Perceived Accommodation: An Examination of

Disability Management in the Workplace

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Abstract

Even though they are protected under the Canadian Charter of Human Rights Act, people living with disabilities have historically been the target of stigma and discrimination (Catano et al., 2016). Society has become more accepting of disabling conditions over the years, but people with disabilities continue to face an uphill battle in the workplace because of the perceived burden of accommodating them (Hernandez et al., 2000; McMahon et al., 2008). Therefore, I examined the extent to which worker perceptions of organizational treatment and accommodations were associated with well-being and functioning outcomes across the United States, Canada, and three Scandinavian countries: Sweden, Finland, and Norway. Disability acceptance and disability social rejection were consistently associated with organizational accommodation and treatment of workers with disabilities. Furthermore, differences in cultural expectations and values surrounding disability management may account for observed differences across countries in the way that workers perceive organizational treatment and accommodations.

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At some point in their life, a major portion of the population will experience living with some form of debilitating condition (United Nations [UN], 2006) be it physical, psychological, or both. In 2011, the World Health Organization (WHO) estimated that 15% of the population 15 years of age and older are affected by one or more disabilities, worldwide. Of concern is the disproportionate prevalence of poverty arising from un- or under-employment of persons with disabilities (UN, 2006, 2014). The UN (2014) reported that 50-70 percent of persons with disabilities are unemployed—even though unemployed persons living with disabilities want to work— furthermore, those who are employed tend to be in occupations/positions beneath their qualifications (Hogan et al., 2012; Schur et al., 2005; UN, 2006; Washington Times, 2005; Wehman, 2011; WHO, 2011). The resulting poverty limits the available resources to a person with a disability that could be used to reduce the debilitating impact of a physical or psychological impairment (e.g. Demerouti et al., 2001) thus contributing to a greater reliance on public support.

To correct this inequity, governments across the developed world have introduced legislation requiring employers to make their premises accessible and to accommodate persons with disabilities (disability management). Societal and organizational values and assumptions in concert with an employer's willingness to accommodate may play a role in determining the impact of a debilitating impairment on a person's well-being. Furthermore, by failing to provide adequately accessible opportunities and to

accommodate basic needs (e.g. dignity, self-esteem), organizations can indirectly create conditions that are conducive to health deterioration and impaired functioning (WHO, 2011). Therefore, I will examine workers with disabilities, how their perceptions of organizational disability management are related to their attitudes towards work and their well-being, and whether there are differences in these perceptions and associated outcomes based on the country in which they reside.

Disability

To understand the role of disabilities and accommodations in the workplace, we must first differentiate between the two terms 'disability' and 'personal condition'. A personal condition is an impairment that is inherent to a person (United Nations, 2014). Disability is the functional limitation that results from an impairment, such that a disability is contingent on the individual's experience (MacKenzie et al., 2009; UN, 2014). For example, an individual may have a speech impediment (impairment), but no functional limitation (disability). Impairment is the actual condition, and disability occurs when a person is impaired in a way that inhibits participation in society, in terms of using transportation, working, managing finances, and/or getting an education (see, UN, 2006; 2014; WHO, 2011). Therefore, experienced disability is the result of the interaction among the impairment, personal factors, and environmental factors. For example, a worker may have a chronic pain condition (impairment) that inhibit them from sitting for long periods of time. Therefore, a job that requires their work to be completed while sitting at a desk (environmental factor) may create circumstances that impair both functioning and participation in the workplace. Alternatively, if they work at a job that involves more standing and moving (which doesn't trigger the condition), their work functioning and participation would not be impaired. Moreover, using this example, even

if the job was initially developed to be completed while sitting, the workplace may be able to provide alternatives to the worker (e.g., a standing desk; opportunities to move around), which may be sufficient to allow pain-free working, and thus, the chronic pain condition would no longer constitute a functional limitation or disability.

Workplace Discrimination

From October 2017 to March 2018, the Canadian Human Rights Commission reported receiving 953 complaints on the grounds of discrimination. To address such grievances, legislation outlines procedures and considerations that need to be taken to ensure equity of treatment for protected groups of workers (Catano, et al., 2016). In this capacity, policies are in place to protect people from unjust practices (see UN, 2006). The term 'protected groups' refers to groups of people that have been deemed to be wrongfully discriminated against in the past, and thus, as a society, we have decided that these groups should be protected against future grievances (Canadian Charter Human Rights Act, 1985; Catano, et al., 2016). Thus, to discriminate is to adversely judge someone's merit because of their race, religion, age, sex, marital status, or physical or mental disability (Catano et al., 2016; UN, 2006). Discrimination also can occur when procedures exist that may appear ethical in nature, but create unfair advantages and disadvantages based on protected grounds (Catano et al., 2016; Canadian Charter of Rights and Freedoms, 1982). In other words, discriminatory practices typically involve failure to assess unique capacities and circumstances, making stereotypical assumptions, excluding persons, denying benefits, and imposing burdens based on protected status (WHO, 2011).

In contrast to more overt forms of discrimination, there are more subtle and less obvious forms of discrimination in the workplace (Canadian Human Rights Act, 1985;

UN, 2006; WHO, 2011). For instance, indirect discrimination occurs when an organization implements a policy or practice that has unintended negative effects on a protected group (Catano, et al., 2016). That is, the intent to harm protected groups is not a necessary condition for discrimination (UN, 2006). In fact, discrimination often occurs without any intent to harm or burden (UN, 2006). Therefore, our society (Lindsay et al., 2011) and workplaces can unintentionally create discriminatory barriers for persons with disabilities through negative and rigid social attitudes and beliefs. By this logic, the barriers themselves are discriminatory, and the burden should be on society to eliminate or reduce them.

The UN Convention of the Rights of Persons with Disabilities and its protocols came into effect in 2008 based on a grass roots movement from the persons living with disabilities population that sought their rights acknowledged and protected (UN, 2014). By combatting actions based on stereotypes, prejudice, harmful practices, and stigma, this convention's primary objectives were to prohibit discriminatory practices directed towards persons with disabilities and to establish reasonable accommodation without undue hardship as a requirement for employers. These objectives aimed to create an equal playing field that ultimately fosters an inclusive workplace.

In Canada, it is illegal to discriminate on grounds that are not considered covered under the BFOR (bona fide occupational requirement) defence (Catano et al., 2016). BFOR refers to policies and procedures that are specific to a certain job's requirements that are reasonably necessary to ensure efficient completion of the duties without endangering employees or the general public (Catano et al., 2016). These procedures and policies can be justified as necessary when defending against allegations of discrimination (e.g., Wayne Douglas vs. SLH Transport INC., 2010). These rules,

policies, procedures, requirements, qualifications, or factors must be shown to be necessary for the associated occupation based on empirical evidence (see, Catano et al. 2016). Therefore, people with disabilities are protected from discriminatory employment decisions based on their disability, as long as that disability is not directly relevant to the necessary job requirements. For a BFOR defence to be valid, the employer must provide evidence that the relevant policies were connected to the job, that they were adopted in good faith, that the standard is reasonably necessary, and that the employer accomplished their duty to accommodate (Catano et al., 2016). In other words, the employer must be inclusive and accommodating up to a point of undue hardship (unreasonable costs to the organization; Catano et al., 2016).

Why do we Care about Disabilities in Workplace?

Statistics Canada (2017) estimates that 19 percent of Canadians between 15 and 65 years of age live with one or more disabilities. Additionally, the proportion of people living with disabilities has increased over the years (WHO, 2011). However, people with disabilities may not feel comfortable disclosing a disability because of fear of stigmatization (Jones, 2011). Therefore, prevalence rates may be drastically underreported (Pransky et al., 1999). Given the prevalence of disabilities, and that people living with disabilities represent the largest unutilized pool of workers (Green, & Brooke, 2001), failing to properly support and accommodate people with disabilities at work may have long-term negative effects on organizations and society at large.

When organizations fail to accommodate persons with disabilities, it can have detrimental consequences for workers, the economy, and societal progress (Lindsay et al., 2010). It is no surprise that most unemployed and underemployed persons living with disabilities want gainful employment (Schur et al., 2005). Indeed, employment is often

central to a person's sense of self and well-being (UN General Assembly, 1948).

