Louisiana Law Review

Volume 48 | Number 4
March 1988

Mental Impairments and the Rehabilitation Act of 1973

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MENTAL IMPAIRMENTS AND THE REHABILITATION ACT OF 1973

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The Rehabilitation Act of 1973[1] assists disabled persons affected by either physical or mental impairments by providing for rehabilitative services and by offering protection from certain forms of discrimination. The Act's provisions include limited protection from employment discrimination.[2] The specific impairments intended to be covered by this statute, however, are not completely apparent from either the act itself or the federal regulations issued to interpret the act.[3] Given the often elusive nature of the sciences of psychology and psychiatry, it is particularly intriguing to examine how courts have analyzed allegations of mental impairments. In other words, what mental disabilities will be recognized as impairments under the Rehabilitation Act of 1973?

Subchapter V of the Rehabilitation Act is the focus of this article. Under that subchapter, a plaintiff must first establish that the defendant is covered by the Act.[4] It must also be shown that the complainant suffers from an impairment;[5] that this impairment results in a substantial limitation;[6] and that the limitation affects a major life activity.[7] In most instances, the defendant acknowledges reliance upon the plaintiff's dis-

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1. Rehabilitation Act of 1973, 29 U.S.C. §§ 701-796 (1985 & Supp. 1987).

2. See infra notes 9-16 and accompanying text.

3. Id.

4. See infra notes 11-18 and accompanying text.

5. Id. Although the statute and regulations provide guidance in determining what is a protected impairment, they do not expressly identify the specific disabilities to be protected. This article will examine cases that serve as examples of how courts make this determination.

6. 29 U.S.C. § 706(8)(B) (1985 & Supp. 1987). See E. E. Black, Ltd. v. Marshall, 497 F. Supp. 1088, 1101 (D. Hawaii 1980) (determining "substantial limitation" requires an examination which focuses upon each claimant's specific circumstances; looking to the number and type of jobs from which the impaired person is disqualified, the geographical area to which the individual has reasonable access, and the individual's job expectations and training).

7. 29 U.S.C. § 706(8)(B). See Jasany v. United States Postal Service, 755 F.2d 1244 (6th Cir. 1985) (visual impairment of stabismus, or crossed-eyes, is not a substantial limitation on a major life activity).

ability.[8] The outcome will then depend upon whether the plaintiff is qualified for the position and whether the defendant can reasonably accommodate the plaintiff's disabilities.[9]

This article examines the question of whether an asserted mental disorder should be regarded as a statutory impairment. The article begins by outlining the Rehabilitation Act and by discussing diagnostic difficulties that exist in the mental health field. It then surveys specific cases arising under the Rehabilitation Act. Selected cases reviewing state statutory language are also examined. The article provides a broad discussion of the questions and concerns that must be considered when formulating a nondiscrimination policy protecting mentally impaired persons. It concludes by suggesting an approach for handling cases alleging discrimination due to a mental impairment.

THE REHABILITATION ACT OF 1973

The Rehabilitation Act of 1973 provides a definition for the term "individuals with handicaps":

> (8) (A) Except as otherwise provided in subparagraph (B), the term "individual with handicaps" means any individual who (i) has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment and (ii) can reasonably be expected to benefit in terms of employability from vocational rehabilitation services provided pursuant to subchapters I and III of this chapter.
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> (B) Subject to the second sentence of this subparagraph, the term "individual with handicaps" means, for purposes of subchapters IV and V of this chapter, any person who (i) has a

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8. If the defendant denies that his or her decision was motivated by plaintiff's disability, the plaintiff can rely upon the McDonnell Douglas Corp. v. Green, 411 U.S. 792, 93 S. Ct. 1817 (1973), approach to establish motivation. See Reynolds v. Brock, 815 F.2d 571, 574 (9th Cir. 1987), citing United States Postal Serv. Bd. of Governors v. Aikens, 460 U.S. 711, 715-16, 103 S. Ct. 1478, 1481-82 (1983); Texas Dep't. of Community Affairs v. Burdine, 450 U.S. 248, 253-54, 101 S. Ct. 1089, 1093 (1981). According to that approach, the plaintiff must establish that he or she is qualified for a position, applied and was rejected. The model is subject to adjustment to fit particular fact situations. The burden shifts to the defendant to articulate a legitimate, nondiscriminatory reason. If the plaintiff comes forward with evidence sufficient to satisfy this burden, the plaintiff can still argue that the reason is pretextual.

9. 29 U.S.C. § 793 (Supp. 1987) requires affirmative action for "qualified" individuals. Section 794 protects "otherwise qualified" individuals. An "otherwise qualified" individual is someone qualified despite his or her handicap. Southeastern Community College v. Davis, 442 U.S. 397, 406, 99 S. Ct. 2361, 2367 (1979). See School Board of Nassau County, Florida v. Arline, 107 S. Ct. 1123, 1131 nn.17 and 19 (1987), where the Supreme Court explains the duty of reasonable accommodation.

> physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment. For purposes of sections 793 and 794 of this title as such sections relate to employment, such term does not include any individual who is an alcoholic or drug abuser whose current use of alcohol or drugs prevents such individual from performing the duties of the job in question or whose employment, by reason of such current alcohol or drug abuse, would constitute a direct threat to property or the safety of others . . . .
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> (17)(A) Except as provided in subparagraph (B), for purposes of this chapter the term "individual with severe handicaps" means an individual with handicaps (as defined in paragraph (8))—
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> > (i) who has a severe physical or mental disability which seriously limits one or more functional capabilities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of employability;
> > (ii) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time; and
> > (iii) who has one or more physical or mental disabilities resulting from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, musculo-skeletal disorders, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia, and other spinal cord conditions, sickle cell anemia, specific learning disability, end-stage renal disease, or another disability or combination of disabilities determined on the basis of an evaluation of rehabilitation potential to cause comparable substantial functional limitation.[10]

Using this language as a starting point, one can begin to identify persons protected by the legislation. Employers who are recipients of federal financial assistance are subject to the provisions of the Rehabilitation Act.[11] Executive Order 12250 directs those executive agencies

10. 29 U.S.C. § 706(8), (17)(A) (Supp. 1987).
11. 29 U.S.C. §§ 793-794 (Supp. 1987).

granting financial assistance to issue guidelines for the programs and organizations receiving that assistance.[12] Executive Order 12250 also directs the Department of Justice to manage the implementation of section 794.[13] Pursuant to that directive, the Department of Justice has issued regulations that further define protected disabilities.

> (b) . . . (1) "Physical or mental impairment" means: (i) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or (ii) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness and drug addiction, and alcoholism.[14]

Furthermore, the agencies granting assistance have issued their own regulations.[15]

Employers that have contracts with the federal government in excess of $2,500 are covered by section 793.[16] The Department of Labor, which is responsible for this section, has also issued regulations defining "handicapped individuals."[17] Section 791 establishes an Interagency Committee

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12. Executive Order 12250, 3 C.F.R. § 298 (1980).

> 1-201. The Attorney General shall coordinate the implementation and enforcement by Executive agencies of various nondiscrimination provisions of the following laws: . . . (c) section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794) . . . .
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> 1-402. Each Executive Agency responsible for implementing a nondiscrimination provision of a law covered by this order shall issue appropriate implementing directives (whether in the nature of regulations or policy guidance). To the extent permitted by law, they shall be consistent with the requirements prescribed by the Attorney General pursuant to this Order and shall be subject to the approval of the Attorney General, who may require that some or all of them be submitted for approval before taking effect.

13. Executive Order 12250, 3 C.F.R. § 298 (1980). 1-1. Delegation of Function.

14. 28 C.F.R. § 41.31(b)(1)(2) (1986).

15. See Larson, What Disabilities Are Protected Under the Rehabilitation Act of 1973?, 16 Mem. St. U.L. Rev. 229, 234 n.13 (1986).

16. 29 U.S.C. § 793 (Supp. 1987).

17. 41 C.F.R. § 60-741.2 (1986):

> "Handicapped individual" means any person who (1) has a physical or mental

on Handicapped Employees which, among other responsibilities, reviews the adequacy of hiring, placement, and advancement of disabled persons in each department, agency or instrumentality of the federal government.[18]

Courts have constructed general approaches for determining whether a protectable impairment exists. *E.E. Black, Ltd. v. Marshall*[19] was a section 793 action in which the court adopted the Webster's Third International Dictionary's definition of impairment and thus concluded the term includes "any condition which weakens, diminishes, restricts or otherwise damages an individual's health or physical or mental activity."[20] The United States Supreme Court in *School Board of Nassau County, Florida v. Arline*[21] relied upon Department of Health and Human Services regulations to define "impairment" in a section 794 action.[22] Those regulations explain that the term includes "such diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, [and] emotional illness."[23] The opinion added that Health and Human Services considered a broad interpretation inherent in the statutory definition and that the term should not be limited to "so-called 'traditional handicaps.'"[24]

Thus the statute, regulations and case law do provide guidance for determining the meaning of impairment. However, there remains a great deal of uncertainty in the complex area of mental impairments. This

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impairment which substantially limits one or more of such person's major life activities, (2) has a record of such impairment, or (3) is regarded as having such an impairment. For purposes of this part, a handicapped individual is "substantially limited" if he or she is likely to experience difficulty securing, retaining, or advancing in employment because of a handicap.

Appendix A: Guidelines on the Application of the Definition of the Handicapped Individual

"Life activities" may be considered to include communication, ambulation, selfcare, socialization, education, vocational training, employment, transportation, adapting to housing, etc. For the purpose of section 503 of the Act [§ 793], primary attention is given to those life activities that affect employability.

