Invisible Hurdles: Perceptions of Chronic Illness Absence in the Workplace

Investigating the Interaction Between Health Reason for Sickness Absence and Disclosure Strategy through Competence on Ostracism Intentions in the Work Context

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Abstract

Purpose: Employees with chronic health conditions (CHC) may face stereotyping and discrimination, which makes discussing invisible chronic illnesses (ICI) challenging in the workplace. Beliefs and responses to mental and physical ICI differ, with various consequences following disclosure. This vignette study investigates how the health reason for sickness absence and the disclosure strategy affect ostracism intentions towards the employee through competence perceptions.

Methods: One hundred fifty-two participants completed an experimental vignette survey outlining a scenario of sickness absence from work due to chronic mental or physical illness. The disclosure strategy, direct or indirect, was also manipulated. Competence was measured consistent with the Stereotype Content Model (SCM) and ostracism intention with items by Curtis et al. (2020).

Results: No significant effect of the health reason for absence on competence was found. Ostracism intentions were significantly higher in the mental health condition than in the physical health condition. Direct disclosure yielded higher competence evaluations than indirect disclosure, independent of the illness. There was no evidence for an interaction between the health reason for absence and the disclosure strategy, nor for a conditional mediation of competence. Competence negatively correlated with ostracism intentions. Lastly, no exploratory evidence was found for a conditional mediation of warmth.

Implications: The direct disclosure strategy enhances competence perceptions, regardless of the illness being disclosed. Individuals with mental illness continue facing higher ostracism intentions than physical health. Further research is needed to capture the separate effects of health reasons for absence and disclosure strategy on ostracism intentions and competence, respectively.

Keywords: ICI, disclosure strategy, stereotypes, competence, ostracism intentions.

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"Any kind of physical illness, you will get sympathy. But mental illness…you won't get sympathy" (Huggett et al., 2018, p.386).

This statement by an individual diagnosed with depression emphasizes prevailing beliefs surrounding mental and physical illness, impacting the occupational reality of those affected. A global survey showed that in developed countries only 45%-51% of respondents believe mental illness to be similar to physical illness (Seeman et al., 2016). These differential beliefs surrounding mental and physical illness are reflective of stereotypes. Stereotypes involve generalizations made about members of a category (e.g., "the mentally ill"), including beliefs about attributes and social roles that characterize a typical group member (Correll et al., 2010). While stereotypes simplify the complex social environment, they limit our perception of others, generating expectations about the target's future behaviour (Cuddy et al., 2008). Given that illnesses involve workplace absences, it is critical to understand how employees are perceived when their health reason for absence is either physical or mental, within the Stereotype Content Model (SCM; Fiske et al., 2002).

In the workplace, employees are confronted with perceptions and behavioural reactions arising from stereotypes. Stereotypes might fuel workplace discrimination (i.e., negative treatment based on social group membership; Dhanani et al., 2018) or indirect harm to the employee via stereotype threat (i.e., the fear of confirming the negative stereotypes; Haft et al., 2022). For instance, employers report competence-related concerns when deciding whether to hire someone with a mental illness (Hand & Tyssenaar, 2006). Further, the SCM proposes that behavioural responses follow stereotypes. Ostracism, a form of discrimination that involves the social exclusion and ignoring of others, is one behaviour that might arise from perceptions of lower competence (Ferris et al., 2018). Despite being a covert behavioural response, ostracism has workplace consequences, including reduced access to

crucial social networks for career advancement and social support (Hebl et al., 2008). Hence, individuals with mental illness might be disadvantaged in the workplace, with stereotypes regarding their competence and behavioural reactions such as ostracism.

Workplace perceptions are particularly relevant in the context of chronic health conditions (CHC), defined as ongoing conditions that can be of a physical, emotional, or cognitive nature (Vickers, 1997). CHC thus encompass both mental and physical illnesses. Around 15-20% of employees live with a CHC (Munir et al., 2007), compromising their well-being and economic and social prospects at work (Beatty, 2011; Hogg et al., 2023). Some CHC are unseen by others, rendering them invisible chronic illnesses (ICI; Joachim & Acorn, 2000). Investigating ICI is essential because of the downstream consequence of greater workplace absences and the additional challenge of communicating about ICI, given their low acceptance in the workplace (Schultz & Rogers, 2011). Previous research mainly examined causes of absenteeism (Patton, 2001; Knapstad et al., 2014) and their financial impacts (Goetzel et al., 2004), with limited attention to comparing perceptions of absences because of physical or mental ICI. Consequently, it remains unclear how employees' communication of workplace absence due to mental or physical ICI influences perceptions (i.e., competence evaluations) and, finally, intended behavioural reactions (i.e., ostracism) towards the employee.

In productivity-driven capitalist societies, ICI and associated workplace absences tend to be unwelcome (Thomson & Grandy, 2017). Employees' physical and mental ability to complete their job duties is presumed, with sick-leave policies catered to acute illnesses marked by a rapid onset and brief, obvious symptoms (Beatty, 2011). The pressure to justify absences and others' perceptions thereof (Beatty, 2011) presents the dilemma of how to communicate ICI at work. Workplace disclosure involves informing others (e.g., colleagues or employers) about one's health condition, symptoms, and/or specific work-related needs

(Schultz & Rogers, 2011). A study indicated that only half of the employees with ICI disclosed their illness status and showed up to work ill to avoid justification of absence (Munir et al., 2008).

Despite fears surrounding disclosure, sharing one's illness status offers emotional and social benefits (Clair et al., 2005). Active concealment may reduce work performance and contribute to a sense of isolation, leaving individuals with ICI with a wish for but fear of disclosure (Kulkarni, 2022). Most previous research has investigated the antecedents of disclosure decisions (Chaudoir & Fisher, 2010; Clair et al., 2005) rather than how to disclose. Further, reactions to disclosure depend on factors beyond individuals' control (i.e., professional norms, diversity climate; Clair et al., 2005). Thus, it is important to investigate the impact of specific disclosure strategies (i.e., how someone informs others about their illness) on competence and ostracism to understand whether disclosure-related fears are confirmed or if specific strategies alleviate the negative perceptions associated with ICI.

Disclosure of ICI can result in discrimination. A common belief is that overt discrimination (i.e., active, explicit negative treatment) is more harmful than covert forms (i.e., passive, negative treatment) (Cuddy et al., 2008; Jones et al., 2016). However, research indicates that both forms detrimentally affect the target through deterioration in physical and mental health, alongside increased turnover (Jones et al., 2016). Understanding the mechanisms behind covert discrimination (i.e., ostracism) is relevant as it is experienced more frequently, more difficult to detect, and ambiguous in its intentions (Jones et al., 2016).

Therefore, this paper examines how the health reason for absence (i.e., physical or mental ICI) and disclosure strategy interact and influence ostracism intentions through competence perceptions. Using an experimental vignette design, this study contributes theoretically by 1) applying the SCM to the realistic scenario of illness-absence while comparing perceptions of mental and physical ICI, 2) integrating theory on CHC and disability with stereotype content

research, and 3) extending the theory on interpersonal perceptions of people with CHC by not only considering the illnesses themselves but also including the behavioural process of reactions to disclosure. The paper offers practical contributions, including disclosure support for individuals with ICI, a foundation for training HR personnel or leaders, and bolstering patient advocacy and awareness campaigns.

Thus, the research question emerges: *How do the health reason for sickness absence and the disclosure strategy used in the workplace impact ostracism intentions towards the employee through competence perceptions?*

Stereotypes: Content and Status Quo Regarding Disability and Illness

In our daily lives, we rapidly form impressions of countless individuals and groups. The SCM (Fiske et al., 2002) proposes that our fundamental perception of others covers two stereotype content dimensions, namely warmth and competence (Cuddy et al., 2009). Warmth involves perceived trustworthiness, morality, and kindness and is used to assess the target's intentions. Competence comprises intellectual and motivational aspects such as capability, intelligence, and overall ability to achieve one's goals (Fiske et al., 2002). Competence judgements are especially relevant in workplace teams where outcomes are contingent upon the competence of the target (Cuddy et al., 2008).

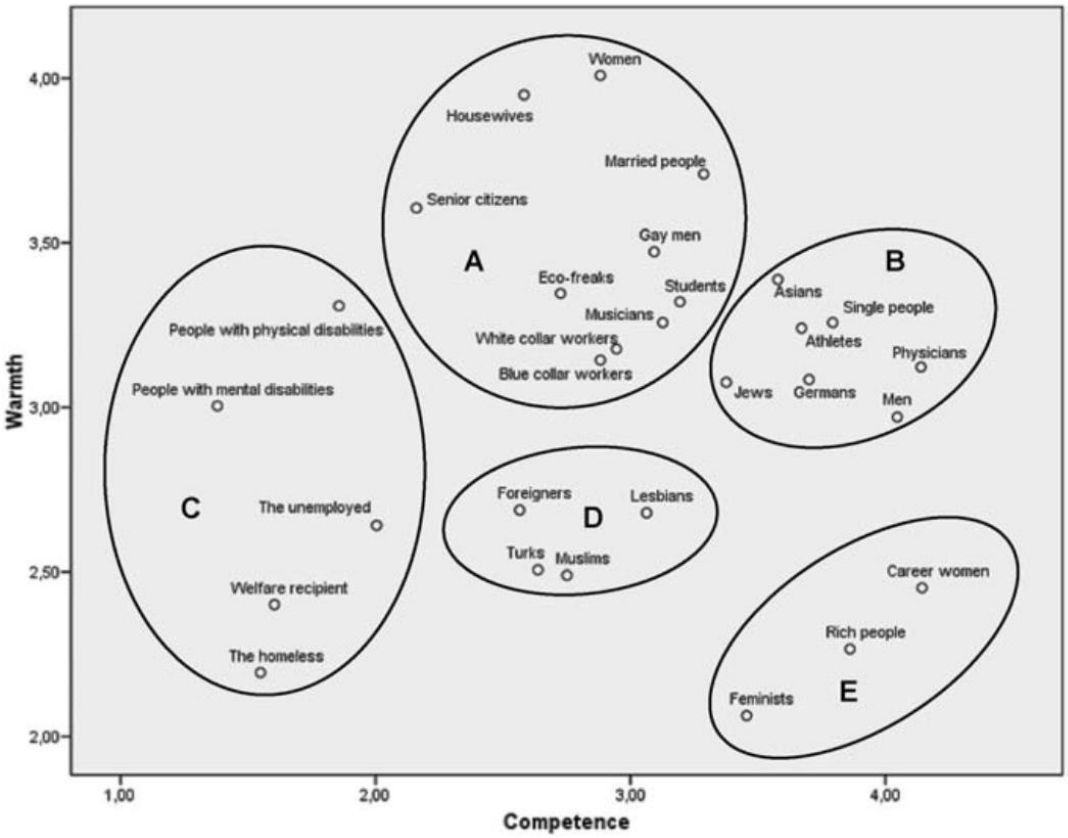
An individual can fall into one of four quadrants of specific combinations of warmth and competence (see Figure 1). Further, specific warmth and competence combinations give rise to emotional responses in the perceiver. Following this, the Behaviour from Intergroup Affect and Stereotypes Map (BIAS-map, Cuddy et al., 2008), an extension of the SCM, predicts specific behaviours to follow from each warmth/competence quadrant. Overall, the SCM therefore proposes a link between stereotype content and behaviour (e.g., discrimination), mediated by affect (Cuddy et al., 2008). This study examines the central premise of the SCM by exploring how health reasons for absence (i.e., mental or physical ICI) may interact with

disclosure strategy to shape perceived competence (i.e., stereotype content) and subsequently affect ostracism (i.e., intended behavioural reactions).

Based on the SCM, "people with disability" fall into the "high warmth/low competence" category (Cuddy et al., 2008). Chronic illnesses often fulfil the criteria of disabilities and are included in the disability category (Canton et al., 2022). However, in this paper, they will be referred to as (invisible) chronic illnesses. Research further differentiating between specific CHC (including ICI) demonstrates that the stereotype content elicited by mental illness differs from physical chronic illnesses, with the former being categorized into the "low warmth/low competence" quadrant (Canton et al., 2022; Sadler et al., 2012). These results suggest that the stereotype content attached to mental ICI might be more negative than that of physical ICI, making it relevant to compare the perceptions of the two within the SCM framework. Figure 1 shows that individuals with mental disabilities (ICI) are rated lower on competence than physical disabilities, with more recent studies (Canton, 2022) confirming this pattern. Specifically, Canton (2022) found that people with depression were perceived as lower in competence compared to people with physical impairments (e.g., blind and deaf people).

