

Individuals with Psychiatric Disabilities: *A Written Guide*



A Collaborative Effort of the
Office of Affirmative Action
and the
University Counseling Center
of the University of New Hampshire

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INTRODUCTORY LETTER

The University of New Hampshire's (UNH) Office of Affirmative Action and the Counseling Center are pleased to collaborate on this project on psychiatric disabilities. This collaboration was inspired by the belief that the combined experience and knowledge of our offices are vital to the effort of raising awareness and providing guidance and support to the University community.

The ultimate goal of the project is to ensure that the University community is welcoming and accommodating to individuals with psychiatric disabilities—where qualified individuals are given equal opportunities in education and employment. Because issues may involve managerial, supervisory and student concerns, the guide is written as a resource for senior administrators, deans and directors, faculty and staff. We hope this guide will be useful to promote a better understanding of disability laws as to how they apply to education and employment through increasing awareness, confronting myths, and reducing stigma related to mental illness and psychiatric disabilities. We also aim to increase communication so that individuals can consult with one another and utilize available campus resources with the goal of successfully navigating solutions to situations involving faculty members, staff members, and students with psychiatric disabilities.

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INTRODUCTION

Many people have a general awareness of the Americans with Disabilities Act (ADA) and its intent. At the same time, many are uncertain about what qualifies as a disability and how to uphold the ADA. While it is commonly known that the ADA protects individuals with physical disabilities, few people realize that it covers individuals with invisible disabilities as well. Psychiatric disabilities are the most recent disabilities to come under the protection of the ADA.

On a college campus, it is important to consider the impact that a psychiatric disability can have on major life functions and requirements of this setting—specifically, working and learning.

Navigating the current landscape of disabilities and accommodation can be a confusing and intricate process. While it can be difficult to recognize a psychiatric disability as such, it can be even more difficult to know how to proceed once a disability is recognized. When attempting to accommodate individuals with disabilities, there is a fine line between accommodation and over-accommodation. Administrators, deans, professors, staff, and students may unexpectedly find themselves attempting to play the role of therapist to an individual with a psychiatric disability. Determining how to be supportive without getting in over one's head is a difficult task. How much flexibility is reasonable?

The goal of this manual is to increase awareness regarding psychiatric disabilities and to help those who interact with, advise, supervise, or teach feel more comfortable with individuals who have psychiatric disabilities. This manual is not intended to be a legal or medical guide; most of us do not have enough coexisting legal and psychological knowledge to make an appropriate decision on our own. The most important decision sometimes is deciding whom to consult for guidance when dealing with a situation involving individuals with psychiatric disabilities. Resources for consultation are discussed throughout this manual, and several are listed in the "Resources" section on page 41.

GENERAL INFORMATION AND TERMINOLOGY

What is the nature and intent of the Americans with Disabilities Act?

The Americans with Disabilities Act (ADA) was enacted on July 26, 1990, with most provisions not taking effect until January 26, 1992. This was the first federal civil rights law for people with disabilities, both physical and mental. A comprehensive law, it prohibits discrimination against people with disabilities in areas such as employment, public transportation, and public/government services. Previously, the Rehabilitation Act of 1973 set the standard for equal access to educational programming. Together, these acts seek to ensure that all people have the equal opportunity to work, learn, and gain access to services.

The spirit of the ADA holds that all people should be given the same opportunities and services, based on qualifications and equal rights, taking into account reasonable accommodations and academic adjustments for their mental or physical disabilities. An employer who provides special equipment that allows a person with a significant loss of hearing to perform his or her job acts consistently with the Act. The ADA also holds that people should not be negatively affected by stigma, myths, and, misperceptions about mental and physical impairment. An employer who, in a promotion decision, considers only a person's qualifications and job performance and not his or her history of depression, is upholding the Act.

Some worry that the ADA gives unlimited concessions and allowances to individuals with disabilities without providing structure or support for the employer, supervisor, staff or professor. This is not the case. The Act, as we explain in this manual, contains guidelines, limits, and expectations of the person with the disability. Though some people feel that the Act seeks to provide unfair advantages for those with disabilities, the ADA seeks only to provide equal opportunity and protection from unjust discrimination for all people.

Thus, while the ADA is clear in its intent, what becomes ambiguous, and what is the source of much confusion and debate, is deciding who are covered under the ADA. A review of basic terminology and concepts will clarify the ADA and individual responsibilities therein:

What is a disability?

According to the ADA, a “disability” is a mental or physical impairment of a severity such that it substantially limits one or more of the “major life activities” of an individual, when compared to the average person.

What is a mental impairment?

Types of mental impairment include, but are not limited to, developmental disabilities (formerly known as “mental retardation”), emotional or mental illness, and learning disabilities. Impairment is not necessarily a disability, and therefore is not covered under the ADA unless it substantially limits one or more major life activities.

What are major life activities?

Major life activities include clearly defined and recognizable activities such as walking, seeing, and hearing. They also include more elusively defined activities such as working, learning, thinking, and interacting with others. Other examples of major life activities, related more specifically to psychiatric disabilities, include caring for one-self, paying attention and concentrating, and exercising judgment. Remember that there must be a substantial limitation on these activities in order for coverage under the ADA to be considered.

What are substantial limitations?

A substantial limitation extensively reduces a person’s ability to perform a major life activity. If the limitation stems from a mental impairment such as Bipolar Disorder (formerly, “Manic Depression”), it must reach the level of rendering a person unable to perform a major life activity, or significantly limiting that performance.

A substantial limitation is difficult to judge; one cannot determine it by diagnosis alone. One person’s psychiatric illness may be substantially limiting, while for another person, with the same illness, it is not. The Act requires that decisions made about substantial limitations of a major life activity be made on a case-by-case basis.

How does this apply to a work setting or school?

A person must be able to perform, with or without reasonable accommodations, the essential functions of his or her job responsibilities or meet the academic requirements and technical standards of the course of study with or without academic adjustments. The Act does not suggest that one should hire someone who is clearly unqualified for a job or pass a student who did not do the work.

What are essential functions and academic requirements and technical standards?

Examples may be helpful: essential functions of a support staff position might be answering phones; essential functions of a professor might be teaching class and grading papers; academic requirements and technical standards of a student might be turning in homework and demonstrating knowledge and skill in a particular area. If the removal of a task from a position or course would fundamentally alter that position or course, then the task is considered an essential function of that position or an essential academic requirement.

What are reasonable accommodations and academic adjustments?

Reasonable accommodations (employment) and academic adjustments (education) are changes made in a work or academic setting that allow an otherwise qualified individual to perform the tasks or functions of the position or course. The terms “reasonable accommodations” and “academic adjustments” will often be referred to as “accommodations.” This topic will be covered in greater detail later.

So how do I know if someone has a disability?

A student or employee should provide proper medical documentation (e.g., from a psychologist or psychiatrist) noting that a disability is present. The student or employee is not required to have documented the exact diagnosis or even type of disability. Generally, in a university setting, students and employees will have services arranged and documentation kept on file by the disabilities student services office staff and/or ADA Compliance Officer. At UNH, the three key offices are Affirmative Action, Access, and Human Resources.

Asking for such documentation is allowed only under specific circumstances. Consult the Office of Affirmative Action, the Access Office, or Human Resources for guidance on this.

Because the Act prohibits discrimination based on disability, an administrator, faculty, staff or student cannot deny a person equal access to a program, service, or activity that is sponsored by the university based on suspicion of a disability. That is, if a person is rumored to or thought to have a psychiatric disability.

How can I make decisions about hiring or promoting an employee or accommodating a student within the ADA guidelines?

Consult with the Office of Affirmative Action, the Access Office, or Human Resources for guidance on this. The Act refers to a “qualified individual with a disability.”

Who is a qualified individual with a disability?

This refers to someone who can perform, with or without reasonable accommodations, the essential functions of a position (employee) or meet the academic requirements and technical standards of the course of study (student).

