DISCLOSURE OF A DEPRESSIVE EPISODE DURING A JOB INTERVIEW

The impact on perceivers' cognitive, emotional and behavioural reactions

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Preface

Over the past nine months I have been working on my master thesis to obtain the degree Master of Science in Clinical and Health Psychology at the Erasmus University Rotterdam. The subject of this thesis is 'stigmatization of psychiatric patients'. I have been investigating the role of earlier depressive complaints during job applications. This document presents a detailed description of the process and the results of this study.

First and foremost I would like to thank my supervisor Arjan Bos. He constantly supported me during the past nine months and was always willing to help me whenever I needed help. Thanks to his advice and critical comments I can finish my master Clinical and Health Psychology successfully. Furthermore, I would like to thank my second supervisor Eva Derous for her valuable suggestions and feedback during the process.

Last but not least I want to give special thanks to my boyfriend, brother and parents for their love and support during the past four years I was a student at the Erasmus University Rotterdam.

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SUMMARY

Earlier research provides evidence for the existence of stigmatization in important life domains of psychiatric patients. The present study is a scenario study which investigates the role of earlier depressive complaints in job applications. The impact of seriousness of complaints is also investigated. Economy and business administration students (N = 180) were given a scenario. The scenario provided a detailed description of an application procedure. A 33-year old woman applied for the job. She perfectly matches the requirements of the job but she has a career gap in her resume. The reason for this career gap (depression, car-accident or no information) and the seriousness of the complaints (low seriousness vs. high seriousness) were manipulated. Differences in perceivers' cognitive, emotional and behavioural reactions towards the applicant were measured. Results showed that disclosure of earlier depressive complaints during a job interview has a negative influence on the chance that the perceiver will hire the applicant and on the personal assessment of the applicant. More negative personal characteristics were attributed towards the depressive applicant compared to the applicants in the other two conditions. Implications of the results and recommendations for future research are discussed.

INTRODUCTION

The social stigma of mental illness

Originally the term stigma refers to bodily signs made by the ancient Greeks (Goffman, 1963). These signs were burned or cut in the body of a person and showed that the person had a bad or lower status, like slaves or criminals. Nowadays there is no widely accepted definition of stigma. Goffman (1963) defined stigma as "an attribute that is deeply discrediting" (p. 3). Jones and colleagues (1984) agreed with this definition, but place stigma in a relational perspective. A condition labeled as deviant for one person, may be attractive according to another individual. They stated that a specific attribute (mark) of a person links a person to an undesirable characteristic (stereotype). According to the relational perspective, this link can be different across cultures. For example, labeling a person as mentally ill will have different effects in different cultures (Angermeyer, Buyantugs, Kenzine, & Matschinger, 2004). Angermeyer and colleagues (2004) showed that labeling a person as schizophrenic will lead to perceptions of dangerousness in Germany. In contrast, no perceptions of dangerousness were found in Russia and Mongolia. What seems discrediting in one culture can be the norm in another. According to the definition of Link and Phelan (2001) stigma only exists when elements of labeling, stereotyping, separating, status loss and discrimination co-occur in a power situation that allows these processes to unfold.

People with a mental illness belong to one of the most stigmatized groups in our society. Research on public opinions in both The Netherlands and Germany shows that people with schizophrenia are seen as dangerous and unpredictable (Angermeyer & Matschinger, 2005; Boon, Nugter & Dijker, 2004). Although people with alcohol dependence and schizophrenia were mostly rejected, people with depression experience a substantial amount of stigma and discrimination too (Angermeyer & Matschinger, 1997). The latter study showed that 45% of the general population would not recommend someone with a major depression for a job and 26% would not like to have a depressed person as a neighbour. These results contradict Western legislation

which is prescribing equal opportunities in work and education, regardless of ethnic background, social class, age, political preference, religious conviction or sexual orientation. Despite this legislation many minority groups, such as mentally ill patients, do not have equal opportunities compared to the general population (Angermeyer & Matschinger, 1997; Boon et al., 2004; Corrigan et al., 2000; Ellemers & Barreto, 2006; Markowitz, 1998). According to the statistics of the UWV (a Dutch organization for employee-insurances) 17.064 employees have applied for invalidity insurance in the period of January till September 2005 (UWV, 2006). Almost 30% (4.916 employees) did this because of mental complaints.

The purpose of the present study is to explore the differences in perceivers' cognitive, emotional and behavioural reactions towards an applicant with an earlier depression compared to a car-accident and a control condition. Moreover, the study investigates the impact of seriousness of depressive complaints on these same emotional and behavioural reactions.

The process of stigmatization

In 1988 Weiner and colleagues proposed an attribution-emotion model of social stigma (Weiner, Perry & Magnusson, 1988). According to this theory there is a causal relationship between cognitions and specific affective reactions towards a stigmatized person. Their attribution-emotion model states that stigmatization is caused by two affective reactions: anger and pity. These emotions are caused by the perceived controllability of the stigmatized condition. When personal controllability is high, people will respond with anger and stigmatization towards a (mentally) ill person. Additionally when personal controllability is low, people will respond with pity instead of anger. For example, according to this theory a perceiver will respond with more anger towards a psychotic patient when psychotic complaints are caused by the use of cannabis. This same perceiver will respond with more pity when psychotic complaints are caused by hereditary factors.

Dijker and Koomen (1996, 2003) extended this attribution theory with other cognitions and emotions. They claimed that, besides pity and anger, the degree in

which a person breaks social norms, the degree in which a person suffers, and contagiousness of the deviant condition play a significant role in the stigmatization process too. In addition, these cognitive dimensions underlie more then the two affective states proposed by Weiner (1988). Dijker and Koomen (1996, 2003) extended these cognitive states with gloating and fear which, according to their theory both lead to social rejection (see Figure 1).

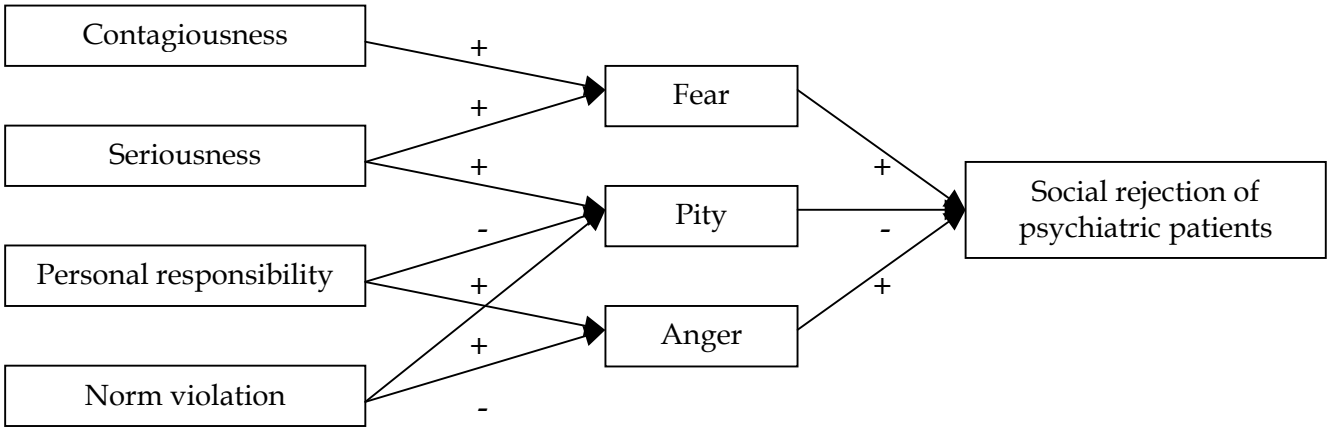

Figure 1. **A cognitive-emotional model of stigmatization of psychiatric clients, based on Weiner et al. (1988); Dijker and Koomen (1996) and Dijker and Koomen (2003).**

An important question is to what extent these models can be applied to stigmatizing responses towards people with a mental illness. Results from research on this topic supported the attribution theory proposed by Weiner (1988) and suggested that mental health disabilities were rated more negatively on the factors controllability and stability compared to physical disabilities (Corrigan, River, Lundin, Uphoff Wasowski, Campion, Mathisen, Goldstein, Bergman & Gagnon, 2000). Another study of Corrigan and colleagues (2003) showed that, consistent with the theories of Weiner (1988) and Dijker and Koomen (1996, 2003), the emotions pity, anger and fear were affected by beliefs about the controllability of the mental illness and lead, in the high

controllability cases, to rejecting responses (Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003). This study also found that perceived dangerousness of a psychiatric patient increased fear which in turn leads to rejection and avoiding behaviour (Corrigan et al., 2003). Finally, this study also revealed that familiarity with mental illness had an influence on discriminatory and emotional reactions. Participants who were more familiar with mental illness were more likely to offer interpersonal help and less likely to avoid mentally ill patients (Corrigan et al., 2003; Angermeyer & Matschinger, 1997; Boon et al., 2004). Angermeyer and Matschinger (1997) attributed this result to an increase in positive emotional reactions and reduced feelings of anxiety towards mentally ill people.

An experimental study of De Graaff-Wijnberg and colleagues (2006) found some support for the theory of Dijker and Koomen (1996, 2003) as well. In their study a scenario was given to 320 health service workers. This scenario described a colleague who returned to work after a period of absence due to depressive complaints. Personal responsibility, seriousness of complaints, and openness about the complaints were manipulated. Evaluations of personal qualities and emotional reactions toward the person were measured. Results showed that participants reported more fear when the colleague had serious versus less serious complaints. However, no support was found for the impact of personal responsibility on stigmatization (De Graaff-Wijnberg et al., 2006).

Functions of stigmatization

There are some theories about the functions of stigmatization as well (Bos, 2001; Crocker, Major, & Steele, 1998; Dovidio, Major & Crocker, 2000). Stigmatization can enhance control over threatening situations, enhance self-esteem, cause in-group enhancement, or buffer against anxiety.

