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ORIGINAL PAPER

Stigma in the Mental Health Workplace: Perceptions of Peer Employees and Clinicians

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Abstract Informed by a structural theory of workplace discrimination, mental health system employees' perceptions of mental health workplace stigma and discrimination against service recipients and peer employees were investigated. Fifty-one peer employees and 52 licensed behavioral health clinicians participated in an online survey. Independent variables were employee status (peer or clinician), gender, ethnicity, years of mental health employment, age, and workplace social inclusion of peer employees. Analysis of covariance on workplace discrimination against service recipients revealed that peer employees perceived more discrimination than clinicians and whites perceived more discrimination than employees of color (corrected model $F = 9.743$ [16, 87], $P = .000$, partial $\eta^2 = .644$). Analysis of covariance on workplace discrimination against peer employees revealed that peer employees perceived more discrimination than clinicians ($F = 4.593, [6, 97], P = .000$, partial $\eta^2 = .223$).

Keywords Stigma · Perceived discrimination · Peer · Clinician · Mental health workplace

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Introduction

Recent studies show that mental health professionals around the globe, despite their involvement in anti-stigma efforts, continue to hold stigmatizing attitudes toward people with mental illnesses (e.g., Peris et al. 2008; Schulze 2007). In particular, the desire for social distance from people with mental illnesses appears to be equal to or more prevalent among mental health professionals than the general public (Lauber et al. 2004; Nordt et al. 2006; Üçok et al. 2004). At the same time, more people living with mental illnesses are joining the mental health workforce in a variety of positions (e. g., peer specialists, peer counselors, mentors and advocates) requiring both a history of and disclosure of a mental health condition (Schwenk et al. 2009). Corrigan et al. (2008) summarize these positions as "peer employees," the term used in this study.

Earlier studies showed some improvement in mental health staff's stigmatizing *attitudes* after peer employees joined the workplace (Cook et al. 1995; Dixon et al. 1994, 1997), but these studies do not specifically include the views of peer employees. In addition, no studies have examined mental health staff members' perceptions of discriminatory workplace *behaviors* toward people living with mental illnesses. Because peer employees are likely to have themselves experienced stigma and discrimination due to their mental health condition, they may perceive workplace behaviors differently than other mental health staff members.

Informed by previous research and a structural theory of workplace discrimination, this study compares peer employees' and mental health clinicians' perceptions of workplace stigma and discrimination. Perceived discrimination is critical to examine because perceptions "characterize reality for those who report it" (Banerjee 2008,

p. 381), perceived discrimination based on other stigmatized identities has been associated with negative mental health outcomes (e.g., Banks et al. 2006; Bhui et al. 2005; Noh et al. 1999; Ren et al. 1999; Schneider et al. 2000; Sellers and Shelton 2003), and perceived discrimination in the workplace may have negative consequences for employees and the organization (Deitch et al. 2003; Ensher et al. 2001; Mays et al. 1996; Sanchez and Brock 1996).

Literature Review

Stigma and People with Mental Illnesses

Goffman (1963) described mental illness stigma as the result of an individual possessing a devalued attribute, which is "deeply discrediting" and is deemed as "justif[ying] a hostile response from society" (p. 3). Corrigan and Kleinlein (2005) use a social-cognitive model to describe the stigma process. First, individuals observe signals, such as symptoms, diagnostic labels, appearance, or skill deficits. The observer reacts by forming a cognitive attitude, often based on a stereotype. Third, the individual may display explicit discriminatory behavior. In this model, stigma refers to negative implicit or explicit attitudes about people perceived to have a mental illness, and discrimination to overt behaviors (e.g., failure to hire) theorized to result from stigmatizing attitudes.

Researchers also view stigma as an issue of social justice (Corrigan et al. 2005) and compare it to the historic social justice efforts of oppressed groups such as people of color and women. Pescosolido et al. (2008) recently developed a model encompassing personal and structural factors to explain the persistence of stigma and discrimination despite interventions at the personal level. The model views stigma within its personal, organizational, and social contexts, creating opportunities for new anti-stigma interventions aimed at larger systems and complex system interactions.