Therefore, the unemployed and underemployed population of workers with disabilities

may be at greater risk for issues related to well-being. Furthermore, when workers are not

adequately supported in the workplace, they may be incentivized to quit, be forced to go

on disability leave, or even become employed in positions beneath their qualifications

(Lindsay et al., 2010; WHO, 2011). Similarly, if people with disabilities are not given the

opportunity to provide for themselves, society will have to financially support them

(especially in more social welfare countries). There is also a case to be made for the

moral obligation to support our vulnerable populations in gainful employment,

particularly given that almost everyone either has, has had, or will have a disability at

some point in their lives (UN, 2006). Additionally, when society financially supports

people with disabilities, it may further increase negative stigma associated with people

with disabilities as they may be seen as an increased burden on society, further

exacerbating the social component of the problem (UN, 2006).

  More recently, increased attention has been directed towards the value of diversity

in the workforce (Forbes Insights, 2011), and there appears to be a consistent

organizational benefit to hiring persons with disabilities. Indeed, turnover, profits, loyalty,

and reputation are commonly associated with the employment of persons with disabilities

(e.g., Hartnett et al., 2011). From a competitive advantage perspective, innovation

increases were also observed as a result of different skills and perspectives associated

with hiring for neurodiversity (e.g. Kalargyrou & Volis, 2014; Scott et al., 2017). As one

also might expect, inclusivity and diversity in work culture were also increased in several

studies (e.g. Hernandez et al., 2008). Additionally, in a systematic review of the benefits

to hiring workers with disabilities, Lindsay et al. (2018) found that hiring people with

various disabilities can improve profitability, organizational competitiveness, and inclusivity. However, it does appear that the majority of research investigating the benefits of hiring workers with disabilities has focused primarily on profitability.

Despite these potential benefits from hiring and retaining workers with disabilities, employers still do not tend to employ workers with disabilities (Ameri et al., 2018; Hernandez et al., 2000; McMahon et al., 2008). Therefore, to effectively accommodate persons living with disabilities, we first need to understand the barriers that are preventing persons with disabilities from finding gainful employment.

Barriers to Persons Living with Disabilities

The Committee of the Rights of Persons with Disabilities (CRPD) and the International Classification of Functioning (ICF) have identified several barriers to persons with disabilities in our society (WHO, 2011) in terms of societal and workplace deficiencies, education, and attitudes towards persons with disabilities. Although these committees discussed these barriers in a general functioning and integration into society and communities' framework, several of these barriers can be examined specifically in reference to the workplace.

For example, insufficient anti-discrimination policies are detrimental because they represent the front-line defences in protecting workers with disabilities from being discriminated against in the workplace (Gilbride et al., 2003). Lack of inclusive health services can prevent persons with disabilities from accessing the support systems they need to maintain a sense of dignity, standard of living, and health needed to gain and retain gainful employment (WHO, 2011). Similarly, a lack of Employee Assistance Programs (EAPs) in the workplace, or lack of health insurance, especially in countries

that don't have socialized health care, can limit work integration and success of persons with disabilities.

Organizational decisions concerning accommodations for workers with disabilities made without consultation of the involved parties can demean and adversely affect workers with disabilities by failing to account for their unique experience (WHO, 2011). Finally, stereotypes and prejudices can be a large contributor to subtle discrimination that prevents workers with disabilities from adequately integrating into work cultures and accessing equal opportunities for growth and development (Catano et al., 2016). As a potential barrier to disability accommodation, stigma can also play a large role in the way a person with a disability is treated (WHO, 2011). Indeed, the visibility of the disability can even influence how a society is ready to treat and accommodate these individuals (Lyons et al., 2017).

Organizational Treatment of People with Disabilities

To explain why workers with disabilities are reporting exposure to discriminatory practices (Schur et al., 2005), we need to consider the influence of culture that may affect attitudes, accommodations, and policy decisions that drive organizational disability management. Along these lines, the UN has put out a significant body of work as a result of the Convention on the Rights of Persons with Disabilities looking at different ways in which people tend to perceive and respond to workers with disabilities. According to the UN (2014), societies often perceive persons with disabilities through the lens of a pity or medically based approach. The medical approach assumes that a person's disability is attached to their identity, whereas a pity approach assumes that persons with disabilities cannot provide for themselves and are therefore burdens on society (UN, 2014). Both approaches fail to support involvement and inclusion in society for persons with

disabilities. Both the medical and pity-based approaches try to attach a person's identity to their condition/disability and fail to account for environmental circumstances, and thus, experienced impairment. By deciding that these individuals cannot provide for themselves, this type of society assumes that persons with disabilities need to be provided for and ultimately fixed. These approaches can eat away at a person's sense of dignity and efficacy (UN, 2014). Although these approaches have good intentions, they are often insufficient to aid such individuals with unique circumstances in an effort to re-integrate into society and the workplace (UN, 2006). More modern approaches related to a social and human rights-based perspective considers people with disabilities such that they put the individual at the center and attempt to eliminate barriers to promote equal status in society, and thus, support their involvement within society. From this framing, instead of accommodations being perceived as providing special treatment, accommodation is perceived as removing discriminating barriers to people with disabilities. Specifically, the human rights approach is based on three core principles: dignity and freedom to make own choices, non-discrimination, and full participation in society (see, UN 2006, 2014). Consequently, by approaching disabilities in this manner, we end up framing people living with disabilities as a benefit to society instead of a burden. Moreover, the human rights model takes this human rights-based approach a step further and considers such barriers and burdens placed upon individuals with disabilities as discriminatory by nature. And thus, it is an approach that is founded on promotion of dignity and support. It is important to note that although these approaches are not necessarily empirically derived or distinct from one another, they do provide an interesting framework by which we can look at organizational approaches to disability management. Indeed, the unique nature of different disabilities calls for unique disability management solutions. Therefore, if

organizations approach disability management from different perspectives that more or less accommodate different disabilities, then we can potentially look at how associated organizational factors (e.g. social support vs. accessibility) may be associated to worker outcomes and gauge accommodation success. Furthermore, it illustrates the way we could be better treating and supporting this vulnerable population. When applied to different kinds of disabilities (e.g., a visible work injury vs. mental illness), it becomes evident that cultural beliefs and attitudes play a role in the way that society treats people with disabilities varying by visibility and social desirability (Lyons et al., 2017). Therefore, this study is inspired from the way that workers with disabilities experience different organizational approaches to disability management.

Disability Accommodation

Although specific work accommodations are generally helpful, they are often insufficient or poorly tailored to the individual and their unique situation in practice (Nevala et al., 2015; UN, 2014). The current literature has primarily focused on the feasibility of disability accommodations in the workplace. Therefore, most published research fails to account for the role of both experienced debilitation and organizational approaches to disability management (Oliver, 2014). Despite the research being conducted into disabilities, accommodation remains an elusive construct that is not easily defined or implemented (Sundar, 2017). Because disabilities are unique to a person's situation, accommodations may need to be unique to the experience of debilitation. As a result, the variety and intricate nature of different kinds of accommodations can be difficult to determine and evaluate (Kensbock et al., 2017). For example, it is often disadvantageous to disclose a disability at work due to the stigma attached to certain kinds of disabilities (Lyons et al., 2017). Likewise, some individuals may not be aware

that they are negatively affected by an impairment (Beart et al., 2005). Such is the case

for the fastest-growing disability category of learning disabilities, where many people live

with learning impairments that could be considered debilitating, yet they may assume that

their learning challenges are typical (see, for example, Beart et al., 2005; Cortiella, &

Horowitz, 2014). As a result, organizations may not be aware of the presence of workers

with disabilities in their workplaces, thus exacerbating the difficulties associated with

accommodations (Sundar, 2017).

The extent to which organizations accommodate workers with disabilities may be

a function of the country in which they operate. External factors associated with

accessibility, policies, socioeconomic status, and services affect the impact of a disability.

Therefore, elements that positively affect these factors qualify as accommodations (UN,

2014). That is, societal cultures and disability management policy approaches specific to

a country or clusters of countries that affect these external factors would directly and

indirectly influence organizations within their domain.

Country Cultures

Countries differ in their approaches to disability management, as reflected in

societal values and assumptions about people living with disabilities (culture), and their

policies and legislation (WHO, 2011). Similar to how societal culture can influence the

policies put in place by political representatives, social policies and legislation can also

influence organizational attitudes toward and support and accommodation of persons with

disabilities. For example, a country's legislation may directly or indirectly protect persons

living with disabilities.