A stigma provides information about possible danger for a perceiver. Knowledge about this possible danger enhances control over threatening situations. For example, HIV related stigma provides information about the contagiousness of the disease (Bos, 2001). Knowledge about this contagious aspect of the disease makes that

a perceiver can protect itself by avoiding HIV patients. The same applies to the stigmatization of psychiatric patients. Several studies showed that 50% of the respondents thought that psychiatric patients can be aggressive (Boon et al., 2004; Angermeyer, Beck & Matschinger, 2003, Angermeyer et al., 2004). By stigmatizing psychiatric patients through, for example, avoiding them, perceivers can protect themselves against the aggressiveness of these patients.

Secondly, stigma can enhance self-esteem through downward comparison (Crocker et al., 1998; Dovidio et al., 2000, Bos, 2001). Downward comparison means comparing oneself with a less fortunate person. This comparison can enhance one's self-esteem, because of the positive influence on the person's sense of well-being. Through active stigmatization of a psychiatric patient one can enhance their own self-esteem by making the other person inferior.

Furthermore, stigmatization can cause in-group enhancement as well (Crocker et al., 1998; Dovidio et al., 2000, Bos, 2001). Stigmatization of a specific group increases the superiority of the stigmatizing group and the differences between the groups. In this manner, the stigmatizing group maintains a positive social identity.

Finally, stigmatization can buffer against existential anxiety (Crocker et al., 1998; Dovidio et al., 2000, Bos, 2001). Awareness of your own mortality and vulnerability can generate feelings of anxiety in a person. For example, contact with a HIV patient reminds someone about their own mortality which in turn increases their anxiety (Bos, 2001; Dechesne, Janssen, Van Knippenberg, 2000).

The consequences of stigmatization

Research among people with mental illnesses has demonstrated that stigmatization has a negative impact on stigmatized people (Link, Struening, Neese-Todd, Asmussen & Phelan, 2001; Hayward, Wong, Bright & Lam, 2002; Rosenfield, 1997; Markowitz, 1998; Major & O'Brien, 2005). The initial labeling theory states that when a person is labeled as mentally ill by a professional, this label will have negative consequences for the mentally ill person. The label will lead to rejection and discrimination in society, which in turn will have a negative influence on outcomes for the mentally ill. Because

of the enormous and sustained criticism on the initial labeling theory, a modified version of this theory is proposed (Link, Cullen, Struening, Shrout & Dohrenwend, 1989). This modified version replaced the strong claim of the initial labeling theory, that a person with a mental illness label is doomed, with a more adapted point of view. Link and colleagues (1989) proposed that, through socialization, every person develops a set of stereotypical attitudes about mentally ill patients and about how most people treat these patients. When psychiatric patients are labeled as mentally ill by professionals, these attitudes become personally relevant. These patients expect to be treated according to their own stereotypical attitudes and these attitudes become self fulfilling prophecies. When psychiatric patients expect to be devalued and discriminated against, they will use certain coping strategies, such as withdrawal. These ineffective coping strategies will lead to a decrease in social networks, lower self-esteem and less job opportunities. To summarize, the 'modified labeling approach' claims that, although stigmatization can't directly cause a mental disorder, it can have a negative influence on the course of the illness. It causes a vulnerability to new disorders or a repetition of the present episode (Link et al., 1989).

Critics of the labeling theory argue that labeling has positive consequences for the mentally ill person as well. Rosenfield (1997) for example, tested a theoretical framework that stated that labeling would lead to negative ánd positive consequences. She found that positive consequences of labeling, such as receiving treatment and high quality services, have a positive influence on life satisfaction. Negative consequences on the other hand, such as stigmatization and discrimination, have a negative influence on life satisfaction. Furthermore, these two influences are related to subjective quality of life through their associations with the person's self-concept. The feeling of being stigmatized affects the person's self-concept and self-efficacy, which in turn has a negative influence on the quality of life. The received treatment and high quality services, on the other hand, have a positive influence on the quality of life, because it increases people's self-concept en self-efficacy.

Additionally, much research has been carried out regarding the adverse effects of stigma. Most of these research states that stigmatization has a negative influence on a persons' self-esteem (Link et al., 2001; Vinken, Bos, Bolman, Van der Plas, 2005;

Hayward et al., 2002; Markowitz, 1998). Link and colleagues (2001) measured perceived stigmatization and self-esteem among 70 members of a clubhouse program for people with mental illness on different time points. Even after adjusting for baseline self-esteem and depressive symptoms, perceived stigmatization strongly predicted self-esteem. Hayward and colleagues (2002) demonstrated this negative effect of stigma on the self-esteem of people with manic depression. Unfortunately, this study of Hayward and colleagues (2002) concerned a cross-sectional design. For this reason, an important limitation of this study is the possible bi-directional relationship between stigma and self-esteem. Stigmatization may lead to lower self-esteem, but those with lower self-esteem, may be more vulnerable for stigmatization as well (Hayward et al., 2002; Markowitz, 1998). Furthermore, research showed that the relationship between stigmatization and self-esteem is dependent on the diagnosed disorder. This relationship is especially apparent in depressive-anxiety types of disorders and not in psychotic disorders like schizophrenia (Markowitz, 1998; Vinken et al., 2005).

Finally, Major and O'Brien (2005) stated that stigma has a direct and an indirect effect on the stigmatized person. It directly affects a stigmatized person through mechanisms as negative treatment and discrimination, expectancy confirmation and automatic stereotyping. Negative treatment and discrimination has a direct influence on the access to important life domains for the stigmatized person, such as opportunities for finding a job and living space (Angermeyer & Matschinger, 1997; Boon et al., 2004; Markowitz, 1998). For example, 38.4% of the German public would rather not rent a room to someone with a major depression (Angermeyer & Matschinger, 1997). A Dutch questionnaire among neighbours of a psychiatric clinic showed that only 52% of the respondents would accept a psychiatric patient as a neighbour. Only half of the respondents had a positive attitude towards psychiatric patients (Boon et al., 2004). According to expectancy confirmation process, also referred to as self-fulfilling prophecies, a stigmatized person will behave according to the negative stereotype. This behaviour confirms the expectations and even leads to changes in self-perception. In addition, stigma also affects the stigmatized person via indirect processes as threats to personal and social identity. According to this theory

stigmatization of a psychiatric patient "puts this patient at risk of experiencing threats to his or her social identity" (Major & O'Brien, 2005; Crocker & Major, 1989).

Coping with social stigma

Being stigmatized can be a very stressful experience and can have a lot of negative consequences for the stigmatized individual. Important to know is if stigmatized individuals can cope with these stressors and which strategies work best. Different kinds of coping strategies can be found in the empirical literature, such as avoidance, denial and acceptance (Crocker et al., 1998; Link, Mirotznik and Cullen, 1991; Miller & Major, 2000; Vinken et al., 2005). According to Miller and Major (2000) the effectiveness of a coping strategy depends on the kind of person, the situation and on the person's goal. In other words, different strategies are effective for different persons in different situations.

Miller and Major (2000) differentiate between problem-focused coping and emotion-focused coping. Problem-focused coping is effective when a person's goal is reducing the stressor, such as trying to conceal or reduce the stigmatizing attribute. When a person's goal is controlling the stressful emotions caused by stigmatization through minimizing negative emotions, emotion-focused coping seems to be more effective. An example of emotion-focused coping is downward social comparison (Bos, 2001; Crocker et al., 1998; Miller & Major, 2000). A stigmatized mental patient can use this social comparison strategy to protect one's self-esteem against the negative consequences of stigmatization. Earlier research shows that downward social comparison plays a moderating role in the relationship between stigmatization and self-esteem (Crocker et al., 1998; Vinken et al., 2005).

Crocker, Major and Steele (1998) differentiate between three different coping strategies which stigmatized people use to avoid negative outcomes. The first strategy is attributing negative outcomes to external factors, such as prejudice and discrimination (Crock et al., 1998). A second strategy which stigmatized persons can use is the downward social comparison technique (Bos, 2001; Crocker et al., 1998; Miller & Major, 2000). The last strategy is making the stigmatized aspect less

important for the self-esteem by psychological disengaging the self-esteem from possible negative outcomes in a specific domain (Crocker et al., 1998). Failure in a specific domain caused by stigmatization, for example social interaction, can have negative consequences for the self-esteem. By psychological disconnecting the self-esteem from this domain, people can avoid this negative impact on the self-esteem.

Disclosure of mental illness on the workplace

Employees with a concealable stigma such as mental illness can choose between concealment or disclosure of their condition. Concealment will probably lead to less stigmatizing reactions, because co-workers are unaware of the stigmatizing attribute of their colleague. On the other hand, disclosure can lead to social support of colleagues. According to Goldberg and colleagues (2005), many professionals in the American public mental health field recommend their mentally ill clients to disclose their illness when applying for a job. Reasons for this preference for disclosure include the opportunity to claim rights for people with a (psychiatric) disability, such as adapted working hours or a low-stress job, and the belief held by many mental health professionals that employees with psychiatric complaints will chronically experience negative symptoms (Goldberg, 2005). Moreover, sometimes it isn't even possible to conceal a mental illness during a job interview, because many psychiatric patients are accompanied by a rehabilitation worker when applying for a job.

Only a few studies tried to explore the consequences of disclosing a mental illness (Corrigan, 2005; De Graaff-Wijnberg et al., 2006; Goldberg et al., 2005; Quinn, Kyoung Kahng & Crocker, 2004). These studies not always support this recommendation of American professionals. Quin and colleagues (2004) studied the effects of disclosing mental illness on test performance. Results indicated that psychiatric patients who directly disclosed their mental illness before taking a test, performed inferior compared to patients who did not disclosed their mental illness (Quin et al., 2004). In a study of De Graaff-Wijnberg and colleagues (2006), openness about depressive symptoms on the workplace was associated with more feelings of fear, pity and anger in coworkers (De Graaff-Wijnberg et al., 2006). This result shows

that disclosure of a mental illness in the workplace will lead to positive reactions, like pity, but to negative emotions, like fear and anger, as well. Ellemers and Barreto (2006) reviewed empirical research concerning the effects of hiding a devalued identity in the workplace. Their review concludes that, although concealment will protect an employee against stigmatizing reactions, it has negative effects as well. For example, hiding a stigmatizing attribute brings substantial emotional and cognitive costs along. These costs can be so severe that they will increase instead of decrease the stress on the workplace. Consequently, people who are concealing their mental illness on their work can experience such an amount of stress that they will perform suboptimal (Ellemers & Barreto, 2006).