The phrase "*substantially limits*" means the degree that the impairment affects employability. The handicapped individual who is likely to experience difficulty in securing, retaining or advancing in employment would be considered substantially limited.

18. 29 U.S.C. § 791 (Supp. 1987).
19. 497 F. Supp. 1088 (D. Hawaii 1980).
20. Id. at 1094, 1097.
21. 107 S. Ct. 1123 (1987).
22. Id. at 1127.
23. Id. at n.5.
24. Id.

uncertainty is in part a function of the difficulty in defining and classifying mental impairments.

THE STATE OF THE ART

Mental impairments are defined in the Justice Department regulations for section 794, for example, as "any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities."[25] The substantial number of people included within this and similar definitions mandates that great care must be taken in applying the statutory term "impairment." It is estimated that 20% of the population is affected by diagnosable psychiatric disorders.[26] More than 5% suffer generalized anxiety; 5-10% are troubled by severe personality disorders; 5-10% suffer from affective disorders; 15% will suffer an episode of severe depression in their lifetime; and 1% develop schizophrenia.[27] Current expenditures for mental disorders exceed $20 billion and, if addictive disorders and alcoholism are included, the economic cost to society exceeds $185 billion per year.[28]

Psychiatry will receive most of the attention in this article. The psychiatrist is a physician and the traditional dominant actor in the mental health field. Psychiatrists do not have a monopoly in this area, however. In ambulatory mental health care, psychiatrists account for only one-third of all visits; psychologists for another third, and non-psychiatric physicians and non-medical providers for the final third.[29] A brief look at the interaction between psychiatry and psychology provides a clear indication of the difficulty of arriving at a consensus regarding a reliable identification system for mental impairments.[30]

Each discipline publishes its own professional journals, and the *American Psychologist* offers an assessment of the relationship between psychiatry and psychology.[31] Professional identities differ in that psychologists' training in research and personality imparts a tolerance for ambiguity

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25. See supra note 14 and accompanying text.

26. Lehmann, The Future of Psychiatry: Progress—Mutation—or Self Destruct, 31 Can. J. Psychiatry 362, 366 (1986), citing Klerman, The Psychiatric Revolution of the Past Twenty-Five Years, Deviance and Mental Illness 177-96 (W. Grace ed. 1982).

27. Lehmann, supra note 26, at 366.

28. Id., citing J. Nemiah, Research on Mental Illness and Addictive Disorders: the Magnitude of the Problem, Overview, 142 Am. J. Psychiatry 10-12 (July supp. 1985).

29. Lehmann, supra note 26, at 365.

30. See generally Persons, The Advantages of Studying Psychological Phenomena Rather Than Psychiatric Diagnoses, 41 Am. Psychologist 1252 (1986) (certain psychological processes such as delusions and hallucinations will be better understood if the phenomena themselves are studied directly rather than diagnostic categories).

31. Berg, Toward a Diagnostic Alliance Between Psychiatrist and Psychologist, 41 Am. Psychologist 52 (1986).

and a predilection for abstraction that can approach obsession. Psychiatrists gravitate toward more concrete and pragmatic approaches and may find psychologists' test reports unclear and weighted down by technical jargon.[32] Medicine's epistemology "is shaped by atomistic, mechanical, nonintentional and objective constructs in contrast to the specific, purposive, wholistic, and intentional approach of psychology."[33] Psychiatry's "former" dominance of the mental health field fans a distrust that includes the fear of a "land grab" by other disciplines, skepticism towards emerging professions' new techniques, and a growing concern with exclusion.[34]

Psychologists' collaborations with psychiatrists may be influenced by the psychologist's envy of higher status and higher earnings and, as a result, the psychologist may project a sense of assurance that obscures acknowledged ambiguities.[35] The psychologist may overvalue his or her diagnostic contribution as a compensation for perceived limits on professional opportunities and as a response to criticism.[36] An editorial in *Psychological Medicine* adds that psychiatrists' current education in psychology often reflects "the days when psychologists were regarded as backroom technicians, analogous to haematologists or biochemists, except that they forgot, or worse refused, to wear their white coats."[37] Psychiatrists may learn about intelligence and memory testing, neuropsychological and personality assessment, and behavior and cognitive therapy, yet may not be trained in skills and techniques.[38] Consequently, psychologists' conclusions may go unheeded.

Even if there is only some truth to this description, there will be consequences. Diagnostic collaboration is one interface where the shock waves are felt and certain attitudes "can fuel an interdisciplinary skirmish in which professional ambitions are frustrated and the patient's welfare is undermined."[39]

The impact of such interdisciplinary squabbling on the search for a reliable diagnostic system need not be explained. Furthermore, it must be kept in mind that psychiatry is not being challenged and influenced by psychology alone. The boundary between behavior and biology is

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32. Id. at 53.

33. Id., citing S. Hunt, The Relationship Between Psychology and Medicine, 8 Soc. Sci. & Med. 105 (1974).

34. Berg, supra note 31, at 54.

35. Id. at 56.

36. Id.

37. Kopelman, Psychiatrist's Education in Psychology: Jackdaw or Sponge, 16 Psychological Med. 13, 14 (1986).

38. Id.

39. Berg, supra note 31, at 54, 57.

shifting as neuroscientists research the biological determinants of behavior. Neuroscientific discoveries may strengthen psychiatry and increasingly require the mental health field to develop expertise that combines psychological and biological knowledge in order both to understand the use of psychopharmacological agents and to treat patients.[40] One critic asserts, however, that psychiatrists' shortcoming is that they do not look enough like doctors and that they respond by claiming either that they are neurologists or that psychotherapy is a bona fide medical treatment for bona fide medical diseases.[41] Such claims may not be accepted as valid much longer by the medical, legal, political and scientific authorities of society.[42]

In light of the competing forces in the mental health field and new research developments, one might narrow the discussion and ask whether psychiatrists can at least agree among themselves as to the presence and nature of mental impairments. This question, however, should not be asked in the abstract. The cases reveal that many courts appear to be directing attention to whether the claimant can produce a recognized psychiatric diagnosis. Because courts are requesting such evidence, the following discussion will address psychiatrists' ability to make consistent and reliable diagnoses. The discussion following the examination of judicial cases, however, asks whether a specific diagnosis should be required. It may be that for determining the existence of a recognizable impairment a formal diagnosis is not necessary. For the moment, however, consider psychiatry and its diagnostic approach.

Psychiatric epidemiology did not begin to emerge until the 1920s.[43] Although nineteenth century psychiatrists were avid data collectors, they were not epidemiologists. They used statistics to demonstrate high curability rates (defined as the ability to resume life in the community) but did not relate recovery to etiology or diagnoses.[44] The status of psychiatric nosology inhibited epidemiological inquiry in that statistics dealt not with incidence but with admission to hospitals.[45]

The adoption of a formal nosology was a controversial issue, and in 1919 Dr. Adolf Meyer of Johns Hopkins, one of the prominent leaders in the field, declared that statistics "will be most valuable if they do not attempt to solve all of the problems of administration and

40. Pardes, Neuroscience and Psychiatry: Marriage or Coexistence?, 143 Am. J. Psychiatry 1205, 1210 (1986).

41. Szasz, Psychiatry: Rhetoric and Reality, Lancet, Sept. 28, 1985, at 711.

42. Id.

43. Grob, The Origins of American Psychiatric Epidemiology, 75 Am. J. Public Health 229 (1985).

44. Id.

45. Id. at 230.

psychiatry and sociology under one confused effort of a one-word diagnosis marking the individual."[46] Yet in 1920 the Census Bureau, conceding its inability to draw clear lines, compiled a nomenclature of diseases that included psychiatric illnesses.[47] Psychiatric nosologies, with few exceptions, rested upon descriptive rather than etiological foundations. Thus the results of epidemiological studies differed because of variations in both the design of studies and classification of systems as well as the subjective observations themselves.[48] As late as 1970 a chairperson at the Johns Hopkins School of Hygiene and Public Health would praise population surveys of incidence because they substitute more accurate "operational definitions of mental illness" (i.e., symptom patterns) for the "often ill-defined syndromes" used by psychiatrists.[49]

Great amounts of energy have been devoted to designing diagnostic classification systems that minimize uncertainty and ambiguity. The World Health Organization's official *International Classification of Diseases, Injuries and Causes of Death* (ICD) and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) are the most widely recognized.[50] DSM-III was designed in the United States as a national system and will be our specific focus. It utilizes diagnostic criteria within a multiaxial framework.

DSM-III has received generally favorable reviews. For example, a survey of one hundred and seventy-five diagnostic experts from fifty-two countries spanning the six World Health Organization Regions[51] revealed that 77% of them used ICD-9 and 72% used DSM-III.[52] However, on a scale measuring "high, medium and low" usefulness, DSM-III was rated as highly useful (46%) more frequently than ICD-9 (29%).[53] A Norwegian study involved a two-hour general introductory course to DSM-III followed by a case study classification exercise wherein clinicians diagnosed depressive disorders under both DSM-III and the commonly

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46. Id. at 233.
47. Id.
48. Id. at 235.
49. Id. at 236.
50. World Health Organization, Manual of the International Classification of Diseases, Injuries, and Causes of Death (9th revision 1977); American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (3d ed. 1980). These publications will be referred to by their acronyms and revision numbers, for example, as DSM-III.

