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Chinese and American employers' perspectives regarding hiring people with behaviorally driven health conditions: The role of stigma

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ABSTRACT

Work opportunities for people with behaviorally driven health conditions such as HIV/AIDS, drug abuse, alcohol abuse, and psychosis are directly impacted by employer perspectives. To investigate this issue, we report findings from a mixed method design involving qualitative interviews followed by a quantitative survey of employers from Chicago (U.S.), Beijing (China), and Hong Kong (China). Findings from qualitative interviews of 100 employers were used to create 27 items measuring employer perspectives (the Employer Perspective Scale: EPS) about hiring people with health conditions. These perspectives reflect reasons for or against discrimination. In the quantitative phase of the study, representative samples of approximately 300 employers per city were administered the EPS in addition to measures of stigma, including attributions about disease onset and offset. The EPS and stigma scales were completed in the context of one of five randomly assigned health conditions. We weighted data with ratios of key demographics between the sample and the corresponding employer population data. Analyses showed that both onset and offset responsibility varied by behaviorally driven condition. Analyses also showed that employer perspectives were more negative for health conditions that are seen as more behaviorally driven, e.g., drug and alcohol abuse. Chicago employers endorsed onset and offset attributions less strongly compared to those in Hong Kong and Beijing. Chicago employers also recognized more benefits of hiring people with various health conditions. The implications of these findings for better understanding stigma and stigma change among employers are considered.

Introduction

Many people with a variety of health conditions are not able to get and/or keep good jobs, partly because of the disabilities associated with these conditions and partly because of employer concerns about hiring people from these groups, which are often based on stigma and prejudice. The stigma of health conditions is worsened when employers view the disorder as behaviorally driven; i.e., when the sufferer seems responsible for his or her illness because it was contracted as a result of actions under his or her control. We examined this situation through employers' reports of their opinions about hiring people with five health conditions: bone cancer, HIV/AIDS, mental illness (psychosis), alcohol abuse and drug abuse. Stigmatizing attitudes are likely to vary by culture, and we focused on differences between Chinese and American hiring perspectives. We used a mixed methods design in which the qualitative arm involved collecting Chinese and American employers' perspectives on the five health conditions, especially in terms of hiring people with these conditions. The subsequent quantitative survey examined perspectives as well as attributions across the five health conditions.

The constructs used here build on past research by our group (Corrigan, 2005) and others (Link & Phelan, 2001; Link, Yang, Phelan, & Collins, 2004). We focus on a form of stigma that affects stigmatized people directly, namely how stigma is reflected in employers' hiring decisions. Specifically, we use the term "hiring perspective" or simply "perspective" to refer to the multifaceted perception and interpretation of an event (here, hiring an employee) from the point of view of those in a specific role or position of power (employers). Stigma here refers to stereotypes or beliefs and attitudes that discredit those from a social group (here, those with certain health conditions). Discrimination is any behavior demonstrating unfair treatment, often arising from stigma.

The hiring perspectives of employers are especially important as employers are gatekeepers to work and its corresponding income, benefits, and inherent social network. Survey research

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suggests that some employers endorse stereotypes, including the idea that people with specific health conditions are dangerous, infectious, lazy, or childlike (Corrigan, Thompson, et al., 2003; Dickerson, Sommerville, & Origoni, 2002). These stereotypes seem to have consequences on employers' decision making. Studies have shown that employers had fewer interpersonal interactions with people labeled with specific conditions and were less likely to give these people job interviews (Farina, 2000; Farina, Holland, & Ring, 1966). Much of this research has been conducted on two groups of people: those with a mental illness and those with HIV/AIDS. What is common to these conditions is the perception that they are controllable and reflect prior behavioral decisions rather than biological processes. We adopt Weiner's (1995) terminology to distinguish between two forms of responsibility for one's condition: onset responsibility, where a person is blamed for initially contracting the condition, often because of diminished personal strength and/or a poor sense of propriety, and offset responsibility, where people are blamed for not acting to overcome their condition.

