in the received database and the unavailability of that recording tapes due to privacy considerations.

The presented conceptual framework for the disclosure process of health issues at work should be accurately tested empirically to provide further evidence for the assumptions made about its suitability for organizational contexts. Also, the framework presented was partly inspired by the DPM (Chaudoir and Fisher, 2010). Expansion of the applicability of new gained insights from this study, for example the three defined questions, can be applied onto other contexts or existing models, such as the DPM of Chaudoir and Fisher.

Remarks should be made about interpreting the findings, since this study does not deal with any specific type of health issue. This means the framework is general and applicable to an inexhaustible list with familiar and less familiar health issues people might face. In the interviews, the health issues varied from mental (e.g. burn-out, insomnia) to physical (e.g. heart failure, vision problems, intestinal problems, rheumatism, cancer). Future researchers could distinguish physical and psychological health issues or visible and non-visible health issues and apply these samples to the defined elements of the disclosure process presented in the framework. For example, they could investigate whether employees with psychological issues mention a denial phase significantly more often than people facing a physical health issue.

Moreover, the study area and respondent characteristics were not clearly restricted; for potential studies a further selection could range from: eliciting one country or region or choosing a specific type of organization (culture), branch or industry. Future studies could also compare gender or the influence of the different personality types (adding one's disposition to trust) in relation to the framework. Moreover, earlier disclosure in other social domains (e.g. family or friends) could influence the disclosure at work and, more specifically, whether the likelihood of disclosing to a manager increases if one has already disclosed to colleagues.

For the disclosure event phase, a variety of disclosure strategies could be distinguished and examined in combination with this framework. Ragins (2008), for example, mentioned that three strategies are used to manage invisible stigmatized identities: 1. Counterfeiting; 2. Avoidance; and 3. Integration. Furthermore, useful strategies are appointed in the RRM, where Afifi and Steuber (2009) highlight direct, indirect and preparation strategies for secret disclosure. Further research could determine whether, to what extent and when disclosure strategies are applicable to health issues in organizational contexts.

In this study a clear distinction emerged between disclosing the health issue to a colleague (i.e. horizontal organizational relationship) and informing a supervisor (i.e. vertical organizational relationship). For this reason, it is recommended that future studies make a clear distinction regarding this difference and what it contains. Also, since direct managers are important in the disclosure decision, it is plausible for future studies to invest in the relational effects of a specific leadership type in disclosures.

Finally, it is recommended, for the abovementioned reasons, to use this framework in further studies when the disclosure process of health issues within organizational context is examined. The framework could be tested on specific components in combination with quantitative research. For example, a questionnaire could track whether and which personality components (the big five?) are among the individual factors that influence the disclosure decision. More technical elements such as the *depth*, *breath* and *duration* of communication of the disclosure during the event (Chaudoir & Fisher, 2010) could also affect the outcomes mentioned in the post-disclosure phase, or perhaps even the impact of a discloser's attitude and unconscious (non-verbal) communication. Thus one could determine if, for example, a more in-depth disclosure event contributes to more positive experiences and outcomes in the form of benefits in the post-disclosure phase. Finally, future researchers can examine where the feedback loop (after the post-disclosure) comes in, at the pre-disclosure phase or if this is taken into consideration in the overall process.

References

Afifi, T., & Steuber, K. (2009). The revelation risk model (RRM): Factors that predict the revelation of secrets and the strategies used to reveal them. *Communication Monographs, 76*(2), 144-176.

Barnes, M. C., Buck, R., Williams, G., Webb, K., & Aylward, M. (2008). Beliefs about common health problems and work: a qualitative study. *Social Science & Medicine, 67*(4), 657-665.

Browne, K. (2005). Snowball sampling: using social networks to research non-heterosexual women. *International Journal of Social Research Methodology, 8*(1), 47-60.

Chaudoir, S. R., & Fisher, J. D. (2010). The disclosure processes model: understanding disclosure decision making and post-disclosure outcomes among people living with a concealable stigmatized identity. *Psychological bulletin*, *136*(2), 236-256.