Figure 1

Stereotype Content Model Differentiating Between Mental and Physical Disabilities



Note. Figure from Asbrock (2010), p. 78.

Linking Stereotype Research and CHC-Related Illness Absence

Absences from work were among the first topics researched in occupational psychology, underlining the costs and productivity losses they involve for organizations (Gosselin, 2018). Absences can be defined as a failure to show up for work (Barling & Cooper, 2008). Most absence research has focused on the antecedents of absence from work (Johns, 2011; Saruan et al., 2020; Steers & Rhodes, 1978). Because workplace absences can have many different causes (Čikeš et al., 2018), judgements of their appropriateness greatly vary (Barling & Cooper, 2008). Nevertheless, absences have a clear negative connotation, with employees tending to underreport their absence (Johns, 1994). Correspondingly,

absenteeism is often regarded as a mild form of workplace deviance according to the deviance model of absenteeism (Johns, 1994). The model proposes that absence is perceived negatively, as others evaluate it as deviating from normative expectations of industriousness (Patton, 2011). Consequently, employees taking an absence might be perceived as unreliable based on scheduling issues, thus shaping their perceived competence (Thomson & Grandy, 2017).

Illness absence has been referred to as a "black hole" of absence research, indicating the lack of clarity surrounding this issue (Nicholson & Martocchio, 1995, p. 605). With their persistent nature, ICI involve symptoms that can interfere with job performance and are, therefore, one prevalent reason for illness absence (Johnston et al., 2019; Sørensen & Ploug, 2013). Indeed, employers demonstrate concerns about hiring individuals with mental illness due to expectations of absenteeism (Hand & Tryssenaar, 2006). Moreover, mental ICI are already subject to negative perceptions, with evidence indicating the categorization of individuals with mental ICI (i.e., depression) as lower in competence than physical ICI (Canton et al., 2022). On top of the negative attitudes surrounding workplace absence in general, the negative bias towards mental health might amplify the perception of mental illness absence as especially deviant (Johns, 1994).

According to the SCM, social status (i.e., the presumed capability of groups to control resources) predicts competence judgements (Cuddy et al., 2008). Because workplace absence is regarded as deviant behaviour (Johns, 1994), it might be punished in ways that influence employees' status evaluations. For instance, employee absence reduces the opportunity to contribute to teamwork equally and to compete for resources such as promotions or acknowledgement. Consequently, individuals might assume that the target employee has a lower capability to control these resources, ultimately diminishing perceptions of competence (Grinyer & Singleton, 2000).

Patton (2011) proposes a model which regards workplace absences as social events followed by judgements, emotional reactions, and behavioural intentions, aligning with the propositions of the SCM (Fiske et al., 2002). In a vignette study to test this model, Patton (2011) found that higher intentions to punish followed absences that were regarded as the responsibility of the employee. In this study, reasons for absence manipulated in the vignettes included illness (a cold) and stress. Judgements of employee responsibility for absence and subsequent intentions to punish were higher for stress than for physical illness (i.e., the cold) (Patton, 2011). These heightened judgements of responsibility and intentions to punish absences due to mental health might stem from the perception that mental reasons (i.e., stress or mental illness) are less legitimate reasons for absence than physical (chronic) illness, possibly due to stereotypes. Accordingly, employees in Canada and China rated depression as a less legitimate reason for absence than doctor's visits, minor illness, bad weather, and poor transport (Johns & Xie, 1998). Consequently, absence due to mental ICI might therefore be seen as a "poor excuse", thereby fuelling lower competence perceptions. Therefore, the first hypothesis is:

Hypothesis 1 (H1): The health reason for sickness absence impacts the perceived competence: Employees showing absence due to a mental ICI are perceived as lower in competence compared to employees showing absence due to a physical ICI (see Figure 3).

The Effects of Disclosure Strategy on Competence Perceptions

Individuals with ICI must manage the information about their illness and decide whether and how to disclose their illness status. An and McDermott (2014) identify disclosure as a potential strategy to counteract prevalent stigma, especially of mental illness. Different theoretical models of disclosure outline the disclosure process and when people tend to disclose their concealable identities (Afifi & Steuber, 2009; Chaudoir & Fisher,

2010). However, there is a lack of clarity on how different forms of disclosure influence perceivers' judgements of individuals in the workplace.

A dilemma arises because explaining one's absence requires disclosure, whereas this same disclosure might come with stereotypes and (expectations of) subsequent discrimination (Joachim & Acorn, 2000; Vickers, 1997). On one hand, non-disclosure might exacerbate already existent distress and inhibit the expression of an authentic self (Clair et al., 2005; Vickers, 1997). On the other hand, disclosure might lead one to be labelled as deviant from the norm or to be mistreated (Vickers, 1997). Gibson (2018) outlines a process model of disclosure, which discusses the relational consequences of "disruptive disclosure" (i.e., sharing information that challenges workplace norms and expectations). Specifically, Gibson (2018) argues that disclosures that violate expectations related to one's organizational role and responsibilities will be especially disruptive. By disclosing their reason for absence and engaging in norm violation, an employee might be seen as "making excuses", thus lowering their perceived motivation and capability to achieve goals involved in the evaluation of competence (Fiske et al., 2002).

Relatedly, Tomas et al., (2022) outline a disclosure process model with four themes influencing disclosure decisions. The main barrier to disclosure is "other-focused factors", including the expected perceptions or behaviours of others (Tomas et al., 2022). To address this reluctance to disclose caused by the expectations of others' perceptions, it is important to investigate reactions towards ICI disclosure strategies. Two such disclosure strategies are indirect and direct disclosure. Indirect disclosure includes conveying one's illness status in an ambiguous manner (e.g., by hinting or asking a third party to tell others; An & McDermott, 2014). Direct disclosure involves explicitly communicating the illness status (An & McDermott, 2014). Empirical research suggests that the perceiver might receive indirect disclosure better, especially when discussing diseases and stigma-laden topics. Further,

individuals with more negative perceptions of mental illness tend to recommend indirect over direct disclosure strategies with the belief that it will minimize social rejection of the disclosing individual (An & McDermott, 2014).

In line with Gibson (2018), direct disclosure will likely be perceived as more "disruptive" and norm-violating than indirect disclosure. Especially in contexts where deviant behaviour, such as direct disclosure, influences the observer (i.e., team context), norm violations are regarded as upsetting, triggering emotions like anger, blame, and moral outrage (Stamkou et al., 2018; Van Kleef et al., 2015). Consequently, observers often disfavour or sanction the norm violator (Van Kleef et al., 2015) by perceiving them as less competent (Wenegrat et al., 1996). Indeed, a survey showed that employees are worried about completely (i.e., directly) disclosing their chronic illness out of fear of being regarded as incapable and being disregarded for promotions (Ghin et al., 2023). Therefore, the second hypothesis is:

Hypothesis 2 (H2): Direct disclosure will cause lower competence perceptions than indirect disclosure (see Figure 3).

The Interaction of Health Reason for Sickness Absence and Disclosure Strategy on Competence

Often, individuals with mental illness choose non-disclosure due to fears of being regarded as less competent (Schultz & Rogers, 2011). Existing evidence indicates that this fear may be justified, as people with depression and schizophrenia are rated lower on competence relative to other CHC (i.e., physical and cognitive; Canton et al., 2022). Further, depression was regarded as more controllable than physical illness in explicit stigma measures (Monteith & Pettit, 2011). Such perceptions of controllability might fuel lower perceived competence and harsher behavioural reactions (Judge & Martocchio, 1995) when disclosing a mental illness absence. Relatedly, a vignette study showed that managers rated

employees disclosing a mental illness more negatively in terms of expected job performance than an employee disclosing a physical illness (Mendel et al., 2015). It is, therefore, conceivable that disclosure of mental ICI will affect competence more adversely than disclosure of physical ICI.

However, further investigation is needed to determine whether the disclosure strategy impacts perceptions of and behavioural intentions toward the individual. The direct disclosure of a chronic mental illness-related absence will likely influence competence evaluations more negatively than indirect disclosure, given that indirect communication reduces the intrusiveness of the negative information on the receiver (An & McDermott, 2014). Hence, an individual disclosing absence due to a mental ICI might benefit more from indirect disclosure and be harmed more by direct disclosure than someone disclosing absence due to physical ICI. Mental illness is often perceived as more deviant than physical illness (Aftab & Rashed, 2020), and in combination with nonconforming behaviour (i.e., health-related absence), mental illness has been found to negatively predict competence (Manago & Mize, 2022). Hence, indirect communication can act as a buffer for such negative perceptions of mental illness, whereas a direct disclosure strategy could be perceived as more confronting and norm-violating when communicating about an already stigmatized (mental) ICI. Therefore, the third hypothesis is:

Hypothesis 3a (H3a): The disclosure strategy moderates the effect of health reason for absence on competence: The negative effect of mental health ICI as the reason for absence on competence will be stronger if the disclosure is direct, compared to indirect (see Figure 3).

In addition to the moderating effect of the disclosure strategy on the effect of the absence reason, it is also important to consider a possible moderating effect of the health reason for absence on the effects of the disclosure strategy. Both moderating effects may occur simultaneously but can occur independently (cf. Xanthopoulou et al., 2013). When making

competence judgements based on the directness of the disclosure, the content of the disclosure may impact the strength of the effect. Evidence on perceptions of people with depression (versus people with physical disabilities) shows that physical impairments are associated with higher levels of perceived courage (Canton et al. 2022). Therefore, the direct disclosure of a physical health reason for absence may lead to less negative effects on competence perceptions because the directness of the disclosure may be interpreted as more courageous, compared to the direct disclosure of a mental health-related absence. To consider the possibility that health reason for absence might moderate this effect, the following hypothesis was formulated:

Hypothesis 3b (H3b): The health reason for absence moderates the effect of disclosure strategy on competence: A physical health reason for absence buffers the negative effect of direct disclosure on competence, compared to mental health reason for absence (see Figure 3).

Competence on Ostracism

Competence judgements are important within workplace teams, as outcomes are contingent on the target employee's competence (Cuddy et al., 2008). In the SCM, competence evaluations are followed by behaviours. The interpersonal behaviours following stereotypes can fall on two dimensions: 1) active to passive, 2) harmful to facilitative (see Figure 2). Specifically, the SCM proposes that the competence dimension will predict passive facilitative or passive harmful behaviour, with lower perceived competence relating to passive harmful behaviour (Cuddy et al., 2008). Passive harmful behaviour distances or degrades others' social worth by excluding, ignoring, or neglecting them (Cuddy et al., 2008). Ostracism intentions, as measured in the current study, are the precursor to covert behavioural discrimination that involves social exclusion or ignoring of others (Ferris et al., 2008). Therefore, ostracism can be considered passive harm due to the direct consequences it

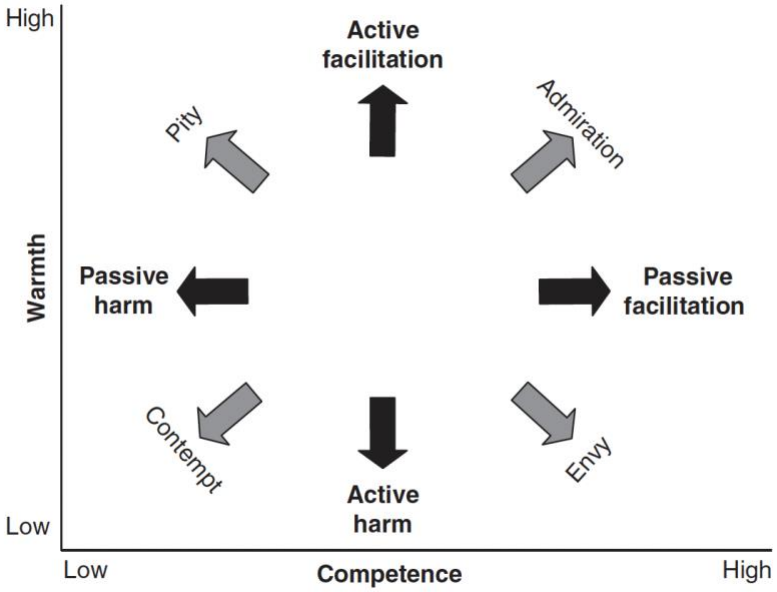
can have on an individual's access to social support and networks, as well as indirect consequences on illness management and performance (Hebl et al., 2008).

