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COGNITIVE DIVERSITY: REASONABLE ACCOMMODATION OF EMPLOYEES WITH ATTENTION DEFICIT DISORDER WITHIN THE GUIDELINES OF THE AMERICANS WITH DISABILITIES ACT

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ABSTRACT

This article examines an issue that is likely to become of great importance to employers in the coming years. Recent medical research has shown that Attention Deficit Disorder (ADD), which had formerly been thought to be a childhood impairment, in many cases persists into adulthood. Due to the projected prevalence of this disorder, employers will increasingly be faced with the conundrum of how to reasonably accommodate workers with ADD into their workforces under the Americans with Disabilities Act (ADD). This article presents an overview of what is known about Adult ADD. Then, suggestions are made as to how employers should manage workers who are actually diagnosed with the condition.

Do you have trouble concentrating in meetings? Do you find yourself forgetting what you just read? Do you constantly fight a losing battle at "getting organized"? Do you become "depressed" too often?

If you answered "yes" to the preceding questions, you are—in all likelihood—perfectly normal! One writer in the *Ladies Home Journal* went so far as to caution women that just because they have a husband who "channel-surfs" with the television remote control does not automatically make their mate a candidate for having a concentration problem [1]! Indeed, *all* adults vary (both between individuals and within one individual at different times) in their ability to concentrate on matters and to organize their work and their life [2]. However, for some

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individuals, situations such as these may be important indications that they have Attention Deficit Disorder (ADD). Formerly thought to be a disorder limited to children, ADD has increasingly both been diagnosed in adults and been recognized as a condition that many individuals do not "grow out of."

When the Americans with Disabilities Act (ADA) was signed into law on July 26, 1990, it was heralded as "the most significant civil rights legislation enacted in the last quarter-century" [3]. The ADA afforded an estimated forty-three million Americans with physical *and* mental disabilities federal protection from discrimination in employment in all but the smallest of businesses [4].

Four years after the ADA's enactment, all employers of fifteen or more employees are subject to its provision prohibiting discrimination against an employee or applicant due to a disabling condition. Still, the most perplexing questions facing employers are just what constitutes a "disability" under the terms of the act and what are the employers' responsibilities to provide "reasonable accommodation" to the disabled individual?

The first question has a relatively defined answer. Title I of the ADA specifically prohibits discrimination against "qualified individuals with disabilities" [5]. The ADA's test for determining whether or not an individual in question in fact has a disability is directly borrowed from the definition employed in the earlier Rehabilitation Act [6]. Under the ADA, persons have a qualifying disability if they meet the following test in that they have (are): "(1) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (2) a record of such impairment; or (3) being regarded as having such an impairment" [7]. One legal commentator posited that this definition means that "the ADA provides protection for a much broader group of individuals than simply the traditional 'wheelchair' handicapped" [8, p. 376]. However, critics have charged that the ADA's definition of a disability is so open-ended as to potentially include "almost anything" [9]. In point of fact, it has been estimated that almost one thousand physical and mental disabilities are covered under the ADA [10].

Eleven percent of the population with disabilities have primarily a mental, as opposed to a physically-disabling, condition [11]. A "mental impairment" has been defined by the enforcement agency for the ADA, the Equal Employment Opportunity Commission (EEOC) as "any mental or psychological disorder" [12]. The ADA did not specifically list *which* mental impairments would be considered covered under the act. Rather, the ADA relies on the precedent of the Rehabilitation Act, under which courts have firmly established the threshold for a mental impairment to rise to the level of a covered disability. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) of the American Psychiatric Association is the diagnostic tool most widely utilized by physicians, psychiatrists, and psychologists in dealing with patients with suspected mental conditions. Courts have held that if a mental disorder is listed in the DSM-III-R, then it has been considered to be a covered disability under the Rehabilitation Act [13].

Whether or not medication or behavioral modification eliminates or diminishes the symptoms associated with the condition, the diagnosed disability will be regarded as conveying protected status under the ADA upon the affected individual [14].

Using this framework, it is clear that an employee or applicant with a *diagnosed* case of Attention Deficit Disorder would have a covered mental condition under the ADA due to the condition's inclusion in the DSM-III-R. With the vast increase in the number of ADD-affected adults, the interaction of ADD and the ADA has the potential to become one of the paramount employment law issues of the next decade. This article addresses this interaction, mindful that all employers will be challenged to develop strategies to respond to the increased presence of employees with ADD in the workforce both to comply with the law and to compete effectively in the new economy. We begin by overviewing what is known about Attention Deficit Disorder, focusing on how it affects adults in the workplace. Then, we look at what employers should do to follow the ADA's mandates to reasonably accommodate those diagnosed with the disorder.

ATTENTION DEFICIT DISORDER

As the name implies, Attention Deficit Disorder is principally characterized by impaired attention abilities or abbreviated attention spans. When it is accompanied by hyperactivity, the condition is known as Attention Deficit Hyperactivity Disorder (ADHD) [15].[1]

The vast majority of the focus in the popular press and scholarly research regarding Attention Deficit Disorder has properly been focused on ADD in children. Children who have either ADD or ADHD are typically diagnosed between the ages of six and eight. This typically occurs sometime between the first and third grade, with boys being diagnosed with ADD at a rate of three to one over girls [15]. Children are typically diagnosed once they become school age because of the increased awareness of ADD among educators and parents. Yet, the symptoms of ADD usually are evident to the trained observer before the child enters school—as early as the age of two [16]!