Clair, J. A., Beatty, J. E., & MacLean, T. L. (2005). Out of sight but not out of mind: Managing invisible social identities in the workplace. *Academy of Management Review, 30*(1), 78-95.

Danna, K., & Griffin, R. W. (1999). Health and well-being in the workplace: A review and synthesis of the literature. *Journal of management, 25*(3), 357-384.

Garcia, J. A., & Crocker, J. (2008). Reasons for disclosing depression matter: The consequences of having egosystem and ecosystem goals. Social science & medicine, 67(3), 453-462.

Greene, K., Magsamen-Conrad, K., Venetis, M. K., Checton, M. G., Bagdasarov, Z., & Banerjee, S. C. (2012). Assessing health diagnosis disclosure decisions in relationships: Testing the disclosure decision-making model. *Health communication, 27*(4), 356-368.

Griffith, K. H., & Hebl, M. R. 2002. The disclosure dilemma for gay men and lesbians: "Coming out" at work. Journal of Applied Psychology, 87: 1191-1199.

Irvine, A. (2011). Something to declare? The disclosure of common mental health problems at work. *Disability & Society, 26*, 179-192.

Jones, K. P., & King, E. B. (2013). Managing Concealable Stigmas at Work A Review and Multilevel Model. *Journal of Management*. doi; 10.1177/0149206313515518

Kelly, A. E., & McKillop, K. J. (1996). Consequences of revealing personal secrets. *Psychological Bulletin*, *120*(3), 450.

Major, B., & Gramzow, R. H. (1999). Abortion as stigma: cognitive and emotional implications of concealment. *Journal of personality and social psychology, 77*(4), 735.

Mann, S. E. (1996). Employee stress: An important cost in mergers. *Business Insurance, 30*(48), 24

McGonagle, A. K., & Hamblin, L. E. (2014). Proactive Responding to Anticipated Discrimination Based on Chronic Illness: Double-Edged Sword? *Journal of Business and Psychology*, *29*(3), 427-442.

Mengov, G. (2015). *Decision Science: A Human-Oriented Perspective* (Vol. 89). Springer. doi: 10.1007/978-3-662-47122-7_1

Munir, F., Leka, S., & Griffiths, A. (2005). Dealing with self-management of chronic illness at work: predictors for self-disclosure. *Social Science & Medicine, 60*(6), 1397-1407.

Oliver, D. G., Serovich, J. M., & Mason, T. L. (2005). Constraints and opportunities with interview transcription: Towards reflection in qualitative research. *Social forces*, *84*(2), 1273-1289.

Omarzu, J. (2000). A disclosure decision model: Determining how and when individuals will self-disclose. *Personality and Social Psychology Review, 4*(2), 174-185.

Pachankis, J. E. (2007). The psychological implications of concealing a stigma: a cognitive-affective-behavioral model. *Psychological bulletin*, 133(2), 328.

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry a personal, experiential perspective. *Qualitative Social Work*, *1*(3), 261-283.

Ragins, B.R. (2008). Disclosure disconnects: Antecedents and consequences of disclosing invisible stigmas across life domains. *Academy of Management Review, 33*, 194-215.

Ragins, B. R., & Cornwell, J. M. (2001). Pink triangles: antecedents and consequences of perceived workplace discrimination against gay and lesbian employees. *Journal of applied psychology, 86*(6), 1244.

Trau, R. N. (2015). The Impact of Discriminatory Climate Perceptions on the Composition of Intraorganizational Developmental Networks, *Psychosocial Support, and Job and Career Attitudes of Employees with an Invisible Stigma. Human Resource Management, 54*(2), 345-366.

Appendix A: The interview protocol (for received data)

Interview someone who works in an organization. It would be most suitable when this person experienced health issues, and thereby faced (now or previously) the decision to tell or hide it at work. Try to capture this process during the interview:

Record your interview with a mobile device (smartphone) and subsequently transcribe the interview. The transcribed interview (Ms-Word document) must be handed in on the black board site. Hand in deadline: Friday November 29, before 12.00h.

Interview protocol:

Introduce yourself and the general outline of what the participant can expect. Also note that the interview results will be treated confidential and cannot be traced back to an individual.