Canada has employment legislation in the form of constitutional law, human

rights law, and employment equity legislation at provincial and federal levels that directly

addresses the organization's duty to accommodate, and outlines the process by which employers must ensure rules, policies, and practices are set up to enable workers living with disabilities to participate fully in society (Canadian Human Rights Commission, 1984). The Canadian government also has committed to signing the Open Protocol of the UN Convention on the Rights of Persons with Disabilities (Wilson & McColl, 2019).

Similarly, the United States (US) enforces the duty to accommodate, such that workers living with disabilities can gain and retain work (American Disabilities Act [ADA], 1990). In contrast to the Canadian approach, the US adopted a federal legislative body early on to standardize protections for people with disabilities across the US (McColl et al., 2010; Wilson & McColl, 2019). Canada is now considering following suit; however, new evidence suggests that despite not having federal statutory policy protections like the ADA, Canadians with disabilities appear to be significantly more integrated into society, spend more time working, and experience lives more similar to people without disabilities than their American counterparts (Wilson & McColl, 2019). When looking at Organization for Economic Co-operation & Development (OECD) countries (i.e., France, Germany, Italy, Japan, Poland), the OECD (2007) reported that persons with disabilities in the US had a below average employment rate of 39%. They also found that compared to the poverty rate for persons without disabilities (29%), 48% of persons with disabilities in the US fall below the poverty line. In both employment and poverty rate, the USA had the largest discrepancy between any OECD country between persons with disabilities and persons without disabilities.

Sweden's disability policy is based on the UN standards and ratified by the Convention on the Rights of Persons with Disabilities (2008). The Swedish Discrimination Act (2008) includes protections against direct and indirect discrimination

based on the concept of inadequate accessibility. Inadequate accessibility is defined as an

instance in which a person living with a disability is disadvantaged based on accessibility,

financial conditions, nature of the employer/employee relationship, and other

circumstances, relative to other people (Swedish Discrimination Act, 2008).

Based on a cluster analysis of disability policy model typology with reference to

OECD countries, the OECD identified three distinct clusters (OECD, 2010). The social

democratic model consists of primarily northern European countries and is characterized

by strong employer obligations, population coverage, employment and rehabilitation

programs, and comprehensive benefits. In contrast, the Liberal policy model cluster that

Canada and the US fall into is characterized by strict eligibility criteria and short sickness

benefits (OECD, 2010). Lastly, the corporatist disability model is characterized as an

intermediate cluster between the social democratic and liberal clusters with relatively

good benefits and employment programs (OECD, 2010).

According to the OCED (2007), Sweden and other social-democratic policy

models performed much better than the North American liberal approaches. Indeed,

Sweden ranked second in proportion of disability benefit recipients, they reported the

highest employment rate of OECD countries, and only 10% of persons with disabilities

fell below the poverty line (lower than the national average for persons without

disabilities).

Although all three countries have protections in place regarding one form or

another of a duty to accommodate, there appears to be marked differences in social

perspectives and approaches to legislations across countries (see, McColl et al., 2010). In

fact, despite the US having statutory protections from the ADA, Canada vastly

outperforms the US in disability outcomes even though it does not have comparable

protections (Wilson, & McColl, 2019). Furthermore, Sweden and many other more socially democratic countries (Finland, Norway) perform much better than Canada on disability outcomes. Therefore, it is important to take into consideration the country in which the workplace is located to help explore and understand differences in accommodations at work.

Therefore, I will look at employees in three different geographic areas –US, Scandinavia (i.e., Sweden, Norway, and Finland), and Canada—that have different perspectives and approaches to workplace accommodations and disability management. From a policy perspective, although it appears that Canada and the US have similar disability specific policies, they have very different disability outcomes. To contrast further, countries with more social-democratic policy models like Sweden that emphasizes full population coverage, large social benefits, and employment rehabilitation (OECD, 2010) appear to have the best disability related outcomes (OECD, 2007). Therefore, examining disability management practices from this lens could provide insight into advancing the Canadian workspace. By utilizing a cross-cultural approach to understanding disability management, we can make use of individual experiences to understand how organizations in different countries with different societal disability management policy models compare.

Measuring Experiences of Workers with Disabilities

Past research has primarily focused on specific accommodations and accommodation feasibility from the employer and organization's perspective (Sundar, 2017). Moreover, past research has primarily focused on physical disability accommodations and has largely ignored the psychological component (Kelloway, 2017; Sundar, 2017). Therefore, in order to conduct research in the area of workplace

accommodations, we first need better means of understanding the individual's experience, to better understand the underlying effects of workplace culture and disability management (Sundar, 2017; Kensbock et al., 2017).

Because there are no scales that directly measure the experiences and perceptions of workers with disabilities, I integrated previous research on perceptions of accommodation. More specifically, I compiled several scales to represent two main components of accommodation. The more common and well-researched component refers to specific accommodations and control over those accommodations.

A less researched area, but arguably just as important component (Sundar, 2017), captures attitudes and values towards workers with disabilities. Attitudes were reflected in perceived social support from the organization and coworkers, discrimination from the organization and workers, and felt workplace dignity. Specifically, the social support and coworker support items were identified as important next steps for accommodation research (Sundar, 2017; Nevala et al., 2015).

Disability During a Pandemic

COVID-19 impacted the targeted workplaces in Canada, the US, and the Scandinavian countries during the development of this project. As such, I incorporated measures into the survey to gain an understanding of how the pandemic may have influenced workers with disabilities across these geographic regions. I was interested in how COVID-19 was associated with worker well-being, whether workers from different countries experienced the consequences of COVID-19, and whether they would feel more or less accommodated and supported as a result of the changes to their work and workplace.

Summary & Hypotheses

Derived in part from the body of work that the UN (2006, 2014) has put out around the narrative surrounding the treatment of persons with disabilities, the present study extends the literature by examining organizational disability management from the perspective and experiences of workers with various kinds of disabilities (Sundar, 2017). The current research examines the experiences of workers with disabilities to better understand the role of perceived treatment, disability management, and accommodation approaches. That is, I am interested in the extent to which persons with disabilities are being supported in the workplace and how perceptions of accommodation might be associated with their health and functioning.

Hypothesis 1: Employees with disabilities that are (a) more socially acceptable, (b) more visible, (c) more debilitating, and (d) less socially ostracizing perceive their organization as more accommodating (in terms of higher social support, more accessibility, higher felt dignity, fewer discriminatory practices, and more control).

Hypothesis 2: Employees who identify their primary disability as being physical perceive their organization's approach to disability accommodation as being more accommodating (i.e., supportive, accessible, dignity, fewer discriminatory practices, and more accommodation control) compared with employees who identify their primary disability as being psychology and compared to employees with both physical and psychological disabilities.

Hypothesis 3a: Employees with disabilities who were more negatively affected by the emergence of COVID-19 report worse individual outcomes (a. higher burnout, b. lower c. work engagement, c. lower job satisfaction, and d. higher stress).

Hypothesis 3b: Employees with disabilities who are working in occupations that have a higher risk of infection report worse individual outcomes (a. higher burnout, b. lower c. work engagement, c. lower job satisfaction, and d. higher stress).

Hypothesis 4: Employees with disabilities who report that their work has changed the most as a result of the emergence of COVID-19 report worse individual outcomes.

Hypothesis 5: Employees with disabilities that report their organization as being more accommodating (i.e., accessible, dignity, fewer discriminatory practices, and more control) report better individual outcomes (a. lower burnout, b. higher c. work engagement, higher job satisfaction, and lower stress).

Based on the OECD (2010)'s distinction of country disability management policy model:

Hypothesis 6a: Employees with disabilities in countries that take a social-democratic approach to disability management (i.e., Sweden, Norway, Finland) perceive their organizations as being more accommodating (supportive, accessible, dignified treatment, fewer discriminatory practices, and more accommodation control) than employees with disabilities in countries that take a liberal approach to disability policy (i.e., Canada, US).

Hypothesis 6b: Employees with disabilities in Canada perceive their organizations as being more accommodating (supportive, accessible, dignified treatment, fewer discriminatory practices, and more accommodation control) than do employees from the US.

Methods

Participants

Using a crowd sourcing website (Prolific), invitation links to the Qualtrics survey were sent to working (part-time or full-time) participants 18 years of age or older that identify as living with a disability. I recruited participants from North America (Canada; N=69; and the US; N=69) and Scandinavia (Sweden, Denmark, and Norway; N=59) to complete a survey related to disability accommodation and wellbeing. Individuals who both did not report having a disability and did not identify as a person living with a disability were excluded from this study (N=8). Upon completion of the survey, participants inputted their identification code to receive compensation on their Prolific account (£1.25).