The Cause of ADD

There have been a variety of theories put forth as to the root cause of ADD, with only limited areas of agreement found in the medical literature. ADD has been associated with the following neurological and environmental conditions: high fevers, birth trauma, cigarette smoking during pregnancy, head injuries, fetal alcohol syndrome, premature birth, and lead poisoning [16, 17]. Researchers

[1] In the medical literature, the terms ADD/ADHD are considered to be virtually synonymous. Thus, in this article, they will be used interchangeably.

noted that while there are increased rates of ADD in these populations, the majority of individuals with these conditions or history of such do not experience ADD-like symptoms [16]. Harold Levinson established a linkage between ADD and inner ear disorders [18]. Likewise, Hauser, Zametkin, Martinez, Vitiello, Matochik, Mixson, and Weintraub found an increased incidence of ADD in patients who have a resistance to the hormone produced by the thyroid [19]. Levine stated that preliminary research using magnetic resonance imaging (MRI) has found differences in brain structure between those with ADD and those without [20]. As Melinda Blau observed, this may mean that persons with ADD are simply "wired differently," which may in turn cause them to "be slower to metabolize certain chemicals that are instrumental in carrying messages from one neuron to the next" [17, p. 47].

Whatever the "root" cause of ADD, there is a strong indication that the role of nature may be more powerful in this case than the nurturing a child receives. This is because of the powerful evidence supporting the theory of a genetic link for ADD. A series of studies performed by researchers at the Harvard Medical School have shown that children with one (or both) parents with ADD are much more likely to develop ADD themselves [21-23]. Forty percent of children with ADD have a parent with the condition. Once one child in a family is diagnosed with the disorder, the other sibling(s) have a little greater than a one in three chance of themselves being diagnosed with ADD. If the children are identical twins, the odds are raised to greater than eighty percent [24]! All this has led to a general conclusion that there is a familial, genetic link to ADD. Russell Barkley , a leading researcher in the field, concluded that "the contribution of genes over environment is ten to one" [quoted in 17, p. 47].

Prevalence of ADD

Current prevalence estimates are that between three and ten percent of young Americans under the age of eighteen have either ADD or ADHD [25]. The most commonly accepted estimate is that 5 percent of school-age children suffer from attention deficit disorder. This amounts to a staggering three-and-a-half million children [24]! While some researchers believe these prevalence figures are vastly exaggerated, others project that the true pervasiveness of ADD in children is far greater than these cautious estimates [26]. Harold Levinson estimates that the true number of people who suffer from some degree of attention deficit deficiency is, in reality, up to three times these commonly accepted estimates—approaching twenty percent or more of the youth population in America [18]! Whatever the true prevalence of ADD among children, it is important to note that this is a "rolling" number—with hundreds and perhaps thousands of new cases being diagnosed each week.

It was formerly thought ADD was something that children simply "grew out of" as they passed through puberty into adolescence and young adulthood [27].

However, studies have disconfirmed this theory, showing that the symptoms of ADD often persist later in life [28, 29]. Evidence suggests that one-third to two-thirds of these individuals continue to experience the symptoms of ADD as adults [15, 30]. This means that between eight and fifteen million adults are estimated to have ADD [31]!

ADD in Adults

Adult Diagnosis

In the majority of cases of ADD in adults, the catalyst for the adult seeking treatment is most often the diagnosis of ADD or ADHD in one of his/her children [17]. Having been asked by their child's physician, pediatrician, or psychologist to review the DSM-III-R criteria for ADD on their child's behalf, the parents often recognize that the descriptors not only characterize the child—but themselves as well.

Wade Horn, the former executive director of CHADD (Children and Adults with Attention Deficit Disorders), observed that one cannot suddenly develop ADD as an adult [cited in 24]. It is impossible to make a "*de novo* diagnosis in adults of ADHD" [25, p. 113]. In fact, the widely utilized "Utah Criteria" for diagnosis of ADD in adults holds that a person must demonstrate not only present-day attentional problems, but also have a childhood history of such [32].

Childhood history is thus essential in the diagnosis of attention deficit disorders in adults. However, the memories of the details of our youth often both change and fade with the passage of time. As such, doctors find that patients' general recollections of their childhood are often inaccurate and "sanitized." The Wender Utah Rating Scale (WURS), recently developed and validated as a retrospective assessment instrument to aid in the diagnosis of ADD in adults, is presented in Table 1 [33]. It can be seen quite clearly that the Wender scale attaches specific behaviors to the vagueness of the DSM-III-R criteria. While the scale should not be used as an "at-home" test for ADD or ADHD, readers should note the significant ($p < 0.0001$) differences in the mean scores found between subjects who had ADD (62.2) and "normal" subjects (16.1) [33].

In regard to the specific forms the symptoms of ADD take in manifesting themselves in adulthood, the University of Massachusetts has developed a checklist of eighteen symptoms, which are presented in Table 2 [34]. The protocol serves as the basis for a semistructured interview, and represent "adult" manifestations of the fourteen criteria employed in the DSM-III-R guidelines. As such, there is not a hard-and-fast decision rule for whether a person demonstrating some of these fourteen characteristics does or does not have ADD [34].

One of the most profound effects of the persistence of ADD into adulthood is the linkage of attention deficits to some very adult problems. As David Woods observed, the manifestations and symptomology of ADD in children and adults are essentially the same. However, while an ADD-affected youth may have a

Table 1. The Wender Utah Rating Scale for ADHD in Adults

INSTRUCTIONS: Answer the following questions regarding yourself. Please respond according to the following five-point scale:

0 = Not at all or very slightly
1 = Mildly
2 = Moderately
3 = Quite a bit
4 = Very much