1. Socio-demographic information
    a. Age
    b. Educational level
    c. Work experience
    d. Experienced health issues
2. Can you tell something about your daily occupation?
3. You are / were confronted with health related issues. Can you tell something about how that affected your daily work routine?
4. Did you tell people within your work environment about these health issues?

4a: If yes:

a. Why did you do that? What were the considerations to do so (try to identify both approach- & avoid-focused goals)
b. What were your expectations regarding the consequences?
c. Please describe the actual telling/concealment, what did you experience at that time?
d. How did the people in your work environment react to the telling?
e. Were there any consequences on the short or long term regarding the reactions of colleagues?
f. Did these experiences change the image you hold of (people within) the organization? (i.e. anger, regret, appreciation, fear..)
g. Would you share these experiences again in the future?

4b: If no:

a. Why did you not do that? What were the consideration to do so (try to identify both approach- & avoid-focused goals)
b. How do you think people would react if you would have told them about it?
c. Do you experience any consequences (positive or negative) in not telling about it?
d. Does or did your choice, not to share these experiences, affect your relationship with direct colleagues?
e. Would you do the same again in the future?

Try to use this interview protocol in a semi-structured way, because participants will have to be able to share their stories with you and explain how they make meaning of the situation!

Appendix B: The Dutch interview protocol (for collected data)

1. Introductie
    a. Bedanken voor deelname
    b. Uitleg over de studie communicatie wetenschap
    c. Kleine uitleg van wat aan bod komt in het interview
    d. Deelname is anoniem en toestemming om op te nemen
    e. Op voorhand al vragen?

2. Kunt u mij iets vertellen over het dagelijkse werk dat u doet? Geef een cijfer voor de algemene werktevredenheid.
3. U kreeg te maken met [ziekteverschijnselen]. In hoeverre beïnvloedde dat de uitvoering van uw werk?
4. Heeft u op uw werk verteld over de klachten?

Zo ja:

a. Waarom? Hebt u overwogen om het niet te vertellen? Wat zou dat voorkomen hebben?
b. Wat verwachtte u dat er zou gebeuren voordat u het vertelde? Hoe zeker was u daarvan?
c. Hoe ging het toen u het vertelde (wanneer, wie, hoe, kende u die persoon al lang)?
d. Hoe reageerde uw gesprekspartner? (hoe zou je willen dat deze reageerde?)
e. Wat waren de gevolgen? (taakuitvoering?)
f. Wat heeft dit gedaan met uw beeld van de organisatie? (spijt, dankbaarheid, boosheid, angst, identificatie?)
g. Zou u het volgende keer weer zo doen?

Zo nee:

a. Waarom niet? Heeft u overwogen om het wel te vertellen? Aan wie dan? Wat zou dat opgeleverd hebben?
b. Wat verwachtte u dat er zou gebeuren als u het had verteld? Hoe zeker was u daarvan?
c. Wat is het gevolg van de beslissing om dit stil te houden? Heeft ’t veel moeite gekost stil te houden? Getracht te peilen wat ervan gevonden zou worden?

d. Heeft de keuze om hier niet over te spreken, invloed gehad op hoe u uw werkomgeving beleeft? (werktevredenheid/ intentie te vertrekken/uitvoering van de taken)
e. Zou u het volgende keer weer zo doen?

5. Demografische gegevens
   a. Geslacht
   b. Leeftijd
   c. Hoogst genoten opleiding
   d. Burgerlijke staat
   e. Kinderen?