To check what kinds of disabilities were reported from the disability filters used on Prolific, descriptive statistics were observed. Of 233 reported disabilities, 139 were psychological disabilities, 81 were physical disabilities, and 13 disabilities were identified as not belong either category. Of the respondents, 30 participants indicated that they had both physical and psychological disabilities. Furthermore, 185 disabilities were reported as "long-term" disabilities whereas only 35 were reported as "short-term" disabilities. Of the respondents, 9 participants indicated that they had both a "short-term" and a "long-term" disability.

Measures

Participants indicated their age, gender, level of education, household income, current occupation, organization's size, disability status, disability type(s), and accommodation policies.

In order to examine the role of disability characteristics, participants completed measures of disability acceptance, rejection, impairment, and visibility.

Disability Acceptance. Disability acceptance was broken down into two separate measures: workplace disability acceptance (two items: ("I feel that my workplace is accepting of this type of disability"; I feel that my coworkers are accepting of this type of disability"; $r = .72$) and societal disability acceptance (one item: "I feel that my soceity is accepting of this type of disability"). In the absence of better scales, items were used as proxies for social disability acceptance. For all items, participants were asked to think about their primary disability and indicate the extent to which they agreed with each item using a 5-point Likert-type scale (1=strongly disagree; 5=strongly agree).

Disability Rejection. Disability rejection was measured using a modified 7-item scale of workplace ostracism/rejection from Ferris, Brown, Berry, and Lian (2008; e.g. "My colleagues ignore me"; "My colleagues treat me as if I wasn't there"). In the absence of better scales, workplace ostracism items were used as a proxy for ostracizing disabilities and stigma. Participants were asked to indicate to what extent they thought they experienced workplace social ostracism/rejection as a result of their primary disability using a 5-point Likert type scale (1= strongly disagree; 5=strongly agree). In this study, Cronbach's alpha was $\alpha = .95$.

Disability Impairment. Disability impairment was measured using a 3-item measure created for this study based on the modern definition of disability ("My disability prevents me from doings things I want to do"; "My disability affects those aspects of my life that I care most about"; "My disability does NOT interfere with achieving what I want to do"). Participants were asked to indicate the extent to which

their primary disability inhibited them using a 5-point Likert-type scale (1=strongly

disagree; 5=strongly agree). In this study, Cronbach's alpha was α=.82.

Disability Visibility. Disability visibility was measured using one created item

("How noticeable or visible is your primary disability to others at work"). Participants

were asked to rate how noticeable their primary disability was on a 5-point Likert-type

scale (1=unnoticeable; 5=very noticeable).

In order to assess organizational treatment and **accommodation experience**,

participants completed measures of support, accessibility, dignity, discrimination, and

control.

Perceived Social Support. Perceived social support in the workplace was

measured using a modified 9-item scale consisting of 5-items from Eisenberger,

Huntington, Hutchison, and Sowa (1986), and coworker social support was measured

with 4 items from the Copenhagen Psychosocial Questionnaire (Pejtersen, Hyld,

Kristensen, Borg, & Njorner, 2010). Items were modified to reference disabilities.

Participants were asked to indicate the degree of perceived organizational support they

perceived relating to their disabilities using a 5-point Likert-type scale (1= strongly

disagree; 5=strongly agree). In the current study, Cronbach's alpha was α = .89.

Because perceived social support is compiled from two separate scales, a principle

axis exploratory factor analysis was performed using an oblique rotation (direct oblimin)

to examine the factor structure (see Table 1). Based on eigenvalues greater 1, the scree

plot, percent variance accounted for (1 factor=57.2%, 2 factors=69.7%), and a visual

inspection of the factor structure, two factors were extracted. The first factor consists of

the organizational social support items, whereas the second factor consists of the

coworker social support items.

Table 1

Factor Loadings for EFA of Perceived Social Support

	Factor	
	1	2
My organization shows little concern for me. (R)	.873	
My organization ignore my disability-related complaints. (R)	.802	
My organization really cares about accommodating my disability.	.676	
My organization cares about my disability management.	.514	
My organization provides me with help and support for my disability.	.482	-.323
My coworkers ignore my disability-related complaints. (R)	.463	-.308
My coworkers provide me with help and support for my disability.		-.936
My coworkers are willing to listen to my disability-related issues and concerns at work.		-.760
My coworkers really care about accommodating my disability.		-.760

Note: (R) indicates the item is reverse scored
Factor 1 = Organization social support; Factor 2 = Coworkers social support

Dignity. Felt workplace dignity was measured using a 6-item workplace dignity scale modified from Thomas and Lucas (2019). Participants were asked to indicate the degree to which they believed their organization treated them with dignity using a 5-point Likert-type scale (1=strongly disagree; 5=strongly agree). In the current study, Cronbach's alpha was $\alpha = .90$.

Discrimination. Discrimination was measured using a 12-item scale consisting of 8 items (4 for coworker; e.g., "My coworkers discriminate against me because of my disability."; 4 for supervisor; e.g., "My supervisor treats me unfairly because of my disability.") from the Blatant Individual Discrimination and Subtle Individual Discrimination scales from Molero et al. (2013), and four items from the Workplace Prejudice/Discrimination Inventory (James & Cropanzano, 1994) that were modified to reflect disabilities as the target of discrimination. All items were scored on a 5-point

Likert-type scale (1=strongly disagree; 5=strongly agree). In the current study,

Cronbach's alpha α = .94.

Accessibility. Accessibility was measure using a created 8-item scale of different

kinds of accommodations derived from the list of accommodations listed under the ADA.

Participants were asked how willing their organization would be to provide various

accommodation types to accommodate a disability (e.g. …adjust work tasks/functions).

All items were scored on a 5-point Likert-type scale (1=strongly disagree; 5=strongly

agree). In the current study, Cronbach's alpha was α = .90.

Control. Control was measured using a 5-item scale of control and autonomy

from Tetrick, and LaRocco (1987; e.g. "I can set my own deadlines"). Accommodation

control is a scale consisting of two items taken from Tetrick, and LaRocco (1987) and

modified to specifically target accommodations (e.g. "I have control over the things that

affect my disability accommodations"). All items were scored on a 5-point Likert-type

scale (1=strongly disagree; 5=strongly agree). In the current study, Cronbach's alpha was

α = .90. An exploratory factor analysis also was conducted: there was one eigen value

greater than 1 that accounted for 63% of the variance.

In order to assess **individual outcomes** related to organizational experiences,

participants completed measures of burnout, work engagement, job satisfaction, and

stress/strain.

Burnout. Burnout was measured using the three components of the Maslach

Burnout Inventory (Maslach et al., 1996). Using a 7-point frequency scale (1= never;

7=daily), participants indicated the extent to which they agree with items pertaining to

emotional exhaustion (e.g., "I feel used up at the end of each workday"), cynicism (e.g.,

"I have become less interested in my work since I started this job"), and professional

efficacy (e.g., "In my opinion, I am good at my job). In the current study, Cronbach's alphas were α = .92 for emotional exhaustion, α = .83 for cynicism, and α = .85 for professional efficacy.

Work Engagement. Work engagement was measured using two of the three subscales from the Utrecht Work Engagement Scale. Participants completed a 16-item work engagement scale to assess dedication (e.g., "I feel happy when I am working intensely") and absorption (e.g., "It is difficult to detach myself from my job"; Schaufeli & Bakker, 2003). Participants were asked to indicate their agreement with each item on a 5-point Likert-type scale (1=strongly disagree; 5=strongly agree). In the current study, Cronbach's alpha α = .74 for dedication and α = .77 for absorption.

Job Satisfaction. Job satisfaction was measured using a 3-item measure from McDonald and MacIntyre (1997; e.g., "I feel good about working at this company"; "On the whole, I believe work is good for my physical health."; "I like my job."). Participants were asked to indicate their agreement with each item on a 5-point Likert-type scale (1=strongly disagree; 5=strongly agree). In the current study, Cronbach's alpha was α = .76.

Stress/strain. The 21-item Depression Anxiety Stress Scale (DASS) was used to assess stress (e.g., "I find myself getting agitated"). Participants were asked to indicate the degree to which each statement applied to them over the last week on a 5-point Likert-type scale (1=strongly disagree; 5=strongly agree). In the current study, Cronbach's alpha was α = .88.