The SCM posits that groups perceived as having lower status and thus being deemed as less competent, will be ignored. Since low competence implies an inability to control resources and achieve goals, individuals regarded as less competent are seen as lacking in contributions (i.e., in the team) and are, therefore, met with passive harm (Cuddy et al., 2008). Competence stereotypes have been found to significantly predict passive harm (social distancing) towards patients with depression (Follmer & Jones, 2017). Thus, the fourth hypothesis is:

Hypothesis 4 (H4): Competence judgements are negatively related to ostracism intentions: The lower the perceived competence, the higher the ostracism intentions (see Figure 3).

Figure 2

Behaviour from Intergroup Affect and Stereotypes Map (Extension of the SCM)



Note. Figure from Cuddy et al., 2008, p.70.

Full Model

Sickness absence has previously been associated with low social support upon returning to work, with stigmatized illnesses being at a higher risk of reduced social support (Knapstad et al., 2014). This suggests, in line with the SCM, that absences due to ICI, especially mental ICI, might relate to increased passive harm behaviour such as ostracism. Further, previous research has found that stereotypes predict social distancing intentions, which are closely related to ostracism intentions (West et al., 2014). Hence, there might be differential reactions to absences due to physical and mental ICI, given the different stereotypes attached to them (Canton et al., 2022).

Specifically, this study proposes that the effect of health reasons for absence mediated by competence on ostracism intentions are contingent upon the disclosure strategy. It is predicted that direct disclosure of mental illness-related absence has more detrimental effects on competence and ostracism intentions than the direct disclosure of a physical ICI, given that mental illnesses tend to carry more negative stereotypes (Canton et al., 2022). Indirect disclosure may be especially beneficial when disclosing mental ICI, as it reduces the "disruptiveness" of the disclosure (Gibson, 2018). Accordingly, an international study with health practitioners found that physical ICI were among the conditions consistently associated with less social distance (i.e., a form of passive harm involving intentions to exclude), while mental ICI were among the illnesses yielding the highest social distance (Westbrook et al., 1993). Further, research suggests that mental illness is often attributed to causes such as "lack of willpower", which in turn predicts social distancing, possibly due to perceptions of unpredictability (Dietrich et al., 2004). The beliefs surrounding mental illness suggest that reactions to mental as compared to physical health reasons for absence will differ. Therefore, it is predicted that mental health reasons for absence will cause higher ostracism intentions than physical health reasons for absence. It is further predicted that the

negative effect of health reasons for the absence on ostracism intentions will be moderated by disclosure strategy and mediated by competence.

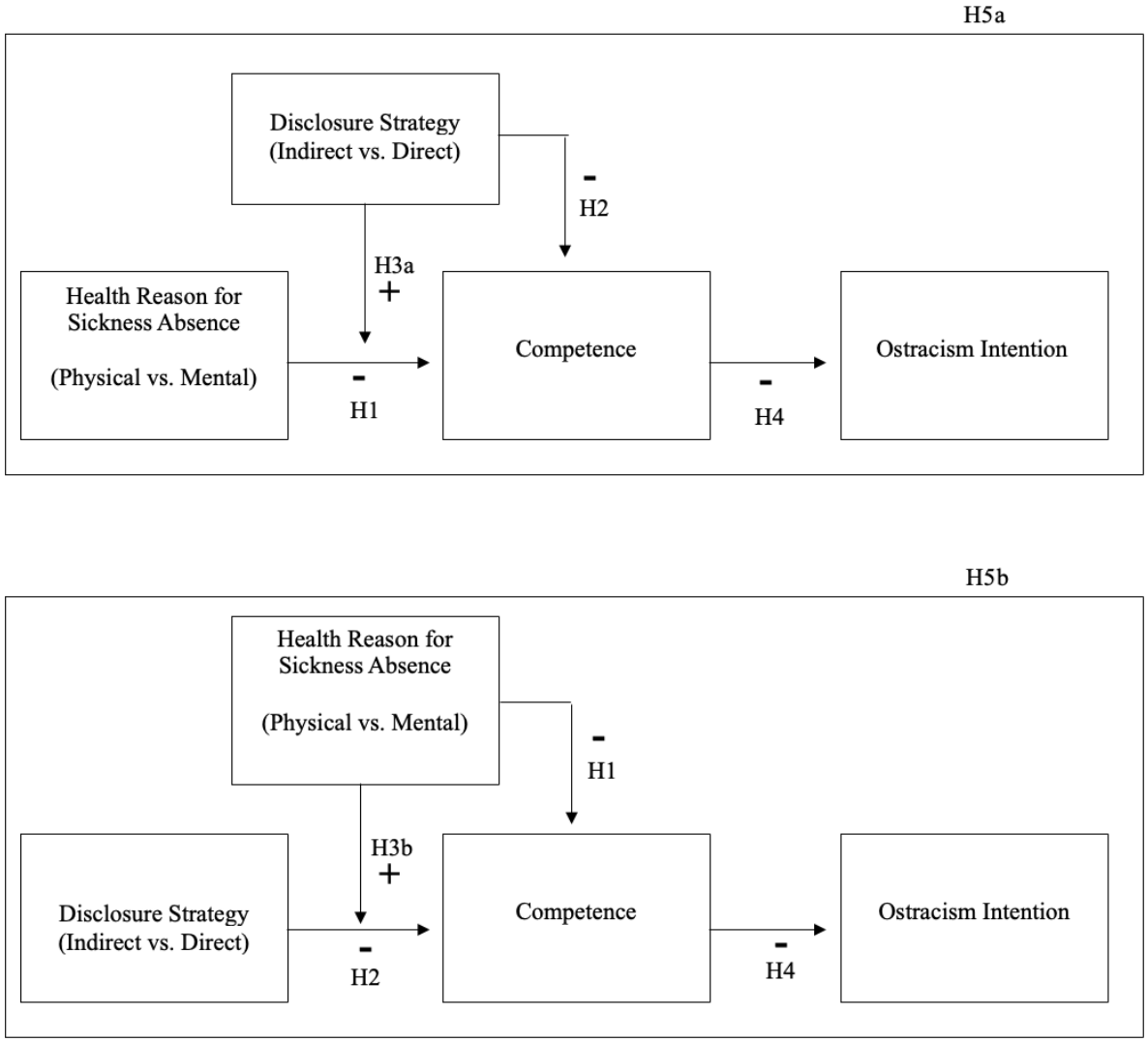
In line with previous hypotheses (see H3b), it is also predicted that direct disclosure will cause higher ostracism intentions than indirect disclosure. This effect should be buffered by a physical health reason for absence (as opposed to a mental health reason) and mediated via competence perceptions. The final hypotheses are:

Hypothesis 5: The effect of the interaction between the health reason for absence and disclosure strategy on ostracism intentions is mediated by competence perceptions in such a way that a) there is a positive effect of mental health (as opposed to physical health) reason for absence, strengthened by direct (as opposed to indirect) disclosure on ostracism intentions that is mediated via lower perceptions of competence (H5a) and

b) there is a positive effect of direct (as opposed to indirect) disclosure, buffered by physical health (as opposed to mental health) reason for the absence on ostracism intentions via lower perceptions of competence (H5b) (see Figure 3).

Figure 3

Proposed Conceptual Model



Methods

Sample Characteristics

Participants were recruited using the participant recruitment system of the University of Amsterdam and through convenience sampling using the personal networks of the thesis research group. To determine the necessary sample size, an a priori power analysis was carried out using G*power (Faul et al., 2007). A linear multiple regression with a fixed model and R^2 increase was selected. To provide a conservative estimate, a small to medium effect

size was set ($f^2 = .085$). Eight predictors were included in total (assuming four control variables). This yielded a minimum required sample size of 146 participants, or given the 4 conditions, approximately 37 participants per condition. Data were collected in the period between the 8th of April 2024 and the 1st of May 2024, resulting in a sample size of $N = 152$. Inclusion criteria included being 16 years or older and being fluent in English or German, as the survey was translated to German for the convenience sample. Following exclusion, the sample consisted of 130 participants: 79 identified as female, 49 as male, one as non-binary, and one as other (fluid).

Design and Procedures

The study used a 2 (physical vs. mental ICI) x 2 (indirect vs. direct disclosure) between-subjects experimental vignette design. Experimental vignettes are optimal for this research topic, by allowing for the use of realistic scenarios within the work context to effectively evaluate perceptions of health reasons for absence (Patton, 2011). Prior to their participation, participants were informed that the study was about "health communication at work". They were told that they would be presented with a workplace scenario in which a person was absent from work due to a health-related issue and that questions would be asked about their perception of this person. The current study is a thesis project with another student as well as a pilot study for the thesis supervisor. Hence, additional variables and measures were included that will not be discussed in detail in the scope of this thesis, with the exception of an additional manipulation that was included as a covariate (see below). The link to the Qualtrics survey (Qualtrics, 2023) was distributed, randomly assigning participants to one of four vignette conditions. At the start of the randomized vignette survey, participants were presented with an informed consent form (see Appendix A) outlining the procedure, general goal (i.e., understanding perceptions of sickness absence) of the study, ensured anonymity of the data and the possibility of withdrawing from the study if desired.

Next, participants proceeded to reporting demographic information (age and gender). Then they continued with the vignettes. Participants were randomly assigned to one of the health reasons for sickness absence vignettes (i.e., physical or mental ICI) (see Appendix B). They were then asked about the legitimacy of this health reason for absence. Participants were also asked about their familiarity with the presented health reason for absence. Following this, participants were randomly presented with one of the two disclosure strategies in the form of an email (i.e., indirect or direct) (see Appendix C). The Qualtrics pages with the vignette manipulations remained visible for 15 seconds without the option to skip to ensure the text was read.

After being presented with the disclosure strategy vignette, participants answered the manipulation check for the disclosure strategy. Following this, the items assessing competence and ostracism intention variables were presented. Then, an attention check for the health reason for absence was presented. Lastly, participants were debriefed about the specific purpose of the study and the manipulations (see Appendix D). On average, the survey took 13 minutes to complete.

Measures and Materials

Manipulations

Health Reason for Sickness Absence. Amongst chronic diseases, depression and gastrointestinal issues (i.e., Crohn's disease) have been shown to contribute the most to absences from work (Bryan et al., 2021). Given that both conditions have symptoms unseen by others, they were chosen as mental and physical ICI, respectively.

Physical Health Condition. Crohn's disease is an inflammatory bowel disease, associated with workplace absence and with a rising prevalence in the Western world (Ng et al., 2017; Paulides et al., 2019). The vignette for this manipulation was created for the

purpose of this study and based on the Mayo Clinic website (Mayo Clinic, 2022a). The vignette scenario was presented as a short text (see Appendix B). This condition was coded 0.

Mental Health Condition. Depression is recognized as one of the main causes of workplace disability and one of the most common mental illnesses (Corbiere et al., 2018). Further, long-term work disability and absence were more prevalent in depression than in anxiety (Deady et al., 2021). The vignette for this manipulation was created for this study, based on information from the international classification of diseases (World Health Organization, 2024) and the Mayo Clinic website (Mayo Clinic, 2022b). The vignette scenario (see Appendix B) was presented as a short text. This condition was coded 1.

Disclosure Strategy. This manipulation was written as an email addressed to John's team members, emphasizing the interdependence amongst colleagues that is relevant to competence perceptions.

Indirect Disclosure. In the indirect disclosure condition, the email was presented as if sent by another team member (see Appendix C). This conceptualization was based on the definition of indirect disclosure (An & McDermott, 2014) as used in the current study. This condition was coded 0.

Direct Disclosure. This manipulation was written in the form of an email sent by John himself to his team (see Appendix C) and was based on the definition of direct disclosure (An & McDermott, 2014) as used in the current study. This condition was coded 1.

