

**Working with IBD: Employee Disclosure to Managers**

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### **Abstract**

*Objective:* This mixed-methods study investigates the individual, interpersonal, and contextual factors associated with disclosing an inflammatory bowel disease (IBD) in the workplace through a quantitative analysis and the costs and benefits disclosure decisions by means of qualitative analyses. *Methods:* The sample consisted of 93 employees managing either Crohn's disease ( $n = 47$ ) or ulcerative colitis ( $n = 44$ ). Information about symptom severity, Leader-Member Exchange (LMX), organizational diversity climate (ODC), the disclosure decision, and the degree of disclosure was assessed through self-report questionnaires. Information about costs and benefits was collected through open questions. *Results:* Both symptom severity and LMX were positively associated with the degree of disclosure. ODC moderated the relationship between symptom severity and degree of disclosure. The qualitative analysis showed that disclosure was associated with little costs and that, in addition to instrumental support, psychological benefits of transparency and understanding were stated by the participants. The costs experienced were caused mainly by negative reactions or being misunderstood by others. *Conclusions:* This preliminary study provides many avenues for future research and emphasizes the importance of ODC and LMX in organizations.

*Keywords:* disclosure, chronic illness, inflammatory bowel diseases

### **Working with IBD: Employee Disclosure to Managers**

The prevalence of chronic illness is steadily increasing (Bodenheimer et al., 2009). The Dutch National Institute for Public Health and Environment (RIVM) estimates that by 2030 40% of the Dutch population will have at least one chronic illness (RIVM, 2014). Although lack of research makes it difficult to estimate, it is thought that approximately 15-20% of employees are working with at least one chronic illness (Munir et al., 2007). This portion of the workforce is often overlooked by researchers and organizations alike. The assumption is generally made that employees are 'base-line' healthy and not impeded physically or mentally while performing their job tasks (Beatty, 2018; Pinder, 1995). However, for employees with one or more chronic illnesses this is not the case (Beatty & Joffe, 2006). Symptoms of chronic illness can hinder employees in their job performance and employment (Varekamp et al., 2011). Reduced ability to work can also cause employees with chronic illnesses to work harder in an attempt to compensate for their illness (McGonagle & Hamblin, 2014). This overexertion may lead to stress, which is a factor that contributes to the progression of many chronic illnesses (McGonagle & Hamblin, 2014). Reduced ability to work not only negatively impacts employees' Quality of Life but can also impact organizations as employee turnover is costly and can reduce profitability (Bernklev et al., 2006; O'Connell & Kung, 2007). Providing employees with chronic illnesses with the proper accommodations will help them manage their symptoms in the workplace.

However, many chronic illnesses are invisible, and supervisors may be unaware of which employees require additional resources. Therefore, supervisors must first be informed about the presence of a chronic illness (Munir et al., 2005). Disclosure of a chronic illness can be challenging, especially when employees risk stigmatization or discrimination as a result (Clair et al., 2005). Inflammatory bowel diseases (IBDs) such as Crohn's disease and ulcerative colitis are particularly stigmatized as the taboos surrounding bowel function and bowel-related symptoms are pervasive (Atarodi et al., 2014; Taft et al., 2011). It is essential that organizations and managers understand how to promote disclosure amongst employees

with IBD, especially when stigmatization (anticipated or experienced) can make disclosure challenging (Beatty, 2018; Defenbaugh, 2013).

Research on employees working with IBD is scarce. A recent study by the Dutch Crohn's and Colitis Organization (van der Horst & Scherpenzeel, 2020) investigated the characteristics of employees with IBD. Over half (64%) of the participants indicated that they were currently employed. The IBD symptoms that most affected the employees at work were fatigue, stress, pain, and difficulty concentrating. Even though 87% did not have any accommodations at work, roughly two-thirds stated that they would like to receive accommodations. The most sought-after accommodations were flexible working hours, decreased working hours, and reduced workload. Research on disclosure of IBD at work suggests that most (81%) employees disclose their illness at work to some extent (Wyke et al., 1988). A qualitative study found that disclosing IBD often leads to feelings of relief (Frohlich, 2014). An experimental study on college students also showed that enacted stigma by others reduced once IBD had been disclosed to them (Rohde et al., 2018). Further qualitative research on IBD indicates that embarrassment about symptoms and fear of stigmatization generally stops people from disclosing (Saunders, 2014). Although these studies provide some initial insight into IBD disclosure, more in-depth quantitative knowledge is clearly needed. To understand how managers and organizations can promote disclosure amongst employees with IBD we need information about the factors that contribute to, or hinder disclosure.

Drawing from the larger body of literature, including research on chronic illness, other hidden social identities, and the Conceptual Model of the Decision to Pass or Reveal (Clair et al., 2005), this thesis will investigate the following research questions: What are the roles of individual, interpersonal, and organizational factors in disclosure of IBD? Which costs and benefits do employees with IBD experience because of their disclosure decision? Data collected through a survey will be assessed using a mixed-method design. Disclosure will be assessed in two ways: a comparison will be made between employees who disclose their IBD and those who do not; and for employees who disclose, the degree of disclosure will

also be measured continuously. The first research question will be explored quantitatively and the second qualitatively. A qualitative methodology was chosen because of the preliminary nature of this study. Not only will this thesis contribute to theory by integrating theories on stigma, diversity and disclosure, the insights gained in this study can also be applied by Human Resource (HR) workers, organizations, and supervisors to promote disclosure amongst employees. Results could perhaps also be used in job coaching or counseling for people with IBD.

## **Theory and Hypotheses**

### **Inflammatory Bowel Diseases**

An illness is considered chronic when it lasts one year or more and requires ongoing medical attention or limits activities of daily living, or both (Centre for Disease Control, 2021). IBD is an autoimmune disease that causes chronic inflammation of the gastrointestinal (GI) tract. The two most common forms of IBD are Crohn's disease and ulcerative colitis. Crohn's disease is characterized by inflammation within the digestive tract, whereas ulcerative colitis refers to inflammation of the colon (Defenbaugh, 2013). People are generally diagnosed with IBD in their 20s or 30s (Centre for Disease Control, 2020). The incidence and prevalence of IBD have been on the rise. In 2015, it was diagnosed in about 1.3% (3 million) of the US adult population (Dahlhamer et al., 2016; Molodecky et al., 2012). Frequently experienced IBD symptoms are abdominal pain, stomach cramps, chronic diarrhea or constipation, bloody stool, inflammation in joints or eyes, fatigue, and rapid weight loss (Crohn's and Colitis foundation UK, 2017). Although these symptoms can significantly impact those with IBD, they are generally not visible to others, which means that IBDs can usually be classified as invisible illnesses.

When an illness is invisible, people have 'informational-control' over who they self-disclose to (Defenbaugh, 2013; Goffman, 1974). According to the communication privacy management (CPM) theory (Petronio, 2010), people believe that they should have control over their personal information, and who accesses it. In the case of health information there exists a tension between privacy and openness (Westerman et al., 2017). An employee with

IBD must decide if and in how much detail they wish to disclose health. Employees can partially disclose at work by informing their managers of the presence of a chronic illness or fully disclose by explaining how the illness affects them at work (Munir et al., 2005). Sharing general health information may be deemed acceptable, whereas sharing details could feel like a violation of one's privacy (Fried, 1968). Therefore, some people may prefer not to disclose or to disclose only partially. However, partial disclosure makes the employee dependent on the manager's knowledge regarding IBD. If a manager is unaware of the symptoms and their influence at work, they may not provide the appropriate accommodation. In this case, full disclosure is beneficial as it allows an employee to clearly communicate their wants and needs. This is in line with research showing that the degree to which employees value supervisor support is related to full disclosure (Munir et al., 2005).

### **Conceptual Model of the Decision to Pass or Reveal**

This paper uses a simplified version of the conceptual model of the decision to pass or reveal developed by Clair and colleagues (2005) as the theoretical basis of the hypotheses. This generalized model of invisible social identity management focuses on the decision to pass or reveal an identity within the workplace context. Invisible social identities are those that lack clear visual indicators, such as being LGBTQIA+<sup>1</sup>, adherence to certain religious ideologies, or having an invisible chronic illness such as IBD. Within the model, disclosure is seen as the personal choice the employee makes to 'pass' or to 'reveal'. The two main antecedents to the disclosure decision introduced within this model are 1) individual factors (such as individual differences and personal motives) and 2) environmental factors (the interpersonal relationship and the organizational context). The model contains a feedback loop, where the costs and benefits experienced in previous disclosures influence the decision to disclose again in the future. Within the model, the disclosure decision is framed as a risk assessment, where the antecedents and previous disclosure experiences are weighed to estimate what the consequences of the disclosure will be. If the benefits

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<sup>1</sup> Acronym for: lesbian, gay, bisexual, trans, questioning/queer, intersex, asexual

outweigh the costs, an employee is likely to disclose, and vice versa, if the costs outweigh the benefits, disclosure by the employee is less likely.

Although the overall structure of the model will be upheld, some alterations have been made. Firstly, I used a simplified version of the model, which excluded the feedback loop and the effect of the contextual factors on the outcomes of disclosure. Secondly, the specific factors have been tailored to the invisible social identity of IBD. This approach is in line with Clair and colleagues (2005), as they stated the following: “There are likely to be specific factors unique to particular social identities that influence how people manage these identities in social interactions at work” (p.11). Lastly, in our hypotheses, we distinguished between disclosure as a dichotomous yes-or-no decision, and disclosure as a spectrum with different degrees. The reason for this approach is that there may be a ceiling effect, as previous research indicates that most employees disclose their IBD to some extent. Furthermore, including hypotheses regarding different degrees of disclosure allows for a richer understanding of disclosure of IBD.

### **Individual Difference**

Chronic illnesses are different from other invisible social identities “because of the potential intrusiveness of periodic symptoms” (Clair et al., 2005, p. 91). In the case of IBDs, which are often cyclical in nature, the disease can be unpredictable, fluctuating between periods of remission and periods of flare-up (Frohlich, 2014; Taft et al., 2011). A flare-up is characterized by a return or worsening of symptoms, with the type of symptoms depending on the type and location of the IBD (Abbvie, n.d.). An increase in symptoms can make work tasks more challenging and employees may wish to work reduced hours during a flare-up to manage their symptoms (Beatty & Joffe, 2006). In other words, increased severity can make disclosure necessary to manage symptom regimes effectively and receive the organizational support required (Beatty, 2004; Munir et al., 2005). Therefore, symptom severity is thought to be an influential individual factor when determining disclosure of IBD. Studies on other chronic illnesses have already shown a positive relationship between symptom severity and

disclosure (Beatty, 2004; Kirk-Brown et al., 2014; Munir et al., 2005) Therefore, the first hypothesis is:

*Hypothesis 1a:* Symptom severity is positively related to disclosure to managers.

*Hypothesis 1b:* Symptom severity is positively related to the degree of disclosure to managers.

### **Interpersonal and Environmental Context**

According to the model by Clair and colleagues (2005), the relationship between the individual difference variables and the disclosure decision is moderated by the context. Employees use the context to assess the likelihood that disclosure will be well-received (Clair et al., 2005). After the individual factors have been placed in the context, a cost-benefit analysis can help determine the best course of action. Within the model a distinction is made between the interpersonal and organizational context.

The interpersonal context refers to the target of the disclosure (in the case of this study, the manager). Supervisors have a major influence on the health of their employees, with research suggesting that leadership behavior is associated with many factors, such as employee health complaints, well-being, and sick leave (Franke, 2014; Inceoglu, 2018; Kuoppala, 2008). Within the model, the manager plays a role in the employee's decision to disclose in two ways. Firstly, the characteristics of the target can influence willingness to disclose. For example, research suggests that there may be increased self-disclosure in therapeutic settings when gender is matched (Zane & Ku, 2014). Secondly, the nature of the relationship between manager and employee will influence the likeliness of disclosure. Research has shown that people tend to disclose more personal information to people with whom they have a close and trusting relationship (Wheeless & Grotz, 1977). As I am interested in disclosure from employees to managers, I will explore the effect of Leader-Member Exchange (LMX). LMX is the relationship between supervisor and employee, characterized by mutual transaction of physical or psychological resources (Graen & Uhl-Bien, 1995). The quality of LMX varies across employees, with some employees having a stronger relationship with the supervisor than others (Graen, 2003). Having high-LMX is

beneficial for the employee as it is associated with more trust, resources, and autonomy (Van Dam et al., 2008). In the case of IBD disclosure, the relationship between symptom severity and disclosure is expected to be moderated by LMX.

The model by Clair and colleagues (2005) characterizes disclosure of IBD as a risk assessment. The quality of the relationship one has with one's supervisor provides important information as to the most likely outcome disclosure would have. When LMX is high, it may be more likely that disclosure will be met with a positive reaction and provision of additional resources. Knowing what to expect from your manager should hopefully lower the bar for disclosure, even when symptoms are (not yet) severe. And on the flip side, having a very poor relationship with the manager may make employees more likely to 'tough it out' and not disclose even when symptoms are more severe. Although this moderating effect has not yet been confirmed by research, research has shown that LMX contributes to an employee's willingness to disclose health information at work (Westerman et al., 2017). Therefore, the second hypothesis is:

*Hypothesis 2a:* LMX moderates the relationship between symptom severity and disclosure in a way that when LMX is high, disclosure to managers is more likely.

