

Running Head: DISCOURSE AS A NORMATIVE INSTRUMENT

DISCOURSE AS A NORMATIVE INSTRUMENT:
ANALYSIS OF MENTAL ILLNESS ON A DISABILITY SERVICES DISCUSSION
LIST

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Dedication

To my faithful service dog, Sydney, I dedicate this work. For the many hours you laid at my feet while I attended classes, worked on projects, and wrote this dissertation, I thank you. The goodwill that you share with everyone you meet is an example that humans should share. You made it possible for me to be out in the world, to achieve my dream, and never asked for more than a little praise and a few treats.

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DISCOURSE AS A NORMATIVE INSTRUMENT:
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Abstract

Publicly available archives of an internet discussion list for people who operate disability service offices at colleges and universities across the U.S. provided a unique insight into the values, interactions, and norms of this professional group. This study critically analyzed the discourse practices of this community. In and through their online interactions, these professionals define and construct the concept of “disability,” attitudes toward students with psychiatric disabilities, and ideological positions on “reasonable” accommodations on the part of their institutions. It was found that some of these professionals are talking in a way that can bring harm to the subjects of their discussions; it is important that this practice is revealed and remedies are taken. The analysis has provided many examples of how psychiatric disability is socially constructed as well as several examples of the decision-making process for accommodations. These features included unbalanced posting patterns, attempts at closure of discussions or debates, invoking greater expertise/experience or the Grand Discourse of law, and allowing misinformation, sarcastic humor, and damaging stereotypes to go unchallenged. The presence of hegemonic discourse in an archived list dedicated to disability support services in higher education has been confirmed. The use of power by DSS officials that results in prejudicial and discriminatory treatment of students with psychiatric disabilities was indicated by the discourse.

Chapter 1

Introduction

I refuse to accept the mark of stigma you would place upon me.
My successes provide the labels I will live with.

"Sticks and stones can break my bones, but words can never harm me" is the schoolyard chant that many children shout. However, words can be very harmful and when combined with power can cause the loss of life chances for the targets of the words. People with mental disabilities are often the target of misinformed words that cause them to live with the stigma of their illness. This study investigated the words used by higher education disability service providers from across the nation as they "talked" about students with mental disabilities on a dedicated discussion list. It was found that some of these professionals are talking in a way that can bring harm to the subjects of their discussions; it is important that this practice is revealed and remedies are taken.

The presence of students with disabilities in higher education, once a rare phenomenon, has become more commonplace. Students with disabilities are now an expected part of the postsecondary student body. According to Census 2000, nearly one-in-five United States residents reported a disability (U.S. Census Bureau, 2002). Of that number, eight percent were between ages five and twenty. These figures are consistent with the findings of Horn, Peter, and Rooney (2002) who reported that nine percent of undergraduates self-report a disabling condition. This increased number of postsecondary students with disabilities follows the trend noted by Henderson (1995) in his study where he found students reporting disabilities rose from under three percent of the student body in 1978 to over nine percent in 1994. Statistics gathered by the U.S. Department of Education (2005) showed a continuing rise of student-reported disability to 11.3 percent.

While there have been no epidemiological studies of mental illness on college campuses, a number of studies have reported differing estimates of numbers of mentally ill college students. Mowbray, et al. (2006) averaged the results of several studies and estimated that 12-18 percent of college students have a diagnosable mental illness. There has been such a large increase in students seeking mental health services at colleges and universities across the nation that researchers are concluding that psychiatric disorders are the fastest growing disability exhibited by college students (Belch & Marshak, 2006; Eudaly, 2002; Gallagher, 2004, 2006).

Evidence that students with psychiatric disorders are entering higher education in ever increasing numbers comes from the 2006 National Survey of Counseling Center Directors (Gallagher, 2006). This survey provided statistics gathered from directors at 367 counseling centers at colleges and universities across the United States. The numbers support the contention that students with serious psychiatric disorders are increasingly participating in higher education. The following statistics reflect a trend of increasing use of counseling centers on campuses across the nation. While some of these students will not be served by disability services offices for varying reasons, many of them will seek the accommodations that will allow them to succeed as students.

- 9% of the students at participating schools sought counseling;
- 25% of center clients are on psychiatric medication. That is up from 20% in 2003, 17% in 2000, and 9% in 1994;
- 91.6% of directors report an increase in students coming to counseling who are already on psychiatric medication;

- 92% of directors believe that in recent years there has been an increase in the number of center clients with severe psychological problems, and 90.6% believe that students with significant psychological disorders are a growing concern on campus;
- Directors report that 8% of their clients have impairments so serious that they cannot remain in school, or can only do so with extensive psychological/psychiatric help, while 32% of clients experience severe problems but can be treated successfully with available treatment modalities;
- 2368 students were hospitalized for psychological reasons;
- Directors reported 142 student suicides in the past year. 14 of these were current or former counseling center clients;
- 66.8% of directors report an increase in student self injury cases (Gallagher, 2006, pp. 1-2).

Purpose of Study

The purpose of this study was to analyze discourse practices in an electronic mailing list used by a community of disability service providers and others whose occupations are involved with disability issues. More specifically, the study examined the discourse of the list for Disabled Student Services in Higher Education (DSSHE-L) that has been archived in a public web page. This electronic mailing list is for people who operate disability service offices at colleges and universities and others who work in the interest of people with disabilities. Only text pertaining to discussions about mental illness was selected for analysis. Text provided evidence of cultural beliefs within

discussions about mental disability and reasonable accommodations. These texts showed how power is expressed overtly or implied through proposed actions. Analysis of the discourse showed the use of power in the position of disability service specialist as it affects students with mental disabilities.

The premise of this study was that knowledge is not fixed but socially constructed by the members of a social group (e.g., disability services professionals) over time. Therefore, cultural beliefs about students with disabilities are fundamentally social and co-constructed processes. In and through their online interactions, these professionals are defining and constructing disability and more specifically mental illness. They are also constructing the meaning of "others" or students with disabilities. From this construction, members of this culture define what a disability is and what reasonable accommodation is. Furthermore, opportunities in higher education for students with disabilities are limited or expanded by these definitions.

Disability Support Services personnel report that few are trained to provide services to the mentally ill (Sharpe, Bruininks, Blacklock, Benson, & Johnson, 2004). Most were reported as having training and experience in accommodating learning disabilities and physical disabilities. This lack of specialized training makes the assessment and accommodation of students with psychiatric disabilities difficult and challenging. While interviewing disability services personnel about the accommodations process for students with a psychiatric diagnosis, Sharpe and Bruininks (2003, as cited by Sharpe, et al., 2004) found several common practices. In the Big Ten colleges and universities investigated there were four requirements to receive services and accommodations. The required documentation must originate from a qualified medical or

mental health practitioner and must be current. The criteria for a psychiatric illness diagnosis must meet the requirements set out by either the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* or the *International Classification of Diseases Manual, Tenth Edition (ICD-10)*. Furthermore, the symptoms of the diagnosed illness must rise to the level of a disability as outlined by the Americans with Disabilities Act (ADA). The professional who makes the diagnosis may outline the functional limitations caused by the disability and recommend accommodations that would mitigate the learning problems resulting from the disability, but the disability services professional makes the final determination of accommodations. For most of the Big Ten schools it is explicit that regardless of the disability, the code of conduct and other rules outlined in the student handbook would be enforced

According to Link and Phelan (1999), how disability service providers talk about mental illness is important.

When people ask and answer the questions, 'What is mental illness?' 'What are people with mental illness like?' and 'What should be done about people with mental illness?' they create and shape social structures that become the realities of everyday experience for people with mental illness (p. 491).

In knowing how disability service providers ask and answer such questions, possible stereotypes can be revealed. A stereotype is knowledge, true or false, that is learned by most members of a social group (Corrigan, 2005). Stereotypes can lead to prejudice and discrimination. In creating knowledge about students with psychiatric disabilities, service providers can fall into the trap of the "clinician's illusion" (Cohen & Cohen, 1984) which can result when the most severely disabled students take the most attention, leading the

service provider to believe that every student with a psychiatric disability is as difficult to work with (Harding & Zahniser, 1994). This tendency to anticipate the worst case scenario based on previous bad experiences can affect anyone dealing with people who have psychiatric disabilities and lend credence to stereotypes.

In general, there is a paucity of research about educational issues of postsecondary students with disabilities. Gajar (1998) explained that the lack of research stems from increased demands upon colleges and universities after federal and state legislative mandates opened the doors of higher education for this minority group. The fairly recent influx of students with disabilities in colleges and universities across the United States caused new programs created to provide services to this population to flourish (Stodden, 2001). Programs aimed at meeting the specialized needs of the postsecondary population were rapidly put into place, and there has been little opportunity to study disability services (Jarrow, 1993). Schools scrambled to put programs into action rather than systematically study the efficacy of what they were doing. Legislative mandates forced schools to become accessible to and useable by students with disabilities (Jarrow, 1992) without explaining how it was to be done. Regulations quickly explained the particulars of physical accessibility, but left the individual academic accommodations to be determined on a case-by-case basis (Americans with Disabilities Act, 1990). Colleges and universities must now take on an "evaluative stance" (Astin & Ewell, 1985) on programs that provide for all students, including students with disabilities. Policy and programs affecting people with disabilities need to be studied on all levels (Hahn, 1985). This study will begin to address that need.

Discourse as a Normative Instrument

As the words in the title indicate, there is a normative element from participation in an online discussion list that is dedicated to one area of expertise. The disability services discussion list is a normative instrument. By and through the language used in the discussions, the discourse creates a social construction about disability in higher education. Each argument about an area of disability services serves to build meaning into the actions and policies of the diverse offices across the nation. Even an inquiry can serve to instruct the other list members about a topic in the way it is worded. As the multiple messages join into a thread of ideas, the readers of the list can be influenced in their thinking when the reflexive textuality begins to weigh in on the side of one idea or another. For example, the text about students diagnosed with oppositional defiant disorder tend to be weighted on the side of not providing services to such students and, at the same time, the rationale for not providing services is that these students may be violent. That this is a stereotype does not cause it to be any less potent in creating an image of these students as incorrigible and undeserving of services. The power of repeating the discourse about students with the diagnosis of oppositional defiant disorder lends credibility to the argument. When said enough times by enough people and then it seems that it must be true. This is how the discussion list serves as a normative instrument. As list members join together to socially construct what a disability is and how it should be treated, the members are being normed. As new subscribers to the list go to the archives for information, the norming and socialization begins anew as they take in what has been said many times before. It is beyond the scope of this project to determine how normative the discussion list may be. As has been discovered, only a few list

members actively posted about mental illness issues. However, it is reasonable to assume that as DSS professionals read the list for instruction to resolve a disability issue for a student, the list will influence their thinking about each issue. The behavior of DSS personnel who do not use the DSSHE-L for instruction may be very different than those who do. The discussion of cultural changes brought about through discourse will illustrate how the discourse on the discussion list is a normative instrument.

Theoretical Framework: Critical Theory

This study was approached from a critical theorist perspective. My ontology is that there are multiple realities and realities change over time. Language reflects both the multiple realities of speakers and changing social realities. For example, there is language that places the problems of disability onto the person with a disability: "She cannot succeed in college because of her disability." Then there is language that puts the problems associated with a disability as caused by social constructs: "He cannot attend the meeting because the building was built with steps instead of a ramp for his wheelchair." The realities of people with disabilities are defined by the language people choose to explain them. As disability service professionals talk about what is "real" in a disabling condition, they change what accepted reality looks like.

Language use is a social practice that is socially shaped at the same time it is socially shaping or constitutive (Fairclough, 1993). "Language use is always simultaneously constitutive of (i) social identities, (ii) social relations, and (iii) systems of knowledge and belief – though with different degrees of salience in different cases" (p. 134). A discursive event is text, a discourse practice and a social practice simultaneously. Text can be in the form of spoken words (utterances) or written (inscribed). Discourse

practice is the production and interpretation of the text (Fairclough, 1993). Occasionally the speaker or writer will utilize discourse from a larger body, such as the discourse of law or medicine which can fill a building with texts of the special discourse. In this project these events will be characterized as the use of Grand Discourse, a discourse of specialized meaning. An argument using Grand Discourses is intended to represent a more persuasive and powerful meaning.

In critical theory, the researcher believes that social constructions directly affect people's life chances. In this study, the power of the disability service provider to accommodate directly affects the abilities of students to succeed in school. While early critical theorists contended that people are treated differently due to race, gender, and social class (Hatch, 2002), this project contends that differential treatment is also due to disability. Because discourse analysis is the critical work of the researcher, it must be remembered that in critical theory "the investigator and the investigated object are assumed to be interactively linked, with the values of the investigator inevitably influencing the inquiry" (Guba and Lincoln, 1994, p. 110). In the worldview of the critical researcher, "it is assumed that knowledge is always mediated through the political positioning of the researcher" (Hatch, 2002, p. 17). In this case the researcher has personal experience with accommodations from disability services at a large university. This experience gave the researcher a worldview unlike other researchers which enriched the analysis.

Critical theory played a vital role in this research in that it allowed the researcher to expose cultural beliefs that serve to support prejudice and discrimination. Positive change can only come about through awareness of such practices. As participants

construct interpretations, their socially constructed reality becomes apparent (Denzin and Lincoln, 2000). Organizational reality is also socially constructed by the actors who participate in the list's discourse. The critical approach to analyzing the text focused on the "power elite," the DSS officers, and their use of discursive strategies on a specialized Internet discussion list to instigate and maintain the inequality of students with disabilities. The inequalities experienced by students with disabilities is a pressing social issue that can be addressed, in part, by analyzing the discursive strategies used to put students in subordinate positions. The list members who are creating hegemony may be outnumbered by list members who are not contributing to the hegemonic discourse, but the lack of "voices" arguing against policies and practices that subordinate students implies consent.

When a college student needs an accommodation, s/he will usually request it through the school's disability services office. The disability service specialist reviews documentation about every facet of a student's disability before granting an accommodation. This documentation comes from a doctor or other licensed professional. Often the doctor will prescribe an accommodation. Occasionally, it is the responsibility of the disability service specialist to determine an appropriate accommodation. Disability service offices have written policies that outline the procedures for requesting an accommodation. Policy says that the doctor must document the diagnosis and make prescribed recommendations for accommodation. It would seem logical that once an accommodation has been prescribed, the job of the disability service specialist is to see that it is granted. As was revealed through the discussion list, disability service specialists have power to change or even deny a doctor's recommendation. If we assume that doctors

are the experts who deal with the conditions that disable their patients, then it is counterintuitive that others should have the power to deny prescribed remedies. What was explored in this discourse analysis was how what is being said builds a social construct of power throughout the service system.

Disability service specialists are always aware of the legal imperatives that impose guidelines on their actions. Perhaps more importantly, they must honor the social needs of a vastly diverse population (Hahn, 1985). It is the great diversity of the people they serve that makes the job of disability service specialist so complex. The same office must be prepared to serve the mentally ill, the physically disabled, and any of the vagaries that each condition presents. Programs that address the needs of students with disabilities must have a built-in flexibility. At the same time, choices must not be constricted by service providers (Hahn, 1985). When constriction occurs because of attitudinal access barriers (Kroeger & Schuck, 1993), then the power of office is being abused.

Key Concepts: Culture, Language, and Power in Policy Implementation

The following sections spell out a critical perspective on five concepts central to the study: culture, language, ideology, power, and policy. Culture, language, and ideology are inextricably linked, and will be discussed together. Then I will lay out the perspective on power that informs the study, ending with two useful ways of synthesizing culture, language, ideology, and power (the culture of power and hegemony). The concept of policy, especially policy implementation as the role of the disability services provider, is integrated throughout.

Culture, Language, and Ideology in Policy Implementation

Culture serves both as a description of the organization of activities and meaning in organizations, its structure, and as a description of the activities by which these meanings come to be produced and shared in organizations: its structuration. An organization's culture consists of whatever a member must know or believe in order to operate in a manner understandable and acceptable to other members and the means by which this knowledge is produced and transmitted (Deetz, 1982, pp. 132-133).

This research will develop insight into the culture of disability service providers through the language they use. Culture, according to Duranti (1997) is often defined as something that "others" have. A person's own culture becomes so much a part of their being that it is only through examining others that culture becomes apparent. Like any culture, the culture of disability service specialists is something "acquired by means of observation, imitation, and trial and error" (Oswalt, 1986, p. 25). Culture is knowledge that members need to acquire in order to belong to the group (Goodenough, 1964). A homogenous view of culture comes from watching and learning from experts within the group. Homogeneity can be perpetuated through linguistic practices (Duranti, 1997). With homogeneity, the disability services providers operate in similar ways based on a shared social reality of what it means to be a disability services provider.

While it is easy to think of an electronic mailing list as something "out there" in cyberspace, the reality is that an identifiable organization is continuously being created and recreated through discourse on the list. The creation of an organizational culture is enacted through language, a social construction that, over time, builds and remodels the

organization's culture (Iedema & Wodak, 1999). The communication of ideas across the United States on a shared list helps to construct a shared ideology of this community. According to Sholle (1988) "'Ideology' is a produced knowledge, a knowledge that is opposed to 'truth,' a knowledge that oppresses and represses" (p. 16). In the investigation of the discourse of an electronic mailing list, which reflects the ideology of its members, the focus will be on socially produced knowledge of mental illness. As the list members struggle to balance knowledge with truth, the ideology that motivates decisions will be revealed. The "knowledge as practice" (Sholle, 1988) will provide the evidence of either a hegemonic ideology or an ideology that embraces the ethics of care (Gilligan, 1982; Noddings, 1984).

"Ideologies do not operate through single ideas; they operate in discursive chains, in clusters, in semantic fields, in discursive formations" (Hall, 1985, p. 104). Fairclough (1989) states that a shared ideology is the primary means of creating shared consent. Once an ideology is constructed, it is easier to build consensus about actions. Whether discussants are purposely attempting to sway others to their way of thinking cannot be determined. But the exchange of ideas does have an effect on the thinking of the recipients and subsequent readers. The electronic mailing list has created a system of social relationships and the discourse within it serves to reflect the realities of the system.

"We suggest that discourse can be most fruitfully examined as a site of power which *produces* organizational subjectivity (identity) in a particular way" (Mumby & Stohl, 1991, p. 316). The discourse of the Disability Support Services (DSS) staffers socially construct an organizational identity even when the list members are not required to join an organization in order to participate. The site of power of the list is global in the

event that a list member enacts the policies or recommended actions discussed. Power is enacted in language by creating a "common sense" (Fairclough, 1989) or a way of thinking about the world that "everyone" should understand. "Common sense is substantially, though not entirely, ideological" (p. 84). Once a dominant group agrees on the assumptions about another group, common sense sustains the naturalization of an unequal power relationship. So as the community of disability service providers agree on how students with disabilities should be treated, they are creating an ideology.

Bourdieu (1991) viewed language as a system that is actively defined by sociopolitical processes in bureaucratic institutions. What he described fits the disability service specialists well. Bourdieu spoke of culture as a system of practices, enacted and reproduced through the language used. The systems become institutionalized and are then able "to exclude others, but also to keep those who are in them under control" (pp. 45-46). This study provides evidence of how people on a disabilities services discussion list attempt to naturalize and institutionalize power through language use.

Culture is also a system of participation (Duranti, 1997). The words that connect us sometimes become a specialized jargon that creates a community. Language plays an important part in every culture, but it becomes especially powerful when the discourse serves to exclude others. Because disability service specialists deal with law, regulations, and policy and at the same time deal with medical documents, they have a specialized jargon that excludes others who are not versed in legalities and disability. Individuals with disabilities may run into barriers within the educational system because of the attitudes and actions of others (Papalia-Berardi, Hughes, & Papalia, 2002; Stage & Milne, 1996) and depend on the advocacy of the disability service office to remove these

barriers. However, when the barrier presents itself in the disabilities services office, there is little the student can do outside of pursuing a legal remedy. Disability services officers may become entrenched in their thinking about how a particular disability should be accommodated and be resistant to new approaches. Resistance to change, for whatever reason, is resistance to ending discrimination. Access is much more than open doors and ramps (Kroeger & Schuck, 1993; Taylor & Nicholson, 2002) and attitudes can be greater barriers to modify. "Attitudes are a key ingredient in the success or failure for students in higher education with disabilities" (Kroeger & Schuck, 1993, p. 105). There are usually prescribed methods of operation with little allowance for deviation. As Reischl (2000) so aptly said,

". . . resistance is inevitable and often reveals the systemic barriers to change" (p. 265).

As is true for any student, access to college is no guarantee of success, but this is especially true for students with disabilities (Wilson & Getzel, 2001).

Cultural approaches to policy analysis show that policy as implemented is sometimes different from the official policy as written (Booth & Ainscow, 1998). Policy may state unequivocally that a disabled student must present a prescription from a doctor in order to receive an accommodation, yet the student complying with this policy may still be denied. Policy may guarantee to the student that the documentation they provide will be kept confidential, but, again, the discourse revealed that this policy is vacant. We cannot assume that a policy is working simply because it is being put into place. Only by weighing policy against practice, or in this case by examining the discourse about practice, can we be assured that intent is being actualized. Examination of the discourse gives a glimpse of policy in action.

Power in Policy Implementation

Because disability service specialists have the authority to decide whether a particular student with a disability warrants an accommodation, they wield power over students. Disability service specialists serve as gatekeepers who allow or disallow accommodations. Multiple uses of power are revealed in the discourse of the discussion list. The hierarchy of power in an organization that is primarily communicative is revealed and reflected in the access members have to constructing meaning through discourse.

This section lays out my conception of power, and thus how I would recognize its presence in the data. Iedema and Wodak (1999) reiterate Gramsci's theory that power is both product and process. Power as product is manufactured and refurbished through the language that communicates policy. Power as process is the social constructions of reality that includes communication of values and practices. This study focuses primarily on power as process. Some authors (Fowler, 1985) limit the definition of power to the concrete ability to control the actions or behavior of others, the "product." In this study, I do not have direct evidence of the use of power to control the behaviors or access of students with disabilities, but I do have enough evidence of power as these actors communicate and construct it to make predictions about their actions. In some cases, the participants also reported on actions they had taken based on the rationales presented or constructed on the list.

According to Reid and Ng (1999) language is an instrument of power. Language reflects, creates, depoliticizes, and routinizes power in their estimation. The use of dominant language, a lexicon of power, allows one group, especially professionals, to

maintain control. The example Reid and Ng use of lawyers employing legal jargon that keeps outsiders illiterate can be compared to the DSS officers who employ both legal and medical jargon in their work and thus elevate their status above the layperson and especially the student.

As Clegg articulated (as quoted by Mumby & Stohl, 1991, p. 316),

To the extent that meanings become fixed or reified in certain forms, which then articulate particular practices, agents and relations, this fixity is power. Power is the apparent order of taken-for-granted categories of existence, as they are fixed and represented in a myriad discursive forms and practices. Power is neither ethical nor micropolitical; above all it is textual, semiotic, and inherent in the very possibility of textuality, meaning and signification in the social world.

Bruins' (1999) analysis of social power and influence theorized that power and influence is maintained through discourse. Extensive contacts between group members often lead to greater attribution of power and influence to certain members. The more one is heard the stronger the message. Contacts between group members accomplish several goals, singularly or in multiple ways. "Such contacts and communications have many functions (e.g., providing a sense of belongingness and safety, exchanging information, and asserting one's identity), but arguably one of the most important ones is to influence others and be influenced by others" (Bruins, 1999, pp. 7-8). It is the attempt to influence and/or be influenced that is under investigation in a critical discourse analysis. The power that is situated in these attempts is frequently the site of hegemonic struggle.

Various types of social power and influence as described by Bruins (1999) are utilized by DSS officers. DSS officers exert power over the students they serve. Reward

power is available to an agent when they are in the position to give the target (in this case the student with a disability) an asset (an accommodation). Coercive power, as its opposite, enables the agent to withhold assets in an effort to compel certain behavior. According to Bruins, the target (the student) does not reevaluate any of his/her own “beliefs, attitudes, or values” because of the application of reward power or coercive power. These types of power over another require monitoring by the agent to maintain leverage. Students with disabilities are required to provide documentation in order to initially receive services. The DSS officer has the reward or coercive power to grant services. Then, periodically, the agent requires the target to provide new documentation or request continuing accommodation (surveillance) and the agent’s use of power is repeated. An additional type of power is in play here. The agent (DSS officer) has legitimate power which is conferred by their institution. Legitimate power is accepted by the target as believable and unchallengeable unless they are willing to undergo some consequence. The obligation to accede to legitimate power lies with the target (Bruins, 1999).

The meaning of social power, according to Van Dijk (1993), “is based on privileged *access* to socially valued resources, such as wealth, income, position, status, force, group membership, education or knowledge” (p. 254). The DSS professional controls the student’s access to opportunities that reside in a higher education. The intent of critical discourse analysis is to expose and campaign against abuses of power. Van Dijk specified power abuse as “breaches of law, rules and principles of democracy, equality and justice by those who wield power” (p. 255). There are legitimate and acceptable uses of power, but unacceptable abuses are termed “dominance.” Van Dijk

acknowledged that “dominance is seldom total” though it can be conscious and explicitly performed. The goal of the critical discourse analyst is to identify dominance that is socially constructed in discourse and especially subtle abuses of power that are so common that they are accepted until challenged by the analyst.

At the same time that DSS personnel are demonstrating their power over students, they are attempting to exert referent power over list members through their discourse. In referent power, the target identifies as a colleague of the agent. However, with referent power the agent can be higher in the hierarchy through the attribution of the target that the agent possesses superior knowledge or experience (Bruins, 1999). When this expert power is acknowledged by the target the agent is able to influence the target’s beliefs, attitudes or values.

Synthesizing Culture, Language, Ideology, and Power

Two theoretical constructs useful for this study coherently synthesize these four key concepts: the culture of power and hegemony.

The Culture of Power. The five aspects of power in “the culture of power” that Delpit (1993) finds in the public school classroom readily transfer to the discourse on the list. The DSS personnel have socially constructed a culture of power in their respective offices. “Issues of power are enacted” every day in the DSS office. These issues relate to granting or withholding accommodations for students with disabilities and are revealed and reflected in the discourse they post to the discussion list. The issues of power are also revealed and reflected in the discourse of the list that the list member chooses to allow to stand without response. “There are codes or rules for participating in power; that is, there is a ‘culture of power’. The rules of the culture of power are a reflection of the rules of

the culture of those who have power” (Delpit, 1993, p. 122). As will be apparent in the discourse of the list, there are possessors of power who are repeatedly represented on the list and who enforce the code of power to other list members who are less powerful. “If you are not already a participant in the culture of power, being told explicitly the rules of that culture makes acquiring power easier. Those with power are frequently least aware of – or least willing to acknowledge – its existence” (Delpit, 1993, p. 122). I add one additional aspect of power as it relates to the electronic mailing list members. Those with hegemonic power will legitimize their position through the misapplication of policy and law. When distorting the meaning of regulatory text, the power will remain with the list member and the institution they represent.

Delpit (1993) compared discursive power with the authority to “silence dialogue.” Delpit’s analysis of the use of silenced dialogue as a means of control considered the plight of minority voices in educational settings. The minority voices were “unheard” by those in power who were making decisions about the public education of children. As Delpit concluded, “Most likely the white educators believe that their colleagues of color did, in the end, agree with their logic. After all, they stopped disagreeing, didn’t they?” (p. 121). In the world of electronic mailing lists, certain members respond to inquiries in either great frequency or with persuasive arguments that serve to “silence” other voices. As will be demonstrated through critical discourse analysis, some writers will be willing to think their reasoning has been accepted by all the members of the list. “After all, they stopped disagreeing, didn’t they?”

Power is demonstrably exercised when list members distort, obfuscate, or confuse the presenting issue and the application of pertinent rules or procedures. When this occurs

it tends to favor the interests of the institution over the interests of the affected student. Power mediates the socialization (Mumby, 1987) of DSS personnel so that its use to dominate the student with psychiatric disabilities is a reflection of the common sense these discussion list members have constructed on the list.

Another aspect of the culture of power is stereotyping, a form of prejudice or stigmatization. To be stereotyped and stigmatized by a label of mental illness “limits their freedom and constrains their outcomes, even their lives. In short, stereotypes exert control . . . through prejudice and discrimination” (Fiske, 1993, p. 621). Nowhere is this more true than in education and employment. As Fiske pointed out, there is a reciprocity between stereotypes and power, because “Power encourages stereotyping – stereotyping maintains power” (p. 621). The power of stereotyping comes from its resistance to change. The cognitive process of stereotyping involves categorizing people based on group membership and beliefs about what it means to be in that group. As the review of the literature in Chapter 2 will show, the stereotype of psychiatric diagnoses and the stigma attached is widespread and indelible. Stereotyping prevents a person from considering the subject as anything else rather than allowing for an attribute-by-attribute evaluation (Fiske, 1993). Stereotyping is one method of exerting power over the labeled individual, of keeping them “in their place.”

Hegemony. The construct of “hegemony” came into use from the work of Gramsci (1971) as well as Hall, Lumley and McLennan (1977) and other critical theorists. The concept is actualized when those who are dominated are convinced by various means, including discourse, to accept their dominance as natural and expected and, in most cases the dominated begin to work in concert with their dominators without

protest. Building consensus, acceptance and legitimacy of dominance is one goal of discourse by those in power (Herman & Chomsky, 2002). “Power and dominance are usually *organized* and institutionalized” (Van Dijk, 1993, p. 255). The discussion list serves to socially construct an organization. At the same time, the discourse on the list institutionalizes the ideology of the list as an organization. The list members who are DSS officers are associated in the hierarchy of power. They enjoy the elite role of “planning, decision-making and control over the relations and processes of the enactment of power” (p. 255). As will be illustrated by texts from the list, the DSS officers are aware of and jealously guard their power over the students who come to them for accommodations.

“The process of hegemony works most effectively when the world-view articulated by the ruling elite is actively taken up and pursued by subordinate groups” (Mumby, 1987, p. 123). In Mumby’s (1997) interpretation of Gramsci, the hegemonic dialectic of power and resistance is performed as social actors compete “over interpretive possibilities and what gets to count . . . Hegemony *always* involves struggle over systems of meaning and the processes by which social reality is framed” (p. 364). Hegemony as described by Gramsci (1971) as a discursive creation. The dominator creates the hegemonic control of others by their talk, their text, and their semiotic representations. The defeat of hegemony, then, is achieved through the understanding and critique of the discourse within a system of power. To do this, the critic must understand the articulating practices employed to achieve hegemony. The discourse must undergo an analysis, an emergent inspection of text, in order to understand the processes of domination. The discursive constructions of social perceptions will disclose the methods by which the

dominant convince the subaltern that the system works in their best interest. Resistance by the dominated becomes a part of the discourse and is defeated through the use of “common sense” by the dominators. Thus the goal of the critical discourse analyst becomes the explication of how common sense is constructed and how it can be reconstructed as “good sense” that works towards equality.

The use of critical discourse analysis of the text residing in the archives will allow for the revelation of hegemonic discourse, if it indeed is present. The definition of what it means to do a critical discourse analysis of text in the pursuit of the social construction of power is best described by Fairclough.

By “critical’ discourse analysis I mean discourse analysis which aims to systematically explore often opaque relationships of causality and determination between (a) discursive practices, events and texts, and (b) wider social and cultural structures, relations and processes; to investigate how such practices, events and texts arise out of and are ideologically shaped by relations of power and struggles over power, and to explore how the opacity of these relationships between discourse and society is itself a factor securing power and hegemony (1993, p. 135).

Fairclough’s critical discourse analysis draws on Gramsci’s theory of hegemony while exploring the intertextuality/interdiscursivity in the text being analyzed. Hegemony resides in discursive control, the use of power to control what is said and who is allowed to speak (or produce text), and within the text itself. Hegemony is always in flux as power is gained and lost and the competition for power is imbedded in discursive practices. Discourse is the means to enact social change (Fairclough, 1992) though its

practice can bring about hegemony when it is used to bring about the subordination of identifiable groups.

The creation and sustaining of hegemonic power through discourse is a fluid process that is always being bolstered or attacked in the discourse community. Fairclough (2005) recognizes four processes of change. First, the *emergence* of new constructions of existing discourses which, in the process, become new discourses. What has been said is reflexively reconstituted as new ideas. Second, *hegemony* becomes a discourse as emergent social constructions are articulated and rearticulated. Third, *recontextualization* takes place as the hegemonic discourses are transmitted across structural boundaries (to other organizations) and scalar boundaries (global dissemination) and are recontextualized in the discourse of the recipients. Fourth, the discourse becomes *operationalized* as organizations enact the discourse on objects and properties of the physical world. Hegemony becomes concrete when it is hidden in the text of policy and practice.

When hegemony is complete, the agent achieves dominance. The definition of dominance by Van Dijk (1993) failed to include people with disabilities. "Dominance is defined here as the exercise of social power by elites, institutions or groups, that result in social inequality, including political, cultural, class, ethnic, racial and gender inequality" (pp. 249-250). Critical feminist theory also overlooks people with disabilities as a dominated group. Dominance for this critical discourse analysis is defined as the social construction of power and its use by individuals, institutions or groups that results in social inequality for people with disabilities. Dominance can be exerted through overt actions and by transmission of hegemonic beliefs, values or attitudes to others in power.

Research Questions

Based on this theoretical perspective, the questions addressed in this study were:

1. How are "mental illness" and "reasonable accommodation" socially constructed in discourse of online discussions about psychiatric disabilities?
2. Do specific discourse features provide evidence of the exercise of power in ways that stigmatize and/or limit access to equal opportunity for students with psychiatric disabilities?

Research Design

Disability service providers sometimes discuss their ideas about an accommodation of students with disabilities with other service providers on the Disabled Student Services in Higher Education - Listserv (DSSHE-L). The DSSHE-L discussion list serves 2,227 subscribers (L-Soft, 2006a). It will not be referred to as a "LISTSERV[®]" because the term is a registered trademark name owned by L-Soft. L-Soft actively monitors the use of its trademark and notifies sites and publications when there is a violation in the usage of the trademark (L-Soft, 2007). The DSSHE-L discussion list will be referred to variously as "list," "discussion list," "email list," or "electronic mailing list." DSSHE-L is part of the LISTS database.

The LISTS database only contains information about public lists. Confidential lists and lists of purely local interest are excluded from the searchable database. In order to appear in the LISTS database, the list must not have a "Confidential=" keyword in its list header (unless it reads "Confidential=NO", which is the same thing) (L-Soft, 2006b).

The DSSHE-L electronic mailing list allows the service providers to step outside their own thinking and social context and get feedback from other disability service specialists across the nation. Because DSS offices are separated by time and space, much of the disability discourse is realized through email texts. The conveyance of local structures and practices to the list, when examined as an intertextual whole, create and revise social practices of the audience. This exchange of ideas through the archived electronic mailing list allowed research into a genre of discourse that is normally not open to view. The thinking of individuals and the social influences on that thinking was open for examination.

Texts for this study were downloaded from the archives of the DSSHE-L electronic mailing list during the period of January 2001 through December 2005. The archive is organized by year and month and begins in October 1995, but for this analysis only the most recent five years were examined. Each month of correspondence is archived in a publicly accessible website. I went through each month's emails and selected any pertaining to mental illness in students. Most emails are clearly identified in the subject line, but some emails had to be opened and read to determine their subject. Each email was converted to an .rtf file so that it could be read by the computer program, Nvivo. The emails were loaded into Nvivo for analysis. A brief analysis of contributors determined there was a representative sample for every Carnegie classification of educational institutions.

The texts analyzed meet Fairclough's (2005) description of being both product and process. As a product, the messages on the list are stored in the archives, can be readily retrieved, and are, on occasion, cited and summarized by list members. The

“texturing” of list text can be understood as each message conveys information that reflects the writer’s social understanding which, when combined with other messages, socially constructs the meanings, attitudes, beliefs, and knowledge of the list as an organization. Without the list members’ constant structuring and restructuring of the organization through discourse, the organization known as DSSHE-L would cease to exist.

The hundreds of texts in this study have created multiple contexts. The definition of “contexts” by Gale (1999), best describe the contexts constructed by the emails written by list members from across the nation. Gale breaks the word “context” into its prefix and root word to determine its meaning in the study of discourse. Contexts “are ‘texts’ which are ‘woven together’ to form ‘connections’” (p. 399). The email texts, taken in their singular form, have very little meaning. But as a thread of discourse excites multiple responses, as these texts become “woven together,” they socially construct meaning. The ideologically informed discourses (Foucault, 1980) exert influence on policy as the contextual relations develop over time and space.

The intertextuality (Gee, 1999) of language in use demands the critical discourse analyst to, at the very least, consider the multiple contexts that precede and influence what becomes an utterance (oral or written). As Fairclough (1995) explained, text producers are subject to the “tension between repetition and creation” (p. 8). In the field of disability services, the reliance on legal text foreshadows much of the discourse. However, the idea that language constitutes and remodels social reality is performed anew with each utterance.

To address research question 2, I was most interested in power as expressed in the discourse. How people talk about the people who are subordinates to them helps to create beliefs and reveal prejudices (Van Dijk, 1984). In order to understand this, the social and cognitive aspects of language must be examined. Discourse analysis provides insights that go far beyond experimental data in revealing prejudice (Van Dijk, 1984). The richness of the data found in discourse analysis, says Van Dijk, makes up for the loss of experimental control.

Limitations

Part of the trustworthiness of this discourse analysis comes from the source of texts. By using archived texts, there is no opportunity for reactivity (Lincoln & Guba, 1985) between the researcher and participants on the list. This lack of interface does, at the same time, lead to one of the weaknesses of this study. Member checking was not possible. Intentionality could not be assumed. Without member checks, I could not assume that the writer intended the statement to mean what it appeared to mean. Future research may allow me to contact some of the discussants of the list because they are identifiable. At that time, I would be able to confirm with them the context and meaning of the statements I have analyzed. For the purposes of this study, however, the texts were taken at face value.

A strength of this study is that I have been a reader of the discussions on the list for five years before beginning the discourse analysis. This prolonged engagement with the materials being analyzed improves scope while persistent observation provides depth of coverage (Lincoln and Guba, 1985). Lincoln and Guba (1985) describe archived texts as "unobtrusive residues." The strengths that recommend their use are face validity and

they are noninterventional resources that are stable and nonreactive. However, the use of these residues leads to difficulty in establishing trustworthiness because they are heavily inferential.

Significance of study

The existing literature does not address how cultural beliefs of disability services personnel at colleges and universities affects the service provided to students with disabilities, and especially it fails to address cultural beliefs among these professionals about students with psychiatric disorders. This research contributes to the understanding of how mental illness is socially constructed through discourse shared by disability services personnel. Disability services policy is co-constructed through the discussion list based upon the shared text.

Researching issues that affect the student with psychiatric disability in higher education is of utmost importance. Anything that affects the way these students are served by disability services personnel should be understood and, in the case of adverse outcomes, necessary remedial steps should be explored. The National Comorbidity Survey (NCS) conducted by the Harvard School of Medicine (2005) provides statistics on the prevalence of psychiatric disorders in the United States. Kessler, Foster, Saunders, and Stang (1995) projected NCS data on school attrition. According to their projections, an estimated 4.3 million people did not complete college because of psychiatric disabilities. Currently this population represents 4.7 percent of the dropouts from higher education. Anything that can positively influence the education system that has failed them is to be applauded. The research I have conducted will begin to answer some of the

questions about the culture of disability services personnel who are there to help the disabled student.

The need for research into the DSSHE-L archives is particularly acute because the archives are often referred to by list members as the repository of answers and solutions about disability services in higher education. A critical discourse analysis of the discourse about students with psychiatric disabilities is relevant at this time. First, recent court cases have found colleges and universities enacting and engaging policies that violate the civil rights of students with psychiatric disorders. Even as this research was being done the courts were announcing findings that changed practices at colleges and universities. The practice of disciplining and expelling students because of the manifestation of their psychiatric disorder's symptoms has even caused the Virginia State Legislature (2007) to pass a law forbidding that practice. Second, the DSS officer has all the authority to grant or deny prescribed and requested accommodations. When all the power resides on one side of a relationship, the occurrence of hegemony is enhanced. Since hegemony is constructed through language, a critical discourse analysis is the best means to expose it. Third, best practices in education change over time. It is important, then, to analyze recommended practices from the archives which may be outdated and even illegal.

Conclusion

The vagaries of disability can make the job of the disability service provider very difficult. The list was created so that providers could share problems and solutions. It is through this sharing that reality is constructed. Discourse analysis allows a backwards look at what is being said and what it represents. It is important to disability service providers to be aware of any practice that leads to discrimination and prejudice. DSS

officials need to be conscious of the cumulative effects that their discourse has. By revealing stigmatizing thoughts and prejudicial talk in the emails of the list, this study may help these professionals learn to do an even better job of serving students with disabilities.

Definitions

Text: Language in use, either spoken or written. Text is a piece of language behavior which has occurred naturally, without the intervention of the linguist (Stubbs, 1983). For this project, the text comes from emails sent to the DSSHE-L list.

Email: Since email is a new genre of discourse, it is important to understand what email is. What email is, what it represents, is different according to its use. Communication sent via Internet, it has been described as letters by electronic medium (Spitzer, 2003) although in this case the emails are not as formal as a letter. Baron (1998) describes email as "speech by other means" (p. 85) and in 2003 declares that it is too early in its genesis to define. Email has been described as a combination of speaking and writing (Crystal, 2001; Yates, 1996), which fits the type of email found on the list.

E-style: Email has an "e-style" (Collot and Belmore, 1996; Ferrara, Brunner, & Whittemore, 1991; Maynor, 1994); it has developed a distinct language style that continues to evolve. Baron (2000) states, "email seems to be Janus-faced" in that it both resembles face-to-face speech and written text. An assumed informality about email messages is apparent in the text under examination in this study.

Disability: There is no clear definition of disability (Lollar, 2002). The very nature of disability creates problems in defining the term. People sharing the same diagnosis may exhibit markedly different symptoms. Complicating matters, U.S. agencies charged with

creating disability policy have differing standards for determining disability. As many as fifty variations that define what constitutes a disability are in use by United States government agencies (Lollar, 2002). As defined in Section 504 of the Rehabilitation Act of 1973, a person with a disability is someone who has a physical or mental impairment substantially limiting one or more major life activities. Examples of major life activities include learning, walking, hearing, and caring for oneself. The exact definition of a major life activity is not possible (Rehabilitation Act of 1973). Also found in the Act is the prohibition of educational exclusion of a person with a disability who is "otherwise qualified."

Hahn (1985) agreed that disability is defined by the policies set out by government entities, as "whatever policy says it is" (p. 294). Hahn outlined the problem that this creates for people with disabilities and for those who attempt to accommodate their needs. There is no clarity of problems or explicit rationales for action. Solutions are often based on guesswork due to the lack of clear definitions.

Critical Discourse Analysis: According to Fairclough (1995), critical discourse analysis can disclose the "connections between language, power, and ideology" (p. 1). Language for analysis will be defined as "communication using particular types of signs organized in particular types of units (e.g., sequences)" (Duranti, 1997, p. 69). For this particular case, language will be written text used to communicate via the Internet on a dedicated electronic mail list. One of the hallmarks of critical discourse analysis is that the research is not just about the language in use by members of an organization but is, first and foremost, an investigation of a social issue that is framed by discourse (Mautner, 2005). Chouliaraki and Fairclough (1999) expressed critical discourse analysis as originating

with “some perception of a discourse-related problem” (p. 60) which Fairclough (2003) reiterates as “beginning with a social problem” (p. 209). In the present case, the analyst has observed the social construction of disability services policies and practices through the DSSHE-L discussion list and will critically analyze the discourse that contributes to hegemonic meanings

Chapter 2

Review of the Literature

As explained in Chapter 1, college students diagnosed as having a mental illness present particular issues for campus services for students with disabilities. This chapter provides a background for understanding these issues. This review of the literature will cover 1) the medical and social constructionist models of mental illness; 2) the stigma of mental illness; 3) the fears that underlie others' stigmatization of persons labeled as mentally ill; 4) previous studies on college and university campuses; 4) the agents of social control that society places "in charge" of those with mental illness, and 5) the characteristics of computer mediated communication.

Mental Illness: Medical/Realist vs. Social Constructionist Models

What is mental illness? There are two competing answers to this question. Bruce (1999) defined mental illness using the medical model:

Psychiatry uses the term *mental illness* for a spectrum of syndromes that are classified by clusters of symptoms and behaviors considered clinically meaningful in terms of course, outcome, and responses to treatment (p. 37).

The medical model uses such terms as "symptoms" and "syndromes" to describe mental illness, for example:

Serious mental illness is based on having a diagnosable psychiatric disorder (based on criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association, 1994), lasting at least a year, and producing an

impairment significant enough to be considered disabling (Mowbray, et al., 2006, p. 227).

“The defining characteristics of the medical model is the assumption that mental disorder is a disease or disease-like entity with a physiological, genetic, or chemical base that can be treated through medical means” (Aneshensel & Phelan, 1999, pp. 6-7). The medical model of mental illness focuses on the disease that, much like physical illness, can be treated so that symptoms are diminished. Pathology creates the disorder that causes deviance and must be treated (Schur, 1979). This parallels the medical model of physical medicine, and brought with it the beginnings of public acceptance of those who treat mental illness as true doctors. The “fatal flaw” in the medical model for mental illness is that, “No demonstrable organic pathology has been established for most disorders” (Aneshensel & Phelan, 1999, p. 7). In other words, since most psychological illnesses have not been linked to physical cause, the medical model is described as a poor fit. However, it works for impression management for the general public. This separation of the physical illness from the mental illness is polarizing. People with most physical disabilities are not stigmatized as strongly as those who are diagnosed with psychiatric disabilities. As will be illustrated in the discourse of the discussion list, the understanding of mental illness and its treatment is very different than the disability services professionals’ understanding and treatment of students with physical disabilities. It is as though the service providers have achieved a level of comfort with the “seeable” disabilities that is lacking for the unseen disability of mental illness.

Why is this discussion of the medical model of psychiatric medicine important to those who carry the stigma of mental illness? Because the alternative, offered up in the

sixties and seventies, was that mental illness was a social myth. Mental illness was not a disease. The “antipsychiatry” movement insisted that mental illness was nothing more than socially unacceptable behavior that had been successfully labeled as a disease (Aneshensel & Phelan, 1999). Marking someone as diseased was more socially acceptable than the alternative because the antipsychiatry movement tended to blame the mentally ill person as personally responsible for their actions.

The argument about whether mental illness is a true illness or simply a social label raged through the world of psychology in the sixties and seventies (Corrigan, 2005). Labeling theory posits that there is nothing to confirm mental illness as a diagnosable disease. Rather, people’s behavior leads to being labeled deviant and that form of deviance has been chosen by society to be called “mental illness.” With this deviant label comes the stigma. Stigma leads to prejudice and discrimination. Eventually, the person labeled mentally ill is forced to accept the sick role and to continue to exhibit deviant behavior. Those who do not escape the stigmatizing mark have created such a strong impression of deviance that they must be set apart as “different.”

Sociologist David Mechanic (1972) disagreed with the idea that mental illness can be defined at all. He based his argument on the fact that the definition assumes that “normal” can be defined. “Attempts to define mental illness in some precise fashion have brought continuing disappointment. Although it is usually defined in terms of some deviation from normality, defining normality is not a simple matter” (Mechanic, 1972, p. 2). Mental illness is an assigned label. Someone does not have to be diagnosed as mentally ill for his or her behavior to be assigned a label. A person can be “marked” (Jones, et al., 1984) as mentally ill based on their public behavior.

The label of *mentally ill* can be formally attached to a person through the diagnosis of doctors or through court hearings. It can also be informally applied to someone due to aberrant behavior or because someone identifies a person as mentally ill. A person breaking the norms of behavior, of acting “crazy,” can be labeled as mentally ill even when the medical profession would not apply that diagnosis to them. Either way, the label carries with it the stigma of deviancy. A label defines the person socially. The label designates what kind of person someone is. Labels can be valenced for or against a person. When a label is negatively valenced, it designates deviancy; when it is positively valenced, it designates a person as normal and acceptable. A deviant is someone who violates the social norms while a “normal” person adheres to the behaviors that society demands (Link & Phelan, 1999).

Berger and Luckmann (1966) developed the idea that reality is socially constructed. As society changes, its reality is also changed. According to Schur (1979), deviance is a socially constructed product. What is deviant for one period of history may not be considered deviant subsequently as witnessed by the additions and deletions of conditions by the APA in the *Diagnostic and Statistical Manual (DSM)*. The meaning of deviance is assigned by society. Therefore, the stigma associated with a deviant act may lessen over time. Sometimes, however, the stigma for some deviance becomes so entrenched that it becomes stereotyped. Stereotyped beliefs, often false, can have real consequences for those who are the object of them. Consequences may be discrimination and prejudice by those sitting in judgment. If the object of stereotyping accepts the beliefs, it can result in self-fulfilling prophecy as their actions change to fit the stereotype. “Deviance-defining, quite simply, incorporates a tendency to construct ‘classes’ of

presumed deviators and to see all members of the class as being essentially alike in some special, distinguishing way” (Schur, 1979, p. 51). The mentally ill are thus grouped into a class of deviators.

Schur (1979) made the observation that “some people find other people or specific types of behavior offensive, threatening, troublesome, contemptible, disgusting, distasteful, or, on whatever ground, just plain unacceptable” (p. 6). When this finding is based on violation of social norms, the offender will be labeled as deviant. Deviants will often be dealt with in a “corrective” manner by punishment or treatment. Often the offender will be isolated as others attempt to avoid interacting with them. People with mental illness are deemed deviant and are frequently treated through segregation, often through hospitalization. The public may react to someone who is mentally ill by ridiculing them, regarding them as less than, or banishing them from social standing (Schur, 1979). Those people so treated may then feel degraded and stigmatized. If these feelings are accepted by the stigmatized person, they may view their life chances as limited and, in turn, become self-limiting.

As more research on the brain has been done, as more psychotropic drugs have successfully treated depression and schizophrenia, the antipsychiatry movement has been quieted. That is a good thing since the antipsychiatry movement meant that those who suffered from mental illness could not explain their behavior as caused by disease. Thus, the stigma of being mentally ill that was worsened by the personal responsibility the antipsychiatry movement forced on the mentally ill was somewhat improved. For purposes of this study, I take the position that mental illness is a medical reality that can be diagnosed and treated. However, the way that people react to and stigmatize the

mentally ill is a socially constructed dimension. It is this social construction of mental illness that will be examined in the words of the disability services professionals.

Mental Illness as Stigma

Sociologists have used the concept of stigma to describe one way of constructing and reacting to deviance. In *Social Stigma: The Psychology of Marked Relationships*, Jones, et al. (1984) came up with the term “marked” to designate the process whereby someone becomes stigmatized. The conditions under which a person may choose to mark someone else are simply the perceived or inferred belief that the person is violating social norms. However, they stress, the decision can be made that the violation of norms is not severe enough to deserve a mark, so some people who might be labeled mentally ill can escape the mark or stigma. Successful treatment does not necessarily alleviate the stigma of mental illness (Link, et al., 1987; Jones, et al., 1984). The enduring stigma that the mentally ill label attaches can lead to public rejection. The mentally ill learn to expect rejection, leading them to act in self-isolating ways (Link, 1987). This behavior can last beyond recovery. Goffman (1961) calls this self distancing as secondary deviance.

The stigma of mental illness will influence the educational experience of students with psychiatric disabilities (Becker, Martin, Wajeeh, Ward, & Shern, 2002; Belch & Marshak, 2006; Blacklock, Benson, & Johnson, 2003; Eudaly, 2002). The label of mental illness brings with it a stigma of deviancy. The stigma of mental illness outweighs the stigma of physical disability. In a test of how much stigma was connected to mental illness or physical disability, Piner and Kahle (1984) consistently found that participants who interacted with the people labeled as mentally ill ranked them as less capable in a task than the people with visible physical disabilities.

According to Kleinman, Eisenberg, and Good (1978) illness is a normative experience that is directly cultural. There are culturally approved ways of being ill. Psychiatric illness falls within this normative experience. The belief in a diagnosis and the treatment are both affected by the cultural understanding of the illness. In some cultures it is not believed that psychiatric disorders can be responsible for the way the patient feels. Everything is explained by some physical cause. In some cultures psychiatric disorders are so stigmatized that they are usually dealt with through somatic complaints and managed through the intervention of a native healer. Cultural differences will affect the perception of psychological illness as well as how the sick person should be treated. The cultural beliefs of the DSS official will affect the way they deal with students with psychiatric disabilities.

If mental illness is looked at as a socially constructed reality, there must be agreed upon markers that set persons with mentally illness apart as deviant. Corrigan (2000) found four behaviors that social attribution linked to identifying mental illness. Someone exhibiting the symptoms of psychiatric illness is labeled mentally ill. In some cases of deficit social skills, such as avoiding eye contact, a person may be marked as deviant even though avoiding eye contact may be an accepted cultural behavior showing deference. A common marker found among the homeless is bizarre and inappropriate physical appearance. And the fourth social attribution of mental illness is the label attached by others, such as a diagnosis. The severely mentally ill may be marked by all four of the attributes. When the mentally ill are able to conceal the discrediting marks of their illness, they can sometimes avoid the stigma. It depends on the individual to conceal the four social attributions (Corrigan, 2000) of mental illness.

The general public believes that the mentally ill should be kept at a distance because they are perceived as dangerous. Two studies by Link, Phelan, and associates in 1999 found this to be true (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). The studies were embedded in the 1996 General Social Survey. Ninety vignettes were created with varied nationality, education level, type of mental illness, or sex. Questions about the vignettes included perceived cause of the mental disorder, how dangerous the mentally ill person was, and a measure of social distance. Regardless of the portrayal of the mentally ill person in the vignette, the response was one of social distancing and avoidance.

Public stigma refers to the social distancing done to the mentally ill. Rejection and discrimination because of the label of mental illness leads to stereotypes. Opportunities in employment, housing, and social interaction can be denied. This can take place through formal means, such as psychiatric hospitalization, or informally, such as social distancing by the public (Corrigan, 2001). In a study conducted by Desforges, et al. (1991), the effects of interacting with someone labeled as mentally ill were investigated. Subjects were given a written description of the other participants in the study. The description included the information that certain participants had suffered from mental illness in the past. Part of the participants had an interaction with the labeled participants and part did not. Overall, there was an increase in positive regard for the labeled participants who had interactions with the research subject.

A research project aimed at investigating if labeling leads to stigmatization was done by Link (1987). Link found that even in the complete absence of any behavior commonly connected to mental illness, people were ready to stigmatize the mentally ill

simply because they had been told the test subjects were mentally ill. This research showed that a label alone is sufficient to cause stigma. Being stigmatized can cause the labeled person to behave in a manner that confirms the label as accurate. What is clear from this research is that continuing stigmatization makes life much more difficult for the mentally ill.

Research by Jones, et al. (1984) found that people with mental illness are sensitive to being stigmatized and will go to great lengths to avoid it. People who have been hospitalized for mental illness can be stigmatized if the community learns of the hospitalization. People who have been diagnosed as mentally ill can be stigmatized by the diagnosis. Moreover, people who behave “as if” they are mentally ill can be stigmatized by the community. In fact, there does not have to be any aberrant behavior, just the report of mental illness, for the stigma to attach. Therefore, most people with stigmatizing conditions will work to conceal the condition. Jones, et al. (1984) found that concealing the fact of hospitalization or diagnosis of mental illness was the first choice of patients. Avoiding stigmatization allows the person to move about socially and to enjoy the treatment of a “normal” person. Behaviors toward individuals marked with the mental illness stigma can be awkward for all involved. Numerous studies that looked at social interactions between the mentally ill, even those identified as former mental patients, and others showed the probability of poor communication. The “normals” were “tense, cautious, and find the experience unpleasant” (Jones, et al., 1984, p. 32).

One of the problems with being labeled as an “other” is that it can be difficult, if not impossible, to shed the label. The stigma that attaches to a person is placed there by society. Society tends to believe that once a person is marked by a mental illness, they

will always be marked. “The community’s feeling that deviant persons cannot change, then, may be based on a faulty premise, but it is repeated so frequently and with such conviction that it eventually creates the facts that ‘prove’ it correct” (Erikson, 1967, p. 302). As studies discussed in this paper support, people with mental illness are perceived as more unpredictable and dangerous even after successful treatment. Successful treatment does not remove the stigma.

Jones, et al. (1984) found that people believe that relapse for mental illness is to be feared and expected. The community does not necessarily know what this relapse may look like so much is left to the imagination. This expectancy of relapse serves to reinforce the stereotype of mental illness.

Stigma also harms society and those in it. It promotes injustices which undermine some of the basic assumptions of a community. It robs society of an important resource: persons with mental illness who could be gainful members of the neighborhood. Stigma perpetuates personal fears of all citizens about becoming mentally ill and losing control (Corrigan, 2005, p. 23).

Perhaps the greatest fear of mental illness that people have is the fear of losing control.

One of the strains placed on relationships with the mentally ill because of stigma is the expectation of different behavior. The general public tends to regard anyone so labeled as highly unpredictable. This expectation is always at the back of people’s minds (Jones, et al., 1984). This can be frightening to someone who only knows the stereotypes about mental illness. It is disruptive to forming a relationship and it “typically invites rejection and avoidance” (Farina, as cited in Jones, et al., 1984, p. 47). Henry Steadman, a researcher and administrator with the New York State Department of Mental Health,

believes the essence of stigma is fear. It is the fear of threatening behavior, even when nothing indicates danger. “Investigations of a variety of blemishes have shown that the more dangerous the possessor is thought to be, the more rejected he or she is” (Jones, et al., 1984, p. 65). This can lead to fear of people who act out their illness in public (Penn & Martin, 1998). Because many of the behaviors of the mentally ill, such as talking out loud, do not respond to treatment, advocates for the mentally ill find it difficult to change society’s view of psychiatric patients. Schizophrenia is one psychiatric disorder that has bizarre behavior as a symptom.

Educating the public that such behavior does not need to be feared does not lead to acceptance. The fear remains (Penn, Guyan, Daily, & Spaulding, 1994), because the behavior is a discrediting mark (Goffman, 1961, 1963). According to Corrigan, et al. (2001), advocates have had varying degrees of success in combating stigma. They have used protest of differential treatment, education about mental illness, and contact with interaction as means of changing attitudes. In their research of the efficacy of these means of change, Corrigan, et al. (2001) used the three methods of advocacy—protest, education, and contact. Participants in the study were either assigned reading materials or direct contact with people who had recovered from mental disorders. Stigma was highest in the two groups who read the educational and protest materials. Interaction with recovered mentally ill persons resulted in less stigma. This study supported the findings of earlier research on reducing stigma (Dichter, 1992; Dickstein & Hinz, 1992; Fink, 1986). The following sections examine some of the fears that the stigma of mental illness may arouse among others on college campuses.

Fear of Danger or Violence. Perhaps one of the most damaging stereotypes about people with mental illness is the belief that they are or may become dangerous, and thus threaten the community. Repeated studies of the general public's belief that the mentally ill will probably be dangerous found that as high as 75% have this belief (Corrigan & Cooper, 2005). This is an increase over the past forty years. That this belief is built on reported instances in the media only serves to magnify this belief. As there are fewer institutions to care for the severely mentally ill, the criminal justice system is called on to handle them and public displays of mental illness are reported by the media.

In a briefing paper published by the Treatment Advocacy Center (n.d.) the stigma of violence by the mentally ill is discussed. "The public's association of mental illness with violence is a major cause, probably *the* major cause, of stigma against mentally ill individuals" (p. 1). In a study of university students it was found that there was a sense that the mentally ill were dangerous and therefore greater social distance should be kept (Penn, et al., 1994). This was found to be particularly true except in cases where the university student had prior contact with someone diagnosed as mentally ill. Another university study found that simply reading a newspaper account about a violent act by a mentally ill person caused negative attitudes and greater social distance (Thornton & Wahl, 1996). As the years pass, it has been found that the general public expects violence from the mentally ill in greater numbers. A 1996 survey found that 61 percent of the general public expected schizophrenics to do "something violent to others" (Pescosolido, et al., 1999).

Using a series of vignettes about the mentally ill, Link, et al., (1987) manipulated the variables of mental illness labeling and aberrant behavior. The results of their study

were that the public reacted more strongly to the mental illness label than to described behaviors. A subsequent study replicated the results (Link, et al., 1999). Another researcher argued that a label is only a temporary stigma and it is the aberrant behavior of the mentally ill that causes the public to avoid contact (Gove, 1975, 1982). Research has drawn a connection between substance abuse and violence by the mentally ill (Mulvey, et al., 2006; Steadman, et al., 1998; Swanson, Holzer, Ganju, & Jono, 1990). One group of researchers found such a strong connection that they declared the idea of violence by the mentally ill is fixed in the thinking of the general public (Mulvey, et al., 2006).

The reporting of mass media promotes stereotypes of the mentally ill (Wahl, 1992, 1995). Stereotypes of violence and unpredictable behavior are supported by news stories that focus on the dangerousness when the mentally ill commit violent acts. Wahl reported that when television did not portray the mentally ill as violent criminals there was still a devalued illustration. The media showed the mentally ill as childlike, incompetent, and unable to take care of themselves. Often they pictured the mentally ill as seedy in appearance. Individuals were held at fault for their disorder and unlikely to recover from their illness. “Both personal experience and media exposure might serve to elicit classical conditioning effects that foster prejudice against people with mental illness” (Ottati, Bodenhausen, & Newman, 2005).

A review of newspaper coverage of mental illness in large U.S. newspapers over a six week period in 2002 found that the stories were a common source of stigmatizing information (Corrigan, Watson, Gracia, Slopen, Rasinski, & Hall, 2005). A variety of mental illness topics were covered with 39 percent of the stories focusing on violence and danger committed by the mentally ill. Stories about the dangerousness of mentally ill

people were found in the front page section of the newspapers. Both print and film media have been blamed for causing stigma and discrimination against people with mental illness. Angermeyer and Matschinger (1995) found that reports of violent attacks on innocent people increased stigma against the mentally ill. The general population reported a desire for increased social distance that did not diminish very much over time.

In an experiment at a university, the volunteers read newspaper articles about the mentally ill and incidences of violence (Thornton & Wahl, 1996). This brought about a marked increase in negative attitudes about mental illness. According to Steadman (1981) it is futile to try to change attitudes about mental illness unless something can be done to address the violence. The reports of violence provide the facts that people use to support their thinking. The stigma will remain as long as violence continues to occur.

The data suggests that public education programs by advocates for the mentally disordered along the lines of 'people with mental illness are no more violent than the rest of us' may be doomed to failure. . . And they should: the claim, it turns out, may well be untrue (Monahan, 1992, p. 521).

Newspaper stories about the mentally ill were used in a study of adolescents' perception of dangerousness. High school and middle school students aged 13-18 were randomly given newspaper stories about the mentally ill. Half the students were given a story about the mentally ill committing violence. The other half were given stories that factually talked about mental illness. The group that read about violence were much more likely to describe the mentally ill as dangerous, even weeks later. Neither group of students wanted to interact with someone labeled mentally ill, indicating that the students

were stigmatizing and wanted to keep a social distance (Dietrich, Heider, Matschinger, & Angermeyer, 2006).

However, the generalization that all mentally ill persons are violent is false (Mulvey, Odgers, Skeem, Gardner, Schubert, & Lidz, 2006). It is estimated that probably no more than five percent of reported violence occurs due to severe mental illness (Walsh, Buchanan, & Fahy, 2002). The U.S. Department of Justice estimated that in 1993 the total number of homicides by the mentally ill in the United States were 1055 of the 24,530 homicides across the nation (Dawson & Langan, 1994). Attempts to reduce stigma in mental illness are proving ineffective. Efforts to reduce stigma by educating the public about mental illness do not work (Corrigan, et al., 2001). These education campaigns fail to address the constant reporting of violence by the media.

Noncompliance with Treatment. Another common fear leading to stigmatization is that persons with psychiatric disabilities will “go off their meds.” The MacArthur Foundation studied psychiatric patients who were compliant with the medication regime (Steadman, et al., 1998). For the patients who did not use alcohol and did not abuse drugs the incidence of violence was no higher than that of the general population where they lived. It is not possible to draw a strong conclusion from this study, however. The inner city where the study took place was a high crime area. Also, the researchers excluded from the study any patients with a history of violence.

Taking antipsychotic medicine as prescribed has long been associated with lower incidences of violence (Grunberg, Klinger, & Grumet, 1978; Sosowsky, 1980). The results of a study by the Epidemiological Catchment Area (ECA) during the late 1990s found that the seriously mentally ill, and especially those using drugs or alcohol, were

less compliant with prescribed medications unless they were seen by their doctors on a regular basis (Swanson, et al., 1997). Another study conducted on inpatient schizophrenics found that the higher the blood level of antipsychotic medication the lower the incidence of violence (Yesavage, 1982).

Fear of Suicide. The possibility of suicide for people with psychiatric illness is very real. The institution's administrators and the professionals who operate disability services offices at colleges and universities are concerned that students with a diagnosis of severe mental illness might harm themselves. According to Mowbray, et al. (2006), the instances of suicide attempts for college students are higher than that of the same age group who do not enter higher education. However, other studies find that the rate of suicide attempts and completions are both overstated. Treatment has a large effect at curbing suicide attempts. In a study of schizophrenics who did commit suicide it was found that 78 percent had psychotic symptoms that were untreated at the time suicide was successful (Heilä, Isometsa, Henriksson, Heikkinen, Marttunen, & Lonnqvist, 1997). A similar study found that of schizophrenics who made serious suicide attempts a reported 81 percent were actively suffering psychotic symptoms at the time of the attempt (Nieto, Vieta, Gasto, Vallejo, & Cirera, 1992).

Sometimes it is inadequate treatment including miscalculation and lack of clinical follow-up that leads to suicide attempts (Appleby, Dennehy, Thomas, Faragher, & Lewis, 1999; Roy, 1982). On some occasions it was the patient who failed to take prescribed medications and avoided clinical care (DeHert, McKenzie, & Peuskens, 2001). The tendency to act out suicidal impulses may be linked to a family history of suicide, a prior

history of suicide attempts, and/or comorbid alcohol or substance abuse (Mann & Currier, 2006).

The threat of suicide among people with severe mental illness carries a stigma. In research of care providers who attended patients who attempted or completed suicide, McGaughey, Long, and Harrison (1995) found attitudes that ranged from studied indifference to fear of patients who were suicidal. It was reported by survivors of suicide attempts that medical staff would ignore them, leading to feelings of isolation (Pompili, Mancinelli, & Tatarelli, 2003). This stigma would lead patients to reattempt suicide.

“Suicide ideation, defined as plans and wishes to commit suicide and as self-reported thoughts of engaging in suicide related behavior, is common in young people” (McAuliffe, Corcoran, Keeley, & Perry, 2003, p. 160). According to the National College Health Risk Behavior Survey (Center for Disease Control, 1997) 10.3% of surveyed college students admitted seriously considering suicide with 6.7% of the students having planned a method. Duane, Stewart, and Bridgeland (2003) researched suicidal ideation of college students. In the two years they investigated they found that more than one-third of the undergraduates sampled had thought of suicide within the last year. More than a quarter of the respondents had made specific plans outlining how they would execute it. Of the 965 respondents in 1992, 29 students made attempts on their lives. Out of the 1535 respondents in 1998, 79 attempted suicide. There was no attempt in the study to measure mental illness in the students. In a study conducted at a large U.S. university it was found that over half of the subjects had thought about committing suicide (McAuliffe, et al., 2003). However, the study found that ideation alone is not a good predictor of attempt at suicide. There was a greater likelihood of suicide attempt when the subject believed that

suicidal behavior is normal, there is a right to die, and a plan has been made. The study failed to correlate poor problem-solving skills with suicide attempts. It is unclear whether poor problem-solving skills are the consequence of suicidal ideation or the opposite.

One thing that the literature confirms: a more comprehensive effort to prevent college-aged suicides needs to be made by colleges and universities (The Jed Foundation, 2005). In a 2002 report, the National Mental Health Association and The Jed Foundation estimated that 1,088 student suicides are occurring annually on college and university campuses in the United States. It is estimated that the number of diagnosable mentally ill will only continue to grow on college campuses, which implies that suicide on campus will also increase. However, different longitudinal research argues that attending college may lower the incidence of suicide of traditional college-aged students. In a ten year study of Big Ten schools it was found that college students commit suicide at a much lower rate than the same age group who are not in higher education. In a comparison of student suicide rates with a sample of similar age, race and gender the “Big Ten Student Suicide Study” (Silverman, Meyer, Sloane, Raffel, & Pratt, 1997) found a student suicide rate of 7.5 per 100,000 compared to the national rate of 15 per 100,000.

Research on College and University Campuses

A limited number of previous studies have focused on students with psychiatric disabilities. News reports and legal analyses have also examined institutional responses to student suicides or the possibilities of suicides.

Students with Psychiatric Disabilities. Drawing on her prior research (Unger, 1993) about students in higher education with psychiatric disabilities, Unger (1997) reported the demographics of the “typical” student who is returning to higher education

after quitting due to psychiatric concerns. The description of these returning students put them in the nontraditional student profile. The student is:

- male or female
- about 35 years of age
- unmarried
- about 85 percent will have spent an average of almost a year in the hospital, beginning at about age 20
- they will have been hospitalized an average seven times
- about 85 percent will be on psychotropic medication
- diagnoses are primarily schizophrenia, major depression and bipolar disorder (Unger, 1997, pp. 85-86).

These returning students will have different psychosocial needs than their younger cohort. They may exhibit delayed developmental growth that can be remedied through participation in higher education. They may be more insistent about what accommodations they think they need. They may be on the road to recovery. Unger (1992) reports that 50 to 70 percent of people diagnosed with a psychiatric disorder will recover, which flies in the face of stereotyped images of the mentally ill.

Symptoms of psychiatric disability can directly or indirectly affect the student (Ekpone & Bogucki, n.d.). Thinking skills, especially memory, can be impaired from the symptoms of the disease or as a side-effect of medications. Some students will exhibit poor judgment; knowing the correct course load to carry or knowing when to withdraw from classes may be difficult for a student to determine. Concentration and information processing skills may be impaired making it difficult for the student to read or write.

Study skills may be inadequate and be complicated by poor organization skills.

Motivation to attend class, complete assignments, and interact socially can diminish due to an exacerbation of the illness. Soyden (1997) and Mancuso (1990) list other activities a person with psychiatric disability may have trouble doing. Environmental stimuli may become overwhelming due to the inability to screen out extraneous sound and movement. Stamina may be lower from both physical and mental strains. Responding to negative feedback on coursework may be over personalized and taken as an attack. Change in routine can disturb the student. Souma, Rickerson, and Burgstahler (2001) add that side effects of medication can cause academic difficulties. Also, some students will exhibit severe test anxiety or fear of authority figures. All of these problems can be mitigated by the correct academic accommodations and mental health support (Mowbray & Megivern, 1999; Unger, 1993).