Before continuing with our literature review, we note that some mental health literature uses the term *stigma* to denote prejudicial attitudes toward people with mental illnesses, while other literature considers stigma to include both prejudicial attitudes and discriminatory behaviors. For clarity in differentiating between attitudes and behaviors, this paper will use the discrete terms *prejudice* and *discrimination* rather than stigma when appropriate.

Prejudice Against People with Mental Illnesses

To date, most studies of mental illness stigma examine personal level factors and measure prejudicial attitudes. Two types of attitudes are typically measured: beliefs about prospects for the individual's improvement and recovery and the desire for social distance from the person with a mental illness. In the general public, whites, women, and people with higher income have been found to be less likely to endorse stigmatizing attitudes (Corrigan and Watson 2007). A study of community college students found that compared to African Americans, Latina/os perceived people with mental illness as less dangerous and wanted less social distance (Rao et al. 2007).

Recently a number of studies worldwide have examined stigma related to mental health professionals from two perspectives. First, professionals claim stigmatization by association, citing medical students' failure to choose psychiatry as a specialty and lower allocation of resources to psychiatric care when compared to other healthcare resources (Schulze 2007). Second, some studies have compared the attitudes of mental health professionals with those of the general public toward people with mental illnesses. This research has found that mental health professionals have social distance attitudes similar to those of the general public (Lauber et al. 2004, 2006; Nordt et al. 2006) and that they have more negative prognoses for people with mental illness than do members of the general public (Jorm et al. 1999; Peris et al. 2008). A possible explanation for the negative prognoses is that mental health professionals work with more seriously ill people, because those with more advanced recovery do not seek care as often. In contrast, Swedish psychiatric nurses had greater hope for improvement and recovery than nurses whose experience was limited to physical health settings (Bjorkman et al. 2008).

Perceived Discrimination

Perceiving that negative treatment is the result of prejudice toward people with mental illnesses requires that an event of negative treatment occur and the target or observer attribute the act to discrimination based on mental health status. Although perceiving discrimination does not necessarily mean discrimination occurred, it nevertheless is critical to examine because "perceptions do characterize reality for those who report it and therefore have real consequences for workers and employees" (Banerjee 2008, p. 381).

Studies have found that service recipients perceive experiencing stigmatizing behaviors from their mental health clinicians (Pinfold et al. 2005; Walter 1998). One study found that service recipients attributed fully one quarter of their total experienced stigma to their clinicians, reporting poor communication, negative prognoses, and failures to describe options and potential side effects of medications (Schulze and Angermeyer 2003). A review of first person accounts noted that service recipients

reported that professionals displayed stigmatizing behaviors including dehumanizing communication, infantilization, and promotion of lowered expectations (Angell et al. 2005).

Multiple studies demonstrate the negative outcomes of perceiving one to be a target of discrimination. Particularly relevant for peer employees who are living with mental illnesses, many studies have found a correlation between higher levels of perceived racial discrimination and negative mental health symptoms (Banks et al. 2006; Bhui et al. 2005; Noh et al. 1999; Ren et al. 1999; Schneider et al. 2000; Sellers and Shelton 2003), though other studies (e.g., Fischer and Shaw 1999) did not find this relationship. Research in this area also suggests those who more strongly identify with their ethnic identity are more likely to perceive subtle discrimination (Operario and Fiske 2001) and identifying positively with one's racial group decreases the negative mental health effects of perceived discrimination (Sellers and Shelton 2003).

Researchers have recently turned their attention to studying the effects of perceived discrimination on people with mental illnesses. A meta-analysis of the effects of stigma, considered broadly as both prejudice and discrimination, found that reporting stigma was associated with worse mental health among service recipients (Mak et al. 2007). Another study suggests that when people with mental illnesses internalize prejudicial attitudes, they may perceive discrimination is legitimate; their level of internalized oppression (or self-stigma) then increases when they perceive they have experienced discrimination (Rusch et al. 2006).