As a child, I was (or had):					
1. Concentration problems, easily distracted	0	1	2	3	4
2. Anxious, worrying	0	1	2	3	4
3. Nervous, fidgety	0	1	2	3	4
4. Inattentive, daydreaming	0	1	2	3	4
5. Hot- or short-tempered, low boiling point	0	1	2	3	4
6. Temper outbursts or tantrums	0	1	2	3	4
7. Trouble with stick-to-it-tiveness not following through, failing to finish things started	0	1	2	3	4
8. Stubborn, strong-willed	0	1	2	3	4
9. Sad or blue, depressed, unhappy	0	1	2	3	4
10. Disobedient with parents, rebellious, sassy	0	1	2	3	4
11. Low opinion of myself	0	1	2	3	4
12. Irritable	0	1	2	3	4
13. Moody, ups and downs	0	1	2	3	4
14. Angry	0	1	2	3	4
15. Trouble seeing things from someone else's point of view	0	1	2	3	4
16. Acting without thinking, impulsive	0	1	2	3	4
17. Tendency to be immature	0	1	2	3	4
18. Guilty feelings, regretful	0	1	2	3	4
19. Losing control of myself	0	1	2	3	4
20. Tendency to be or act irrational	0	1	2	3	4
21. Unpopular with other children	0	1	2	3	4
22. Trouble with authorities, trouble with school, visits to principal's office	0	1	2	3	4
23. Overall a poor student, slow learner	0	1	2	3	4
24. Trouble with mathematics or numbers	0	1	2	3	4
25. Not achieving up to potential	0	1	2	3	4

Source: Ward, Wender, and Reimherr [33, p. 887].

Table 2. The University of Massachusetts Protocol for Assessment of ADHD in Adults

1. Physical restlessness
2. Mental restlessness
3. Easily distracted
4. Impatient
5. "Hot" or explosive temper
6. Unpredictable behavior
7. Difficulty completing tasks
8. Shifting from one task to another
9. Difficulty sustaining attention
10. Impulsive
11. Talks too much
12. Difficulty doing tasks alone
13. Often interrupts others
14. Doesn't appear to listen to others
15. Loses a lot of things
16. Forgets to do things
17. Engages in physically daring activities
18. Always on the go, as if driven by a motor

Source: Kane, Mikalac, Benjamin, and Bakley [34, p. 627].

tendency to get into fights at school, an ADD-affected adult may be more likely to batter his or her spouse. Likewise, where children with ADD have increased problems with relationships at school (i.e., fighting, disruptive conduct, isolation) the same problems are found in adults with adult consequences [29]. Adults with ADD were significantly more likely to engage in criminal behavior and to have been arrested [35]. Further, 20 percent of the adult ADD population is also estimated to be sexually dysfunctional [36].

Study after study has shown that persons with ADD are more likely to become addicted to alcohol and/or drugs [27, 30]. The addiction tendency clearly reaches beyond illegal drugs. This is exemplified by the case of Chuck Pearson. Pearson was an accountant who "self-medicated" himself to counteract his attention problems—this by drinking an average of thirty to forty cups of coffee (not decaf) each day [24]. Recently, researchers have found not only higher rates of substance abuse in adults with ADD than those without an ADD diagnosis, but also higher rates of depression, anxiety, phobias, and speech disorders than a control group [37].

Adult-ADD and Work

The central concern for employers has to be exactly how the symptoms experienced by employees with Attention Deficit Disorder are manifest in the

workplace. Perhaps the leading researcher on ADD, Paul Wender, observed that the impact of an attention deficit on work performance varies greatly from situation to situation and from individual to individual [cited in 17]. However, the aggregate evidence shows ADD profoundly affects those with the disorder. In follow-up studies of adults who had been diagnosed with ADD as children, several research efforts have found significant educational achievement and vocational choice differences between individuals with an ADD diagnosis history and those without [35, 36, 38]. In almost every case—whether or not the symptoms of Attention Deficit Disorder persisted into adulthood—those with an ADD-past did not achieve the educational levels or pursue professions such as law, medicine, or education with the frequency of their cohorts without an ADD-past.

ADD-affected adults are, by and large, more likely to be less well-off economically than those not touched by the disorder [38]. This may be attributable to several factors that relate to the adult manifestations of ADD listed in Table 2 that especially impact on ADD-affected individuals in the work setting. Individuals with ADD indeed change jobs more frequently and are more likely to engage in part-time employment (perhaps several part-time jobs) than adults who do not experience ADD symptoms [39]. Russell Barkley found that adults with ADD are seen by their employers as less able to work unsupervised and to complete assignments in a timely manner [36]. Adults with ADD often seek out jobs where they are not required to concentrate over long periods of time [40]. They may indeed gravitate toward jobs that do not have them working under close supervision or require them to engage in repetitive tasks while remaining sedentary [35]. Overall, results such as these can be interpreted as meaning that even "formerly hyperactive boys might have been less capable of holding 9-to-5 jobs" [41, p. D1]. Also, ADD-affected employees are more likely to have difficult relations with their supervisors. Walid Shekim, a UCLA psychiatrist, states that workers with ADD are more likely to tell their supervisor to "take this job and shove it" [quoted in 24, p. 47].

Krystal Miller commented that indeed "many adults with ADD get fired from job after job and can never quite figure out what is wrong" [31, p. B1]. The distractibility and concentration problems associated with ADD would be most evident when workers are placed in repetitive desk work. In response, some gravitate to high-intensity work environments—such as work on an oil rig or personal sales positions. In such fast-paced environments, an ADD-employee is very likely to perform just as well if not better than non-ADD affected employees [42]. Others, mostly without knowledge of their ADD-condition, take the lessons of the past mismatches between themselves and their employment and gravitate toward entrepreneurship. Researchers have found those with an ADD background were more than three times as likely to own a small business than their non-ADD counterparts [35]. These researchers speculated that the entrepreneurship of those with an ADD-past may be attributable to positive factors—including ingenuity and determination—associated with the condition. In addition, the increased

levels of creativity and decreased levels of inhibition found among adults with ADD may account for their entrepreneurial success [31].

Treatment Options for ADD-Affected Adults

There are two basic approaches to the treatment of ADD in both children and adults—the pharmacological option and the behavioral therapy option.