Ekpone and Bogucki (2006), after referencing the works of Brinkerhoff, McGuire, and Shaw (2002), Taymans, West, and Sullivan (2000), and the Center for Psychiatric Rehabilitation (2002), list possible academic accommodations that might be warranted based on the specific needs of a student. Academic accommodations closely follow the accommodations given to students with physical disabilities. Other than anecdotal reports of the usefulness of these accommodations, I could not find any empirical studies supporting the efficacy of such accommodations. Weiner and Wiener (1996) conducted a needs assessment through interviews with 24 university students who had psychiatric disabilities. The need for academic accommodations to address education issues along with the need for having a one-to-one relationship with a mental health counselor was consistently reported as helpful. In serving the student with a psychiatric

diagnosis it is important that the disability services professional separate treatment issues from accommodation issues (Unger, 1992). The disability services professional should not take on any treatment related issues. Treatment, whether it is mental health counseling, medication compliance, or crisis intervention should be referred to campus or community counseling centers, psychiatrists, or hospitals.

The 2003 research of Blacklock, Benson, and Johnson found that there are five barriers that students with psychiatric disabilities confront in higher education. Blacklock, et al. conducted 39 focus groups with college and university disability service providers and students with psychiatric disabilities who were receiving services. There was a clear consensus from all 39 focus groups that stigma and stereotypes negatively affected the treatment of students who revealed their psychiatric diagnosis. Students reported that managing symptoms while performing to their potential was an ongoing struggle. Limited or inaccessible mental health resources on campus or in the community made continuing care a problem. Inadequate sources for information about psychiatric disabilities and ancillary services presented a barrier to both disability services personnel as well as to the students. The fifth barrier that was brought up by both students and disability services personnel was the difficulty of coordinating support services on campus and in the community.

Research on educational attainment in higher education has proven the benefits of successfully completing a program of study. The lifelong advantages in employment and earnings are well documented (Astin, 1993/1996) as well as the increase in social prestige (Pascarella & Terenzini, 1991/1996) and improved overall well-being (Haveman & Wolfe, 1984). All of these assets acquired through higher education are pointed out by

Mowbray & Megivern (1999), who investigated how supported education would allow students with psychiatric disabilities to reap the rewards of successful completion of higher education degrees or certificates. Mowbray and Megivern concluded that most of the barriers to higher education reported by students with psychiatric disabilities were “technical problems” that could be addressed through supported education. Unger (1993) has shown that supported education is possible utilizing existing community resources including mental health counselors, vocational rehabilitation offices, and disability services offices on college campuses. The literature endorses the idea that a student with a psychiatric disorder can succeed in higher education when given the proper support. The work of disability services personnel is a vital part of what these students need.

Student Suicide. The constraints of federal and state laws concerning confidentiality for student records complicates the handling of students expressing suicidal intent or exhibiting signs of suicidal behavior (Ellen, 2002). The media has given a lot of attention to the litigation involving colleges and universities resulting from the school’s treatment of suicidal students. Ellen supports the establishment of policies for disclosure, even when the student forbids it, so that the necessary lines of communication are open across campus offices when a student exhibits the signs of severe mental illness.

The concern of school personnel and administrators that a student will commit suicide on their campus has led some to summarily dismiss the threatening student. This action may lead to the litigation that the school is hoping to avoid. Colleges and universities do not bear a legal liability from student suicides in most cases, based on legal precedence set in the case of *Jain v. State of Iowa* (Pavela, 2006). A more recent case of parents of a decedent suing the school is *Shin v. Massachusetts Institute of*

Technology (MIT) where the Massachusetts Superior Court issued a summary judgment against the school's counselor and administrators in 2005 (Baker, 2005; Pavela, 2006). In the *Shin* case, the student had established a relationship with administrators and mental health counselors on campus who knew of the student's suicidal intent. No one communicated with the parents and no one took the necessary steps to secure the student's protection against self-harm. The court declared that a "special relationship" existed between the student and the school personnel that required the duty to protect the student.

Relevant to this study, it is not too far to reach to suggest that a special relationship may exist between disability services personnel and the students they serve. The student provides their medical records to the disability services office in order to receive accommodation. In the case of students who have a psychiatric disorder the disability services personnel would be aware if the diagnosis includes suicidal ideation. The office of disability services may be contacted by the student, by student affairs staff, faculty, roommates, or administrators who are aware of a student's dangerous mental state. This awareness of medical history combined with an awareness that the student is headed towards suicide could be interpreted by the courts as a special relationship and create the affirmative duty to care. The suicidal student requires a system-wide response and this requires the system to be in place before there is a need. According to Lake and Tribbensee (2002) it has been long recognized that mental health professionals have the specialized knowledge to recognize and respond to suicidal patients. "It appears that courts sometimes equate special knowledge and experience in this field with a type of control sufficient to impose a duty to prevent suicide" (p. 133).

A problem expressed by college administrators is the restriction of communicating with a student's parents or guardians when a student is in danger. The federal regulations of HIPAA, the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. §1320d) which governs the disclosure of medical records, and FERPA, the Family Educational Rights and Privacy Act of 1974 (20 U.S.C. §1232g) which protects the privacy of education records, sometimes serves to prevent anyone at the school from contacting parents of a suicidal student. However, as Baker (2005) pointed out, FERPA has an exception to confidentiality and allows disclosure of education records to "appropriate parties" where "knowledge of the information is necessary to protect the health or safety of the student or other individuals" (FERPA regulations, 34 C.F.R. 99.36(a) as cited by Baker, p. 517). Baker was unable to find any court decisions that clarified FERPA's disclosure exception. FERPA has an additional general exception to disclosure that applies to financially dependent students as defined by the U.S. Internal Revenue Service (FERPA regulations, 99.31(a)(8) as cited by Baker, p. 518). Even with the exceptions allowed under FERPA regulations there is still the possibility that HIPAA regulations would prevent disability services personnel from disclosing information that may be deemed medical records. Each college or university must also take into consideration local, state and federal laws before breaking confidentiality with the student. Therefore, it is recommended by Baker (2005), Lake and Tribbensee (2002) and Pavela (2006) that schools establish their procedures and a system-wide response to suicide before a situation occurs. That would allow legal counsel, administrators, disability services personnel, student affairs staff, campus mental health professionals, and faculty the opportunity to meet any duty to care. Lake and Tribbensee (2002) warn

that colleges and universities must establish well-thought policies that will stand up to legal scrutiny. “The law has remained relatively protective of institutions of higher education in cases of student suicide. Current legal trends strongly suggest that those protections will begin to erode in the next decade or so” (p. 157). The *Shin* case may be the first indication that erosion has begun.

Regardless of the perceived risk of allowing a suicidal student to remain in class and on campus, Hoffman and Mastrianni (1992) argued that mandatory withdrawal from school or forced medical leave is unproven in psychological benefit for the student and should be considered in only the most severe cases. It appears from recent actions by the courts and by the Virginia State Legislature that summarily dismissing students who express suicidal ideation or who make attempts violates several laws. This matter will be covered in the Findings chapter as the discourse regarding “counseled withdrawal” is analyzed.

Agents of Social Control

Stigma from mental illness also attaches to the people who treat the mentally ill (Persaud, 2000). Research into the attitudes of patients toward different types of doctors found that psychiatrists were stigmatized by their relationship with the mentally ill. Until late in the twentieth century psychiatrists were not considered “real” doctors (Aneshensel & Phelan, 1999). They and their profession were treated as stigmatized much like those they treated. One of the efforts the psychiatrists and psychologists made to answer these critics was to make the profession mirror that of medical doctors. From this effort came the medical model of mental illness.

Erikson (1967) defines deviance as “a sociological phenomenon of control.”

Those who label an individual are the audience that observes behaviors. Those who would be named deviators have done something so outside the norm that a social control agency must do something about it. Social control agencies can be formal, such as the law or a psychiatric hospital, or can be informal, such as community members joining together. Deviance is not strictly based on continuing the behavior but is conferred upon individuals by the audience as an indelible mark. The individual labeled as deviant does not have the power to influence the audience. It is the audience who gets to determine whether any given behavior is to be labeled deviant.

The labeling and stigmatizing of people with mental illness could not occur without someone with power designating them. Schur (1979) called these powerful people control agents. Control agents can have formal, legitimate power such as the doctor who gives a diagnosis or the court officer who hands down a judgment. Family members or employers can also be agents of control. Agents of control decide what, if anything, will be done about the mentally ill patient. Their motives for action come from professional objectives or personal caring. Because agents of control are part of the greater social network, they may be acting in what is deemed public interest (Schur, 1979). DSS officers, through their power over the students they serve, are agents of control.

Social control agencies that handle deviants are the institutions with the social authority to take control. For the mentally ill, these agencies might be the psychiatric hospital or the judicial system. There are some sociologists who insist that these agencies

of control are self-perpetuating (Corrigan, 2005). The argument is that as long as these institutions exist, there will be people judged deviant and in need of these services.

Social psychological theory holds that when members of a majority group are introduced to members of a minority group and the exchange is positive then discrimination and prejudice are reduced (Allport, 1979). Professionals who work closely with the mentally ill should have less prejudice than the general public. However, research has found that some professionals are paternalistic and this leads to coercive treatment strategies (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). When the professional holds a benevolent attitude there is a marked decrease in stigmatization. Pity, however, is likely to cause increased prejudice and discrimination (Corrigan, et al., 2001; Corrigan, et al., 2002). There was an increase in pity for the victim when the biological causes of mental illness were the focus (Corrigan, 2002). Weiner (1995) found that when the mentally ill person was viewed as a victim who had no control of their symptoms there was a higher likelihood that help would be offered. This conclusion was supported by the findings of Corrigan, Markowitz, Watson, Rowan, and Kubiak in 2003. However, it was not always in the best interest of the patient when pity motivated response. Patriarchy and infantilization were often the result of pity for the victim (Corrigan, et al., 2003). Revictimization of the mentally ill occurred when family members and the general public were operating from pity (Brockington, Hall, Levings, & Murphy, 1993; Madianos, Madianou, Vlachonikolis, & Stefanis, 1987).

Disability services personnel use the medical model when deciding whether a student qualifies as disabled by mental illness. The diagnosis of mental illness must be based on the *Diagnostic and Statistical Manual of Mental Disorders* (American

Psychiatric Association, 2000) or the *International Classification of Diseases Manual, Tenth Edition (ICD-10)* (World Health Organization, 2004). For mental illness to qualify as a disabling condition eligible for accommodations it must have a diagnosis based on this medical model. However, in determining appropriate accommodations, the disability service providers often discuss particulars of a case via the electronic mail list. This discussion helps to build a socially constructed image of the student's mental illness. How a student's case is portrayed in the discussion helps to create the way the student is viewed as deviant. Deviance is socially constructed (Schur, 1979) and for the disability services professional the electronic mailing list provides the opportunity to mark (Jones, et al., 1984) the mentally ill student as deviant.

Computer-mediated Communication

This study is an analysis of computer-mediated communication among disability services professionals on college or university campuses across the United States. Researchers have become interested in studying computer-mediated communication. The bulk of the research centers on the quantity of emails exchanged by computer users. Educational researchers have studied how online communication is useful in the classroom. Anthropologists have investigated the social meanings of computer-assisted communications. Sociologists have examined the construction of community through the use of the Internet. This review of the literature will focus on computer-mediated communication as it is useful to electronic mailing list members.

Anthropologists have taken a strong interest in the use of computers for personal interactions. In a review of the literature regarding anthropological research into virtual communities and communicative practices, Wilson and Peterson (2002) concluded that

the text and media broadcast through the Internet holds promising new areas of research. They suggested that the Internet produces a cultural product that anthropologists and researchers from other fields should continue to study. In a study of online interactions (Cook, 2004), remarked that online communications not only produce social constructs but are also reflective of political and economic relations of participants. Using anthropological models of study will “advance our understanding of the interconnections and situatedness of language, new technologies, global media, and social change” (Cook, 2004, p. 103).

Linguists are undecided about whether email is writing, speech or a new mode of communication. Sproull and Kiesler (1986) noted that there are some features of both writing and speaking in computer mediated communication. An email is transmitted quickly, like speech, but is text-based like writing. The fact that email tends to be asynchronous also is like writing. Baron (2000) contended that it is too early to assign an identity to the use of language in email. It may become a distinct, recognizable genre of communication. Emails also tend to be brief and to the point, which is similar to speech. In research about the use of language in computer-mediated communication, Crystal (2001) found that emails were usually written to fit the screen with 70% of the messages analyzed being 16 lines long or shorter. Crystal also noted that personal emails tended to be shorter than institutional emails.

“Talk is epistemic” (Deetz, 1982, p. 133) and on the electronic mailing list the act of knowing is produced by each posting, whether it is produced by the writer or reader. At first glance, the epistemology of computer mediated communication (CMC) appears to be one of transmitted and shared knowledge. The production of knowledge occurs as

the writers build a thread of conversation around a topic. Then the archived text produces a corpus of knowledge that defies both space and time. In Deetz's (1982) synopsis of Ricoeur's work, the inscribed (and in this particular case, the archived) text has resilience over time and may be reread at will, showing a perseverance of ideology. However, the distinction between a speech event and inscribed discourse blurs in CMC that is archived. The poster is self-referenced like the participant in a speech event, and may be contacted for clarification; at the same time, the inscribed text has its own meaning. Again, the distinction Ricoeur made between a speech event and inscribed discourse, as described by Deetz, is obfuscated by the genre of CMC. The distinction lies between a speech event being "about *a* world" and an inscription making "reference to *the* world" (p. 136). The discourse of the list is about a localized world of disability services at colleges and universities. At the same time, the worldview of the writers bring in the realities of the world of a student with a disability in higher education, and those who serve them, that is broader than the instant references of the DSS office. As an example, the references to media releases, legal decisions, and policies that are submitted to the list are introducing a wider worldview to the postings. Then, as a final comparison of a speech event and inscribed text, the list appears to be analogous to inscribed text as it is "addressed to anyone who can read" (Deetz, 1982, p. 136) though the readers of the discourse as it is being constructed are limited to members of the list while readers of the discourse as inscribed is for anyone who goes to the archives.

Online Communities. Chapter 1 explored the possibility of considering the participants in to constitute a professional community. One question of social researchers is how online communication will affect community involvement away from the

computer. Robert Putnam (2000) investigated the growing loss of community involvement and social capital in the United States. He found adults increasingly stayed home rather than participate in community social activities. The research of Horton (2004) began to answer the question of how the world has changed due to computer-mediated communication. Horton affirmed that the use of the Internet builds community. He looked at how online communication by environmentalists pulled individuals interested in a common cause into a stronger coalition. The ability to communicate with a large number of people who had the same interests allowed members to be more active. Putnam would classify this involvement as a means to build social capital. Distinctive subcultures are created within online discussion groups (Baym, 1995). The discourse of an Internet list is a “culture-creating force” (p. 29) that brings people from diverse locations into a distinct community. The exchange of emails provides the locus of cultural meaning according to Baym.

Chat rooms are websites for synchronous communications. Participants in chat rooms usually are identified with user names that are pseudonyms. This provides the chat room participant the ability to “talk” online without openly revealing his/her identity. In an investigation of Internet chat rooms, Waskul and Douglass (1997) found that individuals who corresponded in synchronous chatter created a “self” identifiable to recipients. The researchers emailed surveys, conducted participant observation and did content analysis of chat room text and concluded their research with open-ended interviews with research subjects via the computer. The focus of the research was the social nature of interactions between correspondents and the “cyberself” that emerges for individual posters. The researchers were especially interested in how a personal image is

constructed in communication that is “disembodied, dislocated, anonymous, multiple-simultaneous, and faceless” (Waskul & Douglass, 1997, p. 375). They found that people using the chat rooms actively manipulated their writing, playing a “communication self-game” to construct an online personality. That a personality can be created in a chat room where the participants are identified by screen names affirms the idea that participants in an electronic mailing list where they are identifiable by name would socially construct personal identities.

People sending emails project a personality over time. In chat rooms and on electronic email lists the correspondents develop a reputation that is socially constructed by the other members. Rather than alienating people who isolate themselves in their homes and socially interact only by computer, the Internet has proved to be a medium for communities of users.

“... experienced users of the medium usually deny that it obstructs human contact. It turns out that many ordinary individuals possess a compensatory ‘literary’ capability to project their personality into writing destined for the computer screen” (Feenberg, 1989, p. 23).

Policies about the identification of the writer to online discussion lists vary from complete anonymity through the use of pseudonyms to the required use of legal names. In the present case of DSSHE-L, the email address of the sender is shown. However, posters to the list often end their message with their legal name, school affiliation, and contact information via phone or mail. According to Millen and Patterson (2003) this disclosure of identity lends itself to creating social capital. These researchers helped to create a community-based conferencing site for the small village of Carlisle,

Massachusetts. The use of legal names was required of citizen participants. It was found that this led to more polite interactions. It also led to personal connections when members met each other in the real world. The requirement to self identify as the author of emails kept the posters honest in their remarks about local businesses that were discussed.

Collegiality among a diverse group of people can be improved through the use of computer-mediated communication. The use of email by secondary school teachers in Uruguay and the collegiality it promoted was investigated by Grünberg and Armellini (2004). Teachers who were proficient in using the computer regularly used email “for the exchange of professional resources” (p. 602). They were more likely to contribute useful information than request advice and did so without prompting from others on the list. Three-quarters of all requests to the list were met with a response. However, it was found that teachers frequently went off the list for private exchanges which kept other readers from benefiting. The authors concluded that email list participation supported the formation of a professional community that shares resources. Collegiality was improved and sustained by online interactions.

Public Displays of Attitudes. Critical discourse analysis of an electronic mailing list’s emails is relevant because the beliefs and thinking of the members often reveal more than the correspondents intend. It appears that the members of a discussion list will often write something on the spur of the moment, forgetting that their email is archived in the public domain for all to see.

In the email domain, while we know that the physical medium of email transmission is writing, we often behave as if email, like speech, were ephemeral (e.g. not pausing to edit messages before sending them; ignoring the fact that our

private communication can be accessed and printed by others) (Baron, 1998, p. 140).

Email provides opportunities for people to speak out before they reconsider and edit content. This impulsive writing closely resembles what can happen in face-to-face communication. “It might help to consider the [email] message as a written verbal communication rather than real writing” (Shapiro & Anderson, 1985, p. 21).

The email found on discussion lists contains a rich text for the discourse analyst. Part of the value of online discourse is the uncritical, unedited “talk” between discussion list participants. The willingness of correspondents to pour out their thoughts without a consideration of the consequences is due, in part, to a mistaken belief in the privacy of communications. When a list archives all emails and makes them available to the general public through a website, there is no expectation of privacy or confidentiality. What is said online is put into the public domain. As Weisband and Reinig (1995) stated, “Email users, expecting privacy, risk embarrassment, lawsuits, and worse” (p. 40). In their opinion, “The problem is that users grossly overestimate their expectations of email privacy” (p. 41). This is due to the belief that password protected email accounts are private. Since their email account cannot be accessed by others (except for the computer systems administrator) it creates the perception that no one is watching.

Insight that reframes knowledge (Deetz, 1982) is hampered by the immediacy of computer mediated communication. The ability to post a response as quickly as an inquiry is made is not conducive to careful consideration of what is said and how meaning is conveyed. Then the communication is archived, leading to a petrification of meaning that can trap the reader into taking the archaeology of past events and concepts

as having continuing relevance. The value of insight as an instrument of change is limited (Deetz, 1982). The challenge of archived text is that it becomes reified. Hegemony yields to the constant critical analysis of meanings followed by the social construction of new meanings that foster equality. Archived text does not undergo reconstruction of social meaning. Critical discourse analysis is directed at change in actions as well as in discourse. By critical discourse analysis the archived text will be subject to new interpretation and rebuttal.

The Absence of Social Cues and Possible Consequences. Email has greatly increased the network of people with common interests. Electronic mailing lists bring communities of people together. However, one problem of communicating via email is that most social cues are missing (Weisband & Reinig, 1995). Text-based communication does not provide the cues that are present in face-to-face interactions or even on the telephone. The loss of these social cues can lead people who are writing to a list to forget or disregard the audience who will read what is written. In doing so, the poster might write things that they would not say directly to someone (Weisband & Reinig, 1995). This can have legal implications.

Few employees know they can be held legally accountable for messages they send to others, as well as for messages they receive. . . email messages are treated as documents that, once retrieved, can be used as legal evidence (Weisband & Reinig, 1995, p. 42).

In a discussion list, where correspondents repeatedly post messages and all correspondence is available to discussion list members, the social expectations can be confusing to members. The expected online communication etiquette is learned through

“observation and imitation” (Weisband & Reinig). If inappropriate postings are not reprimanded by list members, it is possible that the wrong message is sent about what is acceptable behavior.

Deliberation and informed debate. One researcher claims that online discussion groups may not be effective at in-depth debating of different points of view. Wilhelm (1998) took 500 postings from 10 different Usenet newsgroups and performed content analysis on the emails. He found that few topics were discussed at length; instead there were overlapping, short-lived postings that did not sustain deliberations. Most of the postings were from like-minded individuals who simply agreed with one another. This is one of the shortcomings of electronic mailing lists. They tend to attract members who have the same agenda. Yet the research by Janssen and Kies (2005) disputes the idea that online discussions are ineffective at providing a means of democratic debate. Their review of research about political online forums found that some discussion lists sponsored by the government and education sites were well facilitated and created an environment for sustained discussion and debate. However, they also found many lists where the subscribers were of similar political backgrounds and where the majority of postings supported one point of view.

Some researchers have used game theory to analyze emails sent to college class discussion lists. Feenberg (1989) suggested that correspondents “win” by posting a message that provokes other discussants to reply. If a message does not receive comments it is judged a failure. Eastmond (1992) cites Feenberg’s idea that a posting to a conference list has two purposes:

. . . to communicate something and to evoke the (passive or active) participation of interlocutors. We can say that playing at computer conferencing consists in making moves that keep others playing. The goal is to prolong the game and to avoid making the last move. This is why computer conferencing favors open-ended comments which invite a response, as opposed to closed and complete pronouncements (Feenberg, 1989, p. 27).

Conflict. Disputes and conflict can easily occur through email communications, but are not as easily sorted out using the medium of email. Friedman and Currall (2003) looked at occasions of disputes that arose from emailed correspondence and proposed a dispute-exacerbating model of email (DEME). They contend that there is some structural feature of email that causes this mode of communication to be more likely to encourage conflict between parties. The work of Clark and Brennan (1991) is cited claiming “asynchrony costs” in using email to communicate. Asynchrony occurs in email due to the fact that communicators are not co-present in time or space, unlike face-to-face conversation.

. . . in conversation people time their utterances with great precision. They can begin an utterance precisely at the completion of the prior speaker’s turn. They can time acknowledgments to mark what it is they are acknowledging. They can interrupt a particular work to show agreement or disagreement on some aspect of it (Clark & Brennan, 1991, p. 144).

However, unlike speech, email can be reviewed repeatedly. The writer also has the opportunity to revise what they have written before hitting the “Send” button. Nothing has to be sent in the heat of the moment. In spite of these traits of email, disputes happen.

Friedman and Currall (2003) suggest that there are four ways the email disputes can be triggered or escalated. When a writer uses aggressive tactics to make a point, conflict can escalate. It is not so much what is said as how it is said. The conflict can escalate because the recipient's view of the sender changes. If the sender is perceived as unfair or immoral there is a lessening of empathy, an increase in deindividuation, or a decrease in identifying the sender positively which intensifies conflict. If the social bonds weaken then conflict becomes easier. Finally, because of the asynchronous nature of emails, either party can become frustrated and tend to grow more aggressive in their responses. Friedman and Currall proposed that in their dispute-exacerbating model of email (DEME) that the added feature of diminished feedback in email and the absence of social cues break down social rules that would prevent conflict. If a lengthy argument is posted, it may violate the interaction norms, making the original conflict seem escalated. Also, the tendency to focus on the ongoing conflict can increase angry mood and encourage an aggressive response. The social ties between correspondents can mediate conflict. Weaker social ties lead to increased conflict. The disposition of email conflicts is not hopeless. The authors conclude their article with several recommendations to manage potential and ongoing email disputes.

Communicative Interaction. When email successfully communicates the sender's ideas, the reader can react and respond. Reactions to email messages can lead to either an adoptive response or an adaptive response (Van der Meij, de Vries, Boersma, Pieters, & Wegerif, 2005). "In an adoptive reaction a group repeats an idea advanced by the other group" (p. 426). The authors cite Tannen (1989) who stated that repeating what has been said allows connection to the conversational partner and moves the conversation along.

Adoptive reactions can also be characterized as attempts to share meaning and express affective and cognitive involvement. In an adaptive reaction, an idea introduced by a partner is extended, doubted, or discussed. Adaptive reactions are attempts to negotiate meaning by advancing new or contrasting ideas to what the partner has written (Van der Meij, et al., 2005, p. 426).

The education literature on communicative interactions in the classroom is abundant. The work of Burbules (1993) translates well to the construct of computer-mediated interactions. According to Burbules, there are four ideal types of dialogue that occur in classroom interactions. In dialogues as instruction there is a knowledgeable facilitator who leads the discussion among participants towards an established learning goal. In dialogues as conversation the questions lead toward sharing information and experiences and are geared toward building “mutual understanding, intersubjectivity and consensus” (p. 125). In dialogues as inquiry there is a question inviting participants to “propose ideas, to reason or to clarify a notion.” In dialogues as debates there are arguments based on evidence and reason. Interactions can be one of these four types or some mixture of type. “Any actual dialogue may be a hybrid of various elements from each” (Burbules, 1993, p. 125). Interactions via email can be classified using these types of dialogue.

Computer-mediated Humor. Occasional flashes of humor emerge in the otherwise serious discussions that take place on professional discussion lists. There has been little research on the use of humor by posters. Baym (n.d.) analyzed a Usenet newsgroup that discussed soap operas and found that some members used humor effectively, helping to create social meaning online. Humor was used to “create and enhance participant

solidarity and group identity” (p. 21). Humor helped to promote group solidarity in what was often an “us versus them” dynamic. Often the humor required knowledge about previous discussions, forcing the audience to be collaborators in seeing what was humorous in the posting. Baym suggested that humor in online discussions creates a feeling of friendliness in spite of the otherwise impersonal elements of news groups. “It is in part through humorous performance that particular posters overcome the seeming anonymity of the computer medium to develop their own voices” (Baym, n.d., p. 25).

The use of humor in an online mailing list helps to set individuals apart from the group while simultaneously creating a sense of community (Hübler & Bell, 2003). Online humor conveys the personal values of the sender. How it is received reflects the values of the group. Humor outside the ethos of the list community is often met with a deafening silence which takes the form of no response from the readers. “The mediation of humor in mailing lists calls for appreciation through some sort of active participation in the dialogue” (Hübler & Bell, 2003, p. 286). Aggressive humor that denigrates others attempts to establish the superiority of the writer and, in turn, superiority of the list community who respond favorably. In their study of a university’s online mailing list for the school’s writing center staff, Hübler and Bell found that aggressive humor posted by a staff member was completely ignored. Further attempts at humor by this staff member were ignored until he quit being aggressive. The group had established its boundaries and developed a group ethos. Members of the group frequently posted humorous comments that invited others to respond. “By laughing at the same joke, individuals can identify with each other and keep the other’s interests in mind, common characteristics of ethos appeals to goodwill” (Hübler & Bell, 2003, p. 292). A group ethos develops as list

members ignore or respond to humor by its correspondents. But the group ethos is apparently suspended when a group of discussants employ aggressive humor without interruption by other list members.

Conclusion

Because disability services personnel interact with the mentally ill on a regular basis, it is important to examine whether they stigmatize the mentally ill students they are serving, and if so, what the consequences might be in terms of student opportunities. This research will examine how mental illness is portrayed in the discussions of the DSSHE-L list. This social construction (Berger & Luckmann, 1966) of mental illness through language will affect the way that services are provided to this special needs population. No research exists that examines the disability service providers' views of mentally ill students who depend upon their accommodation. This research will fill the void of understanding. By knowing whether and how the mentally ill are stigmatized in this setting, corrective measures can be taken to better serve these students.

Chapter 3

Design and Methods

This study looked at discourse practices in an online community of disability service providers at colleges and universities across the United States. An Internet discussion list gives a unique insight into the values, interactions, and norms of this group. The purpose of the study was to analyze how these providers constructed “mental illness” in the students they serve. It analyzed how the discussion list influenced the formation of ways of perceiving, believing, and evaluating what is a “reasonable accommodation” for the mentally ill student. The discourse was studied through a series of linked threads – emails on the list archives. The discourse showed how social content and procedures are constructed in the language used by its members and signal kinds of knowledge and actions necessary in the jobs they do. The language in use was critically examined to determine if these disability service professionals attach stigma to mental illness. The significance of the analysis lies in inferences about how stigmatization may affect policy implementation in disability services offices.

The premise of this study is that knowledge is not fixed but socially constructed by the members of a social group (e.g., disability services professionals) over time. Interpretations can be constructed (Denzin and Lincoln, 2000) to provide evidence of this socially constructed reality. In and through their online interactions, these professionals are defining and constructing mental disability. They are also constructing the meaning of "others" or students with mental illness. From this construction, members of this culture define what mental illness is and what reasonable accommodation is. Furthermore,

opportunities in higher education for students with mental illness are limited or expanded by these definitions. As explained in Chapter 1, this study is approached from a critical theorist perspective. My ontology is that there are multiple realities and realities change over time. Changing realities should be reflected in how language affects the social realities of mental illness. Critical theory played a vital part of this research in that it allowed the researcher to expose thinking and attitudes that serve to support prejudice and discrimination so that attitudes and actions can be changed.

Qualitative research in a critical tradition is not based on the positivistic assumption that there is only one truth. In critical hermeneutics the facts do not speak for themselves; there is only interpretation of these facts, and interpretation can lead to different conclusions (Denzin, 1994). Therefore, conclusions reached in hermeneutics are not value-free but rather descriptions of what can be. The critical theorist as a researcher who works to expose a social criticism of culture does adhere to other basic assumptions. Power relations are a part of all thought and communications, and facts can never be isolated from the power that produces them. Ideology is inseparable from that being communicated. Capitalist production and consumption lends itself to hegemony. Language is central to subjectivity, both conscious and unconscious. There are always groups that are privileged over other groups and these elites work to retain the *status quo*. When the oppressed accept their state as natural or inevitable, it is most difficult to change. Forms of oppression that flow across boundaries, such as racism and gender bias, have interconnectedness. And finally, mainstream research practices only serve to fuel hegemony (Kincheloe and Steinberg, 1997), and new research practices must challenge hegemony.

The critical tradition openly expresses the idea that the researcher has a unique insight into the situation being studied. This lies in direct conflict with science and positivism. Rather than acting unconsciously within social institutions, the critical theorist works to raise awareness of social institutions' contributions to what is causing domination. Rather than freely accepting the world as it is, the researcher points out social determinants and actions that the rest of the world has left to the unconscious. As Travers (2001) argued, "Critical research is not for everyone in that it can arguably only be done effectively if you feel a sense of injustice about the way particular groups are treated in society" (p. 129).

Research Questions

Based on this theoretical perspective, the questions addressed in this study were:

- How are "mental illness" and "reasonable accommodation" socially constructed in discourse of online discussions about psychiatric disabilities?
- Do specific discourse features provide evidence of the exercise of power in ways that stigmatize and/or limit access to equal opportunity for students with psychiatric disabilities?

Data Collection

Texts were taken from the archives of the Disabled Student Services in Higher Education Listserv (DSSHE-L) during the period of January 2001 through December 2005. The archive, posted on the organization's website, is organized by year and month beginning in October 1995. Because readers of the archives would most likely begin a topical search from the most recent years, the older archives were not utilized for this project. Initial analysis showed that over 700 messages about mental illness were posted

in 2001-05. Therefore, a study of the past five years provided an adequate number of examples for critical analysis.

A brief analysis of contributors proved that there was a representative sample for every Carnegie classification of educational institution. Contributors to the list are primarily disability services professionals at colleges and universities across the United States. There are fewer contributors who work in the field of rehabilitation and law who provide an additional richness to the postings. The purpose of DSSHE-L is to provide a forum for discussion on the needs of students with disabilities in higher education. Often the disability services office is the only resource on a campus dealing with disability issues. Therefore the ability to communicate with other professionals who are dealing with similar issues is an important function of DSSHE-L.

There are no qualifications for becoming a member of the DSSHE-L discussion list. While most members are working in the field of disability services at colleges and universities, other people who are not associated with a school are subscribers and contributors to the list. One of the most common ways that people become subscribers to the list is the affiliation with AHEAD (Association on Higher Education and Disability) which promotes the use of DSSHE-L as a means of educating DSS professionals. AHEAD is one national professional organization that is made up of people who work in higher education in the role of disability services providers. At AHEAD conferences, it is not uncommon to hear the speaker who is discussing a disability topic refer to the DSSHE-L as an additional resource for disability services information (B. Hammer, personal communication, April 18, 2007). The ethics of studying the emails that may be the personal thoughts or official opinions of DSSHE-L members was carefully

considered before the pilot project and again for this project. The Institutional Review Board at the University of Missouri, Columbia, gave close scrutiny to proposed actions. It was determined that since the emails were archived and put into the public domain through a website that members who posted to the list were giving permission for their postings to be open to the public domain. At the time that the data was collected for this project the archive website was not password protected or restricted for viewing in any way. Therefore this study was determined to be exempt under human subjects regulations. The researcher protected the identities of the electronic mailing list members through the use of Appendix line numbers when specific text was quoted. All references to names within the texts of the emails were removed.

Data Analysis

In a previous study on discussions of service animals on the DSSHE-L electronic mailing list, *Discourse as a Normative Instrument: Analysis of a Disability Services Discussion List*, I developed a method of data analysis which was applied to the present study. I read through each month's archived emails and selected any pertaining to mental illness. Most emails were clearly identified in the subject line, but some emails had to be opened and read to determine their subject. Each email was converted to an .rtf file so that it could be read by the computer program, NVivo. The emails were loaded into NVivo for analysis. NVivo is a tool for qualitative research which allows a researcher to code and analyze a large amount of text.

The analysis first assumed that disability, and particularly psychiatric disability, is a discourse for the members of the discussion list. The discourse is socially constructed through the language of emailed texts. By employing discursive tactics, the members

construct a relationship of power/knowledge. It is the socially constructed power through knowledge that is the subject of inspection for evidence of hegemony. Analysis involved “taking apart” the texts in order to interpret how the writers used the discursive event to persuade or explain policy and practices in the field of disability services at colleges and universities.

Sociolinguistics allows the nature and function of discourse to be analyzed to guide the analysis. Open coding (Strauss and Corbin, 1998) was used to analyze the text and identify categories of concepts, without applying an *a priori* theory about what would be found. The emails were first coded in broad categories so that the thematic properties became clear. The first step was to group texts into the themes surrounding a single coherent idea. The definitions of “theme” Benoit, et al., (2002) used are applicable to the present study. Benoit, et al., employed several definitions to explain a ‘theme’ – the definition by Berelson (1952) “an assertion about a subject,” by Holsti (1969) “a single assertion about some subject,” or by O’Keefe (1977) that it can be an argument about a subject (as cited in Benoit, et al., p. 13), all describe the criteria for categorizing the discourse by theme. These cited sources of definition for “theme” are from the social sciences and humanities. As is common in critical discourse analysis, methods and concepts are frequently “borrowed” from other disciplines. Critical discourse analysis “requires a true multidisciplinary” that calls on the social sciences for its grounding. It demands an interweaving of meaning produced through “text, talk, social cognition, power, society, and culture” (Van Dijk, 1993, p. 253).

The email texts were first coded in terms of content, identifying diagnoses of psychiatric disorders being discussed or other major themes such as residential housing.

Then each category was coded to group similar linked concepts for critical analysis.

When rhetorical schemes were detected, that section of the email was marked for further analysis. As the text was coded, redundancy of ideas was discovered. Closer analysis of the discourse revealed patterns of thought that could then be more closely analyzed.

When the discourse was determined to be hegemonic or lending itself to abuse of power, the text was selected for interpretation and analysis and pasted into the manuscript. Also included were responses to text that either disputed the contentions of the previous discourse or supported the ideas presented. This follows the practices of critical discourse analysis to provide the reader with examples of the actual discourse as it is analyzed. This practice follows that of anthropologist Boas (1911), who insisted that researchers should publish verbatim accounts so that readers could examine the facts directly from the source without the interference of the researcher.

This critical discourse analysis has borrowed freely from critical rhetorical analysis. Rhetorical schemes are used by the email text producers to move arguments along. The arguer's intention is to persuade other list members of the "common sense" that underlies his/her statements. Hegemony, and the power necessary to enact it, results when the author builds consensus through his/her use of persuasive language and socially constructs power over others (Warnick & Kline, 1992). Consensus was determined by the absence of countering discourse or, in some cases, the presence of affirming discourse.

The question about the choice of texts being analyzed as being representative of the body of text available is an important one. The critical researcher could just as easily choose texts that are inane or common-place discussions of events at a surface level and thus depict the subject of analysis as harmless. But the intent of the critical discourse

analyst as a political being is to expose the discourse that serves to construct hegemony. Therefore, the texts selected to be analyzed were chosen because they are examples of discourse in the service of hegemony. There was the intention of not remaining neutral in the search for hegemonic policy and practice as reflected in discourse. "CDA [critical discourse analysis] is a – critical – perspective on doing scholarship: it is, so to speak, discourse analysis 'with attitude.' CDA is biased and proud of it" (Van Dijk, 2001, p. 96).

In the cases of published policies, a search via the Internet using Google found the text of the policies in use at various institutions across the country. It has become common practice for colleges and universities to publish their housing contracts and student handbooks online. The use of the policies published on the DSSHE-L discussion list in the present day provided relevance for the analysis. If the policies had not been in use, they would not have been critically analyzed. However, their implementation provides evidence of the global intertextuality of the discussion list and the importance of critical analysis.

Trustworthiness

Lincoln and Guba (1985) would describe archived texts as "unobtrusive residues." The strengths that recommend their use are face validity, noninterventional resources that are stable, and nonreactive. However, the use of these residues leads to difficulty in establishing trustworthiness because they are heavily inferential. Part of the trustworthiness of this critical discourse analysis comes from the source of texts. By using archived texts, there is no opportunity for reactivity (Lincoln & Guba, 1985) between the researcher and the participant on the list. This lack of interface does, at the same time, lead to one of the weaknesses of this study. Member checking has not been

possible. Intentionality cannot be assumed. Without member checks, I cannot assume that the writer intended the statement to mean what it appears to mean. Future research may allow me to contact some of the discussants of the electronic mailing list because they are identifiable. By doing so, I would be able to confirm with them the context and meaning of the statements I have analyzed. For the present study, the texts will be taken at face value and through explanation within the criticism the presence of hegemonic discourse will be made obvious.

A second strength of this study is that I have been a reader of the discussions on the electronic mailing list for five years before beginning the discourse analysis. This prolonged engagement with the materials being analyzed improves scope while persistent observation provides depth of coverage (Lincoln and Guba, 1985).

Debriefing with my advisor occurred on a regular basis. Peer review was ongoing throughout the semester as colleagues read and commented on the analysis. The discussion of psychiatric disabilities was reviewed by a clinical psychologist for their accuracy and alternative meanings. A researcher who specializes in the study of indigenous people reviewed the section on the international student. All of these activities improved my analysis and contributed to trustworthiness. Adding to the trustworthiness of findings is the personal expertise in topics regarding disability issues in higher education that I brought to this project.

Researcher as Instrument

The researcher as instrument in much qualitative research, and especially in discourse analysis, requires that the researcher remain as objective as possible (Gage, 1963; Glaser & Strauss, 1967; Guba, 1981; Hatch, 2002; Lincoln & Guba, 1985; Strauss

& Corbin, 1998; Wolcott, 1994, 2001). Yet the researcher in critical discourse analysis brings to the research all his/her knowledge, life-experiences, and learned biases that cannot help but be reflected in the work that is produced. One's subjectivity will become an indelible part of the analysis and must be acknowledged as a part of the research design and implementation (Krieger, 1985; Peshkin, 1988). Earlier researchers may have thought the inclusion of personal information by the researcher as self-indulgent, but it is increasingly common for the researcher to include a brief explanation of the strengths and weaknesses that his/her personal history brings to bear on the issue under examination. As Van Dijk (1993) insisted, "Critical discourse analysts (should) take an explicit sociopolitical stance: they spell out their point of view, perspective, principles and aims, both within their discipline and within society at large" (p. 252).

Lewis (1992) emphasized the importance of the "confessional tale" as Van Maanen (1988) described it. This is the narrative by the critical researcher that "includes an extensive account of the motivations, assumptions, and data-gathering procedures behind interpretations. It lays bare as best as possible the interpretive process of decoding and recoding social and cultural structures and processes" (p. 288). Gale (2001) and Troyna (1994) explain critical policy sociology as a method of policy analysis that operates under a conviction that to understand policy discourse one must "pull apart" the discourse to expose whose interests are represented. Troyna asked the questions, "What is really going on?" and "How come?" (pp. 72-73). These questions shade the analysis that leads to the critique of discourse.

My interest in disability issues in higher education began when my congenitally disabled child entered the University of Missouri, Columbia. The Office of Disability

Services assisted in getting the necessary accommodations that allowed her to successfully complete a B.A. and then an M.B.A in spite of hospitalizations and chronic illness. The quality of services was outstanding. My own personal journey into higher education and the need for academic accommodation came about when Vocational Rehabilitation determined that returning to school would provide me with the necessary tools to re-enter the workforce. I had been forced into disability retirement due to an automobile accident that left me disabled.

The Office of Disability Services accepted me as a student with a neuropsychiatric disorder and provided accommodations. As part of their services, I was directed to the counseling center on campus that provided the mental health support that allowed me to be a successful student. When I had a severe exacerbation of major depression in spite of medications, I was directed to the student mental health center where a psychiatrist corrected my diagnosis to bipolar II. The new medications allowed me to continue with my studies so that I completed the M.A. and entered the Ph.D. program.

During the masters program I spent a summer interning in the Office of Disability Services. I was privileged to participate in many of the activities of disability services. At the recommendation of my supervisor, I subscribed to DSSHE-L and began to observe the online discussions of disability services professionals across the nation. As a “lurker” I observed the many discussions of disability issues and became aware that through these discussions the disability services providers were constructing disability policy. I found myself personally affected by what I read as the discussants talked about service animals

and mental illness. This realization led me to learn all I could about disability in higher education and led to the present undertaking.

Life experiences also prepared me for the task at hand. During my work for the Missouri Governor's Council on Disability, I became well versed in federal, state, and local disability laws and regulations. Added to that expertise was 45 hours of masters level counseling psychology that allowed me to view the discussions of different psychiatric diagnoses with a trained opinion.

Zompetti (1997) stated that the critical researcher must continually commit to self-reflexive questioning that explores how the critic understands the world s/he is exploring. Self-reflexive questioning "is the *sine qua non* for any critical engagement" (p. 74). Critical understanding of self includes the exploration of personal hegemonies that influence theory and practice of the researcher. There were moments in the analysis that caused angst as the realization occurred that I would not have been allowed to attend certain colleges and universities or live in their residence halls because of the policies that forced students with severe depression to withdraw. The awareness that at some DSS offices the documentation was not as confidential as promised, that documentation might be shared outside the DSS office, made me believe that if I had to do it all over again I would probably decline the services of the DSS office rather than risk being expelled. Finally, the discussion of the rights of students to have emotional support animals or service animals caused a stirring of deep anger. As the user of a service animal that also serves to help me with the daily challenges of living with bipolar disorder, I was infuriated that some colleges and universities would even think that they had the right to demand documentation from me or would interfere with my use of a service dog. The

laws are very clear that my partnership with my service dog is not open for interpretation by a public institution. The “humor” that some DSS officials shared about service/emotional support animals was demeaning and gave me a clear message that these people would not be advocates for my equal access to their institutions.

Conclusion

This dissertation project was a work of passion for disability rights for all people and particularly for people with disabilities who wish to pursue a degree or certificate in higher education. The preparation for this project was begun early in my graduate career. From my masters level classes through the Ph.D. classes, I took every opportunity to explore disability issues in higher education. Each of my professors opened doors to new ways of analyzing policy and helped me to read the leading authors of social theory. My work as a research assistant provided opportunities throughout my studies to learn discourse analysis as a technique for analyzing policy. As a consumer of disability services at a major research university I brought an insight into the research that others could not. Through the unpublished pilot study that I completed on the discourse of service animals, I proved that there were occasions where DSS officials’ discourse was hegemonic and determined that further investigation into their discourse was warranted. The passion that has helped me to succeed as a student has also helped me to be a vocal advocate for the rights of people with disabilities and has helped produce this work.

Chapter 4

Findings

This chapter discusses the findings of the critical discourse analysis of discussions of students with psychiatric disabilities on the DSSHE-L discussion list. It begins with an overview of the posting patterns on the list, followed by a discussion of what the discourse on the list accomplishes in three areas: Defining and debating the roles and powers of the DSS officer in relation to students and in comparison with other professionals who make decisions about students; socially constructing and contesting the meanings of key policy terms or psychiatric disorders; and sending unsolicited messages including stories intended to inform and/or alarm other members of the list. The discourse provides an insight into the process of creating and sustaining power over the students DSS offices serve.

Van Dijk (1993) stated that the function of text and talk is to manage the minds of others. The essence of hegemony is that this management causes those who are subordinated to accept their domination as a natural occurrence. “Dominance may be enacted and reproduced by subtle, routine, everyday forms of text and talk that appears ‘natural’ and quite ‘acceptable’” (p. 254). It is the very appearance of naturalness that makes hegemony so persuasive to its subjects. Those who would dispute dominance in discourse can be lulled into allowing hegemonic utterances as acceptable. For example, questions that begin an interchange by asking for methods of control over students with psychiatric disabilities are often phrased in a way that naturally draws responses of controlling policies:

Can we legally require that a student provide us with medical clearance to return the next semester after they have dropped out due to psychiatric issues? (Appendix A, 71-73).

Can anyone point me to some court and/or OCR cases that deal with this subject as related to students with disabilities? (Appendix B, 5-6).

Given this knowledge, the question is how or should we monitor this person's behavior on campus? (Appendix D, 115-116).

Email Posting Patterns

Of the 783 emails that were selected because they discussed an aspect of mental illness as the disability being served by the DSS office, it was found that 162 emails were solicitations for advice (20.7%), 597 were responses to questions asked (76.2%), and 24 were unsolicited sharing of information from other sources (3.1%). The critical analysis of all of these emails allowed the researcher to demonstrate how hegemony can be socially constructed through the questions asked, the answers given, and the information that subscribers felt should be shared.

The assumption of an electronic mailing list, on the surface, is that every participant is more or less a political and professional equal who can participate in the discussions occurring on the list. After all, the list subscribers are all part of the disability services community. The reality is that most list members choose to be readers rather than posters. This limits most list members in the influence they have on the discourse. Because certain list members participate in almost every discussion, sometimes posting multiple times on one thread, while the remainder of the list “lurks” in the background, there is a disparity of influence as the talk is dominated by the few. Table 1 displays the posting patterns of list members who participated in discussions of psychiatric disabilities in the past five years (2001 – 2005).

Table 1. Email Posting Patterns

Number of Posters n = 254		Number of Posts n = 783		
No. of Posters	No. of Posts	% of Posts	% Included in Findings	
142	1	18.1	17.1	
31	2	7.9	5.9	
52	3 – 5	23.1	18.4	
14	6 – 9	14.1	17.1	
18	10 – 15	11.5	9.9	
7	16 +	25.3	31.6	

Table 1 shows that the majority of list members who posted during the period in question posted only one or two times. There is also a notable domination of the discussions by seven list members who contributed 25.3% of all emails collected. The fourth column of Table 1 shows the percentage of samples taken from each posting group that were included in the discussion of findings. The sampling pattern resembles the posting pattern of the total group to a close enough degree that it was representative of all available postings. Table 2 shows the percentage of total posts that each of these seven list members contributed.

Table 2. Posting Patterns of Top 7 Posters (25.3% of All Posts)

	No. of Postings	% of Total Posts
1	24	3.1
2	25	3.2
3	27	3.4
4	49	6.3
5	38	4.9
6	16	2.0
7	19	2.4

Taking more speaking turns allows the speaker to become influential in discourse (Bales, 1970). A similar process of developing influence occurs on a discussion list. As

Reid and Ng (1999) discovered, group members who were regarded highly in a social hierarchy had a greater rate of participation in conversations. The interactive nature of speaking rights confers the power to influence listeners to those who provide the greater content in the conversation. This concept is transferable to the interactive computer mediated communication genre. The greater number of posted messages implies a mastery of disability in higher education issues. Some list members also enhanced their status by providing information about their credentials, the identities of their institution, and their official titles.

People attribute power to others and relinquish some of their own efficacy to those who have power. At the same time, powerful people do not need to attend to their subordinates (Fiske, 1993). On the list, there are those who usurp power by contributing to the discourse with great frequency. Some list members have taken upon themselves to be the mediators of meaning. The “imposter endowed with the skeptron” as Bourdieu (1991) would have labeled them, with tongue in cheek, is able to dictate “the process of representation . . . what constitutes “common sense” and ultimately “the structure of the world” (Everett, 2002, p. 68). As for impression management by writers using computer mediated communication, the frequency that they post messages and the length of posted messages provide nonverbal cues that they are “experts.” The latency of response or when other list members are quiescent can indicate either that there is no argument that can overcome the points made (sometimes in multiple messages) or that the received message is not worthy of a response. It is difficult to interpret what no response to a posting means. So, for the frequent poster, the impression developed over time may be one of competence or of incompetence based on the cumulative effect of their discourse.

However, for the critical analysis of the discourse on the list, all messages must be considered equally. It is the accumulated effects of discourse that socially constructs meaning within the texts and what may appear to be unimportant when examined out of context may reveal a deeper meaning within the context of an online discussion.

Fairclough (1993) recognized Giddens' (1991) concept of reflexivity in discourse. A discourse is reflexive when it systematically utilizes a speaker's knowledge of the social to construct and structure what is said. An example of reflexivity is the expert knowledge that a doctor has as used in the course of talking and dealing with patients. The doctor is acknowledged as holding the power in this relationship. Gee (1999) calls reflexivity the "magical" property of language. There is an ongoing, inseparable "*reciprocity* between language and 'reality': language simultaneously *reflects* reality and *constructs* (construes) it to be a certain way" (p. 82). Gee uses the analogy of two mirrors facing each other where the image can simultaneously be seen and is reflected. So to coordinate Fairclough's and Gee's explanations of reflexivity, it is simplest to consider that when we talk, the words we use are based on the situation we are in (an interview, a speech, a friendly conversation) and, at the same time, the words are chosen based on what we have learned in the past, which makes it possible to deal with the here and now.

List members are reflexive when they post to the list. The list members who have been participating on the list the longest have a greater ability to utilize reflexivity since they can recall what has been said in the past while they compose what they are going to say in the present. List members with the longest history occasionally refer to themselves as "old fogies" or some such reference to their status even as they invite new list members to participate. This is not meant to imply that only select members of the list are

reflexive. In fact, the reality of a communication tool like an online discussion list creates a world of reflexive communication that far exceeds that in a public conversation.

Because each response to an inquiry is based first, on the question(s) posed and, second, on the other replies to the question(s), the reflexivity in multiple, asynchronous messages can operate like funhouse mirrors. It is not always possible to tease out which reality the discourse is based on.

In the following sections, the text of the list members' messages is included complete with errors in word choice, spelling, and tense or numbers. This was done so that the reader has this reference as one means to rate the reliability of what is being said. The meaning behind errors in a message can be simply that the sender is in a rush to get the message sent and thus makes typing errors. However, according to Liu and Ginther (2002), errors, especially when they appear in a series of messages, can indicate that the sender is not a competent professional and therefore the message may be undependable. Errors in typing can also be attributed to disability that affects the manual dexterity of the writer.

The use of emoticons by list members on the DSSHE-L is rare. Emoticons are the symbols that are meant to convey smiles :-), winks ;-), or other feelings. The effect of their use may cause the reader to believe that the discourse is sarcastic or not to be taken seriously. Emoticons can also convey the message that the writer is attempting to erase any suggestion that what they write is intended as aggressive. The absence of informal symbols on the list may indicate that the discussions are more formal constructions of text. However, the use of first names when posts are exchanged between certain members implies a familiarity and informality on occasion.

Some list members can be identified as having an agenda that serves to keep students with certain disabilities in a subordinate position. They advance this agenda by posting messages with frequency and length in an effort to exert influence over readers. The definition of “influence” in computer mediated communication used by Bruins (1999) is borrowed from French and Raven (1959). “Influence” is the force one person (identified as the agent) exerts on someone else (identified as the target) in an effort to change the target’s reality including “changes in behaviors, opinions, attitudes, goals, needs, and values” (Bruins, 1999, p. 8). Such influence can be the execution of power *over* others leading to hegemony; or when influence is used to promote power *with* others the result can be affirmative change. The more control over discourse, the more privileged the participant is to power. The seven posters who contribute a disproportionate amount of discourse have their point of view represented in persuasive quantities while the readers who are not involved in the discourse have no influence. As the privileged control discourse, they ultimately control context. The unheard voices allow their perspectives to be erased in the social construction of reality. “The less powerful are less quoted and less spoken about” (Van Dijk, 1993, p. 260).

Unsolicited Emails

While the bulk of the analysis in this chapter focuses on exchanges or conversations among the list members, some emails to the list were categorized as “unsolicited.” These messages appear on the list without a prompting inquiry that solicits a reply or additional input. Typically, the poster adds very little in the way of a personal statement, but lets the included information from another source tell the story. Choice of topic is a strong indicator of what the poster thinks important at that time. Sometimes the

poster includes the URL for a story. Web pages are notorious for being there one day and absent the next, so posting a URL is of minimal assistance in the archives. Nevertheless, the choice of subject is a telling discourse.

Mental health at college. The post of the URL for a recorded story by Monica Brady on National Public Radio (NPR) covers the noteworthy story of the increased presence of students with psychiatric disorders, sometimes quite severe, at colleges and universities across the United States (Appendix F, 1-10). The story is filled with factual information about how campus counseling centers and other student support systems are ill-prepared to meet the needs of these students. This unsolicited posting provides information about the realities that postsecondary institutions face without resorting to stereotyping or stigmatizing the students being discussed.

Marking students with psychiatric disorders. The subject line of an unsolicited posting is often the only text that is the product of the poster. In the case of one posting, the subject line reads, “Manic/Depressive student gets out’d, loses student gov’t position” (Appendix F, 11-25). An article from Deseret News is then included. The poster chooses to use the term “out’d” in the subject line. The use of the term “outed” is closely associated with gay/lesbian issues. A gay person is outed when his/her previously private sexual orientation is made public without permission. The implication of outing a homosexual is that the person outed has been hiding something that is socially unacceptable. It serves to attach a mark of stigma to the person. The outing of a person with mental illness serves to mark the mentally ill for disparate treatment that leads to stigmatization and discrimination. The included news story presents the basic facts that a college student with a diagnosed psychiatric disorder returned to school after a two-day

absence for treatment only to be met by school officials with the demand that she sign a “wellness contract.” The student was also put on academic and social probation which included being stripped of her elected office of student body vice president. The balance of the story is that the student filed a discrimination suit against the college with the Office of Civil Rights (OCR), Department of Justice.

The story tells the list readers and readers of the archives that schools can require a student with a psychiatric disorder to sign a wellness contract when the student seeks treatment for symptoms of their illness. It should also serve to warn the institutions that do so can lead to litigation for discrimination. Rather than accepting the idea that schools can contract with students who are symptomatic, the reader would be well served to investigate the outcome of the student’s discrimination suit. In the case related to this news story, *Larson v. Snow College* (189 F.Supp.2d 1286 (D. Utah 2000)), the court found the practice of forcing a student to sign a wellness contract was discriminatory. The college paid the student a settlement and agreed to stop issuing wellness contracts (Tee, 2004).

Setting academic standards. Some unsolicited emails provided news stories that did not depict people with psychiatric disabilities as a serious issue at colleges and universities. The particular posting showed how there will be students who attempt to manipulate the system based on self-proclaimed disability (Appendix F, 26-72). The news story discussed the case of a student who had failed to qualify for a study abroad program sponsored by his college. The student sued, stating that his poor grades were the result of depression and the school was discriminating against him due to his disability. The story concludes with the student vacationing in Europe with a friend. Nowhere in the

story is there evidence that the student sought services for his disability, provided the school with documentation of his disability in order to receive accommodations, or that he had even asked for accommodations in his classes. At best, this story may be meant as a warning that students with psychiatric disorders are litigious when academic standards are upheld. This is a stereotypical view of students with psychiatric disabilities. Every DSS officer should know that neither the ADA nor Section 504 prevent a school from setting academic standards as long as those standards do not impact students who are otherwise qualified in a disparate manner. A review of this case found that it was dismissed.

The telling of the story of a student misusing the disability laws is meant to tell a larger moral tale. It does not matter that the words are not those of the list member who posted the news story. As Mumby (1987) explained about the political function of narratives, “Narratives not only evolve as a product of certain power structures, but also function ideologically to produce, maintain, and reproduce those power structures” (p. 113). The moral of the story is that DSS personnel must guard against such students who claim disability in an effort to manipulate the system.

The use of a news story to convey information to an organization is prompted by the ideological meanings that the story builds. The story reflects the social constructions of disability formed by the media which are preempted by the poster. The story, at first reading, forces the reader to choose to side with the affected student or the affected school program. Then, depending on the predisposition of the reader, the story can become a morality tale of undeserved appropriation of rights reserved for the disabled. While the story appears to be recounting an instance of the mistreatment of a student with

a disability, an instance of discursive empowerment of the student through the media, it really leads the reader to discern that the student is attempting to abuse the system set up to protect the “real” disabled. After all, it is reported that the student is able to sue because his father is an attorney, a status of privilege, but also that the student is well enough to enjoy a European vacation with a friend. The school is within its rights to set standards for its programs. The moral turns out to be that colleges and universities must exercise their power to protect themselves against students claiming disability. Such conclusions provide the justification for hegemonic rules and procedures. This event model can be adopted to help generalize negative attitudes about people with disabilities.

Suicide. The link to the New York Times Magazine section brings the reader to “A Suicide at MIT” (Appendix F, 73-79). This news story discusses the suicide of MIT student, Elizabeth Shin. Her parents, according to the story, are suing MIT for failing to protect their daughter from harming herself after she had talked to counselors and administrators about her suicidal thoughts. The story serves to confirm the fear that institutions have that a student suicide will lead to liability litigation.

It is capitalized, so it is important. Again, the choice of using the attention getting headlines as the subject line of a posting lends itself to stereotypical discourse. The fear that students with psychiatric disorders will be violent is acted out by the policies to exclude certain students from classes and housing. The headline of this post is in all capitals, the equivalent to shouting in online etiquette. Since list members choose which emails they are going to open and read based on the subject line, the use of all capital letters, which is not common practice, makes the posting stand out. “COLLEGE STUDENT GUILTY OF KILLING TWO CLASSMATES” (Appendix F, 80-101). The

news story is of a student who murdered two of his fellow students. The student pled insanity as a defense. Nothing in the public records of this case indicated that this was a student with a diagnosed psychiatric disorder who was receiving accommodations at his college. Yet the story is posted on the disability services list as relevant to DSS officers.

The subject line of this unsolicited email reads, “MENTAL HEALTH AND DANGEROUS STUDENTS” (Appendix F, 102-104). Once again, the list member chooses to post a subject line in all capital letters to draw attention to it. The author also vouches for the relevance of the linked article by stating, “Good article on violence and mental health issues.” The discourse of this text, even before the linked article is opened, is that students with mental health disorders are “DANGEROUS” and prone to “violence.” Both of these ideas are stereotypical and lead to stigmatization of students with psychiatric disorders. The included link no longer takes the reader to an article and, since the title and source were not given, there is no way to determine the content of the story. Even without the suggested article the impact of this posting is negative towards students with psychiatric disorders.

A reliable resource. Not all unsolicited postings to the list were negative towards students with psychiatric disabilities. Listed on the subject line as “Psychiatric Resources,” the link takes the reader to the webpage of the American Psychiatric Association (APA) (Appendix F, 105-113). This website is a source for factual information about different psychiatric diagnoses. For the DSS officer who is attempting to understand a student’s diagnosis, this site provides unbiased information.

Emotional support animal approved. “Judge OKs Woman’s Dog as Depression Aid” reads the subject line of this unsolicited email (Appendix N, 252-282). The story

from the U.S. National – Associated Press details the ruling by the Michigan Civil Rights Commission that a woman who suffers from depression could keep her dog in co-op housing that has a “no pets” policy. This post is relevant to discussion list members who have repeatedly debated the legal standing of students with psychiatric disabilities who have a prescribed companion animal and need to live in college housing with the animal. The fact that the ruling was limited to Michigan residents may have caused some list members to perceive this article as less useful.

Emergence of psychiatric disabilities. When articles relevant to DSS officers are published, it is not uncommon for a list member to post the article in its entirety. “Emergence of Psychiatric Disabilities in Postsecondary Education” was copied and pasted to the email (Appendix F, 114-405). This article, released online by the National Center on Secondary Education and Transition (NCSET) was timely information. NCSET is a part of the Institute on Community Integration at the University of Minnesota. The article presents current (at the time) practices in accommodating students with psychiatric disorders by postsecondary disability support services providers.

It is risky to infer the intentions of such unsolicited contributions to the list, especially if they include no personal commentary, but they seem to be intended to inform and sometimes to alarm the list members about current issues in their profession. The next section examines how the list participants collectively constructed and contested their professional status, ethical and legal duties to students and institutions, and their authority in relation to other professionals who make decisions about students with psychiatric disabilities.

Role of the DSS Officer

The required qualifications for being the disability support services officer at a college or university vary from institution to institution. The demographics of DSS officers are not readily available through academic journals or through a search of the Internet. From scanning the job postings on the Internet at schools of various sizes, public and private, and educational emphasis, and the advertised jobs in *The Chronicle of Higher Education* it appears that a person can be designated a DSS officer with as little as a bachelors degree up to, mainly at major universities, a Ph.D. or Ed.D. Backgrounds can vary from the social sciences to psychology or medical backgrounds with some schools requiring a background in disability law while others require expertise in psychological and educational testing. In some cases the DSS officer is only involved with academic accommodations for students with disabilities while at other institutions the DSS officer may act as a counselor, as the ADA coordinator, or as administrator for all disability issues including residential housing. Some DSS officials work as administrators for the institution and are responsible for insuring that students, faculty or staff who ask for accommodations are qualified individuals with disabilities while others work only on academic accommodations for students with disabilities. There are DSS offices with only one staff position and offices with a larger staff. It is from this wide range of educational backgrounds, job responsibilities, and institutional size that the membership of the DSSHE-L list is composed.

Out Counseling

The role of the DSS officer and the DSS office was sometimes explicitly discussed and debated, and implicit in every exchange on the list. Is their role to protect

the rights and access of students with disabilities or to act as gatekeepers to protect the institution that employs them? DSS officials learn much more about a student's academic weaknesses than any other entity in the college or university system. Sometimes they conclude, rightly or not, that a student cannot succeed in their chosen program or career. Such a conclusion led to a discussion of ethical and moral duty towards struggling students. The feminist "ethics of care" as expressed by Gilligan (1982) and Noddings (1984) contrast sharply with the rule driven, by-the-book belief system of some DSSHE list members. Too often the discourse implies an "ethics of justice" as the dictate for actions.

When a discussion of moral and ethical motives occurs in an organization, and I use "organization" to refer to the collective body making up the list, new knowledge about the power that is shared through discourse is revealed. Beliefs, attitudes and values are laid bare by the public reflection of personal motivations in the service of others. Too often, the discourse of the list sets the polarized portrayal as "us versus them." Students are often made to appear as others who are working the system to their advantage. In the discourse about out-counseling, the practice of counseling a student that they will not succeed, the members are conveying a message of "us with them." This is a "rhetoric of tolerance" which strongly conveys the belief in humanitarianism and civil rights (Van Dijk, 1993).

I would appreciate your advice and experience in this situation: A student has a disability where the student lives in a separate reality sometimes. It is unclear if the student understands information from the class because the student's answers do not reflect the subject matter but reflect the student's opinion. The student's behavior is bordering on disciplinary action. The student wants to earn a degree but no one would hire the student in that field. What is the college's ethical responsibility to tell the student that employers would not hire her? Can the college legally tell a student that? (Appendix I, 1-9)

The discussion begins with the questions about the college's (not the DSS official's) ethical responsibility. Then the next question reframes the concern to a legal issue for the college. The rhetorical device of making the issue one of the institution rather than the individual serves to isolate the person from responsibility. If they act on behalf of the institution they are relieved of responsibility for the outcome.

The primary task of a college is to offer academic programs. Our role, as providers is to make academic programs accessible to qualified individuals. (Appendix I, 10-11) . . . It would be out of scope and highly judgemental [sic] for you to make a comment about success for the individual. (Appendix I, 14-16)

The first reply put the responsibility back on the individual and then reminded them of the purpose of the DSS office.

I agree that it is not our responsibility to tell the student whether or not they will be successful at something (i.e. degree or career choices) and of course I think everyone here knows that our job is to provide the accommodations and not discourage students from going into a certain field because of their disability BUT I also believe it is not our job to encourage students to stay in a certain field if we feel they are having a difficult time.... some institutions are criticized for not doing enough for the students BUT I believe some should be criticized for doing too much... how fair is it for us not as disability service providers but as academic institutions as a whole to set some students up for failure by just passing them in courses by giving them D's and keep advocating for and giving them financial aid when they withdraw from all their courses in the middle of the semester perhaps I won't make many friends by saying such things on this listserv but that doesn't mean they shouldn't be said. (Appendix I, 17-31) maybe the question is not what is ethical but what is moral? (Appendix I, 41-42)

The capital BUT is a strong indicator that an argument is about to be made that negates the previous contention that the writer agrees with the responsibility of DSS officers to provide academic accommodations. This poster believes that “it is not our job to encourage students. . . if we feel they are having a difficult time.” The argument is escalated by another capital BUT where the writer expresses, “I believe some [institutions] should be criticized for doing too much.”

If teachers want to give pity grades and perpetuate a negative system, then that is their problem and smacks of some of the problems we face with students coming [sic] to us as high school graduates that have been with IDEA, and a modified curriculum. But I am concerned about DSS abusing their position! Untill [sic] we have the same information on all of our students, that we require from the swd, and then require all students to defend their reasons for being in college; then I think it is not ethical to do "out counseling" just for those that are required to self disclose and give us information like IQ results and Psych reports. (Appendix I, 53-61)

well I guess you misunderstood my email... I didn't say DS workers were responsible I said the institution had a responsibility :) Faculty and admissions and financial aid included! (Appendix I, 66-68)

I believe it's moral to trust the academic process to do its work. If we've assured access to the academic program, it's up to the program to decide who's qualified and who's not. (Appendix I, 69-71) . . . DS officers should take heed with this, for we, like vocational rehabilitation, have no business making decisions about who's qualified. Our job is access, and that's a big enough task in itself. (Appendix I, 75-78)

The declaration that “Our job is access, and that’s a big enough task in itself” serves to remind readers that the duties of a DSS officer is to provide academic accommodations that give equal access to students with disabilities. The trust in the program to make appropriate decisions about the qualifications of its students puts the student with a disability in the proper perspective – that they must compete as a student and not be treated in a way that provides them an unfair advantage.

Over time, if (hopefully not a big IF) a program is properly taught, an individual will either learn and assimilate -or- not learn effectively and not assimilate. It is a brutal filter, but an individual has to learn what can and cannot be done, even with accommodations. (Appendix I, 96-99)

Besides, out-counseling is specifically forbidden by 504. (Appendix I, 105)

Then train the faculty, but remember it's their call. The idea, however, that someone placed in a position of responsibility to advocate for students with disabilities should

- a: advocate anything other than allowing the student to prove or disprove whether they are indeed "otherwise qualified;" and
- b) allow their personal opinions/feelings about the faculty's ability or willingness to determine this through the rigors of academic pursuits is in danger of crossing irrevocably the line dividing moral and immoral, ethical and unethical practice. We are not in control of

everything, and it is our daily task to remind ourselves of this.
(Appendix I, 125-135)

The conclusion of this discussion occurred with the reminder to list members that “We are not in control of everything, and it is our daily task to remind ourselves of this.”

Students with disabilities have the right to succeed or fail just as other students do.

The Role of the Organic Intellectual

The expertise of DSS officers appears to vary. Some information posted to the list is grounded in the expertise of the poster, supported by cited law and regulations, and current with best practices of disability support services at the college or university level. Then there are the posts that are misleading, based on personal opinion, and lacking in professional knowledge. One such email filled with misinformation caught the attention of one of the list’s most trusted experts in disability services. The following posting is the result of an expert realizing that no one else on the list had corrected some misinformation that was provided. The list member starts out by repeating the post and then starts “yelling” (writing in capital letters).

Yesterday, Xxx offered this as part of his post re: forced LD assessment:

--Again, as mentioned by other practicing therapists, It is difficult to assess an adult. The method is assessed learning level must be two percentiles (of the age general age population) below an IQ. To get into college means skills are completed at near or above 2 percentile. A 2 percentile is roughly 3-4 grade levels (sorry for the over simplification), and the average 17 year old would place grade age at about 8th (13-14). This is essentially what the TCAP (Tennessee) graduation test does, so a tennessee [sic] graduate with TCAP should have trouble testing into a Learning Disorder. Other factors lack of Culture, behavior, learning & below 80 IQ prevent the diagnosis. Physical disabilities (hearing-Vision) must be factored in and the assessment under axis III.--

THERE ARE SO MANY THINGS WRONG WITH THIS STATEMENT THAT I DON'T KNOW WHERE TO START... and I don't have the time or energy to be bothered. But when such a blatantly misinformed post goes up on the list and doesn't get challenged, I worry greatly about the many new folks out there who have joined and follow our extensive discussions in an effort to learn how best to help the swd on their campus. I worry that because they see it in print (on screen?) on the list, they believe it must be true. (Appendix J, 1-19)

This writer is serving as what Gramsci (1971) called the “organic intellectual” (p.5) who can serve the interests of either the dominating class or the proletariat (Zompetti, 1997). In this case, the discourse is critical of the misinformation posted by another member of the list. There is also a criticism of the reader who would believe everything “because they see it in print (on screen?) on the list.” In Gramsci’s theory of the misuse of power, he places the critical organic intellectual in the position of leading the resistance against hegemony.

The writer feels strongly about the argument that readers should not suspend their own power of thinking in exchange for ready answers on the list. This is evidenced by the opening line of the response which is written in all capital letters. As Warnick and Kline (1992) suggested, there is a cultural apprenticeship that new members of an organization complete wherein they learn the rules through their use. The critical organic intellectual helps to inculcate in new members the best practices of the organization.

The posting of a public castigation of another list member “serves to reify ideologically the organizational rule system itself” (Mumby, 1987, p. 123). Because the rules of the list are socially constructed, the norms are not apparent to the casual reader. The rules provided by the critical organic intellectual assists in codifying the expected behavior of organization members.

The ideology of an organization refers to the ways in which members, as social subjects, become qualified to participate in and create the organizational reality (mode of rationality) that is represented to them. The process of representation occurs through the discursive practices of the organization (Mumby, 1987, p. 125).