Measures

Competence. To measure competence, participants were asked to rate the degree to which they perceived competence-related adjectives to fit their first impression of John. Response options were on a Likert scale, ranging from 1 (not at all) to 5 (extremely). To have a more complete measure of competence, eight adjectives taken from various studies were included: "intelligent", "skilful", "competent" (Leach et al., 2007), "competitive",

"independent" (Asbrock, 2010; Meyer & Asbrock, 2018) "confident" (Fiske et al., 2002) "capable" (Cuddy et al., 2007) "efficient" (Brambilla et al., 2011). These adjectives were used in a pilot study by the thesis supervisor, yielding a Cronbach's alpha of .91. The reliability in the current study was $\alpha = .86$, $\omega_t = .86$ (McNeish, 2018).

Ostracism Intention. Ostracism was assessed using ostracism intentions as a proxy. Ostracism intention was measured using 10 items adapted from Curtis et al., (2020) preceded by the general question: "To what extent do you think people working with John would show the following behaviours?". A sample behaviour included: "Ignore John at work" (see Appendix E). Response options were on a Likert scale from 1 (never) to 7 (always), with a midpoint of 4 (sometimes). The reliability of the scale in the current study was $\alpha = .93$, $\omega_t = .93$.

Manipulation Check Health Reason for Absence. To assess the effectiveness of this manipulation, participants were asked about the perceived legitimacy of the health reason for absence. Since mental and physical health reasons are often perceived as differing in legitimacy (Johns & Xie, 1998), this is an indicator of the manipulation having worked. This was assessed with the question "To which degree do you agree with the following statements about the scenario?" with answer options ranging from 1 (strongly disagree) to 5 (strongly agree). The three items included: "John's condition is a legitimate reason for sickness absence from work", "John should have tried to work despite experiencing symptoms of his condition" (reverse-coded), and "Most people with John's condition would have stayed at home in this situation". The reliability of the scale in the current study was $\alpha = .70$, $\omega_t = .73$.

Manipulation Check Disclosure Strategy. To assess whether the disclosure strategy manipulation worked, participants were asked "To what extent do you perceive John's communication of the absence reason as direct?". Response options were presented on a Likert scale of 1 (not at all direct) to 5 (extremely direct).

Attention Check. To ensure participants registered the illness described in the vignette (i.e., depression or Crohn's) they were asked: "In the scenario, what was the reason for John's absence at work?". The answer options included Crohn's = 0, depression = 1, knee injury = 2, flu = 3, migraine = 4, sick child at home = 5.

Demographic and Control Variables

Gender. Previous research suggests that gender might influence one's general attitudes (i.e., competence evaluations or ostracism intentions) toward health impairments and mental health conditions (Bretschneider et al., 2022; Curtin et al., 2011). Gender was measured by the item: "Please indicate your gender", coded as 1 = female, 2 = male, 3 = non-binary, and 4 = other. Because some participants identified as non-binary, dummy coding was applied to be able to include gender identifications beyond the binaries.

Age. Given that age has been suggested to influence one's response towards mental illness, it was considered as a potential control variable (Wolkenstein & Meyer, 2008). Age was measured as a continuous variable by asking participants: "What is your age? (please insert your age in years)".

Familiarity with Illness. It is likely that participants' familiarity with the mental or physical illness might influence their reactions toward the illness (Angermeyer et al., 2004). Familiarity was asked with the item: "How familiar are you with the health condition described in the scenario?" on a Likert scale from 1 (never heard of it) to 5 (very familiar).

Leader Status. Due to another member of the thesis group investigating the effect of leader or employee status, this manipulation was also controlled for, with employee = 0, leader = 1 (see Appendix F).

Variable Assessed for Exploratory Purposes

The warmth dimension of the SCM was also assessed; however, only for exploratory purposes to test the possible mediation of warmth, by putting warmth in the place of

competence in the conceptual model, in line with the SCM (see Figure 3). The same structure was used as for the competence measure, asking: "Please rate to which degree the following descriptions fit your first impression of John" on a 5-point Likert scale, ranging from 1 (not at all) to 5 (extremely). The adjectives used included: "honest", "sincere", "trustworthy" (Leach et al., 2007; Brambilla et al., 2011), "likeable", "warm", "good-natured" (Asbrock, 2010; Meyer & Asbrock, 2018), "friendly" (Cuddy et al., 2007) "righteous", "kind" and "well-intentioned" from the supervisor's study. The study run by the supervisor using these adjectives yielded a Cronbach's alpha of .94. The reliability of the scale in the current study was $\alpha = .92$, $\omega_t = .91$.

Ethical Considerations

The study plan and all study documents were reviewed and approved by the Ethics Board of the Faculty of Social and Behavioural Sciences at the University of Amsterdam (FMG-8562).

Results

Data Preparation

Data were analysed using SPSS version 29.0.1.0. Participants were excluded in the case of not having finished the survey or based on a failed attention check. The data were trimmed, as seen in Appendix G (Table G1), yielding a final sample of $N = 130$. See Table 1 for the number of participants per experimental condition.

Table 1

Participant Numbers per Experimental Condition (Including Leader Status Condition)

		Disclosure: Indirect	Disclosure: Direct	Total
AC: Physical	**Total**	34	32	66
	Leader	14	17	31
	Employee	20	15	35
AC: Mental	**Total**	30	34	64
	Leader	16	19	35
	Employee	14	15	29
Total		64	66	130

Note. AC = Absence cause

Assumption Checks

Assumptions for parametric tests were examined. Normality was tested per manipulation condition (i.e., health reason for absence and disclosure strategy) for all relevant outcome (or mediator) variables (i.e., competence, ostracism intention, warmth). Kolmogorov-Smirnov tests showed that scores did not deviate from normality besides competence in the mental condition $D(63) = .12$, $p = .023$, ostracism in the physical condition $D(66) = .13$, $p = .007$, competence in the indirect disclosure condition, $D(63) = .12$, $p = .030$, ostracism intention in the indirect $D(63) = .14$, $p = .002$ and the direct disclosure condition $D(66) = .12$, $p = .015$ (see Appendix H.1 and H.2). Despite some violations of the normality assumptions in certain conditions, this assumption is most important for small samples (<30), as the Central Limit theorem states normality can be assumed in larger samples (Field 2017; Koh & Ahad, 2020).

The linearity assumption was supported (see Appendix H.3 and H.4). The homoscedasticity assumption was mostly met for all outcome variables (i.e., competence, ostracism, warmth) within all conditions of the predictors (i.e., health reason for absence and

disclosure strategy), seen by the scatterplots centring around zero (see Appendix H.5 and H.6) and non-significant Levene's tests (see Appendix H.7 and H.8). Further, there was no multicollinearity, with tolerance values above 0.1 and VIF values below 10 (see Appendix H.9 and H.10). The autocorrelation assumption was also met, as the Durbin-Watson value was around 2 both for the competence outcome (Durbin-Watson Statistic = 1.95) and ostracism intention (Durbin-Watson Statistic = 2.04). The sensitivity assumption was met (see Appendix H11 and H12) with Cook's distance values below 1 and Mahalanobis values below 11 (Field, 2017).

Manipulation Checks

A hierarchical regression with illness familiarity, gender, and leadership status in the first step and health reason for absence and disclosure strategy in the second step indicated a successful manipulation of health reason for absence, B = -0.53, SE = 0.14, $t(123)$ = -3.73 p < .001, 95% CI[-.81, -.25]. This shows that participants in the mental health condition did consider the illness a less legitimate reason for absence than participants in the physical health condition.

The same analysis was used, with the disclosure strategy manipulation check as the outcome. Again, the manipulation check was successful, B = 1.08, SE = 0.16, $t(123)$ = 6.81, p < .001, 95% CI[.77, 1.40]. This indicates that participants in the direct disclosure condition did perceive John's communication as more direct than participants in the indirect disclosure condition.

Descriptive Statistics

Chi-square tests revealed no significant difference in the distribution of the female gender, as compared to the other genders (male, non-binary, other) across the health reason for absence conditions, $X^2(1, N = 130) = 1.25$, p = .264. However, in the direct disclosure condition, participants were 2.47 times more likely to identify as a woman than one of the

other genders, $X^2(1, N = 130) = 6.13$, $p = .013$. Therefore, gender was included as a control variable.

The minimum and maximum ages were 17 and 88, respectively. Of the total sample, $N = 29$ (22.3%) participants filled out the German version of the survey, and $N = 101$ (77.7%) the English version. However, t-tests indicated no significant difference in outcome variables depending on language. Table 2 includes further descriptive statistics. There was a positive relationship between health reason for sickness absence and familiarity ($r = .48$, $p < .001$), indicating higher familiarity with the mental illness (i.e., depression). There was also a positive relationship between disclosure strategy and competence ($r = .26$, $p = .003$) and disclosure strategy and warmth ($r = .34$, $p < .001$), indicating that both competence and warmth were against expectations, rated higher in the direct than indirect disclosure condition (see Figure 4 for competence levels in the respective experimental conditions).

Competence and warmth were positively correlated ($r = .71$, $p < .001$). Health reason for absence was positively related to ostracism intentions ($r = .34$, $p < .001$), indicating that participants had higher ostracism intentions in the mental health compared to physical health condition (Figure 5). Lastly, there was a negative yet non-significant relationship between competence perceptions and ostracism intentions ($r = .48$, $p = .053$). Given that familiarity with the illness correlated positively with health reason for sickness absence and gender (female) correlated positively with disclosure strategy ($r = .22$, $p = .013$), these were included as control variables along with leader status. Age was not correlated with any of the key variables and was therefore not included in subsequent analyses.

Figure 4

The Effect of Experimental Conditions on the Proximal Outcome (Competence)

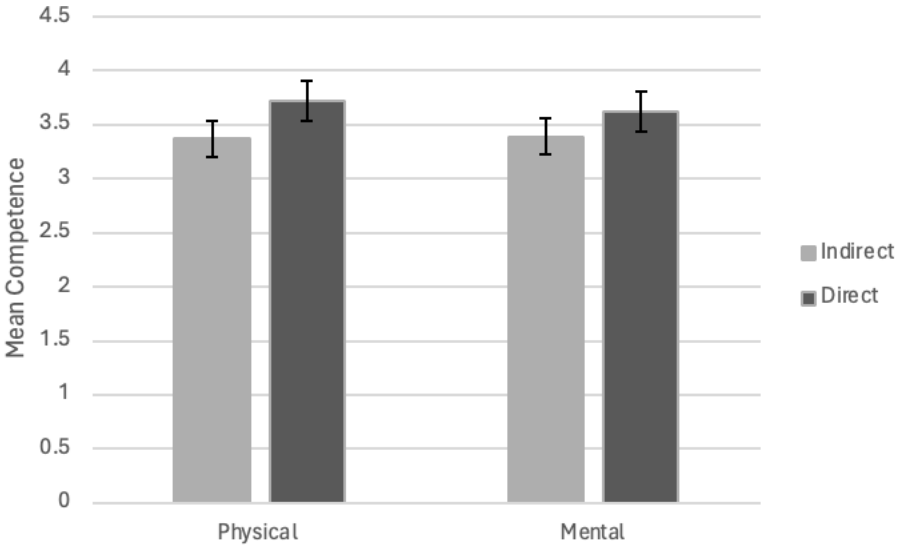


Figure 5

The Effect of Experimental Conditions on the Distal Outcome (Ostracism Intention)

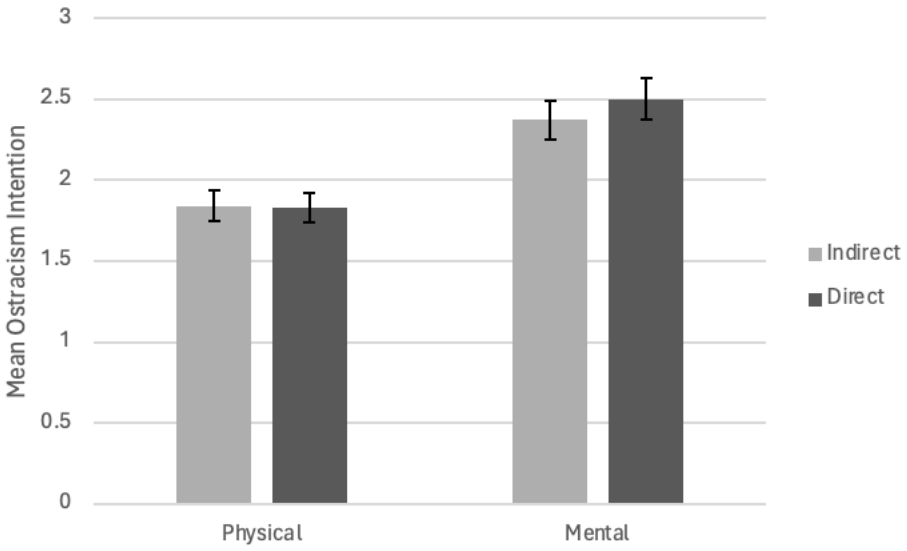


Table 2

Means, Standard Deviations, and Correlations of Selected Study Variables.