Additionally, there were at least fifteen specific multiaxial systems alone from ten different countries published between 1947 and 1984. Mezzich, et. al., International Experience with DSM-III, 173 J. Nerv. & Ment. Disease 738 (1985).

51. Mezzich, supra note 50, at 739. (39 from the Americas, 59 from Europe, 15 from Africa, 13 from the Eastern Mediterranean, 38 from South and East Asia, and 11 from the Western Pacific).
52. Id. at 739.
53. Id.

used ICD-8 system.[54] Although there was only a small group of participants, the study alludes to similar experiences with over three hundred mental health professionals and suggests that the DSM-III system results in a higher percentage of diagnostic agreement than the ICD-8 system.[55]

Yet DSM-III, which is being replaced by a fourth edition, is a frequent subject of commentary and criticism. Its five separate axes are not perceived to be of equal value. For example, detailed criticisms have been directed at axis V[56] (the highest level of adaptive functioning in the past year) and axis II[57] (personality disorder criteria). It has been asserted that the "abuse" and "dependence" distinction for Substance Use Disorders does not carry any substantial prognostic implications,[58] and major revisions have been recommended for that diagnosis.[59] DSM-III diagnoses differ depending upon who is applying the criteria. The Diagnostic Interview Schedule (DIS) is a highly structured, standardized interview designed to allow lay examiners to survey the general population for mental disorders and, with the assistance of a DSM-III computer program, to arrive at diagnoses comparable to those a psychiatrist would obtain. The difficulty of applying diagnostic criteria consistently is illustrated by a Baltimore survey which found only a very low to modest concordance when eight hundred and twelve subjects were diagnosed by both the lay DIS method and by psychiatrists.[60]

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54. Malt, Teaching DSM-III to Clinicians, 73 Acta Psychiatrica Scandinavica 68, 69 (1986).

55. Id. at 72.

56. Fernando, et. al., The Reliability of Axis V of DSM-III, 143 Am. J. Psychiatry 752 (1986) (questioning the prognostic significance of axis V as well as the reliability of ratings).

57. Widiger et. al., The DSM-III Personality Disorders, 42 Arch. Gen. Psychiatry 615 (1985). The authors assert that while the categorical system used may be simpler and easier to employ, such a system is inappropriate in light of the inherent complexity involved in classifying multiple and overlapping maladaptive personality traits. Diagnostic reliability would be increased if a dimensional model were substituted. This would allow a clinician to rate patients on a number of dimensions rather than having to select among a number of alternative categories. Id. at 619. See also, Livesley, The Classification of Personality Disorder: II. The Problem of Diagnostic Criteria, 30 Can. J. Psychiatry 359 (1985).

58. Schuckit, et. al., Clinical Implications of DSM-III Diagnoses of Alcohol Abuse and Alcohol Dependence, 142 Am. J. Psychiatry 1403, 1408 (1985).

59. Rounsaville, et. al., Proposed Changes in DSM-III Substance Use Disorders: Description and Rationale, 143 Am. J. Psychiatry 463 (1986).

60. Anthony, et. al., Comparison of the Lay Diagnostic Interview Schedule and a Standardized Psychiatric Diagnosis, 43 Gen. Arch. Psychiatry 667, 671 (1985). See also, Spitzer, Psychiatric Diagnosis: Are Clinicians Still Necessary, 24 Comprehensive Psychiatry 399 (1983) (introducing an alternative structured interview entitled Structured Clinical Interview for DSM-III (SCID) which, unlike DIS, is designed to allow for greater flexibility in the interview by taking advantage of the strengths of traditional clinical diagnostic interviews. Id. at 402).

Diagnostic difficulties go beyond DSM-III. One less obvious problem is the distribution of information regarding new developments. Knowledge is advancing too rapidly for anyone to have personal experience with all the findings, and physicians are increasingly dependent upon medical journals. A survey of fifteen major psychiatric journals reveals that readers must be familiar with about a dozen statistical techniques to understand approximately 95% of the quantitative methods contained in the articles reviewed.[61] That survey's conclusion includes a call to practitioners to improve their quantitative skills. The unspoken assumption is that not all practitioners have the ability to stay abreast of developments. An additional concern is that patients' falsification of psychiatric history can assume various forms which affect the clinical psychiatric diagnosis.[62]

All of this merely hints at the complexity surrounding the field of mental health. This article will next examine how courts are responding to this complexity.

MENTAL IMPAIRMENTS RECOGNIZED AS PROTECTED

Although there have not been a great number of cases considering which mental disorders qualify as statutory impairments, certain cases do provide some guidance. *Doe v. New York University*[63] involved a medical student who filed an action seeking readmission to medical school under section 794. The plaintiff was described as an individual suffering for many years from serious psychiatric and mental disorders, which manifested themselves in the form of numerous self-destructive acts and attacks upon others. Her actions included an overdose with sleeping pills when she was fourteen years old, self-injection with a powerful cancer drug, plunging a kitchen knife into her stomach, repeatedly severing arteries and veins, self-injection with cyanide, and repeatedly physically and aggressively attacking physicians with her teeth

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61. Hokanson, et. al., Spectrum and Frequency of Use of Statistical Techniques in Psychiatric Journals, 143 Am. J. Psychiatry 1118, 1122 (1986) (the statistical procedures identified are descriptive statistics, dispersion, chi-square, epidemiological statistics, t test, Pearson product-moment correlation and nonparametric correlation, nonparametric tests, simple and multiple linear regression, ANOVA, survival analysis, transformations, and mathematical models). See also, Edlund, et. al., Beta, or Type II Error in Psychiatric Controlled Clinical Trials, 19 J. Psychiat. Res. 563, 566 (1985) (asserting that psychiatric clinical studies themselves may be misleading in that Type II or Beta errors (the probability of failing to reject the null hypothesis when it is in fact false) may go unreported because medical literature is highly biased towards reporting positive, as opposed to negative, results).

62. See, Kerns, Falsifications in the Psychiatric History: A Differential Diagnosis, 49 Psychiatry, Feb. 1986 13-17.

63. 666 F.2d 761 (2d Cir. 1981).

and fingernails, as well as with potentially lethal objects such as scissors.[64] However, over the course of her academic career she excelled, and she also received excellent employment evaluations.[65]

In spite of her substantial medical history, described in detail by the court,[66] Doe applied to medical school and falsely represented that she did not have then and had never had any chronic or recurrent illnesses or emotional problems. She was accepted at New York University Medical School and, during a mandatory medical examination, revealed her psychiatric history. At a later examination Dr. Stern, an associate dean, concluded that Doe had a "fragile personality" and sent her for psychological tests.[67] The psychologist noted that she had a "grossly detached and alienated personality, with no effective intellectual or emotional contact with the world of things or people."[68] Doe eventually made a written proposal for a leave of absence which was granted on the understanding that she could request possible reinstatement.

After a subsequent hospitalization, her condition on discharge was listed as "no improvement" with a diagnosis of "Borderline Personality . . . Personality Disorders, other specified types 301.89."[69] The personality disorder classified as "Borderline Personality" is a serious condition, manifesting itself by a series of five or more recognizable characteristics, according to the DSM-III.[70] A person suffering from this condition is likely to have it continue through most of her adult life, subject to modification only by treatment over a period of years and adoption of a life style which avoids situations which subject the person to types of stress with which she cannot cope.[71]

Doe later applied for readmission and claimed that she was a handicapped person under the Act. This assertion conflicted with her representations on the medical school applications that she did not suffer from any emotional problems. It also conflicted with her own testimony that her ability to function in major life activities had never been impaired and that she had never been unable to work or learn. She had successfully graduated from college, had received a masters degree from Harvard, and had established an outstanding employment record as a member of the Department of Health, Education and Welfare.[72]

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64. Id. at 766.
65. Id. at 770.
66. Id. at 766-70.
67. Id. at 767.
68. Id.
69. Id.
70. Id.
71. Id., citing American Psychiatric Assoc., Diagnostic and Statistical Manual of Mental Disorders (3d ed. 1980).
72. Id. at 775.

Additionally, an Associate Professor of Psychiatry at the Harvard Medical School, who was the superior of one of the psychiatrists who diagnosed Doe as suffering from Borderline Personality Disorder, disagreed with that diagnosis and stated that Doe had a "'chronic neurotic depression'" that was a "'treatable condition.'"[73] The court concluded:

> Notwithstanding this evidence we believe that for present purposes she should be classified as a handicapped person under the Act, in view of the independent evidence of her extensive history of mental impairments requiring hospitalizations and her departure from NYU in 1976 because of psychiatric problems, all of which indicate that she has suffered from a substantial limitation on a major life activity, the ability to handle stressful situations of the type faced in a medical training milieu.[74]

The court was thus convinced not only that she had experienced a mental disorder sufficiently severe to be recognized as an impairment under the Rehabilitation Act, but also that this impairment had been a substantial limitation on a major life activity. The court stated that its conclusion was reinforced by the wide scope of the definition in section 706(7)(B),[75] which includes in subdivision (ii) anyone with a "record of such impairment," as well as by the Rehabilitation Act's legislative history, "which indicates that the definition is not to be construed in a niggardly fashion."[76]

The *Doe* court recognized plaintiff as protected because she was "regarded as having such [a protected] impairment" and also because she had "a record of such impairment."[77] Implicit in the observation about her medical record is the recognition that plaintiff's psychiatric problems were severe enough to warrant protection under the Act. With this kind of history it was not difficult for the court to identify a protected handicap. There have been other relatively straightforward cases.