The post makes the point that on the occasions that mistaken information is shared on the list, another member will correct it. “But when such a blatantly misinformed post goes up on the list and doesn’t get challenged. . .” This statement serves to put list members on notice that they are being watched for the accuracy of their posts. This is a dialectically created new concept (Deetz, 1982) that serves to teach new list members that even though a post may profess to be based on truth, there are some texts that must not be believed. The writer demands communicative competence (Kelly-Kleese, 2004) wherein the list members read critically and write with accuracy.

Blatant Stereotypes

Some statements made on the list are very negative and stereotypical regarding students with psychiatric disabilities.

Service Providers have told me (and I know first hand) that students with psychiatric disabilities often need more help or want more help than [sic] a system can or maybe should, provide. (Appendix K, 2-4)

The belief that students with psychiatric disabilities are difficult to accommodate and make excessive demands on the accommodation system is a stereotype. The writer attempts to support the claim by stating, “Service Providers have told me (and I know first hand)” as justification of this belief. The existence of the “clinician’s illusion” (Cohen & Cohen, 1984) allows the practitioner who has dealt with difficult students with psychiatric disabilities to frame the belief that all students with psychiatric disabilities will be equally difficult to serve.

In response to a discussion of a student’s extensive documentation of a somatoform disorder, a disorder in which there are real, demonstrable physical symptoms that cannot be explained by medical tests, a list member wrote,

Meanwhile, I'd like to remind the list that isn't unheard of for someone to fake a disability as happened this academic year in one of Indiana's universities. (Appendix K, 31-33)

It seems that the belief that students are willing to fake disabilities in order to gain an unfair advantage is undying. The system of documentation and review that is used by the DSS officer when establishing that a student has a qualified disabling condition and should be accommodated is intended to prevent such an occurrence. Though the idea of students faking disability is periodically brought up on the discussion list, no one on the list admits that this has occurred at their institution.

Cultural Difference or Disability?

International students may be especially vulnerable to stigma and stereotypes when dealing with disability support services, because DSS officers and staff may not have cross-cultural expertise. The original inquiry about an international student who had been referred to the DSS office has a subject line that sets the negative image of the student as outside the norms of common students, "HELP!! – Strange accommodation request."

I have a very unusual case that I am assisting our MBA office to work through but, since I am quite new to the disability services arena, I am baffled as how to proceed from here. We have an international student who just completed his first three-week MBA course with great difficulty. During his first class meeting, just after the instructor had introduced herself, this student began raising his hand to ask a series of questions regarding the course, expectations, why he had not yet received results from the required HBDI assessment, etc... (Appendix M, 2-9)

The list member identifies this as "a very unusual case" and starts the description of the student. At first the behavior appears to be that of an anxious student who is not accustomed to the cultural norms of a classroom in the United States. Raising his hand, asking questions, referring to the assessment that determines eligibility, all seem reasonable behaviors for an international student. A competent professor would take this

behavior in stride and arrange to meet the student immediately after class. But the described behavior, and the words chosen for the description, increasingly make this student appear strange.

Although this is not so strange (perhaps just an apprehensive/anxious student), his actions and conversations since the initial course meeting have been quite disturbing. In the classroom where this student takes his MBA courses, the tables and chairs are arranged in a half-moon configuration to facilitate discussions and so forth. During the break of his first class session, he approached the instructor to inform her that the table configuration was giving him a headache. She allowed him to use the one and only rectangular table in the room for that class session. (Appendix M, 10-17)

The list member describes subsequent behaviors as “quite disturbing.” The behaviors described could just as easily be explained as stemming from cultural differences. In some cultures and religions, the position of a person in a room is important as a defense against the evil powers that exist within the physical surroundings. In an online story of how the Okinawans create barriers to the evil spirits, Charles (2005) talks about the presence of Shisa, Himpun, and Ishiganto in homes and office buildings. These protect against evil spirits, bad luck, and negative karma. As an example, the Himpun is placed as a barrier across the front door of a home so that direct access is not possible. The position of the door is very important to prevent evil spirits from entering. Therefore, it is not unreasonable to suggest that this international student may have been reacting to the classroom setting as dangerous to his/her spiritual being. It may indeed have been causing a headache. The list member continues the description of the student’s behavior.

The student came in to meet with his MBA advisor and, during the meeting, shared his theory of a conspiracy against him by the University and everyone in [city]. He believes that, since the HBDI assessment was conducted online, all faculty and students now have access to *his* results and are using them against him. Although he had been sitting in the middle (or at the top, if you will) of the half-moon configuration prior to moving to the rectangular table, he stated that the need for him to turn his head to see other students (which he

hardly would have needed to do at all) was giving him headaches, blurred vision and an upset stomach. He also believes that *everyone* stands or sits to his left. (???)

Further, he believes that the University's conspiracy against him is perpetuated by requiring students to read "Quantum Learning" which has mostly text on the left pages, pictures/reinforcers on the right pages. According to him, this attributes to his suspicion of people *always* sitting or standing on his left side. In this instance, we are dealing with words rather than individuals. (Appendix M, 18-33)

The fear the student expresses about “everyone” knowing about his online assessment can also be explained by culture. In many countries around the world, the government pays close attention to what is done online. Governments get to determine who will get an education and where the student will go to be educated. Again, in certain cultures the positioning of things has explicit meanings that are clear to the beholder. The student may very well be getting sick from fears based on cultural beliefs.

Per the advisor, this student was acting "compulsive, wringing his hands, darting his eyes around the office, opening his bag, peering inside then snapping it shut". He asked over and over if she had anything hot to drink and became very distressed when she told him that there was not anything hot to drink at that time. He further went on to discuss he and the advisor's "relationship" and how it was going to have to be solely a student-advisor relationship from this point on, and that he wanted to make sure they were on the same wavelength. (Appendix M, 38-45)

The behavior in the advisor’s office may also be explained by culture. In many cultures it is inappropriate to make eye contact with a superior. If it is improper in his culture to make direct eye contact, then he may well indeed be acting properly by “darting his eyes around the office.” The expectation that they may share a hot drink during their meeting is also based on culture. In sharing a desk with an international student, there was not a single time that I arrived at the office that she did not offer me a cup of hot tea that she prepared at our desk. It was customary in her culture to honor guests with the offering of a hot beverage. The cultural differences between college and university professors and international students must be acknowledged. The result of this

description of the student brings responses to the list that confirm that no one is thinking culturally about the problems this student has encountered. The inquirer definitely is explaining the student based on a believed psychiatric disorder.

Plus, it is my opinion that this student should seek medical attention immediately to take care of his disorder, whatever it may be, before he proceeds with his educational endeavor. (Appendix M, 60-62)

The use of narrative, or story telling, when making an inquiry to the list serves to provide an edited portrayal of the student. What the writer chooses to include in the description of the problem helps to guide the readers to particular views about the student being discussed. The use of narrative is not always intended to portray a simple reality, but can be a politically motivated depiction of a worldview that privileges the narrator's interests over the subject (Mumby, 1987). This allows list members to rely on the "myth of rationality" (Conrad, 1985; Mumby, 1987; Weick, 1979) which is the belief that decisions and recommendations made on the list are based on objective reasoning aimed at meeting appropriate goals. When decisions are based on ambiguous information that can be interpreted in only a negative way, power is being exercised (Mumby, 1987). In the case of students who are described with intolerable histories or symptoms, the writer creates a social construction of psychiatric disability that serves to disenfranchise the subject.

You know there is a full moon out there! All kidding aside, the student needs to be referred to the person on campus or department that deals with students who might present a danger to themselves or others. On our campus, I would call the Dean of Students ASAP! Good luck. (Appendix M, 63-66)

Somehow the description of the student has been exaggerated from an awkward international student with different beliefs to someone who "might present a danger to themselves or others."

Is the individual claiming disability or government conspiracy?
(Appendix M, 67)

This posting does not seem to take the problem seriously. But the next postings transform this student into someone in need of attention from the authorities.

This student should be refered [sic] to the counseling center for immediate help. In addition, the student needs to come to the attention of the Dean of Students or whoever is responsible for the student code of conduct. It seems to me that this students is or may become disruptive. (Appendix M, 68-71)

Find a counselor who speak [sic] the same language as the student. I doubt city, county, and state law enforcement might help, but the FBI can with its foreign languae [sic] capability. Remember, a lot of countries don't do those kind of testing we do here in the U.S. Or maybe the student is an alien? (Appendix M, 73-77)

This has transformed from an inquiry to help an international student who seems to be having adjustment problems to a “danger to themselves or others,” a “disruptive” student, and someone who needs to be counseled by the FBI. In the argument of coexistence (Warnick & Kline, 1992) connections are made between the actions of a person and the identification of the person. There is a reciprocity between actions and essence. In the case of this international student in the MBA program his actions are classified by the inquiring list member to be “strange,” “quite disturbing,” and “compulsive” in mannerisms. This “unusual case” is then picked up by other list members as “a danger,” imminently “disruptive,” and so foreign that a referral to the FBI is in order. The replies, and in this particular discourse, the inquiry itself, operate on stereotypes that identify this student as a foreign other. The involved list members have taken very little information, and it should be noted that this information was inflammatory, and made judgments about the student. “Stereotypes operate more freely on ambiguous criteria, based on ambiguous and scant information” (Fiske, 1993, *Tales of Two Women*, para. 10). The stereotype allows the writers to construct a social consensus

about differences that justify their proposed treatment of this international student. The student, as the dominated minority, has not been allowed to speak, so the entire discourse is based on stereotyped representations.

In discussing this international student, no one brings up the concept of culture as an attributing element of the student's behavior. Using Matsumoto's (1996) definition of culture, it is "a set of attitudes, values, beliefs, and behaviors shared by a group of people, but different for each individual, communicated from one generation to the next" (p.16). A research project by Parry and Wharton (2007) investigated a group of international graduate students who were participating in an MBA program. Their findings strongly suggest that an international student's culture will impact the sense of control in the learning environment. An external locus of control causes the student to perceive the events in the classroom as being under the control of powerful others and not to be influenced by their own actions. When an international student is thrown into an unfamiliar situation they may perceive it as threatening even when the reality is that they are safe. An ambiguous situation can cause the international student to experience worry, obsessions and panic (Dugas, Gosselin, & Ladouceur, 2001) and may make the student distort information. "Intolerance of ambiguity may be defined as 'the tendency to perceive (i.e., interpret) ambiguous situations as sources of threat' (Budner, 1962, p. 29). As Budner discovered, responses to the perceived threat include the cognitive functions of perception, evaluation and feeling as well as the behavioral actions which are based on the reaction to the "threat." This can include denial which causes the "performance of some act by which the objective reality, even if only in the phenomenological world of the individual, is altered to suit the desires of the perceiver" (Budner, 1962, p. 30). The

act that is performed by this student is to attempt to arrange the physical settings even though this appears strange to others. This description of international students who were researched explains more about what might have been happening to the student being discussed without resorting to stereotyping.

Questioning Professional Ethics/Expertise of Mental Health Professionals

DSS officers at times doubt the expertise of other professionals who make decisions about students with psychiatric disabilities, such as physicians, psychologists, or counselors. The assertion that the DSS staffer has the complete authority to determine whether a student is disabled, if they qualify for services, and what the accommodation will be is repeated throughout the discourse. There is a discussion of the unreliability of the evidence of disability that the students submit in their documentation. The socially constructed reality of who has the power to determine a student's disability is explicitly expressed in the text. The argument that the doctor or therapist who is providing a student's documentation is not acting professionally and, in fact, is not honestly depicting a psychiatric disability, is found throughout the text. There are no counter-arguments made by other list members, which builds the social construction of psychiatric disability diagnoses being open to dispute.

DSS personnel routinely ignore the recommendations of doctors and mental health care professionals if the discourse is to be believed. The DSS office reserves the right to make the final decision about reasonable accommodation. The right to be the final arbiter of accommodations allows the DSS professional to protect the school from unreasonable accommodation requests. Several times the post to the list indicates

skepticism about the credibility of the psychiatric and medical documentation received, with the end result that the student does not receive prescribed accommodations.

If the student is capable of attending classes, I would question if agoraphobia is now an accurate diagnosis. I do not see a diagnosis as anything but a description of a collection of symptoms or behaviors. (Appendix O, 221-223)

That some list members have a stereotyped impression of agoraphobia is apparent. It is clear that they believe a person with the diagnosis of agoraphobia is going to exhibit only the most extreme symptoms of the disorder – that of someone unable to leave their home. There is complete dismissal of the idea that agoraphobia symptoms, like in other psychiatric disorders, range in a continuum from the most severe to near recovery. Thus the discourse about students with the diagnosis of agoraphobia is one of cognitive closure. The questioning of the diagnosis of agoraphobia is supported by the poster's argument, "I do not see a diagnosis as anything but a description of a collection of symptoms or behaviors." The taxonomy of any disease is determined by the presence of symptoms, and in psychiatry behaviors, that the doctor or therapist use to determine diagnosis. Thus it is uncertain about the intent of this argument. The two statements taken together lead one to conclude that a psychiatric disorder is "only" a collection of symptoms and behaviors.

It appears from the cumulative reading of the discourse that DSS personnel are truly not trained to be interpreting what they are reading in psychiatric documentation and the institutions that hire them seem to be complacent about this lack of training. As discussed in the section on the role of DSS professionals, there are many different job descriptions and qualifications in job announcements for the DSS position. Perhaps because the DSS job has not become a recognized profession, the institutions are unaware

of the responsibilities of the people they hire which allows such a broad variance of qualifications for the job.

A posting about another student with agoraphobia (Appendix O, 1-10) echoes the sentiments of the previous posting.

Are we in essence accommodating adverse/negative behavior? My first assumption was that the impact of the Agora on the educational process and this student, was not debilitating [sic] enough to warrant accommodations, or to qualify the person as a student with a disability. That if the swd could maintain enough to get into the classroom and was only worried about oral presentations, then join the rest of the class which are typically just as anxious. (Appendix O, 60-66)

The argument establishes the “fact” that this student is able to attend classes, therefore is not a student with a disability. The fact that every student with a disability is expected to attend class and is not then considered as abled because they “could maintain enough to get into the classroom” is lost in this argument. The additional “fact” that all students are anxious about oral presentations allows the writer to conclude that an accommodation would be “accommodating adverse/negative behavior.” These “facts” taken together lead to the conclusion that there is no need to serve this student. This creates a socially constructed rationale that can be used as a fundamental social cognition by DSS officials. When thinking about students diagnosed with agoraphobia, disqualify them for accommodations because they are not disabled if they attend class.

In reply to a request for a single room in residential housing by a doctor who diagnosed the student with adjustment disorder with mixed anxiety and depression (Appendix L, 1-17), a list member wrote,

Despite the psychologist's use of DSM4isms this is a relatively common problem that is usually short lived. (Appendix L, 19-21) I am not sure that legally, developmentally or therapeutically giving this person a private room is the "right thing" to do. (Appendix L, 23-24)

The diagnosis and recommendation of the psychologist is dismissed out of hand. The comparison of a psychiatric disability to a stereotyped view of most students entering the residential setting serves to negate the diagnosis by the doctor. The writer is disguising his/her attempt at influencing the other list members by using language grounded by stereotypical comparison (Reid & Ng, 1999). This creates the social cognition of students presenting with certain psychiatric disabilities as not “really” disabled and undeserving of accommodation. “Hence social cognitions mediate between discourse and action” (Resnick, Levine, & Teasley, 1991, as cited in Van Dijk, 1993, p. 257). The belief that requests for single rooms based on “DSM4isms” are specious becomes part of the DSS professionals’ thinking. Thereafter, on the occasions that the DSS officer dislikes the diagnosis, there is the socially constructed “permission” to disregard the doctor’s recommendations.

I have the impression both from the list and from talking to colleagues around the country that at any number of schools, the ADA and section 504 have become the ticket to single rooms, with the ticket filled out by a health care provider diagnosing the need on the basis of a psychological impairment. I wonder whether a freshman who cannot cope with change should be attending an institution whose very purpose is to stimulate the possibility of change through exposure to a host of new ideas and experiences. (Appendix L, 29-36)

Too many students fit this profile. As a counseling psychologist I help them adapt to college life, many with these very symptoms. A single room does not seem a reasonable accommodation. (Appendix L, 73-75)

In a discussion on how to accommodate a student diagnosed with oppositional defiant disorder (ODD), the list member replied that ODD was not a disability because it did not substantially limit a major life activity. This contention was lodged in spite of the doctor’s documentation and recommendations.

With many impairments, the question is easy to answer, but when the answer is not obvious, DSS offices need not defer to whatever a health care professional retained by a student asserts substantially limits a major life activity. DSS staff are professionals in their own right, not paper pushers and ticket takers whose only role is to see whether a

student has consulted a health care professional to obtain some documentation. If DSS offices do not assume responsibility for asking whether an impairment does, in fact, substantially limit a major life activity within the meaning of the ADA, other people within the university surely will, and will do so in ways that ultimately redound to the detriment of DSS offices, and more importantly, to students. (Appendix G, 290-300) The appearance of an impairment in the DSM-IV is not proof that it substantially limits a major life activity; remember that the DSM-IV is largely a guide for health care professionals who submit insurance reimbursement claims, and that impairments move into and out of various versions over time. Some of the once commonly diagnosed impairments in earlier versions of the DSM have been dropped from the most recent edition, and others have been called into question, all because we know so much less about psychiatric impairments than about many other impairments. The bottom line is simple -- if DSS offices are to retain their role, they must assume responsibility for all of its aspects, including, when appropriate, questioning the assertion of a health care professional that a particular impairment substantially limits a major life activity. (Appendix G, 290-329)

The employment of a quasi-logical argument to validate the nonaccommodation of students with ODD is used here. The writer argues, “. . . remember that the DSM-IV is largely a guide for health care professionals who submit insurance reimbursement claims, and that impairments move into and out of various versions over time.” This argument uses the rhetorical scheme of transivity (Zanoni & Janssens, 2003). The argument is that (a) = (b) and (a) = (c), therefore, (b) = (c). Students with *ODD* (a) do *not qualify* for accommodations (b); students diagnosed with *ODD* (a) are diagnosed using the DSM-IV which is *intended for insurance reimbursement billing and is changeable* (c); therefore, these students *do not qualify* for accommodations (b) because the diagnosis is based on *criteria for insurance reimbursement billing and is changeable* (c). The argument accomplishes two persuasions by the writer. First, students diagnosed with ODD do not qualify for services from DSS and second, health care professionals who make the diagnosis base their professional opinions on criterion that is not intended for that purpose and changes over time.

“DSS offices need not defer to whatever health care professional retained by a student asserts substantially limits a major life activity.” It is notable that the writer uses the institutional reference “DSS offices” rather than a term that personalizes the argument. This sets up the rhetorical move that Warnick and Kline (1992) call the model and anti-model argument. The DSS office is the model to be imitated and the health care professional is the anti-model. This sets the doctors and therapists, as the anti-model, to be unfavorably regarded. Antipathy for the anti-model is encouraged while imitation of the model (the DSS office) is encouraged. “DSS staff are professionals in their own right, not paper pushers and ticket takers whose only role is to see whether a student has consulted a health care professional to obtain some documentation.” The prestige of DSS staff as “professionals in their own right” is touted to legitimize their evaluations of students and subsequent actions (or inactions) which differ from the prescribed actions of the doctor or therapist. The metaphor of “paper pushers and ticket takers” is denied in the argument, raising the status of DSS personnel from bureaucrats who shuffle papers or people who give admittance to anyone with a ticket to “professionals in their own right.”

Legitimation of power in text justifies the institution’s actions through providing normative and cognitive validity of objectivated meanings (Hall, 1974; Makus, 1990). “Legitimation not only tells the individual why he *should* perform one action and not another; it also tells him why things are what they are” (Hall, 1974, p. 276). An institution of domination uses discourses to build its authority so that domination is simply the natural result of its actions. The setting of policy may be explicitly determined by the institution, but the interpretation and execution may make the allocation of

services by the service providers appear logical and proper. The legitimacy the service providers establish through discourse performs as hegemony.

In an instance where the secondary school psychologist provided documentation and declined to do new evaluations based on his/her conclusion that the student's diagnosis was unchanged (Appendix L, 114-120), the list member took strong exception to the right of the psychologist to make this determination.

It is not the school psychologist or any other professional's right to tell us what is reasonable or unreasonable. That is our determination. (Appendix L, 126-127)

In another case of a student not having his/her documentation at the time of accommodation request (Appendix L, 177-190), the replying list member advocates that the accommodation should be furnished on a temporary basis while the student is evaluated. The general skepticism of diagnoses by mental health professionals is stated.

I'm cynical enough to believe that getting a diagnosis of a general anxiety disorder, not otherwise specified, just isn't all that hard to get. The diagnostician will listen to the student, rule out other possibilities, and anoint the person with the necessary documentation. Then the busy bees in DS land can get the honey flowing. (Appendix L, 249-253)

Though it appears that the poster is acquiescing to the needs of the student, this is, in fact, another argument that the "diagnostician" is performing in a less than professional manner. The work of the diagnostician is reduced to "listen," "rule out," and then "anoint." The writer is expressing the willingness to give up his/her power temporarily, but in the long run will continue to question the professionalism of those providing documentation of psychiatric disabilities. It also appears from the discourse that this writer does not think that generalized anxiety disorder as a diagnosis is a "real" psychiatric disability for most people. The temporary power of the doctor or therapist to determine disability is nebulous, at best.

In response to an inquiry about a student diagnosed with a test phobia (Appendix L, 301-316), a list member replied,

Hmmm, almost sounds as if it had been dictated by the student... (Appendix L, 350) I seriously suspect that your example sounds like the student told the psychologist what to say. (Appendix L, 356-358)

For a student diagnosed with agoraphobia and panic disorder whose documentation first recommended that the student not attend an out of town class but then the doctor reversed their thinking and stated that the student was fit to attend, the list members expressed doubt. The suggestion is that the DSS officer contact the attending doctor in order to “make the doc think first before he starts to take dictation from a patient again.”

As a minimum I would want to hear from the same doctor that it is now safe and what if any accommodations are needed. I would also ask what has changed that it is now safe. That may not be entirely necessary but it might make the doc think first before he starts to take dictation from a patient again. (Appendix E, 379-383)

In my view this is a case of therapist overly advocating for her client. Asking for everything she could get even though it was not justified. (Appendix E, 404-407)

A therapist was always available to call on behalf of a student who would miss classes due to panic attacks (Appendix L, 551-579). The response from a list member expresses the doubt that this is appropriate care and perhaps the student is being attended to by the wrong doctor. A “pill doctor” is unqualified to help.

The fact that her therapist would collude with her in avoiding the aversive situation, thereby preventing her from ever dealing with the feared stimulus (the test) and learning that she can survive it is unbelievable!!!! (Unless he's just a pill doctor and isn't doing any real psychological treatment.) (Appendix L, 608-611)

Constructing and Contesting the Meanings of Key Terms

Much of the discourse on the DSSHE-L list involves questions of policy. From the text analyzed I selected three policy concepts that list members discussed. The

impetus for these policies to be posted to the list came from repeated inquiries requesting that institutions share the policies they have in place as exit strategies for students with psychiatric disabilities. For each policy, I have provided background information on the written policies and then an analysis of how the list members constructed the meaning of the policy. In many cases, the DSS officials discussed fundamental disagreements about their role as the arbiter of academic access. Often the value of protecting the institution trumped the value of protecting the rights of students with disabilities. The discourse in these discussions draws on the Grand Discourses of law and its interpretation. Legalese has the effect of promoting the policy to a “natural” response to a liability issue without exposing the hegemonic effect.

After counseling, you will leave. The DSS office is often asked to contribute to institutional policy when disability issues are involved. Sometimes DSSHE-L members requested that other institutions share their policies, which created a global discourse about how students with disabilities were to be treated. The goal of some policies worked to the detriment of students with disabilities and, especially, set apart students with psychiatric disabilities for punitive actions. Questions posed to the list regarding admissions, involuntary withdrawal, readmission, and leave policies often marked students with psychiatric disabilities as the target for removal from the college or university. The resulting “Counseled Withdrawal Policy” that is discussed is a policy that specifically marks students with psychiatric disabilities as the object for removal. It began with the requests for shared policies.

The following requests for policies demonstrate the general attitude that students with psychiatric disabilities will be in need of special policies for “admission, re-

admission, or judicial processes,” “late drops and/or withdrawals,” or “dismissal of students with psychological disabilities.”

We are interested in knowing if anyone has a policy related to admission, re-admission, or judicial processes for students with psychiatric disabilities. (especially related to students with chronic schizophrenic and/or psychotic symptoms). (Appendix A, 1-4)

We are looking into establishing a process for handling late drops and/or withdrawals as accommodations for students with mental health related issues and/or depression. We are experiencing an increased number of such requests and would like to have some type of process in place. (Appendix A, 5-8)

Can anyone direct me to any universities that have a specific written policy that addresses the behavior and dismissal of students with psychological disabilities? I understand that students can be expected to follow the same behavior policy as all other students, but we have had some unique situations that we feel warrant the need for a more specific policy when addressing the needs/issues of students with psychological disabilities. (Appendix A, 46-51)

The fact that any student, regardless of physical or mental status when entering college, could become ill and need to drop out of school is not even a consideration of these questioners. It is the students with psychiatric disorders, and particularly schizophrenia and depression, who are singled out. Offices of disability services provide accommodations to students with disabilities to insure access, but in these questions the intent is to remove, voluntarily or involuntarily, students with psychiatric disabilities from school.

Each of these requests for policies to remove students has the reasoning that it is “for students with psychiatric disabilities (especially related to students with chronic schizophrenic and/or psychotic symptoms),” “for students with mental health related issues and/or depression,” or “students with psychological disabilities.” The authors of these requests have constructed causality between these mental health issues and the need

for a policy to remove them from the college setting. Using the analysis of argument demonstrated by Warnick and Kline (1992), the argument of cause for removal in these posts is “grounded in culturally held beliefs and presumptions about reality” that assumes that other list members will agree that mental illness provides a reasonable “motive and precedence for action” (p. 5). To be effective arguments for the transitional theory of the authors that links mental illness with the need for removal policies, there must be agreement among the interlocutors that the need to remove students with psychiatric disabilities from school is going to arise as a natural course. There is also the assumption that other colleges and universities have already established a pragmatic and efficient policy to remove the students with psychiatric disorders from their campus.

The transparency of the intent of establishing policies that mark students with disabilities for special treatment is recognized by some list members. Some DSS professionals insisted that students with disabilities, and especially students with psychiatric disorders, be treated the same as other students.

We work through the 'regular' system. That is, any student can ask for a medical withdrawal through our Executive Dean. If the student has a disability related reason for asking for a withdrawal after the withdrawal deadline, we have them write a request to the Dean explaining that they are working with our office and their need for such request. If we need to add information or help them write the letter, we do. My philosophy is to make the system work for students with and without disabilities rather than creating an entirely different system. (Appendix A, 22-29)

This is exactly what we do here as well.....(Appendix A, 30)

we do nothing specific for students with a disability. We are on a ten week quarter. We give students 8 weeks into each quarter to drop a class simply because they want to, no permission is needed. We have no medical leave process. After the eighth [sic] week, All students must get permission to drop the class from the instructor. The instructor will determine the extenuating circumstances and decide whether a failure or drop is in order.

This decision is based on the students performance [sic] during the first eight weeks, saying a GPA is not a valid reason. We will write a letter of support for the swd if we feel it is appropriate and reasonable. (Appendix A, 31-39)

Working through the “regular” system treats students with disabilities the same as other students. There was the willingness expressed to assist the student with the withdrawal process when necessary to help the student. There is a stated philosophy that all students should be treated the same. The request for a dismissal policy for students with psychological disabilities was also met with suspicion of intent:

Are you talking about policies that give breaks to students with psychological impairments or policies that hold them to a stricter or specialized standard of behavior? I think either could sail you into troubled waters. Maybe a better approach would be to update the policies applied to all students with and without disabilities. (Appendix A, 52-56)

i believe that would be discrimination. there is case law and/or ocr precedent to follow. if you do write a policy, refer to behavior and not a psychological disability. (Appendix A, 57-59).

That students with psychological disabilities are treated differently than other students when it comes to withdrawal policies is disguised in the published policies in student handbooks, but the discourse on the list reveals the reality of such policies. Institutions are attempting to identify and remove any student who poses a threat to themselves or others in an attempt to limit institutional liability in the event a student acts out. Disguised in the legal discourse of the policies under discussion is the intent to protect the institution from the imagined actions of students. The discourse in the following post is particularly troubling in the amount of coercive power that is directed at a student with a psychiatric disability if their symptoms are recognized.

We have a process at XXX called a “Medical Leave”. “Medical” is a euphemism for psychological. A student experiencing psychological distress to the point they should not or cannot be in school may be offered a medical leave. The student must meet with a counselor in Counseling and Psych Services (CAPS). The counselor then makes a recommendation to the student’s college that the student be put on a

medical leave, usually for at least 6 months. The leave is granted by the student's college. An explicit condition of the leave is that the student must be evaluated by a counselor at CAPS before they are cleared to enroll again. Students are expected to obtain treatment while they are on leave, also made explicit in the leave documentation. The CAPS counselor usually requests information from the treating therapist about the student's treatment and progress, which is considered in the evaluation to return. So, my understanding is, if the evaluation/medical clearance to return is made a requirement of the leave of absence, it can be enforced. However, if a student takes a leave voluntarily, I don't believe it can be required. We encourage students to take medical leaves if there are psychiatric issues. We find it pretty effective, especially for getting students to accept responsibility for their treatment. (Appendix A, 100-117)

Note that the policy "offers" a medical leave to the student. The attempt to disguise the fact that the school will exert its powers to get the student to leave is in the claim that they are "offered" medical leave which is a "euphemism for psychological." This indicates that the leave policy is not intended for all students, just students with psychiatric disabilities. The coercion is further elaborated as, "The student must meet with a counselor in Counseling and Psych Services (CAPS)." The policy does not leave it to the student to seek care from their own mental health professional. And though it is not stated in the policy, the reality is the counselor will be conducting a forensic psychological examination that will be provided to administrators at the college/ university and will not be treating the student for their disability. It is not clear whether the counselors being used are trained in risk management and forensic psychology, but the counselor's role will be to provide the institution with an evaluation that will potentially cause the student to be removed. Whenever a psychologist or psychiatrist is acting on behalf of an institution in a risk management role they are no longer acting on behalf of the patient. "The counselor then makes a recommendation to the student's college that the student be put on a medical leave, usually for at least 6 months." This puts the student at a disadvantage because their right to privacy and confidentiality is

voided by the forensic setting and, as the policy states, the counselor will be advising the college of the student's current psychological status. The fact that the leave is not of the student's choice is further indicated by the fact that the leave is "usually for at least 6 months." Just because the student is out of school for six months does not end the interference of the school. "An explicit condition of the leave is that the student must be evaluated by a counselor at CAPS before they are cleared to enroll again." The school's control over the student is apparent even while the student is on medical leave. "Students are expected to obtain treatment while they are on leave, also made explicit in the leave documentation. The CAPS counselor usually requests information from the treating therapist about the student's treatment and progress, which is considered in the evaluation to return." So not only does the student have to undergo psychiatric treatment during their leave, the documentation of that treatment becomes part of the reentry requirement. The school demands the right to keep a student under surveillance even when they are no longer matriculated. The DSS staffer continues to show his/her involvement in this subjugation of students who get caught up in this policy by using the inclusive term "we." The DSS staffer admits that the medical leave policy is intended for involuntary withdrawals during which students are subjected to extraordinary scrutiny that other students are not. "However, if a student takes a leave voluntarily, I don't believe it [evaluation by the school's counseling and psychological services] can be required." The implication that students who have psychiatric disabilities are childlike and unable to care for themselves and the institution will provide paternalistic care is in the final sentence of this post. "We find it pretty effective, especially for getting students to accept responsibility for their treatment" as if students who become ill have been irresponsible.

Sometimes psychiatric symptoms can interfere with a student's life even when they are doing everything right. The school is operating *in loco parentis* while the student is in school and, through this policy, extends the control into the student's life at home.

Counseled withdrawal policy. There are other policies that specifically name students with disabilities. In the following policy posted to the list, students with either physical or psychological disabilities are targeted for removal.

COUNSELED WITHDRAWAL POLICY

Xxx College endeavors to provide a safe and orderly environment, insofar as possible, in which all students are able to pursue their academic and social development. In so doing, it reserves the right to require a counseled withdrawal of any student whose behavior or physical or psychological disorder is incompatible with minimal standards of academic performance and/or social adjustment.

Students to whom this policy applies include:

1. Students who are deemed to be a danger to themselves or others. Danger to self or to others is here defined to include any danger of suicide, self mutilation, accident, or assault substantially above the norm for college students which necessitates unusual measures to monitor, supervise, treat, protect, or restrain the student to ensure his or her safety and the safety around him or her.
2. Students whose behavior is severely disruptive to others. Disruptive is here defined to include behavior which causes emotional/psychological/physical distress to fellow students and/or staff substantially above that normally experienced in daily life. Such disruption may be in the form of a single behavioral incident or somewhat less severe but persistent disruption over a more extended period.
3. Students (a) who refuse or are unable to cooperate with recommended assessment and/or treatment and (b) whose behavior or physical condition suggests a disorder, such as an eating disorder, which is likely to deteriorate to the point of permanent disability, disfigurement, impairment, or dysfunction without such assessment and/or treatment. Where standard assessment is impossible because of the student's resistance, indirect behavioral observations will constitute the basis for such judgment.
4. Students whose physical or psychological disorder is such as to require highly specialized services beyond those available locally and whose condition will deteriorate (as in 3 above) without additional resources. (Appendix A, 212-241)

A policy constructed on the premise that any student whose "behavior or physical or psychological disorder is incompatible with minimal standards of academic performance and/or social adjustment" should be dismissed from school is based on an

ideology of exclusion. It assumes a universal validity that deviant behavior or serious physical or mental impairment is subject to extraordinary surveillance, therefore the school has a legitimate right to deny access to identified students. According to Schur (1979), deviance is a socially constructed concept. As Hall (1982) would identify in the policy text, the ideology behind the policy is grounded in “particular constructions in the taken-for-grantedness of ‘the real’” (p. 65). That deviance should naturally be an indicator of unacceptability and subject to sanctions is assumed to be universally acceptable when in truth it is a stereotype. “Deviance-defining, quite simply, incorporates a tendency to construct ‘classes’ of presumed deviators and to see all members of the class as being essentially alike in some special, distinguishing way” (Schur, 1979, p. 51). Erikson (1967) defines deviance as “a sociological phenomenon of control.” Those who label an individual are the audience that observes behaviors. Those who would be named deviators have done something so outside the norm that a social control agency must do something about it. Social control agencies can be formal, such as the law or a psychiatric hospital, or can be informal, such as community members joining together. In this particular policy, the institution has designated certain powerful members including counselors and doctors to be the arbiters of deviance.

“Counseled withdrawal” implies that the student will voluntarily withdraw from school upon appropriate counseling. Upon further inspection, however, the policy is intended to set out the guidelines by which the institution can force a student to leave. The stated purpose of this policy is “to provide a safe and orderly environment” though what the institution considers “safe” and “orderly” is not defined. The policy does not refer to other policies that exist in student handbooks, such as the policies related to

judicial action, to make it clear. Certainly, the ideal of a college being a safe and orderly environment is a positive one, but further reading of the policy reveals the targets for “counseled withdrawal” as “. . . any student whose behavior or physical or psychological disorder is incompatible with minimal standards of academic performance and/or social adjustment.” What is meant by “minimal standards?” Again, the determination of who this includes is unclear. Any student with a physical or psychiatric disability could be determined as “incompatible with minimal standards” because they make demands for accommodations. What a student may deem as appropriate assertive advocacy for their civil rights might be regarded as disruptive. The policy then proceeds to define what the preamble means. However, because the preamble is so broad and encompassing in defining the affected students, the institution could choose to include students that do not fall into any of the four categories of the definition and still be within the intent of the policy.

The first category of student is “a danger to themselves or others.” The definition of what that means includes “any danger” which can be interpreted very broadly. This would include the stressed student who is ideating about suicide. In a study conducted at a large U.S. university it was found that over half of the subjects had thought about committing suicide (McAuliffe, Corcoran, Keeley, & Perry, 2003). The policy could affect up to half of the students on the campus. Then the definition includes “accident.” Does this mean that a student who wrecks their car, twists a knee playing sports, falls on ice, or otherwise hurts themselves is subject to counseled withdrawal? It appears that the liability concerns of the policy writers are overly broad. Then it must be asked, what are “unusual measures” in caring for the affected student? It would seem that hospitalization

of a suicidal student would be the norm of care, so is normal care an unusual measure? The second paragraph of the policy then defines “severely disruptive to others.” This could be construed to include the student who is going through a major breakup with their partner, for many students an extremely trying psychological stressor. Therefore, should the offending partner be removed from school for causing “emotional/psychological/physical distress to a fellow student? After all, the policy specifically states that it can be “a single behavioral incident.” The third criterion of counseled withdrawal is even more broad. By refusing to attend institution-mandated counseling assessment and/or treatment the student can be removed. It is especially vague to base the requirement for counseling or treatment on “behavior or physical condition that suggest a disorder.” The student who prefers to pull all-nighters to accomplish their studying can easily be considered disruptive to the roommate and it could suggest that the student is in a manic state that does not require sleep. It is interesting that the policy specifically names students with “an eating disorder” as subject to counseled withdrawal. Does “disfigurement” include tattooing and piercing? After all, some piercings appear to be disfiguring in this author’s opinion.

The policy also specifically prohibits a student from resisting the application of this policy. In the case of a student who wishes to protect the right to pursue their own medical or psychological treatment, or who refuses to take prescribed medications because of the side effects, the institution will just rely on “indirect behavioral observations” though it is not specified who will be doing the observing. The fourth criterion is especially damning for students with disabilities who require specialized care. It seems that if they have to travel to receive this specialized care, they can be withdrawn

from school if the treatments are not available “locally.” This overly broad policy was found at several colleges and universities across the nation through a Google search. The dissemination by DSS professionals has, perhaps, caused the policy to be constituted as global discourse. That it is based on the Grand Discourse of disability is apparent from the discriminatory way the stigmatized students will be treated – as “others” who need surveillance and control. The agent of control at the institution includes the DSS officer who helps to enforce this policy.

The application of a policy that treats disability as an instance of disciplinary misconduct is absolutely counterintuitive for an institution which is governed by the ADA, Section 504, and, in most cases, state law. These laws and regulations insist on institutional measures to insure access for people with disabilities. In an attempt to explicate the reasoning that allows the University to devise a system of discrimination, the analysis of organizational symbolic power as discussed by Bourdieu (1989) must occur. Point of view is from the dominant agency which is expressed in official discourse. Thus the policy, which is a social construction of dominance, represents the reality of the institution of power rather than those it places in a subordinate position – certain students. First, the agency performs a “diagnostic” which “asserts what a person or thing is and what it is universally, for every possible person, thus objectively” (Bourdieu, 1989, p. 22). Once identified as deviant through “objective” evidence, the student is marked for surveillance and removal.

The posting of the policy received two responses from list members who took exception. One pointed out that a person cannot be forced into counseling and then expelled due to their disability (Appendix A, 242-248). The ADA specifically omitted the

idea that someone in authority could paternalistically protect a person with a disability from taking risks by omitting the phrase “threat to self.” The second response questioned who will have the authority to set the norms (Appendix A, 249-252). This archived policy statement may lead to discriminatory actions by institutions that choose to model their psychiatric withdrawal policies on it. To date, the Office of Civil Rights (OCR) has ruled in several cases that to remove a student from their academic program and/or campus residence based on disability is discrimination (Leibert, 2003). The only exception allowed thus far is the “direct threat” clause. “A person who poses a ‘direct threat’ to the health and safety of others will not be considered a ‘qualified person with a disability’ (Alikhan, 2001, p. 165). However, the direct threat must be immediate and based on objective evidence not on a generalized fear that “something” could happen.

Criminals and deviants need not apply. Colleges and universities are not just forcing students to withdraw from classes when they have a psychiatric disability; they are expanding their policies to allow the removal of students from residential dormitories. On some college and university campuses, the diagnosis of a severe psychological disorder, especially with a history of suicidal ideation or being a threat to others in the past, is sufficient to be denied housing. In the following policy statement, which is in effect at several colleges and universities across the nation, the targeted students can be physically or psychiatrically disabled. An online search found some schools using the policy verbatim in 2007, so it was important to critically analyze it. That DSS professionals have disseminated the policy to other schools is discouraging. They are acting as agents of control rather than agents of academic access.

Any student whose physical or mental health might jeopardize the safety or well-being of that individual or any other resident may be required to have an examination by a University physician or a consultation with

a University counselor. Should the physician or counselor determine that a health or safety concern exists, the Director of Student Housing and Residence Life or designee may amend or suspend the student's housing contract, as appropriate.

The University reserves the right, at its discretion, to determine that their medical condition, past behavior, and/or criminal activity is such that the best interests of the University, the student and/or other students would best be served by alteration or cancellation of the housing agreement. If the University becomes aware that a student has a record of criminal convictions(s) or other actions indicating behavior that could pose a risk to person or property and/or could be injurious or disruptive to the residence hall community or the living-learning environment, the University may not accept or may immediately terminate the housing agreement. (Appendix H, 8-24)

“Any student whose physical or mental health *might* jeopardize (emphasis added)” would include most students with psychiatric disorders and some students with physical disabilities including those with chronic illnesses. “. . . could be injurious or disruptive to the residence hall community or the living-learning environment” serves as justification for the policy based on the imagined threat to the dominant group – students who are not physically or mentally ill. The definition of “the University” includes every office under that jurisdiction, including the DSS office. Therefore, documentation that is required in order to receive services from DSS may be shared with “the University” and used to remove the student or withdraw availability of campus housing.

In the present case the policy asserts that students with disabilities and criminals must be monitored, evaluated, and possibly removed from the society known as residents of dormitories. This will be done after “objective” investigation by the University’s physicians or counselors. The University assigns an identity of deviance to the affected students which, as Bourdieu observed, is Kafkaesque in its ability to create and attach identities to people. After the diagnosis assigns identities to the targeted population, administrative discourse, in the form of the policy text, declares what will be done to this population, what they, in turn, must do, all based on the policy’s definition of what the

affected students are. The establishment of the authority and naturalness of the actions the institution will take will be based on authorized accounts of deviance as provided by the University's physicians or counselors. The only point of view is that of the University. As the policy is implemented it is legitimized as a point of view that everyone should recognize as an institutional repository of common sense (Bourdieu, 1989). The habitus of the institution, the taken for granted understandings from daily practice, obscures the meaning and consequences of the actions taken under the guise of a common sense policy (Bourdieu, 1977). This policy targets disabled students and puts criminals in the same category of unwanted residents. By placing this policy within the contract for housing, the school is subverting any attempt to negotiate out of this clause of the contract. Once again, the student's right to privacy and confidentiality with their health care professional is being violated. This policy makes no pretensions that it is anything other than a means to force students out of housing which can lead to forcing the student to leave school. The rights of the institution are protected from imagined liability while the rights of the student are trampled. The first line of the policy states that the institution can "require" a student to undergo evaluation. Once again, the rules of forensic medicine come into play – the evaluation is not intended to treat the student, it is intended to provide information to the school. The policy targets students whose "medical condition, past behavior, and/or criminal activity" represents a threat as defined by the institution. This means that a student who may have made a suicidal gesture in the past, even though they are perfectly well today, can be forced to undergo invasive evaluation if they are found out. It is open to interpretation what "past behavior" the institution will find troublesome. It is stated

that this policy is acting “in the best interests of the University” although it continues that it is in the interest of the student and other residents.

The fact that ideological constructions are socially formed tends to be lost to consciousness. They are proffered without an inventory as truths which can function in a variety of contemporary contexts to legitimate current practices and interpretations of events. These underlying presuppositions are rarely made explicit and remain largely unconscious both to their authors and to those required to make sense of them (Makus, 1990, p. 498).

Inventories of the “truths” that are used to legitimate the policy are:

1. “physical or mental health might jeopardize the safety or well-being”
2. “an examination by a University physician or a consultation with a University counselor” will “determine that a health or safety concern exists”
3. therefore, it is “appropriate” to “amend or suspend the student’s housing contract
4. “medical condition, past behavior, and/or criminal activity” may cause “alteration or cancellation of the housing agreement”
5. because it is in “the best interests of the University, the student and/or other students”
6. “The University” will “determine that”. . . “medical condition, past behavior, and/or criminal activity” will result in “alteration or cancellation of the housing agreement”
7. in “the best interests of the University, the student and/or other students”
8. “a record of criminal conviction(s) or other actions indicating behavior that could pose a risk to person or property and/or could be injurious or disruptive”

9. will result that “the University may not accept or may immediately terminate the housing agreement.”

Analyzing these “truths” and the presuppositions that are assumed within them reveals the hegemony that is enacted by this policy. The representation that this policy works “in the best interest” of “the University, the involved student, and/or other students” belies the fact that the policy was enacted to protect the University from any liability an affected student could pose. This interpretation of purpose is based, in part, on the fact that it is “an examination by a University physician or a consultation with a University counselor” who will determine if it is in “the best interest of the University” and it will be “The University” who will make the determination to “amend or suspend” or cause “alteration or cancellation,” or “may not accept or may immediately terminate” the contract for housing. All of the power is retained by the University and its agents, the counselor or physician, who acts on behalf of the University.

The policy also creates a class of students that include students who are physically or mentally disabled and criminals. It is interesting how much these special policies for the disabled reflect the policies what once prohibited people from attending school and living in dormitories because of their race. This policy is specifically directed at students with “physical or mental health” whose “medical condition, past behavior, and/or criminal activity” or who have “a record of criminal conviction(s) or other actions” to be subjected to surveillance and the remedies of the policy.

The ideology of the University administration creates the lived realities of students with physical or mental disabilities. There is no alternative reality acknowledged by the policy. The common sense that is called on to construct the policy

does not allow for other interpretations of student rights. Those who are identifiable as “disabled” as defined by the University’s physicians or counselors are marked as undesirable along with criminals. The ideological power of this policy is in the contention that it is enacted to serve “the best interests of the University, the student and/or other students.” When a policy is written that professes to serve the public good, it attempts to give the appearance of the University as uninterested in the legal concerns of the institution. Ball (1994) reminded us that a policy is political as text and action and its ideology is reflected by what is enacted by text as well as by what is intended. In the intertextuality of the policy, the University is relying on surrounding texts including laws and regulations to determine the meaning of the policy because the meaning is not clearly stated. The centrality of power within the institution which formed the concept and execution of the policy suggests that the values represented in the text are institutionalized (Prunty, 1985).

There are several premises that the University assumes to be accepted by the students living in University owned residences. It is probable that the University assumes that in the instance the policy is enforced that the premises will be accepted by the student, the parents, and the courts. The premise that focuses on the real (Perelman & Olbrechts-Tyteca, 1969; Zanoni & Janssens, 2003) is the reality that there will be students residing in the dormitories who are or will become disabled by physical or mental illness. The presumption in this premise is that these students are a danger to themselves or others. The premise that focuses on the preferable (Perelman & Olbrechts-Tyteca, 1969; Zanoni & Janssens, 2003) is that it is in the University’s own interest to remove these students from housing and, ultimately, to remove these students from

classes. The language of the policy reveals the University's coercive power through forced disclosure to University physicians or counselors and clearly states the intention to interfere with the housing contract.

Fairclough (2005) suggested that there are four elements or moments in the social construction of hegemonic discourses. In the "emergence and constitution" of this policy there was discussion of liability concerns related to student suicides, self injury, or harm to others in the discourses of higher education. The news media covered the events of student suicides in detail. There were lawsuits filed by parents which blamed the affected schools for failure to protect students which created discourses in law. This caused the University to engage in writing the text of the policy which resulted in hegemonic discourses. The dissemination of the policy as text includes the presentation of the policy in the discourses of the mailing list where it was recontextualized between the originating institution and others as well as from the local scale to a national scale. The fourth element occurs with endorsing the policy by enacting it. These are all "distinct moments" in the "causal effects of discourses on non-discoursal (as well as discoursal) elements of social life" (Fairclough, 2005, p. 932). The policy reflects a dominant discourse that, through the text on the list, influences other discourses as a concrete model of hegemony for other institutions to adopt.

The dissemination of this policy by the DSS officer posting to the list may have caused it to be enacted at other institutions of higher education. However, in the original post, the list member does express a denial that s/he is in complete agreement with the discourse of the policy, "I have some problems with it" and indicates that through intertextuality these problems can be addressed. "Any thoughts, resources, OCR/court

cases and/or alternative wording would be greatly appreciated.” It appears that rather than inviting others to protest the language and intent of the policy the poster is asking for case law and “alternative wording” that will strengthen the policy. By failing to give the “problem with it” an overt meaning, the policy stands as written. The absence of protest by other list members also allows the policy to stand as written and may imply the agreement of the natural need to remove students identified as deviant from housing. Intertextuality which would have modified the meanings within the policy has not occurred. As is typical of hegemonic discourse, the unspoken, implied meaning is that “there is no dominance, all people in our society are equal, and have equal access to social resources” (Van Dijk, 1993, p. 263).

These policies reside in the DSSHE-L archives as recommended by members. They should be removed. As a review of the literature and, particularly, legal cases will show, the courts are finding these policies as abusive and discriminatory as this critical discourse analyst. There are several reports of students successfully protecting themselves from the actions of universities and colleges that acted to protect the institution’s interests by expelling them. Two of these cases will be reviewed in the section on Housing discourse.

One list member acknowledged that institutions are not as at risk as they indicate by their involuntary withdrawal policies. However, other list members fail to respond in any way to this posting.

According to Gary Pavela, JD, in his book "The Dismissal of Students w/ Mental Disorders", states "Educators often overstate the risk of liability for failing to protect students from the violent acts of others, or from self-destructive behavior...Nevertheless, courts have not held that college

and university officials must somehow guarantee the safety of every member of the academic community, or serve as an insurer of their mental health. Generally, in the absence of a manifest threat, or a pattern of violent behavior in the past, it is unlikely that campus administrators would be expected to determine whether any student (including a student suffering from a mental disorder) might harm themselves or others." (Appendix B, 12-21)

It is especially troubling that DSS officials whose job is to insure access for disabled students are participating in any way in establishing policies for the removal of students with disabilities. Because DSS officials not only enforce academic accommodation and access policies, but also use their authority of office to persuade different administrators, faculty and staff of the appropriateness and legal necessity of their actions, they have legitimate authority which makes them "privileged speakers in the creation of 'local' hegemonic discourses" (Zanoni & Janssens, 2003, p. 56) of disability. The implicit goal to assist the school's administration to revoke access to students with psychiatric disorders while maintaining the appearance that the DSS office is there to provide access to the same students is evidence of hegemony. The discourse constitutes and sustains an unequal power relationship between the DSS official and the student. In both a social and a political context, such a policy enacts dominance and inequality in its text. As Van Dijk stated,

It is also increasingly accepted that concrete text production and interpretation are based on so-called models, that is, mental representations of experiences, events or situations, as well as the opinions we have about them. These models may, in turn, have been constructed during the interpretation of many source texts, e.g., of other media, witnesses or press conferences. At the same time, such models are

shaped by existing knowledge and more or less variable or shared general attitudes and ideologies (Van Dijk, 1993, p. 258).

Policies that are codified in concrete text and transmitted to other institutions (global intertextuality) represent the mental representations and opinions about students who are disabled. A policy may be produced in reaction to a particular experienced event, but in many cases the policy is in reaction to an event in a global setting. The news media covers the case of a student suicide and the litigation by parents that follows and, thus, the need to protect the institution from such possibilities results in policy that addresses the problem. The problem, in this case, is students who attempt or commit suicide and the reasoning then moves to the idea that it must be students who are diagnosed with psychiatric disorders who are going to cause the problems. The model of the policy directly represents “shared general attitudes and ideologies” (Van Dijk, 1993, p. 258). The representation of students with psychiatric disabilities is that they are a danger to themselves and others, can be identified and surveilled, found as deviant, and thus be forced to leave.

The demonstration of power is not always through abuse and control, but by enacting hegemony through the creation of rules and policies that work to create unequal power relations (Fairclough & Wodak, 1997; Zanoni & Janssens, 2003). First, the “fact” that such a policy is required is assumed to be universal by the authors of these texts. Then the request for a policy to remove the affected students presents policy as a logical means to achieve a positive end. By utilizing the Grand Discourse about people with psychiatric disorders, the DSS official avoids revealing that the policy is meant to achieve an institutional goal of protecting the school from litigation (Zanoni & Janssens, 2003).

In this way, the DSS official can argue that their actions are not concerned with power because the policy will help decisions be made rationally (Mumby, 1987).

In the case of an “assisted” withdrawal from school based on explicit policies, the institution will assert they are acting in the “best interest” of the student. The school will provide evaluation by a mental health professional affiliated with the school who will help the student realize the need to withdraw. Such noncoercive relationships are intended to influence the student’s belief system so that s/he acquiesces to the wishes of the institution rather than face an adversarial confrontation. When the student believes that the dominance of the administrators is for their own good, hegemony has been enacted. The policy does not serve the student’s interests; indeed, it may be in direct conflict with the student’s needs (Deetz & Mumby, 1985; Mumby, 1987, 1988, 1997). The student has been convinced to accept a reality that may work in opposition to their own goals (Mumby, 1987).

The discourse in this instance is creating a politics of exclusion by categorizing the students affected by the policy as “others” who belong to an out-group. The objects of policy are the “chronic schizophrenic” and/or a student exhibiting “psychotic symptoms.” They are students “with mental health related issues and/or depression” and those “with psychological disabilities.” By categorizing these students as “others,” the writers are marginalizing them as a group (Reid & Ng, 1999).

Litigation by students who have been thrown out of dormitories or even dismissed from school is proving the hegemony in the policies schools are using to force students to leave. In the case of a “Jane Doe” suing Hunter College of the City University of New York (CUNY), a student went to the hospital from her dormitory after taking an

overdose of Tylenol. While she was hospitalized, the residential life office had the lock to her dormitory room changed. It was only under the direct supervision of the school's security guard that she was allowed to retrieve her possessions. She filed suit, claiming discrimination under the Americans with Disabilities Act. In her settlement with the school she was awarded \$65,000 (*Doe v. Hunter College of the City College of New York, et al.*, No. 04 CV 6740 (SHS) (S.D.N.Y. settlement agreement filed 08/23/06). New York's Attorney General also opened an investigation in the policies at the College and CUNY for other discriminatory practices.

In the case of Jordan Nott against The George Washington University, et al., he was awarded an undisclosed amount when he settled his suit. Nott had been experiencing depression since his friend had committed suicide by jumping out a dormitory window as Nott struggled to get in the locked door. Nott was seen by the University's mental health professional and prescribed a drug to help with the depression. As Nott began to experience recurring thoughts about his friend's suicide he began to worry that he too was becoming too depressed. He had friends drive him to George Washington University Hospital where he voluntarily admitted himself for psychiatric care. The first day that he was there a school administrator hand delivered a letter that informed him he could not return to his dormitory and would be arrested as a trespasser if he tried. The following day another administrator hand delivered a letter informing him that he had violated the school's code of conduct and was facing an administrative hearing. If he voluntarily left school, he would not be disciplined. However, if he was found on University property for any reason he would be arrested for trespassing. In the case against the school and hospital, it was claimed that the University had violated the Americans with Disabilities

Act, the Rehabilitation Act, the Fair Housing Act, the D.C. Human Rights Act, Intentional Infliction of Emotional Distress, Invasion of Privacy, Breach of Confidential Relationship, and the District of Columbia Mental Health Information Act of 1978. The filed complaint begins,

This case seeks relief against George Washington University and various individuals for the callous way they treated a student who sought medical help. Rather than act to help, support or comfort him during his illness, they disciplined him, threatened him with criminal prosecution and ultimately ended his college career at the school of his choice (*Nott v. George Washington University, et al.*, No. 05-8503 (D.C. Super. Ct. settlement 10/31/06)).

According to the report by Appelbaum (2006) titled “Depressed? Get Out!: Dealing with Suicidal Students on College Campuses” there are more cases pending in courts across the country as schools force students out because of their psychiatric disorders. Some students have chosen to sue for readmittance while others have sued for compensation. This highlights the dangers of archived policies being picked up by colleges and universities who are looking to protect the institution from liability but go too far.

The prevalence of policies to use discipline policies and housing policies to remove students, and especially students who were suicidal, at colleges and universities was not missed by the legislators in Virginia. In 2007, the General Assembly of Virginia passed a law unanimously to protect the rights of suicidal students. At the time of this research, the governor had not yet signed it into law, but the report from the sponsoring

legislator indicated that the governor would sign the bill into law. The three-sentence bill is included.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 1 of Title 23 a section numbered 23-9.2:8 as follows:

§23-9.2:8 Policies addressing suicidal students.

The governing boards of each public institution of higher education shall develop and implement policies that advise students, faculty, and staff, including residence hall staff, of the proper procedures for identifying and addressing the needs of students exhibiting suicidal tendencies or behavior. The policies shall ensure that no student is penalized or expelled solely for attempting to commit suicide, or seeking mental health treatment for suicidal thoughts or behaviors. Nothing in this section shall preclude any public institution of higher education from establishing policies and procedures for appropriately dealing with students who are a danger to themselves, or to others, and whose behavior is disruptive to the academic community (Virginia Acts of Assembly, Legislative Information System, 2007).

As a hegemonized out-group, the students who are put through the administrative withdrawal procedure that the policy lays out may indeed remain loyal to the institution that has pushed them out. In the research by Smith and Tyler (1996) and Tyler and Degoey (1996), it was found that even when the outcome was unjust, the subjects who perceived the procedure as fair would have positive feelings about the organization. Van Dijk (1993) explained,

What is involved in dominance are questionable *conditions* of legitimacy or acceptability, including what is usually called ‘abuse’ of power, namely social inequality (p. 250). Power involves *control*, namely by (members of) one group over (those of) other groups. Such control may pertain to *action* and *cognition*: that is, a powerful group may limit the freedom of action of others, but also influence their minds (p. 254).

The archived responses to the inquiries serve to question the intent of such policies. The inquiries for withdrawal policies does inspire a DSS officer to suggest a policy for a student to drop a course.

Here’s a thought. The unforeseen [sic] circumstances, whether mental or physical, whether a disability or not, that make it necessary for a student to drop some, but not all courses after the close of a drop period should not apply selectively to some courses but not others. Why not adopt a policy that permits a student to drop one of four courses, but does not permit the student to pick the particular course to be dropped, leaving the selection to a random draw? In that fashion, you accommodate the unforeseen [sic] need of a student to take a reduced load without creating the incentive to abuse the system to drop a hard course that may adversely impact gpa. Depression does not selectively impair the ability to study chemistry or economics while leaving the ability to study the humanities unaffected. (Appendix A, 11-21)

This writer expresses the idea that the need to drop a course due to “mental or physical” condition that interferes with the student’s ability to carry a full course load is “creating the incentive to abuse the system.” The stated reasoning is that, “Depression does not selectively impair the ability to study chemistry or economics while leaving the ability to study the humanities unaffected.” To allow a critique of this discourse, it is necessary to present alternative ways of viewing the reality presented by the writer. In the case of psychiatric disorders, cognitive impairment is a recognized part of the diagnosis of mood disorders, including depression (American Psychiatric Association, 2000). Cognitive impairment is also caused by psychotropic drugs that are used by students with

psychiatric disorders (Thomson Medical Economics, 2002). The higher mental functioning required for a complex course such as chemistry exceeds that which is required for a humanities class according to research of depressed learners (Smith, Tracy, & Murray, 1993). It is the responsibility of the DSS official to learn about the manifestations of psychiatric conditions as they impair academic functioning. There are professional journals that provide empirical research on cognition and psychiatric disorders. Rebutting the writer's claim that depression does not impact learning ability in some classes and not others, the empirical studies have found that depression affects some cognitive tasks more profoundly than other tasks. For example, the study by Smith, et al. (1993) found cognitive deficits in depressed subjects when thinking required "elaboration for material less meaningful than prose" (p. 331). It would be more difficult to perform the rote memorization of chemical formulas than to read prose. Ellis, Moore, Varner, Ottaway, and Becker (1997) also found that depressed mood reduced recall ability. Depressed subjects had greater difficulty with highly structured tasks. For a disability services professional to disregard accepted knowledge about cognitive ability being impaired by depression indicates a deficit in professional training. Instead of looking for readily available information about cognitive impairment, this writer explicitly states that students with depression "abuse the system."

Direct Threat and Threat to Self or Others. Even as legal cases continue to erode the college's or university's enforcement of exclusion policies that force students to withdraw from school, the DSSHE-L list members share the idea that a student who could be labeled "a direct threat" or "a threat to self or others" will not qualify for

services from their office and, in some cases, even have their acceptance into the school withdrawn.

I've been asked to do research on the issue of "danger to self and others" and "direct threat" as they relate to postsecondary education. I've found a lot of information relating to employment but not education. Can anyone point me to some court and/or OCR cases that deal with this subject as related to students with disabilities? The only one I've been able to find is *Krissik v. Stonehill College* (the school denied readmission to a student with active, prolonged anorexia). Speaking of *Krissik*, does anyone know how or if this case has been settled? (Appendix B, 2-9)

The most important one in my mind is *Tarasoff v. Regents of the University of California*, 1976, where the duty to warn came into play. (Appendix B, 10-11)

The *Krissik v. Stonehill College* case mentioned in the inquiry was settled, but the settlement was undisclosed by either party. A search of case law did not show the case ever being tried in a court of law, so it would not serve as legal precedence. The *Tarasoff* case set the precedence that doctors and therapists have a "duty to warn" the other identifiable party if the patient discloses intent to harm. The case is discussed in psychology and counseling textbooks as well as in the APA books on treatment ethics. The *Tarasoff v. Regents of the University of California* (17 Cal.3d 425 [1976]) case requires the doctor or therapist to break the confidentiality agreement that patients enjoy in their mental health care as a duty to warn potential identifiable victims.

The stereotyped idea that people with psychiatric disorders are prone to violence continues to be played out. As was illustrated in the discussion of "otherwise qualified" and was illustrated in a case involving an international student, the DSS officials are very aware that if they can assert direct threat or threat to self or others, they can, in many cases, refuse to serve the affected student. Therefore, a discussion of the meanings of the phrases "direct threat" and "threat to self or others" will be undertaken as an effort to provide intertextual discourse to help demonstrate when hegemony is occurring.

The phrase “threat-to-self” comes from employment law, though as case law has been acted out the phrase has come to be used in other ways. It should be noted that the ADA deleted the term “threat-to-self” from law because of the paternalistic manner it had been applied to exclude people with disabilities from employment. Therefore, the use of the phrase in legal practice has reinserted it into consideration. The phrase “threat-to-self” comes from the Equal Employment Opportunity Commission’s (EEOC) regulations that allow an employer to refuse employment to a disabled person if the job would cause harm to that person in spite of reasonable accommodation without being in violation of Title I of the ADA (Robinson, Franklin, & Paolillo, 2003). The United States Supreme Court upheld the regulation when it was challenged in the case of *Chevron USA, Inc. v. Echazabal* (536 U.S. 73 (2002)).

The EEOC does define “direct threat” in 29 CFR 1630.2(r) as follows:

(r) Direct Threat means a significant risk of substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation. The determination that an individual poses a “direct threat” shall be based on an individualized assessment of the individual's present ability to safely perform the essential functions of the job. This assessment shall be based on a reasonable medical judgment that relies on the most current medical knowledge and/or on the best available objective evidence. In determining whether an individual would pose a direct threat, the factors to be considered include:

- (1) The duration of the risk;
- (2) The nature and severity of the potential harm;

- (3) The likelihood that the potential harm will occur; and
- (4) The imminence of the potential harm.

The application of employment law in other Titles of the ADA has become commonplace. However, it is not until it has been litigated that case law is established. For the case of “threat to self and others” there have been some cases of students against schools when the institution refused the student the right to participate in sports due to preexisting medical conditions. In most cases the students have prevailed. A brief description of the courts’ decisions will illustrate how the courts are interpreting the threat defense by colleges and universities.

Courts Holding that the Individual's Rational Decision to Take Risk Controls.--

Most courts addressing this issue have held that it was up to the individual and not the school to decide if the risk is acceptable. In *Poole v. South Plainfield Board of Education* (490 F. Supp. 948 (D. N.J. 1980); *Poole*, 490 F. Supp. at 952) the court held a school board violated the Rehabilitation Act when it refused to let a student with one kidney wrestle. The board based its decision on a fear of injury to the student's remaining kidney (Milani, 1998). The court noted: Hardly a year goes by that there is not at least one instance of the tragic death of a healthy youth as a result of competitive sports activity. Life has risks. The purpose of section 504, however, is to permit the handicapped individual to live life fully as they are able without paternalistic authorities deciding that certain activities are too risky for them (p. 892). A public entity may, however, impose neutral rules and criteria that screen out, or tend to screen out, individuals with disabilities if the criteria are necessary for the safe operation of the program in question. Examples of safety

qualifications that would be justifiable in appropriate circumstances would include eligibility requirements for drivers' licenses, or a requirement that all participants in a recreational rafting expedition be able to meet a necessary level of swimming proficiency. Safety requirements must be based on actual risks and not on speculation, stereotypes, or generalizations about individuals with disabilities (28 C.F.R. pt. 35 app. § 35.130 (1996)).

Robinson, et al., (2003) conclude their synopsis of court rulings by affirming that, “Generalized fears about the safety of the applicant or the potential harm to others that might result from the disability are not sufficient to disqualify an otherwise qualified applicant” (p. 4). The generalized fears of DSS officers is repeated throughout the discourse regarding students with psychiatric diagnoses. The invocation of “direct threat” becomes a common discursive ploy.

Confidentiality of disclosures. In order to qualify for academic accommodations to mitigate a disability the student must provide documentation from their health care providers that establish the nature and extent of their disability. To request accommodations is strictly a voluntary action. Students with disabilities have the right to ignore the presence of a disability services office on their campus and have the right to not ask for accommodations. Some students with disabilities choose to pass on accommodations because they do not want to disclose their disability to others. Entering higher education gives some students a “fresh start” in life where they are free of labels and the stigma of disability. This is especially true of students with psychiatric disabilities. Perhaps for the first time since they were diagnosed, these students have the ability to live as though they were not disabled. This may come back to haunt them

should they have a manifestation of their disorder, but the youthful attitude of infallibility will encourage them to try to live without the stigma. Then there are the students who do need academic accommodation, but who do not want to be labeled, and do not provide documentation. Some express the fear that this documentation will be widely dispersed, allowing “everyone” to label and stigmatize them.

I have meet [sic] with a few students lately who are adamant about not providing documentation regarding their psychological disability. I have tried every avenue in which I know in order to relieve their fears about the documentation ending up in the wrong hands or being used against them in any way. I have stressed that the information is kept confidential unless they give written permission of exactly with whom the information in the file can be shared.

I have spoken extensively with each individual. I have clarified that I cannot provide them accommodations without receiving documentation because I will not be able to discern which accommodations they need and how I can best support them. I am struggling because I can see that the students need support.

I would like to know if any of you are finding the same reluctance of students providing documentation? What have you found to be particularly effective in helping the student/parents/specialists understand your documentation needs regarding psychological disabilities? Have you found a way of explaining the confidentiality of each student file? (Appendix C, 1-17)

Several reasons:

They are embarrassed [sic] and refused [sic] to admit they have a psychological disability.

They think it is not right to prove they have a psychological disability in order to get service. Well, who doesn't?

Or they don't have a psychological disability in the first place. (Appendix C, 18-23)

The inquiry as to how to influence students to provide documentation so they can be helped is met with a response constructed from stereotype. Students who choose to attend their college or university without the interference of the DSS officer have every right to do so. When they choose this option, it does not mean “they are embarrassed” or that they are in denial about their psychiatric diagnosis. It is also interesting that this DSS officer also suggests that “they don’t have a psychological disability in the first place.” The succinct declaration that these students are in denial or are not really disabled lends itself

to discursive closure. In the discourse of this writer, there are no other explanations. “Closure frames discourse in a distortive fashion, and often misrepresents the interests of particular groups within organizations” (Deetz & Mumby, 1985, as cited in Mumby, 1987, p. 113). The inquiring writer makes it clear that the stumbling block is the fear of disclosure. The author of the inquiry is convinced that these students would benefit from accommodation, indicating that s/he believes they have a disability. The response suggests that the DSS officer who made it consciously or unconsciously believes that mental illness is something to be embarrassed about which is a stigma. As this study will show, the discourse of other DSS providers presents adequate evidence that these students have every right to be suspicious of how their documentation might be used.

People with mental illness are sensitive to the fact that people will stigmatize them if they are identified as someone with a psychiatric disorder and some are willing to go to great lengths to avoid stigmatization (Jones, et al., 1984). Therefore, many people with stigmatizing conditions will work to conceal their condition. Actions of people with psychiatric disorders include declining assistance that would help them deal with their condition, including avoiding treatment. In the instance of college students, some will not request the academic accommodations they deserve because it requires self-disclosure to the DSS office. Disclosure includes documentation from health care professionals including the doctor or therapist to whom they have revealed their private innermost thoughts.

DSS offices across the nation make the explicit claim to students that their documentation will be kept confidential. A review of DSS web pages at colleges and universities around the nation found that most included a statement that records provided

to the office were confidential and, at many schools, it was declared that the documentation provided would be housed in a file within the DSS office. A further critical analysis of the list's discourse uncovered the reality of confidentiality of documentation in the DSS office. But first one must discuss the definition of privacy and privacy rights since the enactment of the Health Insurance and Portability and Accountability Act of 1996 (HIPAA).

The meaning of "privacy" for student documentation of disability, medical and psychiatric information, is borrowed from Appelbaum (2002). It is important in critiquing the discourse that the terminology be defined.

Privacy, as used in this discussion, is the interest that persons have in maintaining control of information about them; medical privacy refers specifically to information concerning a person's medical conditions. Confidentiality, a term that often is used interchangeably with privacy, refers more narrowly to the obligation to maintain privacy assumed by someone who enters into a relationship marked by the promise that information that is disclosed will not be revealed to others (Appelbaum, 2002, p. 1810).

Note that Appelbaum specifically defines confidentiality as an "obligation to maintain privacy." Appelbaum writes of the erosion of medical and psychiatric privacy boundaries and explains why privacy is important to protect since it impacts the ability of doctors and therapists to effectively treat patients. Of particular interest to this critical discourse analysis is the research cited that found 25% of adolescents would forego doctor's care if they believed their parents would find out (Cheng, Savageau, Sattler, & DeWitt, as cited in Appelbaum, 2002). The deontological, ethical argument that medical

information should be private is magnified when the content of psychiatric information is considered. “The ability to speak freely with another person about one’s innermost thoughts, fears, and passions is clearly dependent on the belief that one’s revelations will go no farther” (Appelbaum, 2002, p. 1811).