*Hypothesis 2b:* LMX moderates the relationship between symptom severity and degree of disclosure in such a way that when LMX is high, the relationship will be stronger.

Aside from the relationship between employee and manager, the environmental context also plays a role in the disclosure decision. Employees assess the social norms of an organization based on the organizational climate that is prevalent (Clair et al., 2005). When it comes to disclosure, the organizational diversity climate (ODC) is particularly influential. This paper will assess ODC, defined as "the perceived formal structure characteristics and informal values of an organization" (Gonzalez & Denisi, 2009, p. 24). Research has shown a positive relationship between a supportive organizational climate and disclosure of stigmatized social identities (Chrobot-Mason et al., 2001). Although diversity often implies racial, ethnic, cultural, and gender components, diversity in health or chronic

illness should also be considered (Ball et al., 2005; Beatty & Joffe, 2006). When weighing the costs and benefits of disclosing their IBD, an employee will likely take ODC into account. As their form of diversity is invisible, they have a choice whether to disclose. In an unsupportive climate, one may wait until it is vital (very severe symptoms) to disclose the fact that you are actually part of a marginalized social group. However, within a very accepting social climate, disclosure should be a lot easier. Although the moderating effect of ODC on this relationship has not been previously researched, the anticipation of future discrimination has been found to lead to more concealment of chronic illnesses at work (McGonagle & Hamblin, 2014). Inversely, a positive organizational diversity climate is associated with more openness (Chrobot-Mason et al., 2001). Therefore, the third hypothesis is:

*Hypothesis 3a:* ODC moderates the relationship between symptom severity and disclosure in such a way that when ODC is high, disclosure to managers is more likely.

*Hypothesis 3b:* ODC moderates the relationship between symptom severity and degree of disclosure in such a way that when ODC is high, the relationship will be stronger.

### **Costs and Benefits of Disclosing**

Chronic illness disclosure in a workplace environment is a high-stakes decision as it can influence many key outcomes (Beatty, 2018). Within the model by Clair and colleagues (2005) these consequences are characterized as the costs and benefits of disclosure. Self-disclosure contains an inherent dilemma (Vickers, 1997): “to tell or not to tell” (p. 240). The outcome remains unknown until the disclosure has been made and there is no going back. In the case of IBD the disclosure decision may be particularly influential to one’s career path. IBD, unlike many other chronic illnesses, has its onset relatively early in life. According to Levinson’s model of life stage development (1978), one’s twenties and thirties are the age at which one develops one’s sense of identity in the workplace. Chronic illness in these early career stages can lead to employees setting more appropriate career goals. However, it can

also lead to disappointment as the career path they may have had in mind can become inaccessible (Beatty & Joffe, 2006).

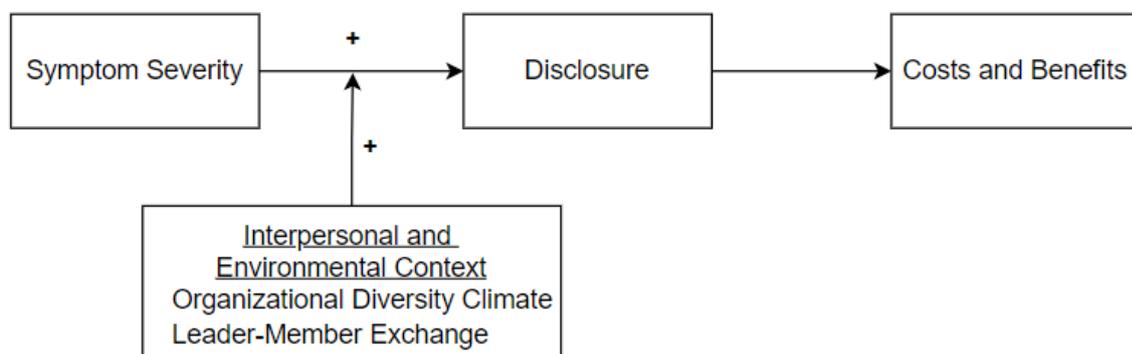
On the one hand, disclosing can have many negative consequences. Disclosure can lead to stigma and discrimination (Beatty & Kirby, 2006). Disclosure can also form a barrier to career development, as there are often misconceptions that managers hold about the chronic illness and its symptoms (Beatty, 2012). It can even lead to loss of employment (Clair et al., 2005). On an interpersonal level, disclosure may also lead to exclusion by colleagues, which is harmful to wellbeing (Dickerson & Zoccola, 2013). On the other hand, disclosure can also be very beneficial. Keeping a facet of one's social identity concealed in the workplace can lead to stress (Smart & Wegner, 1999). Research has shown that disclosure can alleviate this negative effect (Chaudoir & Fisher, 2010). Research has also shown that disclosure leads to more organizational support and increased job retention (Kirk-Brown et al., 2014; Munir et al., 2005).

As suggested by Butler and Modaff (2016), future research should focus on “the response of the supervisor . . . to whom the information was disclosed.” (p. 83). Yet, the number of studies assessing the costs and benefits of disclosing IBD is extremely limited. Therefore, the costs and benefits will be assessed using qualitative measures. The following research question has been formulated:

*RQ1: Which costs and benefits are associated with the disclosure decision?*

## Figure 1

*Conceptual Model of Employee IBD Disclosure*



## Methods

### Sample Characteristics

Participants were recruited through multiple channels. The non-profit organization *Crohn & Colitis Nederland* participated in this study by posting the survey link in the newsletter and on the website. Further data was collected through (Reddit) forums regarding IBD such as r/CrohnsDisease, r/IBD, and r/ostomy and through postings in the thesis supervisor's social networks. To participate in this study, the participants had to meet the following criteria: minimum age of 18, a medical diagnosis of an IBD (according to participant's personal statement), current employment (either part-time or full-time), and not self-employed, on maternity leave or prolonged sick leave. According to the G\*Power calculation, the sample size needed to exceed a minimum of 119 participants (Faul et al., 2007). This calculation was based on the use of linear multiple regression with fixed model and  $R^2$  increase, assuming a moderate effect size of .15 and testing nine predictors in total (assuming inclusion of three control variables).

During the data collection period, a sudden and extreme spike in participants indicated that one or more individuals were submitting automated and/or forged responses to the survey. These responses were clearly not genuine as there were obvious multiple choice answer patterns, copy-pasted answers to open questions, and answers that were unrelated to the open questions. Luckily, the cut-off point within the data set was very clear, and the data could be salvaged. Once data collection was concluded, there was a total of 457 respondents. Of these, 364 responses were excluded because they were either judged to be fraudulent, did not have a direct supervisor, or were incomplete. Hence, the final sample included 93 participants. As this is below the goal of 119 participants a post hoc power analysis will be performed. Of this group, 23 (24.73%) were male and 70 (75.27%) were female, with an average age of 34.18 years old ( $SD = 10.28$ ) and working an average of 32.14 ( $SD = 10.14$ ) hours a week. The type of IBD was evenly split with 47 (50.5 %) having Crohn's disease and 44 (47.3%) having ulcerative colitis. Of the participants, the majority had either experienced one (34.4%) or no (39.9%) flares in the last six months.

## **Design and Procedures**

Data was collected through a self-report survey containing already validated questionnaires as well as open questions. Hypothesis testing was run in SPSS, using the Hayes PROCESS macro with 2000 bootstrapping (Faul et al., 2007). The role of individual, interpersonal, and organizational factors in the disclosure of IBD to a manager was assessed with a cross-sectional analysis using the results from the questionnaires. The costs and benefits experienced based on the disclosure decision were investigated exploratively by qualitatively analyzing the answers to the open questions. The survey was presented in Dutch, English, and German to broaden the scope of the sample. For the Dutch and German versions of the survey, either an already validated version of the questionnaires was used or the items were translated and tested using back-translation. Before starting the survey, participants were presented with a written explanation about the purpose of the study, the anonymity of the data and the possibility to withdraw from the study at any point. This was followed by a consent form laying out the terms of voluntary participation, which had to be accepted to continue. After finalizing the survey, participants received a debriefing containing a list of the assessed variables, the research hypotheses, and the opportunity to state their email address (in a separate dataset) to enter the raffle. Contact information for 'de luisterlijn' (or similar services) was also provided in case any participants felt distressed after completing the questionnaires. This design and procedure received a positive vote from the ethics review board of the respective department at University of Amsterdam.

## **Measures**

### ***Disclosure to Manager***

The model by Clair and colleagues (2005) proposes a dichotomous operationalization of disclosure (passing vs. revealing), which restricts the variance of disclosure and may not be adequate in reflecting the reality of disclosure behaviors, as previous research suggests that the majority of employees with IBD disclose to their employers (Wyke et al., 1988). As disclosure can also be operationalized as a continuum from complete secrecy to complete information (Goffman, 1974, pp. 94-5), we instead

included both a dichotomous and continuous disclosure measurement. Following the operationalization of Munir and colleagues (2005), disclosure was measured by asking participants whether they disclosed their IBD to their manager (yes or no). If participants had disclosed, the degree of disclosure was measured using the 'disclosure of illness' scale developed by Munir and colleagues (2007). The scale contains four items answered on a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*full disclosure*). A higher score indicates a higher degree of disclosure. The four items were: "To what extent have you shared the following information about your IBD with your manager: a) type of IBD and its symptoms; b) ways in which you manage your IBD at work (e.g., medication, diet); c) the effect of your IBD on your work (e.g., on your ability to perform tasks); and d) any time off work needed, related to your IBD?" These items are based on the items used by Hakkarainen and colleagues (2016), replacing 'diabetes' with 'IBD'. Previous research found that this scale had a good to excellent reliability, with  $\alpha = .89$  (Munir et al., 2007). In this study, the reliability was again good to excellent, with  $\alpha = .87$ .

### ***IBD Symptom Severity***

Symptom severity was measured using The Short Inflammatory Bowel Disease Questionnaire (SIBDQ) developed by Jowett and colleagues (2001). The questionnaire contains ten items answered on a 7-point Likert scale ranging from 1 (*none of the time*) to 7 (*all of the time*). A higher score indicates more severe symptoms. An example question is "How often during the last two weeks have you been troubled by pain in the abdomen?" The SIBDQ was proven to be a valid measurement to identify changes in the health status of people with IBD (Irvine, Zhou et al., 1996). It can also be reliably self-administered (Irvine, Feagan, et al., 1996). In this study, the reliability was good to excellent, with  $\alpha = .88$ .

### ***Leader-Member Exchange***

LMX was measured using the LMX-7 developed by Graen and Uhl-Bien (1995). This 7-item questionnaire is answered on a 5-point Likert scale. A higher score indicates a better-quality exchange and relationship between manager and employee. An example question is "How well does your leader understand your job problems and needs?" The LMX-7 was

shown to have good to excellent reliability with Cronbach alpha scores ranging between .8 and .9 and has shown consistent convergent validity with other LMX measures (Graen & Uhl-Bien, 1995). In this study, the reliability was excellent, with  $\alpha = .91$ .

### ***Organizational Diversity Climate***

Organizational diversity climate was measured with the items developed by Herdman and McMillan-Capehart (2010). Within the items, the term “hotel” was replaced with “organization”. The three items are answered on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). A higher score indicates a better organizational diversity climate. An example question is “The organization values differences in its employees.” In previous research, the scale showed acceptable to good reliability of  $\alpha = .76$  (Herdman & McMillan-Capehart, 2010). In this study, the reliability was good to excellent, with  $\alpha = .84$ .

### ***Demographic Variables***

Data was collected on age (in years), tenure (length of employment in years), gender (1 = male, 2 = female, 3 = other/prefer not to say), occupation (select from multiple-choice question), medical diagnosis of an IBD (Crohn’s disease or ulcerative colitis), current employment (either part-time or full-time), and type of contract (permanent, temporary). Gender was included as research has shown that women are more likely to disclose their chronic illness than men or others (Munir et al., 2005). Tenure was included as disclosure is positively related to job tenure, and a longer tenure may also provide more opportunity for disclosure (Kirk-Brown et al., 2014).

### ***Costs and Benefits***

The costs and benefits associated with the disclosure decision were assessed using two open questions: “What (if any) costs do you experience from the degree of your disclosure to your manager?” and “What (if any) benefits do you experience from the degree of your disclosure to your manager?”