Corrigan (2005) discriminates between different levels of disclosing, such as secrecy, selective disclosure, indiscriminant disclosure and broadcasting. In case of the first two types of disclosure, still some secrecy exists. Secrecy means total concealment of the mental illness and selective disclosure means disclosing a mental illness to specific persons, such as the supervisor on the workplace. Jones (1984) states that concealment is mainly an effective approach in short-term contact and casual interactions. When a person chooses for indiscriminant disclosure, everyone could find out about their mental illness, because no efforts are made to conceal their mental illness. This does not mean someone is continuously telling everyone about their illness. This is the case when a person choose to broadcast their mental illness. Broadcasting means educating people about mental illness by telling one's story. According to Corrigan (2005) broadcasting is not only beneficial because of a lack of secrecy. Broadcasting also "fosters the power over the experience of mental illness and stigma" (Corrigan, 2005).

Until now only little research has been done concerning the pros and cons of disclosing a mental illness during a job interview.

The present study

Only little research has been done regarding the influence of disclosure of depressive symptoms on cognitive, emotional en behavioural responses of perceivers and the

influence of seriousness of depressive complaints on these reactions. The study of De Graaff-Wijnberg and colleagues (2006) showed that serious complaints increase fear in perceivers and made them attribute more negative personal traits towards a depressed person, compared to less serious complaints. Moreover, serious complaints had no effect on the amount of compassion. The present study focuses on disclosure of depressive complaints in a job interview and examines the influence of seriousness of complaints on cognitive, emotional and behavioural reactions in perceivers. Most of the research on stigmatization has been aimed at the stigmatized person. The present study also takes some moderating factors of the stigmatizing person into account.

Reason

We expect that the reason for the career gap will have a significant effect on the cognitive reactions in perceivers. Perceivers will attribute more negative personal skills and traits towards the applicant in the depressive condition compared to the applicant in the car-accident and control condition (hypothesis 1). Furthermore, we expect that the applicant in the depressive condition will evoke more negative emotional reactions in perceivers compared to the applicant in the car-accident and control condition (hypothesis 2). Finally, we expect that the depressive applicant will evoke more avoiding behaviour and less approaching behaviour compared to the applicant in the car-accident and the control condition (hypothesis 3). Avoiding behaviour is behaviour that creates social distance between the perceiver en the applicant. Approaching behaviour is the opposite, such as helping someone.

Seriousness

We expect that seriousness of complaints will have a significant negative effect on the cognitive reactions in perceivers. Perceivers will attribute more negative and less positive personal skills and traits towards the applicant in the high seriousness condition compared to the applicant in the low seriousness condition (hypothesis 4). Based on the model of Dijker and Koomen (1996, 2003) we expect that the applicant in the high seriousness condition will evoke more negative emotional reactions in perceivers compared to the applicant in the low seriousness condition (hypothesis 5).

Finally, we expect that the applicant in the high seriousness condition will evoke more avoiding behaviour and less approaching behaviour compared to the applicant in the low seriousness condition (hypothesis 6).

METHOD

Participants and design

Participants (*N*=180, 90 males and 90 females) were economy (*N*=23) or (International) Business Administration (*N*=157) students. Manipulations failed for 11 participants. These participants were excluded for further analyses (*N* = 169, 81 males and 88 females). The mean age of the sample was 20.62 years (*SD* = 1.95). Participants were randomly assigned (in order of entry) to a 3 (reason: depression, car-accident, no information) x 2 (seriousness: high vs. low) between-subjects design.

Procedure

Participants were contacted by telephone and were asked to join the experiment. An appointment was made in the Erasmus Behavioural Lab. The experimenter welcomed the participants and explained the procedure of the study. The experimenter explained that every participant would receive a scenario about an application procedure and several questions about this procedure. It was pointed out that participants had to read the scenario carefully and had to imagine being a recruiter. Subsequently, one of the six scenarios was presented. Participants read the scenario and filled out the questionnaire. At the end of the experiment participants were debriefed and paid for their participation (10 euro).

Scenario

Scenarios were provided in booklets to participants. Each booklet provided a detailed description of one scenario (i.e., application procedure). Participants were asked to imagine being a member of an application committee. The company of this committee was looking for an administrative employee and the job advertisement was presented. This advertisement gave a description of the job, the required skills and the necessary personal skills. These personal skills were flexibility, creativity, independence, exactitude and cooperativeness. Next, participants had to read an application letter of

a 33-year old woman who was interested in the job. The curriculum vitae of this woman perfectly matched the description in the job opening, but had one particular detail. Five years ago, the applicant had a career gap in her resume. Since the gap she had well functioned in a similar job. The applicant was invited for a meeting with the application commission and a description of this meeting was presented. During the meeting the applicant was asked why she had this career gap in her curriculum vitae. The reason for the career gap in the curriculum vitae was manipulated. The participant had either suffered from a depression, or had been involved in a car accident and needed a period of time to recover from her injuries, or the career gap was noticed but the committee did not ask about the reason. Seriousness was manipulated through varying the length of the career gap. In the high seriousness condition the career gap was one year, whereas this was two months in the low seriousness condition.

Measures

After reading the vignette, participants answered several questions concerning their cognitive, emotional and behavioural reactions towards the applicant. Answers were measured on a 7-point Likert scale (1 = not at all, 7 = very much). In the end, background questions were asked concerning gender, age, education and familiarity with depressive symptoms.

Cognitive reactions

Subsequently, questions were asked about how well she matched with the required personal skills described in the job opening (flexibility, creativity, independence, cooperative and exactitude) and about different traits (e.g. friendly, sensitive, shy, insecure, introvert). These different traits were subdivided into categories; positive and negative traits. Positive traits were friendly, nice and talkative (Cronbach's alpha = .75) and negative traits were introvert, shy, stretched, insecure, hesitative and sensitive (Cronbach's alpha = .81)

Emotional reactions

Emotional reactions were measured with the question: '*When I think about Linda (the applicant), I feel…'* The items were based on previous research of Weiner, Perry and Magnusson (1988) and Dijker and Koomen (2003) and concerned pity, anger and fear. Pity was measured with the items 'compassion', 'involvement', 'pity' and 'sympathy' (Cronbach's alpha = .64). Anger was measured with the items 'annoyance', 'fury', 'irritation' and 'anger' (Cronbach's alpha = .87). Fear was measured with the items 'nervousness', 'tenseness', 'uncertainty' and 'fear' (Cronbach's Alpha = .84).

Behavioural reactions

Additionally, intentional behaviour was measured with the questions: '*When I think about Linda, then…'* and '*When I think about Linda, I would…'* These reactions were measured with ten items about social interaction. Five items described approaching behaviour, such as 'sitting next to Linda during lunch' and 'asking Linda for advice when you have a problem' (Cronbach's alpha = .83). The other five items described avoiding behaviour such as 'keeping some distance between Linda and yourself' and 'avoiding Linda' (Cronbach's alpha = .91).

Further, some questions concerning the intentions to select the applicant and her aptitude for the job were asked (e.g., *How big is the chance that you will select Linda?* and *How suitable is Linda for the job?*).

Control variable

During all analyses we controlled for participants' motivation to control prejudice. A Dutch translation of the 12-item Motivation to Control Prejudice Against Persons With Aids (PWAs) Questionnaire was used (Dunton & Fazio, 1997; Pryor, Reeder, & Landau, 1999). Because the present study is about psychiatric patients we changed 'persons with aids' to 'persons with a mental illness' in the questionnaire. The questionnaire contains 12 items. In the present study both alphas were .72 and .76.

Manipulation checks

At the end of the questionnaire four questions concerning the different manipulations were asked (see Appendix A). The first was a manipulation check of the reason for the career gap (See Appendix A). Participants could choose between six possible reasons (the applicant couldn't find a job, a depression, a car-accident, no reason or another reason, namely…). The second and third questions were manipulation checks for the openness of the applicant and the seriousness of the reason (See Appendix A). These items were measured on a 7-point Likert scale (1 = not at all, 7 = very much). The last manipulation check concerned the length of the career gap (See Appendix A). Four different lengths were given.

RESULTS

Manipulation checks

To examine the effectiveness of the manipulations 3 (reason: depression, car-accident or no information) x 2 (seriousness: low vs. high) one-way analyses of variances (ANOVAs) are carried out. Both analyses confirmed the effectiveness of these manipulations. In the high seriousness condition participants judged the reason for the career gap as more serious (M = 4.00, SD = 1.63) compared to the participants in the low seriousness condition (M = 3.26, SD = 1.47), F (1, 165) = 8.59, p <.01. No other significant main or interaction effects were found. Moreover, participants in the control condition judged the applicant as less open (M = 2.66, SD = 1.16) compared to the participants in the car-accident and depressive condition (M = 5.06, SD = 1.32 and M = 6.11, SD = .88), F (2,164) = 175.47, p <.01. Post-hoc analyses showed that both the difference between the depressive condition versus the car-accident and between the depressive condition versus the control condition were significant. Participants in the depressive condition judged the applicant as significant more open compared to the car-accident condition and compared to the control condition. In sum, we can conclude that our manipulations have been induced in the intended way.

Descriptive statistics

Correlations are calculated for cognitive, emotional and behavioural reactions and the control variable 'Motivation to Control Prejudice' (MTCP). Most of the key correlations showed significant relationships. For example, fear and anger (r = .61, p < .01), fear and avoiding behaviour (r = .44, p < .01), anger and avoiding behaviour (r = .51, p < .01) and pity and approaching behaviour (r = .35, p < .01).