According to Appelbaum’s article, every state in the nation had codified the legal protection of medical records and, particularly, psychiatric records. The strengthening of privacy protections came in 1996 with the Supreme Court decision in the case of *Jaffee v. Redmond* (518 US 1 (1996)). Appelbaum quotes from the court decision, which said that

The psychotherapist privilege serves the public interest by facilitating the provision of appropriate treatment for individuals suffering the effects of a mental or emotional problem. The mental health of our citizenry, no less than its physical health, is a public good of transcendent importance (p. 1811).

The U.S. Congress passed the Health Insurance and Portability and Accountability Act of 1996 and gave the U.S. Department of Health and Human Services the authority to write the regulations for the Act. The rules entitled, “Standards for privacy of individually identifiable health information,” found at www.hhs.gov/ocr/hipaa, take over one hundred pages to explain. Within these rules are twelve occasions for the disclosure of patient records without the patient’s consent, or in some cases, without the patient’s notification that disclosure will occur (Appelbaum, 2002). This includes administrative requests by the police or attorneys involved in litigation. That these intrusions into medical records can occur without the necessity of a court order is especially concerning and led many states to enact laws giving greater privacy rights to patients. However, there is still some protection of privacy rights in the case of mental

health records. The psychotherapy notes have been explicitly protected by the HIPAA regulations. The patient must give unequivocal permission for the psychotherapy notes to be released. The Department of Health and Human Services cites the court decision in *Jaffee v. Redmond* as the authority to keep psychotherapy notes protected (Appelbaum, 2002). When releasing the contents of patient records, the therapist should “limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request” (45 CFR §164.502(b)(1)). Appelbaum concluded with the reminder to psychotherapists and psychiatrists that, “In the long run, psychiatrists’ dedication to the ethical principles underlying medical privacy will remain one of the most important protections that can be offered to patients” (p. 1817).

The stated principle of patient protection should be heeded by the DSS officers who come into possession of the psychiatric records of the students who come to them for accommodation.

The Dean of Student Affairs here has posed the following scenario [sic] to me. I am interested on others' response to this situation. I am somewhat surprised by the fact that legal counsel has advised that the college can essentially force the student to disclose as a condition of readmittance. Any advice, thoughts, etc. would be welcome. (Appendix D, 1-6)

This posting cites the school’s legal counsel as advising the institution that the college can force a student to disclose their psychiatric disability by which the lawyers seem to include mental health documentation, before the student can return to school. It is unclear whether the discussion is of students who left school voluntarily or involuntarily. Perhaps the legal advisers include both types of students. As schools “force” students to disclose their most personal information shared with their mental health professional (shared with the promise of confidentiality) as a condition of enrollment, the school’s power is heightened. It is most concerning that the very office empowered to provide access and

accommodations to students with disabilities has possibly become the source of information that administrators utilize to discriminate against students with psychiatric disorders.

As a possible rebuttal to the discourse that allows revelation of confidential information outside the DSS office, the regulation found in Title 45 of the Code of Federal Regulations, Part 84 Nondiscrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance, Subpart E Postsecondary Education, specifically Section 84.42 Admissions and Recruitment may clarify the opinion of the Department of Education on using documents in a manner that is unintended. Under Section 84.42(b)(4) the institution's admissions office is forbidden to "make preadmission inquiry" of a student's disability. However, "after admission, may make inquiries on a *confidential basis* as to handicaps that may require accommodation."

In Section 84.42(c), "the recipient may invite applicants for admission to indicate whether and to what extent they are handicapped, Provided, That: (1) The recipient states clearly . . . that the information requested is intended for use *solely in connection with its remedial action obligations or its voluntary action efforts*; and (2) The recipient states clearly that the information is being requested on a *voluntary basis, that it will be kept confidential, that refusal to provide it will not subject the applicant to any adverse treatment, and that it will be used only in accordance with this part*" (45 C.F.R. 84.42, emphasis added).

The Regulations are very clear that institutions ("recipient") are limited in how they can use the information voluntarily submitted by a student with a disability. Moreover, it is specifically stated that the student who chooses to remain unidentified as

disabled has the right to this privacy. The use of this regulation outside the intended scope is no different than the use of ADA Title I rules and regulations in the decisions DSS officers are making about student eligibility for accommodation.

That DSS officers are willing participants as agents of control is revealed in their discourse. The fact that there will be ethical dilemmas goes with the power of the office. Sometimes the disability services office receives information about a student that they choose to share with others at the school. There are also indications in the discourse that the DSS office colludes with others on their campus to set certain students up for special attention. It appears that the promise of confidentiality of documentation supplied by a student is a hollow promise. At the same time, the information provided by students can be disturbing on occasion.

We have a student enrolling for Spring semester who within the very recent past was cited for indecent exposure on our campus (at the time he was not nor ever had been a student here). As it turns out there is also a history of violence towards others in his past. Given this knowledge, the question is how or should we monitor this person's behavior on campus? Apparently he has a letter from his psychiatrist stating that his behavior is under control (meds?) and he is cleared to participate. At this point, he is not enrolling through DSP&S. (Appendix D, 112-119)

Here is a case where the student is not even enrolling for services from the DSS office and the DSS official is getting involved to “monitor this person’s behavior on campus.”

The fact that the psychiatrist has provided documentation of successful treatment, “Apparently he has a letter from his psychiatrist stating that his behavior is under control” is outweighed by the student’s past. From the brief description provided, it appears that this student has a criminal history (public information) that the school is already aware of and has disseminated throughout its offices. This does not mean, however, that the DSS official has the reciprocal responsibility of disclosing any documentation the student may

eventually provide to that office. The DSS official should not be acting as an agent of control; it is the duty of other appropriate offices including campus police to monitor the student's behavior. The DSS office should provide reasonable and appropriate accommodations, if there are any, when requested and let the other offices perform their duties. If other offices on campus determine the student is a direct threat, then the student will not qualify for the protections of the ADA. It is when the DSS officer blurs the lines of what they are responsible for and what is the purview of another office that the student's rights are threatened.

I was cruising through the listserv in search of help with some documentation I received today and saw that while there has been discussion on this topic, but nothing for the last couple of months seems to help with the situation I seem to have. I just received report about a student who is severe Bipolar and has been institutionalized twice in the past three years because when he decompensate he becomes violent. There is also mention a sexual assault from him when he was 16. His most recent episode resulted in charges from assaulting an officer and a family member in Jan., 2003. He has had two psychiatrists that have refused to work with him because of non-compliance. What I need to make sure I understand, is this something I can share with the Dean of Students, i.e. other administrators at the University, etc.? I am investigating all avenues because this report has given me grave concerns about this student being a direct threat along with being a disruption. I feel I need to mention that this report was sent to me from the student or the clinician based on the student's request, however, I have never met with this student nor do I know what he may be seeking in the way of accommodations but right now I feel that is beside the point as his report is filled with references to violence and non-compliance with medications, etc. Any thoughts out there about this matter? (Appendix D, 120-138)

Several things are problematic about this discourse. For one thing, if it were not for the psychological report the DSS office would never have known of the sexual assault when this student was a juvenile. While adult criminal convictions are a matter of public record, juvenile crimes are usually sealed by the court. The documenting professional had no right to provide information that was in case notes. The rules of HIPAA are very clear that case notes are to be protected and that the only information disclosed is to be the

minimum necessary to achieve the purpose of disclosure. But the reality is that case notes were included to the DSS official that were alarming. The most recent assault, which brought formal assault charges, would be a matter of public record and available to the University. However, the DSS officer wants to provide all of this information, which the student provided with the understanding that it was confidential, to University administrators. The DSS officer admits s/he has never met with this student, so s/he is reacting to the documentation without ever discussing concerns with the student. The response to the list was startling. Most list members had no hesitation to recommend disclosure without the student's permission. In fact, the idea that the student might give his/her permission for disclosure is not even suggested.

I do not think either the ADA or section 504 prohibits you from sharing the information with the Dean or whoever else among the university administration you deem appropriate. (Appendix D, 139-141)

This discourse draws upon the Grand Discourse, the laws of the ADA and Section 504, to persuade others that his/her stance on this issue is grounded in the laws that provide familiar authority.

You can talk to anyone you need to talk to at the University on a need-to-know basis. I think that the people you mentioned have a definite need to know about this situation. (Appendix D, 172-174)

As Zanoni and Janssens (2003) pointed out, "through the selection of recognizable rhetorical schemes and Grand Discourses, the speaker's discourse contributes to their further naturalization into hegemonic 'common sense'" (p. 59). As other posters submit their justifications and rationalizations to the list, it "aggregatively produces a particular version of social reality to the exclusion of other possible worlds" (Chia, 2000, p. 513). Those who protest the loss of confidentiality for their students are drowned out by the greater number of posts agreeing to disclosure. The list members' response of agreeing to

disclosure answers the concerns of the students who were unwilling to document their psychiatric disorder. It appears that confidentiality is only as good as the ethics of the person receiving the documentation. This agent of control is clearly looking out for the institution's interests rather than the student's.

Like xxx said there is nothing in ADA/504 that says you can't share information, per se; but I think the litimus [sic] test is "what you share and what are your assumptions". Plus I think FERPA should be involved. But

If you do this, are you randomly going to share information out of anyone elses' [sic] file? How about all the other students you have with mental illnesses? Or those that the Doctor chose to edit the documentation and leave out all the lurid particulars, that should not be in an appropriate documentation. Do you advertize [sic] that your DSS process is confidential? But not confidential to applicants with mental illnesses. What are your assumptions in giving a "heads up" to everyone? They all going to "watch" him? Are you setting him up for an environment that will be harrassing [sic] and discriminatory in nature? Are you going to tell all his teachers? Where do you stop telling people? Where do you start? Are you going to put him on a drug medication program and spoon feed him every morning? Are you going to put him on a curfew, or refuse him to be anywhere on campus without a security guard? Are you going to spray paint a big 'MI' on his coat for "mental illness"? I see you doing nothing untill [sic] he shows up to discuss the DSS procedures. If he doesn't in a timely manner then either deystroy [sic] the report or send it back to the originator. Or I see you sharing this information with your admin., BUT only if your school has a policy that states that any student is subject to immediate suspension if the school ever finds out you have a "past". And if your college application has all students disclose everything from their "past", and the college routinely runs a "past" check on all applicants. So, I think you need to find out how are people going to act on this information. And if your college is not willing to suspend him or deny him admittance based on what you share. Then why share? The evidence of direct threat must be established by determining the severity of the risk, the likelihood of the risk and the imminence of the risk. If you can determine this then you can deny accommodations or participation of the person. (j.j.) Good Luck if you try it! (Appendix D, 142-171)

This protest to disclosure raises several relevant points. First, it was inappropriate for the documenting professional to include information from case notes in the report. Case notes are protected from disclosure under HIPAA as discussed above. What the doctor revealed about the student's past was not essential in documenting a disability. However, the DSS office has received the damning information and, as the protesting DSS officer

points out, the decision to disclose confidential materials must not be taken lightly. The question posed, “Do you advertize [sic] that your DSS process is confidential? But not confidential to applicants with mental illnesses” is an important one. However, this post was followed by other list members giving permission for the disclosure of confidential documentation. This statement is made by the original inquirer about the consent to disclose s/he had received from list members.

I believe that any student with a past record of violent behavior or sexual abuse has to be addressed in a fair and professional manner, this is only fair to the other students and staff on campus. (Appendix D, 213-216)

The statement makes it clear that the interest is to protect the interests of the institution over that of the student. “. . . this is only fair to the other students and staff on campus.”

The statement that the student will “be addressed in a fair and professional manner” is intended to prohibit the thinking that the disclosure is intended to mark the student as deviant and worthy of special surveillance.

My assumption is that someone with authority and responsibility might consider the information relevant to his/her responsibility to provide a safe educational environment for all students, and to his/her responsibility to protect women from sexual assaults on campus. (Appendix D, 328-331)

The discourse that calls for the protection of women is one drawing on the discourse of actions being taken for the public good. The rights of transgressors can be overlooked without conscience when a greater good is established.

As discussed in the section on email posting patterns, certain members of the mailing list contributed the bulk of the text dealing with psychiatric disorders. Since the discourse about the students serves to socially construct the meaning of mental illness, the individuals who contribute the most tend to become recognized by the readers and thus inherit more social control, which gives their discourse greater acceptance. In the

case of one frequent writer to the list, the credentials attached to the name make him/her a “key mediator of policy.” Others on the list rely upon his/her interpretation of policy and thus this person becomes a gatekeeper. In this context of social control “only certain voices are heard at any point in time” (Ball, 1994, p. 16). In the case of the interpretation of confidentiality and privacy rights for students with disabilities, this poster makes it clear that, in his/her opinion, there is no obligation for DSS officials to keep information they get in documentation private from the administrators of the college or university. The poster is intent on protecting the institution from liability rather than on protecting the student’s right of privacy.

FERPA does not prohibit sharing of information with administrators; it prohibits sharing of information with other students and the public at large. To be precise, *no* federal law prohibits sharing the kind of information at issue with deans and other administrators with the authority and discretion to make judgments for the institution. As I have noted in earlier posts, this discussion has nothing to do with treating students with mental illnesses differently or sharing information randomly; to the contrary, it involves treating one student with a very specific history of violent behavior including a sexual assault differently from all other students with or without mental illnesses. To the extent that there is any difference in treatment, the difference arises from the student's past conduct, not his disability. And as everyone surely knows, the ADA excludes from the definition of disability any sexual behavior disorder (Appendix D, 179-192). As DSS officers, we work for the institution. Finally, I do not know of any institution which reposes in a DSS office either the authority or the responsibility for determining whether a student is a direct threat to the safety of others; that responsibility lies with higher university officers. To withhold from them information of past sexual assaults [sic] and violent behavior is to interfere with their ability to make those judgments, and to put at risk the safety of every student. Appendix D, 180-208)

In the argument to allow disclosure of students’ medical and psychiatric documentation, the discourse uses the rhetorical method of using premises that the readers presumably subscribe to (Warnick & Kline, 1992). This includes reiteration of facts or truths that are known. “. . . it involves treating one student with a very specific history of violent behavior including a sexual assault. . .” This description of the object

of the discussion is such that it is “natural” to fear and dislike the traits, and therefore, the person described. The reminder sets up the premise that someone who is violent and guilty of sexual assault is undeserving of the rights which might be accorded others. This serves to make what follows normal and acceptable to others on the list. “To the extent that there is any difference in treatment, the difference arises from the student’s past conduct, not his disability.”

The author of this post rewrites the reality of the student’s disability from Bipolar to “sexual behavior disorder” which would allow the DSS officer to refuse services since that disorder is specifically excluded from protection by the ADA regulations. The propensity to ignore the original post’s description of the disability, marking the student with a different disability that is not covered by the ADA so that services can be denied is the use of discourse to stigmatize the student. Though the argument is made that this is not a case of treating a student with a disability differently than all other students, the fact is that all other students are not required to provide psychiatric documentation in order to gain access to academic programs. The DSS office has a unique position of power that is intended to be used to provide academic accommodations, not to disclose the confidential material they receive. However, it appears the sentiment of some list members is that protecting the rights of the institution is their first obligation.

The argument, that the rules of privacy and confidentiality that are promised to a student with a disability do not apply in this case, is based on the minimal facts provided by the original inquirer. The arguer is using a schema that activates the “cognitive predispositions” (Warnick & Kline, 1992) of the readers – the mentally ill are violent and

will commit sexual assaults. Therefore, it is permissible to ignore the rules, the preferable answer to the writer, and reveal the student's documentation to others. The premises of the argument thus change the focus of the question, is it permissible to provide this documentation to the "University?" The focus becomes the violent history of the student. The argument schemes are "focus on the real" by using facts, truths and presumptions, and "focus on the preferable" (Warnick & Kline, 1992, p. 2).

"Contemporary culture's preference for certainty, simplicity, and parsimony contributes to the effectiveness of quasi-logical arguments" (p. 4). In using facts provided by the inquirer in the argument, the fact that the original poster admits s/he has never met with the student or talked to the documenting professional is ignored. This allows the arguer to keep the context narrowed to what is known without allowing for mitigation through additional facts the student or doctor could provide.

As the writer contends, "we work for the institution" which does not leave room for the DSS officer to work for the student. There appears to be a dichotomy of beliefs, that the DSS official works either for the institution or for the student and it never appears in the discourse that the DSS officer can serve both. This may be due, in part, to the hiring practices of the particular institution. In some cases, the institution is looking to avoid lawsuits yet wants to be as conservative as possible, thus the DSS officer is hired with the duty to protect the interests of the institution. In other cases, the institution hires a person who is instructed to apply best educational practices to the needs of the student with a disability. It would seem that the DSS officer working with the educational needs of the student in mind will serve both the student and the institution. The normative effect

of the discussion list, however, may tend to lead a new DSS officer to believe that it is best practices to protect the institution.

The discourse of one list member demonstrates how the issue of disclosure of confidential records is not to be made lightly, even when the laws and regulations do not preclude the practice (though it must be noted that, depending upon the state, there may be a greater right of privacy). The emphasis on the DSS role of providing academic accommodations and access to students with disabilities is clear.

If I were to raise the issue of direct threat on campus, the reaction would be significant. Campus authorities would say that if something like this bothers the DS director, then it must be very serious. That's because my role as the university authority on accessibility contrasts starkly against that of a worried whistle blower. Don't get me wrong. If I believed that I had information that revealed a potential danger, I would blow the whistle long and loud. But first I would see if other means, such as the registry mentioned above, would serve just as well. I want to protect my role on campus and be responsible at the same time.

I'm not sure if my words make much sense, but it's a sort of karma thing. Do I want to be a university employee who leans away from what it means to have a disability or a university employee who leans towards changing the university so that it is accessible by students with disabilities? Blowing the whistle based on disability documentation sounds like a person who may be counted on not to be friendly to the cause of equal access. The very least one could do is to talk it over with the student to give the documentation some kind of context. I would also contact the person responsible for the documentation to get more context. It's my understanding that the only thing prompting the question is documentation. Documentation has no meaning for us on its own merits. So, before taking the drastic action of blowing the whistle, I would first make sure I've got enough information based on behavior to take that rather drastic action. Aren't these sort of things the essence of best practices in DS in higher education? I guess I want my role to be that of a person who is responsible, but also a campus authority who may be relied on to speak for equal access to university programs by students with disabilities. (Appendix D, 362-368)

In this reply to the inquiry, the list member contrasts being “the university authority on accessibility” to being “a worried whistle blower.” The use of the metonym, “whistle blower,” is utilization of a familiar idiom. A whistle blower is someone who breaks with an organization’s social norms and takes incriminating information and

evidence to an authority. The whistle blower can be ostracized by members of the organization. Occasionally, a whistle blower is held in high esteem for having the courage to break organizational norms. By using the metonym, this poster acknowledges the conflict between knowing something that his/her office is obliged to keep confidential or disclosing it to superiors. The poster then clarifies his/her belief in the importance of confidentiality by a DSS official, “Blowing the whistle based on disability documentation sounds like a person who may be counted on not to be friendly to the cause of equal access.” Access for students with disabilities is the ultimate cause for this DSS professional. Though this text does not appear to be an argument at first glance, it expresses a viewpoint in anticipation of other list members disagreeing. The emphasis s/he makes to the duty to provide access is meant to nullify other arguments.

Look at the difference in the discourse. The author of this post acknowledges the unique and powerful position of the DSS officer. “I want to protect my role on campus and be responsible at the same time.” This poster would look to alternative public information sources that would achieve the same goal of alerting the institution’s administrators of the possibility of threat from an incoming student. S/he would also put the documentation in context by meeting with the student and contacting the documenting professional. “Blowing the whistle based on disability documentation sounds like a person who may be counted on not to be friendly to the cause of equal access.” The advice is to not take “drastic action.” The reminder to list members that there are established best practices for disability services is important in standing strong for the students s/he represents. “Aren't these sort of things the essence of best practices in DS in higher education? I guess I want my role to be that of a person who is

responsible, but also a campus authority who may be relied on to speak for equal access to university programs by students with disabilities.” This reminds the list readers of their purpose.

The idea that the DSS office is in the business of determining direct threat potential of students who come in for services is apparent in the statement by this list member.

All responsibility starts smack dab in our office! Determining "direct threat" is part of the natural process of determining eligibility [sic] for appropriate and reasonable accommodations. (Appendix D, 231-233)

The message continues

But you are right, the duty of determining whether students are suitable for admissions [sic] is a whole different story. But my understanding is that is why we are two separate [sic] offices. Information gleaned in the DSS office can not be used to make decisions in the admissions office. (Appendix D, 235-239)

The discussion of this case dropped off, but the question of confidentiality in the case of a student's history arose once more.

A student with a disability has registered in this office. His documentation from his psychiatrist reveals a history of extreme violence to himself and others during times when he has stopped taking his medication. Do I have any obligation to alert any other administrator on campus (especially my immediate supervisor, VP for Student Affairs) about this potential? Might this be considered a campus safety issue? Or is my obligation strictly maintaining the confidentiality of this student? It is possible for me to foresee [sic] a violent incident after which it becomes known that an administrator on campus (myself) had foreknowledge of such a possibility. (Appendix D, 407-416)

Once more the DSS officer is placed in an ethical dilemma of maintaining the promised confidentiality or alerting administrators of the potential for violence from the student if s/he goes off medications. The fact that the laws regarding "direct threat" require the danger to be imminent is ignored. The replies to this inquiry are more argumentative than what was previously posted.

My take on this is NO. The Psych probably revealed [sic] more than what is needed for documentation of a mental illness. I don't think it ethical to share something that may or may not happen based on medication, or personal responsibility [sic]. (Appendix D, 419-422)

This claim was followed up fairly quickly with:

The ADA does not forbid sharing disability related documentation with your supervisor; neither does FERPA. As we discussed at last summer's AHEAD, the so called confidentiality requirement of the ADA / Section 504 is an urban legend. (Appendix D, 429-432)

The analogy that confidentiality requirements under the ADA, FERPA, and Section 504 are “an urban legend” strengthens the argument that there is no legal right available to the student to insure confidentiality of documentation. The poster also calls on the Grand Discourse of a national disabilities services association conference, AHEAD. AHEAD is the Association on Higher Education and Disability and many list subscribers are members. From the statement in the post it appears that discourse on breaching confidentiality of students’ records was a part of the conference and was concluded to be “an urban legend.”

It is increasingly apparent from the discourse that confidentiality is an illusion held out to students to inveigle self-disclosure. Once the DSS officer has the documentation, there is every possibility that the student’s worst fears about disclosure will occur.

Yes, you should have a document students sign indicating there may be situations in which information about a student's disability is shared. (Appendix D 417-418)

Yes, there is nothing that sez we can't share disability information. But there is a lot that sez this information can not be used to discriminate against the person, or use the info in a discriminatory manner. (Appendix D, 440-442). . . Plus professional ethics play a part. There is nothing in the law that says that people with mental illnessess [sic] have to register with college officials or college police or college medical folks. No one knows anything about this person except the DSS office. (Appendix D, 438-446)

Every institution reposes in somebody the authority to remove a student from campus, or withdraw admission offers on the basis of newly discovered information; that person is almost certainly not a DSS staffer or director, and therefore disclosure to a supervisor is the proper way to ensure that the information reaches the person with responsibility to make the decision respecting whether the information merits action. (Appendix D, 475-481)

The belief that the disclosure of documentation may lead to the institution to “remove a student from campus,” or “withdraw admission offers” is acceptable to this poster since the institution has a “person with responsibility to make the decision.” By distancing themselves from the consequences of disclosure and making it the responsibility of another to take action against the student there remains no reason to object to disclosure.

Should I have a sign in my office stating "beware what you self disclose because it can be used against you"? (Appendix D, 562-563)

The following posting is not an argument per se, but it has the effect of coming down on the side of nondisclosure. The idea that disclosure could cause discrimination is a new point of view, though other list members do not pick up on the idea.

In one semester, I had two swd students who had history of violent behavior and both were sex offenders. Both had served time for their crimes. Our local police department posts all sex offenders in the area on their web site including photo. In addition, a letter was sent to the cc with notification of this. I might add that my responsibility in DSS was to provide accommodations in the classroom relating to each student's disability. ...which I did. Even though the past history was public knowledge, I never disclosed this info to instructors for fear that discrimination against students could occur. (Appendix D, 576-584)

The attack on the rights of the student continue as the next posting brings up the often used “direct threat” invocation to relieve the DSS office of the need to accommodate the student. The student who is a direct threat is “not otherwise qualified” and can be dismissed from services.

A student who self discloses information which reveals that he/she is a direct threat to the safety of others by reason of his disability (or, for that matter, for any other reason) has disclosed that he/she is not otherwise qualified for protection from discrimination under the ADA or

section 504. Whether the school chooses to rescind its offer of admission is a matter of school policy, judgment and contract law, not the ADA (assuming the student really is a direct threat). (Appendix D, 594-600)

The next post states that “administrators are questioning liability matters.” The students who have assumed responsibility for their own education without interference from the DSS office are viewed as a problem. The U.S. Department of Education made it very clear in the regulations that disclosure of a disability is a voluntary action, but some DSS officials do not seem aware of this fact.

We have a couple of students (wheelchair users) who don't care about utilizing our services. BUT! Evacuation for a fire drill or actual event can be problematic. What do others do in situations like this? Our administrators are questioning liability matters. They seem to think students must disclose. Any thoughts? Please set the wagon straight! (Appendix D, 620-625)

Should a student who is submitting documentation to a DSS office depend on the promised confidentiality of their records? Probably not. The student’s best defense is to know exactly what their doctors and therapists are going to write in their reports that are sent to schools. As schools continue to have liability concerns about students harming themselves or others, they continue to erode the privacy rights of their students. Some DSS professionals are now acting as agents of control. The contention that there are no laws that prevent revealing the documentation provided in the quest for academic accommodation ignores the principles of ethics.

Otherwise qualified. The term “otherwise qualified” appears frequently in the list’s texts. “Otherwise qualified” comes from federal regulations defining the legal concept of the person with a disability being capable of doing an activity such as employment or education when reasonable accommodations make them “otherwise qualified.” Therefore, people with disabilities desire the classification of being otherwise qualified. However, as demonstrated by the discourse of DSS personnel, “otherwise

qualified” has evolved into a condensation symbol. A condensation symbol, according to Edelman (1964) is a word or phrase that is used by those in power to express a positive but corruptible meaning. A condensation symbol is a useful tool of political rhetoric. The “condensation” of emotion provoked by the word or phrase allows those in power to incite a response to the word or phrase even as the meaning is obscured by its use. The usage of the word or phrase by those in power can change its meaning into something different that is not apparent until it has been critically analyzed (Vincent, 1996).

The social construction of meaning for “otherwise qualified” comes about through repeated use in discourse that students can be prevented from receiving DSS services or even have their admission withdrawn or their housing contract cancelled because their status as otherwise qualified is revoked. The idea becomes legitimized as students who represent as difficult to accommodate are discussed on the list. The repeated suggestion in posts to the list that these students can be dispensed with by invoking the denial of their being otherwise qualified makes this practice appear as natural. That students who are difficult to serve are not otherwise qualified becomes, through use in discourse, an inevitable solution and no other solution needs investigation or consideration.

The articulation of individual signs [a single term] also has a wide reaching effect on a culture’s understanding of a situation and the array of meanings and possible courses of action which may be taken in the situation. Alternative descriptions of the situation thus tend to be systematically eliminated from the common sense understanding of what a problem is about (Makus, 1990, p. 504).

The use and misuse of the phrase “otherwise qualified” serves to reinforce power in the hands of the service providers. By changing the meaning of “otherwise qualified” from representing opportunity to meaning disqualification of eligibility, the list members demonstrate their power and domination of students with psychiatric disorders. Reification of the revised meaning creates an ideology of exclusion. “A particular hegemonic social formation is thus articulated through various discursive practices which function ideologically to ‘fix’ meaning in a particular way” (Mumby & Stohl, 1991, p. 316).

DSS offices are using knowledge gained from the documentation they receive to help the school remove the student from campus or from residential housing. The stated purpose of a disabled student submitting documentation is for the determination of appropriate academic accommodations. Its use, according to the discourse on the list, may be something else. The discourse on the list repeatedly shares the idea that a student is not “otherwise qualified” can be determined at any point in the student’s higher education career.

I have a student with a disability related to dysthymia. He indicates that his anger management control issues (which include belligerence, hostility to others, entitlement, blame of others) is directly and intricately related to his depression. In fact he indicates that he needs accommodations because of his anger control disability. Documentation is only for dysthymia. (Appendix E, 1-5)

Dysthymia is defined in the DSM-IV-TR (American Psychiatric Association, (2000) as: Dysthymic Disorder is characterized by at least 2 years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet criteria for a Major Depressive Episode. Several studies suggest

that the most commonly encountered symptoms in Dysthymic Disorder may be feelings of inadequacy; generalized loss of interest or pleasure; social withdrawal; feelings of guilt or brooding about the past; subjective feelings of irritability or excessive anger; and decreased activity, effectiveness, or productivity (p. 376).

It is interesting that the DSS officer writes that “Documentation is only for dysthymia.” The diagnostic description of dysthymia indicates that someone with this diagnosis will demonstrate “decreased activity, effectiveness, or productivity” and “subjective feelings of irritability or excessive anger.” The student apparently told the DSS officer that anger management is one of the problems that need accommodation. The accommodation may be something as simple as permission to leave classes when s/he feels anger building so that s/he can settle themselves. There is no discussion of how this student has acted out anger in the past, but list members are quick to feed off of their stereotypes in their recommendations.

I don't think that there is any accommodation that you could provide for anger management in a classroom that would be appropriate at the college level. If he does not have his anger under some control with medication/therapy, then perhaps he is not a qualified student at this time.

Additionally, what documentation do you have that supports this manifestation of his disability? (Appendix E, 10-15)

The list member has suggested that there is no reasonable accommodation. S/he also suggests that “perhaps he is not a qualified student” because of admitted anger management issues. The question about documentation of the anger as a manifestation of the disability ignores the description of dysthymia in the DSM-IV-TR.

A list member posts an inquiry in response to the posts that indicate that there is no reasonable accommodation for the student with dysthymia. There is reflexivity from

an earlier discussion on the list about behavior modification as an accommodation for severe anxiety and agoraphobia.

I have been thinking about this post compared to the earlier one on Agrophobia [sic]. In that one it seems most responders were all in favour [sic] of this wonderful b-mod plan that was designed by all those involved as an accommodation for the students "behavior" as a result of the neurosis. Yet in this case with anger management, the responses seem to favour [sic] a tone of not doing anything because we can't accommodate adverse behavior. How is accommodating behavior defended in one case, but not the other???

(Appendix E, 32-38)

The difference between agoraphobia [sic] and anger management problems is simple -- one makes life difficult for the student, while the other threatens the safety of those who encounter the student. If b-mod doesn't work for the student with agoraphobia [sic], nobody gets hurt; when therapy doesn't work for the student with anger management problems, people bleed. (Appendix E, 46-50) I remain unconvinced that an anger management problem is a disability, but that is quite beside the point; we already provide accommodations in the traditional sense for people who cannot control their temper -- a bed and three square meals per day -- and it is the prospect of those accommodations which helps with anger management. Unless the student is insane within the meaning of the criminal law, he is obligated to comply with the same conduct standards we impose on everyone else; if he is so mentally ill that he poses an immediate danger to himself or others, he should not be in school. (Appendix E, 55-63)

The student has been transformed from someone who admits his/her anger management issues with the DSS officer in an effort to gain accommodation to a student who will potentially make "people bleed." The described behavior has gone from one of "belligerence, hostility to others, entitlement, blame of others" to someone who is violent. The list member further suggests that the student is violent by the comment about jail being an appropriate accommodation for people who have anger management issues. "If he is so mentally ill that he poses an immediate danger to himself or others, he should not be in school." The diagnosis of dysthymia has gone from a form of depression to a severe mental illness that makes the student an "immediate danger" who should not be allowed in school. The transformation makes the student ineligible for DSS services.

If I was teaching the class I would attempt to soothe the person. It is a kind thing to do. I don't think it is a reasonable accommodation b/c I don't think it is a disability. It is a discipline issue. Acting out anger can seriously interfere with the testing environment. How about a quiet testing place as an accommodation for the dysthymia? (Appendix E, 72-76)

This list member waffles between not accepting the student as disabled to recommending an accommodation. There is the reference to the actions s/he would take as a professor to “soothe the person” to the declaration that it would not be a reasonable accommodation since the student is not disabled. Even though the author of this text does not believe the student is disabled, though, s/he would provide a testing accommodation.

Not to change the subject as it has been fascinating, but I'm having a terminology problem. . . .
 Oftentimes the term "not otherwise qualified" is used to describe situations in which a student with a disability may be deemed "not otherwise qualified" to participate in some program or activity because circumstances around the disabling condition may create an untenable situation. The anger management is simply one example from a number of discussions I have seen on the list.
 I was of the understanding that the phrase "not otherwise qualified" was linked solely with admissions - admission to a university, admission to a particular program of study and so forth. The thrust of being "otherwise qualified" (as I understood it) was to remove the disability from the equation and ask whether the student meets the prerequisites for enrollment.
 Once a student has been accepted into that school/program then they ARE otherwise qualified. When circumstances arise that create disability or accommodation challenges how can we go back to stating he/she is not otherwise qualified? I can see how it would appear that they are not qualified - certainly, as a part-time faculty member I would not want to be held responsible for the prevention of someone else's outbursts - yet, they've completed the admissions process and have been determined to BE otherwise qualified. So, what are they now? (Appendix E, 77-96)

The list member has caught on to the way the term “otherwise qualified” is being used as a means of exclusion. The use of the term when a student is difficult to accommodate, when a student has a diagnosis that includes any reference to anger or other inappropriate acting out in the past, has been co-opted by some list members as a means of disqualification from services, and, on occasion, a rationale to remove the student from

school. “When circumstances arise that create disability or accommodation challenges how can we go back to stating he/she is not otherwise qualified?”

That the meaning of “otherwise qualified” has been changed in a way that disempowers students is demonstrated when a list member uses the term incorrectly. S/he is arguing that a student with anxiety cannot be accommodated. This is in response to an inquiry about accommodating a student with anxiety disorder, whose mental health professional has suggested an unreasonable accommodation (Appendix E, 103-111). The reply uses the term “otherwise qualified” as meaning the student was not appropriate for acceptance into the program of study.

To me this re-enforces why most phobias and Anxiety disorders do not raise [sic] to the disability definition level of the ADA. If the disorder is such that it severely impacts on a persons life, then the student typically becomes "otherwise qualified" because they can not purport [sic] themselves as a student the way your college defines student. Or have the positive student behavior that all students need to have in order to be a student in your college. There are no reasonable accommodations that would not fundamentally alter your curriculum, your scope and role of a college, cause undo [sic] hardships, or give unfair advantages. (Appendix E, 121-130)

The writer buttresses his/her argument by using key words and phrases from the federal regulations including “fundamentally alter,” “scope,” and “undo [undue] hardship.” This employment of Grand Discourses from the law serves to legitimize the argument. The argument built on concepts of law is attempting to build discursive consensus.

This is an unreasonable accommodation recommendation. I do not think this student is "otherwise qualified". (Appendix E, 140-141)

The utilization of declaring a student with a psychiatric disability “not otherwise qualified” as the means to avoid providing services is a demonstration of “power over” (Delpit, 1993). The disability services list members are using communicative strategies of calling up law to validate the actions (or inactions) they take with certain students. The use of disqualifying language does not go unnoticed by other list members.

So do we simply reply that he/she is not "otherwise qualified"? That may be the case, but it doesn't answer anything about the ability of that student to learn, it does convey that students with serious psychiatric disorders do not fit well into the reasonable accommodation module many of us practice; (Appendix E, 199-202)

A post requesting help in dealing with a student who repeatedly expressed suicidal ideation (Appendix E, 217-228) raises the idea that students who act out their depression by voicing the idea of suicide have become unqualified for school. The legal implications of this thinking are covered in more detail in the discussion of the discourse of forced withdrawal from school. But the use of "otherwise qualified" is raised again.

Is this student a qualified student? Remember that being qualified can change throughout a student's academic experience. If the student is not emotionally capable of attending college, the student should be referred to the appropriate authority on campus--Dean of Students, etc. If the student is a direct threat to themselves or others, the student should be referred to the appropriate mental health providers. The Dean or whom ever could require that the student have a letter from an appropriate mental health provider before being allowed to return to college. (Appendix E, 229-236)

If she can not handle the stresses of school without feeling suicidal a couple times a semester, she's not qualified to be there. Sounds like an updated evaluation showing her current state of functioning is needed. (Appendix E, 237-239)

If a student threatens suicide, then you have a legal obligation to report self endangerment to the proper law enforcement. Until a person is able to function without self-endangerment or endangering others then the student should not be in college or attend class. (Appendix E, 240-243)

If a student makes a suicide attempt, we would require that a "Release/Authorization to Return" form be filled out by a psychiatrist stating the person current mental status and their evaluation of the person's ability to function in the college setting. This includes their evaluation of the person's risk to harm themselves [sic] or others. Until that is received, and approved by our committee, the student is not allowed to attend class. (Appendix E, 244-250)

The next posting reflects the "dismay" that the list member experiences when other DSS officers are talking about the student as unqualified to be a student. The fact that the stereotypical portrayals of students with psychiatric disabilities as direct threats and not otherwise qualified is stigmatizing is declared, "These statements do more to continue the

stigma of mental illness than to understand how institutional policy and practice support these students.” The declaration that some DSS officers have been stigmatizing students goes unremarked by others.

As to the question of "what do you do when a student actively expressing suicidal ideation is in your office?" - Answer should be obvious, you get help - whether that be a crisis counselor or security (to transport to campus health services) or other campus resources. The long-term picture is a little different. I'm dismayed by the comments that presuppose a student of this type would not be "otherwise qualified". We have many students with psychiatric disabilities [sic] on our campuses. These statements do more to continue the stigma of mental illness than to understand how institutional policy and practice support these students. (Appendix E, 251-259)

For a student with traumatic brain injury who requested a demonstrable unreasonable accommodation (Appendix E, 288-300), the question of being a qualified student comes up again. Rather than addressing the problem of the unreasonableness of the request and making suggestions for other accommodations, the DSS list members who reply aim to have the student removed from school.

Again, this has to be looked at on a case by case basis, especially the issue of "otherwise qualified". (Appendix E, 246-247)

For a student diagnosed with agoraphobia and panic attacks whose doctor has provided documentation recommending that the school should waive a required course (Appendix E, 355-378) the list members are quick to use the “otherwise qualified” exception to disqualify the student from his/her program of study.

Regardless of the supportive documentation from the doctor, I'm wondering if this student is qualified. It appears that this is a prerequisite and required. Can this student do the essential functions of the course with or without accommodations? If not, then she is not qualified at this time. (Appendix E, 378-381)

Some courts may reason that a student who, by reason of a disability (or for any other reason), poses an immediate threat to his/her own safety is not otherwise qualified, and would not be otherwise qualified even if the direct threat clause were not part of the ADA. (Appendix E, 392-395)

The students [sic] therapist is going to now send us updated documentation stating that she is fully capable to attend, with no accommodations at all! (Appendix E, 401-403)

The discourse repeatedly asserts that students who are difficult to accommodate are not “otherwise qualified.” “It is through this process of differentiating, fixing, naming, labeling, classifying and relating – all intrinsic processes of discursive organization – that social reality is systematically constructed” (Chia, 2000, p. 513). Dominant ideologies establish what is “true” by repeated assertions within discourse. Communication, then, is an organizing practice wherein list members engage in the social construction of a system of meanings (Fairclough, 2005). According to Van Dijk (1993), using persuasion and manipulation to change meaning is an effective construction of power. It is the “jointly produced” discourse that builds organizational dominance.

The evolution of the phrase “otherwise qualified” to its use to disqualify students could be predicted using the “social space” theory of Bourdieu (1989). Social space is shared by “agents” who are in comparable positions and who act under similar conditions. The result of sharing social space, according to Bourdieu, is the agents develop “similar dispositions and interests,” (p. 17) and will develop and follow similar practices. “He [Bourdieu] has us consider language, categorizations, and labels, and their system of production and mode of consumption, as critical in the reproduction and transformation of the social realm” (Everett, 2002, p. 56). In the case of the categorization of students as not “otherwise qualified,” the frequency in which it occurs in the discourse indicates that the transformation of meaning has been accomplished through discourse.

Oppositional Defiant Disorder (ODD). Some list members are skeptical about more recently created psychiatric labels. Students presenting with the diagnosis of

Oppositional Defiant Disorder (ODD) face a DSS organization that has a negative stereotype of people with this disorder. The diagnosis of Oppositional Defiant Disorder for a student may spell the end of their college opportunities. An extended debate of this diagnosis is weighted strongly that ODD is not a disability that DSS offices are required to accommodate. The closure brought on by this discourse places students with this diagnosis in a category of their own that is filled with stereotype and stigmatization. As the discourse will reveal, the argument is that ODD is not covered by the ADA or Section 504 because people diagnosed with this disorder might be disruptive or present a threat to others. The stereotype of a person with ODD as impossible to accommodate was repeatedly aired. The extent of the disparagement of students who present with this diagnosis comes out in the discourse. The hegemony promoted by these texts adversely impact the life chances of affected students, which are proven to be improved with holding a degree or certificate from higher education. The writers not only express personal opinions about people with ODD, they operate as a group to affect the cognitions of subsequent readers. Everyone is justified to discriminate against students whose most discussed trait is danger and violence towards others. But the diagnostic criteria for oppositional defiant disorder does not include any reference to violence. In fact, the *Diagnostic and Statistical Manual of Mental Disorders* expressly states that,

The disruptive behaviors of individuals with Oppositional Defiant Disorder are of a less severe nature than those of individuals with Conduct Disorder and typically do not include aggression toward people or animals, destruction of property, or a pattern of theft or deceit.

Diagnostic criteria for 313.81 Oppositional Defiant Disorder

A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

- (1) often loses temper
- (2) often argues with adults
- (3) often actively defies or refuses to comply with adults' requests or rules
- (4) often deliberately annoys people
- (5) often blames others for his or her mistakes or misbehavior
- (6) is often touchy or easily annoyed by others
- (7) is often angry and resentful
- (8) is often spiteful or vindictive (DSM-IV-TR, 2000, p. 100).

This spring and summer, it seems that there have been a very large number of applying students (some as visiting, and some for Fall) have been diagnosed as O.D. Some have been arrested, some have been on probation, some have punched out principals, parents, other students etc. My opposite number in the Counseling office tells me that they are seeing these students too, and her take is that these students used to be recognised [sic] as ADD, but now they are angry! (failed ADD people? chuckle?) (Appendix G, 3-10)

The challenge is not in whether we are being able to accommodate the students but that of concerns about their behavior on campus. The counseling and security departments at our colleges are not always quite prepared to work collaboratively with the disability services office and develop a comprehensive plan for these students. (Appendix G, 12-19)

The inquirer has described the students diagnosed with oppositional defiant disorder in a way that makes them appear violent criminals, “Some have been arrested, some have been on probation, some have punched out principals, parents, other students etc.” There is no indication of how many of these “some” students have been violent, but the description serves to show the students as out of control. The writer also brings in the discourse of the “Counseling office” who has declared these students as “ADD, but now they are angry!” This helps to create the stereotypical argument that someone with ODD is violent and therefore need not be served by the DSS office. The fact that the described behaviors are not the behaviors indicated by the DSM is ignored. The DSS office may be getting more students with a history of violence, but they are probably not students with

ODD. This stigmatization makes it difficult for students who really do have the diagnosis of ODD when they present to the DSS office.

There is no accommodation for bad behavior as an adult - well, jail maybe! (Appendix G, 22-23)

This list member equates the diagnosis of ODD with criminal behavior.

I feel these students should be working with counseling services but I do not see a need for disability services. How do you academically accommodate ODD??? (Appendix G, 24-26)

1) Oppositional Defiance Disorder is not a disability within the meaning of the ADA or section 504, and therefore need not be accommodated;
2) Waiving basic conduct rules is not a reasonable accommodation; schools may forbid and punish threatening or violent behavior (and threatening speech in circumstances in which the student has the means to carry out the threat or the threat is likely to incite imminent violence) irrespective of its cause. Students who are accustomed to IDEA's treatment of this question may need to be educated on the differences between life under IDEA and life under section 504 and the ADA. (Appendix G, 28-36)

It also states in the ADA that if there is no accommodation that can reduce a threat of risk of harm to oneself and others than an accommodation need not be made. (Appendix G, 37-39)

One reader of all the posts declaring ODD as not disabling and not qualified for academic accommodations questions the thinking of the other posters. However, the discussion remained focused on the disqualification of students diagnosed with ODD as students in need of DSS services.

It's a psychiatric disability that (by assumption) limits one or more major life activities. Doesn't that make it a covered disability? Of course, this leaves open the question of whether academic accommodations are appropriate, but this does seem to me to be a question that needs to be addressed. (Appendix G, 45-48)

Could you expand upon the reasoning behind number one. What part of the disability definition would ODD fail? Number 2 is absolutely correct. (Appendix G, 49-50)

it is not a classified disability under the ADA and also any disability in which an accommodation does not reduce the threat and risk to self or others is not covered under the ADA. (Appendix G, 51-53)

Once again the questioning list member tries to get the other posters to commit to the discussion of the disabling effects of ODD and the need for accommodations.

ADA doesn't list particular disabilities that are covered. Rather, it sets out criteria (rough, we know) that a disability must meet in order to be covered. The question is, how does ODD fail to meet those criteria? It seems to me (see my earlier post) that it does meet them. Am I missing something? (Appendix G, 57-61)

The argumentative scheme of liaisons of succession (Zanoni & Janssens, 2003) is employed to justify the nonaccommodation of students with ODD. The regulations of the ADA do not “classify” any particular condition as qualifying for accommodation under the ADA. The regulations do specifically identify some conditions that are excluded from qualification, but ODD is not one of them. The liaison of succession argument relates the diagnosis of ODD with “threat and risk to self or others” which then disqualifies the student from the protections of the ADA. This argument is repeated by other list members.

I am not Mr. X. but, I would ask what is the substantial impairment with ODD and what could POSSIBLY be accommodated? ODD is coded as Mild, Moderate, or Severe...I think in higher ed., this is not a disability. The essential features, according to the DSM IV, are the person is defiant, losing temper, arguing, refusing to comply with rules or regulations...blaming others...I could go on and on... (Appendix G, 70-75)

It is notable that though the post references the DSM-IV it does not include the statement about the person diagnosed with ODD not being aggressive toward people or animals or destructive of property. This allows the argument of not being a qualified disability because of direct threat to stand.

Exactly what major life activity does ODD substantially limit? (Appendix G, 76)

If the student seeks accommodations your need to look at the student in front of you not a diagnostic label. (Appendix G, 92-93)

it appears that under ADA (private organisations [sic]) and 504 (receiving federal funds) that this OD is not a disability and does not

impair a majour [sic] life activity. the inability to be respectful, kind and nice and socially acceptable is not an impairment of a majour [sic] life activity . is this clearer? (Appendix G, 109-113)

The insistence that ODD be viewed as a disability continued, taking the tack that perhaps prescribed medication might interfere with learning, but again the other list members did not pick up on the inquiry.

If a student is diagnosed with OD disorder, severe, let's say, and is on heavy drugs to control the disorder, and the drugs result in a substantial limitation in, say, learning (which is a life activity we are much concerned with) should we then accommodate for that? (Appendix G, 115-118)

Since the other list members continue to ignore the idea that ODD is in fact a disability that may qualify a student for academic accommodations, the next posting calls on law, the ADA regulations, to strengthen the argument. The posting is ignored in spite of its relevance to the discussion.

Similarly, the definition does not include common personality traits such as poor judgment or a quick temper where these are not symptoms of a mental or psychological disorder. However, a person who has these characteristics and also has a physical or mental impairment may be considered as having a disability for purposes of the Americans with Disabilities Act based on the impairment. (Final Rule "Nondiscrimination on the Basis of Disability in State and Local Government Services" (ADA Title II) as published by the U.S. Department of Justice in 28 CFR PART 35) (Appendix G, 191-196)

Two list members prove their lack of empathy and in fact make outrageous links between ODD and violence against others. The implication is that it serves the public good to exclude students diagnosed with ODD and is the legitimate use of the DSS office's power.

Was Timothy McVeigh ODD? If so it certainly limited a few of his major life activities. (Appendix G, 273-274)

but he was a majour [sic] threat to the health and welfare of others and that is why he has been punished accordingly. that is the danger of this disorder, the student can be the next oklahoma [sic] bombing murderer or the next unabomber. (Appendix G, 275-278)

These comparisons are intended to inflame the reader. The horror of the violence against the public by Timothy McVeigh and Ted Kaczynski will not be forgotten. The definition of a person diagnosed with ODD becomes fixed as an agent of unspeakable violence by this discourse. The social construction of people with ODD is that all people with ODD share the trait of being a danger to others. Therefore, people with ODD do not deserve to be regarded as individuals who have their own agency. As unrecognized others it is common sense to exclude them.

the law says we have to. (Appendix G, 279)

A severely bad personality is not limiting except that nobody wants to be around you. Same with some severe disfigurements. (Appendix G, 349-351)

The argument that ODD symptoms are equivalent to severe disfigurements and “nobody wants to be around you” shows a personal aversion to being around people with “severe disfigurements” that is unexpected in a person who serves people with all sorts of disabilities. It is possible that the sender was in such a hurry to enter the discussion that private prejudices were disclosed.

The frustration with these repeated arguments that students diagnosed with ODD do not deserve services is apparent in the reply by one list member. There is the use of capital letters to place added emphasis to what is being said. What is interesting is that the writer does not use exclamation points. The statement is factual but emphatic.

There is NO classified disability under the ADA, none whatsoever. Virtually ANY condition can rise to the level of disability. You look at it on an individual basis. Does this PERSON (not the condition but the person) have a significant [sic] limitation of a major life activity? If yes, then there is a disability. If no, there is none. One person with a condition may have a disability and another with the same condition may not. (Appendix G, 394-399)

This posting serves to demand that service providers keep an open mind for all diagnosed disabilities. It serves to remind list members that they are serving human beings who

should be judged based only on their singular history. Then the writer states what should be an obvious reality in the service of students with disabilities; each case should be examined based on its merits. “One person with a condition may have a disability and another with the same condition may not.” Finally the momentum of the discussion has swung towards considering each case of ODD on its own merits as possibly qualifying for some academic accommodation.

On our campus we would look at that situation as a health-related disability and ask that the prescribing physician verify the need for the medication, describe the impact of the meds. particularly in terms of learning for this individual and ask him/her to recommend accommodations. (Appendix G, 408-411)

However, within a short time the issue of personality disorders not being disabilities is raised once again. In this case it is a diagnosis of borderline personality disorder (DSM 301.83). The social construction of personality disorders has been reified as unqualified for services. That past discussions on the list have affected the DSS official’s construction of the disability is evidenced by the opening, “I recall something. . .”

I recall something about "personality disorders" not being disability conditions which necessarily warrant academic accommodations, and am reviewing a mental status report presented to this DSS office for a determination of eligibility with this DSM 301.83 as the primary issue and no medications other than amltriptyline [sic]. (Appendix G, 542-546)

The descriptive stereotype of people with ODD in the discourse tells the reader that this group of students will behave inappropriately including endangering themselves and others. This creates a bias against the student presenting with this diagnosis that will set the DSS provider against the person even before their first meeting. Everyone on the list then potentially “knows” the negative connotation of ODD. It becomes socially acceptable to discriminate against these students and easier to reject any attempts to refurbish their reputation. In the critical reality identified by Van Dijk (1993), negative

decisions about people as a group must be defensible with “facts,” thus the majority of discourse that denigrates the targeted group will be biased and stereotypical. This bolsters the impression that decisions against them are based on rational thinking. This is the abuse of power that begets hegemony.

Emotional Support/Companion Animals. There is a large amount of discourse about service animals and emotional support/companion animals in the archives. The archived policies and statements about animals in use to assist people with their disabilities are a mix of correct and clearly stated explanations about the relevant laws and regulations and misleading, and in some cases mean-spirited, comments by list members. The fact is that students with psychiatric disorders who present the DSS office with a prescription for an emotional support/companion animal tends to bring out very polarized discourse with the idea of an animal helping a psychiatric disorder sometimes being ridiculed. In the instances where list members discuss emotional support/companion animals in student housing, there appears to be the reaction that those who post messages to the list encouraging the use of animals as a coping mechanism are not being heard. Even after being presented with applicable laws, there are some on the list who continue to wage a campaign of disallowance of this accommodation.

There is a first for everything....
Has anyone dealt with this issue before? I am working with a student who has a diagnosis of depression and wants to keep her pet rat in her dorm room. She has heard of comfort animals being allowed as an accomodation [sic] for depression. Any thoughts? (Appendix N, 1-5)

What does she do, or have as a "comfort item" to function when not in the room? (Appendix N, 6-7)

Does documentation support the fact that a pet rat minimizes depression? Just wondering. I haven't dealt with this issue...but I would have to think about that one for a long time. :) (Appendix N, 8-10)

Before there are a slew of responses saying the ADA does not cover Companion Animals, Therapy Pets, ... Consider that your residence halls are also covered by the Fair Housing Act and the Fair Housing Act Amendments. These have been supportive of waiving a "no pets" rule as an accommodation for a tenant when specific documentation identifying the role of the animal in therapy is provided.

For more references go to:

<http://www.bazelon.org/fhinfosheet6.html> (Appendix N, 11-18)

According to the cited Bazelon Center for Mental Health Law, emotional support animals are not pets and fall under the protection of The Fair Housing Amendments Act of 1988, Section 504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act. These laws protect the right of a person with a disability to keep an emotional support animal even when the landlord has a "no pets" policy. The regulation that defines discrimination in FHA rules includes "a refusal to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford an equal opportunity to use and enjoy a dwelling" (42 U.S.C. §3604(f)(3)(B)). In *Bronk v. Ineichen*, (54 F.3d 425, 429 (7th Cir. 1995)) and *Fulciniti v. Village of Shadyside Condominium Association*, (No. 96-1825 (W.D. Pa. Nov. 20, 1998)) the courts allowed the tenants to keep their companion animals in spite of "no pets" policies. To qualify for an exception to the no pets rule, the tenant must be a person with a disability, make the request in writing, provide documentation from a doctor or therapist, and demonstrate a relationship between his/her ability to function and the companionship of the animal. Federal law does not require proof that the animal has had any special training or certification. The landlord has the right to propose the defense that the animal represents "administrative, financial, or programmatic repercussions" but the courts have not been persuaded that the presence of a companion animal represents an undue burden. If the request is found to be unreasonable, the landlord is required to propose a substitute accommodation. In doing so, according to the Department of Justice

ADA Technical Assistance Manual (II-7.1100) the individual with the disability should be consulted. The courts have found in favor of the tenant when the proposed substitute accommodations were not as effective as the companion animal (*Green v. Housing Authority of Clackamas County*, 994 F.Supp. 1253, 1256) (The Bazelon Center for Mental Health, n.d.).

Many of the list members repeatedly explain that the student with a psychiatric disability has the right to have an emotional support/companion animal in campus housing. However, there is the occasion where postings by list members make outrageous comments denigrating the usefulness of a companion animal as a mitigation of symptoms.

The student should leave the pet at home or take it to a taxidermist.
(Appendix N, 158-159)

A series of posts by a group of list members works to build aggressive humor that works to demonstrate their unwillingness to take requests for emotional support animals seriously.

Perhaps there is a good taxidermist in the area who can make it possible for the student to take the rat to class as well as keep in [sic] in her dorm. (Appendix N, 19-20)

I liked the taxidermy suggestion very much and am still grinning. Thanks, you, Xxx. What is the functional limitation and how does it relate to academics? A student with depression may ask for a rat, a snake, or a dog as a medication substitute to alleviate symptoms, but is such relief in DSS purview? (Appendix N, 21-25)

At the suggestions that animals be killed and mounted by taxidermists, a list member grows frustrated with the discussion. S/he protests the jokes and disrespect directed at students who request emotional support animals. The argument that the animals should be allowed is strengthened by the inclusion of relevant regulations. In closing, the post reminds the list that all students are deserving of equal treatment.

The conversations regarding the use of comfort/assistive animals for students with mental/emotional issues has greatly worried me in recent weeks. Why is it that students with emotional/psychological disabilities are seen as less worthy as needing comfort/service animals than those with visible/physical disabilities. I have also been greatly dismayed by the jokes and disrespect these students' requests have received on this list. Granted, a rat may seem like an unusual request, but if it provides comfort to a student with depression, is it worthy of our mockery? I have attached the Federal Law regarding such housing laws for the provision of comfort animals. As well as the brief wording for the ADA and the Rehabilitation Act of 1973. May they remind us all of the equity all students deserve. (Appendix N, 26-37)

However, the protest is met with a post that acknowledges the reminder to serve students and then immediately goes into the reasons that emotional support animals should not be allowed. The poster accuses students of “trying to use the ‘disability card’ to obtain special privileges in housing.” “Disability card” echoes the accusation made against people of color who “play the race card” when they are discriminated against. The implication is that the discrimination and perceived slights are not based on race at all. In this case, the implication is that people who would otherwise be “abled” use the claim of disability as a means of gaining an unfair advantage. In the game of cards, that would be a trump that wins the hand. The post also includes the all-encompassing idea that “everyone on the list has had the experience” of the card being played that wins the hand away from the DSS official. That the animal is needed by the student is disputed.

Xxx, thanks for reminding us that we are indeed here to serve students, even ones that make requests we think of as unreasonable. I would not be particularly receptive to a request to have a pet rat or any other animal in a dorm as a comfort animal. I imagine that everyone on the list has had the experience of students trying to use the "disability card" to obtain special privileges in housing. We have dozens of requests every year for special housing arrangements on the basis of disability. The difficult part of the job is to sort through these requests and decide which requests are simply things the student desires and which the student needs. While I can easily believe that a pet rat might make a student feel more comfortable, it would take some convincing for me to believe that a student ****needs**** a comfort animal to succeed in his/her courses. (Appendix N, 38-49)

The discussion deteriorates into a series of posts that treat the issue as something to be poked fun at rather than something that is very serious for the affected students.

We often struggle with this issue. I think perhaps we have approached it from the wrong perspective. Can anyone think of an animal with a claimed service responsibility that they would not believe. Maybe leader hawk, hearing whale, service snail or something. (Appendix N, 50-53)

How about an electric eel that works in place of a tens unit to introduce a painkilling electric shock? And when it gets old and wears down, you can cook and eat it. (Appendix N, 54-56)

But only in "pods" where kitchenettes are provided. You couldn't do an eel in a popcorn popper, could you? (Appendix N, 57-58)

and make a functional and sturdy eel skin wallet with the skin! (Appendix N, 59)

I would certainly hope that the law would protect my inalienable right to bring my service flea to the dorms, to class, and to all proctored exams. It's frequent biting me under the arm serves as a means to help me keep my attention on what's going on in class. Though you might think that such biting would be distracting, it has the opposite effect on me. You see, my distractibility owes not to external factors, but to my own internal thoughts. A teacher might say something, and right away I think of something very different, though related in my mind, and then I'm off, not paying any attention to the lecture or to taking notes anymore for who knows how long.

It is then that the flea's bite brings me round to the present once more, and the important task at hand of listening and taking notes. So you see, without that constant little reminder, or prod, I just don't stand a chance in college. (Appendix N, 60-72)

I take exception to Xxx's post. Xxx distinctly requested information on unbelievable service animals and Xxx's flea is entirely too plausible, not to mention entertaining. I know many people, students included, would greatly benefit from an infestation. How about the service stuffed animal? And I don't mean a cute, snuggly plush toy but a formerly living creature of objectionable proportion, like a coyote or a buzzard? (Appendix N, 73-79)

Good idea. Install some casters in the buzzard's feet. Attach a broomstick to it and the blind student can push it around campus. (Appendix N, 80-81)

Our local service consortium, "Collegeate [sic] Consortium of Disability Advocates," (CCDA) has a stuffed farot [sic] that from time to time gets awarded to the member with the best war story. We haven't quite figured out what it does, however; we think it's more of a companion animall [sic]. (Appendix N, 82-85)

Where should one install the broom stick, or is that obvious???

(Appendix N, 86)

The subjugation of people with disabilities who use assistance animals to the raw “humor” of certain list members represents dominance. “Occasional, incidental or personal breaches of discourse rules are not, as such, expressions of dominance. This is the case only if such violations are generalized, occur in text and talk directed at, or about, specific dominated groups only, and if there are no contextual justifications other than such group membership” (Van Dijk, 1993, p. 261). Van Dijk does not believe that intentionality has to be proven in order to establish that discourses are racist. In the present case, intentionality is irrelevant to declare this discourse as demeaning and discriminatory. The enactment of dominance through “humor” is accomplished when these writers “feel entitled to break normative discourse rules” (Van Dijk, 1993, p. 262) and make fun of people using assistance animals.

A student diagnosed with Bipolar Type II, Atypical, Generalized Anxiety Disorder, and Post-traumatic Stress Disorder brought a statement from her clinical therapist that says the student’s poodle is useful to keep the student calm and focused (Appendix N, 281-288). List members once again expressed their disdain for doctors’ recommendations and the reasonableness of the request.

Faculty are not thrilled about having a poodle in class with them, and have asked me if they must allow the animal in class. (Appendix N, 287-288)

Be glad she doesn't have a security chicken! (Appendix N, 289)

. . . by what yardstick has the poodle been determined to be 'useful' and what other categories of poodledom exist besides useful, as for example: irritatingly worthless, needs frequent bathroom breaks so good to promote exercise, helpful as a teddybear (go with the teddybear in that case), keeps patient from pulling out hair [sic] and nails, patient can't leave the house without it absent a straight jacket, give the poodle the diploma. (Appendix N, 299-304)

Also, what service was the animal trained to do? No training to provide a disability-related service, no service animal. (Appendix N, 323-324)

Next is the pet Python or Boa going to class! (Appendix N, 336)

Once again a list member has the courage to stand up to the inappropriate humor and judgmental statements that have been made.

Just wanted to note my surprise at the level of insensitivity and sarcasm here. Many things help a person manage from day to day, be it sugar pills (placebo), meditation, prayer or other. Important to focus on the issue(s) rather than judge the means a person employs. (Appendix N, 337-340)

Rather than acknowledge that the discussion had gotten out of hand and was serving to denigrate certain students, the reply to the protest defended the actions of the previous posters.

I know I have very little experience in this field and have often asked some of the worst questions and most inexperienced questions in the world but I do know this: this job can truly get to you and burn you out if you do not have a bit of a sense of humor. Now please don't anyone get me wrong. I totally believe that the person that posted this and people who have posted similar messages probably have a great sense of humor..truly. What I also know is this the people that are posting the insensitive emails are also persons who treat all inquiries with a level of professionalism that I have never seen before and are also what I consider the true masters of this art-form called disability services. I also believe that they have never or will never carry that behavior in the office itself ..outloud so to speak. (Appendix N, 346-359)

It is hard to believe that someone would defend the actions of the DSS officers who were making inappropriate remarks about assistance animals, especially since the rationalization is that “they have never or will never carry that behavior in the office itself . . . outloud so to speak.” The fact that the postings went to over 2,000 subscribers of the discussion list is very much “outloud.”

In the following post there is the appearance that there is nothing further the DSS official needs to know in order to allow the accommodation based on the requirements

outlined by the Bazelon Mental Health Center. It is stated that the therapist has documented the need for an animal as a coping mechanism.

We have had several requests recently for "therapy" animals to live in university residences with students. The latest is from a prospective student with a psyche disability who is requesting that she be able to have her hedgehog as an accommodation. We have a letter from her therapist describing the disability and specifically recommending the hedgehog. The therapist states that this animal provides needed comfort and is part of a "coping strategy". I have to admit, we're stumped! We are getting more and more of these types of requests. We are attempting to write policies so that we have guidelines to follow, but aren't there yet. (Appendix N, 87-95)

As is the usual response by an institution to any situation outside the norm, the DSS officer declares, "We are attempting to write policies so that we have guidelines to follow" which indicates that the existing policies in federal and state law are being ignored. Why would the institution need policies when the allowance of emotional support animals is clearly defined by the regulations?

This text can be best analyzed using the standards that have been set for accommodations by DSS. The use of accommodation standards established by DSS officials are being used because it is apparent from the discourse that it is unlikely the legal standards for an emotional support animal are considered. First, there needs to be "A clear diagnosis of the DSM-IV disability." The list member does not state what the diagnosed disability is, but the student is described as having "a psyche [sic] disability" so the presumption is that she meets the first criterion. Second, the documentation must include "A statement that this disability substantially limits a major life activity and which one or more it limits." Again, the writer does not specify what the documentation indicates. However, it appears that the life activity of living on her own and coping with the living situation is impaired absent the presence of the animal. The third criterion is a statement of how it limits the learning process. A better question would be how the

disability limits the living situation. Finally, “A request for accommodations that could give the student an equal opportunity to learn” or, in this case, live in a dormitory.

According to the post, the therapist explicitly states that the “animal provides needed comfort and is part of a ‘coping strategy’.” Using the criterion that is on the list, this student has met every element to be allowed the animal in the dormitory. So why is the inquiry to the list even necessary? Obviously the DSSHE-L archives did not provide an answer to whatever questions remained in this provider’s mind. The replies to the inquiry need to be analyzed in order to reveal the contradictions in the social construction of the concept “emotional support/companion animal.”

The first reply is a series of questions. “In what way has the animal been trained?” This is a misleading statement that an emotional support/companion animal needs to be trained that is put forward as a question. In practice, the question is an argument. “Did the therapist state that she would be unable to live in housing without this?” Again, this is an argument in the guise of a question. In the court cases and opinion letters from the Federal Housing Authority (FHA), the emotional support/companion animal need only mitigate a symptom of a disability. There is no requirement of an either/or determination. The person is not required to show that *either* they have the animal *or* they cannot enjoy their residence. “What would happen to her without the animal?” This is a question asked and answered by the therapist. If additional information is preferred, then it should come from the student.

The next reply posted is based on existing law and regulations without relying on technical jargon.

Maybe this is more a companion animal. Companion animals are essentially pets that are necessary for the participation in University programs by the person with a disability. "Necessary" means that the

disability office can verify through documentation that the person with a disability may experience discrimination based solely on disability if the animal is not permitted to live with the student. (Appendix N, 103-108)

Another list member contributes an explanation with the supportive contention that the allowance of the animal is covered by “HUD and DOT” (Housing and Urban Development and Department of Transportation).

A "Therapy animal" does NOT have to be "trained" or certified as such. It is also known also known as a "companion" animal, "comfort" animal and "emotional support" animal. They are not a "service animal", which is trained to be allowed to accompany their partner with a disability in any area open to the general public. A therapy/companion/comfort/emotional support animal is covered by HUD and DOT for residential and airplanes. Partners with disabilities must show proof from a doctor or psychologist that the animal is required to help with a mental health condition. (Appendix N, 109-117)

However, an authoritative poster, one who posts frequently and includes his/her credentials and title in their text, ignores the law and provides an answer intended to prevent the student from being accommodated.

I hate to say "never," but on this issue, I come close. Make it easy. Start by insisting on proof that the student has a disability, remembering that the definition includes both the requirement of an impairment and evidence that the impairment substantially limits a major life activity. Then ask for documentation of exactly what the animal does to relieve those limits. In almost every case, that will resolve the problem; the student won't have a disability, or will have no documentation that the animal performs any service. . . The student should leave the pet at home or take it to a taxidermist. (Appendix N, 142-159)

The writer identifies the request for a reasonable accommodation as “the problem.” To resolve the problem, there is the suggestion of requiring additional documentation. “In almost every case, that will resolve the problem; the student won’t have a disability, or will have no documentation that the animal performs any service.” The argument then includes every student with a disability who requests the accommodation of an emotional support/companion animal, “In almost every case. . .” The writer concludes with an insensitive, mean-spirited statement, “The student should leave the pet at home or take it

to a taxidermist.” The writer leaves no doubt that their discourse will continue to be against every argument for allowing the accommodation, “I hate to say never, but on this issue I come close.”

Within a short period the question of a service dog/companion animal is posted.

Another student with multiple psychiatric diagnoses, including bipolar. According to her psychiatrist, her many meds can have the side effect of a seizure (mini or grand mal). By having her dog with her, the student feels less anxious and less likely to have a seizure. According to the psychiatrist, if the student does have seizure, the dog will also "help." We are asking for more info on the dog. As far as we know, it's not a trained dog, i.e., seizure dog. It's her pet. The issue is that this entering first year student demands that she can keep her dog in the dorm even though pets are not allowed. I would appreciate your thoughts and comments on these issues. (Appendix N, 167-175)

The first reply to the inquiry supports the student’s right to have the dog in the dormitory.

It is supported with links/URLs to the Fair Housing regulations, the U.S. Department of Justice, ADA service animal page, and ADAdvocates.

For the purposes of the FHA (in the dorm), the animal at least meets the criteria of a ESA (Emotional Support Animal), thus would be lawfully allowed to live in this SWDs dorm, IMO. For the purposes of 504 and ADA, if the SWD says the animal ("her dog") is a "Service Animal" (SA/SD) and the SWD is "disabled" by the legal meaning of the word (including recent case law), then you must allow "her [service] dog" to accompany her wherever she is (and all other students are) allowed to go, period.

See:

<http://www.fairhousing.com/index.cfm?method=page.display&pageid=3607>

And:

<http://www.ADAdvocates.com/pub/animal.html>

And:

<http://www.usdoj.gov/crt/ada/animal.htm> (Appendix N, 177-190)

The list member who has been previously actively campaigning against service dogs and emotional support/companion animals especially, quickly responds to the inquiry.

The student with bipolar disorder makes a seemingly extraordinary claim that by its very presence her dog prevents her from having seizures. As a general rule, extraordinary claims should require extraordinary evidence; at a minimum I would want a detailed written explanation from a qualified health care professional of 1) the mechanism by which anxiety triggers the seizures; and 2) how the health care professional determined that the presence of the dog diminishes the frequency of seizures. Does the dog monitor the electrical activity in the student's

brain and discharge an electrical current when it perceives unusual activity? Did the health care professional measure the frequency of seizures when the dog is present and when the dog is absent? Or is this gastronomic diagnostics (I can't explain it but I feel it in my gut). (Appendix N, 191-202)

S/he takes the original statement from the inquiry, “By having her dog with her, the student feels less anxious and less likely to have a seizure” and changes it to “her dog prevents her from having seizures.” This semantic move changes a reasonable idea into an extraordinary claim that is impossible to support. The writer then bases his/her next argument on the changed meaning. “As a general rule, extraordinary claims should require extraordinary evidence.” There follows some snide questions that serve to build on the extraordinary claim that s/he made up at the beginning of the post. “Does the dog monitor the electrical current in the student’s brain and discharge an electrical current when it perceives unusual activity?” Then the direction of the insult shifts to the prescribing doctor. “Or is this gastronomic diagnostics (I can’t explain it but I feel it in my gut).” This argument is built on a faulty premise devised by the poster which prevents any logical argument in response.

The next list member writes a terse response to the exaggerated argument.