### ***COVID-19 Variables***

The Coronavirus crisis (and co-occurring lockdown) has caused a rapid shift to working from home (WFH) (DeFilippis et al., 2020) and adverse mental health effects (Hamouche, 2020). This applies especially to people with chronic illnesses, because of the uncertainty of disease status and difficulties in receiving routine medical treatment (Brooks et al., 2020; Pellino & Spinelli, 2020). Therefore, items regarding the effects of COVID-19 on the participants were included. To assess the influence on working conditions, the following items were included: “On average, how many days of the week do you currently work remotely?” and “On average, how many days of the week did you work remotely before the COVID-19 pandemic?” I also included the COVID-19 Own Risk Appraisal Scale (CORAS) developed by Jaspal and colleagues (2020). This two-item questionnaire is answered on a 5-point Likert scale. A higher score indicates a greater appraisal of risk. The two items are: “What is your gut feeling about how likely you are to get infected with COVID-19?” (1 = *extremely unlikely* to 5 = *extremely likely*), “I feel vulnerable to COVID-19 infection” (1 = *strongly disagree* to 5 = *strongly agree*). Altered versions of these items were presented to the participants who had previously contracted COVID-19, adding “again” and “another” respectively. The CORAS was found to have good concurrent validity in previous research (Jaspal et al., 2020). In this study, the reliability was calculated separately for those who had and had not been previously infected with COVID-19. Reliability was questionable to acceptable for those who had previously contracted COVID-19, with  $\alpha = .69$ , and good to excellent for those who had not previously contracted COVID-19, with  $\alpha = .86$ .

### **Data analysis**

Hypotheses were tested using logistic regression analyses, linear multiple regression analyses in SPSS, and Model 1 and Model 2 from the Hayes PROCESS macro (Faul et al., 2007). Control variables were selected on a theoretical basis.

To test the second research question (Which costs and benefits do employees with IBD experience because of their disclosure decision?), we used the cutting and sorting technique (Ryan & Bernard, 2003). The answers to the open questions were carefully read, and those that did not answer the question were excluded. The remaining responses were

grouped into four categories: benefits of not disclosing, costs of not disclosing, benefits of disclosing, and costs of disclosing. If an answer mentioned more than one cost or benefit, it was split up into multiple responses. The responses within these categories were then sorted into groups by two raters, who gave each group a name representing the type of answers it contained. It should be noted that I was one of the raters. An Excel spreadsheet was used for the sorting procedure. I then compared the chosen themes and identified the overarching themes that resulted from the cutting and sorting process. Any German responses were translated to English to allow both raters to comprehend them.

Two exploratory analyses were also performed. Combining results from the qualitative and quantitative findings, an independent sample t-test was performed to assess which factors were related to the disclosure costs experienced. The effects of the COVID-19 pandemic were also assessed.

## **Results**

### **Descriptive Statistics and Preliminary Analyses**

Table 1 displays the means, standard deviations, and bivariate correlations between the study variables. Gender was coded dichotomously as 1 = male, 2 = female as no participants selected the third option in this sample. Gender was not significantly correlated with the decision to disclose,  $r = .07$ ,  $p = .512$ , or with the degree of disclosure,  $r = -.10$ ,  $p = .375$ . Tenure was also not correlated with either measure of disclosure,  $r = .11$ ,  $p = .300$  and  $r = .07$ ,  $p = .572$ . Although they did not correlate with the study variables, gender and tenure were still included as controls within the various hypothesis tests as this still had theoretical merit. No other demographic variables were significantly correlated with the study variables.

To assess whether the type of IBD (Crohn's disease or ulcerative colitis) was related to the numeric variables, I conducted an independent sample t-test. Histograms were created to test for normal distribution of the continuous study variables. Results showed that the degree of disclosure was skewed to the right. Therefore, the continuous variables were standardized. The assumption of variance homogeneity was met as the Levine's test for equality of variances showed no significant results. The results from the independent

samples t-test did not show a significant difference between employees with Crohn's disease and ulcerative colitis for any of the test variables (see Appendix G). Therefore, the type of IBD was not added as a control variable. Consequently, all analyses contained two control variables (gender and tenure).

### **Assumption testing**

For the linear multiple regression and logistic regression analyses, the assumptions of multicollinearity, homoscedasticity, uncorrelated residuals, normal distribution, and linearity were either tested and met or corrected for. Multicollinearity of study variables was assessed using a VIF test. All VIF values were  $<5$ . Therefore, the assumption of multicollinearity was met. Homoscedasticity was evaluated by creating ZPRED ZRESID plots. All results from the Durbin-Watson tests ranged between 1.5 and 2.5, which means that the residuals were uncorrelated. Standardized scores (Z-scores) were used to control for the lack of normal distribution. Linearity was assessed using plots created in the chart builder.

As the PROCESS macro utilizes 5000 times bootstrapping, it does not make assumptions about the distribution. Therefore, no further assumptions were tested. Even though it is not required, the Z-scores were used within the Model 1 and Model 2 analyses. This allowed for more consistency and made comparing regression and moderation results easier.

**Table 1**

*Means, Standard Deviations, and Correlations Between the Study Variables.*

Variables	Correlations									
	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8
1. Employee gender	1.75	.43	-							
2. Employee tenure	6.56	7.31	.12	-						
3. Age difference L-F	2.48	.65	.01	-.38**	-					
4. Days WFH	4.69	2.65	-.18	-.01	.77	-				
5. Symptom severity	3.66	1.10	-.05	-.11	.24*	-.02	-			
6. LMX	3.69	.84	.05	-.03	.14	.06	-.25	-		
7. ODC	3.69	.82	.08	<.01	.17	.20	-.22*	.58**	-	
8. Disclosure decision	1.83	.38	.07	.11	.12	-.09	.01	.16	-.02	-
9. Degree of disclosure	3.53	1.26	-.10	.07	-.01	.05	.16	.33**	.14	. <sup>c</sup>

*Note:*  $n = 93$ , Gender was coded as 1 = male, 2 = female, 3 = Other, L-F stands for Leader-Follower, WFH stands for work from home, Disclosure decision was coded as 1 = non-disclosure 2 = disclosure.

\* $p < .05$

\*\* $p < .001$

### Hypotheses 1a through 3a

Hypotheses 1a through 3a were tested by running logistic regressions for the direct effects and Model 1 and Model 2 from the Hayes PROCESS macro for the moderation (Faul et al., 2007). Results from these analyses are stated in Table 2. Of the 93 participants, 16 (17.2%) had not disclosed, and 77 (82.8%) had disclosed their IBD to their supervisor.

I expected that symptom severity would be positively related to the disclosure decision (Hypothesis 1a). This hypothesis was tested using a logistic regression analysis containing the control variables in the first block and the test variables in the second block (see Model 2a). The control variables gender and tenure were not significantly related to the disclosure decision. Results did show that LMX was significantly related to the disclosure decision,  $\beta = .77$ ,  $Wald = 3.87$ ,  $p = .049$ , 95%CI Exp(B) [1.00, 4.68], indicating that increased LMX is associated with increased likelihood of IBD disclosure. More specifically, for every unit increase in LMX, the odds of disclosing increase 2.17 times. Symptom severity was not significantly related to the decision to disclose,  $\beta = .10$ ,  $Wald = 0.10$ ,  $p = .747$ , 95%CI Exp(B) [0.61, 2.00]. Hypothesis 1a was therefore not supported.

**Table 2.**

*Beta values from the logistic regression analysis, regressing disclosure decision on the standardized covariates, predictor, and moderators.*

	Model 1a	Model 2a	Model 3a	Model 4a	Model 5a
Intercept	1.69	1.81	1.81	1.79	1.79
Gender	-.32	-.30	-.39	-.39	-.37
Tenure	.34	.36	.30	.35	.38
Symptom severity		.10	.02	.08	.10
LMX		.77*	.87*	.72	.67
ODC		-.53	-.61	.48	-.45
Severity x LMX			-.23		.10
Severity x ODC				-.39	-.47
Cox & Snell $R^2$	.02	.06	.07	.08	.08
Nagelkerke $R^2$	.03	.10	.12	.13	.14

Note: n = 93, Gender was coded as 1 = male, 2 = female, Disclosure was coded as 1 = non-disclosure 2 = disclosure

\*  $p < .05$

\*\* $p < .01$

To test the moderating effect of LMX (Hypothesis 2a) and ODC (Hypothesis 3a) on the relationship between symptom severity and the disclosure decision, Model 1 and Model 2 from the Hayes PROCESS macro were run (Faul et al., 2007). Model 3a and Model 4a show the moderating effects of LMX and ODC separately, controlling for the direct effect of the other moderator. Neither LMX nor ODC moderated the relationship between symptom severity and the disclosure decision. The same results were found when both moderators were included within one analysis (Model 5a). Therefore, Hypotheses 2a and 2b were not supported.

### **Hypotheses 1b through 3b**

Hypotheses 1b through 3b were tested by running linear multiple regressions for the direct effects and Model 1 and Model 2 from the Hayes PROCESS macro for the moderation (Faul et al., 2007). The regression analysis only included participants who stated that they had disclosed their illness to the supervisor, reducing the sample size ( $n = 77$ ). Results from these analyses are stated in Table 3.

Symptom severity was expected to be positively related to the degree of disclosure (Hypothesis 1b). This hypothesis was tested using linear multiple regression (Model 2b). The first block contained gender and tenure; the second block contained the test variables. The Model including the test variables (Model 2b) predicted significantly more variance than the Model containing only control variables (Model 1b),  $R^2\text{Change} = .173$ ,  $F\text{Change}(3,71) = 5.05$ ,  $p = .003$ . Gender and tenure were not significantly related to the degree of disclosure. Symptom severity was found to be significantly related to the degree of disclosure  $\beta = .23$ ,  $t(75) = 2.03$ ,  $p = .046$ , providing support for Hypothesis 1b. Results also showed a significant effect of LMX on the degree of disclosure,  $\beta = .42$ ,  $t(75) = 2.95$ ,  $p = .004$ , implying that a higher perceived LMX is associated with a higher degree of disclosure.

**Table 3**

*Beta values from the multiple linear regression analysis, regressing degree of disclosure on the standardized covariates, predictor, and moderators.*

	<b>Model 1b</b>	<b>Model 2b</b>	<b>Model 3b</b>	<b>Model 4b</b>	<b>Model 5b</b>
<b>Intercept</b>	.45	.56	.33	.41	.37
<b>Gender</b>	-.26	-.34	-.23	-.29	-.26
<b>Tenure</b>	.07	.09	.06	.08	.07
<b>Symptom severity</b>		.23*	.26*	.23*	.24*
<b>LMX</b>		.42*	.47**	.43*	.44*
<b>ODC</b>		-.06	-.06	-.02	-.02
<b>Severity x LMX</b>			-.19		-.06
<b>Severity x ODC</b>				-.23*	-.19
<b>R<sup>2</sup></b>	.016	.189	.23	.24	.49

*Note: n = 77, Gender was coded as 1 = male, 2 = female*

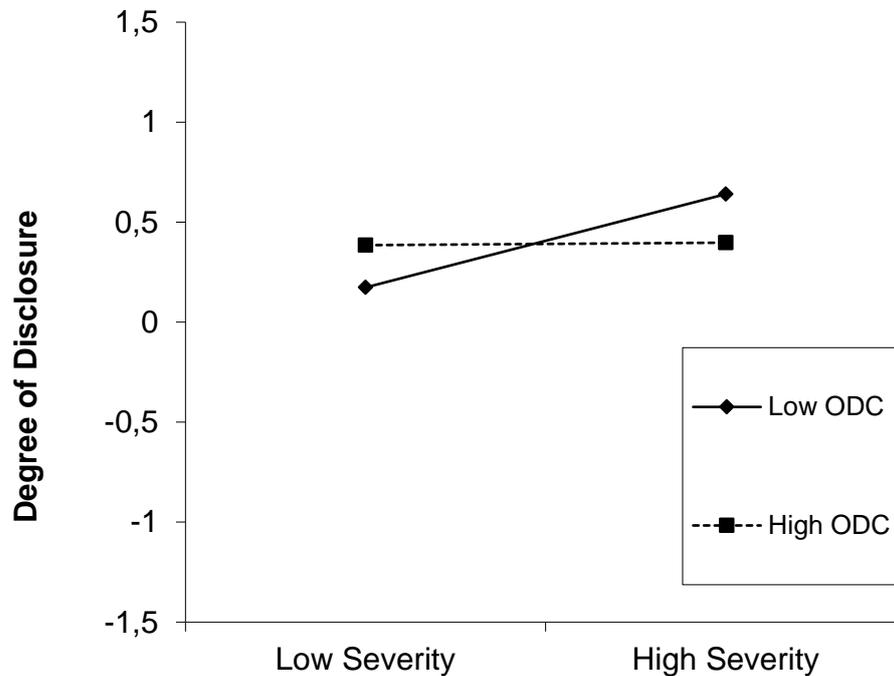
*\* p < .05*

*\*\*p < .001*

Model 3b and Model 4b show the moderating effects of LMX and ODC separately, controlling for the direct effect of the other moderator. Results still show significant direct effects of symptom severity and LMX. Model 3b shows that the interaction between LMX and symptom severity is not significant,  $\beta = -.19$ ,  $t(76) = -1.79$ ,  $p = .078$ , 95% CI [-.40, .02]. Therefore, Hypothesis 2b was not supported. Model 4b showed a significant interaction between ODC and symptom severity,  $\beta = -.23$ ,  $t(76) = -2.18$ ,  $p = .03$ , 95% CI [-.43, -.02]. Visualization of the interaction from Model 4b can be seen in the simple slopes (Figure 2). When ODC is low (- 1 SD), symptom severity has a positive effect on disclosure,  $\beta = .42$ ,  $t(77) = 2.99$ ,  $p = .004$ . When ODC is high (+ 1 SD) symptom severity is not significantly related to the degree of disclosure,  $\beta = -.04$ ,  $t(77) = -.22$ ,  $p = .823$ . This interaction was no longer significant in Model 5, when the interaction of LMX was included,  $\beta = -.18$ ,  $t(76) = -1.27$ ,  $p = .209$ , 95%CI [-.48, .11]. This was most likely caused by the small sample size and lack of power. Therefore, Hypothesis 3b was (carefully) supported.