There are several drug options available for the treatment of ADD. By and large, Ritalin is the most widely prescribed drug for the condition. Ritalin usage has increased over 390 percent thus far in the nineties and more than 1000 percent cumulatively over the past two decades [24, 43]. Ritalin is a "serious, amphetamine-like cerebral stimulant . . . (that) produces a paradoxically calming effect that improves attention span" [43, p. A15]. Other stimulants such as Dexedrine and Cylert are being employed to a lesser degree in ADD patients. Some ADD-affected individuals, however, have fared better with treatment from antidepressants—including Nopramin and even Prozac [1].

The use of Ritalin for the treatment of ADD has received both great praise and intense criticism. Paul Wender stated that when Ritalin or another drug works to counteract the symptoms of ADD, "it is one of the most dramatic effects in psychiatry" [quoted in 24, p. 49]. Craig Reeder, the parent of an ADD child in Texas, plainly wrote:

> Well, I don't care what you call it (ADD), or don't call it, but I saw my 12-year-old son's behavior and report card improve suddenly and dramatically as soon as he began medication (Ritalin) for this mystery condition. Our family, and many others like us, is grateful that whatever it was, it was diagnosed and successfully treated [44, p. A13].

Despite these and other success stories, there have also been concerns aired over the figurative and literal complications of Ritalin usage. There has been concern over the potentially negative symbolic role of Ritalin usage by children. Ritalin can be self-perceived as a "badge of helplessness" by children who take it, with the implicit message that self-control is impossible when the drug is explicitly prescribed to control their behavior [45]. One medical expert stated that "some of the not-so-rare side effects of Ritalin include headaches, insomnia, stunted growth, and a variety of tics, including a very serious form called Tourette's Syndrome" [43, p. A15]. Commentators have further criticized the use of Ritalin for the fact that there has been little research conducted on the long-term effects of its use. While Ritalin has proved to be effective in the treatment of ADD, in truth, the drug is effective in treating the symptoms, rather than the causes, of the disorder [45]. An alternative to drug therapy that is particularly effective in adults is to teach those affected by ADD techniques to compensate for the symptoms of the disorder. These efforts emphasize "organizational skills, time management, and stress reduction" [24, p. 50].

Conclusion

Despite the controversy detailed earlier as to the exact prevalence of ADD, it is undisputed that literally millions today know they are affected by this impairment. As the condition receives more attention both in America's media and schools in the coming years, children and adolescents are increasingly likely to be diagnosed in their younger years with a condition that has been shown to persist in up to two-thirds of all cases into adulthood. As studies have shown, this will likely cause their parents to reflect on their own experiences, both in childhood and as adults, and lead many of them to an ADD diagnosis as well. Using the prevalence estimates reviewed earlier in this article [15, 28-31], it can be seen that by adding ADD to the ranks of the mental impairments potentially covered by the ADA, persons with this single condition could equal or exceed the entire number of those suffering from all other mental conditions in American society today!

The newfound knowledge that Attention Deficit Disorder affects large numbers of adults will present a great challenge to all employers. In fact, it could well turn out that Attention Deficit Disorder will emerge as *the* critical employee health and employment law issue of the nineties and beyond. It is clear that under the terms of the ADA, those diagnosed with a case of ADD would have a covered disability under the terms of the act. It is imperative then that organizations and their management begin to consider what their responsibilities and rights are in dealing with those affected by Attention Deficit Disorder.

Thus, the second part of this article deals with two critical issues. First, under what circumstances does Attention Deficit Disorder trigger the protection of the ADA? Second, what kinds of steps are employers required to take to reasonably accommodate ADD-affected individuals in the work setting to ensure that they are in compliance with the Americans with Disabilities Act?

THE ADA AND EMPLOYMENT DECISIONS INVOLVING ADD-AFFECTED EMPLOYEES/APPLICANTS

There are two key legal variables that must be satisfied in order for the employer to be responsible under the ADA to provide reasonable accommodation to an ADD-affected applicant or employee. The employer must both possess knowledge of the individual's medical condition and the condition itself must have relevance to the employee's work activities.

Employer Knowledge of the Diagnosis

The ADA follows the Rehabilitation Act standard that a discriminatory action can occur only if "the employer *knew or should have known* of the disability at the time when the challenged decision (employment action) was made" [14, pp. 533-534]. Based on the ADA precedent established in *Landefeld v. Marion General Hospital*, if a disabling condition is not manifestly obvious in the physical

appearance of the employee or applicant or no effort is made to explicitly inform the employer of the medical condition, then no discrimination can take place [46].

The employer knowledge issue is thus of central importance in the case of mental disabilities in general—and ADD in particular. One medical expert stated that "it can be very difficult if not impossible to spot individuals—especially adults—with ADD" [18, p. 12]. Courts have been reluctant to rule affirmatively that an employer "should have known" about an employee's mental health based simply on the applicant or employee's appearance and demeanor or their medical and/or personnel records [14]. Nancy Breuer plainly stated that this places an affirmative burden on the employee or applicant with *any* relevant mental condition that could affect that individual's consideration for a job and eventual performance in it to inform the employer up front. This is because quite simply, "the employer who doesn't know about an employee's disability isn't responsible for reasonable accommodation" [11, p. 138].

The employer knowledge issue is made even more troublesome in the case of those affected by Attention Deficit Disorder due to the etiology of the condition. First, it is generally agreed that up to 70 percent of those adults with ADD are undiagnosed [1]. Thus, the seven out of ten individuals affected by ADD who have not been formally diagnosed with ADD would not be considered covered by the ADA and entitled to its protections. Also, the EEOC differentiated between what is to be considered a "disorder" and what is to be thought of as merely "personality traits." The EEOC specifically cited "poor judgment, quick temper and irresponsible behavior" as examples of such personality traits [12, p. 405:6988]. The reader should note that these three personal attributes are synonymous with several of the behaviors given in Table 2 that were listed as being symptomatic of ADD in adults. Thus, the EEOC's policy guidance provides a definite threshold for ADD to be a covered mental impairment, while not inhibiting employer prerogative or protecting individuals from discrimination due to personal characteristics (both good and bad) when they do not give rise to an actual diagnosis of a mental disorder.