Seizure Detection and, or Alert Service Animals are a proven fact, for one. And, State and Federal law require public accommodations (like schools) to grant access to person with disabilities who are partnered with them, period. (Appendix N, 248-251)

The give and take by the different list members over space and time regarding animals as reasonable accommodations leaves the reader of the text uncertain as to the right answer to accommodation questions. That some DSS officials openly choose to ignore the law is apparent in the discourse. Their misuse of the power of their office to not allow an accommodation because of some prejudice contributes to hegemony. As Lewis (1992) stated, “Hegemony is never permanent. It is a continual process of

articulation – of striving to frame various definitions of reality within one particular ideological formation of the dominant in society” (p. 280). The articulation of some list members attempts to put closure on the discourse surrounding animals as accommodations. The definition of reality in their arguments is that students with disabilities do not benefit from the animals and there is no legitimate cause for allowing them. When it proves impossible to refute the law, these dominant writers choose to ridicule the idea of a useful service by an animal. As demonstrated, they even resort of aggressive humor to denigrate the people with disabilities who are partnered with animals.

Animals as service animals or emotional support/companion animals have gone through several translations on the list. There is no clear consensus on the issue of allowing animals as accommodations. The presence in the archives of repeated requests for institutional policies to control the use of animals indicates that some schools have objectified the social meanings (Berger & Luckmann, 1966) of a student with a disability partnered with an animal. “Social meanings are often transformed into institutional or organizational rules that in turn may be used to justify actions” (Lewis, 1992, p. 284). Institutional rules attempt to convince the affected subjects of the common sense in their framing. There are still many list members who are intent on allowing animals as accommodations when justified and appropriate. These champions of service animals and emotional support/companion animals continually attempt to change this institutional “common sense” to “good sense” that obeys the dictates of law. But the confused advice in the archives is the result of dominant ideologies being reinforced by misinformation, negotiated in arguments between members, and continually being contested.

In a move that is uncommon for this particular discussion list, two members engage in an extended argument about service animals/emotional support/companion animals (Appendix N, 405-703). In agenda setting, there are times when a group member isolates another member for discourse in order to exclude the voices of other members. This allows a discussion with controlled content so that the discussion focuses on the points of the agenda preferred by the dominant voice. What is striking is the difference in “tone” between the two. The use of narrative statements show the resistance to alternative interpretations of the law and practices by one poster, a technique in discourse to make the writer’s opinion appear both natural and reasonable. The writer who is resistant to the use of animals on college and university campuses snips the other poster’s email into smaller sections and proceeds to argue each contention. The proponent of animals as accommodations is very gentle in his/her argument, using a tone of reconciliation throughout the argument. The response is a tone of condescension and disbelief, much like an adult “reasoning” with a child. This aggressive arguer uses exaggeration as a means of reducing the real to the unbelievable which defies any attempt at logical argument. For example, “We have come some distance since the days of ritual incantations and magic.” This statement in the argument equates the assistance of animals to voodoo. The poster continues to misstate the original email and continues with exaggerated statements. “A sincere belief in alien abduction is not a demonstration of anything except the limitless capacity of people to confuse fantasy with reality.” This argument based on the ridiculous continues, “My children once believed in Santa Claus, and happily would have sworn under oath to that belief.” “If a dog prevents seizures,

explain how. If you can't, then we are back to worshipping golden calves, and health care professionals have abandoned science for shamanism.”

As this argument goes on for several screens it is apparent that nothing the pro-animal poster writes is being accepted as possible. The protester uses exaggerated statements in an attempt to make alternative arguments outside the realm of possibility. The alternative explanations of the situation are systematically reduced to the ridiculous by doing so. This makes the pro-animal position appear as unreasonable and unrealistic. Domination occurs, in this instance, from the protester repeatedly expressing his/her definition of the situation. The reification of assistance animals as science fiction and child-like wishful thinking serves to denigrate all other viewpoints. Hegemony is a discursive creation (Gramsci, 1971) and the continued ridicule of assistance animals and people who support their use is a social construction of power over reason. The protester utilizes the “myth of rationality” (Conrad, 1985; Mumby, 1987; Weick, 1979) by calling for scientific evidence as the deciding factor for allowing an assistance animal. Evidence would make the decision about the allowance of assistance animals appear to be objective. However, because the protester has reframed the circumstances of this particular inquiry into a fantastic imaginary, there is no evidence available. This discursive closure serves to isolate the power into the protester's discourse. “We can say that power is exercised when ambiguous or equivocal information is interpreted in a way that favors the interests of a particular organizational group” (Mumby, 1987, p. 116). Using the rhetorical devices that restates the facts incorrectly and makes exaggerated claims and then demands rationality and evidence allows the protester to make it appear that power is not involved in the decision process. The protester is using language to

exert a coercive power and communicates a disdain for all other interpretations of truth. Thus, all other discourse promoting the acceptance of assistance animals is regarded as originating from an out-group who should be marginalized along with the students they support. “Agents who see the target as an out-group member will use harder tactics than agents who see the target as a fellow in-group member (Bruins, 1999, p. 11). The use of persuasion, dissimulation and manipulation in discourse is an attempt to change other people’s minds in the furtherance of “modern” power (Van Dijk, 1993). Modern power through discourse attempts to affect social cognitions. Through changing social cognitions, the writer is controlling the implementation of discourse to action.

A Class on Paper

The members of the DSSHE-L discussion list are what Bourdieu (1985) labeled a “class on paper.” They have created an identifiable class through discourse. This is because, as Bourdieu suggested, they occupy similar positions (DSS personnel, predominantly) who work under similar conditions, thus there is a high likelihood that they will demonstrate similar dispositions and interests leading them to follow similar practices. Bourdieu relates these similarities to the ability of the critical analyst to explain and predict their practices and properties. The class on paper will continue to exist as long as members are endowed with “*plena potestas agenda et loquendi*” [full power to act and speak (R. Nice, trans.)] (Bourdieu, 1985, p. 741). The class (DSS officials) will have political force within its field of disability services. “Social space is constructed in such a way that the closer the agents, groups or institutions which are situated within this space, the more common properties they have” (Bourdieu, 1989, p. 16).

This class on paper is very powerful in the field of education. DSS personnel represent the rights of students with disabilities. How well they represent the student is not a subject that has been explored well. This critical look at the discourse of only one area of expertise suggests that much more needs to be done to prepare these professionals to work with the specialized needs of students with psychiatric disabilities. Some suggestions are made in the conclusion that complete the *telos* of this project.

Chapter 5

Conclusion

Before this project comes to an end, it is important to make clear that the criticisms emerging from this analysis are not aimed at the entire disabilities support services community, but every list member is implicated in what is said and not said on the list. Although every DSSHE-L list member owes some responsibility for what is published on the list and what goes unchallenged, the discourse of a relatively few list members has resulted in stigmatization, stereotyping, and discrimination against students with psychiatric disabilities. When certain list members post messages with incorrect information or damaging images, and the readers of the list allow the posting to stand, then there is an implied consent for the policies and images as posted. While it has been my personal experience that the Office of Disability Services has treated me with respect, protecting my documentation as promised, and giving me the support to be a very successful student throughout my graduate career, there are strong indicators that I would have been treated very differently on some college and university campuses. As I read some of the texts, I came to the realization that I would have been rash to seek academic accommodations at some schools. To do the critical analysis knowing all the while that I would have been the target of the policies and decisions of some DSS officials was difficult. The hurt and anger I felt at some of the discourse will remain. If every DSS officer who reads and understands the criticisms leveled at the discourse in the DSSHE-L archives begins to participate in portraying students with psychiatric disabilities as equally deserving of services, including being treated with respect, then this experience has been useful.

The first question posed was,

- How are "mental illness" and "reasonable accommodation" socially constructed in the discourse of online discussions about psychiatric disabilities?

The analysis has provided many examples of how psychiatric disability is socially constructed as well as several examples of the decision-making process for accommodations. The second question was,

- Do specific discourse features provide evidence of the exercise of power in ways that stigmatize and/or limit access to equal opportunity for students with psychiatric disabilities?

These features included unbalanced posting patterns, attempts at closure of discussions or debates, invoking greater expertise/experience or the Grand Discourse of law, and allowing misinformation, sarcastic humor, and damaging stereotypes to go unchallenged. For each of the following categories, I will first summarize the findings and then provide recommendations for remedying the limitations of the list.

Posting Patterns

There is a decided unevenness of representation on the discussion list. As illustrated in the Tables in Chapter 4, a few discussants contributed the most discourse about mental illness. The fact that some list members only posted once or twice for questions about psychiatric disabilities in a five year period while seven list members contributed the bulk of the corpus on mental illness indicates a weakness in the trustworthiness of the DSSHE-L archives. Over one-fourth (198) of all the emails pertaining to psychiatric disorders collected over 5 years (783) were written by seven

discussion list members. There were over two-thousand subscribers to the DSSHE-L list in 2006, indicating that most list members are consumers who do not participate actively in constructing the knowledge that is maintained in the archives. This is a major weakness of the archives. A few list members are dictating policy while the more than 2,000 remaining list members lurk in the shadows. The limited discussion on mental illness issues leads to the appearance that the published policies and interpretations of law are correct and can be depended on when faced with similar issues.

There may be very good reasons that some subscribers did not participate in the discussions about mental illness. It has been found that some disability services personnel admit the fact that they are untrained in psychiatric disabilities. It may also be that some list members are resistant to putting themselves on the public list for fear that they may be castigated for their opinions. Some list members may very well be responding to inquiries by contacting the soliciting person directly and there is no means to discover what is being said if they do not publish their comments. The reasons for silence on issues may be diverse, but the absence of voices when the posting is prejudicial, portraying people with psychiatric disabilities in a stigmatizing way, and result in hegemonic discourse implies that the issues are not important enough to step up and take a stand against what is being said. If the DSSHE-L list is going to be touted as the site for information on accommodating students with disabilities, then it must be maintained in such a way that it only reflects best practices. Subscribers who are only lurking are not contributing to the growing dialogue about students with psychiatric disabilities. Silence to hegemony for whatever reason allows the comment to stand unchallenged. The reality as it is being shaped today shows the probability that a student who is handled in

accordance to the counseled withdrawal policy or the housing amendment policy could successfully sue the institution. Students diagnosed with oppositional defiant disorder in their childhood will react to the denial of their right of accommodation. Service animal users and students prescribed emotional support animals will challenge their exclusion in the courts.

The discourse of the list simultaneously objectifies the students who present to DSS offices and treats them as subjects. This allows the list members to refer to students as objects that can be controlled by various means including the invocation of law and regulations and the “common sense” rules they devise. It is the dissection of the common sense that exposes hegemony. The understanding of the process of the construction of meaning permits the critical analyst to deconstruct the discourse. The tendency of some DSS officials to act as gatekeepers and champions of the institution overrides the rights of the student with a disability.

Recommendations. The DSSHE-L membership (2,227) includes many members who do not actively participate by posting messages. One of the strongest antidotes to hegemonic discourse is the participation of many actors in the discourse community. It is the multiplicity of voices (as described by Mautner, 2005) that can create a groundswell of acceptance and respect for students with psychiatric disabilities. The public and global discourse that computer mediated communication enables encourages the social construction of a reality that is inclusive and democratic. Because the transmission of ideas is instantaneous, at the push of the send button, the list can be sensitive to social change. Submission of unsolicited information that counteracts the hegemony constructed

in many interchanges on the list, along with personal comments and best practices, could also make a difference.

There is every opportunity for intertextuality that would bring broader voices into the discussion. If a list subscriber is afraid to post their own thoughts, they can still post the URL for a web site that provides positive information about psychiatric disorders. There are many journal articles about people with psychiatric disorders that should be a part of the reading by all DSS officials and sharing important research should happen with great frequency, though in the present case it did not occur. The list seemed to be almost operating in isolation from the rest of the world as though DSS officials were working in such specialized jobs that there were no other sources of information. This isolationism must change. There should be a concerted effort to get other professionals onto the list for their perspectives including psychologists, doctors, social workers, and others.

The need for DSS professionals to share best practices for serving students with psychiatric disorders is of utmost importance. As this critical discourse analysis discovered, there is misinformation and stigmatizing text residing in the DSSHE-L archives. There are instances where other list members posted objections to what was discussed, but the repeated discussion on certain topics leaves a mixed message about certain psychiatric disability issues. Therefore, the reflexivity of discourse assumes the knowledge contained in the archives as dependable which leads to the reconstruction of archived ideas. The members of DSSHE-L list owe it to the students with disabilities that they serve to post more frequently when the topic is about serving students with psychiatric disabilities.

Roles and Powers of the DSS Officer

A notable pattern in the discourse of the list was the explicit or implicit debate about whether DSS officers protect the rights and access of students with disabilities or the interests of the institution that employs them. The implicit goal to assist the school's administration to revoke access to students with psychiatric disorders while maintaining the appearance that the DSS office is there to provide access to the same students is evidence of hegemony. The discourse constitutes and sustains an unequal power relationship between the DSS official and the student. In both a social and a political context, such a policy enacts dominance and inequality in its text. The DSS office should represent one thing to a student with a disability – the *access* to academic programs they are qualified to pursue. As privileged speakers in the effort to provide access to students with disabilities, DSS officials owe a duty to students first.

The need for policies that affect students with disabilities, and particularly students with psychiatric disabilities, will occur at institutions. The role of the DSS official in writing these policies should be one of inclusion. Whenever possible, the policy should be one for all students, not just a targeted few. When suggested wording for policies includes the distinction of students with disabilities separate from other students, then alarms that this is discriminatory should loudly ring. The interests of the protected class of students with disabilities will not necessarily be represented by any other office when policies are being considered, so it is important that the DSS official provide a voice to this special needs group. It cannot be said too often, the role of a DSS official is to champion the rights of students with disabilities.

The role of decision maker that results from having medical records should be one of knowledgeable interpreter of these records. When a doctor or other mental health professional makes a diagnosis and prescribes accommodations, there should be a formal review when the DSS officer disagrees rather than dismissing the diagnosis and recommendations out of hand. A review process necessarily includes persons other than the DSS official, so it is important that a student be informed before such a review begins. Some DSS officials seem prepared to place their own expertise above that of doctors and therapists who serve the students with psychiatric disorders. The use of “common sense” rules that have been devised by the discussions on DSSHE-L can lead to trouble. For example, the removal of students who are ideating or even attempting suicide has been found to be discriminatory.

Recommendations. The role of the DSS official must be concentrated on what is best for students with disabilities. As knowledgeable professionals who speak on behalf of these students, the DSS officials must insist on being included in formulating policies that will affect students. However, the DSS official must keep in mind at all times that it is the students’ rights that they are representing. The institution may fund the DSS office, but loyalty should be to the student. By making informed decisions about academic accommodations and following best practices in the field, the DSS officer will be acting in the best interest of both the institution and the students. It is when the DSS official gets involved in areas of exclusionary policies and breaches of confidentiality that the student is harmed. The institution is all powerful in relation to the student and does not need the power of the DSS office to maintain this power. The DSS office should lend its power to the student with a disability so that hegemony cannot occur.

Confidentiality

Students with disabilities are not always provided the promised confidentiality of their records that is stated in most DSS offices' published policies. The discussion of the ethical dilemmas that DSS officials find themselves struggling with on the occasion that a student's documentation reveals a history of any kind of violence or suicide attempts is weighted towards disclosure without the student's express permission. The repeated answers to questions of disclosure give permission to the inquirer to disclose to whomever they want to on their campus. This may be the "legal" answer, but there must be consideration of the moral and ethical answer. The tendency for college and university administrators to expect to know the details of a student's illness has now been proven to be illegal, as more students who have been disciplined for their illness are successfully fighting back. As policies stand at some colleges and universities across the United States, a student may be denied on-campus housing or be denied the right to pursue the academic program they have been admitted to based on the documentation submitted to DSS.

The role of the DSS official as confidant, as someone who can be trusted to take the knowledge they obtain through documentation and use it to provide appropriate academic accommodations, is sacrosanct. When the institution requires this confidentiality to be breached, the DSS official should inform the student before disclosure to allow the student the opportunity to engage legal representation to protect their rights. If there is to be collusion of power, the DSS official should choose to champion the students with disabilities. This includes aggressively protecting the records that students provide in their quest for accommodation.

Recommendations. DSS officers should recognize that there is an unequal power relationship between the DSS officer and the student with a disability. In fact, there is an unequal power relationship between every student with a disability and the administrators and faculty of colleges and universities. To provide a level playing field for students with disabilities is the sole purpose of the DSS office. Academic accommodations for students with disabilities so that they have the opportunity to achieve a higher education is the *sine non qua* of the Office of Disability Services. The academic accommodations that help students with disabilities to succeed are indispensable and speaking up in support of students with disabilities is an essential action. It is possible that the DSS officer on some campuses have other responsibilities such as serving as the ADA coordinator, but their first loyalty should be to the students they serve.

There needs to be a written and accepted code of conduct for DSS officials that addresses the instances where documentation provides information that portrays a student as potentially violent or suicidal. The code should be based on established codes similar to that psychiatrists and psychologists profess. Confidentiality of student records must be guaranteed if the student with a psychiatric disability is to be treated fairly. When documentation provides disturbing information, the DSS official should not have to struggle with the question of whether or not to disclose to others. Unless and until the confidentiality policy for DSS records is made explicit and published for the student, confidentiality should be protected. “Confidentiality, a term that often is used interchangeably with privacy, refers more narrowly to the obligation to maintain privacy assumed by someone who enters into a relationship marked by the promise that information that is disclosed will not be revealed to others” (Appelbaum, 2002, p. 1810).

The promise is that information will not be revealed. It cannot be made more clear. The promise of confidentiality should not be broken.

Disability services providers must work together to create a code of ethics that addresses confidentiality policies in a uniform way. A student has the right to know at the beginning of the relationship whether their documentation is truly confidential as promised or if it may be used against them by another administrative office. The practice of promising confidentiality to students who provide documentation as a requirement for academic accommodations must be stopped if that documentation will, in turn, be shared with anyone outside the DSS office. While there may be legal permissions to share confidential information about a student with other administrators, there must be a consideration of the moral and ethical meanings of doing so. The parameters of confidentiality must be made explicit and absolutely must be made clear to each student before *any* review of documentation takes place. Respect for the student's right of privacy should be of utmost importance. The DSS office should explicitly indicate what they will do with the information received by their office and to whom they will be sharing this information *before* the evaluation of the student's disability occurs. While there is something reprehensible about denying a student with a disability the academic accommodations they have every right to request, it is better to allow the student to withdraw documentation when it would be used against them by another office. There are always going to be students with and without disabilities who have a criminal background. The college or university has the right to examine public records for each and every student they admit. The college or university does not have the right to examine the psychiatric records of students who apply for academic accommodations.

The sharing of information obtained through records of a student's past medical or psychiatric history must not occur without the express permission of the affected student.

The only time it is ever reasonable to report what is learned about a student through his/her records is when there is imminent possibility of harm to self or others. To do otherwise is to betray the trust the student has put into the system that is intended to provide access. While the DSS officer is a member of the college or university administration, his/her loyalty should reside with the student who comes to the DSS office for help. By having explicit, published confidentiality terms that are made clear to each and every student at the beginning of the relationship there will no longer be the dilemmas of whether or not to disclose information. The student and the DSS officer will know how far private information will be disseminated. The reason that documentation of a disability is kept separate from all other records at a school is because this documentation is private and confidential. If that was not the intention, then the documentation records would be housed along with other records in the educational records file.

The profession of disability services, if it ever hopes to be a true profession, needs a better code of ethics similar to that of doctors and psychologists who treat the mentally ill. As one licensed psychologist questioned as he/she read my manuscript, how are these people getting away with making some of these statements without losing their license? He/she was appalled that someone who might receive documentation of a student's psychiatric disability may turn it against the student and that the promised confidentiality that the documentation provided under that promise is ignored. In the practice of psychology and psychiatry, extreme measures are taken to guarantee that the privacy of

patient records is maintained. The people who receive this documentation in DSS offices must do no less.

Meanings of Key Policy Concepts

A review of the withdrawal/readmissions and housing policies posted to the list found many problems with the policies, as they socially constructed the realities of being a student with an active psychiatric disorder as “unwanted others.” It was clear from the policies that colleges and universities did not want these students on their campus or in their housing. The questions that brought the response of shared policies were explicitly stated as policy needs to remove certain students with psychiatric disorders from school. Of the three questions analyzed, none had a consideration that other students might become disabled and need a policy to leave school and then return. There is not enough discussion of the fact that the DSS office is the designated advocate for student access and it goes against everything the office represents to work to exclude students because their disability becomes apparent. To presume that a psychiatric diagnosis is a natural cause for removal from the college setting is to buy in to the stereotype of what it means to be mentally ill.

The critical discourse analysis of the “Counseled Withdrawal Policy” revealed the hegemonic presumptions that the policy was built on. The performance of a diagnostic is intended to give the appearance that what is being done to the student is objective and thus inarguably correct. Continued surveillance of the object determined to be deviant is a natural response to protecting the school and all its members who are deemed acceptable from an identified other who threatens or may threaten the status quo. Once marked as a deviant, the targeted student must go through extraordinary processes to regain the

classification of acceptable so that they can be readmitted. For policies to state that the intent is to manage students with disabilities and criminal histories serves to call up one of the Grand Discourses –that deviance by others does not have to be tolerated by normals.

The idea of risk management as a means to cleanse the student body of deviants borders on the extreme measures of some countries that routinely exercise the cleansing of unwanted people who are identified as “others.” If this statement evokes shock in the reader, that is my intention. Consider the implications: Some schools will go to great lengths to identify and remove students who do not fit the ideal. The students who lose their opportunity to learn at the school of their choice experience great emotional and mental distress from being the targets for removal. The opening words of the Jordan Nott case illustrates the lasting harm that withdrawal policies cause. The courts are seeing these policies for what they are and are consistently siding with the affected student. As Makus (1990) stated, the ideological constructions that are the basis for such policies are lost to consciousness as they appear to be based on natural presuppositions that lead to natural outcomes. It is through critical discourse analysis that the natural consequences that follow are challenged and explained for their hegemonic basis. The class of students with disabilities is a protected class in the United States. The lived realities of students with disabilities are that they are set apart as “different than” and thus are easy targets for disparate treatment.

The criticism of the counseled withdrawal policy and the housing cancellation policy in the archives is being supported by recent court decisions and the actions of the Virginia State Legislature. The days of punitive actions towards students who have active

psychiatric disabilities are coming to an end. As Appelbaum (2006) explained in his analysis of the Washington Post article, “Depressed? Get Out!” (March 13, 2006) disciplining a suicidal student is no longer an acceptable solution. Yes, something needs to be done for students who express suicidal ideation or make attempts at suicide, but punishing them under the student code of conduct is no longer an option. Rather than embracing the students who reach such a low level of emotion and helping them to recover, punitive actions are forcing students to decide between treatment with the chance of discovery or muddling through the darkest time of their lives without help. As the statistics from the National Survey of Counseling Centers (Gallagher, 2004) indicate, the majority of student suicides are not committed by students being seen by the school’s counseling center. It is the unidentified student who is most likely to successfully suicide. To be supported so that academic success is possible is the greatest opportunity for students with psychiatric disorders to dispel the stigma of mental illness. To be counseled and surveilled until forced from school only strengthens prejudices and stigma.

With the continued reporting by the media of instances of student violence and suicide, the colleges and universities are being called on to “do something.” The policies to remove all students who represent the possibility of violence or suicide indicate the first choice of many institutions. Eliminate anyone who could be identified as possibly violent or suicidal and the problem is handled. However, the science of psychiatry and psychology is not exact. The research studies reviewed for this paper that attempted to identify the probability of violence or suicide among the mentally ill college students failed to empirically identify certain markers that are predictive of actions. Colleges and universities are not gated communities that can shut out all danger. To attempt to identify

and remove students with psychiatric disabilities is not likely to result in a safer student body. As Appelbaum (2006) pointed out, only one in one thousand depressed students will attempt suicide, meaning that the school, if it carries out policy, will be removing almost a thousand students who would never make an attempt.

Recommendations. The DSS official should be a part of the solution an institution creates in response to suicidal or violent students. The student code of conduct should be enforced for *actions* that are in violation, but these actions must not include suicide attempts or ideation. The courts have made that clear. If a student with a psychiatric disability acts out in inappropriate ways, then they should stand before the judicial body of the school as would any student who has acted inappropriately. There is no need for a “special” policy for misbehavior by students with psychiatric disabilities.

The institution absolutely must establish a policy to deal with students who are suicidal or ideating about suicide. If such a policy is created, it must insure the safety of the student while, at the same time, provide the supports that would allow the student to remain in good standing with the school. The Supreme Court has established the parameters of “threat to self” and it does not include paternalistic, coercive actions against the affected person.

The presence of policies in the archives that have been found to be discriminatory should be rectified by immediate removal. Psychiatric disability is not a punishable offense. The college or university still has the authority to enforce the student code of conduct, but they no longer can classify suicide attempts or ideation as punishable violations. The ideology of exclusion maintained by certain DSS officers represents everything the DSS office should stand against. Rather than publish exclusionary policies

on the list with the only objection, “I have some problems with it,” every DSS officer should join with the few who posted objections and make it very clear that such a policy should not stand unchallenged. The presence of these policies that have been adopted by other schools should not be allowed to go unprotested.

Otherwise Qualified: A Condensation Symbol

The translation of the term “otherwise qualified” to a condensation symbol of disqualification defies the purpose of disability services. To identify some students with psychiatric disorders as unsuitable and unservable when their documentation includes references to past behavior is not appropriate in many cases. For some psychiatric disorders it can take years of trials with different medications and therapy for symptoms to be well controlled. During the acute phases of a disorder’s exacerbation a person may behave inappropriately. Therefore, the DSS officer would be better served to know the present status of a condition from the health care provider and the student when making decisions about appropriate academic accommodations. The issues of refusing to serve students who have a diagnosis of oppositional defiant disorder (ODD) from their youth should be reconsidered. It appears from the discourse that the diagnosis of ODD may cause some DSS officials to declare the student not otherwise qualified. There is the repeated assertion that someone with ODD is disruptive and sometimes violent. This stereotypical view of someone diagnosed with ODD in their childhood is maintained by the discourse.

Recommendation. Marking students with psychiatric disabilities as targets for removal has to stop. The DSS office should represent one thing to a student with any kind of disability – the place to go for academic accommodations that mitigate their learning

disabilities. The DSS office has no business whatsoever in disclosing the documentation a student has provided under the promise of confidentiality. If the DSS office is a participant in the school's administrative efforts to prevent certain students from matriculating, then there is a duty owed to students to inform them that the documentation provided can be used against them. The duty to warn others of potential danger from a student diagnosed with a psychiatric disorder should be limited to cases that fit the parameters of the *Tarasoff* decision where the danger is imminent and the potential victim can be identified. There was no instance in the reviewed literature that demanded a greater duty to warn. So when the DSS office receives documentation that indicates a past that includes violent acts, it must remain within that office. Public records of criminal acts are available to the appropriate office at a college or university if there is an interest in the student's past. The attribution of dangerousness to students who are properly treated and medicated for psychiatric disorders is overstated.

There needs to be a concerted effort by DSS officials to become educated about psychiatric disabilities. As the literature review found, DSS officials are reporting that they are ill prepared to serve the needs of students with psychiatric disorders. The evidence is growing that there will be an increased pressure on higher education to meet the needs of students with psychiatric disabilities and the pressure begins right in the DSS office. The supported education efforts described by Mowbray and Megivern, 1999, and Unger, 1993, provide a working model to serving students with psychiatric disabilities in higher education. "It takes a village" to support people with psychiatric disabilities and by reaching out to local resources and federal programs such as Vocational Rehabilitation a campus can build a support network that serves the students' needs.

Animals as Assistive Aids

There are DSS officials who disregard every law and regulation that requires that residences be open to emotional support/companion animals and service animals for people with psychiatric disabilities. Some are so insensitive to the feelings of people who depend on their partnership with an animal that they participate in humor intended to denigrate the very idea of an animal as an assistive aid. As one list participant defended the inappropriate humor, s/he made the observation that, “I also believe that they have never or will never carry that behavior in the office itself. . . outloud so to speak.” The truth is, these participants have carried that behavior to the global community of the list – over 2,000 list members “heard” what they wrote. Then the inappropriate words echo and reecho as the archives are opened and read. The absence of a protest by the many members of the list is disheartening. When someone is behaving in an unprofessional way and demeaning people who use animals to cope with their disability there should be a flood of protests.

Recommendation. It is difficult to recommend a change that would be effective when there is so much evidence that anything said in support of emotional support/companion animals and service animals will be ignored or distorted by certain members of the list. The laws written by federal, state, and local governments to protect the rights of service animal and emotional support animal users should suffice to gain access for the population who utilizes an animal as an assistive device. The best that I can do as an advocate is to share what I have learned with others. The impulse to visit the campuses that have “policies” about service animals and dare them to prevent me from going anywhere the general public is allowed was strong. The law suit that would follow

if confronted would perhaps provide the case law DSS officials are always searching for. As the penultimate critical analyst, though, I will publish what is being said so that a broader discourse can occur.

There is a need for the list members who understand the laws and regulations about assistive animals to publish to the list and do so over and over again until it leaves no doubt about the meaning of access. When the protesters who continue to distort meanings and use rhetorical schemes to make arguments that are nonsensical come back with objections, there needs to be reiteration of the laws and regulations. The multiplicity of voices in support of the rights of service animal and emotional support animal users must overwhelm the objections.

Further Recommendation

What needs to happen is a periodic editing of the archives by a committee made up of a disabilities law expert, a psychiatrist or psychologist, a medical doctor, a rehabilitation expert and a student with a disability being served by a DSS office. None of the committee members should be current members of the discussion list. Editing should be done without identification of the sender so that it is the content that is the object of scrutiny. There should be a periodic cleansing of texts that contribute to illegal policies, stigma and prejudice leading to discriminatory acts. This is especially important as list members routinely send inquirers to the archives as a source of information. The archives should represent the best practices of accommodations in higher education.

Professional development for a new profession is complex. The profession is reacting to so many demands by law, by regulation, and by the individuals and institutions they serve that there are many areas of development that need to occur at the

same time that choices must be made. However, the results of this study strongly suggest that professional development in the near future must include psychiatric disability issues. The profession of disability services is old enough now that it should not be as reactive as it was at first and can now be proactive. It is the hope of this work that by recognizing hegemonic beliefs and practices that change can occur.

The Need for Education

Cultural differences should be embraced. That can only occur through taking every opportunity to learn about differences. The incidence of the international student may have been an incidence of a student with a psychiatric disorder though the brief description did not convince this analyst. However, the punitive reaction of discussants was uncalled for. The reality is that other cultures perceive events differently than white, middle-class Americans and this is not a bad thing. To suggest that the FBI be consulted because of a student's actions that seemed harmless when described is to react in an ethnocentric way that excludes and fears "others."

Social psychological theory holds that increased interaction with people diagnosed with psychiatric disorders leads to less prejudice and discrimination (Allport, 1979). DSS professionals have opportunities to know students with psychiatric disorders on a regular basis. However, it is apparent from the discourse on the list that this has not resulted in decreased stigmatization and discrimination. Research has also found that prolonged contact with people with active symptoms of their mental illness may lead to either paternalistic or benevolent attitudes, both leading to infantilization or pity and lessened chances of helping behavior (Corrigan, 2002). The authoritative approach to mental illness is to hold those diagnosed with a psychiatric disorder as inferior and in

need of coercive handling. The benevolent approach is to treat the mentally ill as childlike and incapable of ordering their own lives. Both approaches lead to social distancing and stigmatization. The best antidote to such attitudes is education combined with personal contact.

The evidence that the general public tends to believe that people with psychiatric disorders are more in control of their illness than someone with a physical disability was found by Weiner, Perry, and Magnusson (1988). This belief in the person's control of their illness caused research subjects to view people with psychiatric disorders much more harshly than the physically disabled. Corrigan (2002) replicated this study and found similar results, but also found that people will discriminate "within the mental health spectrum" so that certain psychiatric diagnoses are viewed more negatively by others because of the perceived control that each disorder was attributed. This may explain, in part, the way that certain students, especially those diagnosed with oppositional defiant disorder (ODD) or agoraphobia, are discussed as being less deserving of accommodations.

According to Corrigan's (2002) Prairie State Stigma Studies, protesting discrimination and prejudice against people with mental illness is ineffective in lessening stigma. Corrigan speculated that this was consistent with what other social psychological research has termed the "suppression rebound effect." The more a person is asked to suppress negative attitudes, the greater the recall of events that helped to form those attitudes. Protest of stigmatization and unequal treatment of the mentally ill seems to work only when the target of the protest has something to lose, such as a business that uses the claim that "you have to be crazy to skip these deals!" (Wahl, 1995) would face

an economic boycott. A boycott of DSS offices that are participating in the targeting of students with psychiatric disabilities is simply not possible. However, there was a marked improvement of attitudes about the mentally ill through education. Education helped to erase the idea that the mentally ill are in control of all their actions and therefore responsible for their symptoms and deserving of punishment and coercive control. However, even with this improved attitude towards the mentally ill the willingness to help someone with mental illness did not increase. Research subjects still expressed an unwillingness to work or live with someone who had a psychiatric disorder (Corrigan, 2002). What did work in diminishing the public's fear of dangerousness and the perception that the mentally ill were responsible for all their actions was education combined with personal contacts with people who talked of their experiences with mental illness. The improvements of attitudes toward the mentally ill were sustained over time when personal contact was combined with education.

Disability services professionals report a lack of expertise in dealing with students with psychiatric disabilities (Sharpe, Bruininks, Blacklock, Benson, & Johnson, 2004). This lack of knowledge about psychiatric disorders is further complicated by the stereotypes and prejudices that sometimes serve for "knowing" about a disorder. This allows such beliefs as there being "an incentive to abuse the system" and "ODD is not a disabling condition" to be part of the discourse. While there is anecdotal evidence that students have attempted to claim a disability in order to gain an unfair advantage, the students with documented psychiatric disorders are not usually among them. The stigma of mental illness tends to cause affected students to forego accommodations rather than bear the mark of deviance.

DSS officials need to continually renew their professional credentials through education and it appears from the discourse of the list that it would be appropriate for this education to come from outside sources. Because the same people consistently represent their point of view the discourse, even when hegemonic, appears to be common sense. There is a special need for a better understanding of psychiatric disorders. While education alone has not proven effective at dispelling stigma, education combined with personal experience with the mentally ill helps to change distorted images of what it means to be a person with a psychiatric diagnosis (Corrigan, 2002; Wahl, 1995). While most DSS officials appear to feel confident to interpret medical documentation and documentation of learning disabilities, there seems to be less proficiency in dealing with psychiatric documentation. This professional deficiency can be overcome through education that factually examines psychiatric disorders and the impacts on higher education.

A new discourse about people with psychiatric disabilities needs to occur on the DSSHE-L list and should include students who live with mental illness. The new discourse would be one of understanding and inclusion. The reality that people with mental illness are not to be feared when they are successfully treated and given the support they need must be talked about openly. The new discourse on the list will include the facts about mental illness, not the stereotypes and prejudices. People with the diagnosis of oppositional defiant disorder in particular need to be reframed as worthy of services from the DSS office. There are many trained professionals who could lead an educational dialogue about mental illness and it would be appropriate to have them conduct training sessions at national and regional conferences.

Recommendations for Further Research

The DSSHE-L archives have become password protected in the last year, preventing an analysis of the discourse in the future. According to the Institutional Review Board (IRB), it would take signed consent forms from every DSSHE-L member to do a similar study in the future. This is unfortunate since evidence of hegemony in the discourse was found. In an attempt to understand the reasoning behind closing the archives to the general public, the owner of the list was contacted. He was unable to articulate the reasoning behind closing the archives. In the absence of discourse that can be analyzed, the future researcher might use other instruments to uncover the attitudes, beliefs, and values of DSS officials.

One follow-up study that could be done would be to interview members of the DSSHE-L list to find out why they do or do not participate in discussions of mental illness on the list. It would also be beneficial to try to detect why hegemonic discourse is so seldom challenged by the readers of the list. This would be important research if the DSSHE-L archives are going to be the preferred reference for AHEAD members.

The fact that these professionals are not being studied when they hold such a critical position in the success of a student with a disability in higher education is troublesome. There is evidence through the national and regional establishment of professional organizations that the role of DSS as a profession is growing. There now needs to be empirical research that studies the efficacy of what they do. Accommodations are being provided, but there is little evidence that these accommodations are leading to success for the student. DSS officials have created a class that can be studied and

researchers from organizational studies, anthropology, sociology, education, and other sciences should take an interest in understanding this group.

Conclusion

The presence of hegemonic discourse in an archived list dedicated to disability support services in higher education has been confirmed. The use of power by DSS officials that results in prejudicial and discriminatory treatment of students with psychiatric disabilities was indicated by the discourse. As Van Dijk (1993) stated, it is not worthwhile to worry about those who are criticized for their misuse of power for they have the power to care for themselves. It is the subjects of hegemony who need a voice speaking on their behalf. This project was approached as a passionate endeavor to improve the lives of students with psychiatric disabilities. It is hoped that the reader of this document will feel compelled to share it with others so that a new discourse will begin that embraces differences in people.

I refuse to accept the stigma that others would attach to my disability. I will continue to search for ways to defeat those who would use their power to marginalize people with psychiatric disabilities. After all, a disability is just something you learn to live with, it is not a reason for others to interfere in a mistaken belief that they know what is good for you. So my service dog and I will continue to explore new frontiers as we go out into the world to speak for those who have been silenced. That is the *telos* of this project.

Epilogue

In the week that this dissertation was defended the tragic shootings at Virginia Polytechnic University occurred. In the days after this shooting, the news media reported

the fact that the shooter, Cho Seung Hui, a student at the University, had been treated for mental illness. The media of television, radio, newsprint, and the Internet played up the fact that the mentally ill student had murdered thirty-two faculty and students. Such words as “he was possessed by demons,” and “the mentally ill murderer” linked the ideas of mental illness and violence. A news story in the New York Times blamed the fact that this man was free to kill even though he was mentally ill with the idea that suicidal students could not be removed from school because of lawsuits (Lewis, 2007). This story created the impression that the suicidal student was dangerous to others as well as to themselves. President Bush has directed three cabinet members to set up a taskforce to deal with mentally ill people in the education system. Discussions on conservative talk shows tend to blame the increased civil rights of people with disabilities as the reason Cho was allowed to roam free until his murderous rampage. All of this lends itself to deafening others to the voice in this paper that is calling for an end of discrimination towards people diagnosed with mental illness. The gunshots echoing from Norris Hall were replayed until they became haunting, making the plea for inclusive policies for the mentally ill to seem unreasonable.

Allow me the opportunity to once again point out that the evidence is that the mentally ill are much more likely to be the victims of violence rather than the perpetrators. The hegemonic discourse that calls for segregating the mentally ill must end. More state and federal dollars are needed to rebuild the safety net of psychiatric institutions for the severely mentally ill. For too long it has been demonstrated that putting the severely mentally ill out onto the streets or into the jails has not been working. The few instances of violence by the mentally ill are reported at great length by the

media, making it seem more common than it is in reality. The media has also conflated mental illness with violence. The mentally ill are more stigmatized today because of the actions of one man.

One letter to the editor of the *Salt Lake Tribune* (which was written by the editor of the *National Review*, a conservative news source) blamed the shooting on the work of Foucault (Lowry, 2007) for the “moral disempowerment of sanity.” Foucault’s discourse analysis that showed the repressive power of labeling someone mentally ill is faulted because he “argued that attempts to label and treat madness were inherently arbitrary and repressive.” This paper has demonstrated the power of the label to mark someone for unfair treatment. The actions of one man must not make stigmatizing the mentally ill acceptable.

As the conversations shift from the shocked disbelief about the senseless murder of so many innocent people towards the question of what should be done about the mentally ill, it is my hope that this research will help to illustrate the power of words. It should also be reiterated that the protections of civil rights laws do not prevent a college or university from disciplining a student whose actions violate the school’s student code of conduct even if the actions can be blamed on mental illness. So my *telos* demands that I continue to work towards educating others about the mentally ill college student so that other innocent lives are not wasted – the lives of students who are capable and ready to be successful college students in spite of their mental illness. We must keep the doors to higher education as open as we possibly can to all who would benefit from the opportunity to learn.

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Vita

Barbara Willis was born July 27, 1950, in Poplar Bluff, Missouri. Her life was greatly influenced by her father's work as a Methodist minister and her mother's work as an elementary school teacher. Her sister and two brothers added richness to her life that caused her to believe that with education, anything was possible. A graduate of Lindbergh High School, St. Louis, Missouri, in 1968, Barbara attended Southeast Missouri State University in Cape Girardeau, Missouri, and graduated with a Bachelor of Science with a major in English and a minor in physical education in 1972. Education continued to be important as she attended various community colleges to get accounting credits that enabled her to be a Revenue Agent for the Internal Revenue Service in Denver, Colorado. After retiring, she was accepted into a masters program for counseling education and counseling psychology at the University of Colorado – Denver. With only an internship left for completion of the degree, Barbara was forced to quit school to care for her daughter who was seriously ill. When it became necessary to move home to Missouri, the town of Mexico, Missouri, was chosen as home because of its location near the University of Missouri. However, it was not until her daughter had graduated high school that Barbara was able to return to her studies. Because of the time limit on completing a degree, the master's degree was lost. The dream of a higher education did not die. In 2001 Barbara was accepted into the masters program for Educational Leadership and Policy Analysis (ELPA), Higher & Continuing Education track and the M.A. degree was awarded in 2003. Upon acceptance into the Ph.D. program of ELPA, the study of education policy related to students with disabilities was begun. This dissertation is the result of those years of study.

Appendix A
Admission Readmission Leave Expel

1 <We are interested in knowing if anyone has a policy related to
2 admission, re-admission, or judicial processes for students with
3 psychiatric disabilities. (especially related to students with chronic
4 schizophrenic and/or psychotic symptoms)>
5 <We are looking into establishing a process for handling late drops
6 and/or withdrawals as accommodations for students with mental health
7 related issues and/or depression. We are experiencing an increased
8 number of such requests and would like to have some type of process in
9 place. Currently, we work very well with the academic advisors and the
10 registrar's office. I am just curious what others are doing and how you
11 all are handling this issue.>
12 <Here's a thought. The unforeseen [sic] circumstances, whether mental or
13 physical, whether a disability or not, that make it necessary for a
14 student to drop some, but not all courses after the close of a drop
15 period should not apply selectively to some courses but not others. Why
16 not adopt a policy that permits a student to drop one of four courses,
17 but does not permit the student to pick the particular course to be
18 dropped, leaving the selection to a random draw? In that fashion, you
19 accommodate the unforeseen [sic] need of a student to take a reduced
20 load without creating the incentive to abuse the system to drop a hard
21 course that may adversely impact gpa. Depression does not selectively
22 impair the ability to study chemistry or economics while leaving the
23 ability to study the humanities unaffected.>
24 <We work through the 'regular' system. That is, any student can ask for
25 a medical withdrawal through our Executive Dean. If the student has a
26 disability related reason for asking for a withdrawal after the
27 withdrawal deadline, we have them write a request to the Dean
28 explaining that they are working with our office and their need for
29 such request. If we need to add information or help them write the
30 letter, we do. My philosophy is to make the system work for students
31 with and without disabilities rather than creating an entirely
32 different system.>
33 <This is exactly what we do here as well.....>
34 <we do nothing specific for students with a disability. We are on a ten
35 week quarter. We give students 8 weeks into each quarter to drop a
36 class simply because they want to, no permission is needed. We have no
37 medical leave process. After the eighth [sic] week, All students must
38 get permission to drop the class from the instructor. The instructor
39 will determine the extenuating circumstances and decide whether a
40 failure or drop is in order.
41 This decision is based on the students performance [sic] during the
42 first eight weeks, saving a GPA is not a valid reason. We will write a
43 letter of support for the swd if we feel it is appropriate and
44 reasonable. Another thing you need to factor in is Federal Financial
45 aide. Once a student's FA has paid for their classes, then the student
46 must complete all the classes with a passing grade. Withdrawals, late
47 or early, are considered a negative completion by the FA office and the
48 student will suffer punitive consequences that are not affected by
49 disabilities. They are allowed to contest punitive measures, but only
50 up to a certain point.>
51 <Can anyone direct me to any universities that have a specific written
52 policy that addresses the behavior and dismissal of students with
53 psychological disabilities? I understand that students can be expected
54 to follow the same behavior policy as all other students, but we have

55 had some unique situations that we feel warrant the need for a more
56 specific policy when addressing the needs/issues of students with
57 psychological disabilities.>
58 <Are you talking about policies that give breaks to students with
59 psychological impairments or policies that hold them to a stricter or
60 specialized standard of behavior? I think either could sail you into
61 troubled waters. Maybe a better approach would be to update the
62 policies applied to all students with and without disabilities.>
63 <i [sic] believe that would be discrimination. there is case law and/or
64 ocr precedent to follow. if you do write a policy, refer to behavior
65 and not a psychological disability.>
66 <Here is the problem as I see it. UNLESS you have asked ALL students to
67 disclose mental/physical/criminal past conduct as a requirement for
68 getting accepted to XXX. Then you are singling out only the ones that
69 have come to you to self disclose and document a disability [sic], for
70 how else would the college know anything about the student? So you
71 have tied on negative consequences to a self-disclosal [sic]
72 requirement. You might also burn your bridges as a place for disabled
73 to go, out of fear you will turn them in to the mental health police :-
74) But if on the other hand, all students are required to report this,
75 then I don't see a problem. I believe there have been some big time law
76 suits lately by students that were raped/hurt, by others that the
77 college had known something about them.>
78 <Can we legally require that a student provide us with medical
79 clearance to return the next semester after they have dropped out due
80 to psychiatric issues? Last semester a student enrolled and received
81 accommodations from our office. At the time she was dx with LD, Anxiety
82 and Bipolar disorders. She dropped out after about 3 weeks when she was
83 hospitalized for her psychiatric condition. She returned this semester
84 with a new dx of Dissociative Identity Disorder and was provided the
85 accommodations of extended time for test. She was referred back to me
86 after she informed her art instructor that her five-year old
87 personality wanted to take the class. I spoke with the student and
88 informed her that the course expectations would be set at the level of
89 a [sic] entering college freshman and I wanted her to be clear about
90 the demands of the class. I was very concerned about her ability to
91 function in the college setting based upon her current mental status.
92 The stress of college does not appear to be something that she can
93 handle at this time. It has been reported to me that she has started on
94 a new medication which has made it very difficult for her to get out of
95 bed. To this date, she has not attended more than two classes in any of
96 her course load. She is in a college preparatory math class that
97 doesn't allow missing more than 6 hours of class time before a student
98 is dropped from that class and all other courses that are college
99 level. I suspect that the student will soon be dropped from all her
100 classes as a result of her absences. Our college is an "open admission"
101 facility. My question is whether or not we have a right to
102 request/demand that she provide a medical clearance before she "re-
103 enrolls" next semester.>
104 <Seek legal advice. Having said that my opinion: No you cannot. If it
105 makes her worse to be there that's on her. You cannot protect her from
106 that by denying her rights. Certainly out of compassion and caring, you
107 may wish to explore with her whether she and her health care providers
108 believe it to be in her best interest to be in classes.>
109 <We have a process at XXX called a "Medical Leave". "Medical" is a
110 euphemism for psychological. A student experiencing psychological
111 distress to the point they should not or cannot be in school may be

112 offered a medical leave. The student must meet with a counselor in
 113 Counseling and Psych Services (CAPS). The counselor then makes a
 114 recommendation to the student's college that the student be put on a
 115 medical leave, usually for at least 6 months. The leave is granted by
 116 the student's college. An explicit condition of the leave is that the
 117 student must be evaluated by a counselor at CAPS before they are
 118 cleared to enroll again. Students are expected to obtain treatment
 119 while they are on leave, also made explicit in the leave documentation.
 120 The CAPS counselor usually requests information from the treating
 121 therapist about the student's treatment and progress, which is
 122 considered in the evaluation to return. So, my understanding is, if the
 123 evaluation/medical clearance to return is made a requirement of the
 124 leave of absence, it can be enforced. However, if a student takes a
 125 leave voluntarily, I don't believe it can be required. We encourage
 126 students to take medical leaves if there are psychiatric issues. We
 127 find it pretty effective, especially for getting students to accept
 128 responsibility for their treatment.>

129 <Speaking with a bit of facetiousness, you could ask each of the
 130 personalities to qualify individually for services before being re-
 131 admitted. More seriously, even though the debate continues over the
 132 validity of "multiple personality" diagnosis,since your school is
 133 open admission, I think she is able to come back until whatever policy
 134 the institution has on "acceptable progress" (or similar terminology)
 135 is brought into play, and at that point it is probably not your call. I
 136 have seen medical documentation required for re-admission if a person
 137 presented some kind of danger... It was couched in "behavioral" terms,
 138 rather than disability.>

139 <ours is very similar to XXX only we require that an outside provider
 140 provides the paper work for leaving and returning. we do this for all
 141 students regardless of being registered with the disability office and
 142 medical for us really means medical; could be major surgery or
 143 whatever.>

144 <This comes up at my college from time-to-time, as I'm sure at all
 145 schools. One of the main concerns of some of such students is if they
 146 w/d from school they will lose health insurance coverage under their
 147 parents. This can be an especially huge issue if the student needs
 148 treatment and meds that the insurance helps pay for and the student
 149 wouldn't be able to afford otherwise. Any ideas/helpful suggestions in
 150 these cases?>

151 <Are you sure it was BiPolar [sic] Disorder and Dissociative Identity
 152 [sic] Disorder? That is an unusual combo. My first reaction is that you
 153 would have to alter the course completely for someone who is not
 154 attending class, and at this juncture, the middle of February, I would
 155 think a person who had only attended 2-3 classes would've missed close
 156 to 5-6 weeks of school (@30% of the semester). My first question to you
 157 is what Axis and V Codes is listed on the diagnosis? Then my response
 158 is you will need more information from the therapist/service provider.
 159 Medications are given on Axis #1, BUT Dissociative Disorders are on
 160 Axis #2. The only thing I could see medication being diagnosed would be
 161 for Depression or Anxiety as a response/result of with DID.
 162 Here is an (overly simple) way to look at the DSM Axis:

163 Axis I Clinical Disorders
 164 Axis II Personality Disorders and Mental Retardation
 165 Axis III General Medical Condition
 166 Axis IV
 167 Psychosocial and Environmental Factors

168 In my response, "DID" will represent Dissociative Identity Disorders.
169 For this response, working definition of Dissociation is: "A
170 psychological mechanism that allows the mind to split off traumatic or
171 disturbing ideas from conscious awareness". To be sure there is a DID
172 involved and the extent, I would suggest getting your college's
173 Licensed Counselor (LPC) Social Worker, Psychologist, or Psychiatrist
174 (PE) to review and administer a screen, such as the Dissociative
175 Experiences Scale (DES). If the patient has a high score on this test,
176 he or she can be evaluated further with the Dissociative Disorders
177 Interview Schedule (DDIS) or the Structured Clinical Interview for DSM-
178 IV Dissociative Disorders (SCID-D). I think this would clear up any
179 apprehensions you may have about the diagnosis. An overly general
180 analysis (and please discuss this with one of your consultant sources
181 to get a clearer picture) would be that Dissociative Disorders are
182 marked by a separation from or interruption of a person's fundamental
183 aspects of waking consciousness (such as one's personal identity, one's
184 personal history, etc.). All of the dissociative disorders are believed
185 to stem from trauma experienced by the individual with this disorder.
186 The dissociative aspect is thought to be a coping mechanism in which
187 the person literally dissociates himself from a situation or experience
188 too traumatic to integrate with his conscious self. If the student
189 suffers from DID then the student develops two or more distinct
190 personalities, each with a unique set of memories, behaviors, thoughts,
191 and emotions. At any given time, one of the sub personalities (alters)
192 takes center stage and dominates the person's functioning. Usually one
193 specific personality, referred to as the host, appears more often than
194 the others. Considering that a person dissociates from a situation and
195 you are referring to DID (Identity Disorder), I am not sure a
196 "reasonable" accommodation is possible, at least with given the general
197 information you have supplied. With more information, I would be better
198 able to comment. Usually a health care provider eliminates Physical and
199 Psychotic causes before the diagnosis of DID. In your case, it was
200 different (even seemingly backwards). I think that is very unusual.
201 Usually medication is not given for dissociative Disorders due to a lot
202 of reasons, but if a person exhibits anxiety or depression in response
203 to DID, I guess it would be appropriate. For accommodation purposes, I
204 would think that anxiety or depression could be given an accommodation.
205 In treatment for DID, therapy is a must, and it is one of those long
206 term processes to treat (possibly up to between 5 and 10 years) for any
207 sort of recovery. So I would expect a person though be attending weekly
208 and twice a week visits to a therapist. What ever you decide, I would
209 consult in great lengths with the person who did the evaluation by
210 looking at how the diagnosis was determined. I would also look for
211 screens (the Dissociative Experiences Scale (DES), Dissociative
212 Disorders Interview Schedule (DDIS) or the Structured Clinical
213 Interview for DSM-IV Dissociative Disorders (SCID-D)), and consider
214 their analysis of potential of attending college slipping in and out of
215 personality. Back in 1977, when I was starting out in counseling and
216 higher education, I was working in Academic Advising, I had a MPD (then
217 it was called Multiple Personality Disorder) individual that would now
218 be diagnosed as Dissociative. It was a very difficult job working with
219 him. It actually took 5 years to get an Associate Degree. I am not
220 trying to compare or contrast, but I am saying that it will be a
221 tremendous challenge. If the student is of college age, not disruptive,
222 and meets entry...then the person can enroll. BUT as one person.>
223 <Subject: Eating disorder/self harm policy (fwd)>
224 Good morning all:

225 FYI...something of interest for all of us working w/ students w/ psych
 226 disabilities...from the student health services listserv...
 227 ----- Forwarded message -----
 228 I am sharing one more policy that I missed to send to everyone from
 229 Xxx.
 230 COUNSELED WITHDRAWAL POLICY
 231 Xxx College endeavors to provide a safe and orderly environment,
 232 insofar as possible, in which all students are able to pursue their
 233 academic and social development. In so doing, it reserves the right to
 234 require a counseled withdrawal of any student whose behavior or
 235 physical or psychological disorder is incompatible with minimal
 236 standards of academic performance and/or social adjustment.
 237 Students to whom this policy applies include:
 238 1. Students who are deemed to be a danger to themselves or others.
 239 Danger to self or to others is here defined to include any danger of
 240 suicide, self mutilation, accident, or assault substantially above the
 241 norm for college students which necessitates unusual measures to
 242 monitor, supervise, treat, protect, or restrain the student to ensure
 243 his or her safety and the safety around him or her.
 244 2. Students whose behavior is severely disruptive to others
 245 Disruptive is here defined to include behavior which causes
 246 emotional/psychological/physical distress to fellow students and/or
 247 staff substantially above that normally experienced in daily life. Such
 248 disruption may be in the form of a single behavioral incident or
 249 somewhat less severe but persistent disruption over a more extended
 250 period.
 251 3. Students (a) who refuse or are unable to cooperate with
 252 recommended assessment and/or treatment and (b) whose behavior or
 253 physical condition suggests a disorder, such as an eating disorder,
 254 which is likely to deteriorate to the point of permanent disability,
 255 disfigurement, impairment, or dysfunction without such assessment
 256 and/or treatment.
 257 Where standard assessment is impossible because of the student's
 258 resistance, indirect behavioral observations will constitute the basis
 259 for such judgment.
 260 4. Students whose physical or psychological disorder is such as to
 261 require highly specialized services beyond those available locally and
 262 whose condition will deteriorate (as in 3 above) without additional
 263 resources.
 264 <All I can say about the Xxx policy regarding students who may be a
 265 harm to themselves is that if you don't understand that the ADA and the
 266 disability rights movement in general is pretty much a reaction to the
 267 medical model, then you just don't get it. The civil rights that
 268 protect PWD are not very compatible with well intentioned interventions
 269 by medical authorities. All we folks with disabilities really want is
 270 the opportunity to take risks and to make mistakes.>
 271 <This is indeed an interesting policy, re: "...danger of suicide, self
 272 mutilation, accident or assault substantially above the norm for
 273 college students..." Who get to define the norm of suicide, self
 274 mutilation, accident or assault for college students? just wondering,>

Appendix B
Direct Threat

1 <I've checked the archives but haven't been able to find exactly what
2 I'm looking for. I've been asked to do research on the issue of "danger
3 to self and others" and "direct threat" as they relate to postsecondary
4 education. I've found a lot of information relating to employment but
5 not education. Can anyone point me to some court and/or OCR cases that
6 deal with this subject as related to students with disabilities? The
7 only one I've been
8 able to find is Krissik v. Stonehill College (the school denied
9 readmission to a student with active, prolonged anorexia). Speaking of
10 Krissik, does
11 anyone know how or if this case has been settled?>
12 <The most important one in my mind is Tarasoff v. Regents of the
13 University of California, 1976, where the duty to warn came into play.>
14 <According to Gary Pavela, JD, in his book "The Dismissal of Students
15 w/
16 Mental Disorders", states "Educators often overstate the risk of
17 liability
18 for failing to protect students from the violent acts of others, or
19 from
20 self-destructive behavior...Nevertheless, courts have not held that
21 college
22 and university officials must somehow guarantee the safety of every
23 member
24 of the academic community, or serve as an insurer of their mental
25 health.
26 Generally, in the absence of a manifest threat, or a pattern of violent
27 behavior in the past, it is unlikely that campus administrators would
28 be
29 expected to determine whether any student (including a student
30 suffering
31 from a mental disorder) might harm themselves or others.">
32 <Anyone wanting a nice discussion of "direct threat to self" might want
33 to look at: Can I Play?: The Dilemma of the Disabled Athlete in
34 Interscholastic Sports, Adam A. Milani [Assistant Professor of Legal
35 Writing and Analysis, Mercer University School of Law; J.D., Duke
36 University 1991; B.A., University of Notre Dame 1988.] This author is
37 discussing intercollegiate athletics but the same laws are often
38 applicable outside of sports. There is a copy of Dr. Milani's article
39 at <http://www.law.ua.edu/lawreview/milani.htm>.
40 You will also need to read [Chevron U.S.A. v. Echazabal, U.S. Supreme
41 Court, No. 00-1406 (2002)] to be up to speed on the issue. The two
42 combined nicely illustrate how far the court will go to find support
43 for
44 what they want to do, when they can't find support in the law. In this
45 case they used the EEOC regs. (The same EEOC that they ridiculed a
46 couple years ago.) Be careful what you write on DSSHE the Supremes
47 might use it.>
48 <I am helping organize a multidisplinary [sic] panel discussion on
49 disruptive students at this college and would appreciate your comments
50 with regard to "direct threat" students. What helps and what doesn't.
51 What is appropriate for conduct policy and what role does the DSS
52 office play in all this.

Appendix C
No to Documentation

1 <I have meet [sic] with a few students lately who are adamant about not
2 providing documentation regarding their psychological disability. I
3 have tried every avenue in which I know in order to relieve their fears
4 about the documentation ending up in the wrong hands or being used
5 against them in any way. I have stressed that the information is kept
6 confidential unless they give written permission of exactly with whom
7 the information in the file can be shared.
8 I have spoken extensively with each individual. I have clarified that I
9 cannot provide them accommodations without receiving documentation
10 because I will not be able to discern which accommodations they need
11 and how I can best support them. I am struggling because I can see that
12 the students need support.
13 I would like to know if any of you are finding the same reluctance of
14 students providing documentation? What have you found to be
15 particularly effective in helping the student/parents/specialists
16 understand your documentation needs regarding psychological
17 disabilities? Have you found a way of explaining the confidentiality of
18 each student file?>
19 <Several reasons:
20 They are embarrassed [sic] and refused to admit they have a
21 psychological disability.
22 They think it is not right to prove they have a psychological
23 disability in order to get service. Well, who doesn't?
24 Or they don't have a psychological disability in the first place.

Appendix D
Disclosure

1 <The Dean of Student Affairs here has posed the following scenaro [sic]
2 to me.
3 I am interested on others' response to this situation. I am somewhat
4 surprised by the fact that legal counsel has advised that the college
5 can essentially force the student to disclose as a condition of
6 readmittance. Any advice, thoughts, etc. would be welcome.>
7 <Back in the olden days this matter might have been handled as follows.
8 A few days into the term the floor RA, an upper-class though not
9 imposing person might have spoken with the student. The RA would have
10 suggested that the two of them and the roommate discuss, in no great
11 detail, the student's past depression and her successful treatment.
12 All would agree to contact the RA if it looked as though some kind of
13 support for either student was needed in the future. The RA would have
14 a contact person at the Counseling Center. If the attorney's opinions
15 must be in the behavior contract try the following "the student agrees
16 to cooperate with the floor RA in support her own well being and that
17 of the community in which she lives".>
18 <I like Sam's solution quite a lot but here are a few more
19 considerations. Past crisis and disabilty [sic] to the side for a
20 minute would this student automatically get a single or have to
21 requests [sic] one? The treating professionals say she is ready to
22 come back. Do they suggest that she disclose to her roommate or provide
23 a level and method of disclosure that they feel is important?
24 Potential roommates might (I said might) have a right to know about
25 expected future behavior but what and why do they
26 need to know about the past? Is there a reason to expect self-
27 destructive behavior?>
28 <As a potential roommate, I'd be traumatized to find that she tried it
29 again, and I was the one to find her! Do I have a right to know she's
30 suicidal? possibly. Do I need her past history? no. I say possibly to
31 the Right to Know...I really think it's a curtesy [sic] to let the
32 roommate know that there is the potential of some severe depression and
33 this is what to do. I think the student needs a roommate. Someone she
34 can build a friendship with or some rapport, might even help her break
35 through some of her problems. (ever the counselor here.) just my two
36 cents worth.>
37 <I can understand that a mental health counselor, psychologist, or
38 psychiatrist might be able to say that a student is not ready for
39 readmission, but how the heck is the professional going to be able to
40 vouch for readiness? I think the requirement for verification that the
41 student is ready to return serves the emotional and risk management
42 needs of the school more than anything else. Otherwise how else would
43 we confuse wishful thinking and unpredictability in such matters? We
44 want so much for someone to take charge, when no such certainty exists.
45 I think it's far better to focus on behaviors of and supports for the
46 student when considering readmission. Life just isn't as cut and dried
47 as some would want to make it. And if you agree that the quest for
48 proof borders on the silly, then why not give the student the benefit
49 of the doubt? Sure, we want to support returning students by making
50 sure they have access to quality health care and other elements of
51 support. It may well be that the student doesn't make it. However, it's
52 better to open doors and give people a chance than to work to exclude
53 them.>

54 <According to Gary Pavela, JD, in his book "The Dismissal of Students
55 w/
56 Mental Disorders", states "Educators often overstate the risk of
57 liability
58 for failing to protect students from the violent acts of others, or
59 from
60 self-destructive behavior...Nevertheless, courts have not held that
61 college
62 and university officials must somehow guarantee the safety of every
63 member
64 of the academic community, or serve as an insurer of their mental
65 health.
66 Generally, in the absence of a manifest threat, or a pattern of violent
67 behavior in the past, it is unlikely that campus administrators would
68 be
69 expected to determine whether any student (including a student
70 suffering
71 from a mental disorder) might harm themselves or others."
72 Gerald Amada, PhD, in his book "Coping w/ The Disruptive College
73 Student: A
74 Practical Model, stresses the university developing a code of conduct
75 and going through Discipline Procedures. The requirement of
76 psychotherapy as a
77 coercive measure for re-Enrollment is also covered in the book.
78 There were two articles in the NY Times about MIT's student, Elizabeth
79 Shin,
80 who died by setting herself on fire in her dormitory room. Her parents
81 are now suing MIT. These articles were around 4/28/2002. It might be
82 worthwhile to contact MIT about this case for some additional guidance.
83 Below is an article from CHE that is also worth looking at:
84 Thursday, September 26, 2002
85 Report Urges Colleges to Take Measures to Prevent Suicides
86 By JEFFREY R. YOUNG
87 College administrators need to do more to prevent student suicides,
88 according to a report issued Wednesday by the National Mental Health
89 Association and the Jed Foundation, a suicide-prevention group. The
90 report, which has been mailed to more than 3,000 college presidents,
91 includes a checklist to assess the quality of a college's suicide-
92 prevention efforts.
93 Suicide is the second-leading cause of death among college students and
94 the
95 third-leading cause of death among people ages 15 to 24, according to
96 the report. And the rate of suicide among adolescents has tripled in
97 the past 60
98 years, it adds.
99 "While we may tend to look upon the college years as a time of growth
100 and
101 opportunity, these years are also replete with the stress that often
102 accompanies such a major developmental milestone," the report says.
103 The report, called "Safeguarding Your Students Against Suicide," was
104 generated by a round table of experts from disciplines such as public
105 health, psychology, and sociology, that was convened last year.
106 Among the report's recommendations for college administrators:
107 Set up screening programs to identify at-risk students.
108 Run educational programs for professors, coaches, members of the
109 clergy, and resident advisers on detecting depression.
110 Develop campus wide suicide-prevention education.