	Variable	*M*	*SD*	1	2	3	4	5	6	7	8	9	10
1	Age	28.29	14.65	-									
2	Gender Female[a]	0.61	0.49	-.10	-								
3	Gender Other[b]	0.02	0.12	-.02	-.16	-							
4	Familiarity with Illness	3.26	1.22	.12	.28**	-.03	-						
5	Language[c]	0.78	0.42	-.52**	.06	.07	-.08	-					
6	Leader Status[d]	0.51	0.50	-.01	.06	-.13	.14	-.08	-				
7	Health Reason for Sickness Absence[e]	0.49	0.50	.00	.10	.13	.48**	-.14	.08	-			
8	Disclosure Strategy[f]	0.51	0.50	-.05	.22*	-.13	.15	-.05	.08	.05	-		
9	Competence	3.53	0.56	.03	-.06	-.02	-.08	-.12	.10	-.02	.26**	-	
10	Warmth	3.76	0.57	-.02	.03	-.12	-.07	-.06	.01	-.01	.34**	.71**	-
11	Ostracism Intentions	2.13	0.90	-.05	.12	.07	.14	-.03	-.00	.34**	.05	-.17	-.04

Note. $N = 130$. [a] Dummy coded, female = 1. [b] Dummy coded, other (non-binary and fluid) = 1. [c] 0 = German 1 = English [d] 0 = employee, 1 = leader. [e] 0 = physical health condition 1 = mental health condition. [f] 0 = indirect disclosure 1 = direct disclosure.

*$p < .05$. **$p < .01$

Hypothesis Testing

Hypothesis 1 predicted that there is a negative effect of health reasons for sickness absence on competence. To test the hypothesis, a hierarchical linear regression was run with illness familiarity, gender, and leader status in step one, health reason for absence and disclosure strategy in step two, and competence as the outcome variable (see Table 3). This analysis showed a non-significant effect, $B = 0.02$, $SE = 0.11$, $t(122) = 0.16$ $p = .875$, 95% CI[-.20, .24]. So, Hypothesis 1 was not supported.

Hypothesis 2 predicted that there is a negative effect of disclosure strategy on competence, (i.e., direct disclosure will lead to lower competence perceptions than indirect disclosure). To test the hypothesis, the same output as Hypothesis 1 was used (see Table 3). This analysis showed a significant positive effect of disclosure strategy on competence, $B = 0.32$, $SE = 0.10$, $t(122) = 3.23$ $p = .002$, 95% CI[.13, .52]. This indicates that participants in the direct disclosure condition evaluated John as more competent than participants in the indirect disclosure condition. Thus, Hypothesis 2 was not supported.

Hypothesis 3a predicted that disclosure strategy moderates the effect of health reason for absence on competence so that the negative effect of mental health reason for absence on competence is stronger for direct, compared to indirect disclosure. To test this hypothesis, PROCESS Macro of SPSS, Model 1 with 5000 bootstrapped samples was used (Hayes, n.d.), with disclosure strategy as the moderator. This analysis showed a non-significant interaction effect, $B = -0.10$, $SE = .20$, $t(121) = -0.51$, $p = .612$, 95% CI[-.49, .29] (see Table 3). So, Hypothesis 3a was not supported. Hypothesis 3b predicted that the health reason for absence moderates the effect of disclosure strategy on competence so that the negative effect of direct disclosure on competence is stronger for mental health reasons for absence compared to physical health reasons for absence. Since Hypotheses 3a and 3b differ only in the direction

of the slopes and the interaction effect in the regression was not significant, Hypothesis 3b was also not supported.

Hypothesis 4 predicted that competence is negatively related to ostracism intentions. This hypothesis was tested using multiple regression with competence as a predictor and ostracism intentions as the outcome variable, as well as illness familiarity, gender, leader status, health reason for absence, and disclosure strategy in step one (see Table 4, Model 2b). This analysis showed a significant, negative relationship between competence and ostracism, B = -.29, SE = .14, t(121) = -2.05, p = .043, 95% CI[-.57, -.01]. Thus, Hypothesis 4 was supported.

Hypothesis 5a predicted an interaction between health reason for absence and disclosure strategy onto ostracism intentions, which is mediated by competence: the negative effect of health reason for absence on ostracism intention is strengthened by direct compared to indirect disclosure. PROCESS Model 1 was used to test the total effect (path c) and Model 8 was used to investigate the conditional indirect effect and path a, b and c'. Firstly, the total effect of the interaction between health reason for absence and disclosure strategy on ostracism intention (path c) was non-significant B = 0.15, SE = 0.31, t(122) = 0.49, p = .627, 95% CI,[-.46, .76] (see Table 4, Model 2d).

Next, the effect of the interaction between health reason for sickness absence and disclosure strategy on competence (path a) was not significant B = -0.10, SE = .20, t(121) = -0.51, p = .612, 95%, CI[-.49, .29]. Further, when competence was added to the model, which included the interaction term onto ostracism intention (path c'), the interaction effect remained non-significant, B = 0.11, SE = 0.31, t(120) = 0.36, p = .722, 95%, CI[-.50, .72] (see Table 4, Model 2c).

Table 3

Models Regressing Health Reason for Absence, Disclosure Strategy, Interaction and Covariates on Competence

	Model 1a			Model 1b			Model 1c		
	B	*SE*	*t*	*B*	*SE*	*t*	*B*	*SE*	*t*
Intercept	3.61**	0.15	24.26	3.53**	0.15	23.86	3.51**	0.15	22.80
Illness Familiarity	-0.04	0.04	-0.84	-0.05	0.05	-1.09	-0.05	0.05	-1.09
Gender (Female)[a]	-0.05	0.11	-0.46	-0.11	0.11	-1.04	-0.11	0.11	-1.02
Gender (Other)[b]	-0.06	0.41	-0.16	0.05	0.40	0.12	0.02	0.41	0.04
Leader Status[c]	0.13	0.10	1.28	0.12	0.10	1.21	0.11	0.10	1.16
Disclosure Strategy[d]				0.32**	0.10	3.23	0.37**	0.14	2.70
Health Reason for Sickness Absence[e]				0.02	0.11	0.16	0.07	0.15	0.46
Disclosure Strategy x Health Reason for Sickness Absence							-0.10	0.20	-0.51
R^2		0.02			0.10			0.10	
ΔR^2					0.08**			0.00	

Note. N = 130. Unstandardized regression coefficients are reported for the respective regression models. [a] dummy coded, female = 1. [b] Dummy coded, other (non-binary and fluid) = 1.[c] 0 = employee, 1 = leader. [d] 0 = indirect disclosure 1 = direct disclosure. [e] 0 = physical health condition 1 = mental health condition.

* $p < .05$ **$p < .01$

Lastly, the relationship between competence and ostracism intention (path b) was significant and negative, B = -0.29, SE = 0.14, $t(120)$ = -2.02, p = .045, 95, CI[-.57, -.01] (see Table 4, Model 2c). The indirect effect of the interaction between health reason for sickness absence and disclosure strategy on ostracism intentions via competence was not significant, as the 95% confidence interval included zero, $B_{indirect}$ = 0.03, SE = 0.07, 95%, CI[-.09, .19]. Hence, the conditional mediation hypothesis 5a was not supported. Hypothesis 5b predicted an interaction between disclosure strategy and health reason for absence, which is mediated by competence: the negative effect of direct disclosure on ostracism intention is strengthened by mental compared to physical ICI. Since Hypotheses 5a and 5b differ only in the direction of the slopes and the interaction effect was not significant, Hypothesis 5b was also not supported.

An additional finding was a direct, positive effect of health reason for absence on ostracism, B = 0.64, SE = 0.18, $t(124)$ = 3.58, p < .001, 95%, CI[.29, .99], (see Table 4, Model 2b). In other words, the intentions to ostracise were higher in the mental health condition than in the physical health condition.

Exploratory Analyses

In line with the propositions of the SCM, warmth is the other component of stereotype content. Therefore, this analysis tested the mediating role of warmth in the place of competence in the conceptual model. Firstly, the total effect (path c) of the interaction between health reason for absence and disclosure strategy onto ostracism intention (path c) was non-significant B = 0.14, SE = 0.30, $t(126)$ = 0.47, p = .637, 95% CI[-.45, .74]. Secondly, the effect of the interaction between health reason for sickness absence and disclosure strategy on warmth (path a) was not significant, B = -0.22, SE = 0.19, $t(125)$ = -1.16, p = .247, 95% CI[-.60, .16].

Table 4

Models Regressing Health Reason for Absence, Disclosure Strategy, Interaction, and Covariates on Ostracism

	Model 2a			Model 2b			Model 2c			Model 2d		
	B	*SE*	*t*	*B*	*SE*	*t*	*B*	*SE*	*t*	*B*	*SE*	*t*
Intercept	1.85**	0.23	7.88	2.87**	0.55	5.21	2.88**	0.55	5.20	1.87**	0.24	7.71
Illness familiarity	-0.04	0.08	-0.56	-0.06	0.07	-0.77	-0.06	0.07	-0.75	-0.04	0.07	-0.53
Gender (Female)[a]	0.20	0.17	0.11	0.17	0.17	1.01	0.17	0.17	1.00	0.19	0.17	1.15
Gender (Other)[b]	0.25	0.64	0.03	0.26	0.63	0.68	0.29	0.64	0.46	0.30	0.65	0.47
Leader Status[c]	-0.05	0.16	-0.31	-0.01	0.15	-0.01	-0.01	0.16	-0.06	-0.04	0.16	-0.24
Disclosure Strategy[d]	0.03	0.16	0.20	0.13	0.16	0.77	0.07	0.22	0.33	-0.03	0.22	-0.16
Health Reason for Absence[e]	0.64**	0.18	3.58	0.64**	0.18	3.66	0.58*	0.24	2.43	0.55*	0.24	2.30
Health Reason for Absence x Disclosure Strategy							0.11	0.31	0.36	0.15	0.31	0.49
Competence				-0.29*	0.14	-2.05	-0.29*	0.14	-2.02			
R^2		0.13			0.16			0.16			0.13*	
ΔR^2					0.03*			0.00			0.00	

Note. N = 130. Unstandardized regression coefficients are reported for the respective regression models. [a] Dummy coded, female = 1. [b] Dummy coded, other (non-binary and fluid) = 1. [c] 0 = employee, 1 = leader. [d] 0 = indirect disclosure 1 = direct disclosure. [e] 0 = physical health condition 1 = mental health condition.

*p < .05 **p < .01

Further, when warmth was added to the model, which included the interaction term onto ostracism (path c'), the interaction effect remained non-significant, $B = 0.12$, $SE = 0.31$, $t(124) = 0.40$, $p = .690$, 95% CI[-.48, .73]. Lastly, the relationship between warmth and ostracism intention (path b) was not significant, $B = -0.06$, $SE = 0.14$, $t(124) = -0.46$, $p = .649$, 95% CI[-.35, .22]. Overall, the indirect effect of the interaction between health reasons for sickness absence and disclosure strategy on ostracism intentions via warmth was not significant, $B_{indirect} = 0.01$, $SE = 0.05$, 95% CI[-.06, .14].

