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Mental Illness in the Workplace: Legal and Psychiatric Implications of Mentally Disabled Employees

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Although federal and state laws prohibit employment discrimination against individuals with physical and mental disabilities and require an employer to make reasonable accommodations for both kinds of disabilities, interpreting and implementing the law with regard to mental disabilities has proven very difficult. The process of diagnosing mental disorders such as like depression or anxiety, specifying the related functional impairments, and suggesting accommodations is inherently more complex than providing wheelchair access.

In order to effectively respond to issues that may arise in dealing with employees who have psychiatric disorders, it is important to approach the matter not just from a legal standpoint, but from psychiatric and psychological perspectives as well.

In this article, we will define “mental disability” under the Americans with Disabilities Act (ADA) as well as the California Fair Employment and Housing Act (FEHA). We will describe who is considered qualified for protection, what constitutes a disabling psychiatric disorder, and the roles of a forensic psychiatrist and psychologist in making this determination. The important question of what constitutes reasonable accommodation for persons with psychiatric disabilities (including issues related to fitness for duty evaluations) and the consultative role of a forensic psychiatrist and psychologist in recommending accommodations and performing evaluations will be examined in a subsequent article.

Who are Disabled Under Federal and State Law?

An analysis of the workplace protections afforded to individuals with psychiatric disabilities must start with a discussion of who is covered under applicable statutes. Over ten years ago, Congress enacted the landmark Americans with Disabilities Act, which prohibits discrimination against individuals with disabilities, defined as a physical or mental impairment that substantially limits one or more major life activities. The Act also protects those who may not currently have a disabling impairment but have a record of such an impairment or are regarded by the employer as having such an impairment.

In 1999, the United States Supreme Court held that in determining whether an individual comes within the ADA statutory definition of disability, the extent of the limitation resulting from the person’s physical or mental impairment must be assessed in light of any mitigating measures, including medication. The Supreme Court’s ruling had the effect of severely constricting the number of persons who could claim coverage under the federal statute.

California also has its own legal protections for persons with disabilities under the California Fair Employment and Housing Act. The statute generally has been interpreted in line with the requirements of the ADA. However, in response to the Supreme Court’s narrow interpretation of the ADA definition of disability, the California legislation amended the FEHA to provide that the impact of any limitations on major life activities due to a physical or mental impairment is to be assessed *without* regard to mitigating measures. In addition, the limitation need only make achievement of a major life activity “difficult.” Thus, while an individual with depression who functions quite well as a result of taking Prozac or another antidepressant, in all likelihood, may not be covered under the ADA. The same person, however, would be covered under the FEHA, as long as the depression, without regard to the use of Prozac, makes achievement of a major life activity merely difficult.

The following hypothetical case examples contrasts two depressed employees, one of whom, Fred, is not protected by the ADA or FEHA because, despite his symptoms, he is nevertheless able to function in the major areas of his life and is experiencing no added difficulty in performing major life activities. Sally's condition, on the other hand, appears sufficiently limiting to be covered under the FEHA and ADA.

Fred is a chartered accountant with chronic moderate depression who despite his depressive symptoms is able to work in his office doing tax planning and preparing returns for his clients. Although his range of life activities has always been limited, his functioning both in life and at work is no different than it has ever been.

Sally is also an accountant suffering from recurring depression. In contrast to Fred, she has experienced during the last year increasing difficulty sleeping for more than a few hours at a time, concentrating on her work, and interacting with colleagues and clients. She has recently cancelled client appointments and arrived late for work. Falling significantly behind in her work, she feels mounting guilt and self-recrimination. Sally's depressive disorder has resulted in a dramatic decline in her functioning both in life and at work.

Establishing Coverage Under ADA and FEHA

The diagnosis of a psychiatric disorder is usually sufficient to establish coverage under the FEHA because, in virtually all cases, the disorder may be said to make the achievement of a life activity "difficult." However, the same will not be true for establishing coverage under the ADA. The mental disorder must cause a *substantial impairment in a major life activity* for protection under the ADA. For example, an individual may be depressed with subjective symptoms of blue mood, pessimism about the future, and guilt without exhibiting significant impairment in life activities. In contrast, another individual with the same diagnosis of depression may be chronically fatigued, unable to concentrate, and lack motivation to an extent that the depression substantially interferes with many of the person's major life activities.[1]

Thus, it is critical that psychiatrists and psychologists who diagnose individuals with a particular mental disorder indicate the person's *specific functional impairment* and not just describe mental disorders based upon the self-reporting of subjective distress. It is also important that the mental health evaluator indicate specific life and other job functions that are affected by a disorder and not merely provide general categories of functioning that are impaired. For example, when describing impaired work functioning, it is inadequate to merely say that the claimant experiences stress in the workplace. It *is* appropriate to say that the employee becomes anxious when working in an open plan office environment where the noise of other employees interferes with concentration.