111 Make sure that adequate medical and counseling services are available
 112 on campuses.
 113 To guide administrators through reviewing their current programs, the
 114 report
 115 includes a checklist with questions like, "Do we have a
 116 mental-health-management plan in writing?" and "Have we educated our
 117 students so that they are able to identify at-risk behaviors within
 118 themselves and among their peers?"
 119 "There's more that can be done," said James Radack, the Mental Health
 120 Association's vice president for public education. "Many, if not most,
 121 of
 122 the campuses have various pieces of the puzzle, but it's just a matter
 123 of developing a larger package [of prevention measures] for students."
 124 The Jed Foundation is named for a Jed Satow, who committed suicide in
 125 1998, when he was a student at the University of Arizona.
 126 -----
 127 -----
 128 Background articles from The Chronicle:
 129 A Suicide and Its Aftermath (5/24/2002)
 130 Elite Colleges Struggle to Prevent Student Suicides (2/25/2000)
 131 -----
 132 -----
 133 Copyright (c) 2002 by The Chronicle of Higher Education>
 134 <We have a student enrolling for Spring semester who within the very
 135 recent past was cited for indecent exposure on our campus (at the time
 136 he was not nor ever had been a student here). As it turns out there is
 137 also a history of violence towards others in his past. Given this
 138 knowledge, the question is how or should we monitor this person's
 139 behavior on campus? Apparently he has a letter from his psychiatrist
 140 stating that his behavior is under control (meds?) and he is cleared to
 141 participate. At this point, he is not enrolling through DSP&S.>
 142 <I was cruising through the listserv in search of help with some
 143 documentation I received today and saw that while there has been
 144 discussion
 145 on this topic, but nothing for the last couple of months seems to help
 146 with
 147 the situation I seem to have. I just received report about a student
 148 who is severe Bipolar and has been institutionalized twice in the past
 149 three years because when he decompensate he becomes violent. There is
 150 also mention a sexual assault from him when he was 16. His most recent
 151 episode resulted in charges from assaulting an officer and a family
 152 member in Jan., 2003. He has had two psychiatrists that have refused to
 153 work with him because of non-compliance. What I need to make sure I
 154 understand, is this something I can share with the Dean of Students,
 155 i.e. other administrators at the University, etc.? I am investigating
 156 all avenues because this report has given me grave concerns about this
 157 student being a direct threat along with being a disruption. I feel I
 158 need to mention that this report was sent to me from the student or the
 159 clinician based on the student's request, however, I have never met
 160 with this student nor do I know what he may be seeking in the way of
 161 accommodations but right now I feel that is beside the point as his
 162 report
 163 is filled with references to violence and non-compliance with
 164 medications, etc. Any thoughts out there about this matter?>
 165 <I do not think either the ADA or section 504 prohibits you from
 166 sharing
 167 the information with the Dean or whoever else among the university

168 administration you deem appropriate.>
169 <Like xxx said there is nothing in ADA/504 that says you can't share
170 information, per se; but I think the litimus [sic] test is "what you
171 share and what are your assumptions". Plus I think FERPA should be
172 involved. But
173 If you do this, are you randomly going to share information out of
174 anyone
175 elses' [sic] file? How about all the other students you have with
176 mental illnesses? Or those that the Doctor chose to edit the
177 documentation and
178 leave out all the lurid particulars, that should not be in an
179 appropriate documentation. Do you advertize [sic] that your DSS process
180 is confidential? But not confidential to applicants with mental
181 illnesses. What are your
182 assumptions in giving a "heads up" to everyone? They all going to
183 "watch" him? Are you setting him up for an environment that will be
184 harrassing [sic] and discriminatory in nature? Are you going to tell
185 all his teachers? Where
186 do you stop telling people? Where do you start? Are you going to put
187 him on a drug medication program and spoon feed him every morning? Are you
188 you
189 going to put him on a curfew, or refuse him to be anywhere on campus
190 without a security guard? Are you going to spray paint a big 'MI' on
191 his coat for "mental illness"? I see you doing nothing untill [sic] he
192 shows up to discuss the DSS procedures. If he doesn't in a timely
193 manner then either deystroy [sic] the report or send it back to the
194 originator. Or I see you sharing this information with your admin., BUT
195 only if your school has a policy that states that any student is
196 subject to immediate suspension if the school ever finds out you have a
197 "past". And if your college application has all students disclose
198 everything from their "past", and the college routinely runs a "past"
199 check on all applicants. So, I think you need to find out how are
200 people going to act on this information. And if your college is not
201 willing to suspend him or deny him admittance based on what you share.
202 Then why share? The evidence of direct threat must be established by
203 determining the severity of the risk, the likelihood of the risk and
204 the imminence of the risk. If you can determine this then you can deny
205 accommodations or participation of the person. (j.j.) Good Luck if
206 you try it!>
207 <You can talk to anyone you need to talk to at the University on a
208 need-to-know basis. I think that the people you mentioned have a
209 definite need to know about this situation.>
210 <Thanks for all of the insightful thoughts...it helps.>
211 <Xxx and I have disagreed before over the sharing of information
212 disclosing a potential threat to the safety of other students, and
213 earlier
214 posts are available from the archives. At the risk of repeating what I
215 have said before, I will reply.
216 FERPA does not prohibit sharing of information with administrators; it
217 prohibits sharing of information with other students and the public at
218 large. To be precise, *no* federal law prohibits sharing the kind of
219 information at issue with deans and other administrators with the
220 authority and discretion to make judgments for the institution.
221 As I have noted in earlier posts, this discussion has nothing to do
222 with
223 treating students with mental illnesses differently or sharing
224 information

225 randomly; to the contrary, it involves treating one student with a very
226 specific history of violent behavior including a sexual assault
227 differently from all other students with or without mental illnesses.
228 To the extent that there is any difference in treatment, the difference
229 arises from the student's past conduct, not his disability. And as
230 everyone surely knows, the ADA excludes from the definition of
231 disability any sexual behavior disorder; there is something more than a
232 little ironic in thinking the ADA requires us to expose women to the
233 worst form of sexual harassment.
234 Under no circumstances would I destroy a report of the sort at issue
235 here;
236 I think that would be ground for immediate discharge at most
237 institutions,
238 and could be a criminal act for employess [sic] of public institutions
239 in some states; at a minimum I think that would be an extraordinarily
240 irresponsible act. When as a lawyer I represent an individual,
241 destroying
242 potentially damaging evidence is not part of the service I render; were
243 I
244 to do so, I would be subject to disbarment and potential prosecution.
245 As
246 DSS officers, we work for the institution.
247 Finally, I do not know of any institution which reposes in a DSS office
248 either the authority or the responsibility for determining whether a
249 student is a direct threat to the safety of others; that responsibility
250 lies with higher university officers. To withhold from them information
251 of past sexual assaults [sic] and violent behavior is to interfere with
252 their ability to make those judgments, and to put at risk the safety of
253 every student.>
254 <Great answer...while I knew FERPA allowed me to discuss this case, I
255 wanted to get a variety of opinions just to see where others stood on
256 this. I
257 agree this had absolutely nothing to do with discriminating against a
258 person with a mental illness but concern about past behavior, as we are
259 with any student coming into the university. I believe that any student
260 with a past record of violent behavior or sexual abuse has to be
261 addressed
262 in a fair and professional manner, this is only fair to the other
263 students
264 and staff on campus. By no means are we gathering up a "posse" to
265 persecute this person, we just want to make sure all bases are
266 basically covered in regards to behavior here at the campus. I think it
267 is important
268 to remember that as of Jan. 2003 this student had been arrested for
269 violent
270 behavior, so we are talking very recent "past" behavior. Anyway, thanks
271 to everyone for their responses, I think this matter will certainly be
272 discussed again.>
273 <Xxx writes:
274 Finally, I do not know of any institution which reposes in a DSS office
275 either the authority or the responsibility for determining whether a
276 student is a direct threat to the safety of others; that responsibility
277 lies with higher university officers. To withhold from them information
278 of past sexual assaults [sic] and violent behavior is to interfere with
279 their ability to make those judgments, and to put at risk the safety of
280 every student.
281 ++++++

282 All responsibility starts smack dab in our office! Determining "direct
283 threat" is part of the natural process of determining eligibility [sic]
284 for appropriate and reasonable accommodations. I see this as no
285 different than
286 a student presenting with TBI and applying to my welding or machining
287 programs. But you are right, the duty of determining whether students
288 are
289 suitable for admissions [sic] is a whole different story. But my
290 understanding is that is why we are two separate [sic] offices.
291 Information gleaned in the DSS office can not be used to make decisions
292 in the admissions office. But I don't think you are saying this is ok
293 if the DSS officer, based on her value judgement [sic] feels that
294 certain disabilities, or possible behavior emanating [sic] from them
295 should be part of the admissions procedure? That was my rhetorical
296 question from before. Where do you start, and where do you stop? We
297 all have some pretty damning information on a lot of our students. Last
298 month there was a query about a student with seizures applying to a
299 Child Development program, they also asked similar questions to this
300 post. "Oh my gosh, what can we do to protect the children from this
301 person, and who should we tell?" As if denying [sic] them entrance
302 was the logical answer.
303 As I said in my first post:
304 "So, I think you need to find out how are people going to act on this
305 information. And if your college is not willing to suspend him or deny
306 him admittance based on what you share. Then why share? The evidence
307 of direct threat must be established by determining the severity of the
308 risk, the likelihood of the risk and the imminence of the risk. If you
309 can determine this then you can deny accommodations or participation of
310 the person. (j.j.) Good Luck if you try it!"
311 We can not have it both ways, one direct threat procedure for mental
312 health issues, and one direct threat procedure for all other disability
313 issues. One confidentiality procedure for Mental Health, one for all
314 others. Xxx's own confidentiality statement says that the student must
315 sign off on her sharing any information with anyone. I realize the
316 release isn't worth the paper it is written on, but it is important to
317 her system. Every criminal act mentioned in the psych report is a
318 matter of public knowledge, except probably the stuff from when he was
319 16. Do all schools routinely check the public record files to gather
320 information on all applicants? I will bet dollars to donuts that their
321 are other students presently at UM with a worse criminal record than
322 this student. As a school, we are required to put out current consumer
323 information of all criminal activity that has happened on our campuses
324 year by year. NOT ONE THAT REPORTS WHAT OUR STUDENTS HAVE COMMITTED IN
325 THE PAST! This is mailed to all applicants. We can not list students
326 and a copy of their criminal record. Hell, we can't even post bounced
327 checks to a bulliten [sic] board :-). We cannot put out consumer
328 information of the types of swd we have and a list of their potential
329 criminal activity or other behaviors. The courts are rife with cases
330 where students have sued the schools because they shared information
331 like date rapes and other student conduct issues. I believe that UNLV
332 is involved in an especially heinous one where a student is out on bond
333 for kidnapping, raping and killing a ten year old. And the school and
334 students are up in arms trying to get him suspended. That is what I
335 meant by "why share", there are procedures and policies in place
336 already, put them into action! If you are routinely "sharing"
337 disability [sic] information with others, and nothing is being done,
338 then you are just gossiping and possibly jeopardizing the integrity of

339 your office and system. Ask yourself, what are my assumptions in
340 sharing this information? I think the bottom line of Xxx's query was,
341 based on this information that she releases, can the school now deny
342 admissions to this student, or suspend him if he is already a student?
343 That wasn't answered. IMHO based on what little knowledge I have of
344 504/ada/civil rights '64 et cetera. That if UM sent a letter to the
345 student denying entrance based on information gleaned from a psych
346 report, which was voluntarily submitted by the student to the DSS
347 office, solely [sic] for the purpose of requesting reasonable
348 accommodations for a known disability. That all the proverbial [sic]
349 shit in Wyoming would really hit the fan. The same would happen if UM
350 simply denies him acceptance, but he files with OCR because he
351 submitted documentation of a disability and he states that it was used
352 against him to deny his admissions. Until [sic] the school develops
353 [sic] a policy of "no criminals allowed", for all applicants. The
354 school would be hard pressed to show why this applicant wasn't
355 accepted. Or if the school has a policy that all DSS cases are to be
356 routinely discussed with administration, how is this one justified to
357 OCR? Like we do in all of our cases of conduct on our campuses,
358 divorce the disability from the behavior! In this case you would then
359 have either a student with a criminal record, or a student with a
360 psychiatric disability. So react to one or the other, to react to both
361 is very difficult indeed! But, if normal procedures were followed,
362 like they are for any disability, and direct threat was found, then
363 probably nothing would happen :-). Also, as to destroying [sic] or
364 sending back unsolicited documentation. It seems the consensus of the
365 list last month was that this was appropriate. Any closure on that in
366 lieu of what Xxx brought up?>
367 <This discussion concerns a specific student with a history of very
368 recent
369 violent criminal behavior including at least one sexual assault, not
370 some
371 hypothetical student with a seizure disorder in a child development
372 program. It is the specific criminal behavior, not the disability,
373 which
374 ought to be of concern here; the ADA does not forbid discrimination
375 against applicants [sic] who commit violent criminal acts; it protects
376 applicants from discrimination on the basis of disabilities, not on the
377 basis of conduct. Schools are free to ascribe whatever significance
378 they choose to criminal conduct, and to treat some criminal conduct
379 (sexual assaults) differently from other criminal conduct (bounced
380 checks) in determining to whom to extend offers of admission or revoke
381 offers of admission. Though most schools do not specifically ask in
382 their applications whether an applicant has ever committed a violent
383 sexual assault, their failure to ask does not preclude them from acting
384 when they discover that they have offered admission to someone with
385 that history; my guess is that your school also doesn't ask whether
386 applicants belong to Al Qaeda, but that your school would act promptly
387 upon that discovery.>
388 <Xxx writes:
389 Ask yourself, what are my assumptions in sharing this information?>
390 My assumption is that someone with authority and responsibility might
391 consider the information relevant to his/her responsibility to provide
392 a safe educational environment for all students, and to his/her
393 responsibility to protect women from sexual assaults on campus. My
394 assumption is that the responsible person, who as we know is not a DSS
395 officer, will find it much harder to fulfill that responsibility if I

396 deliberately conceal information that one of our recent admittees has a
397 previously undisclosed history of recent violent behavior including a
398 sexual assault. My assumption is that, possessed of that information,
399 the responsible person will obtain whatever additional information may
400 be helpful in making a responsible decision on how best to discharge
401 the institution's responsibility to its students. That decision may
402 well be that the offer of admission should not be withdrawn, but that
403 decision should be made by someone other than a DSS officer. Do I have
404 to make judgments, distinguishing rumor mongering and gossiping [sic]
405 from the reasonable sharing of information? Yes, and making those
406 judgments should be among the easier moments in my day; I know the
407 difference between conduct and disabilities, between sexual assaults
408 and seizure disorders. I fear I am simply repeating myself; perhaps I
409 should retire from this discussion.>

410 <The original question came from a Montana DS officer. Montana has an
411 online registry of sexual offenders that campus security and other
412 authorities regularly monitor. This information serves the direct
413 threat question better than whatever disability information the DSS
414 office receives. It's particularly great because it separates the issue
415 of disability accessibility from campus safety. According to our legal
416 counsel, Montana enjoys the strongest privacy rules in the nation. Our
417 state constitution stresses Privacy a great deal. Violating a
418 Montanan's privacy, even if that Montanan may be a direct threat to the
419 health and safety of others, should be done very carefully in keeping
420 with the spirit of that strong privacy. The decision whether to
421 disclose information on a student with a disability received by a DS
422 office that may indicate a direct threat merits close scrutiny. It
423 really comes down to a judgment call based on a case-by-case review of
424 the particulars. I am bothered by Xxx's observation that DS officers
425 don't make the call for the university regarding direct threat. It's
426 accurate, but here's what bugs me. If I were to raise the issue of
427 direct threat on campus, the reaction would be significant. Campus
428 authorities would say that if something like this bothers the DS
429 director, then it must be very serious. That's because my role as the
430 university authority on accessibility contrasts starkly against that of
431 a worried whistle blower. Don't get me wrong. If I believed that I had
432 information that revealed a potential danger, I would blow the whistle
433 long and loud. But first I would see if other means, such as the
434 registry mentioned above, would serve just as well. I want to protect
435 my role on campus and be responsible at the same time.

436 I'm not sure if my words make much sense, but it's a sort of karma
437 thing. Do I want to be a university employee who leans away from what
438 it means to have a disability or a university employee who leans
439 towards changing the university so that it is accessible by students
440 with disabilities? Blowing the whistle based on disability
441 documentation sounds like a person who may be counted on not to be
442 friendly to the cause of equal access. The very least one could do is
443 to talk it over with the student to give the documentation some kind of
444 context. I would also contact the person responsible for the
445 documentation to get more context. It's my understanding that the only
446 thing prompting the question is documentation. Documentation has no
447 meaning for us on its own merits. So, before taking the drastic action
448 of blowing the whistle, I would first make sure I've got enough
449 information based on behavior to take that rather drastic action.

450 Aren't these sort of things the essence of best practices in DS in
451 higher education? I guess I want my role to be that of a person who is

452 responsible, but also a campus authority who may be relied on to speak
453 for equal access to university programs by students with disabilities.>
454 <Anyone wanting a nice discussion of "direct threat to self" might want
455 to look at: Can I Play?: The Dilemma of the Disabled Athlete in
456 Interscholastic Sports, Adam A. Milani [Assistant Professor of Legal
457 Writing and Analysis, Mercer University School of Law; J.D., Duke
458 University 1991; B.A., University of Notre Dame 1988.] This author is
459 discussing intercollegiate athletics but the same laws are often
460 applicable outside of sports. There is a copy of Dr. Milani's article
461 at <http://www.law.ua.edu/lawreview/milani.htm>.
462 You will also need to read [Chevron U.S.A. v. Echazabal, U.S. Supreme
463 Court, No. 00-1406 (2002)] to be up to speed on the issue. The two
464 combined nicely illustrate how far the court will go to find support
465 for
466 what they want to do, when they can't find support in the law. In this
467 case they used the EEOC regs. (The same EEOC that they ridiculed a
468 couple years ago.) Be careful what you write on DSSHE the Supremes
469 might use it.>
470 <I am helping organize a multidisplinary [sic] panel discussion on
471 disruptive students at this college and would appreciate your comments
472 with regard to "direct threat" students. What helps and what doesn't.
473 What is appropriate for conduct policy and what role does the DSS
474 office play in all this.>
475 <A student with a disability has registered in this office. His
476 documentation from his psychiatrist reveals a history of extreme
477 violence
478 to himself and others during times when he has stopped taking his
479 medication. Do I have any obligation to alert any other administrator
480 on
481 campus (especially my immediate supervisor, VP for Student Affairs)
482 about this potential? Might this be considered a campus safety issue?
483 Or is my obligation strictly maintaining the confidentiality of this
484 student? It is
485 possible for me to forsee [sic] a violent incident after which it
486 becomes known that an administrator on campus (myself) had
487 foreknowledge of such a
488 possibility.>
489 <Yes, you should have a document students sign indicating there may be
490 situations in which information about a student's disability is
491 shared.>
492 <My take on this is NO. The Psych probably revelaed [sic] more than
493 what is needed for documentation of a mental illness. I don't think it
494 ethical to
495 share something that may or may not happen based on medication, or
496 personal
497 resbonsibility [sic]. Will someone be assigned to medicate him
498 everyday? I would see this the same as those with seizure prone
499 disabilities. While
500 there is a saftey/danger [sic] clause in the ADA, I wouldn't think this
501 would
502 qualify. Also, Anger management is probably asymptamatic [sic] of most
503 mental illnessess.[sic] So you want to be careful to not set him up
504 for disparate treatment based on stereotypes and assumptins.[sic] so my
505 assumption is to do nothing.>
506 <The ADA does not forbid sharing disability related documentation with
507 your supervisor; neither does FERPA. As we discussed at last summer's

508 AHEAD, the so called confidentiality requirement of the ADA / Section
509 504 is an urban legend.
510 Even were there such a requirement, the information you describe may
511 raise
512 the question of whether the student poses a direct threat to himself or
513 others; whoever makes that determination for the institution should
514 have access to relevant information.>
515 <Xxx, can you elaborate on this a little more!
516 Yes, there is nothing that sez [sic] we can't share disability
517 information. But there is a lot that sez [sic] this information can not
518 be used to discriminate against the person, or use the info in a
519 discriminatory manner. There has to be a reason to pass it on, without
520 one then it just becomes gossip. And that is covered under FERPA. Plus
521 professional ethics play a part. There is nothing in the law that says
522 that people with mental illnessess [sic] have to register with college
523 officials or college police or college medical folks.
524 No one knows anything about this person except the DSS office. They
525 inadvertantly [sic] got information that IMHO they should have never
526 got from the referring psych. That damning statement could also be part
527 of any documentation of a mental illness. It is inflamatory [sic] by
528 nature, and forwarding it on serves no purpose. What are the
529 expectations of forwarding it on? Who is a person that determines
530 direct threat on a campus? All this would do is to put the student
531 under a microscope. I would even go so far as to state that the student
532 would have a good case for a grievance if he found out that the campus
533 police and housing had his name down as a possible threat. Even ex-cons
534 have more rights than this.
535 My thinking is that the only class of folks we can legally discriminate
536 against like this are those that fall under sexual perversion laws.
537 They
538 do have to register with local police, who in turn give us a heads up.
539 I
540 think passing it on just to cya causes more problems than it solve.>
541 <Xxx asks me to elaborate on why it does not violate the ADA, section
542 504
543 or FERPA to inform your immediate supervisor that a student who has
544 sought
545 accommodation has asked for and obtained a letter:
546 from his psychiatrist [that] reveals a history of extreme violence to
547 himself and others during times when he has stopped taking his
548 medication. Do I have any obligation to alert any other administrator
549 on campus (especially my immediate supervisor, VP for Student Affairs)
550 about this potential? Might this be considered a campus safety issue?
551 Or is my obligation strictly maintaining the confidentiality of this
552 student?
553 1. The ADA and section 504 prohibit the *institution* from
554 discriminating against a student with a disability. The proposed
555 disclosure is to a
556 supervisor, not to the public, the campus police, or even to faculty
557 members; it is therefore to the *institution*, which will decide what
558 to
559 do with the information. As long as the *institution* does not use the
560 information to unlawfully discriminate against a student with a
561 disability
562 because of his disability, it will not have violated either law. Every
563 institution reposes in somebody the authority to remove a student from
564 campus, or withdraw admission offers on the basis of newly discovered

565 information; that person is almost certainly not a DSS staffer or
566 director, and therefore disclosure to a supervisor is the proper way to
567 ensure that the information reaches the person with responsibility to
568 make the decision respecting whether the information merits action.

569 2. The proposed disclosure relates to past conduct, not to a
570 disability.

571 The ADA does not forbid discriminating [sic] against students who have
572 engaged in and who may be likely to continue to engage in violent
573 behavior. The DSS
574 staffer does not propose to single out students with disabilities; to
575 the
576 contrary, she proposes only to single out students who reveal a history
577 of past violent behavior. Though the past violent behavior may be
578 related to
579 a disability, that is beside the point; it is the violent behavior, not
580 the disability, which is the basis for the decision to pass along
581 information to a supervisor -- the best evidence of that is that she
582 proposes to share information with respect to only this student, not to
583 all or even most students with disabilities.

584 3. To the argument that the institution cannot consider past violent
585 behavior because it is an expression of a disability, the answers are,
586 either, nonsense or who cares.

587 a. The argument is nonsense because for people who are on meds,
588 going off meds is a choice, albeit one they have a right to make, and
589 for
590 most it is a choice which does not inevitably lead to violent behavior.
591 Therefore, considering past conduct is considering just that --
592 considering their voluntary choices leading to violent behavior rather
593 than considering their disability (and is therefore akin to the
594 difference
595 between [unlawfully] discriminating [sic] against alcoholics and
596 [lawfully]
597 discriminating against people with DUI infractions -- alcoholism may be
598 a
599 disability, but it does not cause or excuse the choice to drive while
600 drunk).

601 b. The alternative answer is who cares because the
602 antidiscrimination statutes do not forbid discriminating against a
603 person with a disability who is, by reason of the disability, a direct
604 threat to the health or safety of himself or others. If the decision to
605 go off meds and the resultant violent behavior really are so closely
606 tied to a disability that they are akin to the thump of a crutch (I
607 don't discriminate against people with mobility impairments, I
608 discriminate against people who make thumping noises), then the
609 disability may make the student a direct threat to the safety of
610 others. The ADA does not give students with uncontrollable violent
611 disassociative [sic] disorders a double O license, and it does not
612 require institutions to knowingly subject other students to the threat
613 they pose. The institution has every right to discriminate against a
614 student with an uncontrollable violent disassociative [sic] disorder,
615 who, by reason of that disorder, poses a direct threat to the safety of
616 others.

617 3. We should encourage DSS professionals to develop a sense of
618 professional ethics, but there is no reason to think it unethical to
619 disclose to your supervisor information just because it would be
620 unethical to gratuitously disclose it third parties. The psychiatrist,
621 bound by

622 professional ethics, made a considered decision to disclose information
 623 to
 624 the *institution* for its use in making judgments about how to proceed
 625 in
 626 respect to this student; to withhold that information from the
 627 institution
 628 when it may directly affect the safety and even lives of other students
 629 seems to me to stretch any notion of professional ethics beyond the
 630 breaking point; far from facilitating unlawful conduct, the disclosure
 631 enables the university to make a decision whether to act in
 632 circumstances
 633 in which antidiscrimination law may not forbid it from acting and tort
 634 law may oblige it to act. If the psychiatrist made an unethical
 635 disclosure (highly unlikely since the student presumably requested the
 636 letter and waived the psychotherapist patient privilege), the student
 637 will
 638 be free to complain to the psychiatrist and those who enforce his/her
 639 ethical responsibilities.
 640 4. FERPA is a nonissue here precisely because disclosure is
 641 made
 642 within the institution's chain of authority for reasons directly
 643 related to the institution's duty to its students. Though FERPA forbids
 644 disclosure to those who are not employees of the institution, and
 645 requires
 646 an institution to adopt a policy setting out the circumstances in which
 647 it
 648 will make disclosures to faculty and staff who request disclosures, I
 649 know
 650 of nothing in FERPA which even remotely forbids the disclosure here.
 651 In closing, I should emphasize the qualified nature of my
 652 initial
 653 response -- I don't know the specifics of what the psychiatrist
 654 disclosed;
 655 however, "extreme violent behavior" suggests something far more serious
 656 than throwing a book on the floor, and a past history may mean one
 657 incident in ten years or a pattern which repeats itself every few
 658 months. That information may be highly relevant to the ultimate
 659 determination of
 660 whether the institution chooses to take any action, but the decision is
 661 one for the institution, not the DSS office, to make.>
 662 <Xxx, bear with me here, it is still below 0* here and warm blood
 663 hasn't got to my brain yet.
 664 I know it is hard to deal with specifics, but If I am
 665 understanding the gist here. An accepted student could conceivably get
 666 their acceptance [sic] rescinded, based on something in the
 667 documentation that the student HAD to provide us to enable a
 668 conversation about reasonable accommodations. Is
 669 there no catch-22 here to protect the student? We force the student to
 670 self disclose, students with disabilities are the only group on campus
 671 that are forced to self disclose in order to start a process under the
 672 ADA/504. To take this information and then use it against the student
 673 to
 674 deny their acceptance seems to be contrary to the ADA and the Civil
 675 rights law. Should I have a sign in my office stating "beware what you
 676 self
 677 disclose because it can be used against you"? I would think that if
 678 all

679 applicants had to undergo a background [sic] check, I could then see a
 680 reasonable consequence. Or if the student had been a past student who
 681 had
 682 acted out and was now reapplying. But a brand new student!!!!
 683 I totally understand the uncontrollable violent disassociative
 684 [sic] disorder and would not hesitate in contacting the student and the
 685 psych for
 686 more information and a possible management plan. But the fact that a
 687 student has acted out, or might act out, if off their meds doesn't
 688 raise any red flags with me. Like I said, that is a common denominator
 689 in just about all mental health disabilities. But sure could be tainted
 690 fruit if I pass it on to people who don't understand. I see this as a
 691 gatekeeper role, and
 692 as you said this should be someone other than the DSS office. But
 693 still,
 694 it just doesn't seem right.>
 695 <In one semester, I had two swd students who had history of violent
 696 behavior and both were sex offenders. Both had served time for their
 697 crimes. Our local police department posts all sex offenders in the area
 698 on their web site including photo. In addition, a letter was sent to
 699 the cc with notification of this. I might add that my responsibility in
 700 DSS was to provide accommodations in the classroom relating to each
 701 student's disability....which I did. Even though the past history was
 702 public knowledge, I never disclosed this info to instructors for fear
 703 that discrimination against students could occur.>
 704 <I think Xxx made a reasonable decision, and, coincidentally, one that
 705 is consistent with what I have already said. See below. But as
 706 Xxx suggests, disclosure of a criminal conviction cannot violate any
 707 law; criminal convictions are already matters of public record.
 708 By the way, discrimination against violent sex offenders is lawful
 709 discrimination; it is not forbidden by the ADA or any other civil
 710 rights
 711 act. The college rightly may have concluded that it had an ethical duty
 712 to shield those students from discrimination, but it had no legal duty
 713 arising from the ADA.>
 714 <A student who self discloses information which reveals that he/she is
 715 a
 716 direct threat to the safety of others by reason of his disability (or,
 717 for
 718 that matter, for any other reason) has disclosed that he/she is not
 719 otherwise qualified for protection from discrimination under the ADA or
 720 section 504. Whether the school chooses to rescind its offer of
 721 admission
 722 is a matter of school policy, judgment and contract law, not the ADA
 723 (assuming the student really is a direct threat).
 724 Beyond that, I do not think it useful to equate multiple incidents of
 725 "extreme violent behavior" with "acting out." I don't know anyone who
 726 hasn't acted out at one time or another, irrespective of whether they
 727 went
 728 off meds or, for that matter, ever were on meds.
 729 As for the argument that only students with disabilities must self
 730 disclose, that is incorrect. No student is under an obligation to seek
 731 accommodations, and only otherwise qualified students with disabilities
 732 are entitled to receive them. Though it is true that students who do
 733 not seek accommodations do not self disclose to DSS, that does not mean
 734 that requiring those who do seek accommodations to self disclose is a
 735 form of discrimination. When the information self disclosed shows the

736 student is not entitled to an accommodation, we generally do not call
737 the use of that information a form of discrimination; that should be no
738 less true when the information disclosed shows the student to be a
739 direct threat to the safety of others by reason of a disability, for
740 that student has no more to protection from discrimination on the basis
741 of disability, than does a student who has no disability.>
742 <Hello all in dsshe land -
743 A question - that jumps off from Xxx's point about disclosure.
744 In regards to the disclosure - students who uses a wheelchair or
745 crutches, can decide to or not to disclose. We have a couple of
746 students (wheelchair users) who don't care about utilizing our
747 services. BUT! Evacuation for a fire drill or actual event can be
748 problematic. What do others do in situations like this? Our
749 administrators are questioning liability matters. They seem to think
750 students must disclose. Any thoughts? Please set the wagon straight!>

Appendix E
Otherwise Qualified

1 <I have a student with a disability related to dysthymia. He indicates
2 that
3 his anger management control issues (which include belligerence,
4 hostility
5 to others, entitlement, blame of others) is directly and intricately
6 related to his depression. In fact he indicates that he needs
7 accommodations because of his anger control disability. Documentation
8 is only for dysthymia.>
9 <No disability excuses a student from complying with generally
10 applicable
11 conduct requirements. I would be inclined to tell the student that if
12 he
13 behaves improperly, he will suffer the same consequences as would any
14 other student, and suggest that he pursue whatever therapy he needs.>
15 <I don't think that there is any accommodation that you could provide
16 for anger management in a classroom that would be appropriate at the
17 college level. If he does not have his anger under some control with
18 medication/therapy, then perhaps he is not a qualified student at this
19 time.
20 Additionally, what documentation do you have that supports this
21 manifestation of his disability? I would encourage you to make sure
22 that the student understands the student's rights and responsibilities
23 code at your school and the penalties for violating the student conduct
24 code. He needs to know that ALL students regardless of whether they
25 have a disability or not must adhere to this code. Additionally, I once
26 had a student who did have some issues with anger due to past
27 experiences, and his ADHD symptoms, caused him to react impulsively and
28 get him in trouble. (I had documentation to support this.) He and I
29 worked together for a long time.
30 Some of the things that we did in order to be proactive were:
31 *Having him make regular appointments to discuss areas that were
32 frustrating in order to problem solve. (I would see him quite often in
33 the
34 very beginning and then it was tapered off.)
35 *Letting him know that this was a safe place to come when he got
36 agitated, and needed to see me on a walk-in emergency basis. (Don't do
37 this
38 if you don't feel safe with the student or if you know that the student
39 will
40 constantly interrupt your day. This student was quite successful,
41 transferred, and graduated with honors.>
42 <I have been thinking about this post compared to the earlier one on
43 Agrophobia [sic]. In that one it seems most responders were all in
44 favour [sic] of this wonderful b-mod plan that was designed by all
45 those involved as an accommodation for the students "behavior" as a
46 result of the neurosis. Yet in this case with anger management, the
47 responses seem to favour [sic] a tone of not doing anything because we
48 can't accommodate adverse behavior. How is accommodating behavior
49 defended in one case, but not the other??? Whould [sic] it not be
50 appropriate to accommodate anger issues by requesting the teacher to
51 look for clues in behavior and try to head the problem off before it
52 starts??? In the case of some ADD/HD i [sic] would request that the
53 student sit in the front row, and that the teacher look at the student
54 to get attention before making a special assignment not written in the

55 syllabus, or hand it out in writing. What is the difference? Can not
56 an accommodation be the "anticipation" of a behavior????>
57 <The difference between agoraphobia [sic] and anger management problems
58 is simple -- one makes life difficult for the student, while the other
59 threatens the safety of those who encounter the student. If b-mod
60 doesn't work for the
61 student with agoraphobia [sic], nobody gets hurt; when therapy doesn't
62 work for the student with anger management problems, people bleed.
63 Classroom
64 teachers are just that -- teachers, not psychotherapists trained to
65 recognize early signs of an uncontrollable outburst of anger, and
66 should
67 not have to structure [sic] a class around the elusive trigger
68 mechanisms of
69 someone who, if he cannot control his temper in class, should not be
70 there in the first place. I remain unconvinced that an anger management
71 problem is a disability, but that is quite beside the point; we already
72 provide accommodations in the traditional sense for people who cannot
73 control their temper -- a bed and three square meals per day -- and it
74 is the prospect of those accommodations which helps with anger
75 management. Unless the student is
76 insane within the meaning of the criminal law, he is obligated to
77 comply
78 with the same conduct standards we impose on everyone else; if he is so
79 mentally ill that he poses an immediate danger to himself or others, he
80 should not be in school.>
81 <I remain unconvinced that an anger management problem is a disability,
82 but
83 that is quite beside the point; we already provide accommodations in
84 the
85 traditional sense for people who cannot control their temper -- a bed
86 and
87 three square meals per day -- and it is the prospect of those
88 accommodations which helps with anger management. Unless the student is
89 insane within the meaning of the criminal law, he is obligated to
90 comply with the same conduct standards we impose on everyone else; if
91 he is so mentally ill that he poses an immediate danger to himself or
92 others, he should not be in school.>
93 <If I was teaching the class I would attempt to soothe the person. It
94 is a kind thing to do. I don't think it is a reasonable accommodation
95 b/c I
96 don't think it is a disability. It is a discipline issue. Acting out
97 anger can seriously interfere with the testing environment. How about a
98 quiet
99 testing place as an accommodation for the dysthymia?>
100 <Not to change the subject as it has been fascinating, but I'm having a
101 terminology problem. . .
102 Oftentimes the term "not otherwise qualified" is used to describe
103 situations
104 in which a student with a disability may be deemed "not otherwise
105 qualified"
106 to participate in some program or activity because circumstances around
107 the
108 disabling condition may create an untenable situation. The anger
109 management
110 is simply one example from a number of discussions I have seen on the
111 list.

112 I was of the understanding that the phrase "not otherwise qualified"
113 was linked solely with admissions - admission to a university,
114 admission to a particular program of study and so forth. The thrust of
115 being "otherwise
116 qualified" (as I understood it) was to remove the disability from the
117 equation and ask whether the student meets the prerequisites for
118 enrollment.
119 Once a student has been accepted into that school/program then they ARE
120 otherwise qualified. When circumstances arise that create disability or
121 accommodation challenges how can we go back to stating he/she is not
122 otherwise qualified? I can see how it would appear that they are not
123 qualified - certainly, as a part-time faculty member I would not want
124 to be held responsible for the prevention of someone else's outbursts -
125 yet, they've completed the admissions process and have been determined
126 to BE otherwise qualified. So, what are they now?>
127 <There can be other meanings of not otherwise qualified than just
128 related to disability. A good example is a would-be elementary
129 education student who
130 has a prison record for battery and harm to others. An elementary
131 education
132 program involves practice teaching in a classroom with young children,
133 someone with this background of harm to others is not allowed in such a
134 setting.>
135 <Hi, everyone: Has anyone encountered a student with Social Anxiety
136 Disorder? According to this student's documentation, he severe
137 difficulty with going out in public places, including the classroom. He
138 is on medication, however, his therapist states that he continues to
139 struggle with anxiety when it comes time to attend classes and
140 sometimes cannot enter the building where his classes are scheduled.
141 The accommodations that the therapist suggest are allowing the student
142 to complete as much of his work outside of the classroom setting as
143 possible, and videotaping or audiotaping his classes. Anyone have any
144 suggestions or feedback?>
145 <Hi Xxx, I am surprised that the "therapist" doesn't recommend that you
146 send a teacher to his house and teach him on an individual basis. I
147 just
148 love it when "therapists" use school as part of their therapy program.
149 An
150 then recommend accommodations that are counter-productive to the
151 therapy.
152 Let me guess, this student is also a full time student, and needs to
153 continue for FA and insurance. Sounds like a good candidate for an on-
154 line degree. I would suggest that this "therapist" do the job they are
155 being
156 paid to do and go out with this person in social situations and work
157 with
158 the anxiety as it manifests. Tell the therapist they are welcome to
159 attend the class with the student as a courtesy of the school. To me
160 this
161 re-enforces why most phobias and Anxiety disorders do not raise to the
162 disability definition level of the ADA. If the disorder is such that it
163 severely impacts on a persons [sic] life, then the student typically
164 becomes
165 "otherwise qualified" because they can not purport themselves as a
166 student the way your college defines student. Or have the positive
167 student behavior that all students need to have in order to be a
168 student in your college. There are no reasonable accommodations that

169 would not fundamentally alter your curriculum, your scope and role of a
 170 college, cause undo hardships, or give unfair advantages.>
 171 <Xxx's above comment reminds me that "Anxiety Disorders" seem to be
 172 singled out as not being covered under ADA or Section 504 by many
 173 colleges. I have wondered what the reasoning is for this and what
 174 criteria other colleges use for determining whether or not one of the
 175 DSM listed Anxiety disorders requires accommodation. I understand the
 176 logic that "test anxiety" is not a diagnosis, but if the student has a
 177 valid diagnosis and recommendation from a psychologist or psychiatrist,
 178 what are different schools doing? And on what basis? Are there any
 179 OCR cases regarding accommodating Generalized Anxiety Disorder or
 180 Social Anxiety Disorder?>
 181 <This is an unreasonable accommodation recommendation. I do not think
 182 this student is "otherwise qualified".>
 183 <You asked what other colleges are doing...
 184 At Xxx we have done a few things.
 185 * written a letter to the faculty member stating that the student may
 186 need to slip out of class for short periods of time. This allows the
 187 student to "collect themself [sic]" and then return to class. The
 188 students who have used this accommodation tell me that they rarely need
 189 to use it...it just gives them a way of escape should their feelings
 190 become unmanageable.
 191 * Second, we reaffirm the attendance policy of the college. See below.
 192 CLASS ATTENDANCE POLICY (preliminary 12/02)
 193 For the student handbook:
 194 Class attendance policies are not determined by Disability Services.
 195 Because attendance may be integral to the teaching process, these
 196 policies are set by faculty at the college, at the departmental or the
 197 individual level.
 198 In some cases, attendance is fundamental to course objectives. For
 199 example, students may be required to interact with others in the class,
 200 to demonstrate the ability to think and argue critically, or to
 201 participate in group projects. In others instances, faculty may
 202 determine that students can master course content despite some or many
 203 absences. Rarely, faculty may decide that students do not need to
 204 attend class at all.
 205 What can Disability Services do?
 206 Disability Services can provide written verification of the student's
 207 disabilities based on appropriate documentation. This verification can
 208 address the legitimacy of absences. The letter of verification may be
 209 used to initiate discussions of attendance and make-up policies and
 210 procedures.
 211 For the faculty handbook:
 212 Faculty should make their policies clear so that students can make
 213 informed choices about which courses to take. If faculty intend to
 214 disallow or restrict absences, they may choose to use wording similar
 215 to this: "your presence is fundamental to meeting the objectives of
 216 this course. Consequently, there will be ____ excused absences, and
 217 ____ makeup quizzes/exams."
 218 The Office of Civil Rights has used the following criteria to determine
 219 whether attendance is fundamental to a course:
 220 1. Is there classroom interaction between the instructor and the
 221 students and among the students?
 222 2. Do student contributions constitute a significant component of the
 223 learning process?
 224 3. Does the fundamental nature of the course rely on student
 225 participation as an essential method for learning?

226 4. To what degree does a student's failure to attend constitute a
227 significant loss to the educational experience of the others students
228 in the course?
229 5. What do the course description and syllabus say?
230 6. What are the classroom practices and policies regarding
231 attendance?>
232 <To me the confounding thing about psychiatric disorders is that they
233 generally present themselves as an atypical response to a typical
234 situation. Regardless of etiological factors (many could have been
235 precipitated by atypical situations), the key issue remains of how to
236 blend dysfunctional responses to otherwise normal situations. Going to
237 class is a typical thing for college students unless they are
238 recovering from a three day bender or road trip-including many students
239 with disabilities. Yet the student with a psychiatric disorder,
240 especially something like severe anxiety disorder with agoraphobia,
241 views a normal activity such as going to class as the cause of the
242 condition! It's easy to see how attending class can be such a hurdle.
243 So do we simply reply that he/she is not "otherwise qualified"? That
244 may be the case, but it doesn't answer anything about the ability of
245 that student to learn, it does convey that students with serious
246 psychiatric disorders do not fit well into the reasonable accommodation
247 module many of us practice, e.g., a student who is blind attends class,
248 a student who is deaf attends class, a
249 student with an LD attends class and so on. Serious psychiatric
250 conditions challenge us to be creative when appropriate and advocates
251 when necessary. I am not suggesting that every student with a
252 psychiatric disorder should be allowed to miss class. Not at all.
253 Attendance as we all know is fundamental in most places. What I am
254 saying is if we learn more about how typical situations elicit an
255 atypical response from students with psychiatric disorders, maybe we
256 can influence new ways of learning that respond to these students'
257 desire to learn. A good place to start is the Boston University's
258 Center for Psychiatric Rehabilitation. I think that's what it's called.
259 Anyhoos, just my opinion and as you know Aristotle said opinions are
260 the lowest form of knowledge because everybody has one!>
261 <Thanks Xxx! A very good resource for making decisions about
262 accommodating Anxiety disorders, especially test anxiety.>
263 <I'm very interested to hear how other list members handle students who
264 are
265 continually [sic] suicidal?
266 I have a student who is diagnosed bipolar and has threatened suicide to
267 the DSS provider (myself and the person before me) five times over a
268 period of two and a half years. Each time an on-campus counselor is
269 yanked from what they are working on to sit/talk with her. Usually the
270 student calls her mother and/or psychiatrist for help in calming down.
271 Then, her mom comes and picks her up.
272 It has happened twice so far this semester. I wonder--is our "band-aid"
273 procedure of providing an emergency counselor and waiting with her
274 until
275 her mother comes enough? Too much? Or is this something that happens
276 in
277 every disability services office at colleges across the country?>
278 <Is this student a qualified student? Remember that being qualified
279 can
280 change throughout a student's academic experience. If the student is
281 not

282 emotionally capable of attending college, the student should be
283 referred to the appropriate authority on campus--Dean of Students, etc.
284 If the student
285 is a direct threat to themselves or others, the student should to
286 referred to the appropriate mental health providers. The Dean or whom
287 ever could
288 require that the student have a letter from an appropriate mental
289 health provider before being allowed to return to college.>
290 <If she can not handle the stresses of school without feeling suicidal
291 a
292 couple times a semester, she's not qualified to be there. Sounds like
293 an
294 updated evaluation showing her current state of functioning is needed.>
295 <If a student threatens suicide, then you have a legal obligation to
296 report self endangerment to the proper law enforcement. Until a person
297 is able to function without self-endangerment or endangering others
298 then the student should not be in college or attend class.>
299 <If a student makes a suicide attempt, we would require that a
300 "Release/Authorization to Return" form be filled out by a psychiatrist
301 stating the person current mental status and their evaluation of the
302 person's ability to function in the college setting. This includes
303 their evaluation of the person's risk to harm themself [sic] or
304 others. Until that
305 is received, and approved by our committee, the student is not allowed
306 to attend class.>
307 <As to the question of "what do you do when a student actively
308 expressing suicidal ideation is in your office?" - Answer should be
309 obvious, you get help - whether that be a crisis counselor or security
310 (to transport to campus health services) or other campus resources.
311 The long-term picture is a little different. I'm dismayed by the
312 comments that presuppose a student of this type would not be "otherwise
313 qualified". We have many students with psychiatric disabiliites [sic]
314 on our campuses. These statements do more to continue the stigma of
315 mental illness than to understand how institutional policy and practice
316 support these students. Some questions you can ask:
317 What policies exist related to students who engage in behavior that is
318 harmful to themselves (student conduct codes? medical withdrawal
319 policies?)
320 What is the role of campus counseling services on campus? How are they
321 connected to the policies related to students with psychiatric
322 disabilities?
323 What is your (disability service provider) relationship with your
324 campus mental health services? Does your institution have policies
325 that can mandate psychological assessment? Who is involved in these
326 policy implementations?>
327 <Until a person is able to function without self-endangerment or
328 endangering others then the student should not be in college or attend
329 class. Suicide attempt is on way to be involuntary [sic] committed in a
330 inpatient facility.>
331 <Yes. However, in the original post it wasn't at all implied that an
332 "attempt" was made but rather expressions of suicidal thoughts. There
333 is a huge range of behaviors that exist vis-a-vis suicidal ideation and
334 the assessment of the severity of risk or endangerment should be left
335 to the mental health professionals. Following that, institutional
336 policy should "kick in". In the case of my institutional we would
337 determine whether the threshold for meeting the Involuntary Medical
338 Withdrawal policy was reached. My post was to encourage people to think

339 institutionally so that appropriate policy and practice are followed
340 rather than "fly by the seat" approaches.>
341 <This is my first time writing on the listserv, so please take it easy
342 on
343 me. :-) I am working with a student who has short-term memory loss as
344 a
345 result of TBI. When she was in high school, her IEP allowed her to use
346 her
347 class notes on her tests. She is now requesting that same accommodation
348 for her tests in college. I explained that this would not be a suitable
349 accommodation since it would put her at an unfair advantage over other
350 students and doesn't seem to uphold the academic integrity of the test,
351 but
352 she claims that this is the only possible accommodation that will help
353 her. We reviewed other testing accommodations (extended time,
354 distraction
355 free environment, reader, etc) but she is insisting that using her
356 notes is
357 the only tool that will help her be successful. I just wanted to pick
358 your
359 brains to see if anybody has found a successful way to accommodate
360 tests for students with short-term memory loss?>
361 <Don't be intimidated (not by the student and not by us old fogeys on
362 the
363 list! GRIN). I think you are right on with this one, and for all the
364 right
365 reasons. The key here is your statement (and hers!):
366 "...but she is insisting that using her notes is the only tool that
367 will help
368 her be successful."
369 You're best bet may be to remind her that the purpose of
370 accommodations, at
371 the postsecondary level, is NOT to foster "success," but access. It is
372 one of those changes that comes with moving from high school to
373 college. There is no question but that dealing with short term memory
374 problems in a typical
375 college environment can be very difficult to overcome, but sacrificing
376 the
377 academic integrity of the testing process is not the answer.
378 I'd stick to your guns, if I were you.>
379 <An accommodation that you want to consider for the student is having
380 the tests presented in an alternative format. Multiple choice format
381 would provide her with retrieval cues and would not compromise the
382 integrity of the test.>
383 <I would like to see more discussion regarding this suggestion for
384 accommodation of memory loss or other forms of learning disability.
385 We are not in the habit of specifying to instructors how to structure
386 tests for individual students. First of all, test format is an academic
387 issue specific to instructor [sic] determined approach to teaching. I
388 have a
389 friend who teaches philosophy and she focuses on teaching conceptually.
390 To determine student mastery of her subject, she gives essay format
391 tests because multiple choice tests would not be an appropriate
392 academic vehicle to "test" her students. Another reason for not
393 specifying test formats for individual students is that it would
394 require instructors to make up a separate test.
395 Writing tests requires a lot of time and thought. Writing a second

396 kind of test would double, at least, the effort of the instructor. I
397 question that this is reasonable
398 Memory issues are a big problem in an educational environment in which
399 learning is the purpose of the environment. Seems to me that learning
400 is dependent on memory to a great extent. I am reluctant to believe
401 that cueing via multiple choice answers is effective anyway. Some
402 multiple choice questions I have seen are more confusing than a Rubik's
403 cube. A, B, C, D (A and C), E (B and C), F all of the above, G Go to
404 the corner and guess what to do.
405 In the original post, it was stated that the student had 'short term'
406 memory loss. This is the memory we access when we cram for exams. One
407 approach to this kind of memory problem is longer, more intense study
408 and that is a student issue, not an instructor/testing one.
409 As Xxx pointed out, success of students is not what we exist to
410 promote. We are in the business of access, reasonable and appropriate
411 access.>
412 <I'm wondering if there's another way to approach this and determine if
413 she's
414 making the best use of in class accommodations (assuming she has them)
415 and
416 if she's doing other things like reviewing frequently and rewriting her
417 notes after class to assist the short-term memory loss. Would the
418 instructor allow her to write down as much information that she can
419 remember before the test starts?>
420 <We have had similar situations with TBI and other disabilities.
421 Use of a word bank can be an accommodation as well, provided it is
422 appropriate for the class. Again, this has to be looked at on a case by
423 case basis, especially the issue of "otherwise qualified".>
424 <I have a very strange situation brewing and would love some
425 assistance.
426 I have a student with agoraphobia as well as a panic disorder. She has
427 enrolled in one of our counselling [sic] programs which requires that
428 all students attend a four day workshop in New Hampshire. The is a
429 prerequisite and required course. Classes go all day and programs run
430 into the night. One of the main focuses of this class is on team
431 building and collaboration with peers.
432 First we received a letter from the students [sic] doctor stating that
433 it would be detrimental to her emotional and physical well being to
434 attend the course. It went on to say that requiring her to go would
435 create unnecessary and potentially harmful emotional stress. She
436 requested that she be excused from all participation. She made no
437 request for alternate accommodations. I offered that she did not have
438 to sleep overnight, as all other students did and that we could find
439 her a quiet private place for down time during breaks and lunch. She
440 refused. We met and reviewed in detail the essential requirements of
441 the course. In the end it was determined that the course was required
442 if she chose to continue in the program.
443 She called last week and said that she now was willing to attend. Her
444 doctor made the request the way she did because it would be best for
445 her but she could handle the course anyway. So what do we do now? She
446 is not asking for much in terms in accommodations but her doctor has
447 stated that she is "unsafe to attend". The director of the program does
448 not want her to attend not because of her doctors concern. Can she be
449 excluded because of this documentation?>
450 <That is tough. As a minimum I would want to hear from the same doctor
451 that it is now safe and what if any accommodations are needed. I would
452 also ask what has changed that it is now safe. That may not be entirely

453 necessary but it might make the doc think first before he starts to
454 take dictation from a patient again. I would probably also run it by
455 someone from Risk Management or University Attorney's office.>
456 <Regardless of the supportive documentation from the doctor, I'm
457 wondering if this student is qualified. It appears that this is a
458 prerequisite and required. Can this student do the essential functions
459 of the course with or without accommodations? If not, then she is not
460 qualified at this time.>
461 <Under the "Direct threat" clause for titles II, III; it says that the
462 argument of direct threat can only be used in the context of threat to
463 others; that the individual has the right to assume a risk to self,
464 perceived or real. If this still is true, I think you have to let her
465 go. And, she doesn't have to request accommodations, nor can we require
466 her to accept accommodations.
467 BUT, wasn't there a case earlier this year where a college refused to
468 accept a student because she was a practicing anorexic [sic] and
469 wasn't in control, and the college feared for her life. Seems like the
470 court found in favour [sic] of the the [sic] college. Wouldn't this be
471 similar?>
472 <Some courts may reason that a student who, by reason of a disability
473 (or for any other reason), poses an immediate threat to his/her own
474 safety is not otherwise qualified, and would not be otherwise qualified
475 even if the direct threat clause were not part of the ADA.>
476 <What disability would pose an immediate threat? A deaf person using
477 sign language and the hand might threaten someone passing by? Or a
478 blind person accidentally hitting the cane with a passerby? Or a
479 wheelchair user forcing people to make way and a person fall in a
480 manhole? The student is abusing and misusing the ADA by avoiding
481 situations.>
482 <Thanks so much to everyone for offering your advice and wisdom. The
483 students [sic] therapist is going to now send us updated documentation
484 stating that she is fully capable to attend, with no accommodations at
485 all! In my view this is a case of therapist overly advocating for her
486 client. Asking for everything she could get even though it was not
487 justified. I am going to get a complete explanation from the therapist
488 on what changed of course. Unless something else happens, my student
489 will be attending the course.>
490 <I am not sure I would call it overly advocating for a client and
491 nothing may have changed. Remember the therapist's goals are different
492 than ours. We need to look for ways to educate therapist about the
493 intersection between therapeutic goals and reasonable accommodation.>

Appendix F
Unsolicited Information

1 <Subject: Mental Health At College
2 This was on NPR last night and I thought some of you might be
3 interested in it.
4 Mental Health At College (14.4
5 <http://www.npr.org/ramfiles/atc/20010104.atc.14.ram>
6 <http://www.npr.org/ramfiles/atc/20010104.atc.14.rmm>>) - Better
7 treatments for mental illness are allowing more young people with
8 serious disorders to attend college. But that's putting a strain on
9 college mental health services. Experts say schools are often
10 unequipped to care for students with major problems. Monica Brady from
11 member station WBUR has the story.
12 <Subject: Manic/Depressive student gets out'd, loses student gov't
13 position
14 At Least She Doesn't Live In Massachusetts
15 Coed Just Wants An Apology, But \$\$ Will Do
16 Deseret News
17 What she wanted was an apology. What she's willing to settle for is
18 \$45,000. Former Snow College student Michelle Larson, who has manic
19 depression, says she's ready to put her civil-rights lawsuit against
20 the junior college in Ephraim [Utah] to rest. Larson made waves when
21 she enrolled at Snow College in 1995. She was an honor student and was
22 elected student body vice president at the end of her freshman year.
23 But by the winter of 1996, Snow College officials noticed her for other
24 reasons. Larson's struggle with manic depression, or bipolar disorder,
25 had become somewhat public on the 2,500-student campus. Snow College
26 officials had stripped her of her leadership office, put her on both
27 academic and social probation, and told her to sign a "wellness
28 contract.">
29 <Subject: Student w/ Depression Fights Denial to Study Abroad
30 I saw this in the Pioneer Press, the newspaper of Saint Paul, MN, this
31 morning and thought our members would be interested. I'll keep you
32 posted of developments, if I hear of them.
33 Macalester sued over denial of study abroad
34 Student blames inadequate grades on depression
35 By HANNAH ALLAM PIONEER PRESS
36 A 19-year-old sophomore is suing Macalester College in St. Paul for
37 discrimination and mental anguish because the school denied his
38 application for a German study abroad program set to begin this month.
39 Macalester officials told Colin Kennedy he was turned down for the
40 program because he did not maintain a 2.5 grade-point average his first
41 two semesters, according to the complaint filed last month in Ramsey
42 County District Court.
43 Kennedy claims depression prevented him from excelling at his studies
44 during his first two semesters and that the school failed to make
45 reasonable accommodations for his illness.
46 "When you send your kid to school, you don't expect him to get
47 trampled," said Daniel Kennedy, the plaintiff's father and an attorney
48 in Illinois. "You expect a school to care for your kid."
49 Kennedy is now sightseeing in Europe with a friend, his father said,
50 and hopes a judge will grant an injunction that would allow him to
51 study with the rest of his class in Germany next week.
52 One judge already denied an injunction at a hearing in late December
53 and attorneys for Kennedy plan to ask the court to reconsider this

54 month. The family also is seeking damages. Daniel Kennedy said his son
55 is back on medication to treat his depression.
56 The lawsuit alludes to a turf war between professors who used to choose
57 students for the trips and the newly formed Study Abroad Review
58 Committee, which now oversees selections.
59 Ellis Dye, the professor who has organized the German program for three
60 decades, supports Kennedy; the committee denied the teen's application.
61 Kennedy and his attorneys claim there is no written rule that students
62 must have certain grades to participate.
63 Court papers contain snippets of e-mails sent between Dye and
64 Macalester
65 President Michael McPherson. In copies of the entire e-mails, Dye
66 advises administrators not to "let the Kennedy case spiral out of
67 control."
68 "Such matters should not be influenced by a parent's willingness or
69 ability to threaten legal action," McPherson wrote in response. "To
70 respond to such threats would be unfair to other students whose
71 families happen to be less litigious."
72 Donna Nicholson, Macalester spokeswoman, said she could not discuss
73 Kennedy's case. She said more than half the school's students spend
74 time studying abroad in about 70 countries. The school is committed to
75 helping students with disabilities, she added.
76 "It's not a given that every student who wants to study abroad can,"
77 Nicholson said. "There's a process to go through.">
78 < Subject: NYT article: "A Suicide at MIT"
79 FYI: there was an excellent article on suicide and MIT in last Sunday's
80 NYT magazine. The website below also has an interactive *Readers
81 Forum*--
82 "Who was responsible for Elizabeth Shin?"--and there are a number of
83 thoughtful responses.
84 www.nytimes.com/library/magazine/home
85 This article should be required reading for all college personnel...>
86 <Subject: COLLEGE STUDENT GUILTY OF KILLING TWO CLASSMATES
87 COLLEGE STUDENT GUILTY OF KILLING TWO CLASSMATES
88 Wednesday, May 22, 2002 NEWS 15A Associated Press
89 WASHINGTON (AP) -- A 22-year- old student who claimed images of black-
90 gloved hands ordered him to do evil things was convicted yesterday of
91 killing two classmates at Gallaudet University.
92 Joseph Mesa Jr., a hearing-impaired native of Guam, was found guilty
93 after a D.C. Superior Court jury deliberated three hours. A sign-
94 language interpreter translated for him as the jury foreman read guilty
95 verdicts on each of the 15 counts.
96 Mesa and the two victims had been classmates at Gallaudet, a top
97 college for the hearing-impaired. Eric Plunkett, 19, of Burnsville,
98 Minn., was killed his dormitory room in September 2000. The body of
99 Benjamin Varner, 19, of San Antonio, was found in his dorm room in
100 February 2001.
101 Prosecutors said Mesa beat Plunkett to death and used a paring knife to
102 repeatedly stab Varner. He then robbed both men, using their credit
103 cards to go on a spending spree.
104 Mesa, pleading insanity, testified about a pair of "black hands" that
105 told him to do evil things. He also said he was distanced from his
106 family while growing up, because they did not know sign language.
107 The prosecution countered with a videotaped confession from Mesa
108 describing the killings.
109 <Subject: MENTAL HEALTH AND DANGEROUS STUDENTS
110 [http://www.psych.org/public info/violence.pdf](http://www.psych.org/public_info/violence.pdf)

111 Good article on violence and mental health issues.>
 112 <Subject: Psychiatric Resources
 113 DSSHE subscribers frequently post questions about various psychiatric
 114 conditions. You might want to check out the publications available at
 115 the American Psychiatric Association's website. This link should take
 116 you directly to the categories of their public information. The "Let's
 117 Talk
 118 Facts" series is a good one, as is the "APA Fact Sheet" series.
 119 http://www.psych.org/public_info/index.cfm
 120 If this link doesn't take you directly to the list, go to their main
 121 site and choose "Public Information" from the "Site Guide" drop down
 122 box.>
 123 <Subject: "Emergence of Psychiatric Disabilities in Postsecondary
 124 Education"
 125 National Center on Secondary Education and Transition
 126 <http://www.ncset.org/topics/accommodations/Issue>
 127 Brief Examining Current Challenges in Secondary Education and
 128 Transition
 129 September 2004 * Vol. 3, Issue 1The Emergence of Psychiatric
 130 Disabilities in Postsecondary Education
 131 By Michael N. Sharpe, Brett D. Bruininks, Barbara A. Blacklock, Betty
 132 Benson, and Donna M. Johnson
 133 Issue: An unprecedented and growing number of postsecondary students
 134 report psychiatric disabilities. How can postsecondary personnel
 135 support the success of these students? Defining the Issue
 136 A significant development in the field of postsecondary disability
 137 supports in the last decade has been the proliferation of individuals
 138 with psychiatric disabilities. This phenomenon has emerged at a pace
 139 that one observer characterized as a "rising tide" (Eudaly, 2002).
 140 Measel (1998) found that within one year, five institutions in the Big
 141 Ten Conference encountered an increase from 30% to 100% in the number
 142 of students served with psychiatric disabilities. At one institution,
 143 the University of Minnesota, the number of students reporting a
 144 psychiatric disability as their primary disability (285) was more than
 145 the combination of students reporting learning disabilities and
 146 attention deficit disorders (269). Although there is little
 147 systematically collected data to provide a reliable estimate of the
 148 emergence of psychiatric disabilities in postsecondary education,
 149 information from current sources provides evidence that this issue is
 150 likely to come into sharper focus as data from more studies become
 151 available.
 152 Despite recent recognition in the postsecondary setting, the growth in
 153 the number of individuals declaring a psychiatric disability is
 154 consistent with national statistics. Each year about one in five
 155 Americans experience a diagnosable psychiatric disability, which
 156 includes major depressive disorders, schizophrenia, eating disorders,
 157 and anxiety disorders (National Institute of Mental Health, 2002). Some
 158 psychiatric disabilities remain dormant, manifested only at critical
 159 stages of human psychosocial development or by physiological events.
 160 Unger (1992) noted that the onset of major mental illness often occurs
 161 between ages 18-25*a time when many young adults are seeking
 162 postsecondary education, preparing for future careers, and developing
 163 social relationships.
 164 Perhaps the most influential factor resulting in more individuals
 165 declaring a psychiatric disorder in the postsecondary setting is how
 166 such disabilities are identified and treated. Today diagnostic criteria
 167 have expanded so that the term "psychiatric disability" represents a

168 much broader range of disorders and syndromes than before. While once
169 attention was largely focused on the diagnosis and treatment for the
170 "major" psychopathologies (e.g., schizophrenia), the field has
171 broadened to encompass disorders generally requiring less intensive
172 treatment interventions. For example, there is a dramatic increase in
173 the identification and treatment of a number of anxiety disorders
174 within the last decade, particularly those related to social anxiety,
175 post-traumatic stress, and various types of phobic disorders (Swinson,
176 1997). As diagnostic criteria continue to improve in identifying other
177 types of mental health disorders, it is likely the population of
178 students with psychiatric disabilities in postsecondary education
179 settings will continue to grow. Current Research and Practice
180 Some early efforts to address the needs of individuals with psychiatric
181 disabilities within the postsecondary setting occurred as a result of
182 the emergence of supported-education programs. Based on the definition
183 of "supported employment" in the Rehabilitation Act Amendments of 1986,
184 supported-education programs began in the 1980s as a way of providing
185 supports to individuals with psychiatric disabilities in the
186 postsecondary setting (Unger, 1998).
187 According to Unger (1998), supported-education programs involve three
188 prototypes: (a) a self-contained setting, where students are
189 reintegrated into the postsecondary setting; (b) on-site support, where
190 ongoing support is provided by the institution's disabilities support
191 staff or a mental health professional; and (c) mobile support, where
192 support is largely provided by community mental health service
193 providers. It is estimated that about 30 supported-education programs
194 currently exist in the United States to serve individuals with
195 psychiatric disabilities in postsecondary programs.
196 While supported education is a model for serving the needs of students
197 with psychiatric disabilities, the more typical case is that they are
198 served by disability support services (DSS) staff at the postsecondary
199 level, or by community agencies not necessarily affiliated with DSS or
200 the postsecondary institution.
201 Many DSS staff have traditionally received training in a disability
202 area related to learning and instruction (e.g., learning disabilities)
203 and do not feel adequately trained to address the needs of individuals
204 with psychiatric disabilities. Indeed, some DSS staff report that they
205 are often challenged in meeting the needs of students with psychiatric
206 disabilities. They indicate efforts to provide accommodations are not
207 as clear as in other disability areas (Sharpe & Bruininks, 2003) or
208 that working with students with psychiatric disabilities might require
209 addressing multiple, complex problems such as social isolation,
210 withdrawal, and academic failure (Blacklock, Benson, & Johnson, 2003).
211 In addition, many DSS providers are not fully informed about services
212 available in the community. The resulting lack of collaboration
213 prevents some students from accessing needed services (Whelley, Hart, &
214 Zaft, 2004). Clearly, serving students with psychiatric disabilities in
215 the postsecondary setting represents new challenges to many DSS
216 providers.
217 While there is only limited research on this issue to guide practice,
218 information has recently become available that helps identify some
219 barriers faced by students with psychiatric disabilities and service
220 providers alike (Blacklock, Benson, & Johnson, 2003). Based on the
221 results of 39 focus groups conducted with postsecondary DSS staff,
222 faculty, administrators, and students with psychiatric disabilities,
223 Blacklock et al. (2003) identified five primary barriers that impact

224 the educational experiences of students and service-delivery issues for
 225 providers. These include:

226 *Stereotypes and Stigma**All of the focus groups stated that students
 227 with psychiatric disabilities often face incorrect, stereotyped views
 228 about their disability and endure the stigma and negative consequences
 229 that frequently accompanies disclosure of such a disability.

230 *Complex Nature of Psychiatric Disabilities**Students feel challenged to
 231 simultaneously manage their disability and maintain academic
 232 performance that reflects their abilities. Service providers and
 233 faculty share students' concern about this complex issue.

234 *Access to Resources**All focus groups indicated that students with
 235 psychiatric disabilities face additional barriers because of their need
 236 to seek out services within bureaucracies (educational or governmental)
 237 that are unclear and uncoordinated. These extra efforts are necessary
 238 to maintain their health insurance, student status, and access to
 239 mental health and disability services.

240 *Access to Information and Services**Many students in the focus groups
 241 expressed frustration with the lack of information about psychiatric
 242 disabilities and limited access to services that would allow them to
 243 effectively manage their disability.

244 *Organizational and Institutional**Focus group participants identified a
 245 lack of coordination and communication between service providers on and
 246 off campus as additional barriers students with psychiatric
 247 disabilities face at the postsecondary level.

248 The identification of these barriers appears to be consistent with
 249 other observations (Collins, 2001; Eudaly, 2002; Loewen, 1993; Angle,
 250 1999; Unger, 1992). To address these barriers, Blacklock, Benson, and
 251 Johnson (2003) advocate four strategies: (a) implementing universal
 252 instructional design strategies to improve the learning experiences for
 253 all students, including those with psychiatric disabilities, (b)
 254 creating sub-communities to foster social connections for students with
 255 psychiatric disabilities, (c) improving clarity, coordination, and
 256 communication with all key stakeholders, including inter-organizational
 257 and community-based service providers, and (d) promoting access to
 258 resources for all key stakeholders through information sharing and
 259 training efforts.

260 A common theme in the literature relating to the support of students
 261 with psychiatric disabilities is how such services should be configured
 262 at the postsecondary level. This issue not only involves the "mission"
 263 or "values" of the program (Unger, 1998), but also the need to
 264 articulate the parameters in which students will be served. Efforts to
 265 outline overall program mission and values will establish a scope of
 266 services relative to the institutional and community resources
 267 available. This activity can also be helpful in clearly defining how
 268 support services will be accessed and maintained by students with
 269 psychiatric disabilities. Through a series of interviews conducted with
 270 DSS staff in Big Ten universities and colleges, Sharpe and Bruininks
 271 (2003) identified several basic requirements common to these
 272 institutions:

273 *Documentation**Students with psychiatric disabilities must provide
 274 current documentation by a qualified medical or mental health
 275 professional to qualify for DSS services.

276 *Diagnostic Criteria**Generally, a diagnosis must reflect criteria
 277 established by the Diagnostic and Statistical Manual of Mental
 278 Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or the
 279 International Classification of Diseases Manual, Tenth Edition (ICD-

280 10). Moreover, the diagnosis must meet disability criteria established
 281 by the Americans with Disabilities Act (ADA).
 282 Accommodations*Although clinical input regarding functional limitations
 283 and instructional accommodations are considered, DSS staff generally
 284 make the final determination regarding what specific accommodations
 285 will be provided.
 286 Accountability*In nearly all cases, the declaration of a psychiatric
 287 disability does not exempt one from a code of conduct and similar
 288 policies established by the institution.
 289 The processes used to notify postsecondary instructional staff about
 290 the need for accommodations are not always consistent. In some cases,
 291 the student is obligated to discuss the need for accommodations
 292 directly with the instructor. In others, a letter or memo was sent to
 293 the instructor by DSS staff regarding accommodation needs for a student
 294 (Sharpe & Bruininks, 2003).
 295 While this provides a basic overview of current research and practice
 296 in serving students with psychiatric disabilities within postsecondary
 297 settings, much more work needs to be done. At this point, only a small
 298 glimpse has been captured about this growing population of students.
 299 Much needs to be learned about the overall nature of students with
 300 psychiatric disabilities entering postsecondary education settings.
 301 Currently little accurate information exists regarding the overall
 302 prevalence and variability of students with psychiatric disabilities.
 303 For example, little is known about how many students exhibit severe and
 304 persistent mental illness in relation to those whose illness is
 305 considered "mild." This evidence would do much to illuminate the extent
 306 to which the students with psychiatric disabilities need psychological
 307 treatment concurrent with their educational experience. Strategies for
 308 Practice
 309 Despite little empirical evidence regarding strategies leading to
 310 increased positive academic, social, and employment outcomes for
 311 students with psychiatric disabilities, a range of instructional
 312 accommodations has been collected and disseminated through various
 313 studies, professional networks, and training activities. The
 314 accommodations shown in Table 1 are most common and can be implemented
 315 with cost-efficiency and relative ease.
 316 The accommodations are universal in the sense that they are equally
 317 applicable to most types of disabilities. This is good news for
 318 students with psychiatric disabilities in the postsecondary
 319 setting*accommodations differ little from those typically provided to
 320 all students with disabilities (Sharpe, Johnson, & Murray, 2003). What
 321 remains unknown, of course, is how effective these types of
 322 accommodations are for students with psychiatric disabilities.
 323 Table 1. Accommodations for Students with Psychiatric Disabilities
 324 Extra time and/or a private environment for exams
 325 Priority registration
 326 Audio recording of lectures
 327 Notetakers for lectures
 328 Modified deadlines for assignments
 329 Reduced courseload
 330 Preferential classroom seating
 331 Early availability of syllabus and/or textbooks Recommendations Reflect
 332 upon broader, programmatic issues*specifically, the mission of the DSS
 333 provider and the policies that may*or may not*be in place to address
 334 the needs of students with psychiatric disabilities in the
 335 postsecondary setting. When a clear direction (e.g., a "mission") has
 336 been defined for the DSS program, it is possible to identify

337 opportunities for improving or enhancing services to students with
 338 psychiatric disabilities. For example, developing collaborative
 339 relationships with community-based health professionals might be an
 340 option to begin building a support network for students with
 341 psychiatric disabilities. DSS staff also may opt to communicate with
 342 institutional counseling services to serve as adjunct support system
 343 for students. Realize that, unless trained and licensed, the role of
 344 postsecondary support personnel is not that of mental health
 345 professional. Nor should they feel compelled to expand their role
 346 beyond the scope of their primary responsibility*to facilitate
 347 instructional supports for students with disabilities. Because many DSS
 348 staff are already consumed with excessive caseloads, it is even more
 349 imperative to collaborate with all types of partners to develop,
 350 implement, and maintain innovative strategies for addressing the needs
 351 of students with psychiatric disabilities. Review Unger's (1998)
 352 description of philosophy, mission, values, and program policies for
 353 programs focused on students with psychiatric disabilities. For DSS
 354 staff who want to pursue a comprehensive approach to providing services
 355 to students with psychiatric disabilities in postsecondary settings,
 356 supported education provides a model and template of services that can
 357 be fully or partially replicated. Design and implement policies to
 358 reflect clearly defined roles and responsibilities for postsecondary
 359 support staff. Several of these policies were presented in the previous
 360 section (i.e., documentation, diagnostic criteria, accommodations,
 361 accountability). Further information is available from Web sites of
 362 two- and four-year postsecondary institutions.

363 Conclusion

364 Muckenhoupt (2000) has suggested that the impact of untreated
 365 psychiatric disabilities is "staggering." Only recently has this
 366 population been recognized within the postsecondary setting, presenting
 367 a challenge to service systems and providers alike. While research on
 368 best practice in this area is clearly lacking, efforts continue on
 369 behalf of many disability support service providers to develop and
 370 implement models of service to meet this challenge. To support these
 371 efforts, a "rising tide" of research, information sharing, and training
 372 will also be necessary to match the growth that in all likelihood will
 373 continue.