Discussion

The goal of this study was to investigate how employees' communication of workplace absence due to mental or physical ICI influences perceptions (i.e., competence evaluations) and, finally, behavioural reactions (i.e., ostracism intentions) towards the employee. No support was found for the full proposed conceptual model which predicted that health reason for absence interacts with disclosure strategy to affect ostracism intentions, through competence perceptions. However, support was found for a negative association between competence and ostracism intentions. Further, the direct disclosure strategy caused higher competence evaluations than the indirect disclosure strategy. Additionally, ostracism intentions were higher in the mental health condition than the physical health condition. Lastly, no exploratory evidence was found for a conditional mediation of warmth.

Theoretical and Research Implications

The current study contributes to our understanding of the perceptions of individuals with ICI and their disclosure in the workplace. Thus far, existing research has not yet compared the perception of physical and mental ICI in the context of workplace absences within the SCM framework. This study found that health reasons for absence (mental vs. physical) did not significantly affect competence assessments (H1). Despite the manipulation check of legitimacy showing that mental health (depression) was considered a less legitimate

reason for absence than physical health (Crohn's disease), there was no difference in competence assessment. This finding might be explained by the nature of the sample, involving more educated individuals, including psychology students, who are more aware of what mental disorders entail (Corrigan & Watson, 2007), thus not perceiving them as different from physical health in terms of competence. Further, the mean on the competence measure was $M = 3.53$, which on a 5-point Likert scale is on the higher end, possibly indicating a slight social desirability bias. However, as competence was assessed by asking for first impressions, this does not seem to be a cause for concern.

Contrary to expectations, direct disclosure yielded higher competence evaluations than indirect disclosure (H2). This study hypothesised that direct disclosure would be a more disruptive form of disclosure (Gibson, 2018) and that indirect disclosure might buffer the negative perceptions of stigmatized illnesses (An & McDermott, 2014). However, the opposite was found, which aligns with responsiveness literature suggesting that more direct communication in self-disclosure might be met with more support (Berg, 1978; Cipollina et al., 2022). In line with this, a study by Levine and Cohen (2018) showed that honesty does less relational harm and is more pleasurable than what people tend to expect. Additionally, John directly communicating his situation (i.e., direct disclosure strategy) might convey more bravery and agency (i.e., taking initiative and having control over one's own life), contributing to higher perceived social status, which in turn might enhance competence perceptions (Cuddy et al., 2008; Eteläpelto et al., 2013). Thus, the direct communication of one's illness might be perceived as more courageous, independent of the health reason for absence. This is an interesting point given that physical impairments have previously been associated with higher perceived courage than mental illness (Canton et al., 2022). Hence, the way one communicates an illness may matter more for competence than the illness (physical or mental) being disclosed.

It should be noted that the operationalisation of indirect disclosure in the current study involved both a third party disclosing on behalf of John, as well as not mentioning the specific chronic mental/physical illness (see Appendix C). Therefore, indicating the potential role of a third factor at play, namely the third person disclosing on behalf of John. Particularly, communication of illness status through a third person may promote perceptions of hiding, and thus less courage and competence (Venetis, 2018). It could be interesting for future research to investigate more nuances between direct and indirect communication (i.e., face-to-face or indirect media communication).

Further, there was no significant interaction between health reason for absence and disclosure strategy (H3a/H3b). Yet, participants in the mental health condition had higher ostracism intentions towards John than those in the physical health condition (see Table 4, Model 2b). Together, these findings indicate that the SCM might not fully capture perceptions of individuals with ICI, and that separate processes might be involved. Specifically, it seems that competence is driven primarily by the disclosure strategy used (i.e., direct disclosure causing higher competence evaluations), as seen in Figure 4. Meanwhile, ostracism intentions are driven more by the health reason for absence (i.e., higher ostracism intentions for mental than physical health), as seen in Figure 5.

It is notable that there was an effect of health reason for absence on ostracism, but that this effect was not mediated by competence. Ostracism is a form of discrimination that involves the social exclusion and ignoring of others (Ferris et al., 2018). An explanation for the higher ostracism intentions in the mental health condition might be feelings of uncertainty about how to deal with the mental health issue. It might be that higher ostracism intentions are an expression of insecurity surrounding how to properly talk about the topic of mental health, or a way of avoiding potentially uncomfortable conversations (Carpenter & Theiss, 2023; Chandra & Minkovitz, 2007). Distancing in the form of ostracism intentions, might

reflect ongoing stigma surrounding mental health and may hamper initiatives that encourage conversation and contact, which have been found to reduce stigma in different contexts (Adu et al., 2022; Pescosolido et al., 2020). Although there were higher intentions to ostracise in the mental health condition than the physical health condition, the intentions to ostracise were relatively low, with a mean of 2.5 on a 7-point scale in the mental health condition. One explanation for this is that the current sample might have included people who are more sensitized to the negative outcomes of discrimination. It is also possible that the hypothetical scenario (i.e., the vignettes) enabled participants to maintain a certain mental distance, thereby not revealing the full extent of ostracism they may have exhibited in real life.

Further, it is possible that another mediator (besides competence) could better explain the differential effect of physical and mental ICI on ostracism intentions. In line with previous theorizing, it is possible that the perceived illegitimacy of absence could explain why mental health absences cause increased ostracism intentions (Patton, 2011). For instance, a meta-analysis found a strong positive relationship between workplace incivility (i.e., low intensity, deviant behaviours in the workplace) and ostracism (Bedi, 2021). This might point to the fact that mental health is perceived as more deviant (and less legitimate) in the context of workplace absences, independent of competence judgments.

Additionally, competence evaluations did significantly and negatively predict ostracism intentions (H4). This aligns with the SCM, which predicts that (low) competence evaluations predict passive harmful behaviours.

Overall, the full conditional mediation model (see Figure 3) was not supported, besides the negative association between competence and ostracism intention (path b). This again indicates that there are possibly more complex or separate processes involved in the perception of ICI and the disclosure thereof, that are not covered by the SCM.

Lastly, the exploratory analysis showed that when warmth was entered as a mediator, it did not significantly predict ostracism intentions. This is in line with the SCM, which predicts that competence (rather than warmth) should predict passive harmful behaviour (i.e., ostracism intention).

Strengths, Limitations and Suggestions for Future Research

A strength of the current study is its experimental vignette design. This design is underutilized yet offers a realistic manner of investigating stereotypes and perceptions while also allowing for causal interpretation (Patton, 2011). However, the study also had some limitations.

Firstly, no behavioural outcome measure was included, only a measure of the expectations of ostracism behaviours in John's colleagues to bypass social desirability. In other words, ostracism intentions were measured rather than actual ostracism behaviour. Although behavioural expectations are a strong predictor of actual behaviour (Conner & Norman, 2022), future research might consider study designs with behavioural outcomes. For instance, Roberts et al., (2002) used the number of chairs between a confederate and a naïve participant, as an indirect measure of distance, similar to ostracism. Hence, there are ways to measure ostracism in more realistic settings, to reduce any mental distance that might be created with the use of vignettes.

Further, individual differences that influence perceptions of ICI could be considered as moderators or mediators. For instance, it is possible that fairness endorsement could influence ostracism intentions towards individuals with ICI (Hales et al., 2016). The personality trait agreeableness might also act as a mediator of the relationship between health reason for absence and ostracism intentions, as it has been found to negatively relate with social distancing intentions (Steiger et al., 2022).

Additionally, given that part of the sample was recruited through convenience sampling, and the other part were psychology students, results might have been influenced accordingly. It is possible that the sample, being higher educated might have less of an explicit bias in terms of competence evaluations (Corrigan & Watson, 2007). However, the heightened expectations of ostracism directed at John, with a mental health condition, by John's "colleagues", might point to underlying (covert) discrimination still being an issue. Relatedly, the current sample is primarily from WEIRD (Western, Educated, Industrialized, Rich, Democratic) countries. There might be substantial cultural differences when it comes to sickness absence, both in prevalence of illnesses and their perceived legitimacy (Addae et al., 2013). Different cultures also differently label, perceive and treat mental illnesses (Koschorke et al., 2016). Given the considerable number of multinational workplaces, more culturally diverse samples are needed in this research area.

It should also be considered that the subject in the vignettes used in this study was a male (i.e., John M.). Recent studies have found no difference in the perceived appropriateness of sickness absence depending on the gender of the target across a range of absence causes (Hensing et al., 2024; Mastekaasa et al., 2021). However, the gender of the individual in the vignette might interact with the disclosure strategy, and women in particular might face more backlash when being agentic (i.e., direct) in the workplace (Rudman & Phelan, 2008). Hence, it would be interesting to account for the gender of the vignette subject in future studies.

Next, this study did not account for the comorbidity between mental and physical illnesses and between CHC in general. For instance, the physical health status of individuals with depressive disorder tends to be worse (Dewa & Lin, 2000). It might therefore be of value to consider whether an individual with combined mental and physical symptoms would be regarded differently. Relatedly, this study investigated depression and Chron's as they have been shown to contribute the most to absences from work (Bryan et al., 2021). Yet, it is

useful to consider other prevalent physical and mental ICI, to prevent overgeneralizing across illnesses.

Finally, people might have to disclose repeatedly at work as symptoms worsen or progress or as new colleagues join the workplace (Charmaz, 2010). Hence it is relevant to consider disclosure effects over time, for instance with a longitudinal design. In general, understanding the career trajectory of individuals with ICI over time is important, as ICI are by definition chronic. Additionally, "other-focused factors" (i.e., expectations of others' reactions) were mentioned as the main barrier for disclosure by Tomas et al., (2022). However, this study found that direct disclosure caused higher competence evaluations, suggesting the directness might be appreciated by perceivers. Therefore, it is important to also further understand stereotypical self-perceptions that might enhance such fears of disclosure, to be able to further support individuals facing the disclosure decision (Cuddy et al., 2008).

Practical Implications

The findings of the study provide some guidance for individuals with ICI, employees, and (HR) managers. Particularly, direct disclosure might be beneficial. This is encouraging, as it suggests that it is possible for individuals with mental or physical ICI to influence others' reactions to them with rather small adjustments. Despite fears of disclosure, being more proactive might be beneficial. Relatedly, managers can encourage such direct disclosure if they are made aware of ICIs; however, being careful and continuing to offer support since mental illness is still associated with increased ostracism intention.

This sample demonstrated no differential competence evaluations towards mental and physical health but a negative bias towards mental health (i.e., depression) in terms of ostracism intentions. Given that ostracism intentions have workplace consequences, including reduced access to crucial social networks for career advancement and social support (Hebl et

al., 2008), contributing to the persistence of mental illnesses (Reinhard et al., 2019) and further breeding depression (Rudert et al., 2021), it is highly relevant to further consider this construct, as well as initiatives that could reduce it, such as team-based mindfulness interventions (Ramsey & Jones, 2015) culture or support initiatives (Sharma & Dhar, 2022) and inclusive (Egitim, 2022) or servant (Haq et al., 2021) leadership. Managing cultures of inclusivity, is crucial, to ensure individuals with ICI feel supported in disclosure. This is especially relevant for ICIs, which frequently remain unnoticed despite their significant personal and interpersonal impacts.

Conclusion

Existing research grounded in the SCM has pointed to differential stereotypes and behavioural reactions attached to mental as compared to physical health conditions (Canton et al., 2022; Sadler et al., 2012). Perceptions of mental and physical ICI in the context of workplace absences and the moderating role of disclosure strategy were previously unexamined. The current study found that direct disclosure causes higher competence perceptions regardless of health reasons for absence, while a negative bias towards mental health persists in terms of ostracism intentions. Further research is needed to capture these seemingly separate processes of disclosure strategy and competence, health reason for absence, and ostracism intention.

This study contributes to a more nuanced understanding of perceptions of absences due to physical and mental ICI as well as the disclosure of such illness-related absences. While it is encouraging that direct disclosure is well received, given its benefits (Clair et al., 2005; Kulkarni, 2022), ostracism intentions in response to mental health remain an obstacle.

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Appendix A Informed Consent Form

Um zur deutschen Version umzuschalten, benutzen Sie bitte die Sprachauswahl in der oberen rechten Ecke.

HEALTH COMMUNICATION IN THE WORKPLACE

Participant Information

Welcome to the study "Health Communication in the Workplace" of the Faculty of Social and Behavioral Sciences of the University of Amsterdam (UvA).