Will an individual have the protection of the ADA if his/her psychiatric medications take away his/her symptoms?

Decisions involving medication, an example of a mitigating measure (as would also be glasses, crutches, or any measure that might essentially “correct” an impairment), is currently a point of legal debate. What is important to remember, however, is that the effects of medication can sometimes substantially limit a person’s ability to perform a major life activity. For example, side effects of some medications can include insomnia or dizziness. Due to the nature of mental illness and the variations in illnesses caused by medications, mental illnesses can be fluid and ever-changing. For instance, a medication that works for someone one week can drastically change in its effectiveness the next week, withdrawing its property as a mitigating measure.

What are the Equal Employment Opportunity Commission (EEOC) and the Office for Civil Rights (OCR) and how do they fit in here?

The EEOC was established by Title VII of the Civil Rights Act of 1964. The Commission enforces federal statutes that prohibit employment discrimination based on race, color, religion, sex/gender, national origin, age, and disability. Essentially, the Commission provides guidelines for following the laws, and it upholds the laws outlined by the various acts. The equivalent of the EEOC for academic settings is the Office for Civil Rights (OCR) of the US Department of Education. This office addresses educational entities and enforces non-discriminatory activities and policies for students and employees.

What is the Office of Affirmative Action, and what is the role of the ADA Compliance Officer?

At the University of New Hampshire, the function of the Office of Affirmative Action is to ensure that the campus is non-discriminatory. It does this by upholding the constitutional rights of all members of the University community and by ensuring that the University abides by all federal and state laws applicable to discrimination and harassment. Within this office is the ADA Compliance Officer who is charged with the responsibility of maintaining an environment that is free from discrimination. The ADA Compliance Officer provides educational training, solutions, and guidance on issues pertaining to disabilities, accommodations, and grievances.

MENTAL ILLNESS VERSUS PSYCHIATRIC DISABILITY

At this point, many basic questions have hopefully been answered. An area that necessitates a more thorough discussion, however, is the difference between a mental illness and a psychiatric disability. The distinction is important, as the ADA covers a psychiatric disability but not necessarily a mental illness.

MENTAL ILLNESS

When discussing psychiatric disabilities, the term “mental illness” is typically mentioned. Mental illness refers to a broad range of cognitive and emotional conditions that decrease an individual’s functioning or life satisfaction. Mental illnesses vary in type, duration, and intensity from individual to individual.

Mental health clinicians diagnose mental illnesses by determining which symptoms are present. The term “symptom” refers to a thought, feeling, or behavior that suggests something more pervasive is happening with that individual. An example of this is a runny nose, which could be a symptom of a cold or of an allergy. Since the presence of just one symptom could be indicative of many things, a clinician looks at whether the symptoms form a cluster. It is the clustering or grouping of symptoms that determines whether or not an individual meets the criteria for a mental illness. Mental health clinicians use the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV) to give a name to the experienced set of symptoms. The diagnosis of a mental illness allows clinicians to have a common understanding of what a person’s experience may be and how to best treat that person. Since most of us have or will encounter an individual with a mental illness in our lifetime, having a basic understanding of the more common mental illnesses can also help the non-clinician understand what a person with a mental illness may experience and how it may affect that person’s life.

The National Institute of Mental Health (NIMH) estimates that one in five individuals will experience a mental illness within his or her lifetime and that one in four people knows someone who has a mental illness. Some of the more common mental illnesses include Mood Disorders, such as Major Depression and Bipolar Disorder, Anxiety Disorders, such as Obsessive-Compulsive Disorder,

der and Generalized Anxiety Disorder, and Psychotic Disorders, such as Schizophrenia. A more specific description of the symptoms of these disorders will follow.

Accommodations are typically based on the symptoms of these disorders. It is not necessary for you to know the specific diagnosis that an individual may have received, but it is important to be aware of his or her symptoms and to recognize the possibility that the individual could qualify as having a psychiatric disability.

PSYCHIATRIC DISABILITY

What is a disability?

First we must understand the term “disability.” As previously discussed, a disability refers to a condition or state of being in which a person experiences or is regarded as experiencing a physical or mental impairment that substantially limits major life functions or activities. Some examples of major life functions or activities include walking, speaking, hearing, and learning. The term “major life activities” has been interpreted very broadly by our court systems. The Supreme Court has ruled that “reproduction” is a major life activity, and the Sixth Circuit Court has ruled that “interacting with others” is a major life activity. The broad definition of the term “major life activity” increases the complexity of determining disability and is but one factor in determining whether or not someone has a disability.

Another aspect involved in determining disability is assessing whether or not a major life activity or function is substantially impaired. This involves examining the functional limitations experienced by the individual in question. The term functional limitation refers to impairments in physical, cognitive, or emotional domains that have a direct impact on the performance of specific job or academic duties. The determination of an individual’s functional limitations requires an assessment of the severity, length of time the impairment has been present, and expected duration of the impairment. The functional limitation must rise to the level of a disability in order for accommodations to be required by the Act. A more detailed description of functional limitations often seen in individuals with psychiatric disabilities will follow.

Hopefully, the complexity of the term “disability” is becoming clearer. Individuals in both academic and employment settings use the term disability with at least some understanding of the Americans with Disabilities Act (ADA). Many people have a greater understanding of the concept of a disability when it is a physical or learning impairment, because the impairment can be seen or measured more easily. When a disability is psychiatric in nature, it is often more challenging to understand because it is not as easily detected as some other disabilities, can be carefully hidden by an individual, and continues to be stigmatized by our culture. These challenges must be considered when exploring psychiatric disabilities.

What is a psychiatric disability?

The term “psychiatric disability” refers to the existence of a psychological disorder that substantially limits major life functions such as thinking, learning, sleeping and communicating. Psychiatric disabilities decrease an individual’s ability to perform a variety of functions. These decreases in ability are referred to as the individual’s functional limitations. These limitations include difficulties in:

- focusing attention
- meeting deadlines
- maintaining stamina to complete tasks
- working with others
- receiving negative feedback
- responding to changes in the environment.

It is easy to see how these functional limitations have a negative impact on students, faculty, staff, and supervisors. Try to imagine attending an 8:00 am course when your depression is so severe that you cannot get out of bed. Or perhaps you have a project to complete, and you cannot stop wondering whether or not you turned off the iron, and the thoughts overwhelm you until you have to go home and check. What if, as a faculty member, while you lecture, you often hear someone whispering in your ear, and you have to struggle not to answer the whispers. Available medications are often perceived as “cure-alls,” but even with the sophisticated medications available today, many individuals with psychiatric disabilities continue to face negative side effects. These side

effects include hands trembling, dry mouth, fatigue, and concentration difficulties. Persons having psychiatric disabilities can find their symptoms or functional limitations very difficult to manage. To create a satisfying environment, for all individuals in the classroom or employment setting, these difficulties must be addressed.

Psychiatric disabilities pose unique challenges for the individuals who are diagnosed with such, as well as for those who make decisions regarding accommodations. Mental illness continues to carry stigma in our culture. The stigma associated with mental illness has an impact on all of us. People who have a psychiatric disability often are reluctant to disclose that information for fear of what others might think. These fears do not come without merit, as ignorance related to mental illness continues to exist. Some of the common misconceptions related to mental illness are that individuals diagnosed with a mental illness are:

- lazy
- emotionally weak
- dangerous
- faking their disability
- not people I know
- attention-seekers

A psychiatric disability is more fluid than a physical or a learning disability. Because of its fluidity, mental illness can change over time, and, therefore, there may be a need for changes in accommodations over time. A supervisor may think he/she has accommodated an employee with a psychiatric disability, but the mental illness may worsen and require additional accommodation. A psychiatric condition may also improve, making the accommodation no longer necessary. These changes are infrequently seen in other types of disabilities, making psychiatric disabilities especially challenging to handle for both a person with the psychiatric disability and for those who work to make the appropriate accommodations.