Appendix C: total overview of variables

Document group	Document nr.	Health issue	Disclosed	Affecting work?	Age	Gender	Education	Marital Status	Number of coded segments
Received data	01	CF (taaislijmziekte) en Diabetes	WAAR	ONWAAR	27	N/A	Hbo	N/A	8
Received data	02	fybromyalgie	WAAR	WAAR	22	N/A	Master	N/A	12
Received data	03	burn-out	WAAR	WAAR	39	Male	Mbo	N/A	13
Received data	04	hard of hearing (60/80% deaf)	ONWAAR	WAAR	32	Male	Bachelor	N/A	12
Received data	05	Epilepsie	WAAR	WAAR	54	Male	LTS	N/A	13
Received data	06	Slijmbeursontsteking	WAAR	WAAR	36	N/A	Mbo	N/A	9
Received data	07	Niet lekker in vel vanwege overvallen	ONWAAR	WAAR	62	Female	Huishoudschool	N/A	16
Received data	08	Migraine	WAAR	WAAR	53	Female	Mbo	N/A	4
Received data	09	Buikpijn/prikelbare darm (=psychosomatisch)	WAAR	WAAR	24	Female	Hbo	Samenwonend	12
Received data	10	Burn-out	WAAR	ONWAAR	30	Female	Hbo	N/A	8
Received data	11	Hernia	ONWAAR	WAAR	29	Female	Hbo	N/A	14
Received data	12	the carpal tunnel syndrome, surgery	WAAR	WAAR	46	N/A	Hbo	N/A	12
Received data	13	Hartinfarct, gedotterd	WAAR	WAAR	52	Female	Hbo	N/A	6
Received data	14	Evenwichtsstoornis	WAAR	WAAR	30	Male	Mbo 4	N/A	14
Received data	15	greatly reduced fertility partner	WAAR	WAAR	31	Female	Master	N/A	15
Received data	16	Tennisarm	WAAR	WAAR	50	Female	Mbo	N/A	11
Received data	17	lever nier problemen (disclosed) en buikwandcorrectie (conceal)	WAAR	WAAR	57	Female	Hbo	N/A	14
Received data	18	Burn-out	WAAR	WAAR	34	Female	Mbo	Married, 2 kids	11
Received data	19	Vision Problems	ONWAAR	ONWAAR	22	N/A	Master	N/A	10
Received data	20	Burn-out	WAAR	WAAR	52	N/A	Havo	N/A	14
Received data	21	KNO, en operatie	WAAR	ONWAAR	48	Female		N/A	11
Received data	22	visuele beperking	ONWAAR	ONWAAR	25	Male	WO bachelor	N/A	7
Received data	23	Migraines	ONWAAR	WAAR	29	N/A	Master	N/A	14
Received data	24	Aambeien en 3 operaties	WAAR	WAAR	46	N/A	Mavo	N/A	9
Received data	25	lichte TIA met gevolg minder zicht	WAAR	WAAR	56	Male	Mbo	Married, 2 older kids (girls)	12
Received data	26	Asthma, high blood pressure	WAAR	WAAR	52	N/A	Hbo	N/A	11
Received data	27	Burn-out	WAAR	WAAR	38	N/A	Hbo	N/A	9
Received data	28	Hernia	WAAR	WAAR	59	Male	Mbo	Father of three	14
Received data	29	Migraine	WAAR	WAAR	54	Male	Master	N/A	7
Received data	30	Operatie vanweg overgewicht en later te veel aan huid	WAAR	WAAR	28	Female	Hbo	N/A	19
Received data	31	Burn-out / manisch depressief	ONWAAR	WAAR	53	Male	Mbo	N/A	6
Received data	32	Slapeloosheid	WAAR	ONWAAR	26	Female	Pabo	Married	18
Received data	33	Artrose, 3x surgery	WAAR	WAAR	51	Female	Mbo	N/A	9
Received data	34	PDS (darm klachten)	ONWAAR	WAAR	25	N/A	Hbo	N/A	10
Received data	35	Reuma	WAAR	WAAR	27	N/A	Hbo	N/A	9
Received data	36	cancer, surgery	WAAR	WAAR	33	Male	University	N/A	6
Received data	37	ankle hurt/ flue and cold	WAAR	WAAR	30	N/A	Master	N/A	6
Received data	38	motorcycle accident, big surgery leg	WAAR	WAAR	54	Male	secondary school	N/A	8
Received data	39	vocal cords + oedema, two surgery needed	WAAR	WAAR	57	N/A	Hbo	N/A	5
Received data	40	Beroerte	WAAR	WAAR	53	Female	Mavo 4	Married, 3 kids	13
Received data	41	typhoid	ONWAAR	WAAR	32	Male	Master	N/A	11
Received data	42	diabetes type two	WAAR	ONWAAR	53	N/A	Bachelor	N/A	11
Received data	43	eye disorder called Keratoconus	WAAR	WAAR	31	Male	Bachelor	N/A	12
Received data	44	Trouble wearing contact lenses	WAAR	WAAR	24	Male	University (not completed)	Single	5
Received data	45	Rheumatism (fibromyalgie)	WAAR	WAAR	25	Female	Hbo	N/A	21
Received data	46	inflammations buttocks	ONWAAR	WAAR	55	Male	Hbo	N/A	13
Received data	47	Psoriasis	ONWAAR	ONWAAR	23	N/A	Hbo	N/A	4
Received data	48	Hartproblemen 3x aan geopereerd	WAAR	WAAR	66	N/A	Hbo	N/A	7
Received data	49	breast cancer (cured)	WAAR	ONWAAR	28	Female	Master	N/A	7
Collected data	50	Angst en dwang stoornis	WAAR	WAAR	31	Female	Mbo	Verloofd, 1 dochter thuiswonend en 1 (stief) dochter	12
Collected data	51	Longembolieën (4) met als gevolg astma, en HMS (Reuma)	WAAR	WAAR	31	Female	Mavo	Getrouwd, 3 kinderen	15
Collected data	52	Colitis ulserosa (chronische aandoening in darmen)	ONWAAR	ONWAAR	54	Female	Leao	Weduwe	6
Collected data	53	Angstaanvallen	WAAR	WAAR	33	Female	Hbo	Getrouwd, 1 dochter	12
Collected data	54	Trage schildklier	WAAR	WAAR	28	Female	Master	Samenwonend	9
Collected data	55	Candida, vaginal infection	ONWAAR	WAAR	33	Female	Mbo	Single	13
Collected data	56	Diabetes	WAAR	WAAR	28	Female	Mbo	Getrouwd, 1 dochter	5
Collected data	57	Depressie	WAAR	WAAR	40	Female	Mbo	Getrouwd, 2 dochters	9
Collected data	58	Lichamelijke klachten door stress	WAAR	WAAR	38	Female	MTRO	Getrouwd, 2 zonen	12