Table 1. Intercorrelations for emotional and behavioural reactions, positive and negative traits, chance on employment, required personal skills and Motivation to Control Prejudice.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Pity	1													
2. Fear	.28**	1												
3. Anger	.21**	.61**	1											
4. Avoiding behaviour	-.05	.44**	.51**	1										
5. Approaching behaviour	.35**	-.07	-.10	-.32**	1									
6. Pos. traits	.20**	-.18*	-.20*	-.39**	.50**	1								
7. Neg. traits	.03	.44**	.28**	.29**	-17*	-.36**	1							
8. Chance on employment	.10	-.22**	-.32**	-.37**	.39**	.37**	-.37**	1						
9. Flexibility	.24**	-.04	-.00	-.15*	.43**	.42**	-.23**	.32**	1					
10. Creativity	.27**	.05	.06	-.09	.37**	.31**	.00	.24**	.39**	1				
11. Independence	.13	-.07	-.08	-.29**	.33**	.26**	-.22*	.36**	.28**	.45**	1			
12. Cooperativeness	.16*	-.13	-.08	-.24**	.38**	.43**	-.20**	.27**	.47**	.41**	.32**	1		
13. Accurate	.14	.00	-.08	-.12	.13	.22**	-.19*	.36**	.24**	.20**	.41**	.40**	1	
14. MTCP	.22**	-.01	-.04	-.14	.19*	.17*	.04	.17*	.23**	.17*	.15	.13	.14	1

Note. * p < .05, two-tailed. ** p < .01, two-tailed, MTCP = Motivation to control prejudice.

Cognitive reactions

Required personal skills

A 3 (reason: depression, car-accident or no information) x 2 (seriousness: low vs. high) multivariate analysis of covariance (MANCOVA) is carried out on the five different personal skills which were required for the job. Motivation to control prejudice was included as covariate. No significant multivariate main effect was found for the reason for the career gap (F (5, 154) = 1.60, p = n.s.) and for the seriousness of the condition (F (5, 154) = 1.21, p = n.s.). Moreover, no significant interaction effects were found either.

In contrast with hypothesis 1 and 4, this result indicates that the reason for the career gap and the seriousness of the complaints both have no significant effect on the attribution of the five different personal skills.

Personal traits

To explore the effects of the reason for the career gap and the seriousness of the complaints on the different personal traits a 3 (reason: depression, car-accident or no information) x 2 (seriousness: low vs. high) analysis of covariance (ANCOVA) is carried out on the negative and positive traits. Motivation to control prejudice was included as covariate. This analysis confirmed hypothesis 1. The analysis shows a significant main effect of the reason for the career gap on the negative traits (F (2,156) = 4.82, p <.01). Participants attributed more negative traits towards the applicant in the depressive condition (M = 3.35) compared to the car-accident condition (M = 2.98) and the control condition (M = 2.85). Contrast analysis shows that the difference between the depressive condition and the car-accident is significant. Moreover, this contrasts analysis also shows that the difference between the depressive condition and the control condition is significant as well. Further significant main or interaction effects on negative traits were not found.

This result supports hypothesis 1 which states that participants attribute more negative traits towards the depressive applicant compared to the other two applicants. In contrast with hypothesis 4, no significant effect was found for the seriousness of the condition on the attributed traits, (F (1, 156) = .44, p = n.s.).

Table 2. Means and standard deviations for emotional and behavioural reactions, positive and negative traits, chance on employment and required personal skills.

	Low seriousness			High seriousness		
	Control	*Car accident*	*Depression*	*Control*	*Car accident*	*Depression*
Pity	3.66 (.93)	3.71 (.91)	3.64 (.93)	3.60 (.98)	3.84 (.88)	3.85 (1.00)
Fear	1.97 (.97)	2.51 (.90)	2.42 (1.120	2.13 (.87)	2.40 (1.08)	2.44 (1.23)
Anger	1.50 (.75)	1.84 (.67)	1.72 (.81)	1.63 (.86)	1.93 (1.11)	1.87 (.94)
Avoiding behaviour	1.75 (.66)	2.15 (.76)	1.85 (1.09)	2.05 (.89)	2.21 (.97)	2.01 (.92)
Approaching behaviour	4.30 (.84)	4.21 (.87)	4.10 (1.15)	4.14 (1.12)	3.96 (.94)	4.26 (1.00)
Pos. traits	5.32 (.81)	5.10 (.71)	5.06 (.72)	4.97 (.98)	4.96 (.80)	5.11 (.76)
Neg. traits	2.81 (.66)	2.96 (.95)	3.29 (1.08)	2.93 (.82)	3.02 (.94)	3.40 (.67)
Chance on employment	5.46 (.65)	5.43 (.84)	4.83 (1.21)	5.33 (.88)	5.36 (.83)	4.93 (1.21)
Flexibility	5.16 (1.03)	4.64 (.99)	4.73 (1.08)	4.57 (1.14)	4.54 (1.11)	4.33 (1.07)
Creativity	4.08 (1.23)	4.21 (.96)	4.17 (1.29)	3.90 (1.24)	3.79 (1.20)	4.41 (1.01)
Independence	5.42 (1.27)	5.11 (1.07)	5.17 (1.21)	5.10 (1.37)	5.25 (1.08)	5.33 (.92)
Cooperativeness	4.92 (1.23)	4.96 (.79)	5.17 (.95)	4.73 (1.36)	4.79 (1.00)	5.15 (1.13)
Accurate	4.73 (1.15)	5.11 (1.10)	4.97 (1.27)	4.97 (1.32)	5.07 (1.05)	5.15 (.82)

Note. Means and standard deviations between parentheses.

Emotional reactions

A 3 (reason: depression, car-accident or no information) x 2 (seriousness: low vs. high) multivariate analysis of covariance (MANCOVA) is carried out on the emotions pity, anger and fear. Motivation to control prejudice was included as covariate. No significant multivariate main effect was found for the reason for the career gap, (F (3, 156) = .96, p = n.s.) and for the seriousness of the condition (see Table 1), (F (3,156) = .61, p = n.s.). Moreover, no significant interaction effects were found either. In contrast with hypothesis 2 and 5, result indicates that the reason for the career gap and the seriousness of the complaints both have no significant effect on the amount of pity, anger and fear participants experienced during the study.

Behavioural reactions

Approaching and avoiding behaviour

A 3 (reason: depression, car-accident or no information) x 2 (seriousness: low vs. high) analysis of covariance (ANCOVA) is carried out on both approaching and avoiding behaviour. Motivation to control prejudice was included as covariate. This analysis did not reveal any significant main effect or interaction effect. The reason for the career gap did not have any significant effect on both approaching behaviour, (F (2,158) = .33, p = n.s.) or avoiding behaviour, (F (2,160) = 1.41, p = n.s.). Seriousness of the condition did not have any significant effect on both approaching behaviour (F (1, 158) = .05, p = n.s.) or avoiding behaviour (F (1,160) = 1.52, p = n.s.). This means that, in contrast with hypothesis 3 and 6, the reason for the career gap and the seriousness of the complaints had no significant effect on approaching or avoiding behaviour.

Actual behaviour

To examine if the reason for the career gap and the seriousness of the complaints had any effect on actual behaviour, a 3 (reason: depression, car-accident or no information) x 2 (seriousness: low vs. high) analysis of covariance (ANCOVA) is carried out on the practical questions concerning the application procedure. Motivation to control

prejudice was included as covariate. In line with hypothesis 3, this analysis shows that the reason for the career gap has a significant influence on the chance that the participant will hire the applicant (F (2, 160) = 5.41, p < 0.01). Participants in the depressive condition (M = 4.87) reported a significant smaller chance compared to participants in the car-accident (M = 5.41) or control condition (M = 5.41). The seriousness of the complaints did not have a significant effect on this chance (F (1, 160) = .00, p = n.s.). No significant interaction effects were found as well. Moreover, no significant effects were found on the other questions concerning actual behavior. The reason for the career gap did not have any significant influence on the chance the participants will let the applicant move to the second round (F (2, 160) = .12, p = n.s.), on the judgement of the aptitude of the applicant (F (2, 160) = .16, p = n.s.) or on the expectations concerning the implementation (F (2, 160) = .07, p = n.s.). Furthermore, The seriousness of the condition did not have any significant influence on the chance the participants will let the applicant move to the second round (F (1, 160) = .94, p = n.s.), on the judgement of the aptitude of the applicant (F (1, 160) = .10, p = n.s.) or on the expectations concerning the implementation (F (1, 160) = .05, p = n.s.).

DISCUSSION

Research on stigmatization of psychiatric patients has primarily focused on aspects of the stigmatized individual, such as the negative effects of stigmatization for the self-esteem (Link et al., 2001; Vinken et al., 2005; Hayward et al., 2002; Markowitz, 1998). Far less research among psychiatric patients has focused on aspects of the perceiver and especially on the influence of disclosure of mental problems on cognitive, emotional and behavioural reactions of this perceiver. The present study tried to explore the effects of revealing a depression during a job interview. Particularly, the study focused on the effects of an earlier depressive episode and the seriousness of this episode on perceivers' cognitive, emotional and behavioural reactions towards an applicant compared to an applicant with a car-accident and a control condition. It was hypothesized that the applicant in the depressive condition would cause more stigmatizing reactions compared to the applicants in the other two conditions. Based on the model of Dijker and Koomen (1996, 2003), seriousness of complaints was expected to play a significant role in the process of stigmatization. According to this model, seriousness of complaints increases the emotions fear and pity which in turn can lead to stigmatization of a psychiatric patient. Furthermore, the study explored the impact of disclosure of depressive complaints on the assessment of the applicant.

Reason

The reason which was given for the career gap did not have any influence on emotional reactions, on the attribution of the five required personal skills, on approaching and avoiding behaviour and on some of the questions concerning intentional behaviour. These results contradict earlier research on stigmatization. A Study of Boon and colleagues (2004) for example, showed that mental illness does have a significant effect on cognitive, emotional and behavioural reactions. Almost 50% of the participants valued psychiatric patients as aggressive and unpredictable. Furthermore, half of the participants reported feelings of irritation, fear or insecurity.

Negative cognitive and emotional reactions decreased acceptation of psychiatric patients (Boon et al., 2004).