THE EXPERIENCE OF MENTAL ILLNESS

FOUR SCENARIOS

The preceding information has given you a greater understanding of terminology and technical aspects of psychiatric disabilities. Despite the prevalence of mental illness in our culture, including the university setting, there remain areas of unfamiliarity and fear with the topic. This section is not intended to answer explicit questions. It is to provide you with a flavor of the experience of having a mental illness from the perspectives of four individuals and to illustrate the ways in which mental illness can have a significant impact on a person's life and work.

1) **Florencia** had always considered herself “a worrier.” But after the death of her father and, soon after, the death of a close cousin, she found herself with increasing amounts of anxiety. She felt “unsettled” almost all the time, as though her body and her mind were “coming apart.” She found it hard to fall asleep; often she awoke and could not fall back to sleep. Thoughts about everything she had to do at work and home would race through her mind, growing and growing in intensity, until she truly felt she might “lose her mind.” Though she could not identify exactly what was causing her nervousness, she found that her mind would wander, making it difficult to pay attention. She wanted very much to focus her energies on her job, hoping that it would distract her, but she found that she was making more mistakes, having a hard time paying attention in meetings and concentrating on tasks, and feeling achy and sick to her stomach most of the time. On two occasions, for reasons unknown to Florencia, her anxiety reached the level of panic—her heart raced, she felt dizzy and nauseated, and she felt as though she might pass out. On one occasion, this occurred at work, while Florencia was on the phone with an angry person. Florencia struggled, feeling that her anxiety was unfounded and therefore “silly.” At the same time, however, she knew that these problems were getting worse.

2) **Raymond** was 20 when he first had a depressive episode. A sophomore year transfer, he was far from home, friends, and his romantic partner. He enjoyed his classes and was getting good grades, but after about six months, he began to feel sluggish and irritable. Whereas before he enjoyed socializing with his peers, he started to avoid them. Raymond spent long hours in front of the television

and Internet or simply sitting in his darkened room, feeling as though he could not move to do anything if he tried, and feeling that even breathing was wearisome. Sometimes, even though he felt more lethargic than sad, he found himself crying uncontrollably and berating himself for doing so. Mornings were especially difficult. Friends began to notice small changes, such as Raymond being unshaven sometimes or seeming “a million miles away” when interacting. He began coming late to class and turning in projects past deadline. The contrast from first semester left his friends at a loss. They began to avoid him, thinking he “needed space” or was just going through a “stressful time.” One professor became increasingly concerned about Raymond’s lowered performance, and she thought she would soon need to have a talk with him about “getting back on the ball.”

3) **Louise’s** co-workers perceived her as “eccentric.” Her clothes were often wrinkled and dirty, her hair was always messy, and she had an “awkward and abrupt way” of interacting with others. But she was a good and reliable employee, seldom missed a day, and was thus a prized worker in her department. In the Spring, Louise began leaving notes for her supervisor about how her co-workers and other people on campus were “saying bad things” about Louise and were “watching her” to “get her into trouble for messing up on the job.” When the supervisor asked Louise more about what was going on, Louise told him that people were “coming around to get a good look at her” to see how “stupidly” she walks and how “dumb” she is. When her supervisor told her, with good intentions, that he was sure that could not be the case, Louise became angry, left the office, became more withdrawn from her supervisor, and started coming irregularly to work.

4) When **Ted**, a non-traditional college senior, was diagnosed with Bipolar Disorder, he was pretty sure he could handle it by eating and sleeping well and getting plenty of exercise. After several months, however, during a very stressful time at home, Ted began to notice he required less sleep to remain productive. He began feeling more energetic and productive than ever, getting “really brilliant ideas” about “restructuring his department” and “changing the face of higher education.” He wanted to share his ideas with the dean and faculty and began calling them repeatedly at home and at late hours, excitedly pitching his plans. His schoolwork began to feel “like a waste of time” in comparison to his bigger ideas, and he began to fail to turn in assignments or show up for exams.

THE MOST COMMON MENTAL ILLNESSES

The scenarios that precede this page illustrate aspects of mental illnesses that are the most likely to be seen in a campus setting (and in the general population). Let us move into a more specific profile of the major groupings of mental illness. These are a) *Mood Disorders*, b) *Anxiety Disorders*, and c) *Psychotic Disorders*.

The purpose of this section, albeit fairly specific, is not to encourage diagnosing and subsequent decision-making regarding accommodation. Rather, it is to help widen your understanding of the symptoms, course, and experience of various common mental illnesses so that you can more easily recognize situations that might require consultation and actions of ADA compliance.

MOOD DISORDERS

Major Depression—This is a disorder that may include one or more repeated *depressive episodes*, characterized by at least five of the following symptoms during a period of two weeks or longer:

- down mood
- loss of interest or pleasure in activities
- weight changes or appetite changes
- sleep difficulties (too much or too little)
- restlessness
- lack of energy
- fatigue
- low self-esteem
- excessive feelings of guilt
- difficulty thinking or concentrating
- recurrent thoughts of death or suicide

The previous scenario on **Raymond** might represent someone with Major Depression.

Bipolar Disorder (previously known as Manic-Depression)—There are different types of Bipolar Disorder. The consistent feature is mood fluctuation, which includes both some form of extremely elevated mood (mania) and depressed mood (i.e., Major Depressive Episode). Hallmarks of mania (usually referred to as a “manic phase”) include a substantial decrease in the need for sleep, excessive spending, rapid and excessive speech, and irritability. Moods may change rapidly (e.g., daily) or less frequently (e.g., after weeks or months). The previous scenario on **Ted** might represent someone with Bipolar Disorder in a manic phase.

Other categories of Mood Disorders include **Dysthymic Disorder**, characterized by chronically-depressed mood for at least two years. Symptoms often include sleeping difficulties, poor appetite or overeating, difficulty concentrating or making decisions, feelings of hopelessness, and low energy or fatigue.

Major Depression, Bipolar Disorder or Dysthymic Disorder may be somewhat influenced by seasonal changes. The **Seasonal Pattern Specifier** suggests that Major Depressive Episodes occur at certain times of the year, most commonly beginning in fall or winter and ending in spring. However, there may be recurrent summer depressive episodes as well. Manic episodes may also be seasonally-related.

ANXIETY DISORDERS

Panic Disorder—This disorder includes repeated, unexpected Panic Attacks. A Panic Attack is a period of intense fear or discomfort that reaches a peak within ten minutes and includes several of the following symptoms, many of which resemble a heart attack:

- pounding heart
- sweating
- trembling
- shortness of breath
- choking sensations
- chest pain or discomfort
- nausea or abdominal distress
- dizziness
- feeling “out of it” (i.e., unreality) or detached
- fear of losing control, going crazy, or dying

Because of the intensity and extreme discomfort of the Panic Attack experience, individuals frequently develop fears of having future Panic Attacks. This fear often results in drastic changes in behavior to prevent another attack, such as avoiding situations in which the initial attack occurred (e.g., doctor's office, free-way).

In some individuals, Panic Disorder is accompanied by Agoraphobia (that definition follows).

Generalized Anxiety Disorder (GAD)—This disorder includes excessive anxiety or worry that is difficult to control and is characterized by at least three of the following symptoms:

- restlessness
- being easily fatigued
- concentration difficulties (e.g., mind may go blank)
- irritability
- muscle tension
- sleep disturbance

In order to be diagnosed with GAD, an individual's symptoms must be causing significant distress or impairment in an important area of function, such as work or relationships. The previous scenario on **Florencia** might represent someone with Generalized Anxiety Disorder with symptoms of panic.