Results

Descriptive statistics and correlations for the study variables are presented in Table 2. Prior to each multiple regression, assumptions were assessed for normality,

linearity, multicollinearity, homoscedasticity, and outliers on key variables. The data was examined for univariate and multivariate outliers, however, only one participant was removed for a Cook's distance value greater than 1. Normality was assessed by an inspection of the Q-Q plots of the standardized residuals, no egregious violations were observed. Linearity was also evaluated using p-plots of the standardized residuals, but no large discrepancies were observed. The residual was also plotted against predicted values, but homoscedasticity was determined to be satisfactory. Collinearity was also examined and yielded no tolerance values smaller than .4.

Table 2

Means, Correlations, and Internal Consistencies of Study's Variables (N=195)

Study Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
M	--	32.67	3.77	2.97	3.53	2.38	3.38	3.31	3.17	4.00	2.03	2.98	3.15
(SD)	--	(9.94)	(1.01)	(1.26)	(1.08)	(1.11)	(.72)	(.97)	(.98)	(.83)	(.84)	(1.00)	(1.03)
1. Gender[1]	-												
2. Age	-.02	-											
3. Impairment	.10	.07	(.82)										
4. Societal acceptance	-.20[b]	.00	-.39[b]	-									
5. Work acceptance	-.08	.07	-.29[b]	.55[b]	(.72*)								
6. Visibility	-.14	.10	.04	.06	.02	-							
7. COVID-19 impact	.20[b]	-.10	.39[b]	.20[b]	-.29[b]	.21[b]	(.80)						
Organizational variables													
8. Coworker social support	.06	.03	-.35[b]	.62[b]	.37[b]	.08	-.09	(.87)					
9. Organizational social support	-.12	.05	-.29[b]	.58[b]	.32[b]	.04	-.25[b]	.66[b]	(.87)				
10. Dignity	.01	.02	-.25[b]	.25[b]	.49[b]	.01	-.14[a]	.57[b]	.61[b]	(.90)			
11. Discrimination	.00	-.08	.18[a]	-.24[b]	-.49[b]	.24[b]	.30[b]	-.48[b]	-.48[b]	-.60[b]	(.94)		
12. Accessibility	.01	.04	-.22[b]	.19[b]	.46[b]	.09	-.01	.59[b]	.64[b]	.45[b]	-.29[b]	(.90)	
13. Control/autonomy	-.12	.05	-.29[b]	.24[b]	.45[b]	-.04	-.16[a]	.45[b]	.51[b]	.37[b]	-.27[b]	.64[b]	(.90)
Individual outcomes													
14. Dedication	.06	.06	-.12	.24[b]	.33[b]	.05	-.09	.37[b]	.33[b]	.48[b]	-.25[b]	.38[b]	.44[b]
15. Absorption	.07	.03	-.12	.09	.38[b]	-.01	-.07	.41[b]	.33[b]	.41[b]	-.24[b]	.36[b]	.40[b]
16. Exhaustion	.08	-.13	.34[b]	-.26[b]	-.42[b]	.06	.38[b]	-.32[b]	-.40[b]	-.25[b]	.31[b]	-.29[b]	-.38[b]
17. Cynicism	-.05	-.14	.19[b]	-.15[a]	-.44[b]	.06	.24[b]	-.40[b]	-.46[b]	-.49[b]	.44[b]	-.36[b]	-.39[b]
18. Self-efficacy	.05	.13	-.20[b]	.19[b]	.41[b]	-.16[a]	-.25[b]	.38[b]	.31[b]	.38[b]	-.37[b]	.24[b]	.33[b]
19. Job satisfaction	.10	.09	-.20[b]	.17[a]	.41[b]	-.09	-.19[b]	.45[b]	.48[b]	.48[b]	-.32[b]	.45[b]	.47[b]
20. Stress/strain	.16[a]	-.16[a]	.37[b]	-.32[b]	-.28[b]	.08	.51[b]	-.11	-.24	-.11	.22[b]	-.08	-.23[b]
21. Social Rejection	-.08	.02	.17[b]	-.24[b]	-.38[b]	.19[b]	.20[b]	-.43[b]	-.38[b]	-.57[b]	.74[b]	-.22[b]	-.21[b]
22. Absenteeism	-.05	-.09	.26[b]	-.16[a]	-.24[b]	.00	.18[a]	-.17[a]	-.17[a]	-.09	.17[a]	-.08	-.15[a]

Note. Cronbach's α are reported on the diagonal. [a] $p < .05$. [b] $p < .01$; [1] 1= men 2= women; - one item measure; * Inter-item correlation

Table 2 (continued)

Means, Correlations, and Internal Consistencies of Study's Variables (N=195)

Study Variables	14	15	16	17	18	19	20	21	22
M	3.25	3.34	3.14	2.78	4.00	3.52	3.26	1.70	5.98
(SD)	(1.01)	(.87)	(1.61)	(1.37)	(1.17)	(.98)	(.96)	(.94)	(15.38)
14. Dedication	(.74)								
15. Absorption	.75[b]	(.77)							
16. Exhaustion	-.36[b]	-.28[b]	(.92)						
17. Cynicism	-.59[b]	-.54	.65[b]	(.83)					
18. Self-efficacy	.46[b]	.50[b]	-.21[b]	-.45[b]	(.85)				
19. Job satisfaction	.63[b]	.67[b]	-.41[b]	-.61[b]	.52[b]	(.76)			
20. Stress/strain	-.12	.03	.51[b]	.31[b]	-.18[a]	-.25[b]	(.88)		
21. Social Rejection	-.21[b]	-.20[b]	.22[b]	.39[b]	-.32[b]	-.29[b]	.15[a]	(.95)	
22. Absenteeism	-.09	-.07	.22[b]	.18[a]	-.20[b]	-.11	.24[b]	.14	-

Note. Cronbach's α are reported on the diagonal.

- one item measure

[a] $p < .05$. [b] $p < .01$

Disability

To test Hypothesis 1, that employees with disabilities that are more socially acceptable, more visible, more debilitating, and less socially ostracized, perceive their organization as more accommodating, a series of standard multiple regressions were performed.

In the analyses, perceptions of organizational treatment and accommodations (coworker social support, organizational social support, dignity, discrimination, and accommodation control) were represented as the dependent variables and disability characteristics (workplace disability acceptance, social rejection, visibility, and impairment) as the independent variables. Table 2 displays the unstandardized regression coefficients b and R^2. The four IVs combined accounted for a significant amount of variance in coworker social support ($F(4, 185) = 41.0$, $p < .001$, $R^2 = .47$), organizational social support ($F(4, 185) = 29.1$, $p < .001$, $R^2 = .39$), dignity ($F(4, 185) = 38.2$, $p < .001$, $R^2 = .45$), discrimination ($F(4, 185) = 72.6$, $p < .001$, $R^2 = .61$), accessibility ($F(4, 185) = 14.2$, $p < .001$, $R^2 = .24$), and accommodation control ($F(4, 185) = 13.6$, $p < .001$, $R^2 = .23$). Workplace disability acceptance ($b= .43$, $t= 8.01$, $p<.001$), impairment ($b=-.17$, $t=-3.16$, $p=.002$), social rejection ($b=-.25$, $t=-4.14$, $p<.001$), and disability visibility ($b=.10$, $t=2.14$, $p=.03$) all were unique and significant predictors of coworker social support. Workplace disability acceptance ($b= .42$, $t= 7.24$, $p<.001$), impairment ($b=-.14$, $t=-2.27$, $p=.005$), and social rejection ($b=-.21$, $t=-3.13$, $p=.002$) all were unique and significant predictors of organizational social support. Workplace disability acceptance ($b=.22$, $t=4.59$, $p<.001$), social rejection ($b=-.41$, $t=-7.83$, $p<.001$), and impairment ($b=-.10$, $t=-2.02$, $p<.044$) were all unique predictors of dignity. Workplace disability acceptance ($b=-.19$, $t=-4.81$, $p<.001$), disability visibility ($b=.09$, $t=2.62$, $p=.01$), and social rejection

(b=.56, t=12.3, p<.001) were significant predictors of discrimination. Workplace

disability acceptance was the only unique predictor of accessibility (b=.38, t=5.70,

p<.001) and accommodation control (b=.46, t=5.60, p<.001). In line with Hypothesis 1,

workers with disabilities reported as being more socially acceptable and less socially

ostracizing reported better organizational treatment and accommodations. However,

contrary to Hypothesis 1, workers with disabilities reported as being more impairing,

reported worse organizational treatment and accommodations; workers with disabilities

reported as being more visible did not report better organizational treatment and

accommodations.