**Figure 2**

Simple slopes of the moderating effect of ODC



The final number of respondents was 93, which is below the minimum of 119 participants previously suggested by the G\*power calculation. Therefore, a post hoc power analysis was performed for the analysis that found a significant moderation (Hypothesis 3b). This analysis was performed on 77 participants (those who disclosed) and a total of five predictors (including two control variables) were included. Again, the calculation was based on the use of linear multiple regression with a fixed model and  $R^2$  increase. When comparing the model containing all the test and control variables to the model including the interaction effects, the  $R^2$ Change = .301. The  $f^2$  was calculated and this number was used to calculate the power in G\*Power. This post hoc power analysis showed a power of  $1-\beta = .51$  which indicates that the analysis was underpowered.

### Qualitative analysis

A total of 93 survey responses were analyzed to answer the research question "Which costs and benefits do employees with IBD experience because of their disclosure

decision?”. Of the responses included in the quantitative analysis, a number were excluded here as they did not answer the open question. Coincidentally, as I used all available data, the same number of responses could be included from participants who had only partially completed the survey, but answered the open questions. Of the 93 participants 15 had not disclosed their IBD to their manager, and 78 had disclosed their IBD to some degree.

### ***Not Disclosed***

**Data Cleaning Process.** Of the 27 answers within this category, 17 were excluded from the analysis (see Appendix C), due to several factors: Some participants stated that they experienced no costs or benefits. Other participants misinterpreted the question as “what costs/benefits would you experience if you were to disclose?” (e.g., “People think differently of you and think you can't handle things”). And some participants brought up factors that were not actually related to their disclosure decision (e.g., “Flexibility in work from home due to the pandemic has been advantageous”). The remaining 10 responses were sorted into categories by two raters. Results are stated in Appendices A and B. These categories were then compared. As it was a limited number of responses, I have summarized the findings more generally instead of creating themes.

**Costs and Benefits of Not Disclosing.** While assessing the costs and benefits, an unexpected disclosure category was found. Most people who did not disclose their IBD to their employer did in fact disclose having a “long-term illness” or a “health/medical issue” According to the participants. This benefited them as it allowed them to receive time off and be better understood by their manager while retaining some privacy: “I explained I have a medical issue and I need to take time off on occasion. Ultimately, I don't think It's any of their business. There is no advantage in my opinion to disclosing the exact medical condition.”

The employees that seemingly did not disclose any details to their supervisor reported different benefits: Hiding a part of their social identity was used as a protective tactic to avoid discrimination or prejudice. However, the major cost of not disclosing was that unexplained absence could have negative consequences. When the risk of discrimination is

high, employees with IBD are left between a rock and a hard place, as illustrated by the following response:

Where I live, an employer can fire an employee for any reason including no reason at all. Due to this labor law, I fear of being discriminated against if my employer knew of my condition and made assumptions on my ability to work. ... I fear the regular days off I need for treatment or sudden emergency flares may be misconstrued as skipping work without reason. And this could be another reason for my employer to fire me.

### ***Disclosed***

**Data Cleaning Process.** Of the 84 participants who answered the questions about the costs and benefits and had disclosed to their supervisor, 63 benefits and 23 costs were included in the thematic analysis. The remaining responses were excluded for different reasons (for excluded responses, see appendix F). Most responses were excluded because they did not report experiencing costs or benefits from their disclosure. A small number of responses were excluded as they did not answer the question, or outright stated that they did not understand the question (“I needed to disclose because of covid because I needed him to adjust my schedule to reduce my contacts. I would be disinclined ordinarily to disclose.”, “Don’t understand the question. Costs like money? None. Weird question”). Two raters created categories with thematic names for both the benefits and costs of disclosing.

**Benefits of Disclosing.** The benefits of disclosing were mostly related to authenticity in the workplace, obtaining different types of support, and increased understanding by the supervisor. Three themes were extracted.

The first theme named by the raters was receiving instrumental support. Most responses within this theme were characterized as “receiving physical support” by Rater 2. Rater 1 identified multiple themes: “flexibility”, “receive resources”, and “take time off”. These themes all still fit within the definition of instrumental support, which is defined as “provision of tangible assistance” (Taylor, 2011 p.193). A few types of support were mentioned repeatedly. Many participants stated that disclosing their IBD caused their manager to allow

them time off for rest, doctor's visits, and treatment. Another common benefit was the possibility of flexible working hours, being allowed to change shifts, or have more discretion over the hours worked. Lastly, adjustments to working conditions were also mentioned. Some employees could work from home; others were situated closer to the office bathroom or permitted to take extended bathroom breaks when necessary.

For instance: "My manager is able to interchange me for other employees in instances where my IBD prevents me from doing a job help me get someone to cover while I use the restroom." And: "They've worked with me regarding my hours, workload, and ways to manage pain at work."

The second theme named by the raters was transparency. Rater 1 characterized these responses as "openness", and Rater 2 titled the theme "being honest to my identity". The name transparency was chosen as it was deemed less morally charged than honesty or openness. The comfort of not needing to keep secrets in the workplace was mentioned. "Honesty is the best policy." It also seemed to allow for a better relationship with the supervisor: "Authenticity in relation to my boss." "... there is nothing unmentioned 'between us'."

The third theme is closely related to transparency: understanding and emotional support. This theme included Rater 1's theme of "emotional support manager" and Rater 2's "receiving mental support" and "understanding". Many employees mention that their supervisor understands what is going on with them. Not having to explain things repeatedly and not having their behavior misconstrued as uncommitted was often mentioned as a benefit: "My manager understands the physical symptoms and psychological effects of an IBD diagnosis. I feel confident I would be supported and my job would stay in place if I were to experience a flare during work." "They typically know that problems arise for specific, legitimate reasons and do their best to understand."

**Costs of Disclosing.** The costs of disclosure were mostly related to the way others reacted to the employee. Their professional ability was underestimated, and sometimes they

were discriminated against. However, far fewer costs were mentioned than benefits. The majority (41 out of 65) of those who had disclosed said they experienced no costs.

The first theme identified by the raters was named ability to work. Both raters sorted the responses in this category into two separate themes with Rater 1 creating themes “stunt career growth” and “doubt ability” and Rater 2 “my capacity to work” and “handled with ‘too much’ care”. However, as there were differences between the raters, one larger category was created. It seems that disclosing IBD may impact one’s career in two ways: In the short term, respondents stated that they received fewer tasks and worried that their supervisor might think they were not equipped to do their job. Some even mentioned being handled in an overprotective way: “Sometimes it feels like I’m being handled with kid gloves.” As a long-term consequence, disclosure of IBD can negatively impact employees’ career development. Some mentioned being denied promotion or not being able to get a full-time position. For example: “No direct [costs] (yet) but I suspect it will impact my overall career prospects or could potentially lose work/project opportunities if people worry about me not being available due to my disease and taking time off when sick.”

The second theme identified by the raters was named discrimination and prejudice. Responses within this category were labeled by Rater 1 as “being discriminated” and by Rater 2 as “my character and identity”. When asked to elaborate on this theme, Rater 2 stated that “they [respondents] think the supervisor or person will attribute their shortcomings in the workplace to character traits instead of ‘external’ (disease related) circumstances.” Employees either worried about the stigma of IBD or suffered overt discrimination. Although this was a small minority, it was still deemed important enough to include: “Regularly and openly ridiculed due to embarrassing nature of the condition.” “I felt as though I was looked at differently afterward in a negative way and felt somewhat discriminated against by a few.”

Although the raters identified several other themes, there was either not enough agreement amongst the raters or too few responses to create an additional category. These remaining themes were as follows: work identity, invasion of privacy, and lack of understanding.

**Table 4***Themes Identified in Costs and Benefits of Disclosure*

<b>Benefits of Disclosing</b>	<b>Costs of Disclosing</b>
Receiving instrumental support	Ability to work
Transparency	Discrimination and prejudice
Understanding and emotional support	Work identity Invasion of privacy Lack of understanding

The theme work identity was only identified by Rater 1. A few respondents mentioned that disclosing impacted their relationships in the workplace because their supervisor overemphasized their IBD: “Risk that the manager looks at me as an “employee with an issue” instead of just my professional qualities.” “Being stressed about having to talk to her about my disease every time we have a performance talk, instead of talking about working related stuff.”

The theme invasion of privacy was identified by both raters, however only two responses fell into this category. One participant stated the following: “HR and H&S requesting a copy of my prescription for their records due to drugs testing practices at work.”

And similarly, the theme lack of understanding was identified by both raters but only contained one response: “He still does not understand the true nature of my condition, and does not always take me seriously when I express need for time off to rest.”

**Exploratory analysis*****Disclosure Costs and Context***

Combining the qualitative and quantitative elements, I was interested in exploring the large group of people who disclosed and experienced no costs. Results of an independent samples t-test showed that participants who reported no costs reported significantly higher ODC ( $M = 3.93$ ) than participants who reported experiencing any type of disclosure cost ( $M = 3.63$ ),  $t(65) = -2.87$ ,  $p = .006$ . No significant difference in LMX was found between these

groups,  $t(65) = -1.87$ ,  $p = .066$ . The group of people that experienced costs was smaller than 30 ( $n = 24$ ). However, results from a G\*Power analysis showed sufficient power,  $1-\beta = .79$ .

### **Effects of COVID**

Within the sample, 9 participants had tested positive for COVID-19 at some point. Previous COVID-19 infection was, however, not related to IBD symptom severity experienced in the past year,  $r = .104$ ,  $p = .323$ . Symptom severity was related to how the participants perceived their personal risk of contracting COVID-19,  $r = .205$ ,  $p = .050$ . Before the pandemic, people worked from home an average of 1.59 days a week, and currently, they work from home on an average of 4.69 days a week. Results from a paired sample t-test shows that this was a significant increase,  $t(92) = 11.27$ ,  $p < .001$ .

## **Discussion**

### **Summary Results**

The purpose of this study was to assess the roles of individual, interpersonal, and organizational factors in the disclosure of IBD and the costs and benefits associated with disclosing or not disclosing. The analyses resulted in five main findings.

Consistent with previous research (Beatty, 2004; Kirk-Brown et al., 2014; Munir et al., 2005), this study shows a positive relationship between symptom severity and degree of disclosure. This suggests that when employees experience more severe IBD symptoms, they share more details with their supervisor about the type of IBD, how they manage it at work, how it affects their work, and whether they need time off. The same relationship was not found between symptom severity and the disclosure decision.

Results further showed that the ODC moderates the relationship between symptom severity and degree of disclosure. Employees assess the organizational social norms based on the prevailing organizational climate (Clair et al., 2005). Although previous research had found a positive relationship between ODC and openness within a different population (Chrobot-Mason et al., 2001), this moderation had not previously been studied. This finding aligns with the Conceptual Model of the Decision to Pass or Reveal by Clair and colleagues (2005), which suggests that the environmental context moderates the relationship between

individual differences and the disclosure decision. The results indicated that the relationship between symptom severity and degree of disclosure is only significant and positive when ODC is low. When the employees perceived a very positive diversity climate, the severity of symptoms was no longer related to the degree of disclosure. This supports the proposition in the theory section that an unsupportive climate may make an employee wait until disclosing more information becomes unavoidable because of the severity of their symptoms. Results from the exploratory analysis validate the reluctance to disclose in an unsupportive climate, as employees who mentioned any disclosure costs generally had worse ODC within their workplace.

The costs mentioned by employees who disclosed their IBD fell into two broad themes: the ability to work and discrimination and prejudice. These costs are all related to the way that others respond to the employee with IBD after they disclosed. This is supported by previous research showing that aside from the chronic illness itself, others' reactions to the disease generally form the most significant career boundary (Beatty, 2012). Managers may have misconceptions about what an employee with IBD can or cannot handle, leading to underestimating their ability to work, and the possibility of the respective employee being passed up for promotion. Aside from these misconceptions, disclosure leading to discrimination was also consistent with previous research (Beatty & Kirby, 2006). The benefits of disclosing IBD were more frequently mentioned than costs. The benefits fell under three themes: receiving instrumental support, transparency, and understanding and emotional support. The prevalence of different types of instrumental support reflects the findings from the Dutch Crohn's and Colitis Organization (van der Horst & Scherpenzeel, 2020). Their study showed that the most sought-after accommodations were flexible working hours, reduced workload, and decreased working hours. It seems that disclosure is, therefore, one way to potentially receive these benefits. In addition to these benefits, interpersonal benefits were also reported which is in line with research that shows that the stress of concealing one's social identity in the workplace can be alleviated by disclosing (Chaudoir & Fisher, 2010; Smart & Wegner, 1999).