Blackwell v. United States Department of Treasury[78] is a succinct two-page opinion that demonstrates the weight accorded a psychiatric diagnosis. Plaintiff contended that interviewing officials conspired to eliminate a job opening because plaintiff was a transvestite whom they regarded as being mentally ill.[79] Defendants argued that plaintiff did

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73. Id. at 769. This psychiatrist did, however, acknowledge the possibility of a recurrence as well as the existence of other personality disorders. Id. at 778.

74. Id. at 775.

75. See supra note 9 and accompanying text for the definition.

76. 666 F.2d at 775.

77. Id.

78. 639 F. Supp. 289 (D.D.C. 1986).

79. Id. at 290, citing Plaintiff's Complaint, para. 15.

not state a claim for relief under the Rehabilitation Act because a transvestite is not a handicapped person under the Act. The court considered the case from the perspective of a plaintiff alleging he was regarded as having a handicap.

> The Department of the Treasury acknowledges that transvestitism is recognized by the American Psychiatric Association as a mental disorder. Plaintiff has alleged that the position he sought was eliminated because Treasury officials regarded the fact that he is a transvestite as a handicap. This is enough to state a claim under the Rehabilitation Act.[80]

There have been cases, however, where the existence of an impairment was not as apparent. In *Forrisi v. Bowen*,[81] the employer terminated an employee suffering from acrophobia. During an introductory tour of the plant, Forrisi told his supervisor that he could not climb to certain heights. When management officials responded that it appeared he would not be able to satisfy the job requirements of utility systems repairer, which included climbing stairs and ladders, Forrisi insisted that he could do the necessary work. Approximately two months after Forrisi was hired, he was discharged because he was found "'medically unable to perform the full range of the duties of [his] position.'"[82]

In his testimony Forrisi reported that his fear of heights never affected his life and that it was never a problem before he obtained his current position. By his admission, Forrisi established that he would not be pursuing his claim based upon an assertion of discrimination against a current handicap. Instead, Forrisi argued that although he was not in fact a handicapped individual, he was perceived as being limited in one of his major life activities.[83]

The diagnosis of Forrisi's condition was sufficient evidence to result in an apparent concession that there was a recognizable mental impairment and the case focused on subsequent burdens of proof. More

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80. Id. See also Blackwell v. U.S. Dept. of Treasury, 656 F. Supp. 713, 715 (D.D.C. 1986), where the court stated: "Yet, as a matter of statutory analysis, while homosexuals are not handicapped it is clear that transvestites are, because many experience strong social rejection in the work place as a result of their mental ailment made blatantly apparent by their cross-dressing life-style." Id. at 715.

Although the district court opinion was vacated by the District of Columbia Circuit, the appellate decision addressed the specificity of notice of an impairment that must be provided to an employer. The appeals court agreed with the district court's conclusion that sexual orientation or preference is not protected but did not comment on the lower court's conclusion that transvestism is a distinguishable, protectable condition. Blackwell v. U.S. Dept. of Treasury, 830 F.2d 1183 (D.C. Cir. 1987).

81. 794 F.2d 931 (4th Cir. 1986).

82. Id. at 933.

83. Id. at 934.

specifically, it was not disputed that the perception that an employee has acrophobia might result in protection under the Act. This condition is a recognizable mental impairment. It will only be protected, however, if the plaintiff can establish the additional proof requirements of a substantial limitation on a major life activity. It is in regard to these burdens of proof that Forissi failed.

When a government agency establishes a percentage disability in connection with government service, one might presume that this acknowledgement of a disability would later be recognized by the courts. A plaintiff dismissed because of excessive unscheduled absences asserted a disability resulting from diabetes and mental illness in *Wimbley v. Bolger*.[84] The court declared that it was undisputed that plaintiff had a thirty percent service-connected disability established by the Veterans Administration standards. It further stated, however, that this did not automatically render him a handicapped employee for purposes of the Rehabilitation Act.[85] The *Wimbley* court did not further discuss what percentage would be necessary to establish a protected disability, but instead determined that this plaintiff was afflicted with a sufficient disability to bring him within the definition of a handicapped employee. The court was perhaps willing to make this determination because it then resolved the case by determining that even if the plaintiff was handicapped, he was not "qualified."[86]

The *Wimbley* case is worth discussing because that court adopted an approach that appears in several cases. Wimbley's discharge was judged permissible because he was not terminated due to a mental illness. Rather, he was terminated due to his failure to come to work. The court stated that an employee who does not come to work cannot perform any of his job functions, and thus cannot be a qualified handicapped employee.[87] Several interesting questions are thus raised. Is it appropriate to deny a plaintiff protection by distinguishing between manifestations of a protected impairment and the impairment itself? Furthermore, if such distinctions are to be drawn, how should they be integrated into the Rehabilitation Act analysis?

WHERE DOES A DISABILITY END AND INDEPENDENT CONDUCT BEGIN?

In *Swann v. Walters*,[88] an employee was demoted from a shift supervisor position with access to confidential medical information to

84. 642 F. Supp. 481 (W.D. Tenn. 1986).
85. Id. at 485.
86. Id.
87. Id.
88. 620 F. Supp. 741 (D.D.C. 1984).

the position of housekeeping aide. The demotion was a result of plaintiff's conviction on a felony charge of sexual child abuse in a Maryland state court. As a result of the conviction and in accordance with Federal Personnel Manual Guidelines, plaintiff lost his security clearance and could no longer hold his shift supervisor position.

Plaintiff asserted a Rehabilitation Act claim, alleging his demotion was due to a mental disability based upon a chronic condition of paranoid schizophrenia.[89] The court concluded that plaintiff could not sustain his Rehabilitation Act claim because he was not demoted "solely because of his handicap."[90] Rather, the Veterans Administration acted based not upon any impairment but rather upon plaintiff's criminal misconduct which reflected adversely on his trustworthiness and stability. There was no evidence that plaintiff's psychiatric condition was taken into account.[91] Further, the court considered the plaintiff's claim as an attempt to use his schizophrenia as a basis for exempting himself from a critical criterion of his job, the security clearance. The court stated that this was not within the purpose of the Rehabilitation Act, which was intended to insure that handicapped individuals are not excluded when they can meet the essential prerequisites of a job.[92]

The court cited a third reason in support of its decision not to protect plaintiff. The Rehabilitation Act requires that claimants be "otherwise qualified." In other words, according to the United States Supreme Court's interpretation in *Southeastern Community College v. Davis*,[93] an individual must be able to meet all of the job requirements "in spite of" his handicap.[94] Plaintiff's criminal misconduct made him unsuitable to hold the security clearance, which was a fundamental requirement of his position.

The first reason discussed is particularly interesting. Based upon the absence of any evidence that plaintiff's psychiatric condition was a consideration, the court concluded that the Veterans Administration acted appropriately. Yet there is a clear suggestion that plaintiff's criminal misconduct was a function of his psychiatric condition. A defendant should not be able to avoid the Rehabilitation Act merely by focusing upon an individual's conduct rather than his mental impairment. The *Swann* court's third justification, which addresses the issue of qualification and which was also relied upon by the *Wimbley* court, represents the proper approach.

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89. Id. at 746.
90. Id. at 747.
91. Id.
92. Id.
93. 442 U.S. 397, 99 S. Ct. 2361 (1979).
94. 620 F. Supp. at 747, citing 442 U.S. at 406.

This issue is not as obscure as it may appear. *Guerriero v. Schultz*[95] involved a foreign service officer dismissed as a result of certain off-duty conduct. It was stipulated that while in Uruguay, Guerriero engaged in public sex acts with three or four local prostitutes.[96] It was undisputed that Guerriero had been drinking at the time. Guerriero claimed that his termination constituted unlawful discrimination because the dismissal was based upon "handicaps" which may have contributed to the conduct in question. Guerriero suffered from acute alcohol addiction and a schizoid personality disorder first diagnosed following his return from Uruguay but which nevertheless had existed for years.[97]

Guerriero alleged that he had joined Alcoholics Anonymous, that he was abstaining from alcohol, and that his psychological disorders were in remission. He alleged that those psychological disorders, however, rendered him a handicapped individual within the meaning of the Rehabilitation Act and that those deficiencies could not be used as the basis for adverse personnel actions if he was otherwise qualified and his handicaps could be accommodated.[98]

The court accepted that either his schizoid personality disorder or his alcoholism could be regarded as handicaps within the meaning of the Act.[99] The court concluded, however, that Guerriero's dismissal was not based upon any mental disorder but was a result of his conduct. This conduct was of such an "'immoral, notoriously disgraceful, and prejudicial' character as to have compromised his ability to represent the United States abroad."[100] The Board of Foreign Service, which recommended Guerriero's dismissal, proceeded upon the determination that Guerriero was not an alcoholic. Although this may have been error, the court concluded that this actually supported the Board's position upon appeal. The Rehabilitation Act only prohibits discrimination against an individual because he or she has a handicap such as alcoholism. Because plaintiff's alleged disabilities were accorded no particular significance one way or another in the Board's determination, no violation existed.

Guerriero drew a distinction between the existence of an impairment and conduct which may have been a product of the impairment. This approach can lead to an extremely restrictive reading of the Rehabilitation Act. Interpreted in this manner, the Act arguably only protects against discrimination based upon the label of a particular mental impairment

95. 557 F. Supp. 511 (D.D.C. 1983).
96. Id. at 512 n.2.
97. Id. at 512.
98. Id.
99. Id. at 513.
100. Id.

but does not protect against discrimination towards any of the manifestations of that impairment. Additionally, as will be developed, such a practice denies the full protection intended by the Rehabilitation Act.