Workplace Discrimination

Most studies of workplace discrimination- "unfair treatment on the basis of membership in a social category" (Petersen and Dietz 2005, p. 1287)—focus on treatment based on gender, racial/ethnic group membership, or age (Goldman et al. 2006). Some of this research examines workplace discrimination as consisting of organizational-level events. These structural theories assume most current discrimination is unintentional, and that unintentional discrimination may occur from a practice that appears to be fair but leads to disparate impact (Goldman et al. 2006; also see McConahay 1986).

In her work on gender, Kanter (1977) proposed a structural theory explaining the dynamics of tokenism. The term "token" refers to members of less powerful groups (e.g., women) whose presence in the workplace makes the organization appear to be inclusive, but who are not fully incorporated into organizational culture and processes. This theory has particular relevance for understanding the experiences of peer employees, whose job description requires hiring a member of the social category of people with mental illnesses. According to Kanter, because tokens are different from those who usually fill a certain position (in this setting, being non-professionals with mental illnesses rather than professionals), they are highly visible. Their performance is closely watched to see if they are as capable as those who traditionally held the position. Their visibility also leads others to consider the tokens as representative of all members of their group; if they fail, their failure reflects poorly on all group members. Second, a contrast effect causes others to view tokens as different from themselves, leading tokens to be socially isolated while the non-tokens increase their group solidarity. Third, tokens are stereotyped and expected to take on specific roles based on these stereotypes. (See Goldman et al. 2006 for a review of recent research about token dynamics).

Research about workplace discrimination suggests that members of privileged groups may be less likely to perceive that discrimination occurs in their workplaces. For example, one study found that men of color and women were less likely than white men in the same organization to perceive the company as "fair and inclusive" (Mor Barak et al. 1998). In a study of sexual harassment, women were more likely than men to say that a situation constituted sexual harassment (Wiener et al. 2005). This latter study also found that both women and men who reported personal knowledge of sexual harassment victims were more likely to identify a situation as harassment.

The different experience of peer employees and clinicians in the mental health workforce can also be understood through the concept of microagressions (Sue 2010). Microagressions are everyday insults on the basis of some characteristic (race, gender, sexual orientation, or disability) that usually operate outside of the awareness of the perpetrator. In the workplace, microagressions can include exclusion from social events to which other employees are invited, ignoring or discrediting ideas and contributions, and supervising the individual more closely than other classes of employees (Sue 2010).

No research is available about peer employees' perceptions of the presence or effects of workplace discrimination related to mental illnesses. This area is critical to examine because studies about race-based discrimination indicate perceived discrimination in the workplace may result in such negative outcomes as lower job satisfaction, increased feelings of stress or tension at work, a decrease in volunteering to help coworkers, and lower levels of commitment to the workplace (Deitch et al. 2003; Ensher et al. 2001; Mays et al. 1996; Sanchez and Brock 1996). As noted by Goldman et al. (2006), "From an organizational standpoint, any activity that takes time away from being productive should be thoroughly scrutinized" (p. 808).

In sum, no studies could be found that examined perceptions of clinicians or peer employees about discrimination against people with mental illnesses in the mental health workplace. In addition, although existing literature suggests that some mental health professionals might hold prejudicial attitudes toward people with mental illnesses and that service recipients might perceive that they are targets of discrimination, no studies address whether peer employees also might be targets of discrimination—a critical workplace issue. This exploratory study aims to begin to address this gap.