Appendix D: Code system

Code System			**602**
Pre-disclosure phase			0
	The individual		28
	The environment		14
		Expected reaction	0
			Positive 28
			Negative 11
	Information assessment		0
		Related to the job	32
		Related to the issue	24
	Reasons to disclose		0
		No choice	52
		Benefits	25
		Rights	13
	Reasons to conceal		0
		Discrimination	27
		Unwinning	16
			Not influencign the job 18
		Unaware or unable	6
Disclosure event			22
	Reactions		51
	Manager		39
	Colleagues		29
	Feelings		12
Post-disclosure phase			0
	Positive		54
	Negative		33
	Image of organization		23
	Feedback Loop		45

Appendix E: Code book

1. Pre-disclosure

De eerste fase van de 'disclosure-process'. Hierin wordt overwogen hoe, waar aan wie te onthullen. Alle uitingen die zijn gedaan die behoren tot deze fase zijn onderverdeeld in A. Cues: informational cues, individual differences or target characteristics and expected reactions of B. Given reasons for disclosure or concealment.

1.1 *The individual*

Betreft hoe iemand is en in elkaar steekt. Of iemand geneigd is open en eerlijk te zijn, of niet. Verwachtingen die iemand van zichzelf of de omgeving heeft; perfectionisme bijvoorbeeld. Kortom; persoonlijke eigenschappen die individuen onderscheiden en relevant op werkgebied. Of iemand aandacht/begrip van anderen verwacht, of niet. Uitspraken die hieronder vallen: Ik ben... ik houd van.... ik wil graag... werk=werk, privé = privé

1.2 *The environment*

Kan te maken hebben met de relatie die iemand met zijn leidinggevende heeft of de cultuur die er heerst binnen een organisatie (open cultuur bijvoorbeeld) en veranderingen die binnen de organisatie hebben plaatsgevonden en invloed kunnen hebben op de werkgever-werknemer verhoudingen.