Although the moderating effect of LMX was not supported, a direct effect of this interpersonal environmental factor on disclosure was found. LMX was directly related to both the disclosure decision and the degree to which employees disclosed information about their IBD to their manager. When an employee has a high-quality transactional relationship of resources with their supervisor, they partake in a higher degree of self-disclosure (Graen & Uhl-Bien, 1995). As stated previously, disclosing IBD to your manager can provide tangible benefits in the form of instrumental support. However, self-disclosure also serves an interpersonal purpose. The other benefits mentioned, transparency, and understanding and emotional support, focus on the interactions and relationship with the supervisor. Research has found that self-disclosure is positively related to solidarity, intimacy, and trust (Bauminger et al., 2008; Wheelless, 1976; Wheelless, 1997). This can explain why a direct effect of LMX on disclosure was found.

And finally, results from the qualitative analysis of the costs and benefits of not disclosing provided some interesting findings. The employees who did not disclose their IBD could be further separated into two categories: those who truly did not disclose anything and disclosed “a medical condition/health condition” without explaining that they had IBD specifically. The employees that did not disclose at all seemingly did so out of fear of discrimination and stigma. However, by not disclosing, they perceived a risk of being judged negatively or losing their job because of frequent sick days. The employees that disclosed an unnamed health condition seemingly avoided this cost. By only disclosing a small amount of information, they were able to receive some of the benefits (e.g., time off for medical treatment) without risking the stigma that conditions such as IBD still carry (Taft et al., 2011).

To summarize, the results from this study provide new information about the factors that are related to IBD disclosure and the costs and benefits that result from disclosing or not disclosing IBD at work. These results have both theoretical and practical implications.

### **Theoretical Implications**

A simplified version of the conceptual model of the decision to pass or reveal by Clair and colleagues (2005) was used as the theoretical framework of this thesis. This model has

been used to assess disclosure of invisible disabilities, pregnancy, sexual identity, and autism spectrum disorder (King, & Botsford, 2009; Leven, 2020; Santuzzi et al., 2014; Ragins et al., 2014). However, it had not yet been applied to employees with IBD. Although the overall structure of the model was upheld, some alterations were made.

Firstly, because of the preliminary nature of the research, the feedback loop between disclosure and costs and benefits, as well as the effect of the contextual factors on the outcomes of disclosure that employees experience, were not included in this study. Secondly, the specific factors included in the model were tailored to this particular invisible social identity. Instead of selecting one of the individual factors from the original model, symptom severity was chosen, as this factor is unique to employees with chronic illnesses. And lastly, the disclosure variable was also altered. The original model operationalizes disclosure as a choice, comparing “passing” and “revealing”. However, previous research showed that most participants disclosed their IBD to some extent (Wyke et al., 1988). As disclosure can also be operationalized as a continuum from complete secrecy to complete information (Goffman, 1974, pp. 94-5), this study added a continuous operationalization of disclosure to the model, measuring the degree to which those that disclosed shared information. The results not only provide theoretical support for these changes but also avenues for future research.

Although the feedback loop and effect of contextual factors on the costs and benefits of disclosure were not included in the hypotheses of this study, due in part to the mixed-methods design, some indication of their existence was found. One participant mentioned the following in response to the open question: “In my first job which was a non permanent position (contracted) I was pushed out of my job as I had taken 4 weeks sick leave due to my crohn's. This has stopped me wanting to tell others” (Appendix C.). This clearly indicates the presence of a feedback loop, where the previous disclosure experience makes future disclosure less likely. This feedback loop could be assessed in future research using a longitudinal study design, perhaps focusing on employees with IBD who are starting a new job. In the exploratory analyses, an attempt was made to also assess the factors determining

the costs and benefits. Results showed that those who experienced no costs of disclosing reported a better ODC. The themes identified in the qualitative analysis could be used as a jumping off point to assess the relationship between the context and the outcomes of disclosing. This research could provide an even richer view of employees' IBD disclosure experience.

Results support the choice of symptom severity as the individual difference factor as it was found to relate to the degree of disclosure. Future research may elaborate on this study by using the model to assess the role of other individual or contextual factors tailored to disclosure of IBD. Factors such as anticipated stigma, inclusive leadership, and organizational policies could be included (Bowers et al., 2012; Earnshaw et al., 2012; Munir et al., 2008). The moderating effect that was found for ODC also provides many avenues for future research. The results showed that symptom severity only predicted the degree of disclosure when ODC was low. Future research could assess which individual difference factors predict the degree of disclosure when ODC is high. Some variables that may be considered are privacy perception and disclosure motives (Clair et al., 2005; Westerman et al., 2017).

Results also provide support for the addition of a continuous measurement of disclosure in the model. First, as was expected, the number of employees who did not disclose was very low. Furthermore, results from the open questions showed that those who did not disclose their IBD fell into two categories. This shows that the dichotomous operationalization of disclosure was not ideal for this sample. Future research on disclosure could resolve this operationalization issue in two ways. One option is to use three categories: not disclosed any health information, partially disclosed non-specific health information, and disclosed IBD as was done in previous research (Munir et al., 2005). Another option is to use a continuous measure for those who disclosed their IBD, as in this study.

Results also have implications for future attempts at incorporating research on chronic illness and diversity. Employees working with at least one chronic illness are thought

to make up approximately 15-20% of the workforce (Munir et al., 2007). However, this substantial component of the workforce is often overlooked by companies and researchers alike. When discussing diversity within organizations, this generally implies diversity in characteristics such as race, ethnicity, culture, and gender (Ball et al., 2005; Beatty & Joffe, 2006). Diversity in health or chronic illness is forgotten, as the assumption is often made that all employees are “base-line” healthy (Pinder, 1995). Within this study, diversity was taken into account by assessing the moderating role of ODC on the relationship between symptom severity and disclosure, as suggested within the model by Clair and colleagues (2005). The items used to assess ODC were developed by Herdman and McMillan-Capehart (2010) and were not developed specifically for measuring ODC concerning chronic illness or health. Even when using this general measurement, a significant interaction was found. This indicates that although chronic illness may not be the first thing that comes to mind when discussing diversity, employees who have this social identity are still impacted by the diversity climate within their organization. Future research could further assess the role of diversity in the lives of employees with chronic illnesses. Although development of diversity-related questionnaires specifically applicable to chronic illness could be a valuable avenue for future research, this study shows that preliminary research can use general diversity measurements that are already available.

### **Practical implications**

Concerning practical implications, results from this study emphasize the critical role that organizations and supervisors play in how employees navigate disclosure of IBD in the workplace. Organizational level interventions aimed at improving the ODC could increase disclosure amongst employees with IBD. The ODC is influenced by organizational policies and procedures, transparency of decision making, and the presence of other employees that have openly disclosed (Clair et al., 2005). One such organization procedure is HR initiating discussions about physical and psychological health with employees. Striving towards a better ODC will encourage employees with IBD to not delay disclosing information until their symptoms become severe. To further increase the amount of information employees share

about their chronic illness, especially if the ODC is already good, supervisors must work on improving LMX with their employees. This can be achieved through leadership coaching, where a supervisor is taught how to foster the dyadic relationship with their employees (Scandura, & Graen, 1984).

Furthermore, results about disclosure of chronic illness can also be valuable for employees with chronic illnesses. Expanding the field of research on chronic illness disclosure can provide informational resources for employees. A key example of this is the recent project by researchers at the University of Cologne, who developed an online tool that provides guidance for employees considering disclosure (Niehaus & Bauer, 2015). Results from this study can be used for future development of similar projects or in career counseling of employees with IBD.

The event during the data collection period of this study also has a practical implication for other researchers. An increasingly digitized world carries with it new opportunities but also new threats. During data collection, an onslaught of fraudulent responses was experienced. Although collecting data online means that this is never entirely avoidable, there are some precautions that can be taken. Although the use of forums, such as those on Reddit, can be valuable, when collecting data on less specified groups, it may be safer to distribute surveys through more formal channels or through your own network. If it is necessary to post a survey online, one may wish to refrain from mentioning the reward attached to completing the survey within the recruitment text post. And finally, using a challenge-response test (e.g., Captcha), such as the one included within Qualtrics, can help filter out responses.

### **Limitations and Strengths**

A few limitations of this study design should be noted. As the analysis relies on self-report data only, there is a risk that the relationships found were due to common method variance. However, as I was interested in employees' personal experience, self-report questionnaires were the only feasible option. The data collected was also cross-sectional in nature. Although the theory the hypotheses were based on implies directional relationships

between study variables, these cannot be determined within this data set. A longitudinal study or an experimental vignette study would allow us to explore the cause and effect between individual and contextual factors, disclosure, and outcomes.

Another concern is the size and representativeness of the sample. Firstly, the goal of reaching 119 participants to ensure a power level of  $1-\beta = .80$  was not met. Therefore a post hoc power analysis was performed. Results from the G\*Power analysis showed that the power was  $1-\beta = .51$ , meaning that there was a high chance of type II errors. In other words, although some hypotheses were not supported, there is also not enough support for the null hypotheses. This is especially the case for the hypotheses regarding the disclosure decision (Hypotheses 1a - 3a), as only 16 out of 93 participants did not disclose.

The sample may also differ from the composition of the population of employees with IBD. Predominantly women responded to the survey. Although the prevalence of Crohn's disease is seemingly higher in a female population, this is not the case for ulcerative colitis (Greuter et al., 2020). Gender was included as a control variable within all the analyses and was not related to any of the test variables. The population may also differ because of the sensitive nature of the study, and the way data was collected. Participants were informed that data collection was completely anonymous. However, if someone was very private about their IBD, they may still have chosen not to participate. Furthermore, data was also collected through IBD-related forums and a newsletter sent by the *Dutch Crohn's and Colitis Organization*. Those who responded may identify more strongly with IBD as a part of their social identity than the general population of employees with IBD.

The study design also has several strengths. The research questions were related to a very narrowly defined sample. This made it very challenging to find participants, especially with restrictions in financial and time resources. Although the sample achieved ( $n = 93$ ) was less than initially aimed for, it was still large enough to show interesting relationships between study variables. Furthermore, the use of a mixed-method design provided many avenues for future research. Despite the limitations, undertaking the challenge provided new insights into the experience of employees with IBD.

## Conclusion

Employees with invisible chronic illnesses, such as Inflammatory bowel disorders, are often overlooked in research on organizational diversity and occupational health. To provide these employees with the appropriate accommodations, we must identify ways in which disclosure can be promoted. In this study, the majority of participants disclosed their IBD to their supervisor. The degree of disclosure was related to the severity of symptoms, the relationship with the supervisor, and the climate prevalent within the organization, even after controlling for gender and tenure. Disclosure generally resulted in more benefits than costs. However, a poorer perceived ODC seemingly made the experience of disclosure costs more likely. Through organizational and managerial interventions, the degree of disclosure within this population may be increased. The intersection of chronic illness and diversity research and the other factors related to IBD disclosure, and the outcomes thereof warrant further investigation.