Conceptual Framework and Research Questions

Based on the dynamics of tokenism (Kanter 1977), peer employees might be under increased scrutiny, socially isolated, and stereotyped in the workplace—all of which might lead to increased perceptions of discrimination. Because knowing someone who has experienced discrimination might lead one to identify a situation as discrimination (Wiener et al. 2005), however, it is possible that both peer employees (who likely have been targets of discrimination) and clinicians (who work with people who have been targets of discrimination) might report similar levels of discrimination against both peer employees and service recipients. Further, based on the findings of Corrigan and Watson (2007), these perceptions may vary based on gender and race.

Guided by this conceptual framework, we explored the following research questions: Do peer employees' perceptions of discrimination against service recipients in the workplace differ from mental health clinicians' perceptions? Do peer employees' perceptions that they themselves experience discrimination in the workplace differ from clinicians' perceptions about whether discrimination occurs? If differences exist, do social inclusion, gender, and race/ethnicity affect perceptions?

Method

Participants and Procedures

Peer employees and clinicians in a Southwestern US state were recruited to participate in a semi-structured internet survey hosted on SurveyMonkey. Participants were eligible if they were employed in a mental health organization: peer employees in positions requiring a current or former mental health diagnosis and clinicians in positions requiring a clinical behavioral health license. Because peer employees in particular might question confidentiality if contacted through their workplaces because so few peers worked in each clinic or agency, we recruited participants through a listserv operated by an advocacy organization. The listserv subscribers were known to include possible participants, both peers and clinicians. The listserv agreed to distribute the recruitment email to their subscribers during the period May 2006–February 2007. Individuals receiving the recruitment email were asked to forward it to others who might be eligible for the study. This snowball sampling technique is useful for exploratory studies in which participants (in this case, peer employees) might be hard to locate (Rubin and Babbie 2011). Although this non-probability sampling technique means that our results cannot be generalized, we hope that the fact that their specific workplaces are not known contributed to increased honesty in their responses. All procedures were approved by the university's Institutional Review Board.

Measures

Perceived Discrimination

Because there are no existing scales measuring perceptions of stigma or discrimination against service recipients or peer employees, an existing measure of perceived discrimination was adapted from a 3-item perceived discrimination scale used in a study of Mexican-origin adults (Finch et al. 2000). Upon examining responses to these three items, we found that the three items used in Finch, Kolodny, and Vega's (2000) scale did not meet reliability criteria for a 3-item scale, so they were analyzed as one separate item and a 2-item additive scale. The first dependent variable measured perceptions of discrimination against service recipients. We asked participants, "How often have you seen coworkers treat service recipients unfairly because they have a mental health condition?" The second dependent variable is a 2-item additive scale (Cronbach's $\alpha = .828$) measuring prejudice and discrimination against peer employees. We asked peer employees, "How often do coworkers stigmatize you because you have a mental health condition?" and "How often do coworkers treat you unfairly because you have a mental health condition?" The clinician version of these items asked "How often do coworkers stigmatize peer mentors because they have a mental health condition?" and "How often do coworkers treat peer mentors unfairly because they have a mental health condition?" (The term "peer mentors" was used for these items because of its prevalence in this state's system at the time of the study). Response options for each of the three items were *never*, *sometimes*, *often*, and *always*.

Independent Variables

Based on the conceptual framework, five independent variables are included in the analyses. We measured

employee status as 1 = *clinician* and 2 = *peer employee,* gender as 1 = *female* and 2 = *male*. Participants were asked if they were African American, Asian or Pacific Islander, Caucasian, Latino, or Native American. Because none identified as African American or Asian/Pacific Islander and only two identified as Native American, we collapsed this variable so that 1 = *person of color* and 2 = *white*. We included these three variables based on previous research suggesting that members of more privileged groups may be less likely to perceive that discrimination occurs in their workplaces (see "Literature Review"). Because people who are treated as tokens may be socially isolated and such isolation might lead to perceptions of discrimination, we used social inclusion as an independent variable. To measure social inclusion, we asked peer employees, "What has been your experience participating in social events connected to the workplace?" We asked clinicians about their experience with peer employees participating in such events. Response options were *never included*, *sometimes included*, *mostly included*, and *always included*. Because few participants reported they were never included, this variable was recoded to 1 = *never to sometimes*, 2 = *mostly*, and 3 = *always*. After recoding, the variable was treated as categorical because the distances between responses were no longer relatively equal, a requirement for treating it as a continuous variable.