A similar analysis was provided in *Richardson v. United States Postal Service*.[101] Richardson was suspended from his job when, after attempting to kill his wife and himself, he was charged with assault with intent to kill. He was diagnosed as suffering from deep depression with paranoid tendency and alcoholism. He eventually pled guilty to assault and weapons charges and was thereafter terminated.[102]

The only claim considered by the district court was whether the Postal Service failed to accommodate Richardson's alcoholism handicap. The court concluded that even if Richardson's mental difficulties and alcohol use could be untangled and his alcoholism could be shown to be a substantial cause of his criminal conduct, it would not benefit Richardson. Richardson was discharged for criminal conduct, not because of alcoholism or poor job performance due to alcohol. The court stated that the Rehabilitation Act "does not prohibit an employer from discharging an employee for improper off-duty conduct when the reason for the discharge is the conduct itself, and not any handicap to which the conduct may be related."[103]

This opinion, however, contains some provocative language. The court states that the Rehabilitation Act does not create a duty to accommodate an alcoholic who "commits an act which, standing alone, disqualifies the alcoholic from service and which is *not entirely* a manifestation of alcohol abuse."[104] The court thus recognizes that there may be a connection between alcohol abuse and conduct. Accordingly, the critical inquiry must determine what conduct would be entirely a manifestation of alcohol abuse. Once a court recognizes that there is a connection between an impairment that is presumably provided protection and the conduct manifested by that protected impairment, the perception of what is protected according to the Rehabilitation Act may have to be substantially altered.

But what about the safety of other persons? Should someone who has committed assault with intent to kill receive protected status with federal contractors, in federally assisted programs, and in the federal government? Safety concerns can be taken into account without perverting the handicap analysis. The effects of a disorder cannot be realistically distinguished from the disorder itself. Safety risks are properly

101. 613 F. Supp. 1213 (D.D.C. 1985).
102. Id. at 1214.
103. Id. at 1215-16.
104. Id. at 1216 (emphasis added).

considered at a subsequent stage in the analytic model, when determining qualifications for the position. For instance, the regulations interpreting section 791 (concerning the federal government as employer) define a qualified handicapped person as someone who "with or without reasonable accommodation, can perform the essential functions of the position in question without endangering the health and safety of the individual or others."[105] The Ninth Circuit Court of Appeals established in *Mantolete v. Bolger*,[106] a case involving a successful plaintiff with epilepsy who had applied for a job involving heavy machinery, that an employer cannot reject an applicant without showing "reasonable probability of substantial harm."[107] If a defendant can distinguish conduct possibly resulting from an impairment from the impairment itself at the initial definitional stage, burdens that a defendant should be required to satisfy will be improperly circumvented.

STATE STATUTORY LANGUAGE THAT RESEMBLES THE FEDERAL REHABILITATION ACT

School District of Philadelphia v. Friedman[108] was decided pursuant to Pennsylvania state statutes, but is of interest because the statutes relied upon provide protections which resemble those available under the federal Rehabilitation Act. The lawsuit was brought pursuant to section 5 of the Pennsylvania Human Relations Act,[109] which makes it an unlawful discriminatory practice for an employer to refuse to hire or to discharge anyone because of a non-job related handicap or disability.[110] The Pennsylvania Code, Title 16, section 44.4[111] defines "handicapped or disabled person" as:

(i) A person who:

(a) has a physical or mental impairment which substantially limits one or more major life activities;
(b) has a record of such an impairment; or
(c) is regarded as having such an impairment.

(ii) As used in subparagraph (i) of this paragraph, the phrase:

(a) ". . . mental impairment" means a physiological disorder or condition . . . a mental or psychological dis-

105. 29 C.F.R. § 1613.702(f) (1987).
106. 767 F.2d 1416 (9th Cir. 1985).
107. Id. at 1422.
108. 507 A.2d 882 (Pa. Commw. 1986).
109. Pennsylvania Human Relations Act § 5(a), Pa. Stat. Ann. tit. 43, § 955(a) (Purdon Supp. 1987).
110. Id.
111. 16 Pa. Code § 44.4.

> order, such as mental illness, and specific learning disabilities.
> (b) "Major life activities" means the functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.[112]

Friedman was a computer programmer trainee who was discharged for chronic lateness. He alleged that the school district had discriminated against him because of his mental disability, a personality disorder which results in chronic lateness, which he in turn claimed was not job-related.[113]

In the Court of Commons Pleas the chancellor had found that the school district's physician diagnosed Friedman's condition as a "neurotic compulsion for lateness" and that the school district had received from Friedman's treating physician of ten years a letter which labeled Friedman's chronic lateness as a "behavioral aberration."[114] The chancellor also found that Friedman had been treated by a clinical psychologist trained in behavioral modification therapy. Based upon this evidence the chancellor concluded that Friedman suffered from, and continued to suffer from, a mental disability. As a result of this disability he was chronically late for virtually all of his life activities, including reporting for work.[115]

The record included a letter from Dr. Mock, Friedman's treating physician of ten years. That letter contained the following information regarding Friedman's condition:

> It seems to be a rather infantile and certainly self-defeating way of rebelliously asserting his individuality and of refusing to submit to the rules set down by authority. Although I recognize that his lateness is disruptive to an organization that includes a uniform work schedule in its structure, it is a comparatively benign expression of his determination not to be obliterated by a dominating controlling system of which he conceives himself as a victim. I would like to emphasize an obvious fact, namely that his motivation and rationale for this behavior is almost completely unconscious and literally beyond his control. . . . It is extremely questionable whether this deeply engrained behavioral pattern will ever be modified by means of psychiatric intervention.[116]

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112. Id.
113. 507 A.2d at 883.
114. Id. at 884.
115. Id.
116. Id. at 885.

The chancellor at the trial had asked Dr. Mock to categorize Mr. Friedman's condition. Dr. Mock declined to do so, stating that there was no specific diagnostic label that could be used.[117] Dr. Mock did state that the plaintiff was not psychotic. Additionally, when asked whether Friedman was neurotic, Dr. Mock did not answer either affirmatively or negatively but simply responded "personality disorder."[118] Dr. Mock did agree that what he had termed a personality disorder existed around us everyday in all walks of life. Finally, Dr. Mock admitted that Friedman's condition did not impair his ability to care for himself, to walk, see, hear, speak, learn or work.[119] In light of that observation and in response to Dr. Mock's diagnostic evasiveness, the Pennsylvania Commonwealth Court reversed and declared that the record was clear that Mr. Friedman had no disability as that term is defined by Pennsylvania law.[120]

A dissenting opinion stressed the fact that Friedman had submitted to an examination by a school physician who had diagnosed his condition as a "neurotic compulsion for lateness."[121] The dissent further emphasized that, according to Dr. Mock, plaintiff's motivation and rationale for his behavior were almost completely unconscious and literally beyond his control. Mr. Friedman had received psychiatric treatment since he was a teenager. He had been honorably discharged on account of a non-service connected disability, psychiatric in nature. He had received psychiatric treatment as an inpatient at Philadelphia General Hospital in 1964 and had subsequently attended Horizon House (a social service agency serving former mental patients). Friedman had been treated for many years by Dr. Mock, a psychiatrist, and for a shorter period by a Dr. Jasin, a clinical psychologist. In fact, Mr. Friedman had been referred to the school district for employment by Horizon House, and two Horizon House counselors had accompanied him to the school board administration building for his interview. The dissent concluded that Friedman's mental impairment substantially limited one or more of his major life activities and that his persistent lateness manifested itself in all situations, not just employment.[122] His disability was not job-

117. Id.
118. Id.
119. Id.
120. Id. at 885-86.
121. Id. at 891.
122. Id. at 891. Recall that the court specifically noted that, when asked whether Friedman was neurotic, Dr. Mock responded "personality disorder." See supra text accompanying note 118. There is a category of mental disorders included in DSM-III that is grouped under the title "personality disorders." The court should have considered it sufficient to identify the category of this particularly complex disorder and concentrated its attention on other elements of plaintiff's proof.

related because it did not substantially interfere with his ability to perform the essential functions of the job.

It is difficult to draw any clear conclusions from *School District of Philadelphia v. Friedman*. The majority stated simply that the record supported a conclusion of no disability as the term was defined by regulation.[123] The regulation, however, includes definitions of both mental impairment and major life activities. The majority probably rested its decision upon the finding that there was no limitation of a major life activity. The evasiveness of Dr. Mock and the absence of a specific diagnostic label beyond the identification of a general class of disorders, however, appears to have been of importance and suggests that the court questioned whether an impairment existed. There is a significant degree of uncertainty surrounding the labeling of psychiatric disorders. The fact that Dr. Mock was able to identify a class of disorders that applies to the plaintiff, but did not go further and provide a specific diagnosis, should not necessarily mean that a protected impairment was not present. Recall that personality disorders are represented on axis II of DSM-III and that this axis has been criticized as unclear and lacking in diagnostic reliability.[124]

One can find additional cases interpreting state statutory language similar to that found in the federal Rehabilitation Act. *Sommers v. Iowa Civil Rights Commission*[125] examined whether Iowa law[126] proscribes employment discrimination based upon transsexuality.[127] Sommers, who referred to herself as "she," claimed to be an individual "anatomically male but psychologically and emotionally female."[128] Shortly after being hired, she was questioned about her sexual status, informed that she could not use the restrooms, and ultimately discharged. Sommers filed a complaint alleging she was discriminated against on the basis of a disability in violation of Iowa Code section 601A.6(1) (1981),[129] which

123. Id. at 885-86.

124. See supra note 57 and accompanying text.

125. 337 N.W.2d 470 (Iowa 1983).