It is important that you learn about the procedure of this study before it starts, so please read the following text carefully. If anything is unclear to you, feel free to ask the researcher: a.r.cook@uva.nl. The researcher will be happy to answer any questions you may have.

Goal of the study

The goal of this study is to investigate how people perceive different situations of sickness absence from work and disclosure of the reason for the sickness absence.

Study Procedure

The study will start with questions about your demographic data (age and gender). Then, you will be presented with a brief scenario of a workplace situation in which a person is absent from work due to a health-related reason. We will ask you multiple questions about your perception of the situation and the person in the scenario.
All elements of this study will be presented via the tool Qualtrics. The survey content can be viewed and answered on all standard internet browsers on laptops, tablets, or smartphones. We expect the participants to carefully read the questions and answer in a truthful manner. There are no right or wrong answers.

Participating in this study does not include any risks or inconveniences.
This study takes approximately 15 minutes.

Participation in this study will not be compensated.
The study is available in English and German.

Voluntary participation

Your participation in this study is voluntary: you are not obligated to participate. You may decide to stop your participation during the study. You do not have to provide a reason for stopping.

Privacy

We do not collect any personal data in this study.

Collaborations

In this study, your research data are processed only by UvA researchers.

Data sharing

The results of this study will be shared with other researchers and/or will be shared through a public database (open access) without any (directly identifying) personal data. The results may be used in other future research, which may investigate a different topic than the study you are currently participating in.
Research data will be retained for at least 10 years. There is no directly identifying personal data that will be stored, and the research data will be destroyed as soon as possible.

Ethics and further information

This study has been assessed by the Ethical Review Board of the Faculty of Social and Behavioural Sciences at UvA. If you have any questions about the study, either before you participate or afterwards, please feel free to contact the responsible researcher: Dr. Sasha Cook (a.r.cook@uva.n). You can direct any formal complaints about this study to the member of the Ethics Review Board of the Faculty of Social and Behavioral Sciences of the University of Amsterdam using melding-ethiek-psy-fmg@uva.nl. If you have any questions or complaints about the processing of your data, you can also contact the Data Protection Officer of the University of Amsterdam through fg@uva.nl.

With kind regards,
Dr. Sasha Cook
a.r.cook@uva.nl
Work and Organizational Psychology
Psychological Research Institute
Faculty of Social and Behavioral Sciences
University of Amsterdam
Master thesis students: Frida Schmidt-Didlaukies, Sven Goll
You can download this information here: Download Link

INFORMED CONSENT

If you would like to participate in the survey, click on “Yes” below. With this you declare:
• I am 16 years or older.
• I have read and understood the information.
• I agree to participate in the study and the use of the data obtained within it.
• I reserve the right to withdraw this consent without giving a reason.

• I reserve the right to stop the study at any time I wish.

YES, I agree to participate in this study and to submit my data for analysis.
NO, I do not agree to participate in this study

Appendix B Health Reason for Sickness Absence Manipulation

Translations to German can be requested from the author.

Physical Health Condition

One year ago, John M. was diagnosed with Crohn's disease, inflammatory bowel disease. The disease is characterized by chronic and relapsing inflammation of the intestinal/digestive walls. Common symptoms are abdominal pain, severe diarrhoea, fever, and fatigue.

Recently, John M. has been experiencing symptoms of this chronic health condition, which led him to be absent from work for five consecutive days.

Mental Health Condition

One year ago, John M. was diagnosed with depressive disorder. The disorder is characterized by depressive mood (e.g., sad, irritable, empty) or loss of pleasure accompanied by other cognitive and behavioural symptoms.

Recently, John M. has been experiencing symptoms of this chronic health condition, which led him to be absent from work for five consecutive days.

Appendix C Disclosure Strategy Manipulation

Translations to German can be requested from the author.

Direct Disclosure

In the last week, John M. has been absent from work. He addresses his absence to his team members via email on Friday.

"Hey, everybody. You probably noticed that I have been absent for a couple of days. I was on sick leave. I want to be straight with all of you, so for full disclosure, I have been diagnosed with (an *inflammatory bowel disease called Crohn's disease / a depressive disorder*), and I have been experiencing symptoms in the past few days. The good news is that I feel better and will be back on Monday."

Indirect Disclosure

In the last week, John M. has been absent from work. Another team member addresses his absence the rest of the team members via email on Friday.

"Hey, everybody. You probably noticed that John has been absent for a couple of days. He is on sick leave. I have been in contact with him and he told me that he has been struggling with some symptoms of a (mental/physical) chronic health issue in the past few days. That's the reason why he wasn't able to work in the last days. The good news is that he feels better and will back on Monday. "

Appendix D Debrief

Thanks for taking part in our study!

In this study, we placed participants in different conditions to investigate how people react to sickness absence and health disclosure. We randomly varied: 1. the organizational position of the person in the scenario (leader or employee) 2. the nature of the chronic health condition causing absence (mental or physical chronic health condition) 3. how the reason for sickness absence is communicated (directly versus indirectly). We then assessed the interpersonal perceptions of the employee in the scenario in terms of competence and warmth, as well as expectations regarding the emotional and behavioural reactions of co-workers. Other questions about the situation and health condition help us to investigate why different health conditions may lead to different reactions to different health conditions.

If you have any further questions, please don't hesitate to contact Dr. Sasha Cook (a.r.cook@uva.nl).

Appendix E Intention to Ostracise Scale

These are the original English items adapted from Curtis et al., (2020). Translations to German can be requested from the author.

Likert scale 1 (never) to 7 (always), midpoint 4 (sometimes).

"To what extent do you think people working with John would show the following behaviours towards John."

(1) Ignore John at work.

(2) Leave the area when John enters.

(3) Not answer John's greetings at work.

(4) Refuse to sit with John at meals.

(5) Avoid John at work.

(6) Not look at John at work.

(7) Shut John out of the conversation.

(8) refuse to talk to John at work.

(9) Behave as if John weren't there.

(10) Not invite John out for coffee after work.

Appendix F Leader Status Manipulation

Translations to German can be requested from the author.

Employee condition

John M. has been working as an analyst at Quantum Insights Consulting for five years. He is currently a member of a team of 5 analysts who are tasked with developing a new recruiting strategy for a client. The team works closely together on the project and has frequent meetings.

Leader condition

John M. has been working as a lead analyst at Quantum Insights Consulting for five years. He is currently the supervisor of a team of 5 who are tasked with developing a new recruiting strategy for a client. The team works closely together on the project and has frequent meetings.

Appendix G Data Trimming

Table G1

Data Trimming

	Sample before	Sample after
Respondents with no consent	152	151
Respondents with failed attention check health reason for absence	151	150
Respondents with failed attention check leader status	150	130

Appendix H Assumption Testing

Appendix H.1 Normality per Health Reason for Absence Condition

Tests of Normality

	Manipulation 2: Health condition	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	Sig.
Competence_scale	physical	.105	66	.067	.966	66	.067
	mental	.121	63	.023	.980	63	.383
Ostracism_scale	physical	.130	66	.007	.921	66	<.001
	mental	.110	63	.057	.950	63	.012
warmth_scale	physical	.102	66	.088	.969	66	.097
	mental	.090	63	.200*	.976	63	.257

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Appendix H.2 Normality per Disclosure Strategy Condition

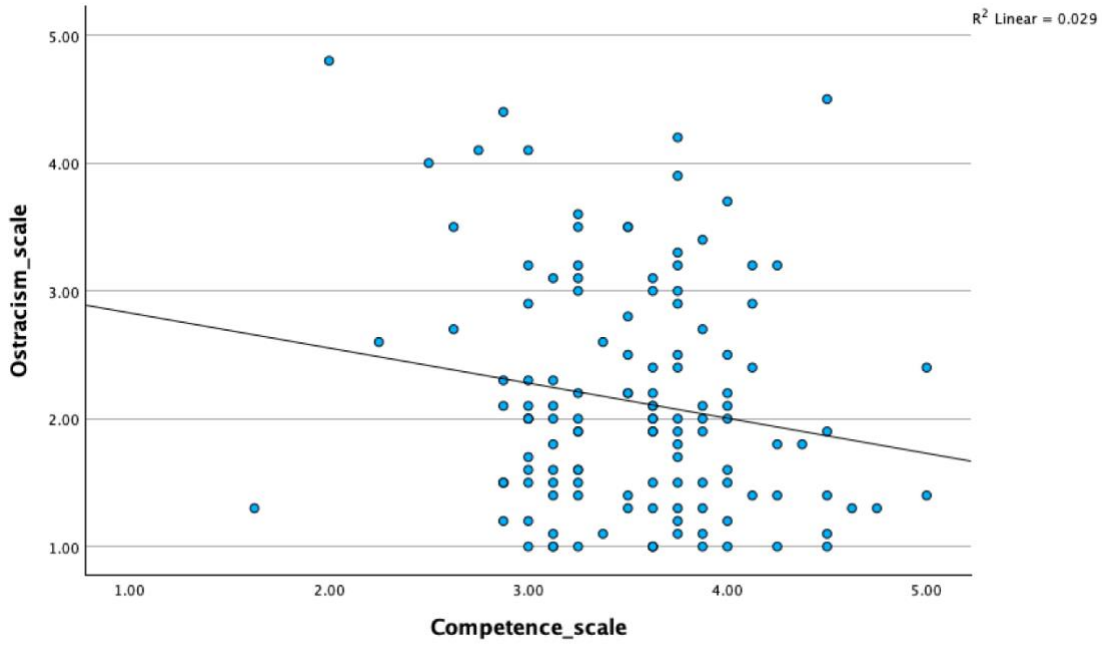
Tests of Normality

	Manipulation 3: Directness of disclosure	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
		Statistic	df	Sig.	Statistic	df	Sig.
Competence_scale	indirect	.118	63	.030	.967	63	.094
	direct	.094	66	.200*	.974	66	.189
Ostracism_scale	indirect	.144	63	.002	.904	63	<.001
	direct	.123	66	.015	.935	66	.002
warmth_scale	indirect	.085	63	.200*	.968	63	.102
	direct	.097	66	.200*	.968	66	.086

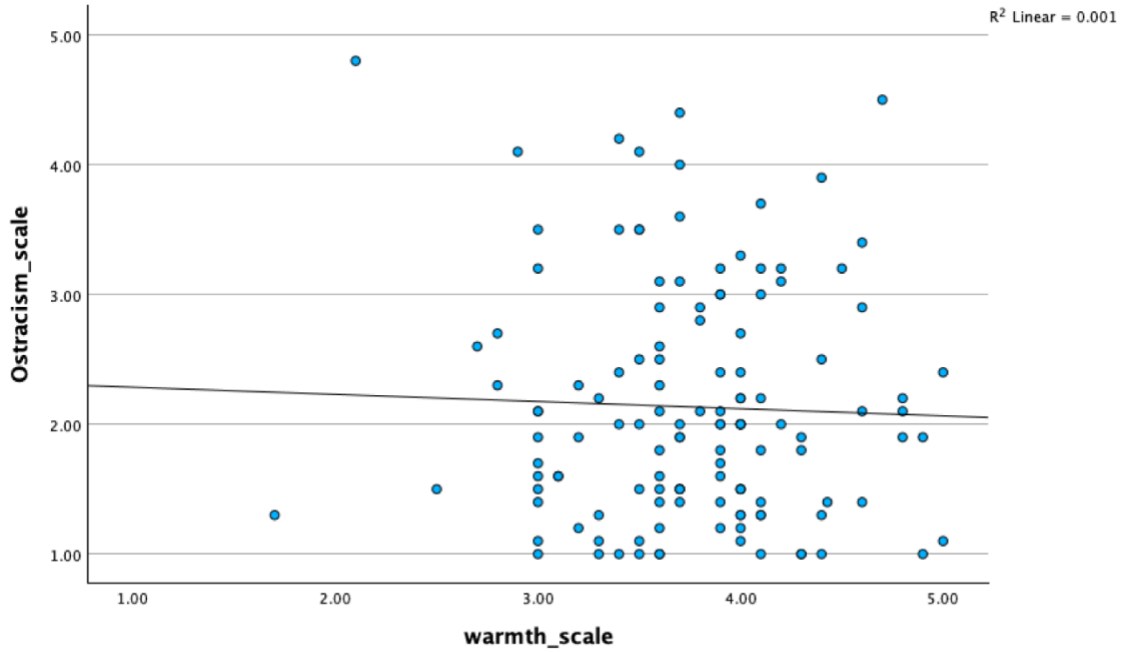
*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