Obsessive-Compulsive Disorder (OCD)—This disorder includes recurrent *obsessions* (e.g., persistent thoughts or images that cause significant anxiety or distress) or compulsions (e.g., repetitive behaviors or mental acts) that are time consuming and cause notable distress or impairment in the individual's life. These individuals usually have awareness that their obsessions or compulsions are "unreasonable" or "irrational." Obsessions are not just extreme worries about real-life problems. Rather, they include less rational or realistic thoughts such as about contamination (e.g., by germs), repeated doubts (e.g., that one locked the door before leaving the house or that they did not inadvertently harm someone while driving to work), or an excessive need to have things in a particular order.

Compulsions may consist of repetitive behaviors such as hand washing or door lock checking or mental acts such as repeating words silently or counting.

Posttraumatic Stress Disorder (PTSD)—This is a disorder that develops as a result of exposure to a horrifying, life-threatening trauma (e.g., accidents, acts of violence, wars, or natural disasters). Being the victim, witnessing, or learning about this type of trauma can all produce these symptoms in an individual. Individuals with PTSD will likely have mental and emotional re-experiences of the traumatic event, avoid stimuli related to the trauma, and have increased fear and arousal in general.

Other Anxiety Disorders that are less common include **Phobias**. **Simple Phobias** are extreme fears of particular situations or objects. **Social Phobia** is fears of certain social or performance situations. **Agoraphobia** is anxiety about situations in which escape might be difficult (e.g., being in crowds, public places, or traveling) or in which no help is available when one is having panic symptoms).

PSYCHOTIC DISORDERS

Schizophrenia—This is a complex disorder that includes a variety of active symptoms such as distortions in

- thinking (delusions)
- perceptions (hallucinations)
- communication (e.g., incoherent speech)
- behaviors (e.g., bizarre behavior)

This disorder also includes more passive symptoms such as

- restricted emotional expression
- social withdrawal
- decreases in goal-directed behavior

These latter symptoms are often an effect of medication prescribed to control the more active symptoms. The previous scenario on **Louise** might represent someone with a type of psychotic disorder.

COMMON PSYCHIATRIC MEDICATIONS

In your everyday encounters, it is probable that you will encounter individuals who are taking psychiatric medication. Having a general understanding of the common medications that are used and their potential side effects will increase your awareness of when a staff member, faculty, or student is experiencing a medication side effect. It may enhance your capacity to empathize with an individual who has a psychiatric disability by illuminating the tradeoffs (i.e., side effects) that are often made to decrease psychiatric symptoms.

Because the development of medication for psychiatric reasons is an imperfect science, medications have a broad effect on the body, not just having an effect on the symptom for which it is prescribed. This widespread effect creates “side effects,” that is, effects other than the intended ones.

It is important to note that effectiveness and side effects of medications vary from person to person and even within the same person over time. Medications are not just a “quick fix,” and research strongly suggests that they work best when accompanied by psychotherapy. It would be inaccurate to assume that an individual should be free from psychiatric symptoms simply because he or she has been prescribed a medication. A supervisor, staff, or faculty member should also be aware that medications designed to reduce impairment may produce side effects for which accommodations need to be made.

The following information will provide you with a listing of common psychiatric medications and their side effects. This list does not include all medications or possible side effects but may be useful in enhancing your awareness of the variety of drugs available and the plethora of potential side effects.

ANTIDEPRESSANTS

BRAND NAME (GENERIC NAME OR DRUG CLASS)

These medications are commonly used in the treatment of depression, and the depressed phase of bi-polar disorder.

Prozac (Fluoxetine)

Paxil (Paroxetine)

Zoloft (Sertraline)
Effexor (Venlafaxine)
Wellbutrin (Bupropion)
Anafranil (Clomipramine)
Remeron (Mirtazapine)

The potential side effects include tremors, headaches, increased energy, decreased energy, anxiety, constipation, nausea, decreased appetite, dry mouth, dizziness, sweating, impaired cognitive abilities, blurred vision, and decreased sex drive or sexual performance.

MOOD STABILIZERS

BRAND NAME (GENERIC NAME OR DRUG CLASS)

These medications are prescribed to help individuals regulate their mood. The hope is that the medication will decrease the extreme emotional highs and lows often experienced with disorders such as Bipolar Disorder.

Lithobid (Lithium Carbonate)
Tegretol (Carbamazepine)
Klonopin (Clonazepam)

These medications, like the others, produce unwanted side effects, which include nausea, vomiting, diarrhea, general weakness, dizziness, confusion, slowed cognitive processing, slurred speech, severe liver damage, weight gain, rash, acne, swelling in the extremities, and heavy sweating.

ANTI-ANXIETY (ALSO KNOWN AS ANXIOLYTICS)

BRAND NAME (GENERIC NAME OR DRUG CLASS)

These medications are used to decrease the symptoms of anxiety.

Buspar (Buspirone)
Nembutal (Barbiturate)

Halcion (Benzodiazepine)
Xanax (Benzodiazepine)
Ativan (Benzodiazepine)
Serax (Benzodiazepine)
Restoril (Benzodiazepine)
Librium (Benzodiazepine)
Klonopin (Benzodiazepine)
Valium (Benzodiazepine)

The potential side effects related to these drug classifications include fatigue, drowsiness, confusion, headache, dizziness, muscle weakness, decreased concentration, memory impairment, and sexual dysfunction.

It should be noted that several of these drugs are highly addictive. If a person stops taking the medication, he or she may experience withdrawal symptoms that may include agitation, heightened anxiety, and insomnia.

ANTIPSYCHOTICS (ALSO KNOWN AS NEUROLEPTICS) BRAND NAME (GENERIC NAME OR DRUG CLASS)

These medications are designed to decrease the symptoms of psychotic and delusional disorders.

Risperdal (Risperidone)
Clozaril (Clozapine)
Haldol (Haloperidol)
Thorazine (Chlorpromazine)

Their potential side effects include insomnia, anxiety, agitation, headaches, runny nose, lowered blood pressure, dizziness, weight gain, constipation, sleepiness, jerky muscle movements, muscle rigidity, involuntary movements of the face and jaw, blurred vision, depressed mood, jeopardized immune system functioning, and decreased sex drive or sexual performance.

ANTIPARKINSONIAN AGENTS
BRAND NAME (GENERIC NAME OR DRUG CLASS)

These medications are given to suppress the side effects of antipsychotic medications.

Diazepam (Benzodiazepine)
Propranolol (Beta-blocker)
Amantadine (Dopamine agonist)

However, these medications have side effects of their own, which include dry mouth, blurred vision, nausea, vomiting, heart palpitations, and increased psychotic symptoms.

PSYCHOSTIMULANTS
BRAND NAME (GENERIC NAME OR DRUG CLASS)

These medications are often prescribed for the treatment of Attention Deficit-Hyperactivity Disorder (ADHD).

Ritalin (Methylphenidate)
Dexedrine (Dextroamphetamine)
Cylert (Magnesium Pemoline)

These medications may produce the following side effects: insomnia, lower seizure threshold, and a rebound in hyperactivity after the medication has worn off.

Hopefully, this review of the various medications and their side effects has increased your understanding of the complexity of the use of medications in treating individuals with psychiatric disabilities. For further clarification regarding a specific medication, you may wish to contact Health Services at 862-2856.

In reading about these specific psychological disorders, and the medications sometimes prescribed to treat them, you can gain a greater understanding of the ways in which individuals' symptoms might impair their ability to fulfill certain tasks or requirements. You can also have a greater understanding of the medication side effects that they themselves can cause impairment. This understanding, in turn, informs decisions about reasonable accommodations. The following section describes the accommodations or changes that are made in order to assist individuals with psychiatric disabilities.

REASONABLE ACCOMMODATIONS AND ACADEMIC ADJUSTMENTS

WHAT CAN YOU EXPECT?

As stated earlier, reasonable accommodations and academic adjustments are changes made in a work or academic setting that allows an otherwise-qualified individual to perform the tasks or functions of the position or course. These terms will often be referred to as “accommodations.”