Data Analysis

SPSS was used to conduct all analyses. First we computed frequencies, means, standard deviations, and correlations. In order to examine differences in group means when adjustment for a covariate correlated with the dependent variable (i.e., years of experience working in mental health) was needed, analysis of covariance (ANCOVA) was selected as an appropriate statistical method (Tabachnick and Fidell 1996). Two separate ANCOVAs were run on the dependent variables perceived discrimination against service recipients and perceived discrimination against peer employees, adjusting for years of experience working in mental health. Employee status, gender, race/ethnicity, social inclusion, and their interactions were entered as fixed factors. When significant effects and interactions were found, estimated marginal means were examined for interpretation.

All authors certify responsibility for the manuscript, and there are no known conflicts of interest.

Results

Table 1 presents the gender, race/ethnicity, age, and years of mental health work experience of clinicians and peer employees in the sample. Means and standard deviations of the independent variables in each ANCOVA are shown in Table 2.

The ANCOVA for perceptions of unfair treatment of service recipients adjusted by years of mental health work experience found significant effects for employment status and race/ethnicity (corrected model $F = 9.743$ [16, 87], $P = .000$, partial $\eta^2 = .644$) (see Table 3). The main effects showed that peer employees perceived significantly

Table 1 Descriptive statistics of independent and dependent variables by employee status ($N = 103$)

Variable	Employee status									
	Clinicians ($n = 52$)					Peer employees ($n = 51$)				
	N	%	*M*	SD	Range	*N*	%	*M*	SD	Range
Gender										
Female (=1)	34	67.4				34	67			
Male (=2)	18	33.6				17	33			
Race/ethnicity										
Person of color (=1)	10	19				10	20			
White (=2)	42	81				41	80			
Age			39.65	10.40	24–59			42.48	7.61	24–59
Years of mental health work experience			11.06	7.74	1–30			3.30	1.92	.25–9
Social inclusion										
Never to sometimes (=1)	4	7.7				16	31.4			
Mostly (=2)	16	30.8				20	39.2			
Always (=3)	32	61.5				15	29.4			
Unfair treatment of service recipients			1.385	.491	1–2			2.196	.693	1–3
Perceived discrimination against peer employees (scale)			2.885	1.096	2–6			3.294	1.221	2–6

Table 2 Unadjusted mean ratings of perceived workplace discrimination

Independent variable	Dependent variable			
	Unfair treatment of service recipients		Discrimination against peer employees	
	M	SD	*M*	SD
Employee status				
Clinician	1.383	.491	2.885	1.096
Peer employee	2.196	.693	3.294	1.221
Gender				
Female	1.882	.723	3.029	1.184
Male	1.660	.695	3.200	1.158
Race/ethnicity				
Person of color	1.600	.503	2.800	1.281
White	1.831	.762	3.157	1.142
Social inclusion				
Never to sometimes	2.200	.894	3.200	1.281
Mostly	1.833	.774	3.111	1.214
Always	1.575	.500	3.021	1.113

Table 3 Results of analysis of covariance for employee status, gender, race/ethnicity, and social inclusion on unfair treatment of service recipients adjusted by years of mental health employment ($N = 103$)

	F	*df*	*P*	Partial η^2
Employee status	27.533	1, 102	.000	.243
Gender	2.527	1, 102	.116	.029
Social inclusion	2.495	2, 101	.088	.055
Years of mental health work experience	.864	1, 102	.355	.010
Race/ethnicity	6.347	1, 102	.014	.069
Gender * race/ethnicity	.046	1, 102	.831	.001
Gender * social inclusion	.943	2, 101	.389	.022
Gender * employee status	.111	1, 102	.740	.001
Employee status * social inclusion	6.579	2, 101	.002	.133
Employee status * race/ethnicity	1.169	1, 102	.083	.013
Race/ethnicity * social inclusion	9.424	1, 102	.003	.099
Gender * employee status * social inclusion	15.463	1, 102	.000	.152