Psychiatric Diagnostic Considerations

The Diagnostic and Statistical Manual, currently in its fourth edition, text revision, published by the American Psychiatric Association (*DSM-IV-TR*), is recognized in California as the authoritative psychiatric diagnostic text. (See *Money v. Krall* (1982) 128 Cal. App. 3d. 378.) Furthermore, the courts have generally relied upon experts to diagnose mental disorders by the criteria delineated in the *DSM*.

A mental disorder, as defined by the *DSM-IV-TR*, involves a psychological pattern or syndrome occurring in an individual that is associated with one or all of the following conditions:

1. The individual experiences subjective distress. For example, the person may experience a painful psychological symptom like anxiety or depression;

2. The individual is impaired in one or more important areas of life functioning, such as the capacity to work, raise a family, or care for personal health;

3. The individual may experience a significantly increased risk of disability, injury, or loss of freedom;

4. The behavioral syndrome is not an expected response to a normal stressful life event, such as brief bout of depression following the death of a loved one.

Diagnoses are made on a matrix of five axes according to the *DSM-IV-TR* classification. The most frequent mental disorders that may find protection under the ADA (and FEHA) are the clinical syndromes of mood disorders, anxiety disorders, and psychotic disorders, including conditions such as panic disorder, post-traumatic stress disorder, major depression, and bi-polar disorder (manic depressive illness). These disorders are listed in the *DSM* under Axis I, the major clinical syndromes. However, some clinical syndromes are specifically not covered under ADA, including illegal drug use, drinking on the job, criminal pathology such as compulsive fire setting or stealing, and behaviors that are “personality traits.”

In addition to symptomatic syndromes listed on Axis I, personality disorders described on Axis II are enduring and rigid patterns of behavior, thinking, and feeling that are maladaptive and may lead to distress (sometimes in oneself and sometimes in others). For example, an individual who has a paranoid personality disorder is highly suspicious and vigilant and may feel threatened much of the time, whereas a person with an antisocial personality disorder may feel little subjective distress but harm others by impulsive, self-gratifying behavior.

Axis I and II diagnoses are not mutually exclusive. Frequently, both are present. The presence of a personality disorder may exert a determining influence upon the behavior that gives rise to an ADA or FEHA claim. For example, some individuals with paranoid personality disorders continually believe that people with whom they work and associate are victimizing them. Such individuals have little or no capacity to recognize their own role in bringing about the very circumstance that they experience as persecutory. It requires expert psychiatric and psychological judgment to distinguish specious claims of victimization motivated primarily by paranoia from legitimate complaints where paranoid traits have either been exacerbated by a real injury or are unrelated to the acute emotional damages. The following are hypothetical examples of Axis I, II, and combined Axis I & II psychiatric diagnoses.

Example of an Axis I Disorder:

Nancy, an unmarried woman of thirty-six, has worked for nine years as a devoted secretary to a senior partner of law firm. Uncharacteristically, she enters an impulsive love affair with a charming, but married, younger attorney at the firm. When other partners learn of the affair, Nancy decides to accept a position at an office of the firm located in a distant city. At the new office, she becomes profoundly depressed, ruminating about lost time and missed opportunities for marriage. She is tearful, arrives late to work, experiences difficulty concentrating, has thoughts of suicide, experiences menstrual irregularities and, for the first time in her fifteen-year career, does not complete assignments. Nancy’s gynecologist refers her to a psychiatrist who diagnoses her as having a Major Depressive Episode, Severe, without Psychotic Features.

Example of an Axis II Disorder:

Sam, a recently divorced forty-eight year-old civil engineer, is employed by an engineering firm where he is assigned to specific projects. He is generally distrustful of the work product of anyone other than himself, delegates little or nothing to subordinates, avoids shared responsibilities, and even rejects offers to go to lunch with coworkers. He tends to be critical and dismissive of the quality of work performed by his

engineering colleagues.

Sam not only boasts an inflated view of his own professional ability but also assumes that he will be assigned to all major projects that the firm obtains. When his company lands a lucrative consulting contract, he is not invited to join the project team and is placed on a temporary lay-off. He subsequently develops feelings of rage and blames his exclusion on the alleged “stupidity and incompetence” of a particular senior manager as well as the “envy” of his colleagues.

At work and at home, he withdraws into a pattern of fitful sleep and solitary brooding. Sam develops the belief that several colleagues have “conspired” to thwart his career. He entertains fantasies of revenge and leaves several veiled threatening messages on the voicemails of management. As a result of these messages and concern about whether Sam poses a direct threat to the health and safety of other employees, the firm’s human resources director informs Sam that he is being placed on medical leave of absence. Before he may return to his job, he must submit to a “fitness for duty” examination. The psychiatrist selected by the firm who examines Sam diagnoses him as suffering from a Paranoid Personality Disorder with Narcissistic Features.