Results of the present study showed that disclosure of earlier depressive complaints during a job interview has a significant impact on the chance that the perceiver will hire the applicant. In the depressive condition this chance was significant lower compared to the other two conditions. Furthermore, perceivers attributed significant more negative personality characteristics towards de depressive applicant compared to the applicant in the car-accident condition and to the applicant in the control condition. According to this result, the assessment of the depressive applicant was inferior compared to the assessment of the applicant in the other two conditions. No effect of disclosure was found on both approaching and avoiding behaviour, on attributed personal skills and on the other questions concerning actual behaviour. Moreover, no significant effect was found of disclosure of an earlier depression on emotional reactions in perceivers. This result contradicts the emotion-attribution model of Dijker and Koomen (1996, 2003). Several studies have confirmed the applicability of this model to the stigmatization of mental illnesses (Corrigan et al., 2000; Corrigan et al., 2003; De Graaff-Wijnberg et al., 2006). These studies showed that seriousness of complaints (De Graaff-Wijnberg et al., 2006) and controllability (Corrigan et al., 2000; Corrigan et al., 2003) both have a negative impact on emotional reactions and can lead to stigmatization of a psychiatric patient.

A possible explanation for the lack of these significant results is the type of mental illness chosen in the present study. The applicant in the scenario had a depressive episode in her past. The study of Corrigan and colleagues (2000) showed that perceivers not only discriminate between different illnesses, they also discriminate between different mental illnesses. Not only were mental illnesses in general rated more negatively on the factors controllability and stability compared to physical disabilities, the study also found a difference *among* mental illnesses. Cocaine addiction was rated as worst, followed by psychotic disorders and AIDS. A depressive disorder was seen as rather benign, comparable to cancer. Depression and cancer were rated relative low on both the stability and controllability factor. It could be that

having a depression is a far less stigmatizing attribute compared to having schizophrenia or an addiction.

A second possible explanation for the lack of these significant results is that there was no actual contact between the participant and the applicant, because the scenario was only hypothetical. This means that giving social acceptable answers could not lead to actual negative consequences.

Seriousness

In contrast with earlier studies, the seriousness of the condition had no significant impact on cognitive, emotional and behavioural reactions. Previous research did find a significant impact of seriousness on cognitive reactions (De Graaff-Wijnberg et al., 2006). Participants in the study of De Graaff-Wijnberg and colleagues (2006) attributed more negative traits towards the person in the high seriousness condition.

The present results are in contrast with the emotion-attribution model of Dijker and Koomen (1996, 2003), which states that seriousness will lead to more feelings of fear and pity. The study of De Graaff-Wijnberg and colleagues (2006) showed that high seriousness of complaints evoked significant more feelings of fear in perceivers compared to low seriousness of complaints. No effect on pity was found. Several other studies found a significant impact of seriousness on emotional reactions towards psychiatric patients, such as patients with schizophrenia (Corrigan et al., 2003; Angermeyer et al. 2003). Previous research also found a significant impact of seriousness on behavioural reactions. Seriousness of complaints did have a negative impact on the desire for social distance towards schizophrenic patients (Angermeyer et al., 2003). The worse the prognosis of the illness, the more social distance participants desired.

A second possible explanation is the time period between the depressive complaints and the application procedure. Depressive complaints were absent for already five years. It could be possible that, because of the time period, participants valued the depressive complaints as less relevant for the current performance of the applicant.

Our manipulation is not responsible for the lack of significant results concerning the seriousness of complaints. Manipulation checks show that varying the length of the career gap was an effective manipulation of seriousness. Participants in the high seriousness condition judged the complaints of the applicant as more serious compared to the participants in the low seriousness condition.

Limitations of the present study

The present study used scenarios to investigate the role of earlier depressive symptoms during job applications. Because the scenario was only hypothetical, there was no real interaction between participant and applicant (De Graaff-Wijnberg et al., 2006). Answers could not lead to actual negative consequences. Furthermore, results could be biased by socially acceptable answers. Because the present study used an explicit research design, only explicit attitudes are measured. Possible implicit negative attitudes towards psychiatric patients could not be measured in the present study.

Another important limitation of the present study is the research population. The study included only economy and (international) business administration students. This means that results are only based on high educated participants. Earlier research showed that there is a difference in stigmatizing attitudes between several levels of education (Bos, 2001). Bos (2001) showed that highly educated participants were more willing to engage in personal contact with people with HIV/AIDS compared to low educated participants.

A final limitation is the use of a questionnaire in the present study. Emotional and behavioural reactions were measured with a more cognitive measurement instrument. This means that actual behaviour is not measured. Only intentional behaviour is measured. This could have biased the emotional and behavioural reactions of participants.

Implications and future research

Disclosure of earlier depressive complaints during a job interview has a negative influence on the chance that the perceiver will hire the applicant and on the personal assessment of the applicant. More negative personal characteristics were attributed towards the depressive applicant compared to the applicants in the other two conditions. These data suggest that stigmatization takes place when psychiatric patients are applying for a job. Teachman and colleagues (2006) also found evidence for the existence of explicit negative biases towards mental illnesses in a sample of students, in the general population and even in psychiatric patients. The presence of explicit negative biases in both studies indicates that evaluating psychiatric patients negatively is still relative social acceptable. Research shows that expression of prejudice in society is strongly dependable on social norms (Crandall, Eshleman, O'Brien, 2002). This means that as long as expressing prejudice towards psychiatric patients is socially acceptable, stigmatization of this minority group will never change.

Despite professionals in the American mental health field prefer disclosure of complaints during an interview (Goldberg et al., 2005), the present study shows that applicants with earlier mental complaints should carefully consider the pros and cons of disclosure of their complaints during a job interview. This result supports the recommendation of Goldberg and colleagues (2005) who say that psychiatric patients should educate themselves concerning different disclosure options, such as selective disclosure or strategically timed disclosure. When they decide to conceal their mental complaints, support should be given to minimize the psychological consequences of this concealment (Goldberg et al., 2005).

In contrast with earlier studies on the process of stigmatization, some expected effects were not found. For example, depressive complaints did not have a different influence on emotional reactions compared to the car-accident and control condition. Furthermore, seriousness of complaints did not have any impact on the amount of stigmatization. Possibly the chosen mental illness in the current study does not evoke all expected stigmatizing reactions in perceivers. Since Corrigan and colleagues (2000) showed that depression was one of the more benign mental disorders, we could

expect that earlier psychotic complaints or addiction problems could evoke even more stigmatizing reactions when disclosing their mental illness during a job interview. Future research should focus on possible differences between specific mental disorders. It could be possible that an applicant with earlier psychotic complaints evokes far more negative emotional and behavioural reactions compared to the current depressive applicant.

Future research should also focus on more implicit negative attitudes towards psychiatric patients. The present study used a more explicit research design. Despite that the included covariate 'motivation to control prejudice' did not change the amount of significant results, it was a significant factor in almost all analyses. Earlier studies showed that implicit negative preconceptions against several minority groups exist even when participants are not consciously aware of these negative attitudes (Nosek, Banaji & Greenwald, 2002; Teachman, Gapinski, Brownnell, Rawlins & Jeyaram, 2003; Teachman, Wilson & Komarovskaya, 2006). For example, Teachman and colleagues (2003) showed that even when participants have feelings of empathy towards fat people, they still have implicit negative biases. A second study of Teachman and colleagues (2006) found evidence for both the existence of implicit negative biases towards psychiatric patients in students, in the general population and even in psychiatric patients. The presence of implicit negative biases indicates that even when participants want to be tolerant towards psychiatric patients or want to evaluate these patients positively, they still can't ignore the pervasive negative picture which is apparent in modern society (Teachman et al., 2006). It is possible that current results indicate that participants in the present study do not have explicit negative attitudes towards mental patients or that participants tried to give socially acceptable answers. This does not mean that these participants do not have stigmatizing attitudes towards mental patients. These attitudes could be implicit or beyond consciousness. Future research should focus on more implicit research methods such as the Implicit Association Test (IAT) used in the study of Teachman and colleagues (2006).

Finally, it is possible that the expected effects of the present study will be supported when decisions made by participants will actually have consequences.

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APPENDIX A. Scenario (depression/high seriousness)

Gezocht:

Administratief medewerker m/v

Wat gaat er gebeuren?

Zometeen zal je gevraagd worden je te verplaatsen in het werk van een selectiemedewerk(st)er. Je zult de vacature doorlezen en de sollicitatiebrief van één van de sollicitanten goed doornemen. Vervolgens lees je hoe het sollicitatiegesprek met deze kandidaat is verlopen. Wanneer je deze informatie allemaal goed doorgelezen hebt, volgt er een vragenlijst. Bij elke vraag in deze lijst wordt een aantal antwoordmogelijkheden gegeven. Hieronder volgt een voorbeeld.

Voorbeeld

Hoe graag ga je naar de bioscoop?

Helemaal niet graag						**Heel graag**
0	0	0	0	0	0	0

Als u heel graag naar de bioscoop gaat, kruist u bijvoorbeeld het meest rechter vakje aan. Als u helemaal niet graag naar de bioscoop gaat kruist u juist het meest linkse vakje aan, etc.

Voor je aan de vragenlijst zal beginnen, allereerst een belangrijke mededeling: alle informatie zal anoniem en vertrouwelijk verwerkt worden. Lees alle informatie die wordt gegeven aandachtig door en probeer zo eerlijk en spontaan mogelijk antwoord te geven.

De situatie

Stel je voor dat je werkzaam bent bij De Jong & Partners BV, een administratief bedrijf welke zich in 1984 gevestigd heeft in Rotterdam. De Jong & Partners neemt administratieve taken over van bedrijven die dit liever uitbesteden. Je moet dan denken aan de boekhouding, salarisadministratie, belastingzaken, enzovoorts. Aangezien het De Jong & Partners de afgelopen jaren voor de wind is gegaan, heeft men besloten te gaan uitbreiden. Zo is men op zoek naar een nieuwe administratief medewerk(ster). Aangezien jij nauw samen zal gaan werken met deze nieuwe collega, zal je deel uit maken van de sollicitatiecommissie. De volgende vacature wordt geplaatst.