Corrected model $F = 9.743$ [16, 87], $P = .000$, partial $\eta^2 = .644$

more discrimination against service recipients than clinicians did, a strong effect. White employees perceived significantly more discrimination against service recipients than did employees of color, a weak effect. Two significant 2-way interactions were found. The first, a moderate effect of race/ethnicity by social inclusion, showed that for participants who reported peer employees were mostly socially included, whites perceived more discrimination than did people of color. The second, a strong effect of employee status by race/ethnicity, showed while peer employees perceived more discrimination overall, those peers who were people of color had the highest perceptions of discrimination occurring against service recipients. The procedure also found a significant three-way effect for the interaction of employment status, social inclusion, and gender. Female peer employees who reported less social inclusion perceived more discrimination against service recipients than did female clinicians who reported peers were less socially included. For males who felt peer employees were more socially included, clinicians perceived significantly more discrimination than did peer employees.

The ANCOVA for perception of discrimination against peer employees adjusted for years of mental health work experience ($F = 4.593$, [6, 97], $P = .000$, partial $\eta^2 = .223$) found an effect approaching significance at $P = .052$ for employee status, and a moderate effect for the 3-way interaction of gender, race/ethnicity, and employment status (see Table 4). Peer employees perceived more discrimination than did clinicians. For female participants who reported peer employees were mostly socially included in the workplace, peer employees perceived more discrimination than did clinicians. The effect was reversed for men, with clinicians perceiving more discrimination

Table 4 Results of analysis of covariance for employee status, gender, and race/ethnicity on perceived discrimination against peer employees adjusted by years of mental health employment ($N = 103$)

	F	*df*	*P*	Partial η^2
Race/ethnicity	1.054	1, 102	.308	.012
Gender	.182	1, 102	.671	.002
Social inclusion	2.158	2, 101	.122	.048
Employee status	3.890	1, 101	.052	.043
Years of mental health work experience	4.014	1, 102	.045	.040
Gender * Race/ethnicity	.117	1, 102	.745	.001
Race/ethnicity * employee status	.213	1, 102	.646	.002
Gender * employee status	.391	1, 102	.533	.005
Gender * social inclusion	.922	2, 101	.400	.021
Race/ethnicity * social inclusion	3.151	2, 101	.079	.035
Employee status * social inclusion	.169	2, 101	.845	.004
Gender * social inclusion * employee status	6.695	1, 102	.011	.072

Corrected model $F = 4.593$, [6, 97], $P = .000$, partial $\eta^2 = .223$

than peer employees. For men who felt peer employees were always socially included, peer employees perceived more discrimination than did clinicians. There was no difference for women by employment status among those who felt peer employees were always socially included.

Discussion

Limitations

This exploratory study examined the perspectives of peer employees and clinicians about discrimination toward service recipients and peer employees. Several limitations are important to consider in interpreting these findings. First, the sample is not random and is limited to one state. The response rate cannot be calculated because we do not know how many peer employees and clinicians did not respond to the invitation to participate nor do we know how many listserv subscribers forwarded the email to other possible participants; the representativeness of the sample thus cannot be known. It is possible that those who are most concerned about discrimination in the workplace were more likely than others to participate. To fully protect confidentiality, participants were not recruited through nor asked to identify their specific workplaces. It is possible that perceptions of discrimination varied widely among workplaces; differences apparently related to employee status and other factors may be at least partially due to differences among workplaces. The sample includes relatively few people of color and men. Though these sample characteristics seem consistent with the demographics of this state's mental health system employees, interpretations of findings related to people of color and men must be considered with caution. In addition, existing measures of perceived discrimination were adapted for use with this population and only one item (rather than a scale) was used to measure perceived discrimination against service recipients. Though these measures appear to have face validity, future studies are needed to develop valid and reliable measures related to this population. Finally, we did not ask clinicians if they have a mental health condition. Clinicians with mental illnesses may view discrimination differently than those who do not have a mental health condition.