In this discussion over what are the employer's and employee's respective responsibilities in regard to knowing about a mentally disabling condition, a final word must be said regarding the diagnostic issues unique to ADD. Larson observed that unlike many categories of physically disabling conditions, a patient's diagnosis with a mental disorder is not nearly so certain or irrefutable: Indeed, a diagnosis of any mental condition often "may be a result of chance" [13, p. 866]. This may be especially true in the case of Attention Deficit Disorder in adults.

Even within the American medical community, there is a great deal of controversy over whether ADD is a distinct disorder. Due to the interpretive nature of the methods used to diagnose ADD, medical researchers have cautioned against the "overdiagnosis" of ADD in both children and adults [47]. Indeed, some researchers believe the symptoms of ADD are merely the manifestations of other,

underlying mental disorders and mental conditions [26]. In fact, the symptoms of ADD often mimic those of other mental disorders, including learning disabilities, anxiety disorders, hypomania, depression, posttraumatic stress disorder, and substance abuse [38]. The behaviors associated with ADD in adults may also be manifestations of medical problems, including head injuries, dementia, pulmonary disease, hyperthyroidism, and renal insufficiencies [34].

Another important element to add to the "chance diagnosis" theory that Larson developed is that of the low interrater reliability found among mental health experts treating the same patient [13]. With the various methods employed for diagnosing ADD in adults relying squarely on both the patient's memories of childhood and the mental health professional's interpretation of them, interrater reliability would certainly be an important issue in cases of alleged employment discrimination involving ADD. As *all* adults vary in their ability to organize themselves and their work, both the question of whether or not a person is truly suffering from a concentration disorder serious enough to warrant a diagnosis of ADD and the issue of whether an ADD diagnosis is an identification of a true "disease" or a condition mimicking the symptomology of another, perhaps more serious disorder may be seen as a matter of opinion. It is thus likely that when an ADD-related disability discrimination case does reach the federal courts, a "battle of experts" may occur between psychiatrists and/or psychologists testifying for both sides on the issue of whether or not the plaintiff-employee does or does not truly have Adult ADD. For employers however, the most prudent—not to mention socially responsible and cost-effective action to take when an applicant or employee states that s/he has ADD—is to take the diagnosis very seriously and to take steps to try to provide the reasonable accommodation of the disability mandated by the ADA.

Nature of the Disabling Condition

Courts have also required the plaintiff-employee to demonstrate a link between the relevant medical condition and any performance difficulties that might have led to the adverse employment action [14]. For a disability to matter at all in the employment process, it must rise to the level of substantially limiting a person in engaging in a major life activity. Under both the Rehabilitation Act and the ADA, work has been regarded as such an activity [48]. However, this concept has been extended beyond disabilities that actually impair a person from performing work. Whether or not a person actually has a qualifying disability, if she/he is treated as such by a current or potential employing organization, then the person is protected under the ADA from an adverse employment action [12].

An individual who discloses to an employer or potential employer that she/he has a disability *or is treated as if s/he does* must still possess the necessary qualifications for the job in question to be covered by the federal disability discrimination law. As Edwina Wilson observed:

> Not only must applicants or employees satisfy the "disability" requirement, but, they must also demonstrate that they are qualified for the position they seek. They must demonstrate, to the employer's satisfaction, that they possess the skills, education, and training to perform the essential functions of the job . . . If they do not possess these qualification standards, no duty to hire or place exists [49, pp. 268-269].

Under the ADA then, the employer "has no obligation to employ or accommodate an individual who lacks the qualifications required to perform a position" [14, p. 538]. The ADA also does not require an employer to hire or promote an employee to a position that s/he could not possibly perform due to his/her disability. However, the ADA *does* require an employer to consider whether or not an applicant or employee could perform the job in question with some form of "reasonable accommodation" being provided to him/her [50]. Thus, to be considered a "qualified individual" under the ADA, the person must be "an individual with a disability who, with or without reasonable accommodation, can perform the essential functions" of a job [7].

How does all this apply specifically in the case of ADD-affected employees being "qualified individuals"? It does so in two principal ways. First, there is an inherent paradox under the ADA. Employers are severely restricted in asking—directly or indirectly—health-related questions of applicants or current employees [51, 52]. Yet, to receive protection from discrimination after being diagnosed with ADD, an employee or applicant must take the initiative in informing the organization of his or her condition. The burden on the employee to inform the employer is probably greater in the case of ADD than perhaps any other mental *or* physical impairment. Remembering that 70 percent of those with the condition have not actually been diagnosed with ADD, it is unlikely the employer would have to defend itself on the basis that it should have recognized that the behavioral characteristics of the employee or applicant constituted an attention deficit condition. This is especially true given: 1) the fact that employers are free to discriminate based upon "personality traits"; 2) that the behaviors characteristic of Adult ADD listed in Table 2 would be likely to negatively affect an individual's work record; and 3) that employers may generally discriminate based on demonstrable conduct [50].

The second issue is whether an ADD-diagnosis could be used as a legal *disqualification* for a position. Certainly, as was demonstrated earlier, ADD affects an individual's work performance to varying degrees, depending on both the individual's condition and the specific job in question. Thus, there are certainly jobs where ADD would be more relevant than others. This calls for specific analysis, as the EEOC urged, for employers to focus on the "essential functions" of a position in determining whether or not an individual with ADD could perform the position regardless of any accommodation efforts [12]. Also, it is likely that a charge of disability discrimination against an employer disqualifying a person due

to having ADD might be accompanied by a charge of gender discrimination as well. Mindful that it has been established that males are three times more likely to be affected by ADD than females, it could be alleged that a policy of excluding those with this condition from specific job(s) could have a disparate impact on men. In such disparate impact cases, the onus is on the organization to be able to prove that such an exclusionary policy would be a "business necessity" [53].