DE JONG & PARTNERS
Financiële,Administratie en Fiscale Zaken

Het bedrijf
De Jong & Partners BV is opgericht in 1984 en is sindsdien uitgegroeid tot een toonaangevend bedrijf op het gebied van financiële en administratieve zaken. Op dit moment is De Jong & Partners BV op zoek naar een:

Administratief Medewerker m/v
(Fulltime)

Werkzaamheden
Als administratief medewerk(st)er ben je verantwoordelijk voor verschillende administratieve taken, waaronder een gedeelte van de loonadministratie en de boekhouding.

Functie-eisen
- MBO werk- en denkniveau (MEAO);
- Enkele jaren werkervaring in een soortgelijke functie;
- Beheersing van de Nederlandse taal in woord en geschrift;
- Ervaring met Word, Excel en Exact;
- Zowel zelfstandig als in teamverband kunnen werken;
- Woonachtig in regio Rotterdam.

Belangrijkste persoonlijke vaardigheden
Flexibiliteit, creativiteit, zelfstandigheid coöperatief en accuratesse

Belangstelling
Voor meer inlichtingen kunt u bellen naar 010-1534221. Bij interesse kunt u, binnen 2 weken, uw sollicitatie richten naar: vacature1@dejongadministraties.

Acquisitie naar aanleiding van deze vacature wordt niet op prijs gesteld.

Al binnen korte tijd reageren er tientallen sollicitanten, waaronder Linda Schuitema. Haar sollicitatiebrief en CV vind je op de volgende pagina. Lees deze beide documenten aandachtig door voordat je verder gaat. Probeer tijdens het lezen een goed beeld te vormen over Linda.

Linda Schuitema
Asterhof 12
3062 XS Rotterdam
Tel.:010-2867540
Email: lindaschuitema@yahoo.nl

Betreft: Vacature administratief medewerkster.

Rotterdam, 10 januari 2006.

Geachte Mijnheer/Mevrouw,

Naar aanleiding van uw advertentie in het Algemeen Dagblad, waarin u gegadigden oproept te solliciteren naar de functie van administratief medewerkster, stuur ik u deze brief. Via deze weg wil ik laten weten dat ik graag voor deze functie in aanmerking kom.

De functie spreekt mij erg aan, juist omdat hij zeer goed aansluit op mijn opleiding en werkervaring. Al tijdens mijn opleiding werkte ik als administratief medewerkster bij Kropak BV waar ik parttime lichte, administratieve taken verrichte. Nadat ik in 1993 mijn MEAO/BA diploma haalde, ben ik gaan werken als administratief medewerkster bij Van Dijk Administratiekantoor BV. Hier was ik verantwoordelijk voor een gedeelte van de loonadministratie. In 2001 ben ik in dienst getreden bij Hortex Zorgverzekeringen BV. Binnen deze nieuwe functie kreeg ik meer verantwoordelijkheden en verzorgde ik naast de loonadministratie ook de boekhouding. In deze functie heb ik erg veel opgestoken over verschillende administratieve taken. Daarnaast heb ik in deze functie zowel alleen moeten werken als in teamverband. Ten slotte beschik ik over goede communicatieve vaardigheden en ben ik erg bedreven in het werken met verscheidene computerprogramma’s, waaronder Word, Excel en Exact.

Verdere informatie over mij is te vinden in het bijgevoegde curriculum vitae. Ik zie uw reactie met belangstelling tegemoet en hoop dat ik mijn interesse voor deze functie in een persoonlijk gesprek mag toelichten.

Met vriendelijke groet,

Linda Schuitema.
Bijlage: Curriculum Vitae

Curriculum Vitae

Persoonlijke gegevens

Naam	Linda
Voornaam	Schuitema
Adres	Asterhof 12
	3062 XS
Telefoon	010-2867540
Mobiele telefoon	06-88764530
Email	lindaschuitema@yahoo.com
Geboren	24 september 1972

Opleidingen

1985 – 1990	HAVO (diploma behaald)
	Willem de Zwijger College te Papendrecht
1990 – 1993	MEAO/BA (diploma behaald) Albeda College te Rotterdam, locatie Haastrechtstraat
1995 – 1996	Computercursus, waaronder Microsoft Office

Werkervaring

Oktober 1986 – Februari 1990	HEMA Papendrecht
	Partime klantenservice + verkoop
December 1990 – Augustus 1993	Kropak BV te Rotterdam
	Ondersteunend administratief medewerkster
Oktober 1993 – September 2000	Van Dijk Administratiekantoor BV te Rotterdam
	Administratief medewerkster loonadministratie
Oktober 2001 – heden	Hortex Zorgverzekering BV te Rotterdam
	Administratief medewerkster

Talen

Goede beheersing van Nederlands, Duits en Engels in woord en geschrift.

Hobby's

Aerobics en Volleybal

Het sollicitatiegesprek

Aangezien Linda Schuitema voldoet aan alle functie-eisen, nodig je haar uit voor een gesprek. Bij dit gesprek zullen jouw leidinggevende, Linda en jijzelf aanwezig zijn.

Die maandagochtend zit je om precies 9.55 samen met je leidinggevende op de komst van Linda te wachten. Wanneer zij arriveert, schudden jullie elkaar de hand en wordt er koffie ingeschonken. Nadat jullie je hebben voorgesteld, vertelt jouw leidinggevende het één en ander over het bedrijf. Vervolgens geeft hij het woord aan Linda en vraagt hij naar haar werkervaringen. Linda vertelt dat zij tijdens haar opleiding al enige ervaring heeft opgedaan in een administratieve functie. Zij werkte namelijk twee dagen per week bij Kropak BV waar zij lichte administratieve taken verrichte, zoals telefoneren, archiveren en het klantenbestand bijhouden. Na het afronden van haar opleiding is zij al snel fulltime gaan werken bij Van Dijk Administratie-kantoor BV. Daar heeft zij in totaal vier jaar gewerkt en hield ze zich vooral bezig met de loonadministratie van het bedrijf. Op dit moment is zij werkzaam bij Hortex Zorgverzekeringen BV. In de loop van de jaren heeft zij steeds meer verantwoordelijkheden gekregen binnen deze organisatie. Zij draagt nu de gehele verantwoordelijkheid voor de loonadministratie van het bedrijf, waarbij zij de leiding heeft over drie andere personeelsleden. Daarnaast levert zij ook een bijdrage aan de boekhouding. Door het faillissement van Hortex is Linda genoodzaakt om ander werk te gaan zoeken. Toen zij de vacature bij De Jong & Partners las, besloot zij direct te reageren.

Het verhaal van Linda klinkt erg goed, maar je vraagt je natuurlijk wel af waarom zij vanaf september 2000 één jaar lang geen werk heeft gehad. Linda geeft hierop het volgende antwoord:

"In september dat jaar heb ik last gekregen van een ernstige depressie, waardoor ik één jaar lang niet meer in staat was om te werken. Door het volgen van intensieve psychotherapie ben ik er langzaam maar zeker weer bovenop gekomen en in oktober 2001 ben ik in dienst getreden bij Hortex. Sindsdien heb ik geen klachten meer gehad."

Vervolgens gaat het gesprek over wat Linda voor het bedrijf zou kunnen betekenen en wat ze van de baan verwacht. Zij vertelt dat ze ervan overtuigd is dat zij goed zal functioneren, omdat zij al zoveel ervaring heeft met de verschillende taken en omdat zij zichzelf volkomen herkent in de functiebeschrijving.

Na een gesprek van bijna drie kwartier nemen jullie afscheid. Je vertelt aan Linda dat zij binnen twee weken bericht zal krijgen.

APPENDIX B. Questionnaire 1

VRAGENLIJST 1

Er volgt nu een aantal vragen. Bij elke vraag krijg je een aantal antwoord-mogelijkheden. Maak bij elke vraag het antwoord zwart dat het beste bij jou mening past. Probeer zo spontaan en eerlijk mogelijk te antwoorden. Nogmaals: alle informatie zal anoniem en vertrouwelijk verwerkt worden.

Als ik denk aan Linda voel ik ……

	Helemaal niet						**Heel erg**
Medelijden	0	0	0	0	0	0	0
Zenuwachtigheid	0	0	0	0	0	0	0
Betrokkenheid	0	0	0	0	0	0	0
Gespannenheid	0	0	0	0	0	0	0
Ergernis	0	0	0	0	0	0	0
Nijdigheid	0	0	0	0	0	0	0
Medeleven	0	0	0	0	0	0	0
Irritatie	0	0	0	0	0	0	0
Nervositeit	0	0	0	0	0	0	0
Boosheid	0	0	0	0	0	0	0
Sympathie	0	0	0	0	0	0	0
Angst	0	0	0	0	0	0	0

Als ik denk aan Linda, dan ……

	Helemaal niet						**Heel erg**
'Hou ik liever enige afstand tot Linda.'	0	0	0	0	0	0	0
'Voel ik me niet op mijn gemak.'	0	0	0	0	0	0	0
'Zou ik haar het liefst vermijden.'	0	0	0	0	0	0	0
'Zou ik niet graag met haar omgaan.'	0	0	0	0	0	0	0
'Zou ik liever niets met haar te maken willen hebben.'	0	0	0	0	0	0	0

Zou je graag ……

	Helemaal niet						**Heel graag**
Nauw met Linda samen werken	0	0	0	0	0	0	0
Bij haar gaan zitten in de lunchpauze	0	0	0	0	0	0	0
Een luisterend oor bieden aan Linda	0	0	0	0	0	0	0
Een keer met Linda gaan stappen	0	0	0	0	0	0	0
Linda om raad vragen wanneer je een probleem hebt	0	0	0	0	0	0	0

Hoe denk je dat Linda is in haar werkhouding?

	Helemaal mee oneens						**Helemaal mee eens**
Flexibel	0	0	0	0	0	0	0
Gedreven	0	0	0	0	0	0	0
Creatief	0	0	0	0	0	0	0
Passief	0	0	0	0	0	0	0
Zelfstandig	0	0	0	0	0	0	0
Besluiteloos	0	0	0	0	0	0	0
Coöperatief	0	0	0	0	0	0	0
Accuraat	0	0	0	0	0	0	0
Onverschillig	0	0	0	0	0	0	0
Stressbestendig	0	0	0	0	0	0	0

Hieronder volgt een aantal eigenschappen. Geef aan in hoeverre deze volgens jou op Linda van toepassing zijn.