1.3 *Information Assessment*

Dit zijn situationele elementen waarnaar verwezen wordt en die bijdragen aan de overweging in het wel/niet onthullen. Deze kunnen onderverdeeld worden in elementen van het werk en elementen van de gezondheidsklacht (zie hieronder).

1.3.1 *Due to the job*

Verklaringingen waarom de onthulling wel/niet heeft plaatsgevonden. Bijvoorbeeld de mate van zelfstandigheid en mobiliteit. Het takenpakket. De mogelijkheid tot ander of aangepast werk. Iemand die bijna met pensioen gaat versus een sollicitant. Maar ook de vrijheid om zelf werkzaamheden te plannen en mate van verantwoording die moet worden afgelegd en die aantal uren dat iemand werkt.

1.3.2 *Due to the issue*

Verklaringen betreft elementen van de klacht. Dat de (niet)onthulling afhankelijk is van de ontwikkeling van de health issue. Zichtbaarheid van de ziekte. Aanpassingen die iemand moet doen. De behandelbaarheid (medicatie, genezing enzo). Taboe die erbij komt kijken (bij een vaginale infectie meer dan bij diabetes) en in hoeverre iemand in staat is werkzaamheden uit te voeren.

1.4 *Expected reactions*

Dit is de verwachte reactie in de pre-disclosure phase vaak gerelateerd aan een onthulling (als... dan...) omdat er anders ook geen reactie verwacht hoeft te worden. De citaten die hierin vallen zijn onderverdeeld in drie keuzes:

1.4.1 *Positive*; hierin wordt de verwachte reactie bij onthulling geuit als gunstig of iemand heeft er vooraf niet over nagedacht en zich dus geen ernstige zorgen gemaakt

1.4.2 *Negative*; hierbij wordt de verwachte reactie bij onthulling geuit als discriminerend

1.5 *Reasons to disclose*

De redenen die zijn aangegeven als men had verteld over de klachten op het werk. Er zijn drie redenen hierin herkend waarin de quotes zijn onderverdeeld: no choice, benefits en rights.

1.5.1 *No Choice.* Hierbij gaven geinterviewden aan dat zij geen keuze hadden. Vaak konden zij de issue niet verhullen.... omdat men het zag, direct naar vroeg of zou gaan vragen. Ook situaties waarbij men een hardaanval krijgt op het werk vallen hieronder.

1.5.2 *Benefits.* Allerlei voordelen in (in)directe zin.Antwoord op de vraag Waarom. Antwoorden varieren van het zowel op fysiek als emotioneel niveau hulp verwachten te krijgen. Dit kan zijn begrip, financiële steun, rust of vrij krijgen voor bijv. ziekenhuisbezoeken etc.

Ook binnen dit begrip valt dat mensen een verklaring willen geven voor bepaald gedrag (anders eten door dieet, keuzes als dichter bij het bord zitten verklaren of "ik wilde je niet negeren ik zag je gewoon niet omdat ik slecht zicht heb") Dit valt hieronder men voordelen haalt met het uitleggen van gedrag. Het voorkomen van onrust is ook een "benefit" omdat dit vaak wordt gedaan ter voorkoming van discriminatie (dat de naaste omgeving anders over de persoon gaat denken).

1.5.3 *Rights.* Uitspraken waarbij wordt aangegeven dat men vond dat de ander recht had om het te weten.

1.6 *Reasons to conceal*

Hiermee wordt de redenen bedoeld die interviewees hebben genoemd om te verhullen. Hier zijn er wederom drie onderdelen herkend voor de verdeling van redenen: Discrimination, Unwilling (not influencing the job) en unaware/unable.

1.6.1 *Discrimination.* Men is bang er anders tegen hen wordt gedaan of gedacht. Dit kan verieren van ontslag tot "wat zal een ander wel niet denken"

1.6.2 *Unwilling.* Vaak genoemde reden is omdat het niet de baan beinvloedt maar ook niet vertellen omdat men dat niet wil of nodig vindt.