126. Iowa Code § 601A.6(1)(a) (1981).

127. Transsexualism differs from homosexuality or transvestism. Homosexuals, according to the court, do not suffer from gender identity disturbances as do transsexuals and transvestites. Homosexuals accept their anatomical structure and the male or female role, except with regard to their sexual preference. A transvestite represents a status between the homosexual and the transsexual and obtains satisfaction by dressing in the clothing of the opposite sex. Citing Doe v. Minnesota Dep't of Public Welfare and Hennepin County Welfare Bd., 257 N.W.2d 816, 818 (Minn. 1977), the court stated that transsexualism is irreversible and can only be treated with surgery to remove some of the transsexual feelings of psychological distress. 337 N.W.2d at 473.

128. 337 N.W.2d at 471.

129. Id. at 471-72.

states: "It shall be an unfair and discriminatory practice for any: a. Person to . . . discharge any employee . . . because of age, race, creed, color, sex, national origin, religion or disability of such . . . employee . . . ."[130] Section 601A.2(11) defines "disability" as "the physical or mental condition of a person which constitutes a substantial handicap. In reference to employment, under this chapter, 'disability' also means the physical or mental condition of a person which constitutes a substantial handicap, but is unrelated to such person's ability to engage in a particular occupation."[131] The Iowa Civil Rights Commission rules further define "substantially handicapped person" and state that mental impairment means "[a]ny mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities."[132]

The court stated that the disorders identified in the Commission rules are inherently likely to have a limiting effect on one or more major life activities. The court concluded that although transsexualism may have an adverse effect on a person's capacity to engage in activities such as learning and working because of the attitudes of other people, this does not mean that the condition itself meets the definition of impairment. The court summarized:

> An adverse societal attitude does not mean that the transsexual is necessarily perceived as having a physical or mental impairment. Although a transsexual may have difficulty in obtaining and retaining employment, the Commission could reasonably believe that difficulty is the result of discrimination based on societal beliefs that the transsexual is undesirable, rather than from beliefs that the transsexual is impaired physically or mentally as that term is used in the statute and defined in the rule. While we do not approve of such discrimination, we do not believe it is prohibited by the Iowa Civil Rights Act.[133]

The Commission's efforts to distinguish Sommers' situation are unconvincing. An employee must generally be able to socialize with co-workers and managers.[134] A significant number of jobs also involve communicating with customers. Many jobs depend upon the ability to interact with others. If transsexualism interferes with interaction, there is a strong

130. Id. at 472, citing Iowa Code § 601A.6 (1981).

131. Iowa Code § 601A.2(11) (1981).

132. 240 Iowa Admin. Code r. 6.1(2)(b)(1982).

133. 337 N.W.2d at 477.

134. Sommers was hired as a clerical worker and apparently had contact with other employees because she was first recognized by an acquaintance who was also an employee.

argument that a substantial interference with the ability to work also exists and that transsexualism should thus be protected.[135]

Sommers was able to assert a recognized diagnostic label. In other cases, this has worked to the plaintiff's advantage. In *Blackwell v. United States Department of Treasury*,[136] the court determined that because transvestitism is recognized by the American Psychiatric Association as a mental disorder, a defendant that perceives an employee to be a transvestite will be held to regard that person as impaired within the meaning of the Rehabilitation Act. The reading given the Iowa statute by the Commission, which was determined to be reasonable by the Supreme Court of Iowa, was unnecessarily restrictive. Although the supreme court may have protected Sommer's condition under circumstances involving full judicial review, some disorders may be so socially unattractive that even with a diagnostic label it will be difficult to establish protected status.

Barnes v. Barbosa[137] involved a Chicago Transit Authority bus driver alleging discrimination based upon his mental handicap of carbon monoxide phobia. Before his discharge, plaintiff had been overcome by carbon monoxide fumes while operating a bus and treated for carbon monoxide poisoning. Psychiatrist David Brueckner saw the plaintiff at least eight times after the incident and concluded that plaintiff was suffering from a "carbon monoxide phobic reaction."[138] Plaintiff was also examined by Dr. Arieff, who determined that there was no objective evidence of any organic disease of the central or peripheral nervous system or any evidence of outward anxiety except for plaintiff's history.[139] The plaintiff could return to work whenever he desired, according to Dr. Arieff.

Although the court decided that plaintiff did have an impairment, the dissent objected to the majority's primary reliance upon the report of Dr. Brueckner, which was limited to a single paragraph concluding that plaintiff was suffering from a carbon monoxide phobic reaction.[140] Dr. Brueckner conducted no independent tests or examinations and made no findings of any kind to support this impression. Dr. Arieff, on the other hand, submitted a lengthy, detailed three-page report which stated

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135. See infra notes 174-76 and accompanying text. (School Bd. of Nassau County, Florida v. Arline, 107 S. Ct. 1123, holds that the effects of disease (tuberculosis) on others cannot be separated from the effect on the patient.)

136. 639 F. Supp. 289, 290 (D.D.C. 1986). See supra notes 78-80 and accompanying text.

137. 144 Ill. App. 3d 860, 494 N.E.2d 619 (1986).

138. 144 Ill. App. 3d at 862, 494 N.E.2d at 521.

139. Id.

140. Id. at 866, 494 N.E.2d at 621.

that the plaintiff could go back to work but that Dr. Arieff did not believe plaintiff wanted to resume driving buses.

POLICY CONCERNS AND RECOMMENDATIONS

Several conclusions can be drawn from the preceding cases. If a plaintiff suffers from a mental impairment that has been labeled with a DSM-III diagnosis, that plaintiff possesses a protected impairment.[141] The diagnosis itself appears to command great deference concerning the issue of whether an impairment is sufficiently severe to warrant protection. There has been little discussion of the degree of impairment once a diagnosis has been offered in testimony.

The presence or absence of a DSM-III diagnosis, however, should not be overemphasized. A random survey completed by five hundred and fifty-seven United States psychiatrists and four hundred and ninety-eight psychiatric residents indicates that 35% of the practitioners and 20% of the residents would not continue to use DSM-III if it were not required.[142] Of particular concern is the fact that about 48% of the psychiatrists' patients and 36% of the residents' patients receiving official DSM-III diagnoses do not fulfill all the necessary criteria.[143] An earlier survey found that only one of three hundred and one psychiatrists surveyed in 1980 was using all the required DSM-III criteria to diagnose schizophrenia.[144] DSM-III may only be a convenient source of labels for diagnoses independently determined, and the reliability and validity so

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141. But see Pridemore v. Rural Legal Aid Soc. of W. Cent. Ohio, 625 F. Supp. 1180 (S.D. Ohio 1985), and Pridemore v. Legal Aid Society of Dayton, 625 F. Supp. 1171 (S.D. Ohio 1985), where the court found that plaintiff, an attorney, had a record of a mental impairment but did not discuss the nature of the impairment or the diagnosis. In both cases, plaintiff neglected to assert a claim of mental impairment. However, in the interest of justice, the court considered plaintiff's mental condition on its own initiative. 625 F. Supp. at 1185. Pridemore's condition was not thoroughly discussed because the impairment issue was not argued and developed by counsel and because of the specific allegation involved. The court analyzed the case as one alleging a record of an impairment rather than a present impairment. The court focused upon Pridemore's substantial hospital record and not the actual condition that led to the hospitalization. The court perhaps did not fully develop Pridemore's medical history because it had already decided to rule against Pridemore based upon his failure to establish material facts susceptible to an inference that he had been rejected solely because of his impairments. Id. at 1186.

142. Jampala, Sierles, and Taylor, Consumers' Views of DSM-III: Attitudes and Practices of U.S. Psychiatrists and 1984 Graduating Residents, 143 Am. J. Psychiatry 148, 149 (1986).

143. Id. at 151-52.

144. Id. at 152, citing Lipkowitz and Idupuganti, Diagnosing Schizophrenia in 1980: A Survey of U.S. Psychiatrists, 140 Am. J. Psychiatry 52 (1983). The result was similar in 1982. Jampala, supra note 147, citing Lipkowitz, et. al., Diagnosing Schizophrenia in 1982: the Effect of DSM-III, 142 Am. J. Psychiatry 634 (1985).

eagerly promoted by its developers may not be reflected in practice.[145]

Numerous factors contribute to the decision of whether to include a particular disorder in DSM-III. The factors are not all scientific. Affected or interested groups concerned with social stigmas have lobbied against inclusion.[146] Additionally, there is an undisputed degree of uncertainty in psychiatry. Between the current third edition of DSM and the upcoming fourth edition, there have been over two hundred changes and additions.[147] As a result of this lack of definiteness, the fourth edition will provide an appendix which will include specific conditions too controversial to be included in the main text.[148]

In certain instances, the acquisition of a diagnosis may be a result of chance. If a person has a family support group that assists in the management of a disability, for instance, that person may not rely on professional care and may not obtain a diagnosis. If a primary care practitioner is consulted, she typically under-diagnoses the mental illness, with magnitudes of error from those omissions reaching fifty to eighty percent.[149] One study recorded primary care physicians identifying as depressed only twenty-six percent of new patients so assessed on the highly structured DIS.[150] Additionally, diagnostic consistency is not guaranteed.[151] An increasing number of providers are entering the mental health care field. Social workers, psychologists, family counselors and clergy are joining psychiatrists in the treatment of persons with mental impairments. The availability of a psychiatric diagnosis sufficient for introduction into evidence may decline in reverse proportion to the expanding practices of alternative mental health care practitioners.