Ik vind Linda ……

	Helemaal niet						**Helemaal wel**
Vriendelijk	0	0	0	0	0	0	0
Aarzelend	0	0	0	0	0	0	0
Introvert	0	0	0	0	0	0	0
Gevoelig	0	0	0	0	0	0	0
Aardig	0	0	0	0	0	0	0
Verlegen	0	0	0	0	0	0	0
Meegaand	0	0	0	0	0	0	0
Nerveus	0	0	0	0	0	0	0
Gespannen	0	0	0	0	0	0	0
Spraakzaam	0	0	0	0	0	0	0
Onzeker	0	0	0	0	0	0	0

Geschiktheid…

Hoe groot is de kans dat je Linda aanneemt?

Heel laag						**Heel hoog**
0	0	0	0	0	0	0

Zou je Linda naar de 2e ronde laten gaan?

Zeer zeker niet						**Zeer zeker wel**
0	0	0	0	0	0	0

Hoe geschikt is Linda volgens jou voor de functie?

Helemaal niet						**Heel erg**
0	0	0	0	0	0	0

Hoe goed denk je dat Linda de functie van administratief medewerkster zal uitvoeren?

Heel slecht						**Heel goed**
0	0	0	0	0	0	0

Welke reden geeft Linda voor het gat in haar CV?

0 Zij kon in deze periode geen baan vinden
0 Een depressie
0 Een wereldreis
0 Een auto-ongeluk
0 Zij geeft hiervoor geen reden
0 Een andere reden, namelijk ……

Hoe open vind je dat Linda zich opstelt over het gat in haar CV tijdens het sollicitatiegesprek?

Zeer gesloten						**Zeer open**
0	0	0	0	0	0	0

Hoe ernstig is volgens jou de situatie waardoor Linda een gat in haar CV heeft?

Helemaal niet ernstig						**Heel ernstig**
0	0	0	0	0	0	0

Hoe lang vind is het gat in het CV van Linda?

0 0 - 3 maanden
0 4 - 6 maanden
0 ½ - 1½ jaar
0 2 – 3 jaar

Ten slotte volgt er nog een aantal algemene vragen.

Sekse

Je bent 0 Man

0 Vrouw

Leeftijd .....jaar.

Algemeen

In welke mate heb je wel eens last (gehad) van depressieve klachten?

Helemaal niet						**Heel erg**
0	0	0	0	0	0	0

In welke mate hebben mensen in je directe omgeving last (gehad) van depressieve klachten?

Helemaal niet						**Heel erg**
0	0	0	0	0	0	0

Opleiding

Welke opleiding volg je?

0 Bedrijfskunde

0 Economie

0 Psychologie

0 Anders, namelijk.....

APPENDIX C. Questionnaire 2

VRAGENLIJST 2

De volgende vragenlijst bestaat uit 21 rijtjes uitspraken. Leest u elk rijtje a.u.b. aandachtig en kies uit elk rijtje één uitspraak, die het best beschrijft hoe u zich **de afgelopen twee weken met vandaag erbij** gevoeld heeft. Zet een kruisje in het hokje voor de door u gekozen uitspraak. Als meerdere uitspraken in een rijtje even goed van toepassing zijn, zet dan een kruisje in het hokje bij de uitspraak met het hoogste cijfer. Let er op dat u niet meer dan één uitspraak per rijtje kiest, ook bij vraag 16 (Veranderingen in Slaappatroon) en 18 (Veranderingen in Eetlust).

1. Somberheid, verdriet

- □ Ik voel me niet somber.
- □ Ik voel me een groot deel van de tijd somber.
- □ Ik ben de hele tijd somber.
- □ Ik ben zo somber of ongelukkig dat ik het niet verdragen kan.

2. Pessimisme

- □ Ik ben niet ontmoedigd over mijn toekomst.
- □ Ik ben meer ontmoedigd over mijn toekomst dan vroeger.
- □ Ik verwacht niet dat de dingen goed voor mij zullen uitpakken.
- □ Ik heb het gevoel dat mijn toekomst hopeloos is en dat het alleen maar erger zal worden.

3. Mislukkelingen

- □ Ik voel me geen mislukking.
- □ Ik heb teveel dingen laten mislukken.
- □ Als ik terugkijk, zie ik een hoop mislukkingen.
- □ Ik vind dat ik als persoon een totale mislukking ben.

4. Verlies van plezier

- □ Ik beleef net zoveel plezier als altijd aan de dingen die ik leuk vind.
- □ Ik geniet niet meer zoveel van dingen als vroeger.
- □ Ik beleef heel weinig plezier aan de dingen die ik vroeger leuk vond.
- □ Ik beleef geen enkel plezier aan de dingen die ik vroeger leuk vond.

5. Schuldgevoelens

- □ Ik voel me niet bijzonder schuldig.
- □ Ik voel me schuldig over veel dingen die ik heb gedaan of had moeten doen.
- □ Ik voel me meestal erg schuldig.
- □ Ik voel me de hele tijd schuldig.

6. Gevoel gestraft te worden

- □ Ik heb niet het gevoel dat ik gestraft word.
- □ Ik heb het gevoel dat ik misschien gestraft zal worden.
- □ Ik verwacht gestraft te worden.
- □ Ik heb het gevoel dat ik nu gestraft wordt.

7. Afkeer van zichzelf

- □ Ik voel me over mezelf net als altijd.
- □ Ik heb minder zelfvertrouwen.
- □ Ik ben teleurgesteld in mezelf.
- □ Ik heb een hekel aan mezelf.

8. Zelfkritiek

- □ Ik bekritiseer of verwijt mijzelf niet meer dan gewoonlijk.
- □ Ik ben meer kritisch op mezelf dan vroeger.
- □ Ik bekritiseer mezelf voor al mijn tekortkomingen.
- □ Ik verwijt mijzelf al het slechte wat gebeurt.

9. Suïcidale gedachten of wensen

- □ Ik heb geen enkele gedachte aan zelfdoding.
- □ Ik heb gedachten aan zelfdoding, maar ik zou ze niet ten uitvoer brengen.
- □ Ik zou liever een eind aan mijn leven maken.
- □ Ik zou een eind aan mijn leven maken als ik de kans kreeg.

10. Huilen

- □ Ik huil niet meer dan vroeger.
- □ Ik huil meer dan vroeger.
- □ Ik huil om elk klein ding.
- □ Ik wil graag huilen, maar ik kan het niet.

11. Agitatie, onrust

- □ Ik ben niet rustelozer of meer gespannen dan anders.
- □ Ik ben rustelozer of meer gespannen dan anders.
- □ Ik ben zo rusteloos of opgewonden dat ik moeilijk stil kan zitten.
- □ Ik ben zo rusteloos of opgewonden dat ik moet blijven bewegen of iets doen.

12. Verlies van interesse

- □ Mijn belangstelling voor andere mensen of activiteiten is niet verminderd.
- □ Ik heb nu minder belangstelling voor andere mensen of dingen dan vroeger.
- □ Ik heb mijn belangstelling voor andere mensen of dingen grotendeels verloren.
- □ Het is moeilijk ergens belangstelling voor op te brengen.

13. Besluiteloosheid

- □ Ik neem beslissingen ongeveer even makkelijk als altijd.
- □ Ik vind het moeilijker om beslissingen te nemen dan gewoonlijk.
- □ Ik heb veel meer moeite met het nemen van beslissingen dan vroeger.
- □ Ik heb moeite met alle beslissingen.

14. Waardeloosheid

- □ Ik heb niet het gevoel dat ik waardeloos ben.
- □ Ik zie mezelf niet meer zo waardevol en nuttig als vroeger.
- □ Vergeleken met anderen voel ik me meer waardeloos.
- □ Ik voel me volstrekt waardeloos.

15. Energieverlies

- □ Ik heb nog evenveel energie als altijd.
- □ Ik heb minder energie dan vroeger.
- □ Ik heb niet voldoende energie om veel te doen.
- □ Ik heb niet genoeg energie om wat dan ook te doen.

16. Verandering van slaappatroon

- □ Mijn slaappatroon is niet veranderd.
- □ Ik slaap wat meer dan gewoonlijk.
- □ Ik slaap wat minder dan gewoonlijk.
- □ Ik slaap veel meer dan gewoonlijk.
- □ Ik slaap veel minder dan gewoonlijk.
- □ Ik slaap het grootste deel van de dag.
- □ Ik word 1-2 uur te vroeg wakker en kan niet meer inslapen.

17. Prikkelbaarheid

- □ Ik ben niet meer prikkelbaar dan anders.
- □ Ik ben iets meer prikkelbaar dan anders.
- □ Ik ben veel meer prikkelbaar dan ander.
- □ Ik ben de hele tijd prikkelbaar.

18. Verandering van eetlust

- □ Mijn eetlust is niet veranderd.
- □ Mijn eetlust is wat kleiner dan gewoonlijk.
- □ Mijn eetlust is wat groter dan gewoonlijk.
- □ Mijn eetlust is veel kleiner dan gewoonlijk.
- □ Mijn eetlust is veel groter dan gewoonlijk.
- □ Ik heb helemaal geen eetlust.
- □ Ik verlang de hele tijd naar eten.

19. Concentratieproblemen

- □ Ik kan me net zo goed concentreren als altijd.
- □ Ik kan me niet zo goed concentreren als anders.
- □ Het is lastig om mijn gedachten ergens lang bij te houden.
- □ Ik kan me nergens op concentreren.

20. Moeheid

- □ Ik ben niet meer moe of afgemat dan gewoonlijk.
- □ Ik word sneller moe of afgemat dan gewoonlijk.
- □ Ik ben te moe of afgemat voor veel dingen die ik vroeger wel deed.
- □ Ik ben te moe of afgemat voor de meeste dingen die ik vroeger wel deed.

21. Verlies van interesse in seks

- □ Ik heb de laatste tijd geen verandering gemerkt in mijn belangstelling voor seks.
- □ Ik heb minder belangstelling voor seks dan vroeger
- □ Ik heb tegenwoordig veel minder belangstelling voor seks.
- □ Ik heb alle belangstelling voor seks verloren.