374 Michael Sharpe, Brett Bruininks, and Donna Johnson are with the
 375 Institute on Community Integration at the University of Minnesota;
 376 Barbara Blacklock and Betty Benson are with Disability Services at the
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Appendix G
Oppositional Defiant Disorder (ODD)

1 <Is anyone else seeing large numbers of Oppositionally [sic] Defiant
2 students? About 4 years ago we had a six month period when about every
3 third student was classified as Tourette's. This spring and summer, it
4 seems that there have been a very large number of applying students
5 (some as visiting, and some for Fall) have been diagnosed as O.D. Some
6 have been arrested, some have been on probation, some have punched out
7 principals, parents, other students etc. My opposite number in the
8 Counseling office tells me that they are seeing these students too, and
9 her take is that these students used to be recognised [sic] as ADD, but
10 now they are angry! (failed ADD people? chuckle?) Any comments? Are
11 they all coming to County College of Morris?>

12 <We have seen an increase in the number of students in our 10 college
13 system in Arizona. The challenge is not in whether we are being able to
14 accommodate the students but that of concerns about their behavior on
15 campus. The counseling and security departments at our colleges are not
16 always quite prepared to work collaboratively with the disability
17 services office and develop a comprehensive plan for these students. We
18 are working on it but it is taking time and discussion just to develop
19 interest among all involved to work together. It truly is a challenge
20 and one that will need the involvement of all college personnel to work
21 together.>

22 <The bottom line would seem to be that, regardless of disability,
23 students at college are expected to abide by the code of conduct
24 stipulated (hopefully) in your catalog. There is no accommodation for
25 bad behavior as an adult - well, jail maybe!>

26 <I fully agree with Xxx's comment. I feel these students should be
27 working with counseling services but I do not see a need for disability
28 services. How do you academically accommodate ODD????>

29 <There are two responses here that are appropriate:

30 1) Oppositional Defiance Disorder is not a disability within the
31 meaning of the ADA or section 504, and therefore need not be
32 accommodated;

33 2) Waiving basic conduct rules is not a reasonable accommodation;
34 schools may forbid and punish threatening or violent behavior (and
35 threatening speech in circumstances in which the student has the means
36 to carry out the threat or the threat is likely to incite imminent
37 violence) irrespective of its cause. Students who are accustomed to
38 IDEA's treatment of this question may need to be educated on the
39 differences between life under IDEA and life under section 504 and the
40 ADA.>

41 <That is well said. It also states in the ADA that if there is no
42 accommodation that can reduce a threat of risk of harm to oneself and
43 others than an accommodation need not be made. IDEA has made it so many
44 students get away with poor behaviour [sic] taking away from their
45 ability to learn and be productive citizens. In the real world of fiber
46 glass cubicles (work) there are rules to be followed and those who do
47 not abide are terminated from their jobs. In universities if one does
48 not behave they can be expelled from the university. c'est la vie>

49 <It's a psychiatric disability that (by assumption) limits one or more
50 major life activities. Doesn't that make it a covered disability? Of
51 course, this leaves open the question of whether academic
52 accommodations are appropriate, but this does seem to me to be a
53 question that needs to be addressed.>

54 <Could you expand upon the reasoning behind number one. What part of
55 the disability definition would ODD fail? Number 2 is absolutely
56 correct.>
57 <it is not a classified disability under the ADA and also any
58 disability in which an accommodation does not reduce the threat and
59 risk to self or others is not covered under the ADA. IDEA covers more
60 of the "behaviour [sic] disorders". ADA and 504 deal more with what the
61 real word could accommodate in a university or work place with
62 reasonably low threat and risk to societal members.>
63 <This doesn't help me, I'm afraid. ADA doesn't list particular
64 disabilities that are covered. Rather, it sets out criteria (rough, we
65 know) that a disability must meet in order to be covered. The question
66 is, how does ODD fail to meet those criteria? It seems to me (see my
67 earlier post) that it does meet them. Am I missing something?>
68 <I half agree with Xxx - but I won't say which half. Seriously, I agree
69 100% with Xxx's second response. Rules of conduct are not waived as an
70 accommodation. Threatening behavior is unacceptable no mater what its
71 origins and etiology.
72 While I agree that a person with Oppositional Defiance Disorder is
73 automatically or categorically covered by the ADA I don't believe they
74 are automatically excluded either. Is it not a question of wether [sic]
75 the impacts of the condition substantially limit a major life
76 activity?>
77 <I am not Mr. X. but, I would ask what is the substantial impairment
78 with ODD and what could POSSIBLY be accommodated? ODD is coded as
79 Mild, Moderate, or Severe...I think in higher ed., this is not a
80 disability. The essential features, according to the DSM IV, are the
81 person is defiant, losing temper, arguing, refusing to comply with
82 rules or regulations...blaming others...I could go on and on...>
83 <Exactly what major life activity does ODD substantially limit?>
84 <Right- this is the key question. My point is that this question needs
85 to be addressed in order to determine whether ODD is covered. When I
86 say it 'by assumption' limits an activity, I am here assuming the
87 original context of discussion- that is, the query that started this.
88 Does it in fact limit a major life activity? I don't know. As far as
89 I'm concerned, that's a question to be answered by a mental health
90 professional.>
91 <Xxx posted:
92 "I would ask what is the substantial impairment with ODD and what could
93 POSSIBLY be accommodated?"
94 And followed up with a partially excerpt from the DSM IV suggesting
95 that the typical student diagnosed with Oppositional Defiance Disorder
96 would not have a substantial limitation.
97 Fair enough but.... You need to focus the first question on the student
98 at hand. Is he or she a typical student with Oppositional Defiance
99 Disorder or is there, in this case a substantial limitation.
100 If the student seeks accommodations your need to look at the student in
101 front of you not a diagnostic label.>
102 <I'm not making myself clear here. I don't know that ODD is a
103 legitimate disability. Personally, I've got my doubts. But the point
104 I'm making is a legalistic one: the matter of ADA coverage hinges on
105 the question of activity-limitation, and this is a technical question,
106 to be answered by the appropriate profesionales [sic]. It's not clear to
107 me that we, as service providers (unless we're also psychiatrists,
108 which I'm not) are qualified to answer this question. We are qualified
109 to determine what accommodations are appropriate if, indeed, any are.>
110 <well the ADA/504 states there are 3 criteria for disability:

111 One: it must impair a majour [sic] life activity such as walking,
 112 talking, seeing, hearing, performing manual tasks, working,
 113 coordination, breathing, learning
 114 two: regarded as impairment such as a condition like asthma, cancer,
 115 heart disease, etc
 116 three: a disfigurement that can be perceived as disabled even though
 117 in fact there is no impairment it appears that under ADA (private
 118 organisations [sic]) and 504 (receiving federal funds) that this OD is
 119 not a disability and does not impair a majour [sic] life activity. the
 120 inability to be respectful, kind and nice and socially acceptable is
 121 not an impairment of a majour [sic] life activity. is this clearer?>
 122 <There is an aspect of this that puzzles me, although I have not had to
 123 deal with this question yet. If a student is diagnosed with OD
 124 disorder, severe, let's say, and is on heavy drugs to control the
 125 disorder, and the drugs result in a substantial limitation in, say,
 126 learning (which is a life activity we are much concerned with) should
 127 we then accommodate for that?
 128 Please excuse the run-on sentence.>
 129 <To deal with the basic legal question of whether ODD is a covered
 130 disability under the ADA, I offer the following excerpt from the Final
 131 Rule "Nondiscrimination on the Basis of Disability in State and Local
 132 Government Services" (ADA Title II) as published by the U.S. Department
 133 of Justice in 28 CFR PART 35. Apologies for the long excerpt, but you
 134 really need to read it all to understand the full import.
 135 ***begin excerpt
 136 Physical or mental impairment. Under the first test, an individual must
 137 have a physical or mental impairment. As explained in paragraph (1)(i)
 138 of the definition, "impairment" means any physiological disorder or
 139 condition, cosmetic disfigurement, or anatomical loss affecting one or
 140 more of the following body systems: neurological; musculoskeletal;
 141 special sense organs (which would include speech organs that are not
 142 respiratory such as vocal cords, soft palate, tongue, etc.);
 143 respiratory, including speech organs; cardiovascular; reproductive;
 144 digestive; genitourinary; hemic and lymphatic; skin; and endocrine. It
 145 also means any mental or psychological disorder, such as mental
 146 retardation, organic brain syndrome, emotional or mental illness, and
 147 specific learning disabilities. This list closely tracks the one used
 148 in the regulations for section 504 of the Rehabilitation Act of 1973
 149 (see, e.g., 45 CFR 84.3(j)(2)(i)).
 150 Many commenters asked that "traumatic brain injury" be added to the
 151 list in paragraph (1)(i). Traumatic brain injury is already included
 152 because it is a physiological condition affecting one of the listed
 153 body systems, i.e., "neurological." Therefore, it was unnecessary to
 154 add the term to the regulation, which only provides representative
 155 examples of physiological disorders.
 156 It is not possible to include a list of all the specific conditions,
 157 contagious and noncontagious diseases, or infections that would
 158 constitute physical or mental impairments because of the difficulty of
 159 ensuring the comprehensiveness of such a list, particularly in light of
 160 the fact that other conditions or disorders may be identified in the
 161 future. However, the list of examples in paragraph (1)(ii) of the
 162 definition includes: orthopedic, visual, speech and hearing
 163 impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple
 164 sclerosis, cancer, heart disease, diabetes, mental retardation,
 165 emotional illness, specific learning disabilities, HIV disease
 166 (symptomatic or asymptomatic), tuberculosis, drug addiction, and
 167 alcoholism. The phrase "symptomatic or asymptomatic" was inserted in

168 the final rule after "HIV disease" in response to commenters who
169 suggested the clarification was necessary.
170 The examples of "physical or mental impairments" in paragraph (1)(ii)
171 are the same as those contained in many section 504 regulations, except
172 for the addition of the phrase "contagious and noncontagious" to
173 describe the types of diseases and conditions included, and the
174 addition of "HIV disease (symptomatic or asymptomatic)" and
175 "tuberculosis" to the list of examples.
176 These additions are based on the committee reports, case law, and
177 official legal opinions interpreting section 504. In *School Board of*
178 *Nassau County v. Arline*, 480 U.S. 273 (1987), a case involving an
179 individual with tuberculosis, the Supreme Court held that people with
180 contagious diseases are entitled to the protections afforded by section
181 504. Following the Arline decision, this Department's Office of Legal
182 Counsel issued a legal opinion that concluded that symptomatic HIV
183 disease is an impairment that substantially limits a major life
184 activity; therefore it has been included in the definition of
185 disability under this part. The opinion also concluded that
186 asymptomatic HIV disease is an impairment that substantially limits a
187 major life activity, either because of its actual effect on the
188 individual with HIV disease or because the reactions of other people to
189 individuals with HIV disease cause such individuals to be treated as
190 though they are disabled. See Memorandum from Douglas W. Kmiec, Acting
191 Assistant Attorney General, Office of Legal Counsel, Department of
192 Justice, to Arthur B. Culvahouse, Jr., Counsel to the President (Sept.
193 27, 1988), reprinted in *Hearings on S. 933, the Americans with*
194 *Disabilities Act, Before the Subcomm. on the Handicapped of the Senate*
195 *Comm. on Labor and Human Resources, 101st. Cong., 1st Sess. 346 (1989)*.
196 Paragraph (1)(iii) states that the phrase "physical or mental
197 impairment" does not include homosexuality or bisexuality. These
198 conditions were never considered impairments under other Federal
199 disability laws. Section 511(a) of the statute makes clear that they
200 are likewise not to be considered impairments under the Americans with
201 Disabilities Act.
202 Physical or mental impairment does not include simple physical
203 characteristics, such as blue eyes or black hair. Nor does it include
204 environmental, cultural, economic, or other disadvantages, such as
205 having a prison record, or being poor. Nor is age a disability.
206 Similarly, the definition does not include common personality traits
207 such as poor judgment or a quick temper where these are not symptoms of
208 a mental or psychological disorder. However, a person who has these
209 characteristics and also has a physical or mental impairment may be
210 considered as having a disability for purposes of the Americans with
211 Disabilities Act based on the impairment.
212 Substantial limitation of a major life activity. Under Test A, the
213 impairment must be one that "substantially limits a major life
214 activity." Major life activities include such things as caring for
215 one's self, performing manual tasks, walking, seeing, hearing,
216 speaking, breathing, learning, and working.
217 For example, a person who is paraplegic is substantially limited in the
218 major life activity of walking, a person who is blind is substantially
219 limited in the major life activity of seeing, and a person who is
220 mentally retarded is substantially limited in the major life activity
221 of learning. A person with traumatic brain injury is substantially
222 limited in the major life activities of caring for one's self,
223 learning, and working because of memory deficit, confusion, contextual
224 difficulties, and inability to reason appropriately.

225 A person is considered an individual with a disability for purposes of
226 Test A, the first prong of the definition, when the individual's
227 important life activities are restricted as to the conditions, manner,
228 or duration under which they can be performed in comparison to most
229 people. A person with a minor, trivial impairment, such as a simple
230 infected finger, is not impaired in a major life activity. A person who
231 can walk for 10 miles continuously is not substantially limited in
232 walking merely because, on the eleventh mile, he or she begins to
233 experience pain, because most people would not be able to walk eleven
234 miles without experiencing some discomfort.

235 The Department received many comments on the proposed rule's inclusion
236 of the word "temporary" in the definition of "disability." The preamble
237 indicated that impairments are not necessarily excluded from the
238 definition of "disability" simply because they are temporary, but that
239 the duration, or expected duration, of an impairment is one factor that
240 may properly be considered in determining whether the impairment
241 substantially limits a major life activity. The preamble recognized,
242 however, that temporary impairments, such as a broken leg, are not
243 commonly regarded as disabilities, and only in rare circumstances would
244 the degree of the limitation and its expected duration be substantial.
245 Nevertheless, many commenters objected to inclusion of the word
246 "temporary" both because it is not in the statute and because it is not
247 contained in the definition of "disability" set forth in the title I
248 regulations of the Equal Employment Opportunity Commission (EEOC). The
249 word "temporary" has been deleted from the final rule to conform with
250 the statutory language.

251 The question of whether a temporary impairment is a disability must be
252 resolved on a case-by-case basis, taking into consideration both the
253 duration (or expected duration) of the impairment and the extent to
254 which it actually limits a major life activity of the affected
255 individual.

256 The question of whether a person has a disability should be assessed
257 without regard to the availability of mitigating measures, such as
258 reasonable modifications or auxiliary aids and services. For example, a
259 person with hearing loss is substantially limited in the major life
260 activity of hearing, even though the loss may be improved through the
261 use of a hearing aid. Likewise, persons with impairments, such as
262 epilepsy or diabetes, that substantially limit a major life activity,
263 are covered under the first prong of the definition of disability, even
264 if the effects of the impairment are controlled by medication.

265 Many commenters asked that environmental illness (also known as
266 multiple chemical sensitivity) as well as allergy to cigarette smoke be
267 recognized as disabilities. The Department, however, declines to state
268 categorically that these the determination as to whether an impairment
269 is a disability depends on whether, given the particular circumstances
270 at issue, the impairment substantially limits one or more major life
271 activities (or has a history of, or is regarded as having such an
272 effect).

273 Sometimes respiratory or neurological functioning is so severely
274 affected that an individual will satisfy the requirements to be
275 considered disabled under the regulation. Such an individual would be
276 entitled to all of the protections afforded by the Act and this part.
277 In other cases, individuals may be sensitive to environmental elements
278 or to smoke but their sensitivity will not rise to the level needed to
279 constitute a disability. For example, their major life activity of
280 breathing may be somewhat, but not substantially, impaired. In such
281 circumstances, the individuals are not disabled and are not entitled to

282 the protections of the statute despite their sensitivity to
283 environmental agents.

284 In sum, the determination as to whether allergies to cigarette smoke,
285 or allergies or sensitivities characterized by the commenters as
286 environmental illness are disabilities covered by the regulation must
287 be made using the same case-by-case analysis that is applied to all
288 other physical or mental impairments. Moreover, the addition of
289 specific regulatory provisions relating to environmental illness in the
290 final rule would be inappropriate at this time pending future
291 consideration of the issue by the Architectural and Transportation
292 Barriers Compliance Board, the Environmental Protection Agency, and the
293 Occupational Safety and Health Administration of the Department of
294 Labor.

295 *** excerpted from <http://www.usdoj.gov/crt/ada/reg2.html>>
296 <Was Timothy McVeigh ODD? If so it certainly limited a few of his
297 major life activities.>
298 <but he was a majour [sic] threat to the health and welfare of others
299 and that is why he has been punished accordingly. that is the danger of
300 this disorder, the student can be the next oklahoma [sic] bombing
301 murderer or the next unabomber.>
302 <the law says we have to.>
303 <Without belaboring a point fairly made already, I think it important
304 to consider whether the "question of activity-limitation...is a
305 technical question to be answered [sic] by appropriate professionals."
306 Appropriate professionals concluded in the Sutton trilogy of cases that
307 the impairments substantially limited a major life activity, but the
308 plaintiffs lost of all of those cases on the grounds that their
309 respective impairments did not substantially limit the claimed major
310 life activities. In case after case, ADA plaintiffs have lost precisely
311 because, contrary to the assertion of a health care professional, a
312 court determined that an impairment did not substantially limit a major
313 life activity.

314 With many impairments, the question is easy to answer, but when the
315 answer is not obvious, DSS offices need not defer to whatever a health
316 care professional retained by a student asserts substantially limits a
317 major life activity. DSS staff are professionals in their own right,
318 not paper pushers and ticket takers whose only role is to see whether a
319 student has consulted a health care professional to obtain some
320 documentation. If DSS offices do not assume responsibility for asking
321 whether an impairment does, in fact, substantially limit a major life
322 activity within the meaning of the ADA, other people within the
323 university surely will, and will do so in ways that ultimately redound
324 to the detriment of DSS offices, and more importantly, to students.

325 Whether the student claims a specific learning disability, oppositional
326 defiance disorder, or some other impairment whose severity and effects
327 vary significantly from person to person, the statement of a health
328 care professional that the impairment substantially limitis [sic] an
329 identified major life activity is only evidence to that effect. Its
330 weight depends heavily upon its reasoning, analysis, and explication
331 much more than upon its ultimate conclusion. If it says no more than,
332 "I have examined the student, found him to have [fill in the blank],
333 and have concluded that it substantially limits the major life activity
334 of [learning, or perhaps some other major life activity]," it should
335 have little weight.

336 Health care professionals are honest and well meaning people who, for
337 the most part, are not selling diagnoses to high bidders. But the
338 impairments they diagnose range from those about which our knowledge of

339 limitations is exhaustive to those in which we barely have scratched
340 the surface. Psychiatric impairments typically fall in the latter
341 category, not because there is something less legitimate about
342 psychiatric impairments, but because we know so little about how they
343 affect each impaired individual.

344 The appearance of an impairment in the DSM-IV is not proof that it
345 substantially limits a major life activity; remember that the DSM-IV is
346 largely a guide for health care professionals who submit insurance
347 reimbursement claims, and that impairments move into and out of various
348 versions over time. Some of the once commonly diagnosed impairments in
349 earlier versions of the DSM have been dropped from the most recent
350 edition, and others have been called into question, all because we know
351 so much less about psychiatric impairments than about many other
352 impairments.

353 The bottom line is simple -- if DSS offices are to retain their role,
354 they must assume responsibility for all of its aspects, including, when
355 appropriate, questioning the assertion of a health care professional
356 that a particular impairment substantially limits a major life
357 activity.>

358 <Title II of the ADA is silent about being a threat to oneself. It's
359 Title I, the part that addresses employment discrimination, that says
360 that the ADA doesn't protect workers with disabilities who are a direct
361 threat to themselves. Both titles say the ADA doesn't apply to those
362 who are a direct threat to others. We've talked about this before, but
363 I believe that, unlike within the employment arena, Title II covered
364 colleges may not disregard ADA protections because the student with a
365 disability is a direct threat to him or herself. If the direct threat
366 is to others, then the ADA doesn't apply.>

367 <that is probably the best accommodation would be for them to have
368 extended time on tests and to take them in isolation. however, if the
369 person is argumentative and a threat to others, they are not covered
370 under the ADA>

371 <title III also discusses the threat issue for places of public
372 accommodation of which a college or university falls in that category>

373 <I believe that is one of the better statements about the role of the
374 DSS Professional in reviewing documentation. And I say that as a
375 trained clinician, someone who spent many years as a DSS counselor and
376 Director and am now potentially in the role of a that [sic] outside of
377 DSS University representative who gets involved.>

378 <I'm surprised to hear about the third criteria. I wasn't aware of it.
379 It almost seems like ODD would almost fall under the third criteria. A
380 severely bad personality is not limiting except that nobody wants to be
381 around you. Same with some severe disfigurements. But just like with a
382 severe disfigurement where there is nothing you can do to help the
383 student academically I would wager the same can be said for the person
384 with ODD other than to have the person do exams in isolation to avoid
385 any chance of them disturbing major exams.>

386 <Record of disability and Regarded as disabled cover discrimination
387 only and do not require an accommodation.>

388 <The "regarded as" prong of the ADA forbids treating someone
389 differently because of what is wrongly regarded as a disability, but
390 would not generally require accommodation since an impairment wrongly
391 regarded as a disability by definition does not substantially limit a
392 major life activity and therefore should not require accommodation.>

393 <Before people get confused about this post, let me try to offer some
394 clarification.

395 On Wed, 13 Jun 2001, Xxx wrote:

396 -Title II of the ADA is silent about being a threat to oneself. It's
397 Title I, the part that addresses employment discrimination, that says
398 that the ADA doesn't protect workers with disabilities who are a direct
399 threat to themselves. Both titles say the ADA doesn't apply to those
400 who are a direct threat to others.-
401 Actually, [sic] all titles of the ADA are silent on whether it covers
402 people who are a threat to themselves. Accordingly, courts have held
403 that someone cannot be barred from a job or activity because they are a
404 threat to themselves. The statute, however, does specifically say
405 that someone can be barred from an activity if they are a threat to
406 others_. This is consistent with case law under section 504.
407 -We've talked about this before, but I believe that, unlike within the
408 employment arena, Title II covered colleges may not disregard ADA
409 protections because the student with a disability is a direct threat to
410 him or herself. If the direct threat is to others, then the ADA doesn't
411 apply.-
412 The ADA actually has been interpreted to mean exactly the opposite
413 [sic]. The statute does not apply to someone who is solely [sic] a
414 threat to himself. It does apply if someone is a threat [sic] to
415 others.>
416 <well the last post does mention the threat to others. as a matter of
417 fact examples used are infectious diseases like hepatitis [sic] B and
418 of course psychiatric disorders>
419 <the accommodation does not come under regarded or recorded, that is so
420 the person does not get discriminated in the job or programme [sic] but
421 this student for example, if he needs accommodation it would fall under
422 the substantial limitation of a life activity which in his case may be
423 learning or working>
424 <At 08:25 PM, Xxx wrote:
425 -it is not a classified disability under the ADA-
426 There is NO classified disability under the ADA, none whatsoever.
427 Virtually ANY condition can rise to the level of disability. You look
428 at it on an individual basis. Does this PERSON (not the condition but
429 the person) have a significant [sic] limitation of a major life
430 activity? If yes, then there is a disability. If no, there is none. One
431 person with a condition may have a disability and another with the same
432 condition may not.>
433 <However, only those meeting the first part/criteria of the definition
434 of disability are considered [sic] disabled (as in legally) and you do
435 not accommodate those who fit into the second and third criteria.>
436 <true, under ADA it is based whether it is a substantial limit to a
437 life activity, record or regarded as an impairment. Also thank you for
438 the clarification on threats to self./ I conduct ADA lectures on title
439 I and discussed that with human resource professionals where hepatitis
440 [sic] B was an example as was HIV and other infectious diseases>
441 <On our campus we would look at that situation as a health-related
442 disability and ask that the prescribing physician verify the need for
443 the medication, describe the impact of the meds. particularly in terms
444 of learning for this individual and ask him/her to recommend
445 accommodations.>
446 <First post on the ODD question didn't elaborate on currency of the
447 documentation or if there was a comprehensive psych assessment/report.
448 I would note that a current and thorough diagnostic assessment of the
449 individual would be important since ADD is commonly associated with
450 ODD; also, it is commonly associated with mood disorders and psychotic
451 disorders. A professional highly skilled in differential diagnosis
452 would be very important. In general, I would be very cautious of

453 documentation which only identifies ODD; a second professional opinion
454 might be warranted.>

455 <The stated assumption that "an impairment wrongly regarded as a
456 disability by definition does not substantially limit a major life
457 activity and therefore should not require accommodation" is at least
458 partially flawed. For example, read 28 CFR 35.104 (definitions under
459 the regulation enforcing Title II of the ADA). I quote the pertinent
460 excerpt below:

461 (4) The phrase is regarded as having an impairment means--

462 (i) Has a physical or mental impairment that does not substantially
463 limit major life activities but that is treated by a public entity as
464 constituting such a limitation;

465 (ii) Has a physical or mental impairment that substantially limits
466 major life activities only as a result of the attitudes of others
467 toward such impairment; or

468 (iii) Has none of the impairments defined in paragraph (1) of this
469 definition but is treated by a public entity as having such an
470 impairment.

471 May I draw your attention to (4)(ii): "...that substantially limits
472 major life activities only as the result of the attitudes of others..."
473 Therefore, "an impairment wrongly regarded as a disability" may indeed
474 substantially limit major life activities, and therefore may
475 theoretically require accommodation.>

476 <that is partly where regarded as having an impairment comes in even if
477 no impairment actually exists.>

478 <I'm the first poster!

479 I'm seeing both recent (last year or so) ed and psych evaluations which
480 list this as diagnosis (from NJ, from PA), and adult diagnosis, from
481 medical and psych professionals (mostly NY) which diagnose adults
482 within the last two years which include this with ADD, sometimes also
483 adjustment disorder.

484 We see very large numbers of L.D. kids (our primary focus) with 590
485 last semester and an expected 250 + for summer/fall, and only graduated
486 50 out. Virtually every third set of documentation I have seen in the
487 last three months has included OD or listed as the only condition. We
488 have two offices at CCM which give accommodation letters, and one of my
489 issues is : should these students be referred to the other office
490 (which does non-ld issues), shared, or are they ours? We are making a
491 case by case decision, which I know is the right way to do this, but
492 the number is mind boggling. I've seen three kids this week (with
493 attached parents) [with this diagnosis] for interviews, and if half of
494 what they have told me is true, I'd be ticked off at their school
495 systems too. So is it the kids? Is it the professionals? Is it the
496 school systems? Is it the parents?

497 My history teacher half wonders if this condition is really reflecting
498 the kid, or the attitude to the school system (or society)? I wrote
499 Marcia wondering if society, by sanctioning an attitude as a
500 disability, and therefore something to be accommodated, is actually re-
501 inforcing [sic] negative behavior? (the nuns would literally have
502 crucified me if I'd done some of the things I see in the
503 documentation!)

504 I've copied and forwarded some of the posts to my dean, and am enjoying
505 tremendously the stimulation of the discussion. Thanks to all for
506 participating!>

507 <The attempt to identify circumstances in which a person wrongly
508 regarded as having a disability might actually require an accommodation
509 seems something like a search for a hen's tooth -- you can look for

510 years without finding one, but there is always the possibility that one
511 is out there, waiting to be found. If other patrons of a public
512 accommodation or government institution interfere with the right of
513 someone wrongly regarded as having a disability to have access because
514 of their misperception, then they are violating the section 503(b) of
515 the ADA, but the operator/government is not. If the operator/government
516 protects other patrons from harassment, but declines to protect the
517 person wrongly perceived as having a disability from harassment, then
518 the operator/government is violating the ADA through intentional
519 disparate treatment.

520 Patrons may bring bad attitudes with them, but as long as the operator
521 does not single out people with disabilities and deny them protection,
522 or encourage others to harass them, then it is hard to see how the
523 operator can violate the ADA when others misbehave.

524 28 CFR 35.104(4) (ii) describes a problem that is hard to particularize:
525 a person who "[h]as a physical or mental impairment that substantially
526 limits major life activities only as a result of the attitudes of
527 others toward such impairment" I have difficulty identifying an
528 example of someone who has trouble walking, seeing, or breathing
529 because of the attitudes of others toward his impairment, so I suspect
530 that the real target of the that language is the person who is
531 substantially limited in the major life activity of learning or working
532 because of the attitude of others. Since the latter problem implicates
533 Title One, what is the real world example of (4) (ii) applied to a
534 public or private university?

535 I have no doubt that most of us would expect our schools to discipline
536 a student who repeatedly and seriously harassed a student rightly or
537 wrongly perceived to have a disability, but that has less to do with
538 disability law or antidiscrimination law than with generally enforced
539 codes of civil conduct. We don't limit the protection of our conduct
540 codes to members of protected classes. We would also expect the school
541 to act if the student repeatedly and seriously harassed someone because
542 he was ugly, or was the child of a convicted spy, or preferred
543 Gregorian chants to Staind.

544 Some of our students may shun students with disabilities; others shun
545 students of a different race, or students who like classical music, or
546 who play football. That is regrettable, but it does not mean that we
547 must modify policies and procedures to ensure that the shunners embrace
548 the shunned in the name of equal access. We can regulate conduct, but
549 we cannot regulate attitudes.

550 So where is this toothy hen? Can someone translate the hypothetical
551 need to accommodate a person who is wrongly regarded as having a
552 disability into a concrete example?>

553 <An example from reality.

554 A student in a professional school who is slovenly. The professor comes
555 to the person responsible for disability services and inquires whether
556 the student is disabled (which she is not). The professor then suggests
557 the student needs to be accommodated by a special clinical placement
558 where her slovenliness will not be regarded as unusual. In addition,
559 the professor suggests the disability coordinator provide assistance in
560 instructing the student in hygiene and appropriate attire. Of course
561 the disability coordinator instructs the professor that slovenliness is
562 not a disability (and points out that some of his peers are not the
563 most dapper dressers and have are "hair-challenged"). And, suggests to
564 the professor that part of the instruction for students in a clinical
565 program might be appropriate attire and decorum, etc.

566 Should this have been an accommodation - maybe - but what is the
567 physical or mental impairment - should she have been asked to go for
568 testing? So should many of the students. Every time someone acts
569 strange in class for an extended period of time I get an e-mail or they
570 pop in my office. When someone returns after a few weeks absence which
571 suggests mental health treatment I get reports and people asking "is so
572 and so on their meds?" (which always brings an irreverent response).>
573 <We recently had a student with the ODD diagnosis arrive here. More
574 than anything, he needs a coach, it seems to me. He needs to talk
575 things through and have someone to tell him "That's not appropriate;
576 Yes, you have to attend class and do your homework; No, you shouldn't
577 tell your classmates that you'll meet them outside to settle this
578 dispute...!" So I would say that's more counseling than accommodation,
579 but it tends to fall to this office if the student identifies
580 him/herself to us. This student has panic attacks, too. I'm not sure if
581 that goes along with the ODD. It, along with paranoia, seems to be a
582 very difficult condition for us to be successful with!>
583 <This will be my second posting request to this listserve, although I
584 try to make time to review most of the messages with timely topics, and
585 have appreciated the shift to the new format which seems to keep the
586 discussions to disability topics of merit. I recall something about
587 "personality disorders" not being disability conditions which
588 necessarily warrant academic accommodations, and am reviewing a mental
589 status report presented to this DSS office for a determination of
590 eligibility with this DSM 301.83 as the primary issue and no
591 medications other than amltiptyline. (I have of course already
592 requested some additional specific functional limitations information
593 from the service provider and contacted the regional ADA technical
594 assistance center.) Directions to pertinent resources and/or your
595 opinions would be greatly appreciated.>

Appendix H
Housing Policy

1 <I've been asked to do some research on housing policies regarding the
2 behavior of students. I explored the DSSHE archives but was unable to
3 find anything about this specific subject. I've been asked to review
4 language for a proposed housing statement. I have some problems with it
5 and I'm hoping for some input from the experts on the list. Any
6 thoughts,
7 resources, OCR/court cases and/or alternative wording would be greatly
8 appreciated!
9 "Any student whose physical or mental health might jeopardize the
10 safety
11 or well-being of that individual or any other resident may be required
12 to have an examination by a University physician or a consultation with
13 a University counselor. Should the physician or counselor determine
14 that a health or safety concern exists, the Director of Student Housing
15 and Residence Life or designee may amend or suspend the student's
16 housing contract, as appropriate.
17 The University reserves the right, at its discretion, to determine that
18 their medical condition, past behavior, and/or criminal activity is
19 such
20 that the best interests of the University, the student and/or other
21 students would best be served by alteration or cancellation of the
22 housing agreement. If the University becomes aware that a student has a
23 record of criminal convictions(s) or other actions indicating behavior
24 that could pose a risk to person or property and/or could be injurious
25 or disruptive to the residence hall community or the living-learning
26 environment, the University may not accept or may immediately terminate
27 the housing agreement.">
28 <Here is the problem as I see it. UNLESS you have asked ALL students to
29 disclose mental/physical/criminal past conduct as a requirement for
30 getting accepted to Xxx. Then you are singling out only the ones that
31 have
32 came to you to self disclose and document a disability [sic], for how
33 else would the college know anything about the student? So you have
34 tied on negative consequences to a self-disclosure [sic] requirement.
35 You might also burn your bridges as a place for disabled to go, out of
36 fear you will turn them in to the mental health police :-). But if on
37 the other hand, all students are required to report this, then I don't
38 see a problem. I believe there have been some big time law suits lately
39 by students that were raped/hurt, by others that the college had known
40 something about them.>
41 <The trick to this stuff is to stay focused on the behavior which
42 indicates a danger to self or others or is significantly disruptive.
43 Stay away from decisions based on the condition. This is how you stay
44 out of trouble.>
45 <Xxx, it seems like a sweeping statement, and invasive.
46 If there is a problem with any student whether they are in residence or
47 not,
48 I believe there should be one basic policy that is the same for all
49 students,
50 not singly out what appears to be students with disabilities.
51 I'd recommend that you duplicate the general policies of a Dean of
52 Students Office, e.g., for behavior issues. If there is a discipline
53 issue, it should

54 be handled just like every other student, with the policies that are in
55 place. Consider developing for the whole campus a withdrawal policy
56 initiated by the university. For example, the Director of the
57 Counseling Center, the Director of Health Services, the Dean of
58 Students could be a committee called together to review unusual student
59 circumstances where a department feels there is a question of safety
60 for the student and/or others. The Director of Residence could present
61 their case to them for determination of withdrawal from housing, for
62 example. Those are my thoughts this morning...>
63 <A big thanks to everyone who responded to my inquiry about the housing
64 statement. Happily, the housing office was very open to our suggestions
65 and concerns.>
66 <I have a student with a learning disability, ADHD, anxiety disorder,
67 and OCD.>
68 <Unless living in the residence hall is a requirement, I have always
69 wondered
70 why a person with specific aversions to being around people chooses to
71 live
72 in a communal environment, and that it is an expectation that the
73 institutions will change that environment to "support" the existence of
74 a behavior. I do have a strong concern for the roommate who would have
75 to put up with someone with OCD. Are one on one classes offered for
76 persons with social phobias?>
77 <Not a yes or no situation---it depends. I would get more information
78 from
79 the psychiatrist on how this disorder effects the student. You may
80 decide
81 to provide a single room to spare a student who may happen to be
82 assigned as the roommate. But as Dan says, in the order you received
83 the request. If
84 this is a freshman and your college has a requirement they live on
85 campus,
86 you may consider getting this requirement waived so the student can get
87 a single off campus. I have done this in the past and it was best for
88 the student as well as university housing.>

Appendix I
Out Counseling

1 <I would appreciate your advice and experience in this situation:
2 A student has a disability where the student lives in a separate
3 reality sometimes. It is unclear if the student understands information
4 from the
5 class because the student's answers do not reflect the subject matter
6 but
7 reflect the student's opinion. The student's behavior is bordering on
8 disciplinary action. The student wants to earn a degree but no one
9 would
10 hire the student in that field. What is the college's ethical
11 responsibility to tell the student that employers would not hire her?
12 Can
13 the college legally tell a student that?>
14 <The primary task of a college is to offer academic programs. Our role,
15 as providers is to make academic programs accessible to qualified
16 individuals. It is the role of employers to make decisions on hiring.
17 There are laws and regulations [sic] to be followed for operations,
18 procedures [sic], and compliance in every area. It would be out of
19 scope and highly judgemental [sic] for you to make a comment about
20 success for the individual.>
21 <I agree that it is not our responsibility to tell the student whether
22 or
23 not they will be successful at something (i.e. degree or career
24 choices)
25 and of course I think everyone here knows that our job is to provide
26 the
27 accommodations and not discourage students from going into a certain
28 field because of their disability BUT I also believe it is not our job
29 to encourage students to stay in a certain field if we feel they are
30 having a difficult time.... some institutions are criticized for not
31 doing enough for the students BUT I believe some should be criticized
32 for doing too much... how fair is it for us not as disability service
33 providers but as academic institutions as a whole to set some students
34 up for failure by just passing them in courses by giving them D's and
35 keep advocating for and giving them financial aid when they withdraw
36 from all their courses in the middle of the semester perhaps I
37 won't make many friends by saying such things on this listserv but that
38 doesn't mean they shouldn't be said.
39 The days that voc rehab counselors used to make those decisions for
40 individuals with disabilities are long gone but I still feel that
41 perhaps all options and alternatives should be available to these
42 students and although they should not be forced to get into a certain
43 field, best choices should be available to them based on their
44 strengths. Lets [sic] not push a four year college on a student if they
45 are
46 really interested in working and they may benefit from a trade school
47 or
48 associate degree. lets [sic] not say just because one does not have a
49 college
50 degree they couldn't pursue something else that is worthwhile. maybe
51 the question is not what is ethical but what is moral?>
52 <--Xxx commented [sic]:
53 some institutions are criticized for not doing enough for the students
54 BUT I believe some should be criticized for doing too much... how fair

55 is it for us not as disability service providers but as academic
56 institutions as a whole to set some students up for failure by just
57 passing them in courses by giving them D's and keep advocating for and
58 giving them financial aid when they withdraw from all their courses in
59 the middle of the semester perhaps I
60 won't make many friends by saying such things on this listserv but that
61 doesn't mean they shouldn't be said.--
62 ++++++

63 If teachers want to give pity grades and perpetuate a negative system,
64 then
65 that is their problem and smacks of some of the problems we face with
66 students comming [sic] to us as highschool graduates that have been
67 with IDEA, and a modified curriculum. But I am concerned about DSS
68 abusing their position! Untill [sic] we have the same information on
69 all of our students, that we require from the swd, and then require all
70 students to defend their reasons for being in college; then I think it
71 is not ethical to do "out counseling" just for those that are required
72 to self disclose and give us information like IQ results and Psych
73 reports. For some reason admissions qualified them to be part of your
74 student body, as any other student. The requirements for students to
75 get financial aide are minimal, and the whole system is fraught with
76 horror stories of students and swd. Again, this has no bearing on any
77 decisions.....>

78 <well I guess you misunderstood my email... I didn't say DS workers
79 were responsible I said the institution had a responsibility:) Faculty
80 and admissions and financial aid included!>

81 <I believe it's moral to trust the academic process to do its work. If
82 we've
83 assured access to the academic program, it's up to the program to
84 decide
85 who's qualified and who's not. When DS providers get into this, it
86 usually
87 means someone thinks they can choose for others. That's why vocational
88 rehabilitation has changed so much over the past few years. They used
89 to
90 play god with other people's lives. Now they're moving more and more
91 into
92 the proper supportive role the agency ought to play. DS officers should
93 take heed with this, for we, like vocational rehabilitation, have no
94 business making decisions about who's qualified. Our job is access, and
95 that's a big enough task in itself.>

96 <And I guess Jim I am going a step beyond ... what I am talking about
97 here is really questioning the academic process... you have faith in it
98 and I don't ... I see many students who move on to higher level courses
99 and have a hard time handling these courses and I have many
100 conversation with faculty who call and say "I can see this student
101 struggling so I feel bad about failing them" It is not my job as a DS
102 worker to stir students one way or another but I definitely see my job
103 in educating admissions and faculty pushing a student along just
104 because they have a disability.... I have a disability myself and I
105 would hate to think someone gave me an advantage just because of my
106 disability and not because of my ability....>

107 <Any given charity grade work is just as crippling as non compliance.
108 To place the resposibility [sic] of predictive success ignores the
109 developed adaptive tool [sic] one develops with having a disability.
110 It also creates a forced judgement [sic] decision over an individual.
111 We as service providers set up accommosations [sic]. It is up to

112 faculty to teach in a fair manner by allowing an accommodation and
 113 having reasonable expectation that an individual can and will do the
 114 work EVEN with the accommodation. Over time, if (hopefully not a big
 115 IF) a program is properly taught, an individual will either learn and
 116 assimilate -or- not learn effectively and not assimilate. It is a
 117 brutal filter, but an individual has to learn what can and cannot be
 118 done, even with accommodations. The impact of one course in a 120 - 150
 119 credit hour program is 1/60th of a grade point hour. This affects GPA
 120 is in the hundreths [sic](.01). the only exception is, If one is unable
 121 to function in a basic class, then the skills required will impact
 122 later altering GPA and success. so if an individual obtains one or
 123 maybe two inflated grades, the results would not hurt or help.>
 124 <Besides, out-counseling is specifically forbidden by 504. Paragraph
 125 84.47
 126 (b) of the regulations states that colleges and universities that
 127 provide
 128 personal, academic, or vocational counseling, guidance, or placement
 129 services to their students shall provide these services without
 130 discrimination based on handicap. In addition, institutions must ensure
 131 that qualified disabled students are not counseled toward more
 132 restrictive
 133 career objectives than are nonhandicapped students with similar
 134 interests and abilities.">
 135 <I tend to react viscerally to anyone who wants to tell me what is best
 136 for
 137 me (I fight authority and authority always wins), and for that reason
 138 alone, would be reluctant to counsel a student not to undertake a
 139 particular course of study. That said, I cannot help but note the
 140 incoherence of a regulation which prohibits discouraging a student
 141 whose disability hinders career objectives from pursuing those
 142 objectives unless I offer similar counsel to nondisabled students with
 143 similar abilities.
 144 When a career objective requires the ability to [fill in the blank with
 145 a
 146 major life activity], and the inability to [fill in the blank with a
 147 major
 148 life activity] makes that student a person with a disability, what
 149 exactly
 150 is a nondisabled student with similar abilities? Almost by definition,
 151 the set of nondisabled students with similar abilities is the null
 152 set.>
 153 <Then train the faculty, but remember it's their call. The idea,
 154 however,
 155 that someone placed in a position of responsibility to advocate for
 156 students
 157 with disabilities should
 158 a: advocate anything other than allowing the student to prove or
 159 disprove whether they are indeed "otherwise qualified;" and
 160 b) allow their personal opinions/feelings about the faculty's
 161 ability
 162 or willingness to determine this through the rigors of academic
 163 pursuits
 164 is in danger of crossing irrevocably the line dividing moral and
 165 immoral, ethical and unethical practice. We are not in control of
 166 everything, and it
 167 is our daily task to remind ourselves of this. What's more, the
 168 quickest

169 way to get a spanking on this campus, and to seriously damage the
170 credibility of this office is to get into the faculty's realm. Would it
171 be
172 different if we were working to exclude, rather than include students?
173 Very
174 likely, they'd be patting us on the head. Hold the instructors
175 accountable,
176 and make them hold students accountable.
177 The ringing example in my mind is the white teacher who told Malcolm X
178 that he should not pursue a career in the law, but be realistic and
179 become a carpenter. He told him this for his own good, and I suspect,
180 as Malcolm
181 suggested, that he really wanted the best for him. He apparently
182 figured it
183 was his ethical/moral duty to help the kid understand the realities of
184 the world. After all, he may have thought, if he didn't, wouldn't the
185 knocks be much harder later?>
186 <--Mike asked:
187 That said, I cannot help but note the
188 incoherence of a regulation which prohibits discouraging a student
189 whose
190 disability hinders career objectives from pursuing those objectives
191 unless
192 I offer similar counsel to nondisabled students with similar abilities.
193 When a career objective requires the ability to [fill in the blank with
194 a
195 major life activity], and the inability to [fill in the blank with a
196 major
197 life activity] makes that student a person with a disability, what
198 exactly
199 is a nondisabled student with similar abilities? Almost by definition,
200 the set of nondisabled students with similar abilities is the null
201 set.--
202 +++++
203 People choose to go to school for all the wrong reasons. As counselors,
204 teachers, advisors, or DSS we can intrinsically or intuitively pick out
205 students who "we just know" are not going to make it, or picked the
206 wrong
207 major, simply because there is "something" about them. SWD as well. But
208 Because of the self disclosure process inherit in DSS, I don't feel
209 this
210 should make the swd a target for "special" career advice from us
211 because we
212 happen to have more information on them than the run of the mill
213 student, or because we have misplaced codependency issues. Untill [sic]
214 all students are
215 required to sit down and defend their choice of college and major or
216 job,
217 during the application process; then I think it is a hands off
218 approach to swd and their choices, good or bad, as we perceive it. The
219 same would hold true for teachers and advisors. I assume we all get
220 this alot, "you should be more realistic with your students!" Don't
221 you just love how they become "our students"!>

Appendix J
Expertise

1 <Yesterday, Xxx offered this as part of his post re: forced LD
2 assessment:
3 --Again, as mentioned by other practicing therapists, It is difficult
4 to assess an adult. The method is assessed learning level must be two
5 percentiles (of the age general age population) below an IQ. To get
6 into college means skills are completed at near or above 2 percentile.
7 A 2 percentile is roughly 3-4 grade levels (sorry for the over
8 simplification), and the average 17 year old would place grade age at
9 about 8th (13-14). This is essentially what the TCAP (Tennessee)
10 graduation test does, so a tennessee [sic] graduate with TCAP should
11 have trouble testing into a Learning Disorder. Other factors lack of
12 Culture, behavior, learning & below 80 IQ prevent the diagnosis.
13 Physical disabilities (hearing-Vision) must be factored in and the
14 assessment under axis III.--
15 THERE ARE SO MANY THINGS WRONG WITH THIS STATEMENT THAT I DON'T KNOW
16 WHERE TO
17 START... and I don't have the time or energy to be bothered. But when
18 such a blatantly misinformed post goes up on the list and doesn't get
19 challenged, I worry greatly about the many new folks out there who have
20 joined and follow our extensive discussions in an effort to learn how
21 best to help the swd on their campus. I worry that because they see it
22 in print (on screen?) on the list, they believe it must be true.>

Appendix K
Stereotype

1 <I am working on article about working with students with psychiatric
2 disabilities. Service Providers have told me (and I know first hand)
3 that
4 students with psychiatric disabilities often need more help or want
5 more help
6 then a system can or maybe should, provide. I would like to talk to
7 some
8 folks about how they provide services, how they set boundaries, what
9 other
10 help they enlist and also what kind of committees or teams exist on
11 campuses to address the needs of this student population. I would like
12 to talk to
13 some student service administrators, counseling center types and people
14 in
15 mental health agencies on campus---all in the vein of how they work
16 with DS providers to solve problems and make plans. If you could
17 recommend people on
18 your campuses who wouldn't mind talking about these issues i would
19 appreciate it.>
20 <I've been thinking about this post since yesterday and I have a couple
21 of general questions for the listserv regarding the issues surrounding
22 the situation Xxx has described.
23 Essentially, if I read the post correctly, no less than a psychologist
24 has indicated the individual's psychological profile is invalid. Does
25 that mean there is NO psychiatric diagnosis? And, if that is so,
26 without a diagnosis of a limiting psychiatric condition and with no
27 medical verification of a limiting medical condition (other than
28 diabetes), what is there to accommodate?
29 As DSS professionals, we depend on the documentation to establish
30 eligibility for services and guidelines into what supports and
31 auxiliary
32 aids are needed, appropriate, and effective. How do we justify
33 setting aside documentation that essentially says there's nothing to
34 accommodate in order to provide services anyway? What are the
35 implications of this action in relation to how we coordinate supports
36 for students with bona fide documentation who ask for accommodations
37 that are not supported by this documentation?
38 Privately, I've posted Xxx that she might look further into whether
39 or not somatoform disorder is a valid diagnosis. Meanwhile, I'd like to
40 remind the list that isn't unheard of for someone to fake a disability
41 as happened this academic year in one of Indiana's universities.>

Appendix L
Mental Health Professionals?

1 <The Director of Housing contacted me to consult about student with a
2 disability who has requested a single room. Our freshman class for fall
3 2001 is very big and housing is at a premium. Since our residence halls
4 don't have any single rooms, this means that a double room will be used
5 as a single room. The housing director wants to do the "right thing".
6 The student provided documentation with a diagnosis of adjustment
7 disorder with mixed anxiety and depression. She was diagnosed in 1995
8 and she has had ongoing counseling since that time. She has tried
9 medications at times but is not currently on any medications.
10 Her symptoms include: frequently tearful, anxious, rapid speech
11 depressed mood and increased sensitivity to change. Her documentation
12 states that change is very hard for this young woman. She has insomnia,
13 concentration and sleep related issues due to the anxiety. It also
14 states that the student is easily distracted, needs predictability,
15 quiet and extra time to focus her energies and attentions.
16 The doctor states that a single room would be a great benefit to her
17 from both a medical and psychological standpoint.>

18 <It is finals week here so this sounds like most of the students on my
19 campus. That last statement was not meant to be flippant. Despite the
20 psychologist's use of DSM4isms this is a relatively common problem that
21 is usually short lived. It does not in many cases rise to the level of
22 a disability but an interview and perhaps a GAF score will let you
23 determine that. I am not sure that legally, developmentally or
24 therapeutically giving this person a private room is the "right thing"
25 to do. If the goal or "right thing" is to reduce the student's anxiety
26 the private room might indeed help but I think we have some higher
27 goals as well. I will now patiently await Xxx's opinion. [This is the
28 second time this week I have come out against a private room and I'm
29 from a large Catholic family.]>

30 <I have the impression both from the list and from talking to
31 colleagues around the country that at any number of schools, the ADA
32 and section 504 have become the ticket to single rooms, with the ticket
33 filled out by a health care provider diagnosing the need on the basis
34 of a psychological impairment.
35 I wonder whether a freshman who cannot cope with change should be
36 attending an institution whose very purpose is to stimulate the
37 possibility of change through exposure to a host of new ideas and
38 experiences. Residential colleges have never attempted to replicate
39 high school; they offer, and for freshman and sophs often require on
40 campus residence to expose them to the kinds of experiences that home
41 life cannot offer. A student who cannot cope with the kinds of
42 experiences that routinely arise when living with others in a dormitory
43 may well be better advised to attend a community college than to
44 attempt to convert a residential college into an extension of home.
45 There will be circumstances which require a private room; I am far from
46 certain that this is one of them.>

47 <As usual I have more questions than comments. (Of course the questions
48 are simply a thinly veiled rhetorical device to make my comments- also
49 as usual)

50 Xxx said in her post that the college offered no singles. If that is
51 true then it would be considerably easier to defend a decision to say
52 no. Consistency counts to OCR.

53 I am not sure if the student's condition reaches the definition of
54 disability we have inherited from Sutton. Like Xxx, it seems unlikely
55 that a court would say so from what was shared in the documentation. On
56 the other hand we are not a court and I hope we would want to consider
57 what is right and in the spirit of the law not just "black letter law".
58 Both Xxx and Xxx spend some time on what the GOALS of residence hall
59 programs are. Is there information on the Residence Life Program that
60 sets its goals and mission as something other than a place to sleep?
61 Is there discussion of "learning to live in a community", "exposure to
62 diverse cultures and individuals" or other educational, co-curricular&
63 developmental themes?
64 The answer to that last question is the key point for me. If an
65 experience has been designed in a programmatic or purposeful way - Then
66 a single undercuts a legitimate educational goal of a residential
67 experience and is not reasonable.
68 I think most student affairs divisions are moving towards these
69 residential programs and learning communities rather than providing
70 dorms. For those residence life programs (rather than some coincidental
71 programming in a Dorm) it does raise the bar on making those programs
72 accessible by making the building accessible. This may include basic
73 access (ramps, elevators, bathroom dimensions, ...) but should also
74 include considerations for larger rooms to be shared when one student
75 needs more space for adaptive equipment or perhaps more space to create
76 some additional level of privacy within a shared room.>
77 <My sentiments exactly. Too many students fit this profile. As a
78 counseling psychologist I help them adapt to college life, many with
79 these very symptoms. A single room does not seem a reasonable
80 accommodation. If single rooms were easy to come by, I would suggest
81 the student aim for one, but that is the most I would do.>
82 <Excellent points, Xxx! I agree, as well (for whatever that is worth).
83 Just wanted to clarify that we in the community colleges are also not
84 trying to replicate high school. We do tend to be commuter institutions
85 and many students continue to live at home while commuting.
86 Experiencing life in a dorm setting during undergrad years contributes,
87 of course, a very meaningful part of the total personal growth for
88 budding academics on college and university campuses. That may be
89 something that community college students, those in the early
90 undergraduate years, miss (on the other hand, our campuses are
91 unencumbered with the hoop-la and distraction of big-business sports
92 extravaganzas, or binge drinking Greek lodges). From my observations
93 when my daughter was a freshman living in a dorm (UC Davis), it was
94 amply provisioned for social interaction and dorm meetings formal and
95 otherwise, and marginally appropriate for study (some may recall the
96 importance of libraries for study, for example). Resident hall life, of
97 course, has enormous value, whether or not structured as some "program"
98 with well outlined pedagogical objectives, as suggested by Scott
99 (Sorry, Xxx, as your other points are also well presented).

100 Places for study? On this community college campus, we have a
101 marvelous library, study nooks here and there and a half dozen
102 "learning labs" in various academic divisions. I spend a considerable
103 effort persuading my students to use them! And they do, by the way.
104 But the self discipline required is nothing like anything that would
105 replicate a high school experience (much of which was not well crafted
106 for college transition, for my SWD). Just a note from a community
107 college perspective (chuckle)>
108 <The issue came up several months ago regarding the "need" for a
109 single, and a question was posed, not answered, but it could be

110 important in making some determinations. Are students required to live
111 on campus or do they have options? Or is it an expectation that the
112 University is obligated to provide housing for all students. Is there a
113 further expectation that all individual needs must be met by the
114 University. It is a matter of expectations, what families are led to
115 believe and are or have been treated (specifically K-12) and that a
116 diagnosis, in and of itself, is sufficient to warrant accommodations.
117 What bothers me the most is an expectation that the institution will do
118 everything to meet "needs," and students are not expected to make any
119 adjustments or compromises. Expectations are a big peeve of mine,
120 because they seem to change without discussions ever occurring.>
121 <I have a situation where a school psychologist is indicating to us
122 that a
123 student's disability [dysthymic disorder, DSM 300.40] has not changed
124 in
125 almost five years and that is unreasonable for our college to request
126 an updated evaluation. The documentation submitted stated this as the
127 student's primary disability. Can a school psychologist make this
128 determination? Or would a licensed clinical, counseling psych or
129 psychiatrist be more appropriate??>
130 <Is the school psychologist the primary care provider? I doubt it. Has
131 the student been provided any mental health care in the past five
132 years?
133 If so, they must be records. The school psychologist might be able to
134 make the diagnosis but I question what their true credentials are. Do
135 they have a professional license? If not, then they can't make that
136 determination.
137 It is not the school psychologist or any other professional's right to
138 tell us what is reasonable or unreasonable. That is our determination.>
139 <Check out this website:
140 <http://www.psycom.net/depression.central.dysthymia.html>.
141 There's lots of info about this disorder, including the diagnostic
142 criteria from the DSM-IV. There is so much that must be ruled out or
143 alternate possibilities explained and information about meds, etc. -
144 ask the school psychologist if s/he can address all those items. Like
145 Xxx just said, it's possible that s/he cannot!>
146 <as soon as I sent the request out I realized that it could be implied
147 that I was dismissing/questioning this professional's credentials...and
148 that was not my intent. I do apologize to you and the rest.
149 p.s. my concern was the timeframe of the diagnosis and that
150 this psych had not interviewed the student.>
151 <School psychologists can make this determination if they are also a
152 licensed psychologists, which they can be. The reason that I say that
153 is because here in Texas we have Licensed Specialists in School
154 Psychology who have a master's and would not be qualified to make that
155 determination. The school psychologist can also be the mental health
156 care provider, again if they are a licensed psychologist.>
157 <The recency [sic] issue is the salient one here from my perspective
158 [sic], not the credentials of the psychologist per se. Psychiatric
159 diagnoses change
160 over time, especially mood disorders and especially in adolescents. I
161 would not accept documentation which 5 years old for a psych disorder.
162 The next issue would be severity, as by definition dysthymic disorder
163 is mild.>
164 <As some of the other responses have indicated, the school psychologist
165 may

166 also be a licensed clinical psychologist and qualified to make the
167 diagnosis. As a psychologist, I would need for current mental status
168 information. While dysthymia tends to be a chronic condition, it can
169 improve over time with or without therapy. I would require a
170 reevaluation.
171 Just because the student was dysthymic five years ago doesn't mean
172 he/she
173 is now.>
174 <But Xxx, he did receive a follow up from the school psych stating that
175 there has been no change in the last five years, and the psych is also
176 questioning the validity of the a [sic] re-evaluation in this case. As
177 I saw it the only recourse would be to deny the student's request
178 outright. Or to
179 secure and pay for a current evaluation at the schools expense. do you
180 see it this way from your schools policies. And wasn't this an issue in
181 the "big case" a few years ago?>
182 <Query: Why would a student with dysthymic disorder be a person with a
183 disability? Doesn't the defintion [sic], which differentiates
184 dysthymic
185 disorder from major depression, virtually rule the former out as
186 substantially limiting a major life activity?>
187 <It is not clear from the original posting that he received a thorough
188 clinical re-assessment, only that the school psychologist asserts the
189 condition has not changed in the last 5 years. I would want to see a
190 thorough re-assessment by a mental health professional which
191 establishes his current clinical condition. Especially since dysthymia
192 is not really disabling. If it is, it gets pumped up to a diagnosis of
193 major depression. And no, this was not the issue in the "big case", as
194 you and the list well know.>
195 <I would like your input on a situation I have with a student on our
196 campus. He has not attended class in over a month and is requesting
197 that he test in a separate room away from everyone. He believes he can
198 pass all his exams without a problem if only he can test in a secluded
199 area. One of his professors has granted his request, but he wants
200 assistance in convincing the other three.
201 His documentation consist [sic] of a copy of his actual Rorschach.
202 There is
203 no diagnosis or a letter from the psychologist with additional
204 information. He did send a copy of his psychological evaluation from
205 when he was six years old (he is currently 19 years old) and he is
206 diagnosed with Anxiety Disorder but does no academic recommendations
207 were made on this evaluation.
208 I believe I already know what I need to do, but since I am just
209 returning to disability services (having been away from it for almost
210 four years) I really need your assistance.>
211 <Without an update on the documentation, with diagnosis and statement
212 that this is a disability, you can't do anything. You don't have the
213 documentation to back up giving this student any accommodations at all.
214 It also might not be a bad idea to find out why a professor would give
215 him accommodations without any evidence of a disability, since doing
216 that certainly would open him to complaints from other students. It
217 also puts you in the position of being the bad guy when you have to
218 deny
219 this accommodation, and that's a hard place to be. Just remember that
220 the student has set this up by not following the procedures, and the
221 OCR
222 would back you up all the way on this if he complains.>

223 <I don't think you have enough information/documentation to qualify him
224 as a student with a disability. Refer him back to his doctor for an
225 update and
226 tell him he is on his own in negotiating with his teachers. But I can't
227 believe any teacher would simply let him register, and take tests in a
228 secluded area, and not attend the class. That sounds like a fundamental
229 alteration of your instructional delivery system even if his anxiety
230 raises to the level of an ADA disability.>
231 <You might try offering the requested accommodation on a provisional
232 basis while the student secures evidence of a disability and its
233 impact. Be sure to set a time limit up front so that the provisional
234 doesn't turn into something more permanent. Asking for a quiet place to
235 take exams sounds like a very reasonable accommodation to grant, and
236 it's highly unlikely such an accommodation would provide a benefit to
237 anyone except for a person with a disability. All this stuff about no
238 documentation, no accommodation may fall within what is legal, but,
239 darn it, DS folks don't have to be so hard-nosed all the time.
240 Sometimes we should do what what's right by the student, especially
241 when no harm stems from a simple modification.>
242 <I would like your input on a situation I have with a student on our
243 campus. He has not attended class in over a month and is requesting
244 that he test in a separate room away from everyone. His documentation
245 consist [sic] of a copy of his actual Rorschach. Seriously, your
246 instincts are correct.>
247 <Xxx writes:
248 " All this stuff about no documentation, no accommodation may fall
249 within
250 what is legal, but, darn it, DS folks don't have to be so hard-nosed
251 all the time. Sometimes we should do what what's right by the student,
252 especially when no harm stems from a simple modification."
253 Wow Xxx, what are you smoking out there in Montana? I've never seen
254 this
255 new kinder and gentler side come out in your posts before :-)
256 While a temporary accommodation might be appropriate in some cases, I
257 don't think this is one that fits the bill, and would definitely open
258 one up for a lot of problems. As I understood it, the student had quit
259 going to class for a whole month, and was just asking to be able to
260 take tests, and I assume continue to not go to class. Plus do this for
261 all his classes, future ones too! So now we are looking at alternate
262 test site, and a waiver of attendance. If this is the case, then I
263 wouldn't touch this with a ten foot pole, without a room full of very
264 appropriate documentation. and would probably still deny it as not
265 reasonable and a fundamental alteration.>
266 <I'm not smoking anything, really. But your post made me go back and
267 look at the original question. According to the original post, the
268 student claiming to have an anxiety disorder asked to be tested in a
269 quiet room. There was no request for modification in attendance
270 policies. My point is that testing in a quiet place just isn't all that
271 big of a deal, so lighten up on the call for documentation and grant
272 the request provisionally. Had there been a request to modify
273 attendance policies, my advice would have been to get the necessary
274 evidence of disability and its impact. We've got to apply a little
275 common sense in what we do. Some accommodation requests merit going by
276 the book, especially when it comes to messing with attendance,
277 curriculum, and other essential academic functions. But testing in a
278 quiet room is a tiny thing. Plus, I'm cynical enough to believe that
279 getting a diagnosis of a general anxiety disorder, not otherwise

280 specified, just isn't all that hard to get. The diagnostician will
281 listen to the student, rule out other possibilities, and anoint the
282 person with the necessary documentation. Then the busy bees in DS land
283 can get the honey flowing. So why not get cracking with granting a very
284 reasonable request while the student gets the label? Of course, there
285 should be a time limit on the provisional accommodation. WE should
286 expect the student to provide the evidence because the evidence will
287 assist the student in meeting his goals, not to mention crossing out
288 one more item on the DS officer's to do list. Again, if the request
289 were to modify attendance policies, my approach would be more strict.
290 It's all about the links we can establish. We can establish many a link
291 without paper evidence. And we sure can provide very reasonable
292 provisional accommodations while the student seeks out diagnostic
293 information and treatment.>
294 <Can I suggest the simple solution of recommending that the student buy
295 some cheap ear plugs and be able to independently resolve their
296 problem.>
297 <"Quiet room" implies more than just lack of noise, in my estimation.
298 It also
299 means lack of movement, such as students shuffling around in their
300 seats,
301 writing movement, paper movement, students getting up to turn in their
302 tests etc. One of the most difficult things for students with anxiety
303 disorder is
304 other students who finish quickly, or before the student with the
305 disability. This can cause added pressure/anxiety as the student with
306 the anxiety disorder begins to worry about the fact that others are
307 finished, will they have enough time to finish, why are others
308 finishing while I'm still in the middle of the test and all sorts of
309 other distracting thoughts.
310 I would give the student interim accommodations while they begin the
311 process of obtaining documentation. What's the worse that could happen?
312 One student
313 received a quiet room to test in, but didn't meet all the criteria for
314 a
315 documented disability?>
316 <Good one Xxx, I recommend that so much to all my students during a
317 study skills/test taking workshop. And especially to ADD students. I
318 had one
319 student show up to take their test with sound headphones, like what an
320 airport worker would wear out on the Tarmac. The professor wouldn't let
321 him wear them because he thought it was a radio and someone would send
322 him
323 the answers :-) I also tell students to sit in the back row and turn
324 their
325 desks around to face the back wall, but again the professors get upset
326 because they think the students are doing something wrong. Some live in
327 little teeny tiny worlds :-)>
328 <Sometimes the anxiety manifests itself in different manners. I had a
329 student with an anxiety disorder who was not in the least disturbed by
330 other students in the class taking tests. But taking the test would
331 create a
332 level of anxiety that needed to be "released" when the exam was turned
333 in,
334 so the student would neatly re-arrange all of the chairs in the
335 classroom.

336 The only problem was the student was usually first to complete the
 337 exam. We
 338 proctored all exams after that and had our testing room re-arranged
 339 many
 340 times and ended up with a very functional design.>
 341 <I actually had a student one time whose anxiety on tests was triggered
 342 by the quiet in the classroom. She wanted background noise, as in an
 343 office setting. She provided documentation from a mental health
 344 professional corroborating the anxiety and the need for the
 345 accommodation. This was the
 346 only accommodation she requested. We generally administered her tests
 347 in our office, with the door to the testing room open.>
 348 <A couple of weeks ago I posted a question about test anxiety. Most
 349 agreed with me that I did not have enough documentation and that "test
 350 anxiety" is not a real diagnosis. I wrote the student back and told her
 351 she didn't qualify for services based upon this diagnosis alone. The
 352 psychologist sent us an addendum that states:
 353 "She exhibits behaviors and history characteristic of Specific Phobia,
 354 Situational Type (DSM Code 300.29). Her specific fear is cued by a
 355 specific situation (taking math exams). Student recognizes her fears to
 356 be excessive or unreasonable, cued by the anticipation of the testing
 357 situation. She has endured this situation with intense anxiety and
 358 distress with panic attack symptoms (pounding heart, palpitations,
 359 trembling, sweating, nausea, etc.). Her distress in the feared testing
 360 situation interferes significantly with her academic (math) functions,
 361 and she is substantially limited in her evidencing her true math
 362 ability due to this specific phobia. Her specific phobia reaction
 363 occurs every time she takes a math exam." Okay, what do you guys
 364 think?>
 365 <Phobias and panic attacks can rise to the level of a disability. We
 366 usually allow accommodations (usually time and a half) and strongly
 367 encourage continued treatment since they are "curable", through
 368 desensitization and possibly medication.>
 369 <Is this an accommodation or a therapeutic intervention? How does
 370 extra
 371 time, a different location or any *reasonable* accommodation eliminate
 372 the fear of a math test? It is still there in front of her, same
 373 questions, same expectation (show your work and answer) regardless of
 374 where she is and how long it takes to complete. Based on what the
 375 therapist has noted, the only way to effectively avoid this reaction is
 376 not take math courses (at this particular time) which have the normal
 377 class activity known as tests.>
 378 <This is not my typical starting place but the psychologist's
 379 statements
 380 begs it to be asked, Is the inability to take a math test or to
 381 "evidence your true math ability" a major life activity? That said, I
 382 will fall back on the more common question. Let's assume that this is a
 383 disability [sic], what accommodations can reasonably be expected to
 384 address the situation? Extra time? I am not sure why based on the
 385 information below. Waiving math, possibly but unlikely to be
 386 reasonable.>
 387 <Accommodations may not ELIMINATE the fear of a math test or the
 388 anxiety, however, isn't it possible the accommodations may REDUCE the
 389 effect of the anxiety? How is that any different than the use of a
 390 Kurzweil 1000? The Kurzweil won't eliminate blindness but will reduce
 391 the effect of blindness.

392 You may wish to read "Accommodations for Test Anxiety Under the ADA?"
 393 by G.E. Zuriff - The Bar Examiner, February 1999 or an earlier
 394 version in the Journal of the American Academy of Psychiatry and the
 395 Law, 25 (2): 197-206 (1997)>
 396 <"And how does extended time alleviate the anxiety?"
 397 I don't know but why not ask the student how it alleviates the anxiety?
 398 "... but how is anxiety specific to math tests an impairment....?"
 399 As we all know, anxiety is a disorder and with some it may manifest
 400 itself
 401 in a specific way and at a specific time (math included).
 402 Xxx ... your discussion of extended time is another discussion. The
 403 subject here is test anxiety. It's late and I am not cranky.>
 404 <Hmmm, almost sounds as if it had been dictated by the student...We
 405 recently
 406 had a student drop off a two line letter of "documentation" from a
 407 physician
 408 who said because of the student's TBI, she should be given open book
 409 tests in her nursing courses. Not in any other courses mind you, but
 410 only nursing.
 411 So my assumption (remember the first three letters of that word!) was
 412 that
 413 the TBI only affected her nursing course memory and none of the rest of
 414 her
 415 classes would have been affected by the short-term memory loss. (LOL).
 416 I
 417 seriously suspect that your example sounds like the student told the
 418 psychologist what to say. If it were I, I would follow up with the
 419 psychologist directly and ask some more direct questions & ask some
 420 clarifying questions, for example, does the phobia ONLY manifest with
 421 math?
 422 What about chemistry? Or economics? How 'bout a course in logic?
 423 Does the student have any other supporting documentation of
 424 experiencing phobias in the past (test anxiety in math)?
 425 What is the student requesting in terms of accommodation? Extended
 426 time? A private room? Some other, more complicated accommodation?>
 427 <We have a similar situation. A student has been diagnosed with anxiety
 428 w/ panic. The student says that having extended time reduces her
 429 anxiety
 430 (even though she may not actually use the extra time) and says when she
 431 does not have the accommodation that alone triggers panic. Any thoughts
 432 about that?>
 433 <I can tell you from personal experience that for some people it isn't
 434 the math that is the problem it is the time pressure. Unfortunately,
 435 beginning in elementary school math is often taught and practiced with
 436 an emphasis on speed, and this can create anxiety in some people. I
 437 can still remember the physical sensation of anxiety that I had when a
 438 teacher would pull out a stop watch for math fact drills. I never
 439 remember reading or writing being taught with a stop watch. They may be
 440 tested under timed conditions, but they are not usually taught this
 441 way. Fortunately for me, my math skills were good enough that the
 442 anxiety didn't get the better of me.>
 443 <My experience with students who come in with panic attacks and phobias
 444 is
 445 that they have problems with focus and concentration (anxiety depletes
 446 blood
 447 flow in the frontal lobe---sound familiar?). In the behavoir [sic]
 448 modification treatment (desensitization) they begin to train their

449 bodies to rapidly respond to deep breathing to relax while exposed to
450 the thing that triggers the panic (snakes, heights, math tests??). This
451 isn't hocus pocus
452 stuff---been around for decades. In another life I was a psychiatric
453 social
454 worker; this was successfully used for many patients.
455 I agree with the folks who do not accommodate for test anxiety. If
456 there is
457 a diagnosis of a phobia or panic attacks (clinical term escapes me at
458 the
459 moment) we will work with a student while they are learning to control
460 the
461 symptoms [sic] that can interfere with academic settings---such as
462 focusing on a test. We all tell students to takes walks, deep breathe,
463 etc. before tests
464 they are anxious about ("get the blood flowing so you can remember what
465 you
466 do know"). For those that have a severe diagnosed condition, 50% more
467 time
468 to get control seems reasonable to me. We do require updated
469 documentation
470 each semester for these students since these are conditons [sic] that
471 respond well to treatment.>
472 <From the GW case:
473 Tests are the gatekeepers to ever higher levels of learning, not
474 just in the field of medicine, but in almost every field. An inability
475 to demonstrate competency on tests due to a serious, longstanding
476 impairment, such as plaintiff's dyslexia, could block an individual
477 from
478 attaining success in a variety of ways in both education and the
479 workplace. Cf. McGuinness v. U. of N.M. Sch. of Med., 170 F.3d 974,
480 978-79 (10th Cir.1998) (holding that a mere anxiety associated with
481 taking science tests that could be mitigated through study habits did
482 not rise to an ADA disability and that such a subject-specific anxiety
483 that apparently limited just one career, medicine, did not
484 substantially
485 limit the plaintiff's learning). Therefore, whether test-taking is
486 itself a major life activity or a crucial component of the major life
487 activity of learning, the court concludes that a plaintiff with an
488 impairment that substantially limits her ability to perform on tests
489 has
490 an actionable ADA claim.
491 the difference as I see it is that your student seems to be requesting
492 accommodations for all tests. While Judy's student is requesting Math
493 only. I see this to be the problem with anxiety being considered an ADA
494 disability and determining what the significant impact is on learning,
495 compared to their peers. College Math classes at best probably have
496 about a 60% success rate for all students. Some like applied calc can
497 dip to a 35% rate. This alone is cause enough for all students to
498 experience temporary anxiety and panic attacks :-). To only give
499 accommodations to one, because a Dr. writes that she has anxiety/panic
500 attacks when only taking math tests, I think is an unfair advantage. I
501 do have students here with anxiety, some are receiving accommodations,
502 some are not. I also look to documentation in regards to medication
503 being perscribed [sic] and how that affects the student in the
504 classroom. In some cases I am really accommodating the medication, not
505 the anxiety :-)>

506 <I understand your reasoning, but is there any other disability that we
 507 monitor treatment outcomes on and require documentation for each
 508 semester? The same reasoning --- that treatment may cause improvement
 509 from one semester to the next---could apply to many disabilities.
 510 Therefore, I prefer to treat anxiety like any other psychological
 511 disorder and require yearly documentation.>
 512 <We have asked for updates on conditions that can change----such as
 513 psychiatric and TBI, some medical conditions such as Chron's [sic]. But
 514 you are right, this is more on a yearly basis. This is not a usual
 515 occurrence [sic], but we do it when the student is in treatment or
 516 improving---so that we know how the condition/disability impacts the
 517 student at that time. For panic attacks, severe anxiety and the like, I
 518 am not comfortable establishing an accommodation for several semesters
 519 when it could just impact for the one
 520 semester or year. Sometimes, the diagnosis is enough and we work with
 521 the
 522 student on how it impacts them at any given time---fibromyalgia comes
 523 to
 524 mind when the cold weather can be brutal to them.
 525 We also do it for students who have a condition that is becoming worse,
 526 such
 527 as cancer, AIDS and so on when we may need to provide more
 528 accommodtions [sic].
 529 We try and meet with the students each semester and develop
 530 accommodations
 531 appropriate to each class---the same letter does not suffice for each
 532 class for all students. For the most part we rely on students to give
 533 information
 534 on impact [sic] of their disability once adequate documentation is
 535 obtained---but
 536 for some we may need updated documentation. This may not be feasible on
 537 some campuses due to the volume of students you work with---I didn't do
 538 it when at Clemson when we had close to 800 students with two of us.>
 539 <It is Friday, and I am feeling argumentative (obviously). I just
 540 couldn't
 541 resist jumping into the fray...
 542 Xxx said:
 543 --Is this an accommodation or a therapeutic intervention? How does
 544 extra
 545 time, a different location or any *reasonable* accommodation eliminate
 546 the fear of a math test? It is still there in front of her, same
 547 questions, same
 548 expectation (show your work and answer) regardless of where she is and
 549 how long it takes to complete. Based on what the therapist has noted,
 550 the only way to effectively avoid this reaction is not take math
 551 courses (at this particular time) which have the normal class activity
 552 known as tests.--
 553 and Xxx rightly pointed out that the purpose of accommodations IS NOT
 554 to
 555 eliminate the problem -- it is to mitigate the impact of the problem on
 556 the
 557 functioning [sic] of the individual. If extended time in a quiet,
 558 proctored setting helps the student to cope with or lessen her panic
 559 attacks (which is NOT the problem, but her RESPONSE to the problem),
 560 then it is no different than (as Xxx suggested) a Kurzweil for a blind
 561 student (that helps her cope with printed material), or a voice

562 activated keyboard that helps a quadriplegic student cope with his
 563 limitations in speed and dexterity.
 564 Meantime, Xxx said:
 565 --This is not my typical starting place but the psychologist's
 566 statements
 567 begs it to be asked, Is the inability to take a math test or to
 568 "evidence your true math ability" a major life activity?--
 569 One of the few times that I find myself at odds with Xxx. Just as Xxx,
 570 in his later post, scoffed at the idea of anxiety specific to math
 571 tests as a qualifying condition for protection, Scott seems to be
 572 limiting his view
 573 of what constitutes a major life activity to the act of taking a math
 574 test (it IS impacted, but so what?) instead of taking a larger view.
 575 For this
 576 student, I would argue that one of her major life activities at this
 577 point in time and space (!) is that of being a college student. In
 578 order to continue with that major life activity, she has to pass her
 579 classes, including her math class. If her limitation is such that it
 580 substantially limits the "condition, manner, or duration" of her
 581 performance in the act of being a college student (and it seems to me
 582 that she has provided some fairly straightforward evidence of that),
 583 then why would we NOT want to look at what kind of accommodation we
 584 might provide that would be helpful in providing full access? Can I
 585 make that argument on sound legal footing? Probably not. But is it
 586 GOOD PRACTICE in the context of being a disability service provider? I
 587 think so.
 588 Xxx then presented his concerns about providing extended time for
 589 tests.
 590 It is an argument that he and I have cyclically, both on and off the
 591 list.
 592 Allen is right -- it is a full argument for another time and place, but
 593 in the context of THIS PARTICULAR (fact-specific) scenario, I simply
 594 can't let a chance go by to score a point. Xxx said (in part):
 595 --Absent a physical impairment or a processing impairment or a learning
 596 disability, what does giving extended time accomplish other than boost
 597 a low grade?--
 598 If EVER there was a circumstance in which it is difficult to make a
 599 case for
 600 suggesting that extended time gives an advantage to students, I would
 601 think it would be in the case of math tests. Math tests don't require
 602 synthesis and language skills and ability to compare and contrast --
 603 they require knowing which formulas to apply and how to apply them. And
 604 if you don't know that when you sit down, all the extra time in the
 605 world ain't gonna help you! I suppose when you get into theoretical
 606 math applications that might change. But Xxx already told us that this
 607 is an undergraduate and gave no indication that this is anything other
 608 than a pretty straight-forward, calculations type math class we are
 609 talking about. Lighten up! GRIN
 610 Are we gate-keepers or service providers?
 611 Is our goal to do only what we MUST, or to do what we CAN to assist
 612 students with disabilities?
 613 Let me put it a different way... What is the potential cost to the
 614 institution (or to the integrity of the curriculum) if I err on the
 615 side of the student in allowing this accommodation? What is the
 616 potential cost to the student if I err on the side of principle and
 617 deny the accommodation?
 618 Xxx asked us what we thought. I think I just told you what *I* think.