## References

- Abbvie. (n.d.). *UC flare-up*. <https://www.crohnsandcolitis.com/living-with-crohns-uc/ulcerative-colitis/flare-ups>
- Atarodi, S., Rafieian, S., & Whorwell, P. J. (2014). Faecal incontinence-the hidden scourge of irritable bowel syndrome: A cross-sectional study. *BMJ Open Gastroenterology*, *1*(1), 1-6. <https://doi.org/10.1136/bmigast-2014-000002>
- Ball, P., Monaco, G., Schmeling, J., Scharz, H., & Blanck, P. (2005). Disability as diversity in Fortune 100 companies. *Behavioral Sciences and the Law*. *23*(1), 97-121. <https://doi.org/10.1002/bsl.629>
- Bauminger, N., Finzi-Dottan, R., Chason, S., & Har-Even, D. (2008). Intimacy in adolescent friendship: The roles of attachment, coherence, and self-disclosure. *Journal of Social and Personal Relationships*, *25*(3), 409–428. <https://doi.org/10.1177/0265407508090866>
- Beatty, J. E. (2004). *Chronic illness as invisible diversity: Disclosing and coping with illness in the workplace* (Document No. 3122094) [Doctoral dissertation, Boston College]. ProQuest Information and Learning Company.
- Beatty, J. E. (2012). Career barriers experienced by people with chronic illness: A US study. *Employee Responsibilities and Rights Journal*, *24*(2), 91-110. <https://doi.org/10.1007/s10672-011-9177-z>
- Beatty, J. E. (2018). Chronic illness stigma and its relevance in the workplace. In Thomas, S.B. & Grandy, G. (Eds.), *Stigmas, work and organizations* (pp. 35-54). Palgrave Macmillan. [https://doi.org/10.1057/978-1-137-56476-4\\_3](https://doi.org/10.1057/978-1-137-56476-4_3)
- Beatty, J. E., & Joffe, R. (2006). An overlooked dimension of diversity: The career effects of chronic illness. *Organizational Dynamics*, *35*(2), 182-195. <https://doi.org/10.1016/j.orgdyn.2006.03.006>
- Beatty, J. E., & Kirby, S. L. (2006). Beyond the legal environment: How stigma influences invisible identity groups in the workplace. *Employee Responsibilities and Rights Journal*, *18*(1), 29-44. <https://doi.org/10.1007/s10672-005-9003-6>

- Bernklev, T., Jahnsen, J., Henriksen, M., Lygren, I., Aadland, E., Sauar, J., Schulz, T., Stray, N., Vatn, M., & Moum, B. (2006). Relationship between sick leave, unemployment, disability, and health-related quality of life in patients with inflammatory bowel disease. *Inflammatory Bowel Diseases*, *12*(5), 402-412.  
<https://doi.org/10.1097/01.MIB.0000218762.61217.4a>
- Bodenheimer, T., Chen, E., & Bennett, H. D. (2009). Confronting the growing burden of chronic disease: Can the U.S. health care workforce do the job? *Health Affairs*, *28*(1), 64-74.  
<https://doi.org/10.1377/hlthaff.28.1.64>
- Bowers, K. W., Robertson, M., & Parchman, M. L. (2012). How inclusive leadership can help your practice adapt to change: The most effective leaders realize that everyone's input is valuable. *Family practice management*, *19*(1), 8-11.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3796957/pdf/nihms509901.pdf>
- Brooks, S. K., Webster, R. K., Smith, L. E., Woodland, L., Wessely, S., Greenberg, N., & Rubin, G. J. (2020). The psychological impact of quarantine and how to reduce it: Rapid review of the evidence. *The Lancet*, *395*(10227), 912-920.  
[https://doi.org/10.1016/S0140-6736\(20\)30460-8](https://doi.org/10.1016/S0140-6736(20)30460-8)
- Butler, J. A., & Modaff, D. P. (2016). Motivations to disclose chronic illness in the workplace. *Qualitative Research Reports in Communication*, *17*(1), 77-84.  
<https://doi.org/10.1080/17459435.2016.1143387>
- Centre for Disease Control. (2020, August 11). *Inflammatory Bowel Disease Prevalence (IBD) in the United States*. <https://www.cdc.gov/ibd/data-statistics.htm>
- Centre for Disease Control. (2021, April 28). *About Chronic Diseases*.  
<https://www.cdc.gov/chronicdisease/about/index.htm>
- Chaudoir, S. R., & Fisher, J. D. (2010). The disclosure processes model: Understanding disclosure decision making and postdisclosure outcomes among people living with a concealable stigmatized identity. *Psychological bulletin*, *136*(2), 236-256.  
<https://doi.org/10.1037/a0018193>
- Chrobot-Mason, D., Button, S. B., & DiClementi, J. D. (2001). Sexual identity management

- strategies: An exploration of antecedents and consequences. *Sex Roles*, 45(5), 321-336. <https://doi.org/10.1023/A:1014357514405>
- 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. <https://doi.org/10.5465/AMR.2005.15281431>
- Crohn's and Colitis foundation UK (2017, July). *What are the symptoms?*  
<https://crohnsandcolitis.org.uk/about-crohns-and-colitis/what-are-the-symptoms>
- Dahlhamer, J. M., Zammitti, E. P., Ward, B. W., Wheaton, A. G., & Croft, J. B. (2016). Prevalence of Inflammatory Bowel Disease Among Adults Aged  $\geq 18$  Years — United States, 2015. *Morbidity and Mortality Weekly Report*, 65(42), 1166-1169.  
<https://doi.org/10.15585/mmwr.mm6542a3>
- Defenbaugh, N. L. (2013). Revealing and concealing ill identity: A performance narrative of IBD disclosure. *Health communication*, 28(2), 159-169.  
<https://doi.org/10.1080/10410236.2012.666712>
- DeFilippis, E., Impink, S., Singell, M., Polzer, J. T., & Sadun, R. (2020). Collaborating during coronavirus: The impact of COVID-19 on the nature of work. *National Bureau of Economic Research*. 27612, 2-31. <https://doi.org/10.3386/w27612>
- Dickerson, S. S., & Zoccola, P. M. (2013). Cortisol responses to social exclusion. In DeWall, C. N. (Ed.). (2013). *The Oxford handbook of social exclusion* (pp. 143–151). Oxford University Press.
- Earnshaw VA, Quinn DM, Park CL (2012) Anticipated stigma and quality of life among people living with chronic illnesses. *Chronic Illness*, 8(2), 79–88.  
<https://doi.org/10.1177/1742395311429393>
- Faul, F., Erdfelder, E., Lang, A.-G., & Buchner, A. (2007). GPOWER: A general power analysis program. *Behavior Research Methods, Instruments, & Computers*, 28(1), 1-11.  
<https://doi.org/10.3758/BF03203630>
- Franke, F., Felfe, J., Pundt, A., Dortmund, H., Pundt, A., Felfe, J., & Pundt, A. (2014). The impact of health-oriented leadership on follower health: Development and test of a new

- instrument measuring health-promoting leadership. *German Journal of Human Resource Management*, 28(1–2), 139-161. <https://doi.org/10.1177/239700221402800108>
- Fried, C. (1968). Privacy. *The Yale Law Journal*, 77(3), 475–493. <https://doi.org/10.2307/794941>
- Frohlich, D. O. (2014). Support often outweighs stigma for people with inflammatory bowel disease. *Gastroenterology Nursing*, 37(2), 126-136. <https://doi.org/10.1097/SGA.0000000000000030>
- Goffman, E. (1974). *Stigma; Notes on the management of spoiled identity*. Jason Aronson. <https://doi.org/10.2307/2575995>
- Gonzalez, J. A., & Denisi, A. S. (2009). Cross-level effects of demography and diversity climate on organizational attachment and firm effectiveness. *Journal of Organizational Behavior*, 30(1), 21-40. <https://doi.org/10.1002/job.498>
- Graen, G. B. (2003). Interpersonal workplace theory at the crossroads: LMX and transformational theory as special cases of role making in work organizations. In G. B. Graen (Ed.), *Dealing with diversity* (pp. 145-182). Greenwich: Information Age Publishing
- Graen, G. B., & Uhl-Bien, M. (1995). Relationship-based approach to leadership: Development of leader-member exchange (LMX) theory of leadership over 25 years: Applying a multi-level multi-domain perspective. *The Leadership Quarterly*, 6(2), 219-247 [https://doi.org/10.1016/1048-9843\(95\)90036-5](https://doi.org/10.1016/1048-9843(95)90036-5)
- Greuter, T., Manser, C., Pittet, V., Vavricka, S. R., & Biedermann, L. (2020). Gender differences in inflammatory bowel disease. *Digestion*, 101(1), 102-108. <https://doi.org/10.1159/000504701>
- Hakkarainen, P., Moilanen, L., Hanninen, V., Rasanen, K., & Munir, F. (2016). Short report: Educational and psychological aspects disclosure of Type 1 diabetes at work among Finnish workers. *Diabetic Medicine*, 34(1), 115–119. <https://doi.org/10.1111/dme.13134>
- Hamouche, S. (2020). COVID-19 and employees' mental health: stressors, moderators and

agenda for organizational actions. *Emerald Open Research*, 15(2).

<https://doi.org/10.35241/emeraldopenres.13550.1>

Herdman, A. O., & McMillan-Capehart, A. (2010). Establishing a diversity program is not enough: Exploring the determinants of diversity climate. *Journal of Business and Psychology*, 25(1), 39-53. <https://doi.org/10.1007/s10869-009-9133-1>

Inceoglu, I., Chu, C., Plans, D., & Gerbasi, A. (2018). Leadership behavior and employee well-being: An integrated review and a future research agenda. *Leadership Quarterly*, 29, 179–202. <https://doi.org/10.1016/j.leaqua.2017.12.006>

Irvine, E. J., Feagan, B. G., & Wong, C. J. (1996). Does self-administration of a quality of life index for inflammatory bowel disease change the results? *Journal of Clinical Epidemiology*, 49(10), 1177-1185. [https://doi.org/10.1016/0895-4356\(96\)00136-9](https://doi.org/10.1016/0895-4356(96)00136-9)

Irvine, E. J., Zhou, Q., & Thompson, A. K. (1996). The Short Inflammatory Bowel Disease Questionnaire: A quality of life instrument for community physicians managing inflammatory bowel disease. *The American Journal of Gastroenterology*, 91(8) 1571-1578.

Jaspal, R., Fino, E., & Breakwell, G. M. (2020). The COVID-19 Own Risk Appraisal Scale (CORAS): Development and validation in two samples from the United Kingdom. *Journal of Health Psychology*. 1-15. <https://doi.org/10.1177/1359105320967429>

Jowett, S. L., Seal, C. J., Barton, J. R., & Welfare, M. R. (2001). The Short Inflammatory Bowel Disease Questionnaire is reliable and responsive to clinically important change in ulcerative colitis. *American Journal of Gastroenterology*, 96(10), 2921-2928. [https://doi.org/10.1016/S0002-9270\(01\)03244-0](https://doi.org/10.1016/S0002-9270(01)03244-0)

King, E. B., & Botsford, W. E. (2009). Managing pregnancy disclosures: Understanding and overcoming the challenges of expectant motherhood at work. *Human Resource Management Review*, 19(4), 314-323. <https://doi.org/10.1016/j.hrmr.2009.03.003>

Kirk-Brown, A. K., Van Dijk, P. A., Simmons, R. D., Bourne, M. P., & Cooper, B. K. (2014). Disclosure of diagnosis of multiple sclerosis in the workplace positively affects employment status and job tenure. *Multiple Sclerosis Journal*, 20(7), 871–876.

<https://doi.org/10.1177/1352458513513967>

Kuoppala, J., Lamminpää, A., Liira, J., & Vainio, H. (2008). Leadership, job well-being, and health effects: A systematic review and a meta-analysis. *Journal of Occupational and Environmental Medicine*, 50(8), 904-

915. <https://doi.org/10.1097/JOM.0b013e31817e918d>

Leven, D. (2020). *Invisible social identity in the workplace: Narrative research exploring how experiences of autistic adults influence their decision to disclose* (Publication No. 27742768) [Doctoral dissertation, University of Massachusetts]. ProQuest Dissertations Publishing

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. <https://doi.org/10.1007/s10869-013-9324-7>

Molodecky, N. A., Soon, I. S., Rabi, D. M., Ghali, W. A., Ferris, M., Chernoff, G., Benchimol, E. I., Panaccione, R., Ghosh, S., Barkema, H. W., & Kaplan, G. G. (2012). Increasing incidence and prevalence of the inflammatory bowel diseases with time, based on systematic review. *Gastroenterology*, 142(1), 46-54.

<https://doi.org/10.1053/j.gastro.2011.10.001>

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

<https://doi.org/10.1016/j.socscimed.2004.07.012>

Munir, F., Yarker, J., Haslam, C., Long, H., Leka, S., Griffiths, A., & Cox, S. (2007). Work factors related to psychological and health-related distress among employees with chronic illnesses. *Journal of Occupational Rehabilitation*, 17(2), 259-277.

<https://doi.org/10.1007/s10926-007-9074-3>

Munir, F., Yarker, J., & Haslam, C. (2008). Sickness absence management: encouraging attendance or 'risk-taking' presenteeism in employees with chronic illness? *Disability and Rehabilitation*, 30(19), 1461-1472. <https://doi.org/10.1080/09638280701637380>

Niehaus, M., & Bauer, J. (2015). Sag ich's oder sag ich's nicht? Konstruktion einer

Entscheidungshilfe (Decision Aid) für Arbeitnehmer mit einer chronischen Erkrankung zum „Coming out“ am Arbeitsplatz. *Das Gesundheitswesen*, 77(08/09), A11.

<https://doi.org/10.1055/s-0035-1562967>

O'Connell, M., & Kung, M.-C. (2007). The cost of employee turnover. *Industrial Management*, 49(1), 14-19.

Pellino, G., & Spinelli, A. (2020). How coronavirus disease 2019 outbreak is impacting colorectal cancer patients in Italy: A long shadow beyond infection. *Diseases of the Colon and Rectum*, 63(6), 720-722. <https://doi.org/10.1097/DCR.0000000000001685>

Petronio, S. (2010). Communication privacy management theory: What do we know about family privacy regulation? *Journal of Family Theory & Review*, 2(3), 175-196.