Hieronder worden 100 stellingen gegeven. Denk aan uzelf en geef per stelling aan hoe vaak u vindt dat u dit doet in vergelijking met andere mensen. Dit kunt u aangeven door het rondje, bij het door u gekozen, zwart te maken.

1. = Veel minder vaak dan anderen.
2. = Minder vaak dan anderen.
3. = Noch meer, noch minder dan anderen.
4. = Meer/vaker dan anderen.
5. = Veel meer/vaker dan anderen.

	1.	**2.**	**3.**	**4.**	**5.**
1. Ik neem tijd voor een praatje	0	0	0	0	0
2. Ik word gauw boos	0	0	0	0	0
3. Ik doe dingen zonder planning	0	0	0	0	0
4. Ik ben ten einde raad	0	0	0	0	0
5. Ik doe wat me gezegd wordt	0	0	0	0	0
6. Ik breng de stemming erin	0	0	0	0	0
7. Ik span me in voor anderen	0	0	0	0	0
8. Ik houd van orde en regelmaat	0	0	0	0	0
9. Ik denk dat alles wel goed komt	0	0	0	0	0
10. Ik praat anderen na	0	0	0	0	0
11. Ik houd me op de achtergrond	0	0	0	0	0
12. Ik vraag hoe het met iemand gaat	0	0	0	0	0
13. Ik werk graag volgens schema	0	0	0	0	0
14. Ik praat mezelf problemen aan	0	0	0	0	0
15. Ik beslis op eigen verantwoordelijkheid	0	0	0	0	0
16. Ik voel me slecht op mijn gemak	0	0	0	0	0
17. Ik houd rekening met belangen van anderen	0	0	0	0	0
18. Ik laat spullen slingeren	0	0	0	0	0
19. Ik zie altijd wel een lichtpuntje	0	0	0	0	0
20. Ik neem de leiding	0	0	0	0	0
21. Ik praat zacht	0	0	0	0	0
22. Ik wacht op mijn beurt	0	0	0	0	0

1. = Veel minder vaak dan anderen.

2. = Minder vaak dan anderen.

3. = Noch meer, noch minder dan anderen.

4. = Meer/vaker dan anderen.

5. = Veel meer/vaker dan anderen.

	1.	**2.**	**3.**	**4.**	**5.**
23. Ik doe dingen die anderen vreemd vinden	0	0	0	0	0
24. Ik ben bang iets verkeerd te doen	0	0	0	0	0
25. Ik laat me alles wijsmaken	0	0	0	0	0
26. Ik amuseer me opperbest	0	0	0	0	0
27. Ik accepteer mensen zoals ze zijn	0	0	0	0	0
28. Ik doe gekke dingen	0	0	0	0	0
29. Ik houd emoties onder controle	0	0	0	0	0
30. Ik laat me afschrikken	0	0	0	0	0
31. Ik vermijd gezelschap	0	0	0	0	0
32. Ik denk eerst aan mezelf	0	0	0	0	0
33. Ik doe iets op het laatste moment	0	0	0	0	0
34. Ik zie de toekomst somber in	0	0	0	0	0
35. Ik neem risico's	0	0	0	0	0
36. Ik houd van grote feesten	0	0	0	0	0
37. Ik probeer ruzie te voorkomen	0	0	0	0	0
38. Ik maak werk op tijd af	0	0	0	0	0
39. Ik vrees meteen het ergste	0	0	0	0	0
40. Ik laat beslissingen aan anderen over	0	0	0	0	0
41. Ik babbel graag	0	0	0	0	0
42. Ik maak ruzie	0	0	0	0	0
43. Ik gedraag me zoals het hoort 0	0	0	0	0	
44. Ik zet tegenslag snel opzij	0	0	0	0	0
45. Ik bekijk iets van verschillende kanten	0	0	0	0	0
46. Ik ben bang voor nieuwe ontmoetingen	0	0	0	0	0
47. Ik houd rekening met andermans gevoelens	0	0	0	0	0
48. Ik werk volgens een vast patroon	0	0	0	0	0
49. Ik kan tegen een stootje	0	0	0	0	0

1. Veel minder vaak dan anderen.

2. Minder vaak dan anderen.

3. Noch meer, noch minder dan anderen.

4. Meer/vaker dan anderen.

5. Veel meer/vaker dan anderen.

	1.	**2.**	**3.**	**4.**	**5.**
50. Ik neem het initiatief	0	0	0	0	0
51. Ik vrolijk anderen op	0	0	0	0	0
52. Ik gebruik mensen voor eigen doelen	0	0	0	0	0
53. Ik zoek gevaar op	0	0	0	0	0
54. Ik barst in tranen uit	0	0	0	0	0
55. Ik doe wat anderen willen	0	0	0	0	0
56. Ik zonder me af	0	0	0	0	0
57. Ik leef mee met anderen	0	0	0	0	0
58. Ik wil dat alles precies klopt	0	0	0	0	0
59. Ik bekijk de dingen van de zonnige kant	0	0	0	0	0
60. Ik ben makkelijk klein te krijgen	0	0	0	0	0
61. Ik knoop gesprekken aan	0	0	0	0	0
62. Ik vertel sterke verhalen over mezelf	0	0	0	0	0
63. Ik laat werk liggen	0	0	0	0	0
64. Ik kan problemen van me afzetten	0	0	0	0	0
65. Ik wacht af wat anderen doen	0	0	0	0	0
66. Ik houd anderen op afstand	0	0	0	0	0
67. Ik doe graag iets voor een ander	0	0	0	0	0
68. Ik doe de dingen volgens het boekje	0	0	0	0	0
69. Ik weet me te beheersen	0	0	0	0	0
70. Ik sluit me bij de meerderheid aan	0	0	0	0	0
71. Ik ben het liefst alleen	0	0	0	0	0
72. Ik leg anderen mijn wil op	0	0	0	0	0
73. Ik werk hard	0	0	0	0	0
74. Ik sta stevig in mijn schoenen	0	0	0	0	0
75. Ik reageer snel	0	0	0	0	0

1. Veel minder vaak dan anderen.
2. Minder vaak dan anderen.
3. Noch meer, noch minder dan anderen.
4. Meer/vaker dan anderen.
5. Veel meer/vaker dan anderen.

	1.	2.	3.	4.	5.
76. Ik beweeg me makkelijk in gezelschap	0	0	0	0	0
77. Ik wil de leiding hebben	0	0	0	0	0
78. Ik laat me afleiden	0	0	0	0	0
79. Ik raak in paniek	0	0	0	0	0
80. Ik ga uitdagingen aan	0	0	0	0	0
81. Ik leef in mijn eigen wereldje	0	0	0	0	0
82. Ik voer het hoogste woord	0	0	0	0	0
83. Ik kom afspraken na	0	0	0	0	0
84. Ik zit in de put	0	0	0	0	0
85. Ik weet wat ik wil	0	0	0	0	0
86. Ik klap dicht bij onbekenden	0	0	0	0	0
87. Ik respecteer iemands mening	0	0	0	0	0
88. Ik bereid me goed voor	0	0	0	0	0
89. Ik raak uit mijn humeur	0	0	0	0	0
90. Ik ben gemakkelijk voor de gek te houden	0	0	0	0	0
91. Ik maak makkelijk vrienden	0	0	0	0	0
92. Ik commandeer mensen	0	0	0	0	0
93. Ik doe onverwachte dingen	0	0	0	0	0
94. Ik pieker ergens over	0	0	0	0	0
95. Ik zit vol met ideeën	0	0	0	0	0
96. Ik straal vreugde uit	0	0	0	0	0
97. Ik plaats me in het middelpunt	0	0	0	0	0
98. Ik verwaarloos taken	0	0	0	0	0
99. Ik houd het hoofd koel	0	0	0	0	0
100. Ik begeef me in discussies	0	0	0	0	0

Ten slotte worden er nog 12 stellingen gegeven. Geef per stelling aan in hoeverre u vindt dat deze stelling op u van toepassing is door het rondje, bij het door u gekozen antwoord, zwart te maken.

1. Ik probeer onbevooroordeeld te reageren op mensen met een psychische stoornis, omdat dit persoonlijk belangrijk voor mij is.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

2. Ik ben persoonlijk gemotiveerd door mijn geloof om geen vooroordelen te hebben tegenover mensen met een psychische stoornis.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

3. Geen vooroordelen hebben tegenover mensen met een psychische stoornis, is belangrijk voor mijn eigenwaarde.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

4. Mijn persoonlijke normen en waarden bepalen in sterkere mate hoe ik reageer op mensen met een psychische stoornis, dan mijn zorg over de reactie van andere mensen.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

5. Hoe ik reageer op mensen met een psychische stoornis wordt in sterkere mate bepaald door mijn persoonlijke normen en waarden dan door mijn zorg over hoe anderen zullen reageren.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

6. Ik probeer al mijn negatieve gedachten over mensen met een psychische stoornis te verdrukken, zodat ik geen negatieve reacties bij andere mensen teweegbreng.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

7. Wanneer ik bevooroordeeld zou reageren op mensen met een psychische stoornis, zou ik me zorgen maken over anderen die misschien boos op me worden.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

8. Volgens mijn persoonlijke normen en waarden is het hanteren van stereotypen voor mensen met een psychische stoornis correct.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

9. Ik doe net alsof ik onbevooroordeeld ben over mensen met een psychische stoornis, om afkeuring door anderen te voorkomen.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

10. Het is belangrijk voor mij net te doen alsof ik geen vooroordelen heb tegenover mensen met een psychische stoornis, omdat andere mensen anders kunnen denken dat ik stigmatiseer.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

11. Ik wil niet dat mijn vrienden denken dat ik vooroordelen heb over mensen met een psychische stoornis.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

12. Ik probeer onbevooroordeeld te reageren op mensen met een psychische stoornis, vanwege de druk van anderen.

Helemaal mee oneens **Helemaal mee eens**

0 0 0 0 0 0 0 0 0

Hartelijk dank voor je medewerking!