Example of combined Axis I and an Axis II Disorder:

John, a fifty-two-year-old married “workaholic” CPA, is characteristically brusque and irritable with associates in his accountancy practice. Although usually quiet and compulsive in his work habits, he periodically explodes with frustration and rage, often shouting abusive epithets at assistants who have not performed to his expectations. On one or two occasions, John has actually thrown a paperweight across his office, smashing a glass bookcase door and the glass cover of his own desk. During his twenty years’ tenure at the firm, more than a half-dozen secretaries and younger associates have left their employment due to his abusive and humiliating behavior.

One morning during tax season, John Suddenly develops crushing chest pain and is taken by ambulance to the local hospital emergency room where he is admitted to the coronary care unit. After extensive medical and cardiac evaluation, John is told by the cardiologist that his coronary arteries are “clean as a whistle” and that although he has not suffered a heart attack, he has indeed experienced a severe panic attack. The doctor refers John to a psychiatrist who diagnoses him as suffering from an anxiety disorder (Panic Attacks) as well as an Obsessive Compulsive Personality Disorder.

The Role of Psychological Testing

A comprehensive set of psychological tests can provide objective data about the nature, extent and severity of a mental disorder and related functional impairments. A comprehensive test battery might include self-report questionnaires (such as the MMPI-2), cognitive and intellectual problem-solving tasks (such as the Wechsler Intelligence Scales, and indirect tests, called “projective tests” because the individual may reveal personality traits through their images, responses, and stories). By employing different methods for gathering data, a psychologist can search for patterns occurring across many different kinds of tests that are likely to be more diagnostically reliable and valid than if only a single test is utilized. To be maximally accurate, test data should be interpreted within the overall context of the person’s history and current functioning.

The most widely used self-report test, the Minnesota Multiphasic Personality Inventory (MMPI), offers a procedure for gathering and interpreting behavior under standardized conditions of administration, test scoring, and interpretation. The individual’s pattern of test responses can be scored by computer and yield objective interpretations. For example, a computer program sums up all the items an individual endorses as true about himself related to depression. A report is issued that provides an indication of just how severely that individual is depressed compared to the normal population. In addition, there is a large database of research that correlates particular test scores with behavior characteristics. For example, individuals with significantly elevated scores on the “Paranoia scale” are generally described by others as suspicious and mistrustful.

Test responses, especially on self-report questionnaires, can never be taken at face value because individuals may have a variety of motivations to create a particular impression through their test answers. Some individuals may exaggerate the extent and severity of their symptoms, while others may minimize their psychological distress. Some objective tests like the MMPI-II have “validity” scales that measure—although not perfectly—the degree to which persons are motivated to present a particular impression regarding the nature and extent of their illness.

Another check on the validity of a self-report test is to administer the Rorschach Inkblot Test in which there are no obvious cues about how to respond to create a particular kind of impression. Over the last twenty-five years, a large research database has been created that can be utilized for reliable interpretation and scoring of data. Indirect tests such as the Rorschach can be especially revealing of personality traits that may not be acknowledged in a self-report questionnaire.

Often, a disagreement arises as to the amount of time that may be devoted to testing an individual or even whether the person should be tested at all. This conflict is frequently based upon the misunderstanding that psychological testing represents a duplication of the forensic psychiatrist’s efforts. In a properly conducted evaluation, there should be no overlap between the evaluation activity of a forensic psychiatrist who conducts clinical

interviews and reviews medical and treatment records and that of a psychologist who administers, scores, and interprets the psychological tests.

Psychological assessment is a separate activity from interviewing and record reviewing and provides a different type of data. Accordingly, sufficient time must be allowed for comprehensive psychological testing. Using the test results, a professional can draw a diagnostic conclusion by pointing to objective evidence that was used in forming a particular opinion. Moreover, other professionals trained to evaluate psychological test data can critically examine the basis for that opinion.

In this respect, psychological testing can play a very important role in the scientific evaluation of individuals who are disabled by psychiatric disorders. By providing objective reliable data, psychologists can help to distinguish the truly disabled from those who may claim to be disabled but do not have scientifically verifiable mental disorders and impairments.

The determination of whether a person has a psychiatric disability covered under the FEHA or ADA is best made by highly trained forensic psychiatric and psychological professionals. Unlike medical judgments about a physical disability, an opinion about psychiatric impairment should be based upon the review of the broadest array of data, including independent medical evaluations; personal interviews; detailed psychiatric and psychological review of all available clinical documentary evidence, treatment records, deposition transcripts, and employment records; and the administration of a comprehensive set of psychological tests to confirm or rule out diagnostic hypotheses. Such judgments are best made by experienced experts utilizing the best scientific methods available to delineate all the psychological motivations of an individual, both conscious and unconscious, together with the neurobiological and psychopharmacological factors that affect human behavior and underlie claims of psychiatric disability.

This article is the second in a series. The authors welcome questions, comments, and suggestions for future forensic psychiatric articles. Email Mark Levy at mark@levymd.com.

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[1]The Equal Employment Opportunity Commission has identified the following major life activities as being relevant to the assessment of psychiatric disabilities: thinking, concentrating, interacting with others, and sleeping. The impact upon a person's major life activity of working should be considered only if none of the other major life activities of the individual is substantially impaired.