<https://doi.org/10.1111/j.1756-2589.2010.00052.x>

Ragins, B. R., Singh, R., & Cornwell, J. M. (2007). Making the invisible visible: Fear and disclosure of sexual orientation at work. *Journal of applied psychology*, 92(4), 1103-1118. <https://doi.org/10.1037/0021-9010.92.4.1103>

RIVM. (2014, June 24). *Toekomstverkenning RIVM: Een gezonder Nederland met meer chronisch zieken*. <https://www.rivm.nl/nieuws/toekomstverkenning-rivm-gezonder-nederland-met-meer-chronisch-zieken>

Rohde, J. A., Wang, Y., Cutino, C. M., Dickson, B. K., Bernal, M. C., Bronda, S., Liu, A., Priyadarshini, S. I., Guo, L., Reich, J. S., & Farraye, F. A. (2018). Impact of disease disclosure on stigma: An experimental investigation of college students' reactions to inflammatory bowel disease. *Journal of Health Communication*, 23(1), 91-97.

<https://doi.org/10.1080/10810730.2017.1392653>

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. *Field Methods*. 15(1), 85-109. <https://doi.org/10.1177/1525822X02239569>

Santuzzi, A. M., Waltz, P. R., Finkelstein, L. M., & Rupp, D. E. (2014). Invisible disabilities: unique challenges for employees and organizations. *Industrial and Organizational Psychology*, 7(02), 204–219. <http://doi.org/10.1111/iops.12134>

Saunders, B. (2014). Stigma, deviance and morality in young adults' accounts of inflammatory

bowel disease. *Sociology of Health & Illness*, 36(7), 1020-1036.

<https://doi.org/10.1111/1467-9566.12148>

Scandura, T. A., & Graen, G. B. (1984). Moderating effects of initial leader–member exchange status on the effects of a leadership intervention. *Journal of Applied Psychology*, 69(3), 428–436. <https://doi.org/10.1037/0021-9010.69.3.428>

Smart, L., & Wegner, D. M. (1999). Covering up what can't be seen: Concealable stigma and mental control. *Journal of Personality and Social Psychology*, 77(3), 474-486. <https://doi.org/10.1037/0022-3514.77.3.474>

Taft, T. H., Keefer, L., Artz, C., Bratten, J., & Jones, M. P. (2011). Perceptions of illness stigma in patients with inflammatory bowel disease and irritable bowel syndrome. *Quality of Life Research*. 20(9), 1391-1399 <https://doi.org/10.1007/s11136-011-9883-x>

Taylor, S. E. (2011). Social support: A review. In H. S. Friedman (Ed.), *The Oxford handbook of health psychology* (pp. 189–214). Oxford University Press.

Van Dam, K., Oreg, S., & Schyns, B. (2008). Daily work contexts and resistance to organisational change: The role of leader-member exchange, development climate, and change process characteristics. *Applied Psychology*. 57(2), 200-207 <https://doi.org/10.1111/j.1464-0597.2007.00311.x>

Van der Horst, D., & Scherpenzeel, M. (2020, April). *Werken met IBD Hoe is de huidige arbeidssituatie van Inflammatoire Darmziekte (IBD) in Nederland?* (18052020) Crohn & Colitis Nederland. <https://www.crohn-colitis.nl/onderzoek/crohn-colitis-en-onderzoek-7/>

Varekamp, I., Verbeek, J. H., de Boer, A., & van Dijk, F. J. H. (2011). Effect of job maintenance training program for employees with chronic disease - a randomized controlled trial on self-efficacy, job satisfaction, and fatigue. *Scandinavian Journal of Work, Environment and Health*. 37(4), 288-297. <https://doi.org/10.5271/sjweh.3149>

Vickers, M. H. (1997). Life at work with “invisible” chronic illness (ICI): the “unseen”, unspoken, unrecognized dilemma of disclosure. *Journal of Workplace Learning*, 9(7), 240–252. <https://doi.org/10.1108/13665629710190040>

Westerman, C. Y. K., Currie-Mueller, J. L., Motto, J. S., & Curti, L. C. (2017). How supervisor

relationships and protection rules affect employees' attempts to manage health information at work. *Health Communication*, 32(12), 1520-1528.

<https://doi.org/10.1080/10410236.2016.1234538>

Wheeless, L. R. (1976) Self-disclosure and interpersonal solidarity: Measurement, validation, and relationships. *Human Communication Research*, 3(1), 47–61,

<https://doi.org/10.1111/j.1468-2958.1976.tb00503.x>

Wheeless, L. R., & Grotz, J. (1977). The measurement of trust and its relationship to self-disclosure. *Human Communication Research*, 3(3), 250-257.

<https://doi.org/10.1111/j.1468-2958.1977.tb00523.x>

Wyke, R. J., Edwards, F. C., & Allan, R. N. (1988). Employment problems and prospects for patients with inflammatory bowel disease, *Gut*. 29(9), 1229-1235,

<https://doi.org/10.1136/gut.29.9.1229>

Zane, N., & Ku, H. (2014). Effects of ethnic match, gender match, acculturation, cultural identity, and face concern on self-disclosure in counseling for Asian Americans, *Asian American Journal of Psychology*, 5(1), 66-74, <https://doi.org/10.1037/a0036078>

## Appendices

### Appendix A

*Comparison of the Themes and Groupings Between Raters of Benefits of not Disclosing.*

<b>Benefits of not Disclosing</b>	<b>Rater 1</b>	<b>Rater 2</b>
I let him know that I was diagnosed with a “long-term illness” and he was extremely understanding, letting me take off whatever time I needed until the medicine started taking effect.	Receive resources	Receiving mental support / Receiving physical support
Letting them know that it’s a health issue why I have to call off last minute for flares or doctors appointments is beneficial so they don’t think of me as uncommitted.	Receive resources	Being honest to my identity
they know I have some health trouble, but not the full extent or the diagnosis or what exact problems it results in, so they are good at responding, but don't have the information to plan ahead or keep in mind what difficulties I might face with some assignments if I had disclosed more information.	Receive resources	Receiving physical support
I explained I have a medical issue and I need to take time off on occasion. Ultimately I dont think its any of their business. There is no advantage in my opinion to disclosing the exact medical condition.	Receive resources	Receiving physical support
By not disclosing my IBD I save myself embarrassment, ridicule, and prejudice.	Avoid negative consequences	Being honest to my identity / Stress and Fear
Where I live (North Carolina, United States), an employer can fire an employee for any reason including no reason at all. Due to this labor law, I fear of being discriminated against if my employer knew of my condition and made assumptions on my ability to work. By not disclosing my disease, I can be confident that any decision made on my continued employment is not tied to my disease.	Avoid negative consequences	Stress and Fear / Being honest to my identity

### Appendix B

*Comparison of the Themes and Groupings Between Raters of Benefits of Not Disclosing*

<b>Costs of Not Disclosing</b>	<b>Rater 1</b>	<b>Rater 2</b>
Feel a bit ashamed when taking a sick leave without explaining why	Consequences unexplained leave	My character & identity

By not disclosing my IBD I am more likely to be fired if I have a flare and cannot come into work.	Consequences unexplained leave	My capacity to work
Perhaps if my condition were to worsen to the point I couldn't work, they wouldn't be aware of it	Consequences unexplained leave	My capacity to work
I fear the regular days off I need for treatment or sudden emergency flares may be misconstrued as skipping work without reason. And this could be another reason for my employer to fire me.	Consequences unexplained leave	My character & Identity / Capacity to work

## Appendix C

### Excluded Responses Not Disclosing.

Benefits	Costs
	I think I told him the right amount - any more and I felt I would've overshared. I did feel guilty as my work is still not up-to-par (a few months after treatment began) but I think if he was concerned he would reach out.
None. Entirely neutral. Although if I told about it, I might have to explain that it's not an issue.	None
	Embarrassment, worry about not being promoted or given more duties. They could tell other people my medical issues. People who know people with ostomy bags often dont see it as a serious condition.
I have not disclosed IBD specifically, but I have disclosed that I have a chronic illness due to the current pandemic situation.	Flexibility in work from home due to the pandemic has been advantageous.
Due to the low hours at the job, I don't believe it to be of relevance to me or my employer to know about my condition.	
Increased flexibilities in days/hours	The manager above him treating me poorly if he were to disclose it to her. No chances of raise/promotion. Blatant and covert discrimination. Preventing lateral or upward career movement.
None.	They would make me disclose it to Human Resources and apply for FMLA. I have

seen other coworkers retaliated against for using FMLA, so I am not interested in that at the moment unless I have exhausted all other options. For now, I have enough sick time to cover my absences from Ulcerative Colitis and would not benefit from disclosing UC to my employer.

In my first job which was a non permanent position (contracted) I was pushed out of my job as I had taken 4 weeks sick leave due to my crohn's. This has stopped me wanting to tell others

People think differently of you and think you can't handle things

Niets, het is gewoon nog niet ter sprake gekomen

Niets, het is gewoon nog niet ter sprake gekomen

## Appendix D

Comparison of the Themes and Groupings Between Raters of Benefits of Disclosing.

Benefits of Disclosing	Rater 1	Rater 2
Less pressure because I can deal with the subject openly.	Comfort	Stress and fear
Leidinggevende houdt beter in de gaten of ik niet teveel werk op mijn bordje krijg of teveel stress ervaar van werk	Emotional support manager	Receiving mental support
I find it helpful for my manager to be aware of any health conditions in case I need support in future or advice regarding sickleave etc	Emotional support manager	Receiving mental support
He is sympathetic and will accommodate my needs. I needed meeting times changed, ability to work from home, unexpected time off, patience.	Emotional support manager	Receiving mental support
Manager's understanding of lack of completed work is due to health issues	Emotional support manager	Receiving mental support
Flexible work hours in case I feel unwell during my work day.	Flexibility	Receiving physical support
Hij toont meer begrip voor mijn situatie en daarmee meer flexibiliteit.	Flexibility	Receiving mental support / Receiving physical support
Ik hoef geen late diensten te draaien, omdat dat nadelige invloed heeft op mijn gezondheid. Als ik een mindere dag heb, word ik ontzien op de werkvloer.	Flexibility	Receiving physical support

My manager is able to interchange me for other employees in instances where my IBD prevents me from doing a job help me get someone to cover while I use the restroom	Flexibility	Receiving physical support
He has been flexible with my scheduling around doctor's appointments	Flexibility	Receiving physical support
She's very understanding and works with my schedule in terms of doctors visits and sudden hiccups	Flexibility	Receiving mental support / Receiving physical support
Ik heb meer vrijheid gekregen in het indelen van mijn werkdagen, dus kan bv naar eigen inzicht later beginnen mocht dat nodig zijn. Of delen vanuit thuis werken	Flexibility	Receiving physical support
Het is makkelijker om te overleggen over flexibiliteit	Flexibility	Receiving physical support
Flexibility in scheduling	Flexibility	Receiving physical support
Flexibele begintijden in de ochtend/ flexibele urenverdeling over de werkweek.	Flexibility	Receiving physical support
Authenticity in relation to my boss.	Openness	Being honest to my identity
Dit geeft mij persoonlijk ook veel lucht, omdat er niks onbenoemd "tussen ons" hangt.	Openness	Being honest to my identity
It provides a "valid" reason for when I miss work. Since the disease can be somewhat invisible I think it's important to disclose my symptoms and experiences. I feel comfortable with my supervisor who is empathetic but have had other supervisors in the past I would worry about disclosing my symptoms to who would definitely not care or potentially use the disclosure against me. Once it gets to the point where I'm missing multiple days of work and need to submit doctor's notes, etc. I find it's better to be honest and open with my symptoms.	Openness	Receiving mental support / Being honest to my identity
I feel more open talking about when I need to attend doctor's appointments or get my medication, so that I am not mysteriously late or leaving early for no reason. Even though it's not necessary to disclose the info, I am glad he knows that I have a	Openness	Being honest to my identity

legitimate reason to have to miss meetings or come late occasionally.