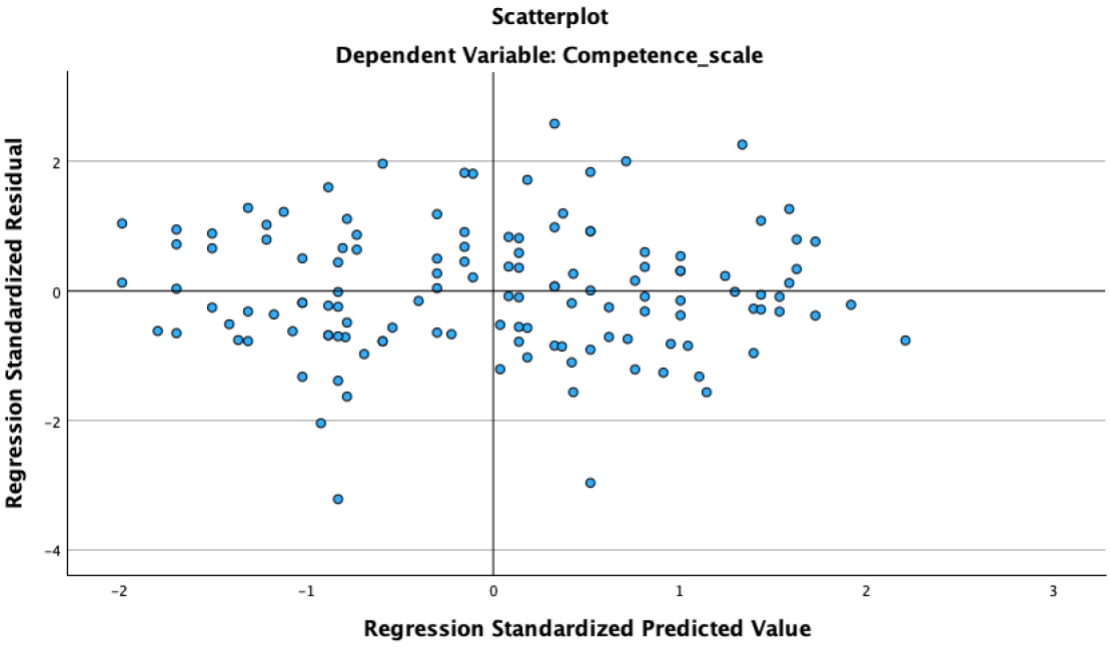
Appendix H.3 Linearity Between Competence and Ostracism



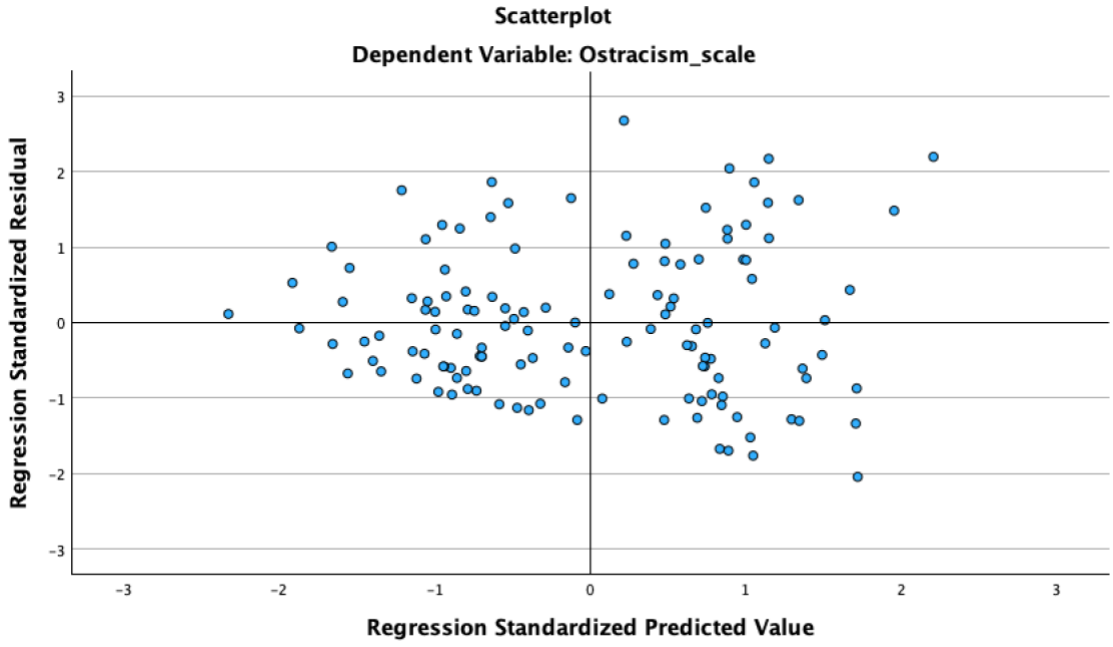
Appendix H.4 Linearity Between Warmth and Ostracism



Appendix H.5 Homoscedasticity with Competence as Outcome



Appendix H.6 Homoscedasticity with Ostracism as outcome



Appendix H.7 Levene's Test for Health Reason for Absence Manipulation

Test of Homogeneity of Variance

		Levene Statistic	df1	df2	Sig.
Competence_scale	Based on Mean	.083	1	127	.774
	Based on Median	.172	1	127	.679
	Based on Median and with adjusted df	.172	1	125.053	.679
	Based on trimmed mean	.087	1	127	.768
Ostracism_scale	Based on Mean	12.576	1	127	<.001
	Based on Median	10.323	1	127	.002
	Based on Median and with adjusted df	10.323	1	112.741	.002
	Based on trimmed mean	11.941	1	127	<.001
warmth_scale	Based on Mean	2.171	1	127	.143
	Based on Median	2.080	1	127	.152
	Based on Median and with adjusted df	2.080	1	120.921	.152
	Based on trimmed mean	2.074	1	127	.152

Appendix H.8 Levene's Test for Disclosure Strategy Manipulation

Test of Homogeneity of Variance

		Levene Statistic	df1	df2	Sig.
Competence_scale	Based on Mean	.414	1	127	.521
	Based on Median	.277	1	127	.600
	Based on Median and with adjusted df	.277	1	126.990	.600
	Based on trimmed mean	.436	1	127	.510
Ostracism_scale	Based on Mean	.374	1	127	.542
	Based on Median	.351	1	127	.555
	Based on Median and with adjusted df	.351	1	126.927	.555
	Based on trimmed mean	.369	1	127	.545
warmth_scale	Based on Mean	.377	1	127	.540
	Based on Median	.332	1	127	.566
	Based on Median and with adjusted df	.332	1	126.989	.566
	Based on trimmed mean	.377	1	127	.540

Appendix H.9 Multicollinearity Assumption for Competence Outcome

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	3.610	.149		24.263	<.001	3.315	3.904					
	How familiar are you with the health condition described in the scenario?	-.036	.043	-.079	-.842	.401	-.120	.049	-.075	-.075	-.075	.908	1.101
	Gender female	-.049	.107	-.043	-.460	.646	-.262	.163	-.055	-.041	-.041	.901	1.110
	Gender other (non-binary/fluid)	-.064	.411	-.014	-.157	.876	-.877	.749	-.020	-.014	-.014	.961	1.041
	Manipulation 1: Leadership status	.130	.101	.116	1.284	.202	-.070	.330	.104	.115	.114	.966	1.035
2	(Constant)	3.526	.148		23.855	<.001	3.234	3.819					
	How familiar are you with the health condition described in the scenario?	-.051	.047	-.112	-1.086	.280	-.145	.042	-.075	-.098	-.093	.696	1.436
	Gender female	-.109	.105	-.096	-1.038	.302	-.318	.099	-.055	-.094	-.089	.872	1.147
	Gender other (non-binary/fluid)	.047	.404	.010	.117	.907	-.753	.848	-.020	.011	.010	.928	1.078
	Manipulation 1: Leadership status	.119	.098	.106	1.209	.229	-.076	.313	.104	.109	.104	.963	1.038
	Manipulation 2: Health condition	.018	.112	.016	.157	.875	-.204	.239	-.021	.014	.014	.741	1.350
	Manipulation 3: Directness of disclosure	.322	.100	.288	3.232	.002	.125	.520	.257	.281	.278	.931	1.074

a. Dependent Variable: Competence_scale

Appendix H.10 Multicollinearity Assumption for Ostracism Intention Outcome

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Tolerance	VIF
1	(Constant)	1.845	.234		7.878	<.001	1.381	2.308		
	Manipulation 2: Health condition	.635	.177	.352	3.582	<.001	.284	.985	.741	1.350
	Manipulation 3: Directness of disclosure	.031	.158	.017	.199	.843	-.281	.344	.931	1.074
	Manipulation 1: Leadership status	-.048	.155	-.027	-.309	.758	-.356	.260	.963	1.038
	How familiar are you with the health condition described in the scenario?	-.042	.075	-.057	-.561	.576	-.190	.106	.696	1.436
	Gender female	.199	.167	.108	1.190	.236	-.132	.529	.872	1.147
	Gender other (non-binary/fluid)	.246	.641	.034	.385	.701	-1.022	1.515	.928	1.078
2	(Constant)	2.867	.550		5.211	<.001	1.777	3.956		
	Manipulation 2: Health condition	.640	.175	.355	3.658	<.001	.293	.986	.741	1.350
	Manipulation 3: Directness of disclosure	.125	.163	.069	.768	.444	-.197	.447	.858	1.166
	Manipulation 1: Leadership status	-.014	.154	-.008	-.088	.930	-.319	.292	.952	1.051
	How familiar are you with the health condition described in the scenario?	-.057	.074	-.077	-.766	.445	-.203	.090	.690	1.450
	Gender female	.167	.166	.091	1.009	.315	-.161	.495	.864	1.157
	Gender other (non-binary/fluid)	.260	.632	.036	.411	.682	-.992	1.512	.928	1.078
	Competence_scale	-.290	.142	-.180	-2.047	.043	-.570	-.010	.902	1.109

a. Dependent Variable: Ostracism_scale

Appendix H.11 Sensitivity Assumption for Competence Outcome

Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	3.1786	3.9162	3.5281	.17597	129
Std. Predicted Value	-1.986	2.206	.000	1.000	129
Standard Error of Predicted Value	.095	.389	.122	.037	129
Adjusted Predicted Value	3.0116	3.9456	3.5295	.18569	129
Residual	-1.75696	1.41418	.00000	.53364	129
Std. Residual	-3.214	2.587	.000	.976	129
Stud. Residual	-3.284	2.635	-.001	1.003	129
Deleted Residual	-1.83386	1.46658	-.00135	.56546	129
Stud. Deleted Residual	-3.425	2.702	-.002	1.015	129
Mahal. Distance	2.859	63.960	5.953	7.469	129
Cook's Distance	.000	.132	.009	.019	129
Centered Leverage Value	.022	.500	.047	.058	129

a. Dependent Variable: Competence_scale

Appendix H.12 Sensitivity Assumption for Ostracism Outcome

Residuals Statistics[a]

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	1.3019	2.9213	2.1333	.35726	129
Std. Predicted Value	-2.327	2.206	.000	1.000	129
Standard Error of Predicted Value	.148	.611	.205	.059	129
Adjusted Predicted Value	.6263	4.5737	2.1324	.43601	129
Residual	-1.74730	2.28956	.00000	.83099	129
Std. Residual	-2.044	2.679	.000	.972	129
Stud. Residual	-2.924	2.924	.001	1.034	129
Deleted Residual	-3.57371	3.57371	.00093	.96211	129
Stud. Deleted Residual	-3.020	3.020	.002	1.044	129
Mahal. Distance	2.866	64.424	6.946	7.575	129
Cook's Distance	.000	1.117	.025	.138	129
Centered Leverage Value	.022	.503	.054	.059	129

a. Dependent Variable: Ostracism_scale