619 I'd give her the accommodation.>
620 <Xxx is feeling argumentative and I feel like reasoning - now there is
621 trouble!
622 XX said in part,
623 --For this student, I would argue that one of her major life
624 activities at this point in time and space (!) is that of being a
625 college student. In order to continue with that major life activity,
626 she has to pass her classes, including her math class. If her
627 limitation is such that it substantially limits the "condition, manner,
628 or duration" of her performance in the act of being a college student
629 (and it seems to me that she has provided some fairly straightforward
630 evidence of that), then why would we NOT want to look at what kind of
631 accommodation we might provide that would be helpful in providing full
632 access? Can I make that argument on sound legal footing? Probably
633 not. But is it GOOD PRACTICE--
634 College as a major life activity? - Maybe as part of working. In the
635 vein of miracle on 34th street - both the Internal Revenue Service and
636 the Bureau of Labor Statistics consider a full time student "fully
637 employed". For a number of reasons related to gate keeping tests (Law
638 and medical boards) I would like to see this approach but I suspect the
639 courts are not going to buy college as a major life activity.
640 On the other hand handling your money, grocery shopping, check book,
641 following a recipe in a cook book, ... And a hundred other activities
642 involving mathematics might well add up to a major life activity. But
643 the documentation summary provided did seem tailored to taking math
644 tests not these other activities, and we could neither observe the
645 student or ask questions [sic]. If Janie were the student she may well
646 have connected the dots, I don't need to fully understand how an
647 accommodation mediates the impact of a disability just be presented
648 with plausible [sic] evidence that it does. That evidence might come by
649 way of explanation [sic] from the student about what the accommodation
650 [sic] does (or does not do) for them and it might come from more formal
651 evaluations.>
652 <I have a student who always calls me the night before the exam and
653 says that she can't come in because she is having panic attacks. Then
654 of course her therapist calls the day of in support of her not coming
655 in. Usually in the past her professors have been very accommodating and
656 either let her reschedule or work out something with her. This semester
657 , although the professor has been accommodating , he has made some
658 comments about not wanting to create make up exams and feeling that
659 this is not fair to him or other students who have to take the exam on
660 the day of , he also suggested on putting more value on the final exam
661 (but the student didn't like that idea at all since she feels that
662 would be too stressful for her).
663 I set up a meeting with the student and the faculty in order to figure
664 out what the issues were. Student claims that she takes medication to
665 deal with panic attacks but it makes her very tired and effects her
666 concentration so the night before the exam, she doesn't take her med
667 but as a result on the day of the exam, she becomes very anxious and
668 physically sick (I have actually seen her have a panic attack and she
669 really gets very ill). So my question to the list : does anyone have a
670 similar situation and what are students rights as opposed to faculty
671 who doesn't do make ups. To make matter just a bit more complicated,
672 the professor asked the student this question : well if you get so
673 anxious during the actual day of the exam why is it that you are not
674 anxious when you come in for the make up... you still don't take your
675 med the night before so you probably have panic attacks on the day of

676 the make up too... so what is the difference... student didn't have an
677 answer ... she just smiled and said well I have a bit more time to deal
678 with the idea of taking the exam... his reply... well you should
679 probably prepare better so you can take it on the actual date of the
680 exam...so can anyone give me any feedback on what to do... I think I
681 have tried to work with the faculty and student as much as I can but I
682 can see this becoming a bigger issue later on in her academic career.>
683 <I think the main problem concerns her medication. The fact that she
684 reports that her medication makes her tired and reduces her
685 concentration suggests that she is taking some variety of
686 benzodiazepine (such as Xanax). These medications are short-acting and
687 have a "rebound effect" when they are abruptly stopped. So when she
688 does not take her med the night before an exam, it is the worst thing
689 she can do, because this brings on extreme anxiety. Of course, she
690 should consult with her physician, but most psychiatrists are now
691 prescribing an SSRI medication (such as Paxil or Zoloft) for panic
692 attacks, instead of benzodiazepine. They are longer-acting and do not
693 have the negative side-effects on concentration.>
694 <would it help if she had her exam at a later time in the day but the
695 same day in the office of disabled by herself with just a proctor? does
696 she also get extended time and breaks?>
697 <I like to thank everyone for their response to my little dilemma! ...
698 it basically supports what I was thinking. We don't have a policy for
699 make ups either, so the student really needs to figure out what she
700 needs to do in order to take her exams on the actual date. Other than
701 extended time, I have offered a later time on that day but she has
702 rejected that idea too!>
703 <Don't work in Disability Services but pursuing a Ph.D. in Counseling
704 Psychology am somewhat acquainted with the disability resources office
705 here and with treatment of panic attacks. It certainly sounds like the
706 student is taking advantage more of the extra time than anything else.
707 (It wouldn't have been so bad if her reason for functioning normally
708 during the make-up exam was that there weren't as many people, etc. --
709 although this might be part of it and she just didn't mention it.)
710 This definitely sounds unfair to the other students. I would think an
711 accommodation might be having her take the exam in a quiet room
712 separate from the class, taking whatever time she needed (within
713 reason) ahead of time to calm down, breathe deeply, whatever. The fact
714 that her therapist would collude with her in avoiding the aversive
715 situation, thereby preventing her from ever dealing with the feared
716 stimulus (the test) and learning that she can survive it is
717 unbelievable!!!! (Unless he's just a pill doctor and isn't doing any
718 real psychological treatment.)
719 Sounds to me (and I am a student with ADHD who has struggled like hell
720 to make it in this graduate program -- so I know a little bit about
721 what it's like to be on the other (disabled student) side) like this
722 young woman is definitely taking advantage of the situation. Maybe the
723 professor or disability resources person would be willing to work with
724 the therapist on the treatment goal of taking the test. At first she
725 could take it in a quiet room, and maybe even initially the professor
726 could facilitate with helping her to calm herself down, etc. Maybe even
727 small steps like giving the class (or her in particular, if there were
728 some benefit to singling her out for this) a small pretest as an
729 example of what to expect might alleviate some of her anxiety. But
730 aside from some accommodations like that, I would think the professor
731 would have a right to expect her to be in class (or in a designated
732 test-taking room) at the same time the other test is taking place.

733 Aside from the fact that it's not fair and it's not helping this girl
734 because she's not dealing with the anxiety and therefore cutting it off
735 before it gets too painful and she learns she can live through it, the
736 concept of "panic attacks" is so broad, I would think the school would
737 be opening up a can of worms if it let her get away with this. I don't
738 have a DSM-IV in front of me, but my recollection is that "panic
739 attacks" require far fewer criteria than actual "panic disorder" -- and
740 I would expect more students to make a case for such "impairment" if
741 there is a great benefit attached to being so identified.>

Appendix M
International Student

1 <HELP!! - Strange accommodation request/sufficient
2 I have a very unusual case that I am assisting our MBA office to work
3 through but, since I am quite new to the disability services arena, I
4 am baffled as how to proceed from here. We have an international
5 student who just completed his first three-week MBA course with great
6 difficulty. During his first class meeting, just after the instructor
7 had introduced herself, this student began raising his hand to ask a
8 series of questions regarding the course, expectations, why he had not
9 yet received results from the required HBDI assessment, etc...
10 Although this is not so strange (perhaps just an apprehensive/anxious
11 student), his actions and conversations since the initial course
12 meeting have been quite disturbing. In the classroom where this student
13 takes his MBA courses, the tables and chairs are arranged in a half-
14 moon configuration to facilitate discussions and so forth. During the
15 break of his first class session, he approached the instructor to
16 inform her that the table configuration was giving him a headache. She
17 allowed him to use the one and only rectangular table in the room for
18 that class session.
19 The student came in to meet with his MBA advisor and, during the
20 meeting, shared his theory of a conspiracy against him by the
21 University and everyone in Columbus, Ohio. He believes that, since the
22 HBDI assessment was conducted online, all faculty and students now have
23 access to *his* results and are using them against him. Although he had
24 been sitting in the middle (or at the top, if you will) of the half-
25 moon configuration prior to moving to the rectangular table, he stated
26 that the need for him to turn his head to see other students (which he
27 hardly would have needed to do at all) was giving him headaches,
28 blurred vision and an upset stomach. He also believes that *everyone*
29 stands or sits to his left. (???)
30 Further, he believes that the University's conspiracy against him is
31 perpetuated by requiring students to read "Quantum Learning" which has
32 mostly text on the left pages, pictures/reinforcers [sic] on the right
33 pages. According to him, this attributes to his suspicion of people
34 *always* sitting or standing on his left side. In this instance, we are
35 dealing with words rather than individuals.
36 Later in the meeting with his MBA advisor, he asked his advisor to
37 explain why before the class break, a classmate sat to his left but
38 after break, sat to his right. From this point on, his conspiracy was
39 about people standing or sitting on his right, not his left.
40 Per the advisor, this student was acting "compulsive, wringing his
41 hands, darting his eyes around the office, opening his bag, peering
42 inside then snapping it shut". He asked over and over if she had
43 anything hot to drink and became very distressed when she told him that
44 there was not anything hot to drink at that time. He further went on to
45 discuss he and the advisor's "relationship" and how it was going to
46 have to be solely a student-advisor relationship from this point on,
47 and that he wanted to make sure they were on the same wavelength.
48 In response to the MBA advisor's request for physician documentation,
49 what he provided was a hand-written fax that stated, "Please provide a
50 rectangular table for [student] to sit at as a semicircular table
51 gives him headaches. He will certainly require a workup to discover
52 why. [signature]". To my knowledge, we do not have specific policies as
53 to what type of documentation is needed in order to provide
54 accommodations. Basically, I tell students to have the medical

55 professional they see send me documentation with the diagnosis and an
56 explanation of how the diagnosis may affect the student in an adult
57 learning environment.
58 With that **very** lengthy post, do any of you veterans out there have
59 any suggestions as to how I should handle this situation? Another MBA
60 advisor is meeting with the student tomorrow at 10:00am. I understand
61 that the "accommodation" of a rectangular table is not difficult to
62 provide, but I do not believe that the physician's documentation
63 warrants a medical need. Plus, it is my opinion that this student
64 should seek medical attention immediately to take care of his disorder,
65 whatever it may be, before he proceeds with his educational endeavor.>
66 <You know there is a full moon out there! All kidding aside, the
67 student needs to be referred to the person on campus or department that
68 deals with students who might present a danger to themselves or others.
69 On our campus, I would call the Dean of Students ASAP! Good luck.>
70 <Is the individual claiming disability or government conspiracy?>
71 <This student should be refered [sic] to the counseling center for
72 immediate help. In addition, the student needs to come to the attention
73 of the Dean of Students or whoever is responsible for the student code
74 of conduct. It seems to me that this students is or may become
75 disruptive. He needs to get his behavior stabilized if he is to gain
76 anything from the MBA program.>
77 <Find a counselor who speak [sic] the same language as the student. I
78 doubt city, county, and state law enforcement might help, but the FBI
79 can with its foreign languae [sic] capability. Remember, a lot of
80 countries don't do those kind of testing we do here in the U.S.
81 Or maybe the student is an alien?>

Appendix N
Comfort/Emotional Support Animals

1 <There is a first for everything....
2 Has anyone dealt with this issue before? I am working with a student
3 who has a diagnosis of depression and wants to keep her pet rat in her
4 dorm room. She has heard of comfort animals being allowed as an
5 accomodation [sic] for depression. Any thoughts?>
6 <What does she do, or have as a "comfort item" to function when not in
7 the room?>
8 <Does documentation support the fact that a pet rat minimizes
9 depression?
10 Just wondering. I haven't dealt with this issue...but I would have to
11 think about that one for a long time. :)>
12 <Before there are a slew of responses saying the ADA does not cover
13 Companion Animals, Therapy Pets, ... Consider that your residence halls
14 are also covered by the Fair Housing Act and the Fair Housing Act
15 Amendments. These have been supportive of waiving a "no pets" rule as
16 an accommodation for a tenant when specific documentation identifying
17 the role of the animal in therapy is provided.
18 For more references go to:
19 <http://www.bazelon.org/fhinfosheet6.html>>
20 <Perhaps there is a good taxidermist in the area who can make it
21 possible for the student to take the rat to class as well as keep in in
22 [sic] her dorm.>
23 <I liked the taxidermy suggestion very much and am still grinning.
24 Thanks, you, Xxx. What is the functional limitation and how does it
25 relate to academics? A
26 student with depression may ask for a rat, a snake, or a dog as a
27 medication
28 substitute to alleviate symptoms, but is such relief in DSS purview?>
29 <The conversations regarding the use of comfort/assistive animals for
30 students with mental/emotional issues has greatly worried me in recent
31 weeks. Why is it that students with emotional/psychological
32 disabilities are seen
33 as less worthy as needing comfort/service animals than those with
34 visible/physical disabilities. I have also been greatly dismayed by the
35 jokes and disrespect these students' requests have received on this
36 list.
37 Granted, a rat may seem like an unusual request, but if it provides
38 comfort
39 to a student with depression, is it worthy of our mockery?
40 I have attached the Federal Law regarding such housing laws for the
41 provision of comfort animals. As well as the brief wording for the ADA
42 and the Rehabilitation Act of 1973. May the remind us all of the equity
43 all students deserve.>
44 <Xxx, thanks for reminding us that we are indeed here to serve
45 students,
46 even ones that make requests we think of as unreasonable. I would not
47 be
48 particularly receptive to a request to have a pet rat or any other
49 animal in a dorm as a comfort animal. I imagine that everyone on the
50 list has had
51 the experience of students trying to use the "disability card" to
52 obtain special privileges in housing. We have dozens of requests every
53 year for special housing arrangements on the basis of disability. The
54 difficult part

55 of the job is to sort through these requests and decide which requests
 56 are
 57 simply things the student desires and which the student needs. While I
 58 can
 59 easily believe that a pet rat might make a student feel more
 60 comfortable, it
 61 would take some convincing for me to believe that a student ****needs**** a
 62 comfort animal to succeed in his/her courses.>
 63 <We often struggle with this issue. I think perhaps we have approached
 64 it from the wrong perspective. Can anyone think of an animal with a
 65 claimed service responsibility that they would not believe. Maybe
 66 leader hawk, hearing whale, service snail or something.>
 67 <How about an electric eel that works in place of a tens unit to
 68 introduce a painkilling electric shock? And when it gets old and wears
 69 down, you can cook and eat it.
 70 <But only in "pods" where kitchenettes are provided. You couldn't do an
 71 eel in a popcorn popper, could you?>
 72 <and make a functional and sturdy eel skin wallet with the skin!>
 73 <I would certainly hope that the law would protect my inalienable right
 74 to bring my service flea to the dorms, to class, and to all proctored
 75 exams. It's [sic] frequent biting me under the arm serves as a means to
 76 help me keep my attention on what's going on in class. Though you might
 77 think that such biting would be distracting, it has the opposite effect
 78 on me. You see, my distractibility owes not to external factors, but to
 79 my own internal thoughts. A teacher might say something, and right away
 80 I think of something very different, though related in my mind, and
 81 then I'm off, not paying any attention to the lecture or to taking
 82 notes anymore for who knows how long.
 83 It is then that the flea's bite brings me round to the present once
 84 more, and the important task at hand of listening and taking notes. So
 85 you see, without that constant little reminder, or prod, I just don't
 86 stand a chance in college.>
 87 <I take exception to Xxx's post. Xxx distinctly requested information
 88 on
 89 unbelievable service animals and Xxx's flea is entirely too plausible,
 90 not to mention entertaining. I know many people, students included,
 91 would greatly benefit from an infestation.
 92 How about the service stuffed animal? And I don't mean a cute, snuggly
 93 plush toy but a formerly living creature of objectionable proportion,
 94 like a coyote or a buzzard?>
 95 <Good idea. Install some casters in the buzzard's feet. Attach a
 96 broomstick to it and the blind student can push it around campus.>
 97 <Our local service consortium, "Collegiate [sic] Consortium of
 98 Disability
 99 Advocates," (CCDA) has a stuffed farot [sic] that from time to time
 100 gets awarded to the member with the best war story. We haven't quite
 101 figured out what it does, however; we think it's more of a companion
 102 animall [sic].>
 103 <Where should one install the broom stick, or is that obvious???)>
 104 <We have had several requests recently for "therapy" animals to live in
 105 university residences with students. The latest is from a prospective
 106 student with a psyche disability who is requesting that she be able to
 107 have her hedgehog as an accommodation. We have a letter from her
 108 therapist describing the disability and specifically recommending the
 109 hedgehog. The therapist states that this animal provides needed comfort
 110 and is part of a "coping strategy". I have to admit, we're stumped! We
 111 are getting more and more of these types of requests. We are attempting

112 to write policies so that we have guidelines to follow, but aren't
113 there yet.>
114 <I have two questions:
115 In what way has the animal been trained?
116 Did the therapist state that she would be unable to live in housing
117 without this? What would happen to her without the animal?>
118 <Therapy animals are animals owned by a therapist who use the animal as
119 a component of therapy for a person with a disability. The fact that
120 the
121 student owns the animal is confusing as this makes me lean toward it
122 being a
123 pet. Maybe this is more a companion animal. Companion animals are
124 essentially pets that are necessary for the participation in University
125 programs by the person with a disability. "Necessary" means that the
126 disability office can verify through documentation that the person with
127 a disability may experience discrimination based solely on disability
128 if the animal is not permitted to live with the student.>
129 <A "Therapy animal" does NOT have to be "trained" or certified as such.
130 It is also known also known as a "companion" animal, "comfort" animal
131 and "emotional support" animal. They are not a "service animal", which
132 is trained to be allowed to accompany their partner with a disability
133 in any area open to the general public.
134 A therapy/companion/comfort/emotional support animal is covered by HUD
135 and DOT for residential and airplanes. Partners with disabilities must
136 show proof from a doctor or psychologist that the animal is required to
137 help with a mental health condition.
138 There are ethical issues with therapists diagnosing therapy animals and
139 their own training that they have had in the field of "therapy animals"
140 to verify that they are "experts". Also to consider whether the student
141 is functioning will enough emotionally to provide the care, behavioral
142 training and nourishment to the animal. The student cannot be
143 accompanied by the "therapy animal" into the classroom, though. HUD and
144 DOT only cover the therapy animals in residences and airplanes, etc.
145 The "therapy animal" is considered a pet, not a service animal.>
146 <There are many misstatements in some recent posts in this thread. As a
147 general rule, there is no obligation to waive no pet rules for students
148 with so called therapy animals. Contrary to one post, HUD has no
149 regulations that require making exceptions to no pet rules for therapy
150 animals. Contrary to another post, no court has compelled waiving a no
151 pet rule for a therapy animal, and several have refused to do so.
152 The ADA, section 504, and the Fair Housing Act require making
153 exceptions
154 to no pet rules for service animals because a service animal performs a
155 task or renders a service for a person who, because of a disability,
156 cannot herself perform that task or render that service for
157 himself/herself. Though there is no requirement that a service animal
158 be certified as such, the animal nevertheless must be trained to
159 perform a task or render a service. With some animals (guide dogs),
160 equipment makes obvious what task/service the animal performs; when the
161 appearance or behavior of the animal does not indicate what it is that
162 the animal does, one reasonably can ask, and asking does not violate
163 the ADA or other related laws.
164 I hate to say "never," but on this issue, I come close. Make it easy.
165 Start by insisting on proof that the student has a disability,
166 remembering that the definition includes both the requirement of an
167 impairment and evidence that the impairment substantially limits a
168 major life activity.

169 Then ask for documentation of exactly what the animal does to relieve
170 those limits. In almost every case, that will resolve the problem; the
171 student won't have a disability, or will have no documentation that the
172 animal performs any service.

173 Does the student want to take the pet to class? I'll bet the answer is
174 no, and that the student only wants to keep it in the residence hall.
175 Contrast that to what you know about service animals; they accompany
176 their
177 owner in public places precisely because they are trained to and do
178 perform a service for a person with a disability. An animal in a
179 residence hall is not performing any service for a student in a
180 classroom.

181 You can pull up earlier posts I have written from August and October of
182 last year, and you can watch for the article I plan to write in a
183 forthcoming issue of DCHE. The student should leave the pet at home or
184 take it to a taxidermist.>

185 <This is my first post to this group. I have a couple of questions.
186 First, some background info about our college. We have 1,800 students,
187 not large enough to have a separate Disability Services Coordinator. An
188 academic advisor is appointed to deal with ADA issues and
189 accommodations. The Counseling Services has two full time staff. As
190 director of Counseling Services, I serve as consultant to this academic
191 advisor regarding ADA issues.

192 Another student with multiple psychiatric diagnoses, including bipolar.
193 According to her psychiatrist, her many meds can have the side effect
194 of a seizure (mini or grand mal). By having her dog with her, the
195 student feels less anxious and less likely to have a seizure.

196 According to the psychiatrist, if the student does have seizure, the
197 dog will also "help." We are asking for more info on the dog. As far
198 as we know, it's not a trained dog, i.e., seizure dog. It's her pet.
199 The issue is that this entering first year student demands that she can
200 keep her dog in the dorm even though pets are not allowed. I would
201 appreciate your thoughts and comments on these issues.>

202 <For the purposes of the FHA (in the dorm), the animal at least meets
203 the
204 criteria of a ESA (Emotional Support Animal), thus would be lawfully
205 allowed to live in this SWDs dorm, IMO.

206 For the purposes of 504 and ADA, if the SWD says the animal ("her dog")
207 is a "Service Animal" (SA/SD) and the SWD is "disabled" by the legal
208 meaning of the word (including recent case law), then you must allow
209 "her [service] dog" to accompany her wherever she is (and all other
210 students are) allowed to go, period.

211 See:
212 <http://www.fairhousing.com/index.cfm?method=page.display&pageid=3607>
213 And:
214 <http://www.ADAAdvocates.com/pub/animal.html>
215 And:
216 <http://www.usdoj.gov/crt/ada/animal.htm>>

217 <The student with bipolar disorder makes a seemingly extraordinary
218 claim that by its very presence her dog prevents her from having
219 seizures. As a general rule, extraordinary claims should require
220 extraordinary evidence; at a minimum I would want a detailed written
221 explanation from a qualified health care professional of 1) the
222 mechanism by which anxiety triggers the seizures; and 2) how the health
223 care professional determined that the presence of the dog diminishes
224 the frequency of seizures. Does the dog monitor the electrical activity
225 in the student's brain and discharge an electrical current when it

226 perceives unusual activity? Did the health care professional measure
227 the frequency of seizures when the dog is present and when the dog is
228 absent? Or is this gastronomic diagnostics (I can't explain it but I
229 feel it in my gut).

230 Although a dog that could prevent seizures plausibly might be a service
231 animal (and a trained seizure dog certainly is a service animal), I
232 would
233 be deeply skeptical of a claim that the presence of a dog can forestall
234 or
235 prevent electro-chemical disturbances in the human brain. I suspect
236 that
237 the dog is a pet, and that the causal link between its presence and the
238 frequency of seizures is closely related to the link between the
239 crowing of my neighbor's rooster and the morning sunrise. In short, the
240 dog does
241 what every pet does for every pet owner -- it provides emotional
242 support;
243 that is, after all, the reason we keep pets. A pet does not become a
244 service animal simply because its owner loves it.
245 A service animal performs a service for a person with a disability;
246 that
247 is why a school must modify its policies respecting pets to accommodate
248 a student with a disability who has a service animal. No DoH or HUD
249 regulation equates an "emotional support animal" with a service animal,
250 and there is no reason to think that either the ADA or the Fair Housing
251 Act should require modification of no pet rules for an "emotional
252 support animal."

253 If the dog is a pet, it belongs at home. Here is a useful thought
254 experiment. Would you modify rules limiting residence in dormitories to
255 students when asked to do so by a student with a disability who has a
256 live in personal care attendant? Yes, because the personal care
257 attendant
258 performs essential personal care services for a student that the
259 student
260 cannot perform for himself/herself. Would you modify those same rules
261 when a student brings his girlfriend [sic] or boyfriend from home to
262 live with
263 him in the dormitory because she/he provides "emotional support" that
264 prevents seizures? Of course not. Why would we treat students with
265 pets
266 differently from students with girlfriends or boyfriends?
267 I recently wrote a column in DCHE trying to debunk the claim that the
268 ADA
269 requires us to open dormitories to students with pets who happen to
270 provide emotional support. Perhaps because some of the people who make
271 the claim have cats, the claim seems to have nine lives.
272 None of the links below support the argument that we must make
273 accommodations for students with "emotional support animals." Here is
274 the example from the joint statement of HUD and DoJ; it is a standard
275 illustration of a service animal, not an "emotional support animal:"
276 Example 3: A housing provider has a "no pets" policy. A tenant who is
277 deaf
278 requests that the provider allow him to keep a dog in his unit as a
279 reasonable accommodation. The tenant explains that the dog is an
280 assistance animal that will alert him to several sounds, including
281 knocks

282 at the door, sounding of the smoke detector, the telephone ringing, and
283 cars coming into the driveway. The housing provider must make an
284 exception to its "no pets" policy to accommodate this tenant.
285 Students with disabilities have every right to bring their service
286 animals to class and to keep them in their residence halls. Students
287 with disabilities who have pets should respect the no pets rules of
288 campus residence halls.>
289 <Seizure Detection and, or Alert Service Animals are a proven fact, for
290 one. And, State and Federal law require public accommodations (like
291 schools) to grant access to person with disabilities who are partnered
292 with them, period.>
293 <ROYAL OAK, Mich. - A judge has upheld an order blocking an apartment
294 complex
295 from evicting a woman who says she needs to keep her late mother's dog
296 because it helps her fight depression over the mother's death.
297 Christine Emmick has a disability and is entitled to keep her Shih Tzu,
298 Max,
299 despite the no-pets rule at Royalwood Cooperative Apartments, the
300 Michigan
301 Civil Rights Commission ruled.
302 The apartment complex "refused to reasonably accommodate her mental
303 disability by allowing her to keep a dog," and violated the state's
304 Persons
305 with Disabilities Civil Rights Act, the commission ruled earlier this
306 year.
307 The ruling was upheld last week by Oakland County Circuit Judge Fred
308 Mester.
309 "I was skeptical of the case at first," Mester told the Detroit Free
310 Press on Monday. "But when you look at the facts of the case, the
311 cooperative was violating the law.
312 "This is not a case where somebody says, 'I have a headache, and a dog
313 would
314 make it better.' This woman had a well-documented disability and was
315 able to
316 prove that the dog helps her in coping with that disability."
317 The commission awarded Emmick \$107,749 in emotional damages and
318 attorney fees.
319 A lawyer for the co-op criticized the ruling. "The dog, as far as the
320 cooperative is concerned, is nothing more than a pet," said Patrick
321 Rode.
322 Emmick, a former graphics designer, brought her mother to Michigan in
323 1998,
324 along with Max, to care for her after she was diagnosed with terminal
325 lung cancer.
326 The co-op board told Emmick the dog had to go. She later moved her
327 mother to
328 an apartment building that allowed pets, but after her mother died in
329 2000
330 she brought Max back to her Royalwood apartment.
331 In April 2001, the cooperative's board of directors voted to evict her.
332 A psychiatrist, Dr. Michael Abramsky, told the commission that Emmick's
333 relationship with Max "kept her afloat and stabilized her functionally
334 and
335 emotionally ... without the dog, she would probably spend most of her
336 life in bed.">
337 <Hello everyone. My latest challenge involves a student, and her
338 poodle. The student is diagnosed as Bipolar Type II, Atypical;

339 Generalized Anxiety Disorder; and Post-traumatic Stress Disorder. A
340 statement from her Clinical Therapist says that in her opinion, Nathan
341 (the poodle) would be "useful" to the student in the classroom, and
342 elsewhere on campus, as he helps her stay calm and focused when away
343 from home.
344 Faculty are not thrilled about having a poodle in class with them, and
345 have asked me if they must allow the animal in class.>
346 <Be glad she doesn't have a security chicken!
347 You might want to ask the therapist to clarify the clinical meaning of
348 the term "useful" and don't give her any hints. Useful is not the same
349 as essential and I'd base my decision accordingly.
350 If I were a betting sort of person, I'd lay odds that the poodle isn't
351 clinically necessary but you won't know until you ask. Before you
352 call the therapist, go read up on BiPolar [sic] Type II, Atypical and
353 familiarize yourself with the condition, prepare a good list of
354 questions that will assist you do determine severity of condition,
355 medications (if any) and their side effects and effectiveness,
356 frequency of therapy visits, by what yardstick has the poodle been
357 determined to be 'useful' and what other categories of poodledom exist
358 besides useful, as for example : irritatingly worthless, needs
359 frequent bathroom breaks so good to promote exercise, helpful as a
360 teddybear (go with the teddybear in that case), keeps patient from
361 pulling out hair and nails, patient can't leave the house without it
362 absent a straight jacket, give the poodle the diploma.
363 Okay, I might be stretching things a bit. Give me a call if you have
364 questions!>
365 <does anyone else think what i'm [sic] thinking?
366 Bipolar II Atypical + GAD + PTSD + Zsa Zsa POODLE = Calm and Focused.
367 I'm sold.
368 Follow Xxx's advice. She regularly kicks pups off the porch!>
369 <I typed my response in haste and forgot to add an "etc." after the
370 first listed diagnosis; then the LD or fatigue or unstoppable aging
371 process caused me to type the wrong homonym a few sentences later.
372 In addition, I had to go chase a few blue ticks, catahoulas, and red
373 bones (Xxx can explain those breeds) off the porch again so I failed to
374 add my last question about the poodle itself. Standards are noble dogs,
375 occasionally trained to work as guide or assistance animals. The
376 Miniatures and Toys are less noble in my opinion although perhaps they
377 may be cute when allowed to grow a more natural coat and absent blue
378 nail polish. Some of the smaller varieties can be yappy and more
379 nervous than a hound on my front porch, so much so it is they who may
380 be in need of human companions every waking moment. It's a valid
381 point.>
382 <Also, what service was the animal trained to do? No training to
383 provide a disability-related service, no service animal.>
384 <I have a toy mix and I can attest to it's [sic] yappyness. Also likes
385 to guard.>
386 <Your subject is very appropriate. It sounds as if Nathan is causing
387 anxiety among the faculty. I really don't think an untrained animal
388 here is appropriate in the classroom. It does not sound like Nathan is
389 a service animal. Could the therapist work on substituting a picture of
390 Nathan for the individual to look as a way to reassure the person?
391 The therapist will need to connect a whole lot of dots here to show me
392 the individual is stable and that the pet is clinically necessary. I
393 can see the animal being more disruptive than helpful in the class. Get
394 a second opinion from another therapist, and advice from your
395 counseling staff on this situation.

396 Next is the pet Python or Boa going to class!>
397 <Just wanted to note my surprise at the level of insensitivity and
398 sarcasm here. Many things help a person manage from day to day, be it
399 sugar pills (placebo), meditation, prayer or other. Important to focus
400 on the issue(s) rather than judge the means a person employs. Regarding
401 animals, what service does it provide? Needs to be trained, is it
402 trained (formal or informal)? Is there a disability with functional
403 impact? Is the accommodation appropriate, reasonable? The question is
404 what you, as a service provider, are willing or able to provide.
405 Acceptance or approval is another issue.>
406 <I know I have very little experience in this field and have often
407 asked
408 some of the worst questions and most inexperienced questions in the
409 world but I do know this: this job can truly get to you and burn you
410 out if you do not have a bit of a sense of humor. Now please don't
411 anyone get me wrong. I totally believe that the person that posted this
412 and people who have posted similar messages probably have a great sense
413 of humor..truly. What I also know is this the people that are posting
414 the insensitive emails are also persons who treat all inquiries with a
415 level of professionalism that I have never seen before and are also
416 what I consider the true masters of this art-form called disability
417 services. I also believe that they have never or will never carry that
418 behavior in the office itself ..outloud so to speak. I am guessing also
419 that these people are helped by things like meditation, prayer or
420 otherwise but they are at a point of self-actulization [sic] to which
421 they can make fun of themselves. We all need that sort of therapy of
422 humor.>
423 <Blessed are they that can laugh at themselves for they shall never
424 cease [sic] to be amused (annonymous [sic])>
425 <The individual should be qualified for the classroom. An animal would
426 be a possible disruption in the classroom. Nothing was mentioned about
427 a qualified service animal, just a pet. We have to view the concept of
428 a qualified service animal to make sure the dog is prepared to enter
429 the class otherwise disruption and safety issues abound. I am sorry
430 that you took my comment as insensitive, but I replied in the light
431 that such an accommodation might be too extreme and disruptive for the
432 classroom. Actually I thought if there was a jab, it was more toward
433 the faculty. I just think, with therapy, a transference to a photo of
434 the dog would be less disruptive to the class and serve as a simpler
435 approach. Keep in mind, this is Bipolar Disorder. The approach uses in
436 this case is interesting, because what the task does is place a
437 distracting agent(the dog) to occupy as a distraction and attention
438 someone with Bipolar Disorder will (more than likely) need. In an odd
439 way helps the disorder in a negative (reinforced) way, and down the
440 road it is possible that when more attention a distraction is needed
441 it will be difficult to accomplish this task.>
442 <I am not sure Xxx's student falls into it but I think there is a
443 space, albeit a small one, between Service Animal and Pet. I have come
444 across instances where an animal was was [sic] identified by an
445 appropriately credentialed professional as an integral, planned and
446 purposeful part of therapy or as necessary in order for the individual
447 to function in the residential college environment. In short a licensed
448 professional was willing to "prescribe" the presence of the animal and
449 identify benefits that went well beyond the postive [sic] impact of
450 pets. I will refer to a creature that fits this category as an LTA
451 (Living Therapuetic [sic] Aid) to avoid the semantic and communications
452 problems inherent in names such as "companion animals" and "therapy

453 pets" If a student passes the first hurdle and the animal can be
454 classified as an LTA then there are a series of considerations to see
455 if allowing it on campus is a reasonable accommodation.
456 1) I see real limits on access to places where animals are typically
457 forbidden beyond the residence halls. I do not see allowing LTAs into
458 classrooms or resteraunts [sic] unless they are trained and perform a
459 function in that specific environment. In essence if you need that
460 level of access you need a service animal.
461 2) Within the residence hall there are the usually health and safety
462 issues. I would also defer to state and federal statutes about exclude
463 or limit ownership of endangered, exotic or dangerous animals.
464 3) The animal would have to abide by the appropriate correlaries [sic]
465 to the
466 code of conduct (noise, threatening [sic] behaviors,)
467 So in that small space I would consider an animal on campus and have
468 about a half a dozen times in the last 20 or so years.>
469 <--The student with bipolar disorder makes a seemingly extraordinary
470 claim that by its very presence her dog prevents her from having
471 seizures.--
472 Ah... Another person who misunderstands the incredible value of life
473 that a Psychiatric Service Dog can bring to a PWD.
474 --As a general rule, extraordinary claims should require extraordinary
475 evidence; at a minimum I would want a detailed written explanation from
476 a qualified health care professional of 1) the mechanism by which
477 anxiety triggers the seizures; and--
478 Why?
479 --2) how the health care professional determined that the presence of
480 the dog diminishes the frequency of seizures.--
481 As long as it's demonstrable disability mitigation, shouldn't that
482 suffice? Thus, an affidavit to that effect would suffice as well?
483 --Does the dog monitor the electrical activity in the student's brain
484 and discharge an electrical current when it perceives unusual
485 activity?--
486 Why does this matter in the presense [sic] of said affidavit of said
487 demonstrable disability mitigation above?
488 --Did the health care professional measure the frequency of seizures
489 when the dog is present and when the dog is absent? Or is this
490 gastronomic diagnostics (I can't explain it but I feel it in my gut).--
491 See the same questions above...
492 --Although a dog that could prevent seizures plausibly might be a
493 service animal (and a trained seizure dog certainly is a service
494 animal),--
495 What is the difference between the two? I know people who use both and
496 both are legally recognized SDs.
497 --I would be deeply skeptical of a claim that the presence of a dog can
498 forestall or prevent electro-chemical disturbances in the human brain.-
499 -
500 So, what you're saying is that, in select cases (you, or someone of
501 your kind, being the selectors) whether an animal is an real service
502 animal(SA) should be left up to some selective criteria that/which the
503 selector's -- having never been partnered with a SA in their/your life
504 -- determine? I think not. After all, didn't I read somewhere that the
505 PWD knows their disability(s) and, thus, knows which accommodation
506 would best mitigate it/them, thus, primary consideration should be
507 given to the PWD's choice of accommodation(s)?
508 --I suspect that the dog is a pet, and that the causal link between its

509 presence and the frequency of seizures is closely related to the link
510 between the crowing of my neighbor's rooster and the morning sunrise.
511 In short, the dog does what every pet does for every pet owner -- it
512 provides emotional support; that is, after all, the reason we keep
513 pets. A pet does not become a service animal simply because its owner
514 loves it.--

515 Are you aware that every SA "provides" the very same (if not more)
516 "emotional support" which you admit is in a class of animals known as
517 "emotional support animal[s]" does?

518 See: <http://www.uwsp.edu/psych/dog/LA/davis1.htm>

519 --A service animal performs a service for a person with a disability;
520 A SA is defined as "any [...] animal ****individually trained**** ****to**
521 **provide assistance to**** an individual with a disability [...]."--
522 Who are you (or we, for that matter) to decide what the exact meaning
523 of "to provide assistance to an individual with a disability" is? I
524 think we need to think out of the box on this issue and if I were a
525 judge I would do just that -- and "on a case-by-case basis."
526 --that is why a school must modify its policies respecting pets to
527 accommodate a student with a disability who has a service animal. No
528 DoH or HUD regulation equates an "emotional support animal" with a
529 service animal, and there is no reason to think that either the ADA or
530 the Fair Housing Act should require modification of no pet rules for an
531 "emotional support animal."--

532 So, dorms do not constitute [sic] "public [sic] housing?" I thought a
533 tenant with a disability was allowed an ESA in "public housing," but I
534 could be wrong on that one Xxx.

535 --If the dog is a pet, it belongs at home. Here is a useful thought
536 experiment. Would you modify rules limiting residence in dormitories to
537 students when asked to do so by a student with a disability who has a
538 live in personal care attendant? Yes, because the personal care
539 attendant performs essential personal care services for a student that
540 the student cannot perform for himself/herself. Would you modify those
541 same rules when a student brings his girlfriend [sic] or boyfriend from
542 home to live with him in the dormitory because she/he provides
543 "emotional support" that prevents seizures? Of course not. Why would
544 we treat students with pets differently from students with girlfriends
545 or boyfriends?--

546 Nice analogy ... Not certain it applies here. Good thing we're all
547 allowed our own opinions.

548 --I recently wrote a column in DCHE trying to debunk the claim that the
549 ADA requires us to open dormitories to students with pets who happen to
550 provide emotional support. Perhaps because some of the people who make
551 the claim have cats, the claim seems to have nine lives.--

552 Ah... Now I see the reason for the above analogy, as well as this
553 response (for the most part) of yours to my post. Do you believe in
554 non-task-trained SAs? Hmmm... Well the Psychiatric Medical Profession
555 is just beginning to wake up to the fact that PSAs and PSDs are real
556 and here to stay.

557 [See <http://www.psychdog.org/> - "The Psychiatric Service Dog Society is
558 a 501(c)3 nonprofit organization dedicated to responsible Psychiatric
559 Service Dog (PSD) education, advocacy, research ..."]

560 --None of the links below support the argument that we must make
561 accommodations for students with "emotional support animals." Here is
562 the example from the joint statement of HUD and DoJ; it is a standard
563 illustration of a service animal, not an "emotional support animal:"--
564 Yes. The "standard" for a SA a housing provider must allow a person
565 with an obvious [sic] disability -- what about a invisible disability?

566 --Example 3: A housing provider has a "no pets" policy. A tenant who is
567 deaf requests that the provider allow him to keep a dog in his unit as
568 a reasonable accommodation. The tenant explains that the dog is an
569 assistance animal that will alert him to several sounds, including
570 knocks at the door, sounding of the smoke detector, the telephone
571 ringing, and cars coming into the driveway. The housing provider must
572 make an exception to its "no pets" policy to accommodate this tenant.--
573 What if the tenant is lying and the dog is not a SA -- but just a very
574 well-behaved pet?
575 --Students with disabilities have every right to bring their service
576 animals to class and to keep them in their residence halls. Students
577 with disabilities who have pets should respect the no pets rules of
578 campus residence halls.--
579 I agree with the above statement. I just think we, as people, need to
580 think more outside of the box. Let's give the benefit of the doubt to
581 the PWS when they say their animal is a SA and then time will tell if
582 it is or isn't, instead of some appointed "gate-keeper/policy."
583 A few more URLs of possible interest:
584 <http://www.psychdog.org/About.html>
585 <http://www.psychdog.org/news.html>>
586 <My comments on emotional support dogs are interspersed below, but
587 circle back to a simple point; I recognize that many people bond deeply
588 with their pets, but that doesn't make them service animals.
589 --Ah... Another person who misunderstands the incredible value of life
590 that a Psychiatric Service Dog can bring to a PWD.--
591 No; I am just another person who understands that the ADA is not a
592 license to turn a dormitory into Noah's Ark. I have two dogs and six
593 cats, and know well what pets can bring to my life, but what they offer
594 is what every pet offers to every pet owner -- unqualified affection
595 (if you keep feeding them) -- and that doesn't make them more than they
596 are, and what they are is pets. They are not service animals because,
597 in the simplest of terms, they do not perform any service that a PWD
598 cannot perform for herself. If the dog who loves me is a service
599 animal, then so is the chicken that produces the eggs I eat for
600 breakfast; I have an even more basic need for food than for canine
601 affection.
602 I wrote: As a general rule, extraordinary claims should require
603 extraordinary evidence; at a minimum I would want a detailed written
604 explanation from a qualified health care professional of 1) the
605 mechanism by which anxiety triggers the seizures; and
606 -- Why?--
607 Because we are a reasoning species. Because DSS staffers exercise
608 independent *professional* judgment. We have come some distance since
609 the days of ritual incantations and magic; if there is a basis for the
610 claim that a dog prevents the electro-chemical disturbances that cause
611 seizures, a *qualified* health care professional should be able to
612 explain the process, not merely recite the claim. Otherwise, we abandon
613 professional judgment for faith.
614 The principle that an expert, whether a health care professional, a
615 physicist, or an economist, must offer more than a belief -- must offer
616 a scientific or technical basis for the belief, rooted in generally
617 accepted scientific principles, is deeply rooted in our legal system;
618 it applies across the spectrum of legal issues we decide, and is in no
619 sense unique to disability rights law.
620 I wrote: 2) how the health care professional determined that the
621 presence of the dog diminishes the frequency of seizures.

622 -- As long as it's demonstrable disability mitigation, shouldn't that
623 suffice? Thus, an affidavit to that effect would suffice as well?--
624 The key word here is demonstrable. A sincere belief in alien abduction
625 is not a demonstration of anything except the limitless capacity of
626 people confuse fantasy with reality. Professionals explain.
627 I wrote: Does the dog monitor the electrical activity in the student's
628 brain and discharge an electrical current when it perceives unusual
629 activity?
630 -- Why does this matter in the presense of said affidavit of said
631 demonstrable disability mitigation above?--
632 At most the willingness to take an oath establishes the sincerity of
633 the affiant's belief; it establishes nothing about the credibility of
634 the affiant or the reliability of his belief; it establishes nothing
635 about the soundness of the methodology underlying the belief.
636 Here's a useful analogy -- we accommodate students with dyslexia, but
637 we don't do so on the basis of an affidavit from a doctor swearing that
638 a student has dyslexia; we require the diagnostice [sic] evidence on
639 which she bases her diagnosis. The same principle operates here --
640 explain the basis for the claim that the dog prevents seizures, don't
641 just make the claim. My DSS office operates on evidence, not oaths.
642 My children once believed in Santa Claus, and happily would have sworn
643 under oath to that belief. Though they were sincere, they were wrong.
644 I wrote: Did the health care professional measure the frequency of
645 seizures when the dog is present and when the dog is absent? Or is
646 this gastronomic diagnostics (I can't explain it but I feel it in my
647 gut).
648 --See the same questions above...--
649 And see the answers. Suppose I claim my dog is a cancer dog, and that
650 by its presence it prevents the recurrence of lung cancer? Does that
651 make it so? How is the claim that a dog prevents seizures any
652 different? My point is not that dogs cannot prevent seizures, but is
653 only that whoever makes the claim that they can has an obligation to
654 account for the mechanism, not merely to make the claim.
655 I wrote: Although a dog that could prevent seizures plausibly might be
656 a service animal (and a trained seizure dog certainly is a service
657 animal),
658 --What is the difference between the two? I know people who use both
659 and both are legally recognized SAs.--
660 Legally recognized by whom? Can you give me one example of a dog
661 characterized by a court as a service animal based on the claim by its
662 owner that by its presence alone it prevents the owner from having
663 seizures? I know what atrained seizure dog does, and what it does is
664 very different than radiate antiseizure vibes.
665 I wrote: I would be deeply skeptical of a claim that the presence of a
666 dog can forestall or prevent electro-chemical disturbances in the human
667 brain.
668 --So, what you're saying is that, in select cases (you, or someone of
669 your kind, being the selectors) whether an animal is an real service
670 animal (SA) should be left up to some selective criteria that/which the
671 selector's -- having never been partnered with a SA in their/your life
672 -- determine? I think not. After all, didn't I read somewhere that the
673 PWD knows their disability(s) and, thus, knows which accommodation
674 would best mitigate it/them, thus, primary consideration should be
675 given to the PWD's choice of accommodation(s)?--
676 The ADA does not require us to abandon twenty-five centuries of
677 empirical evidence and reason in favor of epistemological privilege.
678 Whether an animal is, as you put it, a real service animal, is a

679 question of fact, not belief, and the accessibility of the evidence to
680 support the claim is not dependent upon whether someone does or does
681 not have a disability. If a dog prevents seizures, explain how. If you
682 can't, then we are back to worshipping golden calves, and health care
683 professionals have abandoned science for shamanism.
684 --Are you aware that every SA "provides" the very same (if not more)
685 "emotional support" which you admit is in a class of animals known as
686 "emotional support animal[s]" does?
687 See: <http://www.uwsp.edu/psych/dog/LA/davis1.htm>--
688 There is no class of animals known as "emotional support animals;" the
689 phrase is just a longwinded synonym for pet. All pets provide emotional
690 support to their owners; that's why we feed them rather than eat them.
691 --A service animal performs a service for a person with a disability;
692 A SA is defined as "any [...] animal ****individually trained**** ****to**
693 **provide assistance to**** an individual with a disability [...]."--
694 Wrong. Here's the regulatory definition of a service animal:
695 "Service animal means any guide dog, signal dog or other animal
696 individually trained to do work or perform tasks for the benefit of an
697 individual with a disability including, but not limited to guiding
698 individuals with impaired vision, alerting individuals with impaired
699 hearing to intruders or sounds, minimal protection or rescue work,
700 pulling a wheelchair or fetching dropped items." 28 CFR 36.104
701 --Who are you (or we, for that matter) to decide what the exact meaning
702 of "to provide assistance to an individual with a disability" is?--
703 A DSS provider interested in whether, in the language of the
704 regulation, the dog is "individually trained to do work or perform
705 tasks."
706 --I think we need to think out of the box on this issue and if I were a
707 judge I would do just that -- and "on a case-by-case basis."--
708 I agree that DSS providers and judges both should decide on a case by
709 case basis, but on the basis of demonstrable facts, not unsubstantiated
710 claims.
711 --that is why a school must modify its policies respecting pets to
712 accommodate a student with a disability who has a service animal.--
713 No DoH or HUD regulation equates an "emotional support animal" with a
714 service animal, and there is no reason to think that either the ADA or
715 the Fair Housing Act should require modification of no pet rules for an
716 "emotional support animal."
717 --So, dorms do not constitute "public housing?" I thought a tenant with a
718 disability was allowed an ESA in "public housing," but I could be wrong
719 on that one Xxx.--
720 Dorms are not public housing projects, but they are covered by the Fair
721 Housing Act. The Fair Housing Act does not impose any greater
722 obligation to accommodate than does the ADA or section 504; that is why
723 DoJ and HUD issued a joint statement. The joint statement makes no
724 reference to so called emotional support animals.
725 I wrote: If the dog is a pet, it belongs at home. Here is a useful
726 thought experiment. Would you modify rules limiting residence in
727 dormitories to students when asked to do so by a student with a
728 disability who has a live in personal care attendant? Yes, because the
729 personal care attendant performs essential personal care services for a
730 student that the student cannot perform for himself/herself. Would you
731 modify those same rules when a student brings his girlfriend [sic] or
732 boyfriend from home to live with him in the dormitory because she/he
733 provides "emotional support" that prevents seizures? Of course not.
734 Why would we treat students with pets differently from students with
735 girlfriends or boyfriends?

736 --Nice analogy ... Not certain it applies here. Good thing we're all
737 allowed our own opinions.--
738 Just so; explain how the PWD with a loving dog is different from the
739 PWD with a loving boyfriend. The point is simple; the rights of the PWD
740 in question trace to the work or task the animal or person performs,
741 not to the difference between an animal and a human.
742 --Ah... Now I see the reason for the above analogy, as well as this
743 response (for the most part) of yours to my post. Do you believe in
744 non-task-trained SAs? Hmmm... Well the Psychiatric Medical Profession
745 is just beginning to wake up to the fact that PSAs and PSDs are real
746 and here to stay.
747 [See <http://www.psychdog.org/> - "The Psychiatric Service Dog Society is
748 a 501(c)3 nonprofit organization dedicated to responsible Psychiatric
749 Service Dog (PSD) education, advocacy, research ..."]--
750 What I believe is quite beside the point. Or should I say, that is
751 precisely the point; beliefs are irrelevant; facts matter. A "non-task-
752 trained SA" is an oxymoron. Task training is exactly what distinguishes
753 a service animal from a pet.
754 --Example 3: A housing provider has a "no pets" policy. A tenant who is
755 deaf requests that the provider allow him to keep a dog in his unit as
756 a reasonable accommodation. The tenant explains that the dog is an
757 assistance animal that will alert him to several sounds, including
758 knocks at the door, sounding of the smoke detector, the telephone
759 ringing, and cars coming into the driveway. The housing provider must
760 make an exception to its "no pets" policy to accommodate this tenant.
761 What if the tenant is lying and the dog is not a SA -- but just a very
762 well-behaved pet?--
763 A real case; the U.S. Court of Appeals for the Seventh Circuit decided
764 it in *Bronk v. Ineichen*, 54 F.3d 425 (7th Cir. 1995). If the tenant is
765 lying by claiming the dog is a trained service dog, the landlord has
766 not violated the Fair Housing Act by refusing to permit the deaf tenant
767 to keep the dog in his apartment.
768 Students with disabilities have every right to bring their service
769 animals to class and to keep them in their residence halls. Students
770 with disabilities who have pets should respect the no pets rules of
771 campus residence halls.
772 --I agree with the above statement. I just think we, as people, need to
773 think more outside of the box. Let's give the benefit of the doubt to
774 the PWS when they say their animal is a SA and then time will tell if
775 it is or isn't, instead of some appointed "gate-keeper/policy."
776 A few more URLs of possible interest:
777 <http://www.psychdog.org/About.html>
778 <http://www.psychdog.org/news.html> --
779 Schools are of course free to open their campuses to all animals if
780 they choose; they are also free to "give the benefit of the doubt" to
781 someone who claims to have a disability and who claims that his/her pet
782 is a service animal, but they are under no obligation to do so. As for
783 useful resources on the wonderful ways in which dogs can provide
784 support, don't forget "A Boy and His Dog" by Harlan Ellison; it is at
785 least as useful as the psychdog site.

Appendix O
Agoraphobia

1 <I have had a prospective student contact me who has a diagnosis of
2 agoraphobia from a psychiatrist. She is currently taking classes at a
3 technical school, but wants to transfer to our university next year as
4 a business major. She said that she wants to be excused from all oral
5 presentations as an accommodation for her disability. I am questioning
6 if this will be a reasonable accommodation for a business student. I
7 would guess there are a number of classes in a business major that
8 would be fundamentally altered by removing oral presentations. I would
9 like to get your thoughts and advice about her accommodation request,
10 other ways to accommodate her disability, etc.>
11 <As a psychologist, I would like to respond to this from the point of
12 view of: (1) What is agoraphobia? and (2) What is in the best long-term
13 interests of a person with agoraphobia?
14 (1) Agoraphobia is a type of anxiety disorder in which the individual
15 has an extreme, but irrational, fear of being in places or situations
16 in which they would feel unsafe. As a result, they avoid the feared
17 situation. Typical situations avoided by a person with agoraphobia are
18 shopping malls, public transportation, restaurants, supermarkets, etc.
19 In severe cases, people with agoraphobia are totally unable to leave
20 their house, sometimes for years on end.
21 (2) Whenever a person with agoraphobia avoids the feared situation, it
22 reduces their anxiety. That might seem good in the short-term because
23 they feel better at that moment. However, reducing anxiety by avoidance
24 perpetuates avoidance. It is better in the long-term to help the person
25 learn to feel safe in public situations.
26 Psychological treatments have proven quite effective for agoraphobia.
27 Such treatments concentrate on reducing agoraphobic avoidance. This is
28 done by arranging conditions in which the patient can gradually face
29 the dreaded situations and learn that there is really nothing to fear.
30 Patients can also receive medication, cognitive therapy and relaxation
31 training.
32 Now, with regard to accommodations: She wants to be excused from all
33 oral presentations as an accommodation for her disability. This would
34 certainly reduce her anxiety about class presentations and help her
35 feel better about attending class. However, this is a short-term remedy
36 which only makes the long-term condition worse. Why? Because being
37 excused from oral presentations is a form of agoraphobic avoidance. It
38 reinforces avoidance as a way for this student to cope with her
39 anxiety.
40 A far better accommodation would be to arrange conditions in which this
41 student can gradually face making oral presentations and learn that
42 there is really nothing to fear. This is what we call using exposure,
43 rather than avoidance, to reduce anxiety. Sometimes a therapist
44 accompanies the person with agoraphobia on their exposure exercises, so
45 this could be the accommodation in this case.>
46 <Agoraphobia is a specific anxiety disorder. The school has to decide,
47 is this requirement "essential" for the class. I can see both ways on
48 this.
49 My suggestion is presentations with the teacher in a comfortable
50 setting and gradually encourage -possibly non graded- building up to a
51 public oral presentation. We really don't know the degree of progress
52 the individual has made to this point, so The only problem is if there
53 is a setback during the process, it might be in such a degree as to go
54 back to an earlier stage.

55 I hope any situation has the goal of helping the individual be the most
56 effectivs [sic] as possible, and not to just be a hurdle to overcome.>
57 <Xxx and Xxx bring up an interesting question I havn't [sic] thought of
58 before. They are really suggesting that the therapy be accommodated,
59 not the disability. This is an interesting concept, especially when
60 dealing with mental health issues. I could see a paradox forming where
61 there is pressure to allow the fundamental alteration of a class
62 requirement to accommodate the theraputic [sic] process of non-
63 avoidance. What if this doesn't happen during this class, this semester
64 or even this year????

65 Now where are we? Therapy is not an overnight success! Are we in
66 essence accommodating adverse/negative behavior? My first assumption
67 was that the impact of the Agora on the educational process and this
68 student, was not debiltating [sic] enough to warrant accommodations, or
69 to qualify the person as a student with a disability. That if the swd
70 could maintain enough to get into the classroom and was only worried
71 about oral presentations, then join the rest of the class which are
72 typically just as anxious. What are others thoughts?>

73 <--Xxx said: Xxx and Xxx bring up an interesting question I haven't
74 thought of before. They are really suggesting that the therapy be
75 accommodated, not the disability. This is an interesting concept,
76 especially when dealing with mental health issues.--

77 I agree. The first thought I had in reading posts from Barry and Fred
78 was that they were giving excellent advice if you were TREATING the
79 student, but I am/was not sure where that fit with our duty to
80 accommodation the student. As my friend Xxx has noted on a number of
81 past occasions, nothing within Section 504/ADA gives us (as service
82 providers) either the right or the obligation to engage in
83 rehabilitative services.

84 Are we in essence accommodating adverse/negative behavior?
85 I don't think that is either our (DSS) call to make in this case any
86 more than it is in other circumstances. Should we refuse to provide
87 textbooks on tape to a student whom we think would be better served by
88 learning Braille? Should we refuse to provide sign language
89 interpreters to a deaf student who won't wear a hearing aid? I am not
90 sure that those examples are so far off the mark from what Barry and
91 Fred suggested here.

92 "Don't provide accommodation in resonse [sic] to the student's
93 functional limitations. It is not in her best interest." Says who? On
94 what authority? My first assumption was that the impact of the Agora
95 on the educational process and this student, was not debiltating [sic]
96 enough to warrant
97 accommodations, or to qualify the person as a student with a
98 disability. That may well be. I am not sure we have enough information
99 to answer that question, based on what Becky provided. But IF we
100 determine that the agoraphobia is substantially limiting and that some
101 accommodation is warranted, THEN I think the question Becky originally
102 asked must be judged against the curriculum, not weighed simply in
103 relation to the student.

104 Becky said (in part): She said that she wants to be excused from all
105 oral presentations as an accommodation for her disability.

106 Becky asked if this were a reasonable accommodation. My immediate
107 response is that it is NOT reasonable, for the same reason that we
108 often tell faculty that something IS reasonable and they must bend...
109 the use of the word "all."

110 It seems to me that any time the request OR the refusal include the
111 words "all", "never," or "always" the proposal is self-defeating. In

112 making this request, the student clearly is NOT considering, on a case-
 113 by-case basis, what other options (besides being "excused" from the
 114 assignment) might exist in some circumstances. Depending upon the
 115 severity of the problem, I MIGHT be prepared to help negotiate some
 116 alternatives in some circumstances. The odds of going through a
 117 complete business degree without ever needing to demonstrate this
 118 skill/ability (in the context of a typical campus-based degree program)
 119 seem slim, and I would want to make it clear to the student from the
 120 start that you make NO such promises.>

121 <This is a crossroads issue. Again if the oral presentation is an
 122 ESSENTIAL part of the program, then the only way to accommodate may
 123 well be to push coping and adjustment skills. I remember as a child
 124 spending three hours a day -after- school at the speech and hearing
 125 center being trained to do hearing things (lip read, learn word
 126 pronunciations, adjust to a hearing aid). Those things were as
 127 important as todays [sic] "take a step back accommodations" such as
 128 extra time and flexibility.

129 Is it so far out of scope to view behavioral coaching and adaptive
 130 training as a method of effectiveness?? Are we helping really helping
 131 if we only view our jobs as getting them there without the
 132 coping/adaptive skills needed for the future?!?!>

133 <When I was in graduate school, I was allowed more minutes when I gave
 134 presentations to my classes since I had two sign language interpreters
 135 who also did voice interpreting for me. The student with agoraphobia
 136 should come up with solutions and suggestions rather than avoiding and
 137 justify his/her disability.>

138 <Just to clarify my post: I didn't mean to suggest that "the therapy
 139 should be accommodated, not the disability." My point is that in many
 140 psychological/psychiatric disorders it is crucial to understand the
 141 nature and causes of the disorder in considering accommodations.
 142 Because sometimes what might seem on the surface to be a good thing for
 143 the student can actually make them worse.

144 Likewise, these analogies are also off the point:
 145 "Should we refuse to provide textbooks on tape to a student whom we
 146 think would be better served by learning Braille? Should we refuse to
 147 provide sign language interpreters to a deaf student who won't wear a
 148 hearing aid?"

149 It's not so much that I think you should refuse the requested
 150 accommodation, it's that I would want the student with agoraphobia (and
 151 others) to understand that there are specific accommodations
 152 (regardless of how well-meaning they might be) which can be clearly
 153 recognized as harmful once you understand the dynamics of the disorder.
 154 As someone, somewhere said:
 155 "Above all, do no harm.">

156 <--In a message 11:21:17 AM, Xxx writes (in part): Is it so far out of
 157 scope to view behavioral coaching and adaptive training as a method of
 158 effectiveness?? Are we helping really helping if we only view our jobs
 159 as getting them there without the coping/adaptive skills needed for the
 160 future?!?!--

161 You are right, Xxx. This IS a very basic issue for the field. I think
 162 it is also a very difficult judgement [sic] to make for folks who are
 163 responsible for providing 504/ADA mandated accommodations AND who are
 164 part of the Student Affairs division at their institution (or some
 165 division, whatever the name, that has student development as part of
 166 its mission). Are behavioral coaching and adaptive training appropriate
 167 activities for the DSS provider?

168 In the context of providing equal access (that is, 504/ADA and
169 accommodations) I would say "NO... those are outside your purview" in
170 no uncertain terms. In the context of being educators, preparing
171 students to be more independent and functional in the future, you are
172 right -- these seem very appropriate activities. But engaging in such
173 activities under the heading of "accommodation" (which was the original
174 question) seems to me to be a mistake. I would also be concerned about
175 whether the adaptive behaviors we are attempting to employ for a given
176 student are the RIGHT ones for that given student, as applied by folks
177 who may not have the right credentials/background to be making these
178 decisions. I can remember discussions in the past of whether or not to
179 allow a student who was anorexic to modify the "dining" portion of the
180 residence hall contract (as I recall, she was asking that she be
181 charged half as much as everyone else because she was going to eat only
182 a small portion of what everyone else ate). Is this a logical thing to
183 do? Is it appropriate or is it contradindicated [sic]? I am not sure
184 that, as a service provider, I would want to be held responsible for
185 (presumed) accommodations decisions that trail over into the arena of
186 treatment. That is why a focus on case-by-case, and the impact on the
187 CURRICULUM (rather than just the student), seems a good bet in the
188 specific situation presented to us here.>
189 <--I remember as a child spending three hours a day -after- school at
190 the speech and hearing center being trained to do hearing things (lip
191 read, learn word pronunciations, adjust to a hearing aid).--
192 The key words here are "after school", not during school or in a class.
193 It would have been counter productive to you, the teacher and the other
194 students to be part of your therapy if this was done simultaneously in
195 the class. This would be similar to the therapist comming [sic] in with
196 the Agora student and making the class part of their therapy sessions.
197 I am not sure how the blind examples fit in or how they got started.
198 The student is asking that an essential part of the course be waived
199 for her. Then it was suggested that the scenario be turned into a
200 therapy session and the possibility exists that we accommodate the
201 therapy. That as DSS, we should be working with the totality of the
202 students experience and not just the impact of the disability. This is
203 similar, I think, to what Sam was doing with a student while she
204 attended therapy. Now she has quit therapy but still wants whatever
205 accommodations Sam was allowing. As DSS and under ADA, We can't allow
206 accommodations on a contract basis, ie: you do this and we will do
207 that. I am sure Sam was sharp enough to allow a temporary accommodation
208 based on further investigation and documentation :-). But that is
209 exactly the paradox I had in mind. Their is no guarantee that the
210 therapy is going to work, and at the end of the class we have a student
211 that never did oral presentations, and now what do we do? We allowed
212 an unreasonable accommodation based on a therapeutic [sic] assumption
213 that didn't work or take place. Do we pass the student or fail the
214 student?
215 If I am reading Xxx right, I think she is right on in referring the swd
216 to the counseling office. I wear both hats in my job. I did have an
217 Agora student present, with her doctor, so we could stratagize [sic] on
218 how to include being a student into their therapy. My office became
219 her safe place, I would escort her to classes, even sitting in them
220 with her if needed or providing trial runs, et cetera. But these were
221 not formal accommodations, and she suffered the consequences of any
222 avoidance behavior in regards to the class syllabus. And we discussed
223 that upfront, that failure could be a logical outcome for her as a
224 student if her coping behaviors didn't manifest.>

225 <Beg to differ, it was a team approach the teachers were given
226 approaches to work, while I was given specific learning>
227 <I agree with Xxx. Having treated a number of students with various
228 anxiety disorders, I understand that perpetuating her avoidance is not
229 helping her. It do not feel it is the school's responsibility to help
230 her get treatment or provide a tretment [sic] regime that would
231 desensitize her to the anxiety. That is a treatment issue and should
232 not be offered as an accommodation, although she should be referred to
233 stress management and test anxiety workshops. Perhaps the university
234 mental health/counseling center would be appropriate as well. I think
235 offering to allow the therapist to be present during her first few
236 presentations is appropriate and does not constitute provision of
237 therapy on the part of the school because the therapist is providing it
238 and the student is paying the therapist. The accommodation is simply to
239 allow a support person to be in the classroom.
240 If the student is capable of attending classes, I would question if
241 agoraphobia is now an accurate diagnosis. I do not see a diagnosis as
242 anything but a description of a collection of symptoms or behaviors.
243 The root causes to these symptoms/behaviors may be very different from
244 one person to another (hense [sic] the nature/nurture arguments;
245 biology vs. psychology; meds vs. therapy). Sounds like a more accurate
246 diagnosis at this time would be performance anxiety or social phobia.
247 Certainly it may have been agoraphobia and she has progressed to a
248 point now through medication and therapy to venture out in the world.
249 Her psychiatrist should be encouraging her to take more risks and not
250 to avoid this situation. I would get a release of information and ask
251 for records from the psychiatrist. There may be some other things going
252 on here.
253 Again, I agree with Becky that it would fundementally [sic] change the
254 course not to require her to make oral presentations in a class.>
255 <I have always struggled with accommodations which are counter-
256 theraputic [sic]. Why can't we provide therapy as the appropriate
257 accommodation for a treatable anxiety disorder, particularly severe
258 anxiety triggered by exams? The studies show such therapy is often very
259 effective and effectiveness is a key measure of what constitutes an
260 appropriate accommodation. The student retains the right not to use the
261 therapy/accommodation just as some blind students refuse to use a cane.
262 (The fact that they won't use a cane doesn't mean we provide sighted
263 guides.) Is there an inalienable right to refuse appropriate therapy
264 that trumps that therapy being the appropriate accommodation? If so,
265 what is the legal basis of this "right"? Last year I did temporary
266 exam accommodations for a student with a "social phobia/severe test
267 anxiety." She came back this year to extend the accommodations and
268 told me that, after one visit she quit the therapy the university had
269 been providing for her to learn to control her anxiety. Am I providing
270 a civil right or simply a government paid enabler?
271 I lost a similar argument, to Xxx or Xxx or both, a couple years ago
272 but this one has a slightly different twist.>
273 <We here are reluctant to provide treatment, that is not part of our
274 educational mission. Plus the liability is too great.
275 I think everyone has the right to refuse medical treatment for almost
276 any reason (or none) as long as they do not put others in danger.>
277 <In playing around with Sam's remarks, the question comes to mind as to
278 why not attempt to forge a working relationship with the student's
279 therapist to see if principles of therapy could be applied to the
280 accommodation process in a manner which would not violate either

281 process? I've experienced this kind of "interagency" cooperation in
282 other of my occupational incarnations.>
283 <I guess I am coming to the point...is waiving as effective a REAL
284 WORLD device as, maybe setting up the oral presentation as a modified
285 form of accomplishment. Is it so wron [sic] or out of scope to offer
286 coaching for success?