Men probeert te begrijpen wat IBD inhoudt, maar voelt dat natuurlijk zelf niet. Dus door eerlijk een beeld te geven en zoveel mogelijk binnen mijn kunnen wel te doen, is het ook niet erg als het een keer niet lukt omdat ik ziek ben. Loyaliteit werkt 2 kanten op.	Openness	Being honest to my identity
Transparantie	Openness	Being honest to my identity
openheid/respect/vertrouwen/eerlijkheid	Openness	Being honest to my identity / Receiving mental support
Openheid en duidelijkheid bij afwezigheid door ziekte.	Openness	Receiving mental support
Open eerlijk zijn is het beste. Als iets dan niet lukt kun je het uitleggen.	Openness	Being honest to my identity
Open dialogue and understanding	Openness	Receiving mental support
I get understanding and openness from my team leader and the team in which I work. I have been open about my diagnosis since the beginning.	Openness	Receiving mental support / Being honest to my identity
Geen geheimen op de werkvloer en openheid	Openness	Being honest to my identity
Er is begrip, en door mijn openheid vertrouwen ze volledig op mijn inschattingen over mijn inzetbaarheid, belastbaarheid en benodigde flexibiliteit.	Openness	Receiving mental support / Being honest to my identity
Don't have to lie	Openness	Being honest to my identity
Clarity, if you stand out as an employee, no secrecy	Openness	Being honest to my identity
Begrip, eerlijkheid duurt het langst	Openness	Being honest to my identity
The possibility of hoping for allowances and support, because I've made it public.	Receive resources	Receiving physical support / Receiving mental support

They can understand where In the office I need to be located.	Receive resources	Receiving physical support
They've worked with me regarding my hours, workload, and ways to manage pain at work.	Receive resources	Receiving physical support
The ability to work from home at any given time. The understanding of last minute sick days for doctors appointments.	Receive resources	Receiving physical support
My supervisor has understood my desire to work from home, and allowed me to do so.	Receive resources	Receiving physical support
Appreciation of symptoms, no judgement, allowances for prolonged toilet breaks if necessary.	Receive resources	Receiving mental support / Receiving physical support
I was able, but for a very limited time (few weeks), to be assigned to the morning shifts only. (Instead of working at night every other week)	Receive resources	Receiving physical support
So it's easier to plan the work. If I have to away for a week or 2 it needs to be properly prepared. It feels nice to be able to tell my managers that I'm away and it's ok and they understand.	Receive resources	Receiving physical support
My supervisor has been extraordinarily supportive of me and my Crohn's. He allows me to work from home as needed and did this even before WFH became a "thing" for my job.	Receive resources	Receiving mental support / Receiving physical support
ability to work from home full time during the pandemic.	Receive resources	Receiving physical support
FMLA - it's an American program that guarantees a certain amount of time off a year (480 hours) free from retaliation. You aren't guaranteed pay, but you using the leave can't be held against you.	Take time off	Receiving physical support
He is understanding when I need to take off for doctor's appointments.	Take time off	Receiving mental support / Receiving physical support
I can take off for rest during unexpected flares	Take time off	Receiving physical support
, and gives me time to rest when I am visibly fatigued.	Take time off	Receiving physical support

Resting assured time off is valid	Take time off	Receiving physical support
Allowances are made for medical appointments in work hours	Take time off	Receiving physical support
She fully understands when I need to take time off for medical appointments, infusions, procedures, etc.	Take time off	Receiving mental support
I was told to stop using sick/vacation time for doctor's appointments and the time needed would be paid.	Take time off	Receiving physical support
I can take time off, no questions asked. I can also leave for appointments or infusions without first asking. My leader is informed via calendar and from her administrative support.	Take time off	Receiving physical support
ability to take time off when needed for doctor appointments.	Take time off	Receiving physical support
Begrip voor afwezigheid/onbereikbaarheid, doordat mijn leidinggevende wis wat er op dat moment speelde.	Understanding	Receiving mental support
Als ik ziek ben weet ze mijn achtergrond en hoef ik haar op dat moment niet uitgebreid bij te praten. Ze weet hoe het zit.	Understanding	Receiving mental support
They know in case something is off	Understanding	Receiving mental support
By keeping my managing fully in the loop, he understands what's going on with me and nothing comes as a surprise when I have to run to the ER or a doctors visit or have surgery. He's prepared and prepares the rest of the team in a way that my absence doesn't slow things down.	Understanding	Receiving mental support
They typically know that problems arise for specific, legitimate reasons and do their best to understand	Understanding	Receiving mental support / Being honest to my identity
He is empathetic toward my disease, and checks in to see how I'm feeling from time to time.	Understanding	Receiving mental support
My manager knows what to expect regarding my need for the rest room and that I will be taking days off for infusions of medicine	Understanding	Receiving mental support

Zij kan mij beter begrijpen en snapt dus beter wanneer iets niet lukt. Zij ondersteunt mij waar nodig. Zij is persoonlijk betrokken.	Understanding	Receiving mental support
Ze weten waarom ik parttime werk en maar halve dagen kan werken	Understanding	Receiving mental support
Ze weet wat er speelt, als mijn ziekte opvlamt of ik naar het ziekenhuis moet	Understanding	Receiving mental support
Understanding when I need to take time off work for medical issues, and frequent trips to the bathroom	Understanding	Receiving mental support
Understanding	Understanding	Receiving mental support
They know some days I might need to go to the toilet more frequently	Understanding	Receiving mental support
Begrip van leidinggevende.	Understanding	Receiving mental support
My manager understands the physical symptoms and psychological effects of an IBD diagnosis. I feel confident I would be supported and my job would stay in place if I were to experience a flare during work.	Understanding	Receiving mental support
Meer begrip	Understanding	Receiving mental support
In het begin bij onderzoeken begrip.	Understanding	Receiving mental support
Dan ervaar ik meer begrip voor mijn manier van werken, namelijk niet van half 9 tot 5 zoals de rest.	Understanding	Receiving mental support
Better understanding	Understanding	Receiving mental support
Begrijpt de balans die nodig is.	Understanding	Receiving mental support
Als er wat speelt of plotseling een opvlamming krijg dan weer ze altijd wat er aan de hand is en word er heel goed op gereageerd. ik kan dan uitzieken en door contact te houden weet ze wanneer ik weer in staat ben om te werken.	Understanding	Receiving mental support

## Appendix E

*Comparison of the Themes and Groupings Between Raters of Costs of Disclosing.*

Costs	Rater 1	Rater 2
Worry about stigma. Worry about being judged worse/negatively/weaker	Being discriminated	My character & identity
The fact that they think I'm disclosing it to get special privilege	Being discriminated	My character & identity
Immediate retaliation - I was submitted to a health review to determine if I could still work in my position at all, and after 6-8 months of being home for the process, it was eventually determined that I am able to work. The process was then begun again 6 months later after using FMLA leave.	Being discriminated	My capacity to work
I felt as though I was looked at differently afterward in a negative way and felt somewhat discriminated against by a few	Being discriminated	My character & identity
I feel a little embarrassed because there is such a stigma around IBD/Crohn's Disease.	Being discriminated	My character & identity / Invasion of privacy
Regularly and openly ridiculed due to embarrassing nature of the condition.	Being discriminated	My character & identity / Invasion of privacy
Wordt gepasseerd voor sommige taken.	Doubt ability	Handled with 'too much' care
Sometimes it feels like I'm being handled with kid gloves.	Doubt ability	Handled with 'too much' care
Minder vertrouwen in mijn kunnen op bepaalde momenten.	Doubt ability	My capacity to work
Ik krijg minder projecten toebedeeld, uit angst voor overbelasting	Doubt ability	Handled with 'too much' care
I became unreliable in my manager's eyes	Doubt ability	My capacity to work
I am generally private about my personal life in almost every regard so disclosing this info can seem dramatic and there often isn't a "right time." I also worry that it will seem like I am making excuses when I have a few appointments within a month; I don't want it to seem like I can't handle my job and IBD together	Doubt ability	My character & identity / Invasion of privacy
Embarrassment	Embarrassment	My character & identity / Invasion of privacy

HR and H&S requesting a copy of my prescription for their records due to drugs testing practices at work.	Lack of Privacy	Invasion of privacy
Being asked questions, assumptions made He still does not understand the true nature of my condition, and does not always take me seriously when I express need for time off to rest. I am in a leadership position myself, and he relies on me heavily. I sometimes think his need for my help outweighs his empathy for my symptoms.	Lack of Privacy Misunderstood	Invasion of privacy Lack of understanding
Worrying about things that have nothing to do with my IBD being attributed to it all the same.	Overtakes work identity	My capacity to work
Risico dat leidinggevende kijkt naar mij als 'medewerker met een issue' in plaats van alleen naar mijn professionele kwaliteiten.	Overtakes work identity	Handled with 'too much' care
No real disadvantages other than personal worries that he judges me and personal anxieties that I will miss time at work or feel unwell at work	Overtakes work identity	My character & identity
Dis: being stressed about haveing to talk to her about my disease every time we have a performance talk, instead of talking about working related stuff.	Overtakes work identity	Handled with 'too much' care
Possibility of if coming into play when considering me for a promotion	Stunt career growth	My capacity to work
Overlooked for success due to illness	Stunt career growth	My capacity to work
None, however I have a temporary, part-time contract with Edmonton Public Schools, and I'm worried about IBD affecting my chances of getting hired full time.	Stunt career growth	My capacity to work
No direct ones (yet) but I suspect it will impact my overall career prospects or could potentially lose work/project opportunities if people worry about me not being available due to my disease and taking time off when sick.	Stunt career growth	My capacity to work / Handled with 'too much' care
I would have been worried I may have worse chance of promotion if my IBD had interrupted my work a lot this year	Stunt career growth	My capacity to work
I am not able to perform certain tasks and upper management used this to not move me into a full time position for quite a while.	Stunt career growth	My capacity to work

Denied promotion.

Stunt career  
growth

My capacity to work

## Appendix F

### *Excluded Responses Disclosed*

Benefits	Costs
<p>Niet veel. Ik heb het gevoel dat ik elke keer moet vechten om een "uitzondering".</p>	
	<p>Voor mijn gevoel kost het mij niks dat mijn werk op de hoogte heeft. Ik was hier wel bang voor, maar dat bleek onterecht.</p> <p>Team meetings or trainings don't take enough breaks for my IBD.</p>
<p>I needed to disclose because of covid because I needed him to adjust my schedule to reduce my contacts. I would be disinclined ordinarily to disclose.</p>	
<p>None at all lack of education leaves my manager understanding anytime I've had to request off for Crohn's they think it an EXCUSE.</p>	
	<p>geen, hoogstens soms wat overbezorgdheid. Adv: being able to have steady shifts (at least for few weeks) amnd being more regular with my diet and medication time.</p>
<p>Er zijn weinig voordelen. Als ik mij ziekmeld, word ik niet eens serieus genomen als ik wel serieuze klachten heb. Zelfs met een opflaming en nierontsteking moest ik naar de werkvloer komen.</p>	<p>Geen idee</p>
	<p>Geen.</p>
	<p>Geen</p>
	<p>Geen</p>
<p>Weinig verschil. Maar dat komt omdat ik zelf weinig praat over mijn colitis en omdat ik nu geen klachten heb en soms zelfs</p>	<p>Geen</p>

"vergeet" dat ik een chronische aandoening heb.

Toevallig kende ik mijn werkgever al voordat ik bij dit bedrijf werkte en hij wist mijn situatie daardoor al. Dat heb ik als prettig ervaren, want daardoor kon ik er meteen open over zijn en ervaarde ik dat de drempel lager was om eventuele problemen te bespreken. Zo durf ik te bespreken dat ik in een risicogroep val en qua Corona dus extra voorzichtig ben. Helaas kan ik helaas niet bepalen wat mijn werkgever daar vervolgens mee doet, maar toen ik begon bij m'n baan vond ik het wel fijn dat m'n werkgever/leidinggevende het gewoon wist. En eigenlijk ook heel prettig dat ik zelfs, ondanks m'n ziekte, gekozen werd om daar te werken! Dat voelde als een overwinning.

Parkeerkaart ontvangen voor werk in binnenstad

Ik vind de vraag een beetje vaag, maar ik maak geen extra kosten o.i.d. door mijn ziekte.

None

Nothing

None so far

None so far

Geen

Geen

Geen

None so far

None - it has all been positive.

Geen

Geen

Geen

Ik werk al lang bij deze werkgever en deze leidinggevende is nieuw en is erg managementgericht. Ik ervaar geen voordelen, ik deel niet veel op gebied van ibd.

Geen

Geen

None so far

I don't feel there are any disadvantages in my organization

None, I work in a hospital so there would not be any change to how I perform my job as I readily have access to bathroom facilities. Informing my manager of my IBD diagnosis would not negatively impact on my job.

I don't, but I've had one bad flare up and I was already off work for anxiety and depression. I think if I had a really bad flare up at work I would be embarrassed to say anything and probably ring my dr to sign me off.

No perceived disadvantages

Geen

None

Geen voordelen. De toilet is toch dichtbij. Geen inlevingsvermogen wat IBD voor gevoel geeft of impact kan hebben.

Nvt

/

N/A

Geen

Geen

Geen.

None // keine

Bij een opvlamming is het verstandig om het te delen. Ook gebruik ik regelmatig oogdruppels, wat natuurlijk opvalt als je normaal gesproken op kantoor aan het werk bent. Mijn leidinggevende heeft zelf een achtergrond in de zorg, dus dat scheelt ook. Er hoeft echter niet altijd naar mijn ziekte gevraagd te worden, als er iets is, meld ik het zelf wel.

Geen

None

	Snap de vraag niet. Kosten als ik geld? Geen. Rare vraag
	None
Next to nothing.	None
Geen, geen extra aandacht voor	Geen, werkgever is neutral
Niet veel	Geen kosten
Eigenlijk niets.	?
Geen, geen voordelen en geen nadelen.	Geen

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## Appendix G

*Results from the Independent Samples t-test*

<b>Variables</b>	<b>t-value</b>	<b>df</b>	<b>sig. (2-tailed)</b>
<b>Symptom severity</b>	-0.02	89	.985
<b>ODC</b>	-0.05	89	.963
<b>LMX</b>	1.71	89	.092
<b>Degree of disclosure</b>	1.21	73	.229

*Note:* table shows the results comparing group Crohn's disease with ulcerative colitis