The so-called "business necessity" test was established in 1971 by the Supreme Court in *Griggs v. Duke Power Co.* [54]. It requires an employer to demonstrate a very good rationale for a facially neutral rule, policy, or practice that, in practice, causes a disparate impact in that it serves to discriminate against a protected class of employees [55]. The business necessity must be in place either because it is essential to effective job performance or because it serves to promote the safety of the employee and others on the job [56]. According to the Supreme Court in *Dothard v. Rawlinson* [57], a business necessity must be so integral to the goals of the employer that without the practice, the "essence of the business" would be undermined. Thus, the hurdle established by the Supreme Court for an employer to justify such a disqualification is an extremely high one—one that would be difficult, if not impossible, for an organization to meet in the case of ADD.

REASONABLE ACCOMMODATION OF ADD-AFFECTED EMPLOYEES

Like the earlier Rehabilitation Act, the ADA does not explicitly define what an employer must do in order to provide "reasonable accommodation" to a qualified worker with a disability. However, as Barbara Lee noted, the ADA contains two major deviations from the earlier law that will serve to strengthen the standards for what will be considered to be a "reasonable" accommodation [50]. First, the ADA allows a job transfer or reassignment to be considered as a potential accommodation—an option unavailable under the Rehabilitation Act. The second, and perhaps more far-reaching change for employers, is the alteration of the "undue hardship" standard [58].

Prior to the ADA, an employer would not be required to make alterations to the physical workspace or to the job itself if doing so would compel the employer to expend more than a minimal amount. While the so-called *de minimus* standard was established in the 1977 *Trans World Airlines, Inc. v. Hardison* [59] (which actually involved alleged religious discrimination), it had been applied to cases of alleged handicap discrimination as well. However, the ADA replaced the *de minimus* standard in favor of a stricter definition from the employer's perspective, defining an "undue hardship" as meaning that the employer would face "significant difficulty or expense" in accommodating the disabled employee's needs [60].

One legal commentator has stated that compliance with the ADA's reasonable accommodation requirements may be a moot point for many employers. This is

because many organizations have voluntarily taken steps to adapt the work environment for the needs of their employees with disabilities [11]. However, when this is not the case, Michael Collins observed that it was possible for businesses to comply with the ADA's requirements on a low cost basis if managers apply a great deal of ingenuity to these efforts [61]. In fact, it has been estimated that in the case of physical disabilities, half of all necessary accommodations can be made at no cost, and eighty percent will require an expenditure of no more than $500 [62].

What managers need to do in order to reasonably accommodate workers with disabilities is very different when speaking of physical versus mental disabilities. Compliance in regard to mental disabilities should in fact prove less costly than efforts necessary to reasonably accommodate physically disabled employees. This is because the changes that need to be made in the workplace to facilitate the employment of workers with physically disabling conditions involve physical changes in the working environment. Whether the modifications involving altering workspaces to accommodate employees in wheelchairs or purchasing telecommunications equipment that meets the needs of hearing-impaired employees, the principal change to accommodate the worker is *physical.* In contrast, when dealing with employees with a mentally disabling condition, management must make continuing efforts to accommodate the worker—rather than making a one-time expenditure or modification. As Laura Mancuso, a psychological rehabilitation expert, observed, employers must make long-term, permanent changes in their management practices to accommodate the mentally impaired worker [63].

How do you accommodate the mentally impaired worker—and specifically, employees diagnosed with ADD—to satisfy the reasonable accommodation requirements of the ADA? The EEOC has clearly stated what the goal of an accommodation effort should be. The agency directed that:

> *A reasonable accommodation must be an effective accommodation.* It must provide an opportunity for a person with a disability to achieve the same level of performance or to enjoy benefits or privileges equal to those of a similarly-situated, nondisabled person. However, the accommodation does not have to ensure equal results or provide exactly the same benefits or privileges (emphasis in the original) [12, p. 405: 7000].

Some monetary expenditures can indeed be made to provide a "distraction-free environment" for ADD-affected employees, including redesigning work spaces and adding "white-noise" machines [24]. Some changes are even simpler and less costly. If a person works best in either total quiet or with the radio on, let him/her do so. If a person needs to sit on the front row during staff meetings to pay attention, let him/her do so. If a person can work best at home or in an isolated space, let him/her do so [42].

The EEOC has also weighed in regarding the accommodations that might be given to a person with a mental impairment which might have an impact on performance on tests used in the employment selection process. The agency believes employers should be required to allow applicants or employees with such conditions both to have longer periods of time to complete such tests and/or to have the chance to take such tests in isolation. Such accommodations would need to be provided if the employer is made aware of the condition and the potential or actual employee believes that these arrangements would provide him/her with the opportunity to perform better on the tests [64]. The EEOC specifically cited conditions such as dyslexia, visual problems, and learning disabilities as fitting this description [12]. However, given the foregoing analysis that ADD is a covered mental impairment under the ADA, it would appear employers should consider such potential alterations in their pre- and post-employment testing procedures for ADD-affected employees and applicants.

Yet, in the end, the most effective accommodations may come in the form of changes in day-to-day managerial practices. These may include changes in communication practices, job design, and work scheduling [63]. Taking steps to clarify communications (i.e., putting things in writing, simplifying messages, asking for feedback) will help a manager in dealing with *all* of his/her subordinates. Likewise, encouraging supervisors to engage in goal setting and monitoring with their subordinates and to provide increased levels of feedback to employees on their work performance is a positive step. In the end, management practices to accommodate workers with attention deficits may serve to improve the management—and ultimately productivity and job satisfaction—of all workers.