The ADA does not require that the performance standard be lowered for individuals with psychiatric disabilities but that accommodations are made to assist the individual in meeting the academic or work standards. To qualify for a reasonable accommodation or academic adjustment, a person must have a disability, not just an impairment, and the disability must have an impact on the essential functions of a job, or an academic requirement or technical standard. Therefore, an individual may experience impairments and qualify as having a disability, but still not be eligible for a reasonable accommodation or academic adjustment. Regardless of the person’s qualification for reasonable accommodations or academic adjustments, individuals with disabilities are always protected against discrimination under the ADA. It is the job of the Office of Affirmative Action and Human Resources (employees) and the Access Office (students) to establish whether or not an individual qualifies as having a disability that requires a reasonable accommodation or academic adjustment.

Given the non-tangible nature of mental illness, it is often difficult to think of how best to make an accommodation. First, you must determine the functional limitations that are caused by the psychiatric disability. The job or required task that is creating difficulties for the individual must be analyzed and understood in terms of its essential functions or academic requirements. If an employee with a psychiatric disability has difficulties working with others, perhaps a group project could be divided into sections, allowing the individual to work alone on his or her separate part. An essential requirement of a course may be to turn in homework assignments; however, it may not be necessary that the student turn in the assignment on the original due date. The following strategies are often suggested to accommodate an individual with a psychiatric disability:

Possible accommodations for employees:

- Purchasing of assistive technology such as non-glare-anti-flickering computer screens (that can sometimes cause seizures in people on psychiatric medications), white noise machines, and altering light.
- Changing the work environment (e.g. decrease noise level, remove distracting objects, make environment more aesthetically-comfortable).
- Creating flexibility in work hours (e.g. allow later arrival times, increase frequency of breaks, allow extra time to complete projects).
- Restructuring job duties (e.g. clearly define essential job functions, provide part-time or job sharing options, break jobs down into concrete steps).
- Improving support (e.g. make sure positive feedback is provided as well as negative, determine pre-established meeting times between the supervisor and the employee to create consistency and opportunities for the employee to express concerns about the job).
- Reassigning to a vacant position.

Possible accommodations for students:

- Providing course notes or taping the lecture to help fatigued or distracted students leave class with essential course information. This can be accomplished by using a note-taker, copying the lecture notes, or providing the student with a tape recorder.
- Altering the classroom environment by seating the student in the front of the room, or by a door, depending upon individual needs. This can reduce anxiety or environmental distractions.
- Establishing pre-arranged breaks and/or allowing the student to have a beverage in class. This may help the fatigued student increase his or her energy or may help the student with dry mouth, which is caused by many psychiatric medications.
- Altering examination formats by extending time, administering the exam in private, or reading the test out-loud.
- Providing course material in an alternate format such as web page accessibility.

As a supervisor, staff, faculty member, student, or co-worker, it is important to increase your awareness of and knowledge regarding psychiatric disabilities. You need to know with whom to consult when you feel someone might have a psychiatric disability and how your setting, whether it is an office or a classroom, could potentially have an impact on an individual with a psychiatric disability. However, making a determination of whether or not someone has a psychiatric disability, and then deciding what accommodations should be made, is a difficult task. This is not a task that as a supervisor, faculty member, staff member, or co-worker should be expected to or attempt to make. An accommodation for an individual with a psychiatric disability is made on a case-by-case basis. In some instances the precise nature of an effective accommodation for an individual may not be immediately apparent. Such decisions in determining accommodations are made as a result of an “interactive process” that involves the employee or student with a psychiatric disability. As deemed necessary, others may be asked to participate in this process and will include the ADA Compliance Officer, a Human Resource Partner, the direct supervisor, Access staff, and faculty member.

Who has a disability and how the individual might be accommodated are decisions made primarily by the staff of the Office of Affirmative Action, Human Resources, and the Access Office. These offices are significant campus resources and are available for your consultation needs. Consulting the appropriate offices may reduce your feelings of frustration and perplexity, while simultaneously decreasing the likelihood that your actions, or lack thereof, are discrimination.

What can I do to make the environment safe, and more accommodating for individuals with psychiatric disabilities?

The following suggestions may help create a more accommodating environment:

- Increase your knowledge of mental illnesses, including their prevalence and associated symptoms.
- Be aware of your own stereotypes or biases regarding mental illness. These stereotypes may come from the media, your family, or a past negative experience.
- Meet people who are now experiencing or have previously experienced a psychiatric disability. As with most diversity experiences, getting to know someone who is not like us can often debunk our stereotypes and biases.

- Notice your language—does it contain derogatory statements about mental illness (e.g. “What, are you, crazy?” or “I think I’m going nuts”).
- Be aware of the strengths and abilities that are exhibited by those who have psychiatric disabilities rather than focus on their weaknesses or limitations.
- Keep in mind that we all ask for accommodations at one point or another, such as an altered work schedule to accommodate child care needs, a decrease in workload because of school responsibilities, or an avoidance of a particular task that creates excessive anxiety, such as giving a speech. Many people ask for these accommodations routinely but rarely would this be thought of as “special treatment.” A person with a psychiatric disability simply is in need of an accommodation that will enable the completion of essential employment functions or academic requirements.

FAILURE TO ACCOMMODATE

What does it mean if I do not provide an accommodation to a qualified individual?

The purpose of the Americans with Disabilities Act (ADA) is to create accommodating employment and academic settings that do not discriminate against individuals with disabilities. Employers, supervisors, staff and faculty must ensure that they are acting within the parameters of the ADA. This means being aware of the Act’s intent, seeking consultation when appropriate, and providing accommodations recommended by the Office of Affirmative Action, Access office and Human Resources. If it is recommended that you provide reasonable accommodations or academic adjustments for an individual and you do not, you may be found to be discriminating against the individual.

The presence of discrimination is determined within the court system as case law precedents are being established regarding psychiatric disabilities. It is therefore not your responsibility to determine the legal rules regarding discrimination. You are, however, required to be aware of the ADA and its intent. Psychiatric disabilities, including the fluid nature of the illness, the decision of disability qualification, and the determination of accommodations, pose extremely complex challenges for all involved parties. This is why consultation and team-

work are critical when handling these issues. It is also why, to decrease the likelihood of a discriminatory environment, all individuals within the campus community need to increase their awareness of the ADA, and consult whenever they are faced with a possible mental illness impairment issue. It is better to err on the side of being cautious.

OVER-ACCOMMODATING

One of the dilemmas in accommodating individuals with psychiatric disabilities is determining what accommodations are appropriate. Due to lack of experience with these situations or, in our attempts to be supportive and to operate according to the ADA, we can sometimes over-accommodate individuals with psychiatric disabilities. However, this can be harmful to individuals with disabilities as well as to the individuals who work with them. Limitless accommodations can leave individuals feeling confused and uncertain about how to respond. A well-intentioned over-accommodation may feel condescending to a person with a disability, or it might cause tension between that person and his or her co-workers, making the situation worse than if no accommodations had been made. In more rare cases, over-accommodation might exacerbate symptoms or enable an individual to remain more symptomatic than if there were appropriate accommodations that could promote better self-care and help the individual remain more reasonably accountable.

In deciding where the line is, it is important to remember that the goal of the ADA is not to provide “special privileges” to individuals with psychiatric disabilities, but to provide them with equal opportunities. If after making reasonable accommodations or academic adjustments, it becomes apparent that an individual is unable to perform his or her essential responsibilities as a professor, staff, or student, further accommodations should not be made. Other options, such as assisting a person in their hospitalization, withdrawing from school, or taking a leave of absence, should be explored.

It is important that, throughout this process, you keep documentation of your efforts and related activities. Also, keep other records such as memos and emails, and any other records by you and by the individual. This will help the process as it proceeds through various stages.

CONFIDENTIALITY

As a supervisor, staff, or faculty member, you cannot disclose to co-workers or other students that an employee or student has a psychiatric disability. The Office of Affirmative Action, Human Resources, Counseling Center, and Access Office cannot disclose to you the presence of a psychiatric disability without the written permission of the individual. In some cases, these offices cannot even confirm or deny that an individual is involved with the office. However, this does not deny you the opportunity to discuss concerns you may have about an employee or student and receive general information on how to proceed.