Table 3

Multiple Regression of Perceived Organizational Treatment and Accommodation on Disability Characteristics (N= 187)

	Perceived organizational treatment and accommodation					
	Organizational support	Coworker social support	Dignity	Discrimination	Accessibility	Accommodation control
	b	b	b	b	b	b
1. Workplace disability acceptance	.42[c]	.43[c]	.23[c]	-.19[c]	.38[c]	.46[c]
2. Social rejection	-.21[c]	-.25[c]	-.41[c]	.56[c]	-.07	-.08
3. Visibility	.06	.10[a]	.06	.09[b]	.09	-.03
4. Impairment	-.14[b]	-.17[b]	-.10[a]	.00	-.10	-.14
Total R^2	.39[c]	.47[c]	.45[c]	.61[c]	.24[c]	.23[c]

Note. [a] $p < .05$; [b] $p < .01$; [c] $p < .001$.

To add to our understanding of disability characteristics, and to test Hypothesis 2 a MANOVA was used to assess whether disability type (1=physical disability; 2=psychological disability; 3=both physical and psychological disabilities) was associated with organizational treatment and accommodations. There was no multivariate statistically significant difference in organizational treatment and accommodations based on disability type, $F(12, 344)=1.11$, Wilk's $\Lambda=.93$, $p=.39$, $\eta_p^2=.04$. As part of an exploratory investigation of the unexpected relationship out of interest, the univariate effects were observed as presented in Table 3. Only accommodation control was significantly related to disability type $(F(2,177)= 4.74, p=.01, \eta_p^2=.051)$, such that workers with physical disabilities reported having more accommodation control than workers with psychological disabilities. To further investigate the role of disability type, a follow up one-way ANOVA analysis was conducted to determine whether the nonsignificant relationship could be the consequence of no differences in disability acceptance across disability types.. Results showed that disability type was predictive of perceived workplace disability acceptance $(F(2, 177)=4.74, p=.048)$, with physical disabilities being the most accepted in the workplace.

Table 4

Univariate Effects of Disability Type (1=Psychological, n=101; 2=Physical, n=50, 3=Both Physical and Psychological, N=29)

Dependent variable	$F_{(2,177)}$	η_p^2	Disability type	Means	LL	UL
Coworker	.65	.007	Psychological	3.250	3.065	3.435
social support			Physical	3.385	3.122	3.648
			Both	3.147	2.802	3.492
Organizational	2.92	.03	Psychological	3.042	2.854	3.229
social support			Physical	3.404	3.137	3.671
			Both	2.966	2.615	3.316
Dignity	1.26	.01	Psychological	3.936	3.776	4.096
			Physical	4.140	3.912	4.368
			Both	3.897	3.598	4.195
Discrimination	1.07	.01	Psychological	2.101	1.937	2.265
			Physical	1.897	1.664	2.130
			Both	2.095	1.789	2.401
Accessibility	1.97	.02	Psychological	2.897	2.705	3.090
			Physical	3.195	2.921	3.469
			Both	2.810	2.451	3.170
Accommodation	4.74[a]	.051	Psychological	3.020	2.790	3.250
control			Physical	3.640	3.313	3.967
			Both	3.155	2.726	3.584

Note. [a] $p < .05$; [b] $p < .01$; [c] $p < .001$.

COVID-19

To test whether COVID-19 is associated with workers with disabilities (i.e., Hypothesis 3 and 4), I conducted a series of standard multiple regressions to examine the relationships of COVID-19 impact, COVID-19 work changes, and risk of infection at work as the independent variables and individual outcomes as the dependent variables (see Table 3). The COVID-19 factors jointly accounted for a significant amount of variance in burnout (exhaustion, $F(3, 189)=14.8$, $p<.001$, $R^2=.19$; cynicism, $F(3, 189)=6.37$, $p<.001$, $R^2=.09$; Professional efficacy, $F(3, 189)=4.49$, $p<.001$, $R^2=.06$), $R^2=.03$), job satisfaction ($F(3, 189)=6.43$, $p<.001$, $R^2=.09$), and stress/strain ($F(3,

189)=25.8, $p<.001$, $R^2=.26$), but not in work engagement (dedication, F(3, 189)=2.22, $p=.09$, and absorption, F(3, 189)=2.80, $p=.059$, $R^2=.04$).

COVID-19 impact ($b=.82$, t=-5.23, $p<.001$) and risk of infection ($b=.24$, $t=2.76$, $p=.006$) were uniquely associated with exhaustion. COVID-19 impact ($b=.49$, $t=3.44$, $p<.001$) and risk of infection ($b=.15$, $t=1.99$, $p=.047$) were uniquely associated with cynicism, whereas only COVID-19 impact ($b=-.42$, t=-.35, $p<.001$) was uniquely associated with professional efficacy. COVID-19 impact ($b=-.28$, $t=-2.82$, $p=.005$) and changes ($b=.19$, $t=2.89$, $p=.004$), and risk of infection ($b=-.12$, $t=-2.14$, $p=.033$) were uniquely associated with job satisfaction. Only COVID-19 impact was uniquely associated with stress ($b=.64$, $t=7.24$, $p<.001$). Hypothesis 3a was supported, such that workers who reported greater negative impact of COVID-19 also reported worse individual outcomes. Hypothesis 3b was also supported, such that workers in job that were at greater risk of infection reported worse individual outcomes. In contrast, Hypothesis 4 was not supported, such that job satisfaction was the only outcome of interest that was significantly associated (and in the opposite direction) with work changes as a consequence of the COVID-19 pandemic.

Table 5

Regression of Individual Outcomes on COVID-19 Factors (Impact, Changes, and Risk) (N= 193)

	Individual outcomes												
	Burnout						Work Engagement						
	Exhaustion		Cynicism		Professional efficacy		Dedication		Absorption		Job satisfaction		Stress/ strain	
	b	ΔR^2	b	ΔR^2	b	ΔR^2	b	ΔR^2	b	ΔR^2	b	ΔR^2	b	ΔR^2
1. COVID-19 impact	.82[c]		.44[c]		-.48[c]		-.12		-.08		-.29[b]		.64[c]	
2. COVID-19 changes	-.03		.12		.11		.08		.11		.19[b]		-.02	
3. Risk of infection	.24[b]		.15[a]		-.02		-.06		-.10		-.12[a]		-.03	
Total R²		.19[c]		.09[c]		.08[b]		.03		.04[a]		.09[c]		.26[c]

Note. [a] $p < .05$; [b] $p < .01$; [c] $p < .001$.

Organization

To test Hypothesis 5, that physical accommodations (accessibility and accommodation control) and psychosocial treatment (felt workplace social support, felt workplace dignity, and experienced discrimination) are both uniquely associated with worker outcomes, I conducted a series of hierarchical multiple regressions. Table 5 displays the unstandardized regression coefficients and R^2. Accessibility, accommodation control, coworker social support, organizational social support, dignity, and discrimination jointly accounted for a significant amount of variance in exhaustion, $F(6, 185)=9.86$, $p<.001$, $R^2=.24$; cynicism, $F(6, 185)=14.9$, $p<.001$, $R^2=.33$; professional efficacy, $F(6, 185)=8.87$, $p<.001$, $R^2=.22$), work engagement (dedication, $F(6, 185)=8.32$, $p<.09$, $R^2=.18$; absorption, $F(5, 185)=11.8$, $p<.001$, $R^2=.28$), job satisfaction ($F(6, 185)=17.5$, $p<.001$, $R^2=.36$), and stress/strain ($F(6, 185)=3.98$, $p<.001$, $R^2=.11$). In the first step, control/autonomy ($b=-.55$, $t=-4.04$, $p<.001$) was a unique and significant predictor of exhaustion, whereas in the second step organizational social support ($b=-.47$, $t=-2.7$, $p=.007$) and discrimination ($b=.41$,, $t=2.41$, $p=.017$) were all unique significant predictors of exhaustion. Control ($b=-.39$, $t=-3.41$, $p=.001$), access ($b=-.25$, $t=-2.11$, $p<.001$), dignity ($b=-.31$, $t=-2.03$, $p=.044$), and discrimination ($b=-.30$, $t=-2.26$, $p=.03$) were uniquely and significantly associated with cynicism. Only control ($b=-.33$, $t=-3.21$, $p=.002$), and coworker social support ($b=-.23$, $t=2.02$, $p=.04$) were significantly associated with professional efficacy.   Only control was uniquely and significantly associated with dedication ($b=.22$, $t=3.55$, $p<.001$). Control ($b=.24$, $t=3.20$, $p=.002$), accessibility ($b=.16$, $t=2.14$ $p=.034$), coworker social support ($b=.20$, $t=-2.41$, $p=.017$), and dignity ($b=-.36$, $t=3.63$, $p<.001$) were uniquely and significantly associated with absorption. Control ($b=.27$, $t=3.65$, $p<.001$), accessibility ($b=.27$, $t=3.37$, $p<001$), and

dignity (b=.37, t=3.51, p<.001) were uniquely and significantly associated with job satisfaction. Control (b=-.25, t=-2.94, p=.004) and discrimination (b=.22, t=2.01, p=.046) were uniquely and significantly associated with stress/strain. Hypothesis 5 was supported; such that organizational accommodations and treatment were significantly associated with better individual outcomes. Furthermore, the organizational treatment domain (step 2) was significantly associated with individual outcomes beyond the organizational accommodations' domain (step 1).