Despite these limitations, several important findings emerged from this exploratory study. The findings suggest that peer employees are more likely than mental health clinicians to perceive that their workplaces are sites of discrimination against service recipients and perhaps against peer employees. The findings also suggest that white employees are more likely than employees of color to perceive discrimination against service recipients, but not against peer employees. In addition, employee status, race/ethnicity, gender, and perceptions of whether peer employees are included in social events interact in different ways to affect perceptions of discrimination against peer employees and service recipients.

The finding that many study participants perceived discrimination again service recipients is consistent with previous research (Angell et al. 2005; Schulze and Angermeyer 2003). The finding that peer employees were significantly more likely than clinicians to perceive that their coworkers discriminated against service recipients and also tended to perceive more discrimination against peer employees is consistent with findings that members of more powerful or privileged groups may be more likely to perceive their organization as "fair and inclusive" (Mor Barak et al. 1998) or to not identify a situation as harassment (Wiener et al. 2005). Wiener and colleagues also found that those who knew victims of sexual harassment personally were more likely to identify a situation as harassment. As applied to this study, we expected clinicians—who have worked with people with mental illnesses

and likely have knowledge of anti-stigma campaigns—might be just as likely as peer employees to perceive discrimination. Our findings, however, do not support this possibility.

Our findings that peer employees who report less social inclusion in the workplace perceive the highest levels of discrimination against service recipients is consistent with Kanter's (1977) theory that employees who are perceived as tokens in the workplace are socially isolated. Our finding that among women who reported the most social inclusion of peer employees, peer employees still perceived more discrimination against peer employees than did clinicians might reflect differing perceptions of social inclusion. For example, our findings might be explained if female clinicians interpreted social inclusion as acceptance but female peer employees were more able to separate social inclusion from other discriminatory incidents. It also is possible that female peer employees who participated more in social events with clinicians were exposed to increased incidents of microagressions and other forms of discrimination.

Consistent with the conceptual framework, our finding that white employees perceived more discrimination against service recipients than did employees of color may be related to the finding of Corrigan and Watson (2007) that whites were less likely to endorse stigmatizing attitudes toward people with mental illnesses than were people of color. If whites do not endorse such attitudes, they may be more likely to recognize discrimination when it occurs. Our finding that gender did not have a main effect, however, is not consistent with the findings of Corrigan and Watson.

Finally, we note that concepts from modern racism theory and work on microagressions might be useful to consider in light of our findings. Modern racism theory asserts that modern racists do not consider themselves racist and may discriminate when they hold what they consider a reasonable, non-prejudiced belief justifying what others might perceive as discriminatory behavior (McConahay 1986), a concept shared in work on microagressions (Sue 2010). For example, in the context of our study, clinicians may have lower expectations for service recipients or peer employees because they believe people with mental illnesses require less stress, or they may not be aware their expectations are too low. Acting on these lower expectations, however, may be perceived as a microagression of infantilization and may lead to increased stress, internalized oppression, and/or an increase in negative mental health symptoms for service recipients and peer employees. Based on their lower expectations, clinicians may discriminate against service recipients and peer employees in covert ways. Indeed, the covert nature of some discrimination might explain why clinicians perceived less workplace discrimination than did peer employees. Education efforts thus must address any unconscious prejudice—which staff members may consider reasonable—that leads to discrimination.

Implications for Mental Health Organizations

The fact that many study participants perceived discrimination against both service recipients and peer employees in mental health organizations has important implications for such organizations. As noted earlier, people of color who perceive that they have experienced race-based discrimination have been found to report higher levels of negative mental health symptoms. We thus must consider the possibility that mental health organizations, which aim to assist service recipients toward recovery, may in fact be exacerbating their symptoms. As organizations become more outcome-driven, they might consider that reducing discrimination in their workplace might also help improve the outcomes of service recipients.