1.6.3 *Unaware or unable:* het niet willen vertellen, onder ogen komen of weten van de health issue. Soms weten mensen zelf niet dat ze een burn-out hebben en kunnen het daarom ook niet aan anderen vertellen. Of, zij achten zichzelf niet in staat het te vertellen.

2. <u>Disclosure-event</u>

Dit betreft hoe de onthulling in zijn werk is gegaan, de situatie zoals die plaatsvond wordt daarbij weergegeven. Waar het is verteld, naar aanleiding waarvan en waarom, wie heeft de onthulling gedaan? En Op welke manier? Zijn vragen die hier worden ingedeeld. Daarnaast zijn er nog drie elementen waarin onderscheid is gemaakt, naast dus de beschrijving van het "event": reactions, manager/colleageus and feelings. Indien de uiting niet onder een van deze vier elementen in te delen is, maar wel alszijnde onderdeel zijn van het event kan deze onder "disclosure-event" worden ingedeeld.

2.1 *Reactions.* Reacties na het onthullen van de health issue aan een manager of collega.

2.2 *Manager.* Dit gaat over verklaringen dat de issue is onthuld aan managers, leidinggevende, begeleiders, supervisors etc. (bovenliggende persoon in lijn)

2.3 *Colleagues.* Hier betreft onthullingen aan collega's.

2.4 *Feelings.* Hierbij gaat het om het gevoel dat wordt beschreven vlak voor of tijdens de openbaring.

3. <u>Post-disclosure</u>

Wat er met iemand gebeurt na het (niet)vertellen. Kan zijn dat iemand moet herstellen (fysiek of psychologisch). Wordt iemand achterdochtig? Is de relatie met de organisatorische omgeving beschadigd? Moet iemand smoezen ter compensatie verzinnen om niet te hoeven onthullen? Alle quotes uit dit gedeelte zijn onderverdeeld in een van de volgende onderdelen:

3.1 *Positive*. Dit houdt vaak in dat er uitspraken zijn gedaan waarbij voordelen worden ervaren (zie omschrijving benefits) na de (niet)onthulling.

3.2 *Negative*. Dit houdt in dat er negatieve kanten genoemd zijn van de (niet)onthulling. Discriminatie is hier uiteraard een onderdeel van maar ook dat de organisatie geen maatregelen heeft getroffen, geen interesse heeft getoond, dat men harder moet werken om issues te kunnen blijven verhullen of niet te willen overkomen als zeur op het werk.

3.3 *Image of de organization*. Het imago of beeld dat men na de ervaring relateerd aan de organisatie. Dit kan verbeterd of verslechterd zijn of hetzelfde gebleven. Men kan dankbaar zijn voor wat de organisatie heeft gedaan bijvoorbeeld.

3.4 *Feedback* loop. Hierin wordt de vraag beantwoord of die persoon het een volgende keer weer zo zou doen. Ook hierin kunnen verschillende antwoorden mogelijk zijn en vaak is de ervaring een leerproces die bijdraagt aan de overwegingen die worden genomen in de pre-disclosure phase een eventueel volgende keer.

Appendix F: Kappa calculated with the three phases

A = pre-disclosure

B = disclosure-event

C = post-disclosure

	A	B	C	total
A	39	1	2	42
B	3	23	3	29
C	1	4	21	29
total	43	28	26	**97**

Number of observed agreements: 83 (85.57% of the observations)

Number of agreements expected by chance: 34.0 (35.01% of the observations)

Kappa= 0.778

SE of kappa = 0.054

95% confidence interval: From 0.671 to 0.884

The strength of agreement is considered to be 'good'.

The calculations above only consider exact matches between observers. If the categories (A, B, C...) are ordered, you may also wish to consider close matches.

In other words, if one observer classifies a subject into group B and the other into group C, this is closer than if one classifies into A and the other into D.

The calculation of weighted kappa, below, assumes the categories are ordered and accounts for how far apart the two raters are. This calculation uses linear weights.

Weighted Kappa= 0.802

Assessed this way, the strength of agreement is considered to be 'very good'.

Used source: http://graphpad.com/quickcalcs/kappa1.cfm