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145. Jampala, supra note 142, at 152.

146. See, e.g., Psychiatrists Wrangle Over Controversial Diagnoses, American Medical News, June 6, 1986.

147. Id.

148. APA Reaches Compromise on Diagnoses, American Medical News, July 18, 1986. One of the conditions that will be listed in the appendix is periluteal phase dysphoric disorder, which refers to women with "clinically significant emotional and behavioral symptoms" during most menstrual cycles. Id. The significance of the appendix is unclear.

149. Schulberg, et. al., Psychiatric Decision Making in Family Practice, 8 Gen. Hosp. Psychiatry 1 (1986). One must keep statistical assertions in proper perspective, however. There is no absolute standard against which one can make such measurements.

150. Id. at 1, citing Schulberg, Saul, McClelland, Ganguli, Christy, and Frank, Assessing Depression in Primary Medical and Psychiatric Practice, 42 Arch. Gen. Psychiatry 1164 (1985).

151. There are numerous examples of experiments similar to the one arranged by D.L. Rosenham, who planted eight volunteers in psychiatric wards and instructed them to behave normally. Staff psychiatrists never recognized them as sane. Psychiatry on the Couch, Time, April 2, 1979, at 74. For an example of how diagnostic categories can change and of the impact such revisions can have on the legal system, see Judge Burger's concurrence in Blocker v. United States, 288 F.2d 853, 860-61 (D.C. Cir. 1961).

Furthermore, the interrater reliability of two psychiatrists doing independent examinations of the same individual is less than perfect,[152] proving that at least one of them must have been in error. Pairs of psychiatrists attempting to apply DSM-III criteria can disagree for at least two reasons: (1) while criteria may be clearer than they once were, ambiguities remain and result in different judgments based upon identical data; and (2) even when testing procedures are completely standardized a respondent may not reveal symptomatology consistently, which leads to differences in the information to be evaluated.[153] The information required for DSM-III diagnoses far exceeds the information necessary for ICD diagnoses.[154] The more strictly a clinician adheres to the criteria, the more time it takes to collect the information. The interviewer is directed towards details in symptomatology, which may be perceived to be of limited relevance for therapy.[155] Clinicians may stop short of exhausting the diagnostic schedules. Psychotherapists tend to ignore the manual and rely upon individual psychodynamic formulation to guide treatment. Although class diagnoses offer some broad guidance in choosing between drug, behavioral, psychotherapeutic or other approaches to certain disorders, these diagnoses are less helpful when dealing with personality disorders.[156]

Psychiatric treatment may be a function of class, race and cultural background.[157] There is also strong evidence that these factors influence

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152. Helzer, Robins, McEvoy, Spitznagel, Stoltzman, Farmer, and Brockington, A Comparison of Clinical and Diagnostic Interview Schedule Diagnoses, 42 Arch. Gen. Psychiatry 657 (1985), citing Spitzer, A Re-analysis of the Reliability of Psychiatric Diagnosis, 125 Br. J. Psychiatry 341 (1974).

153. Helzer, supra note 152, at 665. For a discussion of the Diagnostic Interview Schedule (DIS), which was designed to be used by lay examiners, in an attempt to achieve consistency through a highly structured standardized interview, see Robins, Epidemiology: Reflections on Testing The Validity of Psychiatric Interviews, 42 Arch. Gen. Psychiatry 918 (1985); see also Wittchen, A Comparison of Two Diagnostic Methods, 42 Arch. Gen. Psychiatry 677 (1985) (describing a German study involving 171 former psychiatric inpatients and 172 subjects from the general population and concluding that, using ICD-8 as a measuring device, the DIS can be used successfully to diagnose major types of nonpsychotic psychiatric disorders). For a discussion of computer programs intended to assist clinicians in reaching correct diagnoses, the use of conversational, interactive models, and on-line diagnostic monitors and artificial intelligence, see generally Gelernter, Expert Systems and Diagnostic Monitors, 11 Med. Inform. 23 (1986); Copeland, Schwab, and Warheit, A Computerized Psychiatric Diagnostic System and Case Nomenclature for Elderly Subjects: GMS and Agecat, 16 Psychological Med. 89 (1986); and Lesse, The Uncertain Future of Clinical Psychiatry, 40 Am. J. Psychotherapy 4, 11-12 (Jan. 1986).

154. Malt, Five Years of Experience with the DSM-III System in Clinical Work and Research: Some Concluding Remarks, 73 Acta Psychiatrica Scandinavica 76, 81 (1986).

155. Id.

156. Chodoff, DSM-III and Psychotherapy, 143 Am. J. Psychotherapy 201, 202 (1986).

157. Mollica, From Asylum to Community: The Threatened Disintegration of Public Psychiatry, 308 New Eng. J. Med. 367, 371 (1983).

psychiatric diagnoses.[158] Assuming this is true, a strict reliance upon psychiatric diagnoses in the employment context may in some instances indirectly perpetuate employment discrimination based upon factors expressly prohibited in other legislation, such as the Civil Rights Act of 1964.[159]

The past few decades witnessed a dramatic change in philosophy towards the treatment of the mentally disabled. Although for a substantial period it was thought appropriate to institutionalize and isolate patients for treatment, in the 1960s and 1970s deinstitutionalization and reintegration into the community were perceived as much more beneficial. Discharge was not necessarily proof of cure but rather a possible form of treatment. Although this approach is no longer universally accepted, patients with questionable prognoses continue to be discharged.

Is it desirable to coordinate discharges with efforts to integrate persons with mental impairments into the workplace? Once popular notions that a return to the community will benefit the patient are now subject to debate.[160] If persons with mental impairments do not improve as a result of involvement in the community and workplace, one can begin to question the assumptions underlying at least the employment sections of the Rehabilitation Act.

Accepting for the moment that recovery will not be substantially encouraged by participation in the workplace, there is always a rather pragmatic reason to protect employment opportunities. A full or part-time job may allow a disabled person to assist in paying for his own treatment and care. The cost of providing custodial care is great, and employment might ease the strain on family and community. Additionally, while it has not been clearly established that employment assists recovery, neither has it been established that employment interferes with recovery. Employment might be encouraged as a curative treatment, with an eye towards determining therapeutic benefits. Finally, the uncertainty that pervades the area of mental illness has been noted. A person may receive a diagnosis that has significant implications in the job market, and thus capable persons can become the victims of labels. Nondiscrimination assumes that broad generalizations will not be applied to exclude capable individuals.

Cost considerations are influencing treatment of the mentally impaired. Diagnosis-related groups (DRGs) are the response of third party payors to rising medical costs and represent a system of hospital reim-

158. Id. at 371-72.

159. Civil Rights Act of 1964, 42 U.S.C. § 2000e (1982).

160. Arnhoff, Social Consequences of Policy Toward Mental Illness, 188 Science 1277 (1975).

bursements based upon groupings of patients requiring similar treatment. As third party dollars are "capped," psychiatric patients will be shifted or returned to state mental hospitals.[161] Community hospitals have provided outpatient care for the mentally ill, and general hospitals have been the primary source of medical and psychiatric treatment for deinstitutionalized patients.[162] Fiscal policies are decreasing the capacity of these units. If the choice becomes more clearly defined as either a return to state institutionalization or integration into the community, the question of who should be afforded employment protection increases in importance.[163]

Employment may be only one component of a complete support system. It is debatable whether financial independence should be a goal when society cannot or will not guarantee a complete support system. Yet an unemployed person may have no other connection with any support system. Employment may avoid increasing the burden on family and friends, benefit general community health, and—in the absence of family and friends—prevent a drift into homelessness. Even if an impaired person's parents are providing more than adequate care today, the parents are older and may very well die first. The question of comprehensive care must then be faced. Although calculating the benefit of employment to those with mental impairments is beyond the scope of this article, it is fundamental to determining the appropriate scope of protection for persons with mental impairments under the Rehabilitation Act.

There are additional concerns associated with financial independence for persons with mental impairments. Birth rates for impaired persons living in the community exceed birth rates for such persons institutionalized.[164] Consequently, concern has been expressed regarding the effects on gene pools.[165] There are numerous responses to this concern, although they may not resolve the issue. First, the origin of mental disorders is unclear. Chemical imbalances, rather than irreversible hereditary forces, may be the source of mental disorders and these imbalances may prove treatable. Second, there is a legitimate fear regarding the homogenization of the human race. The same author that inquires about effects on gene

161. English, Sharfstein, Scherl, Astrachan, and Muszynski, Diagnosis-Related Groups and General Hospital Psychiatry: The APA Study, 143 Am. J. Psychiatry 131, 137 (1986).

162. Id.

163. See generally, Light, Phipps, Piper, Rismiller, Mobilio, and Ranieri, Finding Psychiatric Diagnosis-Related Groups That Work: A Call for Research, 143 Am. J. Psychiatry 622 (1986) (the failure of DRGs to accurately predict hospital costs and a proposal to substitute a system of DCGs - diagnostic cost groups).

164. Arnhoff, supra note 160, at 1280.

165. Id.

pools also mentions that some of the offspring of impaired persons are gifted.[166] It may be better to allow the natural spectrum of human attributes and talents to evolve, rather than attempt to narrow the range. Finally, given the indefinite nature of the relevant science, it is questionable whether anyone is sufficiently knowledgeable to justify drawing a restrictive line as to who should have the financial means to live independently (and procreate) and who should not.