We selected five health conditions that appear to constitute a continuum of behaviorally driven disorders. At one end is serious mental illness, typically described as depression, schizophrenia, bipolar disorder or psychosis (Corrigan, River, Lundin, & Uphoff Wasowski, 2000; Weiner, Perry, & Magnusson, 1988). In addition, alcohol and drug abuse are viewed as especially negative mental conditions (Pescosolido, Monahan, Link, & Stueve, 1999), perhaps because they are understood as more behaviorally driven compared to other mental health conditions. Cancer is another condition included here because although it was once stigmatized, it is less so now (Miller, Fellows, & Kizito, 2007; Mosher & Danoff-Burg, 2007), perhaps because of ex-patients' speaking out about their illness (Gray, Doan, & Church, 1991). HIV/AIDS was included because it seems to fall in a fuzzy middle ground. At the beginning of the epidemic, HIV/AIDS was understood as a moral blemish, and sufferers were ostracized (Burkholder, Harlow, & Washkwich, 1999; Swendeman, Rotheram-Borus, Comulada, Weiss, & Ramos, 2006). As the illness became better understood and a more diverse group of people revealed that they had HIV/AIDS, attributions about responsibility diminished (World Health Organization, 2003). Admittedly, research on this topic is muddled, with some studies showing more positive stereotypes of individuals with HIV/AIDS and others not (Brown, Macintyre, & Trujillo, 2003; Herek & Glunt, 1988). Hence, we tentatively hypothesize that HIV/AIDS falls between mental illnesses and cancer on the continuum of behaviorally driven disorders.

Finally, given the inherent social character of stigma, research has sought to explain the phenomenon in terms of cultural mediators. More specifically, we expected societal forces to interact with stigma and influence employer perspectives (EL-Adl & Balhaj, 2008; Yang et al., 2007). Constructs like individualism and collectivism might be useful for explaining the interaction of cultural and stigma effects (Triandis, 2005; Triandis, Chen, & Chan, 1998). Chinese and American cultures might reflect these constructs, so we recruited employers from Chicago (relatively individualistic) and Beijing (relatively collectivist). Given Hong Kong's many years as part of the British Commonwealth, we selected it as a place with cultural influences in between those of Chicago and Beijing. Cultures higher in collectivism are expected to be more stigmatizing (Au, Hui, & Leung, 2001).

Based on past research, we established several goals and hypotheses for the study. We expected employers' self-reports of two important attributions underlying health stereotypes – onset and offset responsibility – to differ by health condition. We also expected employers' hiring perspectives to reveal other aspects of their stereotypes as bases for hiring discrimination. Consequently, we used qualitative methods to elicit critical elements of their perspectives that could then be used to create items for quantitative assessment. We then examined the relationships between these hiring perspectives and responsibility judgments. Finally, we expected more collectivistic societies to more strongly endorse restrictive perspectives about hiring people with health conditions. Hence, employers from Beijing were expected to attribute more responsibility and blame to people with behaviorally driven health conditions than were employers from Chicago, with Hong Kong employers in the middle.

Methods

We used a mixed methods approach to address the goals of this paper. We began with a qualitative study to identify elements of employers' perspectives regarding hiring people with behaviorally driven health conditions. Information from the qualitative interviews was integrated with findings from relevant existing research to develop a survey-based quantitative instrument representing employers' perspectives on the five health conditions. We then assessed the hiring perspectives and attributions of responsibility of a randomly recruited stratified sample of employers from Beijing, Chicago, and Hong Kong. Ethical approval was granted by institutional review boards at the University of Chicago, Evanston Northwestern Healthcare and Illinois Institute of Technology. Both arms of the study were conducted between July 2006 and January 2008.

Development of instrument representing employer perspectives

We conducted 90-min qualitative interviews with employees from small firms with 3–100 employees and without a human resource department. We sought only interviewees who were owners of their firms or personally charged with making hiring decisions. The enterprises in our study were selected from six sectors: business, education, health, high tech (information systems, health, travel technologies and other complex equipment), low tech (maintenance and service that do not require special training), and manufacturing (industries involved in the production of commodity and technologies). These sectors were defined by consensus of an expert panel ($N = 11$), which also made additional decisions described later in this section. The panel included researchers from Beijing, Chicago, and Hong Kong with expertise in rehabilitation psychology (important for decisions about health conditions) and industrial/organizational psychology (for work-related decisions). The expert panel used definitions of occupational titles from the U.S. Department of Labor that their Chinese colleagues reported as meaningful.

The expert panel also identified physical and mental health conditions that varied in terms of perceived responsibility (seemingly behaviorally driven). As in the definitions of business sectors, health conditions were selected for the study when they were identified as meaningful to both the American and Chinese members of the expert panel. With this in mind, five conditions were selected: drug abuse, alcohol abuse, psychosis, bone cancer, and HIV/AIDS. We selected psychosis as the mental illness because the Chinese members of the expert panel reported that schizophrenia and bipolar disorder would be unfamiliar to employers in their cities. The Chinese researchers also argued that depression is viewed more as a somatic condition in their culture. Although a bit harsh in English, the term "psychosis" was viewed by the expert panel as representing a behaviorally driven mental illness in the "serious" range. Several issues were also considered when selecting a cancer condition. The expert panel eliminated breast, ovarian, and prostate cancer from consideration because their gender-related nature might affect stigma differently across cities. The expert