Table 6

Regression of Individual Outcomes on Perceived Organizational Treatment and Accommodations (N= 192)

	Individual outcomes												
	Burnout						Work engagement						
	Exhaustion		Cynicism		Professional efficacy		Dedication		Absorption		Job satisfaction		Stress/strain	
	b	ΔR^2	b	ΔR^2	b	ΔR^2	b	ΔR^2	b	ΔR^2	b	ΔR^2	b	ΔR^2
Step 1		.16[c]		.18[c]		.11[c]		.17[c]		.18[c]		.25[c]		.05[b]
1. Accessibility	-.09		-.23		.06		.09		.16[a]		.27[c]		.22[a]	
2. Control/ autonomy	-.55[c]		-.39[c]		.33[c]		.23[c]		.25[c]		.27[c]		-.28[c]	
Step 2		.09[c]		.15[a]		.12[c]		.04[a]		.10[c]		.11[c]		.06[a]
1. Coworker social support	-.07		-.025		.23[a]		.13		.20[a]		.11		.08	
2. Organizational social support	-.45[c]		-.20		-.03		-.01		-.09		.11		-.27[a]	
3. Dignity	.30		-.31[a]		.19		.13		.36[c]		.37[c]		.16	
4. Discrimination	.41[a]		.31[a]		-.23		.01		.13		.09		.22[a]	
Total R^2		.24[c]		.33[c]		.22[c]		.22[c]		.28[c]		.36[c]		.11[c]

Note. [a] $p < .05$; [b] $p < .01$; [c] $p < .001$.

Country Analyses

To test Hypothesis 6a and 6b, that country and cultural disability policy approach were associated with organizational treatment and accommodations MANCOVA was conducted with planned contrasts to compare disability policy models (liberal vs. social democratic). It was expected in Hypothesis 6a that Scandinavian workers would report better organizational treatment and accommodations than workers in North America. Whereas, it was expected in Hypothesis 6b that Canadian workers would report better organizational treatment and accommodations than workers in the US. Perceived organizational treatment and accommodations was reflected through 5 dependent variables. The 5 dependent variables consisted of social support, dignity, discrimination, access, and accommodation control. The MANCOVA was statistically analyzed while controlling for disability characteristics (impairment and visibility) as well as COVID-19 impact. There was a statistically significant difference in organizational treatment and accommodations based on country, $F(12, 366)=1.98$, Wilk's $\Lambda=.88$, $p=.025$, $\eta_p^2=.061$. Significant univariate effects were found for coworker social support ($F(2,188)=4.44$, $p=.013$, $\eta_p^2=.045$), organizational social support ($F(2,188)=7.82$, $p=.001$, $\eta_p^2=.077$), and accommodation control ($F(2,188)=4.76$, $p=.01$, $\eta_p^2=.048$, such that the workers with disabilities from the US and Canada reported experiencing better coworker social support($M_{Canadadiff}=.44$, $p=.011$; $M_{USdiff}=.48$, $p=.007$), organizational social support ($M_{Canadadiff}=.55$, $p=.001$; $M_{USdiff}=.63$, $p<.001$), and accommodation control ($M_{Canadadiff}=.46$, $p=.03$; $M_{USdiff}=.66$, $p=.003$) than workers with disabilities from Scandinavia. Additionally, workers with disabilities from the US reported experiencing better accessibility ($M_{diff}=.38$, $p-=.018$) than Scandinavian workers.

Contrary to Hypothesis 6a, planned contrasts revealed that workers living with disabilities in countries that take a social-democratic approach to disability policy model report significantly worse coworker social support (t=-.46, *p*= .003), organizational social support, (*t*=-.59, *p*<.001), accessibility (*t*=-.35, *p*=.036) and accommodation control (*t*=-.56, *p*=.004). Furthermore, contrary to Hypothesis 6b, no significant univariate differences were observed between Canadian and American workers with disabilities.

Table 7

MANCOVA of Country (1=Canada, N=68; 2=US, N=69; 3=Scandinavia, N=55)

Effect	Wilks' $F_{(12, 366)}$	Coworker social support	Org. social support	Dignity	Discrimination	Access	Accommodation control
			Univariate analysis of variance $F_{(2, 185)}$				
Country	.88[a]	4.44[b]	7.82[b]	1.15	1.76	2.57	4.76[a]
MS_{erro}		.67		.65	.62	.96	1.36
	$F_{(6, 183)}$			Covariates $F_{(1, 185)}$			
COVID-19 impact	.79[c]	3.64		.001	.61	.08	.003

Note. [a] $p < .05$. [b] $p < .01$. [c] $p < .001$.

Table 8

Univariate Effects of Country

Dependent variable	F (2,192)	η_p^2	Country	Means	LL	UL
Coworker social support	4.44[a]	.045	Canada	3.425	3.198	3.651
			US	3.456	3.229	3.682
			Scandinavia	2.981	2.725	3.236
Org. social support	7.82[b]	.077	Canada	3.290	3.070	3.509
			US	3.370	3.150	3.590
			Scandinavia	2.741	2.493	2.989
Dignity	1.15	.012	Canada	4.117	3.920	4.314
			US	3.992	3.794	4.189
			Scandinavia	3.890	3.668	4.113
Discrimination	1.76	.018	Canada	1.929	1.738	2.121
			US	2.000	1.808	2.192
			Scandinavia	2.199	1.983	2.415
Accessibility	2.57	.027	Canada	3.008	2.768	3.247
			US	3.151	2.911	3.391
			Scandinavia	2.733	2.463	3.004
Accommodation control	4.76[a]	.048	Canada	3.276	2.996	3.557
			US	3.471	3.191	3.752
			Scandinavia	2.812	2.496	3.129

Note. [a] $p < .05$. [b] $p < .01$. [c] $p < .001$.

Discussion

The goals of this study were to examine how workers with varying disabilities perceived workplace treatment and accommodations (Hypotheses 1 and 2), how COVID-19 is related to the well-being and work functioning of workers with disabilities (Hypotheses 3a, 3b, and 4), how perceived workplace treatment and accommodations are related to worker well-being and functioning (Hypothesis 5), and how these perceptions differed across countries and cultural disability policy models (Hypothesis 6a and 6b).

Disabilities

The first goal of the study was to examine whether workers with disabilities that are more socially acceptable, less socially ostracizing, more visible, and more impairing, reported experiencing better workplace treatment and accommodations (Hypothesis 1).

Past research suggests that organizations may be more likely to support and accommodate disabilities that are more easily noticeable and that generate more sympathy and empathy (Lee, 1996; Popovich, et al., 2003; Sundar, 2017; Telwatte et al., 2017). Consistent with past research, I found workplace disability acceptance and disability social rejection were the disability characteristics most consistently associated with better perceived workplace accommodations and treatment.

Contrary to Hypothesis 1 disability visibility was positively related to both the discrimination and coworker social support dimensions of workplace treatment. Interestingly, it appears that workers that report that their disability is more noticeable, perceived both increased discrimination and coworker social support. This finding could be support for an interaction or suppression effect, such that if a disability is more easily noticeable, then sometimes it may be linked to more discriminatory practices, whereas other times, it may be linked to more support. Another potential explanation may exist in which more discriminatory practices directed towards a worker with a noticeable disability may be linked to more coworker support to compensate (Goussinsky, 2020; Sloan, 2012). Likewise, contrary to Hypothesis 1, disability impairment was negatively associated with coworker social support, organizational social support, and dignity dimensions. Therefore, I found that workers who needed support the most, reported

receiving the least. This finding follows past research, such that organizations that perceive more associated costs and burden with hiring a person with a disability is less likely to do so (Hernandez et al., 2008; 2000).