PROVIDING ACCOMMODATIONS: FIVE SCENARIOS

1) You are a department supervisor with an employee who, over the past two months, has been coming to work increasingly late. After his third tardy arrival, you speak with him about his lateness, to which he replies “Yeah, I’ll work on it.” You notice that his hygiene is becoming poor, and you become concerned due to his increased isolation from others while at work. You again ask him if anything is troubling him and he denies it. What might your next step be?

After documenting the employee’s behavior and being clear with him about his performance, you should likely involve Human Resources. It is your responsibility to ensure that the employee knows he may be covered under the ADA if he qualifies as having a disability. This could be accomplished by contacting the Affirmative Action Office and requesting an in-service for all employees on the topic of the ADA and reasonable accommodations. You cannot ask the employee if he has a disability.

2) You are working closely with a student who has had several discipline problems with various campus offices. The student seems to be quite fond of you and appears to benefit from your discussions. While talking with the student, she discloses that she cannot concentrate because she has found notes in her backpack written by several campus administrators stating their intention to kill her. She shows you the notes and you notice that the handwriting is her own. What would be your next step?

Given the active delusional state of this student, it would be best to contact the Counseling Center for consultation on this matter. You may wish to support or console this person,

but do not attempt to become this person's "therapist;" it is likely that she is in need of professional psychiatric services. If you are already aware that this student has a psychiatric disability and is working with the Access Office, you may contact that office to convey this information. It is most important that you not try to handle this situation alone—get other offices involved in the situation.

3) As a professor, you are asked by a student to make a few accommodations for him, and he presents you with a letter from the Access Office. You gladly accommodate him by not deducting points for attendance, and you allow him to turn in assignments late. After two weeks pass, the student stops attending class. He returns on the day of the final and asks you to exempt him from all homework assignments, disclosing that he has a psychiatric disability. How would you respond?

In this situation, meeting the student's request would be over-accommodating, as he is clearly not meeting the academic requirements and technical standards of the course of study. However, contacting the Access Office and the Office of Affirmative Action to discuss your course of action is still necessary. When facing issues of disability and accommodations, never act alone.

4) You have been assigned to work with two co-workers on a time-sensitive project. The duties are split equally among the three of you, and you begin your portion. At regularly scheduled meetings, you notice that one of your co-workers never has her section completed. When you confront her, she becomes extremely angry and begins to berate you. You attempt to calm her down by your reflection of your understanding to her of her reasons why she does not have the task completed. Your attempts to calm her down appear to be creating more tension, and eventually she storms out of the room, goes to your supervisor, and complains about how difficult you are to work with. Your supervisor advises you to complete your co-worker's section and to not confront your co-worker further. You become angry at your supervisor and ask for an explanation. None is provided. At this point, what could you do to resolve your anger?

Contacting Human Resources and the Employee Assistance Program through UNH would allow you to discuss your feelings and to decrease your frustration. Contacting the Office of Affirmative Action and Human Resources would also provide you the opportunity to seek solutions and receive guidance. Keep in mind that the existence of a psychiatric disability is confidential, and your supervisor cannot disclose that information to you.

5) You, as a supervisor, have noticed that Craig, an employee, has become increasingly irritable and accusatory in recent weeks. After you confront Craig, he informs you that he is currently engaging in psychological treatment. One day, you notice Craig arguing with hostility with one of his co-workers. You ask him into your office in an attempt to diffuse the situation. He stands with clenched fists and jaw and tells you it is “none of your business.” Craig then says that he is going to “beat up” the co-worker with whom he was arguing. Is this related to psychiatric disability? What are your options?

The vast majority of people with psychiatric disabilities are not violent. The campus community must be a safe place to work and learn. If you feel physically threatened by someone or fear that someone will harm another person, it is important to contact campus police. This is a case of a “direct threat,” and the ADA has provisions for this type of case. The ADA clearly supports the safety of all individuals. In situations about which you are concerned which are not of an emergent-danger nature, you may also contact the Counseling Center or the Office of Affirmative Action for consultation.

COMMUNICATING WITH AND RESPONDING TO PEOPLE WITH PSYCHIATRIC DISABILITIES

Some people worry about communicating with a person with a psychiatric disability, fearing the person might be offended, troubled, or, worse yet, caused to “fly off the handle.” However, communication with a person who has a psychiatric disability is really the same as with any other person. The “rules” and techniques of productive and helpful communication remain the same. They are to:

- **Be clear**—Choose words that will be clear in getting across your thought, feeling, or request. Avoid words that have pejorative meaning that may block communication by making the listener get defensive.
- **Be thorough**—Transport yourself into the shoes of the listener, and share everything that he/she will need to know. Do not leave out important information—an incomplete communication is sometimes worse than having none.
- **Be succinct**—Be thorough but concise in your language. Extraneous or jargon-laden information can be confusing and could be misinterpreted.
- **Be concrete**—Abstract or vague language about an uncomfortable topic is often used to “soften” a message or “talk around” it. However, this can lead to misunderstanding.
- **Be accurate**—Sometimes, important information is skipped over or altered for fear that it will upset another person or create discomfort for both parties. However, this most often can only hurt the cause of good communication. If the information being conveyed is false or misleading, even the best communication technique cannot save the message.
- **Be a good listener**—Good listening requires giving total attention to the speaker and includes attending to verbal content and body language. When a person feels heard, he/she spends less time attempting to capture the attention of another. Questions and comments such as, “Tell me more,” “Are you saying that...?” and “What about this is troubling?” show that you are listening and attempting to understand.
- **Be consistent**—Responding in a consistent manner helps establish good personal boundaries.

Obviously, there are unique situations related to psychiatric disabilities that sometime come up and call for special considerations and particular responses:

THE DEPRESSED PERSON. Symptoms of the various depressive disorders include low mood, low motivation, difficulty concentrating, guilt, low self-esteem, and feelings of worthlessness and hopelessness. Appropriate and helpful responses are to:

- **Note your sense of his or her mood.** Let the person know you recognize that he or she seems to be feeling down.
- **State that you care.** Verbalize concern and a desire to help in ways that he or she might need help.
- **Inquire if you feel the person might be suicidal.** You won't "plant" the idea in the person's head—chances are he or she has already thought about it to some extent. Your asking can help him or her ask for help.
- **Avoid trite statements.** "Chin up!" or "Everything will be okay."

THE SUICIDAL PERSON. Suicidal behaviors can be part of many mental illnesses. When someone has reached a level of hopelessness and helplessness and/or a level of self-hatred where suicide seems the "best option," it is important that those around the person do their best to respond appropriately. When people tell you about thoughts of suicide, they are most often making a last ditch effort to be talked out of it and to be helped. Therefore, appropriate responses would be to:

- **Take the verbalization seriously.** Ask about his or her plan, his or her true intention, and his or her access to weapons, medications, or other dangerous means.
- **Avoid a situation where you "promise to tell no one."** If you do, break your promise.
- **Avoid trite or judgmental statements.** "You'll feel better tomorrow," or "Suicide is wrong. Don't even think about it."
- **Call the police if the person is in imminent danger or even if you just cannot be sure that the person will be okay.** Recognize your limitations and realize that you cannot protect someone around the clock. Do not feel guilty about this or worry that you are being overly dramatic. You could potentially save a life.