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ENDNOTES

1. S. Stich, Why Can't Your Husband Sit Still? *Ladies' Home Journal, 110*:9, pp. 74-77, 1993.
2. G. Weiss and L. T. Hechtman, *Hyperactive Children Grown Up: ADHD in Children, Adolescents, and Adults* (2nd Edition), The Guilford Press, New York, 1993.
3. P. A. Susser, The ADA: Dramatically Expanded Federal Rights for Disabled Americans, *Employee Relations Law Journal, 16*:2, pp. 157-176, at 157, 1990.
4. E. H. Fry, The 1990 Americans with Disabilities Act and the Employer's Obligation to Accommodate, *SAM Advanced Management Journal, 59*:2, pp. 4-9, 1994.
5. ADA, 1990, 42 U.S.C.A. 12111(ł)(a).
6. H. E. Gerson and J. G. Addison, Handicapped Discrimination Law and the Americans with Disabilities Act, *Mississippi College Law Review, 11*, pp. 233-253, 1991.
7. ADA, 1990, 42 U.S.C.A. 12111(8).

8. D. Chin, The Americans with Disabilities Act: The EEOC Regulations, in *Proceedings of New York University 44th Annual National Conference on Labor*, B. Stein (ed.), Little, Brown and Company, Boston, 1991.
9. L. Reynolds, ADA Is Still Confusing after All These Years, *HRFocus, 71*:11, p. 1, 1994.
10. K. R. Fine, The Americans with Disabilities Act, *ALI-ABA Course Materials Journal, 15*:5, pp. 7-12, 1991.
11. N. L. Breuer, Resources Can Relieve ADA Fears, *Personnel Journal, 72*:9, pp. 131-142, 1993.
12. Equal Employment Opportunity Commission (EEOC), *EEOC: Technical Assistance on Title I of ADA, Fair Employment Practices Manual*, The Bureau of National Affairs Inc. (Issued January 17, 1992, N-405:6981) at 405:6988, Washington, D.C.
13. D. A. Larson, Mental Impairments and the Rehabilitation Act of 1973, *Louisiana Law Review, 48*, pp. 841-874, 1988.
14. P. F. Mickey, Jr. and M. Pardo, Dealing with Mental Disabilities Under the ADA, *The Labor Lawyer, 9*, pp. 531-552, 1993.
15. J. Biederman, Attention Deficit Hyperactivity Disorder (ADHD), *Annals of Clinical Psychiatry, 3*:1, pp. 9-22, 1991.
16. S. Weiss and E. Wender, Attention Deficits: What We Know Now, *NEA Today, 12*:6, p. 17, 1994.
17. M. Blau, A.D.D.: The Scariest Letters in the Alphabet, *New York, 26*:49, pp. 44-51, 1993.
18. H. N. Levinson, *Total Concentration: How to Understand Attention Deficit Disorders with Treatment Guidelines for You and Your Doctor*, M. Evans and Company, Inc., New York, 1992.
19. P. Hauser, A. J. Zametkin, P. Martinez, B. Vitiello, J. A. Matochik, A. J. Mixson, and B. D. Weintraub, Attention Deficit-Hyperactivity Disorder in People with Generalized Resistance to Thyroid Hormone, *New England Journal of Medicine, 328*:14, pp. 997-1001, 1993.
20. A. J. Levine, Attention-Deficit Disorder: It's Real, *The Wall Street Journal*, p. A13, March 18, 1993.
21. S. V. Faraone, J. Biederman, B. K. Lehman, K. Keenan, D. Norman, L. J. Seidman, R. Kolodny, I. Kraus, J. Perrin, and W. J. Chen, Evidence for the Independent Familial Transmission of Attention Deficit Hyperactivity Disorder and Learning Disabilities: Results from a Family Genetic Study, *American Journal of Psychiatry, 150*:6, pp. 891-895, 1993.
22. S. V. Faraone, J. Biederman, K. Keenan, and M. T. Tsuang, Separation of DSM-III Attention Deficit Disorder and Conducted Disorder: Evidence from a Family-Genetic Study of American Child Psychiatric Patients, *Psychological Medicine, 21*, pp. 109-121, 1991.
23. J. Biederman, S. V. Faraone, K. Keenan, R. Steingard, and M. T. Tsuang, Familial Association between Attention Deficit Disorder and Anxiety Disorders, *American Journal of Psychiatry, 148*:2, pp. 251-256, 1991.
24. C. Wallis, Life In Overdrive: Doctors Say Huge Numbers of Kids and Adults have Attention Deficit Disorder—Is It for Real? *Time, 144*:3, pp. 43-50, 1994.
25. M. B. Denckla, The Child with Developmental Disabilities Grown Up: Adult Residua of Childhood Disorders, *Neurologic Clinics, 11*:1, pp. 105-125, 1993.