Past research also shows that organizations are particularly bad at supporting/accommodating psychological disabilities as opposed to physical disabilities (Kelloway, 2017; Sundar, 2017). Therefore, in Hypothesis 2, it was anticipated that psychological disabilities would be associated with worse perceptions of workplace treatment and accommodations. However, the multivariate analysis was not significant, and therefore the hypothesis was not supported. This finding is interesting given that past research seems to suggest that physical disabilities are more readily accommodated and thus accepted.

In a follow up analysis, I also found that physical disabilities were reported as being more accepted in the workplace than psychological disabilities. Perhaps one explanation as to why disability type was not associated with organizational treatment and accommodations but was associated with workplace disability acceptance could be that psychological disabilities are less likely to be disclosed and known within an organization (Brohan, et al., 2012). This potential explanation would also partly explain why at the univariate level only accommodation control was reported significantly higher for psychological disabilities. In other words, when a person with a disability does not disclose, then they are inherently less involved with the accommodation process.

COVID-19

Hypothesis 3a looked at the extent to which negative COVID-19 experiences were associated with workers outcomes. Hypothesis 3a was partially supported such that workers with disabilities who reported being more negatively impacted by the COVID-19 pandemic also reported having higher burnout, lower job satisfaction, and higher stress. However, negative COVID-19 experiences were not associated with the dedication and absorption dimensions of work engagement. Therefore, it appears that COVID-19 negatively affected workers with disabilities. Whether workers with disabilities were impacted more than workers without disabilities by the COVID-19 pandemic still needs to be explored. Likewise, Hypothesis 3b was partially supported such that those who reported higher risk of infection with their job, also reported higher exhaustion, cynicism, and job satisfaction.

In contrast, changes to the workplace because of Covid restrictions and reorganizations were associated with greater job satisfaction; contrary to Hypothesis 4. It is possible that the changes due to Covid (i.e., in the form of working from home or reduced work hours) may alleviate some burdens and permit better accommodation control related to organizational disability management (see for example, Hess, 1995), and thus be associated with greater satisfaction with one's job.

Organization

Employees who rated their organization as being more accommodating and supportive reported better individual outcomes, thus supporting Hypothesis 5. Notably, the perceived organizational psychosocial treatment component in the analysis which largely represented the beliefs and attitudes towards persons with disabilities, was

uniquely associated with individual outcomes beyond the physical accommodations'
component. In other words, something about the way organizations treat workers with
disabilities outside of specific accommodations (i.e., support them, treat them with
dignity, don't discriminate) is associated with better outcomes for persons with
disabilities. This finding may suggest that more informal accommodation systems like
social support and civility, may play a significant and unique role in accommodating
persons with disabilities.

That is, a lack of psychosocial support, even while providing physical
accommodations could be linked to negative interactions and discriminatory practices,
and thus physical accommodations alone may not be enough to accommodate persons
with disabilities. In line with past research, accommodations provided because of legal
mandate may result in worse treatment of persons with disabilities (Cleveland et al.,
1997; Stone, & Colella, 1996). Therefore, a more holistic approach to disability
management may be needed. These results may also explain, in part, why countries with
fundamentally different and more supportive values and assumptions like Scandinavian
countries, as reflected in their disability policy models (social-democratic), have superior
outcomes for persons with disabilities. (OECD, 2010)

Country

Counter to Hypothesis 6, employees with disabilities in the US and Canada
appeared to report slightly better organizational accommodations and treatment than did
Scandinavian employees. These results are particularly interesting given that past
literature has suggested that the Northern European countries outperform North America
in disability outcomes (OECD, 2007, 2010; UN, 2006). Given the stark differences in

disability management approaches, perhaps these Northern European countries hold fundamentally different value systems, such that individuals within these countries may have higher expectations and standards for organizational treatment and accommodations. This line of thought is consistent with past literature, such that employees within their country may have biased perceptions and expectations because of localized social comparisons (Paetzold et al., 2008; Suls, & Wheeler, 2013).

Limitations and Future Research

Although this study provided insight into the experience of workers with disabilities across several countries, several limitations should be noted. Because of small sample sizes within each country, my ability to detect significance may have been limited. Despite trying to recruit a greater variety of disability types, the sample used in this study is limited by the number of each disability type observed. That is, most of the disabilities observed in the sample were long-term psychological disabilities. In contrast, according to Stats Canada (2017) 34.1% of people with disabilities reported having either a pain, flexibility, mobility, or dexterity related disabilities, whereas 26.2% reported having either a mental health, seeing, hearing, learning, memory, or developmental disability. Therefore, future research could look at why less people identified as persons living with physical disabilities as opposed to psychological disabilities, whether physical and short-term disabilities are less likely to be perceived as disabilities, and whether those perceptions are influenced by stigma.

The study also made use of a cross-sectional design, which limits the conclusions about causation. Future research should look to incorporate longitudinal designs to assess changes in accommodation practices over time. The longitudinal approach could also be

used to evaluate mediation models to incorporate country, organization, and outcomes into the same model. Furthermore, a longitudinal design would allow us to assess directionality and causation. Additionally, future research can look at multilevel designs with multiple organizations and or countries to observe effects across multiple levels of analyses in reference to country and organizational variables. In other words, a multilevel design would allow us to more adequately examine organizational approaches to disability management by examining several large enough samples each within a different organization.

Furthermore, perceived accommodations and current state of well-being may have been affected by COVID-19. Although I measured aspects of worker experiences with COVID-19, it is still unknown whether the pandemic has affected workers with disabilities to a greater degree than workers without disabilities. Future research should examine whether workers with disabilities are at greater risk during times of crises.

 In reference to country comparisons, one limitation of this study could be the expectations that exists within different country cultures. As a result, future research should look to control for this potential factor by priming workers with accommodation data across the world in advance. Another limitation of this study was worker self-identification as a person living with a disability. Using the Prolific filter to identify qualified participants, workers with conditions/impairments/disabilities in Scandinavian countries were less likely to self-identify as a person living with a disability (even after indicating that they have a physical or psychological disability) than were workers in Canada or the US. This discrepancy in self-identification may refer to something about the beliefs and assumptions that people hold in the Northern European countries, that may suggest that they are better able to use individualistic and collective strategies that

redefine stigmatized disability characteristics and permeate between disability identifications (Nario-Redmond et al., 2013).

Practical Implications

Because of the differences in acceptance of varying disabilities, organizations should take care to consider the kinds of disabilities that exist in their workplaces and how those disabilities might affect their workers, particularly within the context of the workplace and the organization's social culture. It also appears that self-report data for use in feedback for organizations may not be as effective if perspectives and expectations of workers within a country are biased. Additionally, the role of informal accommodations and interactions with workers with disabilities appears to potentially play a unique role outside of physical accommodations in disability management. Furthermore, workplaces and societal disability acceptance appear to be the strongest disability characteristic predictor of perceived workplace treatment. Therefore, employers may want to use greater care to create work environments and cultures that are more supportive and anti-discriminatory.

Conclusion

There were several noteworthy findings relating to disability characteristics, COVID-19 pandemic, organizational approach to disability maangement, and country/cultural disability policies. Perceptions of disability acceptance and rejection were associated with workers' experiences of disability management. Indeed, perceived stigma may play a role in the way that disabilities are accommodated. As such, different disabilities with different characteristics may need different kinds of supports and accommodations. Having negative COVID-19 experiences was associated with increased

burnout, job dissatisfaction, and stress, but workplace changes due to the pandemic were positively associated with job satisfaction, suggesting that these changes may support positive work accommodations for workers with disabilities. At the organizational level, psychosocial treatment was associated with personal well-being and functioning for persons with disabilities beyond the variance accounted for by physical accommodations. Contrary to expectations and past research showing that Northern European countries tend to outperform Canada and the US in disability management (OECD, 2010), workers with disabilities in the US and Canada reported better organizational treatment and accommodations than Scandinavian workers, suggesting differences in social comparison and expectations around disability management issues. This study has provided a solid avenue for future research on workers' perceptions, expectations, and outcomes of organizational disability management across the globe.

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