THE ANXIOUS PERSON. Symptoms of the various anxiety disorders include nervousness, restlessness, poor sleeping, difficulty concentrating, and a host of physical problems. Appropriate responses are to:

- **Allow venting of feelings.** Talking about concerns can help relieve some anxiety.
- **Avoid inundating the person with information.**
- **Reassure as needed and as appropriate.** The anxious person may seek reassurance or verify something several times (because of self-doubts or problems with concentration). Your patience will help relieve anxiety.
- **Be explicit and clear.**

THE PERSON IN POOR CONTACT WITH REALITY. Symptoms of the psychotic disorders include illogical speech and beliefs, confusion, fear, and strange or inappropriate behaviors. Appropriate responses would be to:

- **Recognize the irrational beliefs without supporting the person.** “I hear that you feel people are watching you and laughing at you. I don’t see that same thing happening, and I wonder if there could be another explanation.”
- **Focus on the present and divert conversation from the irrational.** Be warm but firm in this.
- **Avoid challenging his or her convictions or “irrational beliefs.”** Rather than convincing, you can often cause the person to become more defensive in his or her beliefs.
- **Let the person know it and ask for clarification if you don’t understand.**
- **State your concerns and share your recognition of his or her need for help.** “Things seem pretty confusing and difficult right now. I’m concerned and would like to help.”

THE SUSPICIOUS PERSON. This person holds fears about the lack of safety in the world and of other people. While others might call this type of thinking “irrational,” they are very real concerns to the suspicious person, and strong

efforts to convince the person otherwise are fruitless or can cause the person to become suspicious of your intent. The suspicious person is prone to slights at one end of the continuum; at the other end, this person may fear that others are out to kill him or her. Appropriate responses are to:

- **Avoid getting too friendly or explicitly compassionate.** The suspicious person needs emotional “space” to feel safe and to trust you—don’t try to be a “buddy”—be a “concerned other.”
- **Be firm, clear, and consistent.** This will help to instill your trustworthiness.
- **Be exact about expected standards of behavior.**
- **Avoid challenging his or her convictions or “irrational beliefs.”** At the same time, don’t agree—simply hear him or her.

THE VERBALLY AGGRESSIVE PERSON. This is really no more common with a person with a psychiatric disability than for a person in the general population. But when a person feels he or she lacks control over a situation affecting his or her life, he or she can become verbally aggressive or verbally abusive. Most often, the anger being expressed at you is not related to you, rather to the situation or his or her emotional state that feels so terrible. You are just getting the brunt of it. Appropriate responses are to:

- **Set limits.** Be clear about behavior expectations.
- **Allow appropriate venting.** Oftentimes, anger comes out of feeling frustrated and unheard. When a person feels that you are willing to listen, his or her anger is likely to lessen.
- **Empathize and reflect.** Anger can often be decreased just by someone showing that the emotion is understood. This can be demonstrated by naming the emotion and indicating your understanding of its origin: “It seems like you’re angry because you feel left with the bulk of the work.”
- **Reduce stimulation.** Bring the person to your office or a quiet place. Reducing stimulation can have a calming effect. It also sends the message that you are taking time to listen and to discuss the issue.
- **Help the person strategize; be open to problem-solving if appropriate:** “Is there any way we can work together to solve this problem?”

- **Listen for agreement.** Finding a point to agree on can decrease conflict, “I see your point, that is a bad situation.”
- **Sit the person down.** A person will tend to be less aggressive in a seated position.
- **Stand with a neutral (non-defensive, non-threatening) posture.** Arms at your side, standing with body slightly turned away from the person.
- **Don’t get into a yelling match.**
- **Don’t give away your own rights as a person.** Maintain your own personal and professional boundaries (e.g., time, job description, and safety).

THE VIOLENT PERSON: Again, this is extremely rare. However, when working with a very angry individual, it is important to be aware of and to heed the signs of potential violence. Possible signs include: inability to follow directions, pacing, clenched fists or jaw, sitting on the edge of the chair, increased volume and/or profanity of speech, history of violence, or threats of violence. Appropriate responses to the violent person would be to:

- **Note the anger.** “Clearly you are very angry. I am taking your concern seriously, and to assist you in this, I need you to be seated.”
- **Set clear, concrete limits.** “Being angry is fine, but destroying things is not.”
- **Secure your physical safety.** Call for a co-worker to be with you, remain in open places. This is different from the “angry” or “verbally-aggressive” person in that physical safety is threatened and, at this point, is more important than problem-solving.
- **Notify the police.** Sometimes people worry this will escalate the situation or “give in” to fear. However, it increases personal safety, sets a limit, and serves to contain an individual who cannot manage his or her behavior and may get his or herself into more trouble if not contained.
- **Remain calm but concerned.** (i.e., not apathetic)
- **Remain physically distant from the person.** This will protect you and limit threat to the individual.

CONCLUSION

We hope that in reading this manual, you have become more familiar with the Americans with Disabilities Act, the experience of mental illness, and ways to begin the process of navigating through difficult situations involving the two.

Our hope is to provide increased awareness to facilitate greater accommodation for individuals with psychiatric disabilities in the University community and increased confidence for dealing with challenging situations. We hope that we have also made it clear that, when making the difficult decisions regarding determination of disability, reasonable accommodation, academic adjustment, and negotiating these matters with an individual with a psychiatric disability, you need not feel alone. This is for two reasons: 1) this can be an emotionally-taxing and confusing process; 2) most people are not, and should not be expected to be, experts. Therefore, it is important to receive both support and guidance toward helpful, appropriate, and lawful decision-making. There are resources both on and off this campus that can help (see the Resources section).

By reviewing this manual, you are participating in making the University of New Hampshire campus a more supportive and accommodating place for all people.

RESOURCES

Providing Consultation, Information, and Support

ON CAMPUS

Office of Affirmative Action	862-2930 (Voice and TTY) affirm.action@unh.edu
University Counseling Center	862-2090 (Voice) RELAY NH (800-735-2964)
Access Office – Support Services for Students with Disabilities	862-2607 (Voice and TTY) tph@cisunix.unh.edu
Human Resources	862-0501 (Voice) 862-3227 (TTY)
University System of New Hampshire: Employee Assistance Program (EAP)	1-800-424-1749 (Voice) RELAY NH (800-735-2964)
University Police	862-1425 (Voice and TTY))

ADDITIONAL RESOURCES

Legal Information:

Americans with Disabilities Act	800-514-0301 (Voice info line) 800-514-0383 (TTY info line) www.usdoj.gov/crt/ada/adahom1.htm
Rehabilitation Act of 1973 (As amended through 1998)	www.nfb.org/rehabact.htm

**Department of Education
Office for Civil Rights**

800-421-3481 (Voice info line)
877-521-2172 (TTY info line)
www.ed.gov/offices/OCR/

**Equal Employment Opportunity
Commission (EEOC)**

General information & links
800-669-4000 (Voice)
800-669-6820 (TTY)
www.eeoc.gov

**Equal Employment Opportunity
Commission (EEOC)**

EEOC Guidance on the ADA
and Psychiatric Disabilities
800-669-4000 (Voice)
800-669-6820 (TTY)
www.eeoc.gov/docs/psych.html

**New Hampshire Commission
for Human Rights**

603-271-2767 (Voice)
RELAY NH 800-735-2964
humanrights@nhsa.state.nh.us (E-Mail)
<http://webster.state.nh.us/hrc/>

Mental Health Information On-line:

American Psychological Association

www.apa.org

National Institute of Mental Health

www.nimh.nih.gov/

**Center for Psychiatric Rehabilitation;
Sargent College of Health and
Rehabilitation Services;
Boston University**

www.bu.edu/sarpsych/reasaccom

APPENDIX

PSYCHIATRIC DISABILITY CASE LAW VIGNETTES

The following are actual examples of legal cases involving psychiatric disabilities in work or academic settings. These cases are shared to familiarize you with some of the issues or concerns that arise in situations involving psychiatric disabilities and to illustrate appropriate and inappropriate responses to these situations:

The first case is taken from: *The ADA and People with Mental Illness: A Resource Manual for Employers*, by Deborah Zuckerman, Kathleen Debenham, and Kenneth Moore. (1993)

CASE 1:

Ron Stahl, a reporter for television station KOCO in Oklahoma City, Oklahoma, experienced a series of anxiety attacks while on-the-air and feared he might have to give up the occupation in which he had achieved so much success. Ron's station manager, however, remained supportive and flexible while Ron sought treatment. Eventually, employer and employee developed a mutually beneficial reasonable accommodation.