26. R. Reid, J. W. Maag, and S. F. Vasa, Attention Deficit Hyperactivity Disorder as a Disability Category: A Critique, *American Psychologist, 60*:3, pp. 198-214, 1994.
27. S. H. Klee, B. D. Garfinkel, and H. Beauchesne, Attention Deficit in Adults, *Psychiatric Annals, 16*:1, pp. 52-56, 1986.
28. P. H. Wender, F. W. Reimherr, and D. R. Woods, Attention Deficit Disorder ('Minimal Brain Dysfunction') in Adults, *Archives of General Psychiatry, 38*, pp. 449-456, 1981.
29. D. Woods, The Diagnosis and Treatment of Attention Deficit Disorder, Residual Type, *Psychiatric Annals, 16*:1, pp. 23-28, 1986.
30. W. O. Shekim, R. F. Asarnow, E. Hess, K. Zaucha, and N. Wheeler, A Clinical and Demographic Profile of a Sample of Adults with Attention Deficit Hyperactivity Disorder, Residual State, *Comprehensive Psychiatry, 31*:5, pp. 416-425, 1990.
31. K. Miller, Attention-Deficit Disorder Affects Adults, but Some Doctors Question How Widely, *The Wall Street Journal*, pp. B1, B5, January 11, 1993.
32. E. M. Hallowell and J. J. Ratey, *Driven to Distraction*, Pantheon Books, New York, 1994.
33. M. F. Ward, P. H. Wender, and F. W. Reimherr, The Wender Utah Rating Scale: An Aid in the Retrospective Diagnosis of Childhood Attention Deficit Hyperactivity Disorder, *American Journal of Psychiatry, 150*:6, pp. 885-890, 1993.
34. R. Kane, C. Mikalac, S. Benjamin, and R. A. Barkley, Assessment and Treatment of Adults with ADHD, in *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment*, R. A. Barkley (ed.), The Guilford Press, New York, 1990.
35. S. Mannuzza, R. G. Klein, A. Bessler, P. Malloy, and M. LaPadula, Adult Outcome of Hyperactive Boys: Educational Achievement, Occupational Rank, and Psychiatric Status, *Archives of General Psychiatry, 50*, pp. 565-576, 1993.
36. R. A. Barkley, Developmental Course and Adult Outcome, in *Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment*, R. A. Barkley (ed.), The Guilford Press, New York, 1990.
37. J. Biederman, S. V. Faraone, T. Spencer, T. Wilens, D. Norman, K. A. Lapey, E. Mick, B. K. Lehman, and A. Doyle, Patterns of Psychiatric Comorbidity, Cognition, and Psychosocial Functioning in Adults with Attention Deficit Hyperactivity Disorder, *American Journal of Psychiatry, 150*:12, pp. 1792-1798, 1993.
38. G. Weiss and L. T. Hechtman, *Hyperactive Children Grown Up: ADHD in Children, Adolescents, and Adults* (2nd Edition), The Guilford Press, New York, 1993.
39. R. E. Goodwin and M. D. Corgiat, Cognitive Rehabilitation of Adult Attention Deficit Disorder: A Case Study, *The Journal of Cognitive Rehabilitation, 10*:5, pp. 28-35, 1992.
40. S. A. Weinstock, Attention-Deficit Disorder Mythology, *The Wall Street Journal*, p. A15, March 1, 1993.
41. D. Levy, Lasting Effects of Hyperactivity, *USA Today*, p. D1, July 14, 1993.
42. P. Stuart, Tracing Workplace Problems to Hidden Disorders, *Personnel Journal, 71*:6, pp. 83-95, 1992.
43. R. Vatz, Attention-Deficit Disorder Mythology, *The Wall Street Journal*, p. A15, March 1, 1993.
44. C. Reeder, Attention-Deficit Disorder: It's Real, *The Wall Street Journal*, p. A13, March 18, 1993.

45. Attention Deficit Disorder: Taking the Hype Out of Hyperactivity, *Psychology Today, 27*:1, p. 13, 1994.
46. *Landefeld v. Marion General Hospital*, 994 F.2d. 1178 (6th Cir. 1993).
47. R. D. Ciaranello, Attention Deficit-Hyperactivity Disorder and Resistance to Thyroid Hormone—A New Idea? *The New England Journal of Medicine, 328*:14, pp. 1038-1039, 1993.
48. S. L. Mikochik, Employment Discrimination against Americans with Disabilities, *Mississippi College Law Review, 11*, pp. 255-262, 1991.
49. E. A. Wilson, Practical Considerations for Compliance under the Americans with Disabilities Act, *Gonzaga Law Review, 28*, pp. 265-290, 1993.
50. B. Lee, Reasonable Accommodation under the Americans with Disabilities Act: The Limitations of Rehabilitation Act Precedent, *Berkeley Journal of Employment and Labor Law, 14*:2, pp. 201-257, 1993.
51. R. B. Fitzpatrick, Employer Screening Procedures under the Americans with Disabilities Act (Part 1), *ALI-ABA Course Materials Journal, 18*:5, pp. 7-31, 1994.
52. R. B. Fitzpatrick, Employer Screening Procedures under the Americans with Disabilities Act (Part 2), *ALI-ABA Course Materials Journal, 18*:6, pp. 31-62, 1994.
53. D. P. Twomey, *Equal Employment Opportunity Law* (3rd Edition), South-Western Publishing, Cincinnati, 1994.
54. *Griggs v. Duke Power Co.*, 401 U.S. 424 (1971).
55. A. Cava, Pregnancy and the 'Role Model Rule', *Business & Economic Review, 36*:4, pp. 24-26, 1990.
56. *Hawkins v. Anheuser-Busch, Inc.*, 697 F.2d 810 (8th Cir. 1983).
57. *Dothard v. Rawlinson*, 433 U.S. 321 (1977).
58. M. B. Schiff and D. L. Miller, Reasonable Accommodation under the Americans with Disabilities Act, *Gonzaga Law Review, 28*, pp. 219-234, 1993.
59. *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63 (1977).
60. ADA, 1990, 42 U.S.C.A. 12111(10(A), (10)(B).
61. M. C. Collins, The ADA and Employment: How it Really Affects People with Disabilities, *Gonzaga Law Review, 28*, pp. 209-218, 1993.
62. P. S. Irby, Jr., The ADA: The Employer's Perspective, *Mississippi College Law Review, 11*, pp. 263-270, 1991.
63. L. L. Mancuso, Reasonable Accommodation for Workers with Psychiatric Disabilities, *Psychosocial Rehabilitation Journal, 14*:2, pp. 3-19, 1990.
64. S. Alexander, Preemployment Inquiries and Examination: What Employers Need to Know about the New EEOC Guidelines, *Labor Law Journal, 45*:11, pp. 667-678, 1994.

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