Because mental health clinicians in our sample perceived less discrimination in the mental health workplace than did peer employees, we recommend efforts to improve the workplace climate that focus on clinician attitudes and behaviors. Mental health organizations need to develop education programs, particularly aimed at clinicians, to help them consider their own biases and understand how various behaviors can be perceived as discriminatory. Organizations can consult with established advocacy organizations or with peer employees and service recipients in the development of such programs. If the latter approach is taken, we recommend that peer employees and service recipients who are not directly connected with the organization be consulted to prevent the stress that could be caused if staff members resent the education program.

Organizations also need to assess their practices to learn whether clinicians engage in poor or dehumanizing communication, offer negative prognoses, have low expectations, and fail to describe options and potential side effects of medications, or infantilize service recipients (see Angell et al. 2005 and Schulze and Angermeyer 2003). Organizations also need to consider whether clinicians engage in similar behaviors with peer employees. Are peer employees treated as equal partners in the helping process, or do clinicians talk down to them or engage in other dehumanizing behaviors? Organizational policies (e.g., scope of work for peer employees and clinicians, decision-making responsibilities) should also be assessed for the presence of rules that may be (unintentionally) discriminatory. Organizational assessments co-conducted by service recipients, peer employees, clinicians, and administrators who know the dynamics of prejudice and discrimination—including people from a range of gender and ethnic groups and with a variety of years of mental health workplace experience—would enrich such an assessment.

Implications for Future Research

This study is the first to explore perceptions about discrimination toward peer employees in the mental health workplace. Findings from this exploratory study suggest the need for further research in several areas. First, studies with representative samples of clinicians and peer employees, including samples with more people of color and men and from a range of geographic areas, are needed. Studies also are needed to refine the measurement of social inclusion and perceived discrimination. Instruments measuring constructs such as everyday discrimination (e.g., see Deitch et al. 2003; Essed 1991) and work in the area of microagressions (see Sue 2009) might offer guidance in refining instruments measuring perceived discrimination, as would qualitative studies that focus on the experiences of peer employees and service recipients in mental health organizations. What do peer employees and clinicians mean when they report that peer employees are stigmatized or that service recipients are treated unfairly due to their mental health conditions? Studies comparing perceptions of administrators, counselors, peer employees, and service recipients within specific workplaces also are needed. Do these various actors hold differing or similar perspectives about the present of discrimination toward peer employees and service recipients within the same workplace?

Studies examining the *effects* of perceived discrimination in the mental health workplace are of critical importance, focusing on the effects of discrimination on both the targets of discrimination and on the workplace itself. Some research with people of color has found that having a strong racial or ethnic identity decreases the negative effects of perceived racism (Sellers and Shelton 2003). Future research might explore whether similar elements related to an individual's status as a person with a mental illness might have comparable moderating effects. Does having a positive identity related to one's mental illness (e.g., being proud of one's recovery or being an active member of a strong advocacy community) serve as a buffer against the negative effects of perceiving discrimination in the mental health workplace? Conversely, it also is possible that a strong identification as a person with a mental illness—as is required for peer employees—may lead to increased stress, internalized oppression (or self-stigma), and more negative mental health symptoms. Findings from studies in this area may suggest strategies for supporting peer employees.

Future research needs to examine the relationships between perceived discrimination and workplace characteristics, including the numbers and responsibilities of peer employees and clinicians, the length of time the workplace has employed peers, and the nature and extent of workplace efforts to reduce prejudice and discrimination. Finally, interventions that address perceived discrimination need evaluation. What kinds of interventions, in which types of organizations, presented by whom (e.g., organizational members or non-members, peer employers, service recipients, clinicians, administrators) might produce the most change in the mental health workplace?

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