A psychiatric diagnosis may represent a valuable step in recovery or treatment. Yet, paradoxically perhaps, it can be extremely destructive in the employment context. This will certainly be the result if an employer is allowed to broadly separate conduct and disability. Employers must not be permitted to isolate the identification or mere existence of an impairment from the manifestations of that impairment. For example, an employer must not be allowed to assert that she is not discriminating against epilepsy, but rather only responding to her employee's intolerable seizures. This represents too extreme a limitation on the Rehabilitation Act. Once courts choose to protect manifestations of particular mental impairments, however, difficulty arises in determining how close the connection must be between conduct and impairment. Although such a causal relationship may be difficult to prove, a claimant should be afforded the opportunity.

Even though alcoholism is expressly protected by the Rehabilitation Act,[167] one still encounters courts refusing to grant alcoholics protection under the theory that alcoholic behavior is distinct from the protected impairment. In *McKelvey v. Turnage*,[168] a veteran brought an action challenging the Veterans Administration's denial of his request for extension of the cut-off date for the use of his educational benefits. The veteran suffered from a condition known as primary alcoholism, which was not associated with a separate and distinguishable psychiatric condition. Consequently, in accordance with Veterans Administration's regulations, no extension of the cut-off date was allowed. The Veterans Administration rules stated that all alcoholism, except that which is the result of an acquired psychiatric disorder, is a result of "willful misconduct" and thus renders veterans ineligible for extensions of educational benefits.[169]

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166. Id. at 1279, citing Anthony, 6 J. Psychiatric Res. 293 (Supp. 1968).

167. 29 U.S.C. § 706(8)(B) (Supp. 1987); see supra note 10 and accompanying text.

168. 792 F.2d 194 (D.C. Cir. 1986), cert. granted, 107 S. Ct. 1368 (1987).

169. Id. at 196-97. The United States Supreme Court recently heard oral argument in this case concerning the question of whether the Veterans Administration's regulation violates the Rehabilitation Act. Daily Labor Report, Westlaw, Dec. 8, 1987.

Although there is a split in the circuits,[170] the *McKelvey* court determined that the Veterans Administration regulation, which stated that primary alcoholics suffer from a willfully caused handicap, was a reasonable regulation and should be sustained. The court recognized that much controversy exists as to the nature and cause of alcoholism.[171] Although the plaintiff presented evidence that medical science recognizes alcohol abuse as generally outside the individual's control, the Veterans Administration produced a substantial body of medical literature to contest the proposition that alcoholism is a disease, much less a disease for which the victim bears no responsibility.[172] Because of that medical testimony, the court of appeals sustained the Veterans Administration regulation. Thus a veteran who is effectively incapacitated because of severe alcoholism problems can be prevented from getting an extension of veterans educational benefits because his behavior may be determined to be willful conduct, and not the alcoholism intended to be protected under the Rehabilitation Act. When a court decides that "primary" alcoholics are not protected because they are not impaired, but rather are engaging in willful conduct, the court goes beyond the Rehabilitation Act, which only restricts protection of alcoholics and drug abusers to periods when their substance abuse affects their job performance, or places property or personal safety at risk.[173]

If a court adopts the position that conduct is independent of a disability, plaintiffs with mental impairments will be essentially unprotected. There may not be any reason to seek psychiatric assistance until there is an instance of disturbing conduct. If a court requires a diagnosis but then allows a defendant to discriminate based upon the conduct that gave rise to the diagnosis, the Rehabilitation Act will be effectively eliminated. The Act would then only prohibit discrimination against a specific label or diagnosis, a charge which could be avoided easily in many instances by claiming that action was taken in response to separable conduct and not in response to a disability.

The recent case of *School Board of Nassau County, Florida v. Arline*[174] offers guidance for distinguishing the effects of a condition from the condition itself. Petitioners argued that the school board dismissed Arline not because of her impairment (tuberculosis) but because of a threat to the health of others.[175] The United States Supreme Court responded:

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170. Tinch v. Walters, 765 F.2d 599 (6th Cir. 1985) (Veterans Administration regulation equating primary alcoholism with "willful misconduct" violates Rehabilitation Act).

171. 792 F.2d at 200-01.

172. Id.

173. 29 U.S.C. § 706(8)(B) (1985 & Supp. 1987).

174. 107 S. Ct. 1123 (1987).

175. Id. at 1128.

> We do not agree with petitioners that, in defining a handicapped individual under section 504 [794], the contagious effects of a disease can be meaningfully distinguished from the disease's physical effects on a claimant in a case such as this. Arline's contagiousness and her physical impairment each resulted from the same underlying condition, tuberculosis. It would be unfair to allow an employer to seize upon the distinction between the effects of a disease on others and the effects of a disease on a patient and use that distinction to justify discriminatory treatment.[176]

Conduct resulting from an impairment should not be considered separately. Only this approach will provide the full protection mandated by the Rehabilitation Act. If a government contractor, the government itself, or a federally funded program can distinguish the conduct associated with an impairment from the impairment itself and thereby exclude an individual based upon that conduct, that individual's Rehabilitation Act case will end prematurely. The manifestations of an impairment should be regarded as a component of the impairment. Once an impairment is established, the complainant should proceed and prove a substantial limitation on a major life activity. The respondent (federal contractor, government or federally funded program) will then have an opportunity to show that the complainant is not qualified. It is at this stage that the complainant's arguably unacceptable conduct should be considered.

The key factor is that here the complainant receives one last chance. An individual will be considered qualified if there can be a reasonable accommodation of his or her impairment. The Supreme Court in *Arline* explained that "[e]mployers have an affirmative obligation to make a reasonable accommodation for a handicapped employee."[177] If conduct can be separated and the case terminated at the impairment stage, this explicit protection will be denied.

Given the imprecise nature of psychology and psychiatry, it is truly a difficult task to determine which mental impairments are appropriate for protection. From a pragmatic viewpoint, it is fortunate for courts confronted by this question that an action under the Rehabilitation Act requires more than merely the existence of a mental handicap or impairment. There must be a substantial limitation on a major life activity, as well as a showing that the plaintiff is qualified for a particular position. As a consequence of this series of requirements and in light of the complexity and difficulty of classifying mental disorders, a court should solicit detailed descriptive evidence of the alleged disability and,

176. Id.
177. Id. at 1131 n.19.

noting the broad remedial nature of the Rehabilitation Act, make a determination as to impairment. The court can then concentrate on the additional requirements that must be established.

A claimant should not be required to satisfy too strict a standard as to what constitutes an impairment. Any person with an impairment occupies a precarious position. Sufficient disability must be shown to establish impairment. On the other hand, if too much disability is proven, an individual will no longer be qualified. Thus, only a small area exists within which one can successfully pursue a complaint. The more evidence that is required to show impairment, the more difficult it will be to establish that one is still qualified.[178]

Dr. Glenn Miller, one of the psychiatrists in the John Hinckley, Jr. case, recommends that diagnoses be excluded from insanity trials.[179] Twelve diagnoses were offered in that case. Given the nature of DSM-III, however, the experts cannot be faulted.[180] Once symptoms, life history, and course are described, diagnoses are superfluous for courtroom purposes and may actually mislead.[181] Much of Dr. Miller's argument is persuasive in the context of the Rehabilitation Act.

CONCLUSION

The question of how to accomodate persons with mental impairments in the workplace will not disappear. National Institute of Health statistics assert that one out of every five Americans suffers from a mental disorder.[182] The determination of whether a protected impairment exists should not be strictly a function of whether a diagnosis is offered into evidence. Additionally, any attempt to completely separate the existence of an impairment and conduct that may be a manifestation of that impairment must be avoided. Otherwise, persons with recognized impairments will be deprived of the reasonable accommodation of the Rehabilitation Act of 1973.

Defendants will not be overburdened by this approach. They can still assert that the disability is not a substantial limitation on a major life activity or that the plaintiff is not qualified for the position. As knowledge about mental impairments grows and as the startling costs

178. Furthermore, there is authority suggesting safety and business necessity are distinct defenses available in addition to the defense that claimant is not qualified. See 29 C.F.R. § 32.14 (1986) (administrative regulations for § 794) and Bentivegna v. United States Dep't of Labor, 694 F.2d 619, 621-22 (9th Cir. 1982).

179. Miller, Prohibiting Psychiatric Diagnosis in Insanity Trials, 49 Psychiatry 131 (1986).

180. Id. at 137.

181. Id. at 139.

182. See supra note 26 and accompanying text.

associated with the treatment of mental disorders become better understood,[183] it will become necessary to review whether existing legislation encourages the appropriate degree of employment participation for the mentally impaired.

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183. The annual cost to society as a result of treatment, social services and lost productivity for schizophrenics alone has been calculated at $20 billion by the National Institute of Mental Health and at $48 billion by the Institute of Medicine of the National Academy of Sciences. Schizophrenia Puzzle: Toll Rises Amid Hope, N.Y. Times, March 16, 1986, § 1, at 1, col. 1. A prevalence-based costing estimated the direct and indirect costs of schizophrenia in the United States in 1975 to be between $11.6 and $19.5 billion. The lowest of these estimates amounted to 2% of the gross national product for 1975. Andrews, Hall, Goldstein, Lapsley, Bartels, and Silove, The Economic Costs of Schizophrenia, 42 Arch. Gen. Psychiatry 537, 542 (1985).