In this section, Ron describes his experience with mental illness and its effect on job performance. Although his experience pre-dates the ADA, Ron clearly represents a qualified individual who needed and was able to find a reasonable accommodation.

We spent the afternoon putting together stories for the later newscasts and I prepared to anchor the five o'clock news just as I had done hundreds of times before. I started on the lead story but right in the middle of reading the introduction the world began to close in on me. I blacked out and could not finish the sentence I had started. The director quickly went to a commercial and the floor crew helped me off the set. It was half an hour before I could walk out on my own.

I took the next two days off and went to see my doctor. He diagnosed exhaustion and dehydration and told me that a few days' rest would put me back in shape. Physically, it did.

I went back to work and resumed my normal routine. At ten minutes to five that evening I walked out and sat on the news set. I was fine until we began the introduction to the newscast. I was seized with uncontrollable panic; I began to get tunnel vision, I hyperventilated, and felt like I was blacking out again. I ran from the set.

Over the next few days I managed to get through my newscast without running away again. But the anxiety attacks began to take a different form. Instead of tunnel vision, I suffered from back spasms. For the first five minutes of every show I was in agony.

My physician could find no physical reason for my continuing problems and recommended that I see a psychologist. It didn't take long to get some answers. My psychologist told me that I had developed a mental reaction to the news set—that because I had blacked out on the set on live television, my mind was trying to protect me from a potentially embarrassing situation.

I was absolutely devastated. I believed that my career was over. After almost 20 years, I could not do what the television station was paying me to do. After almost 20 years, a place where I had been very comfortable was suddenly a place of great sorrow and pain. I knew I could not keep going this way. I had to tell my boss that I could no longer be an anchorman.

The general manager at KOCO was the man who had first put me on the anchor desk and I had counted him as a friend, as well as a supervisor, for many years. Still, I did not know how he would react to what I had to tell him. After all, what good is a television anchor who is allergic to the news set. And there were plenty of other reporters ready to move into that spot. I believed that he would have no alternative but to void my contract.

I received a pleasant surprise. Instead of booting me out the door, the manager suggested an alternative. He outlined a plan to begin a new feature in our news lineup, called Assignment Oklahoma. He wanted me to be a feature reporter and to do stories about the interesting people and places in Oklahoma. Most important, I would never have to do another live newscast.

It's been over four years now, and Assignment Oklahoma is working out very well for me and for my employer. It is a popular feature and I have never been happier in my work. I consider myself lucky. Had it been another place, another time or another boss, my story might have had a different ending.

The following cases are taken from *A Review of Case Law as Applied to Students with Psychological Disabilities in Institutions of Higher Education* by Jeanne M. Kincaid, Esq. (revised 4/94)

CASE 2: NORTHEASTERN UNIVERSITY (MA)

The university barred a student with an emotional disability from attending the last two classes of a course. The student's journal entries contained violent, threatening and explosive language that was racist in content. In one entry, the student threatened to kill another student. The student also suggested that she might have a gun or was going to get one. The university first learned that the student was receiving professional counseling when the Dean requested to meet with the student to discuss the university's concerns. The Dean gave the student the option of taking a take-home exam for the quarter or withdrawing from the class with a full refund. The student chose the latter. Office for Civil Rights concluded that the university did not discriminate against the student on the basis of disability because it did not know that the student had a disability when it took the actions that it did.

CASE 3: COLLIN COUNTY COMMUNITY COLLEGE (TX)

A college required a student with a Generalized Anxiety Disorder and Paranoid Personality Disorder to drop a child abuse prevention course and an advanced administration of child care course until a "specified group of persons unanimously decided that she could perform child care responsibilities without supervision." The college contended that the student was not qualified based on technical standards related to state licensing requirements for employees at child care centers.

In finding the college in violation of Section 504, Office for Civil Rights determined that the catalog contained no prerequisites for enrollment in either of the courses. The child abuse prevention course required the student to work at a shelter for women with strict confidentiality mandates. College officials did not believe the student could meet these standards because of behavior and judgment difficulties they observed in previous classes. The administration

course involved working with administrators, not children, in various off-campus facilities. Topics included financial management, personnel procedures, program evaluation, facility design, and planning. College officials believed that the student would be unlikely to meet state licensing requirements based on what they considered to be inappropriate behavior observed in previous classes and laboratories. They believed that direct supervision by faculty members was necessary.

Office for Civil Rights emphasized that the college's decision to deny the student enrollment was not based on information provided by anyone who had direct knowledge of the student's behavior. Office for Civil Rights underscored that the college did not obtain "objective information from psychologists, counselors, or other persons qualified to assess or project whether she could perform the essential requirements for the two courses "based only on speculation about her ability to meet (state licensing) standards. She was not tested, assessed, observed, or otherwise objectively evaluated in the actual provision of child care." Office for Civil Rights concluded that state licensing standards were not standards for admission to enrollment in these classes. Finally, Office for Civil Rights faulted the college for failing to conduct an assessment to determine if and what academic adjustments or auxiliary aids it could have provided the student to allow her to enroll.

Office for Civil Rights also found that the college supervised the student more closely than other non disabled students while she attended a child care conference. Indeed, the student had to remain with a faculty member. The college also admitted that, unlike her colleagues, the student was under constant supervision in classes and laboratories. The college videotaped the student more than other students in the child development lab.

Finally, Office for Civil Rights found that the college violated Section 504 by placing unlawful conditions on the student, unlike any other students, such as signing a statement agreeing to certain terms and conditions before she could enroll in child development classes, agreeing to receive individual counseling as well as assistance from the Disabilities Student Services (DSS) office.

CASE 4: CALIFORNIA STATE UNIVERSITY

A student with an anxiety disorder and major depression alleged that the university unlawfully discriminated against her by terminating her student teaching early and by denying her requests for academic adjustments. In ruling for the university, Office for Civil Rights found that the student had failed to notify the university of her disability, thus not legally entitling her to any accommodations. Although the DSS Coordinator and her advisor were aware of the student's disability, she did not request any academic adjustments from them. The student requested academic adjustments from other staff but failed to indicate to them that she needed such accommodations because of her disability. Office for Civil Rights ruled that the student failed to provide sufficient notice to justify action on the part of the university.

CASE 5: UNIVERSITY OF TENNESSEE AT KNOXVILLE

The university twice terminated a student's financial aid for failing to maintain a satisfactory GPA. He failed to complete 24 hours of coursework per year as required by federal law. Federal regulations give the university discretion to waive the satisfactory progress requirement for continued financial aid eligibility. Specific examples in the regulations include illness of the student or undue hardship as a result of special circumstances. The university did not waive the requirement because the student's medical documentation suggested that his condition should not affect his school attendance. Office for Civil Rights found no violation of Section 504.

CASE 6: DADE COUNTY SCHOOL DISTRICT (FL)

Although this case involves employment, it illustrates the types of concerns likely to occur in an educational setting. Co-workers called a lab technician with bipolar disorder names and placed cartoon caricatures of him on his desk or on the bulletin board. One cartoon referred to him as "losing his marbles." None of the other name calling or cartoons directly referenced the employee's disability. Supervisors saw the cartoons and observed the name calling. The university had

a non-harassment policy which prohibited slurs, innuendoes or other verbal or physical conduct reflecting on an individual's disability which have the purpose or effect or creating an intimidating, hostile or offensive educational or work environment. One supervisor took down the cartoons and told staff to cease the name calling, yet the harassment continued. Office for Civil Rights found the university responsible for the co-worker harassment because the name calling and cartoon caricatures created a hostile environment at a time when the employee's co-workers and supervisors were aware of his disability.