**FORENSIC PSYCHIATRY IME's**

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## I. Introduction

### A. Scope of the problem.

Stress related illness is an increasing problem in the workplace. A recent Gallup poll of 201 U. S. corporations revealed the extent of this problem, showing significant percentages of the workforce affected by disorders ranging from fatigue and difficulty concentrating, to substance abuse problems, to actual mental illness. In these companies, nearly 60% of all managers felt that stress related illness was pervasive among their workers and decreased productivity at an estimated cost of 16 days of sick leave and $8000 per person in a year.

Among stress related illnesses, depression or depressive disorders alone are estimated to cost the American workplace a staggering $43 billion dollars per year, including the cost for absenteeism, lost productivity, treatment and rehabilitation, and loss of earnings from accidents and suicide. In addition, workplace violence has increased dramatically in the last 15 years, with homicide accounting for 17% of all occupational fatalities. Furthermore, claims of physical and sexual assault, verbal threats or intimidation, and harassment have risen at alarming rates. In conjunction with these claims, the diagnosis of posttraumatic stress disorder has emerged as validation of the harm suffered, and is probably one of the most popular diagnoses in litigation today. Finally, these stress related illnesses do not even begin to take into account physical disabilities such as low back pain or repetitive motion injury, which can have strong psychological and psychosocial factors accompanying them. With this rise in stress related illness, there has been a corresponding rise in worker's compensation claims for them.

### B. Why conduct an IME?

Because of the subjective nature of stress related illness, and mental disorders generally, as well as their high cost to the American workplace, verification of claims through an Independent Medical Evaluation (IME) is frequently sought. The opinions of the treating psychiatrist (this discussion applies equally to psychologists, social workers, counselors and other mental health therapists) are thereby reviewed by an independent psychiatrist, i.e., one who is not allied to the patient or the patient's claim. The independent psychiatrist may be just another clinician in the community, or a forensic psychiatrist who has special training and experience in legal issues that surround the claim, and ways to objectify it. The specific questions which are addressed in a psychiatric IME are similar to those for medical injury claims:

1. Has the mental disorder been properly diagnosed?
2. Did the workplace cause or contribute to the mental disorder?
3. What is the current level of impairment?
4. Has the treatment been appropriate?
5. Has the patient reached maximum medical improvement (MMI), and is there a permanent impairment rating?

## II. Treating psychiatrists versus independent psychiatrists.

### A. General considerations.

Treating psychiatrists have known their patient over a period of time and are, therefore, often said to be in the best position to render an opinion about the mental state of that patient. Indeed, the Social Security Administration and Industrial Labor Boards frequently give greater weight to the opinions and testimony of treating psychiatrists. However, closer inspection of many mental disorder claims shows that the history, taken by treating psychiatrists, of a mental disorder following an alleged workplace injury is not always accurate.

Case Example:

> T.N. is a 49-year-old man who was employed as a maintenance worker at a state-operated halfway house for criminal offenders. He left work claiming disability because of severe anxiety symptoms caused by his job. He said he began to experience chest pain, numbness in the side of his head and arm, and shortness of breath. He also felt depressed, saying he was abused by his employer. He was tired and no longer had any ambition to work. In supporting the claim, T.N.'s psychiatrist reported (based on the patient's history) that T.N. claimed that his supervisor had been unduly critical of him and his work. Since he was the only person assigned to clean the building, he would get all the blame when it was not perfect. He alleged that no one else in the building would help him out and it was impossible for him to do his job to his supervisor's satisfaction. With increasing criticism, he gradually felt more alienated from the other staff. In addition, he was advised not even to speak to the offenders. Finally, on the day that he left work, he was given a letter that changed his hours from 5:30 a.m. to 2:00 p.m., to 7:30 a.m. to 4:00 p.m. He felt that this was would give him no time to spend with his wife in the afternoon, before their children returned from school. For him, this was the last straw which he said totally overwhelmed him. This was just another way for T.N.'s supervisor to harass him.
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> In contrast to T.N.'s own account, reports from his supervisor, as well as T.N.'s personnel file, indicated that T.N. had a negative personality. He became easily aggravated and routinely blew up at fellow employees. When the quality of his work was criticized by anyone, he would scream at them. Staff commented that when T.N. would come in at 5:30 a.m., he would not actually start work until much later when he saw the supervisors arriving down the long driveway leading to the halfway house. Instead, he would sit on the porch, smoking and talking with the offenders. T.N. was confronted repeatedly about his unsatisfactory work performance, to which he would answer that he was not getting sufficient supervision. For this reason, his hours were being changed so that his supervisor would be more available to him.
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> A more careful look at T.N.'s past history shows that he began working for the state twenty years ago. During most of his early years of service, he worked on a paint crew. However, to avoid layoffs, he frequently transferred positions, but in the process lost his salary grades. Therefore, his present salary grade was providing only minimal wage to him. He had frequently expressed dissatisfaction with his salary as well as the work at the halfway house. In addition, it was known that T.N. bought a piece of land five years earlier which he had been developing for a home site. He spent long hours outside of his job putting in a road, adding a septic system and well, cutting logs, clearing the property and building a log cabin. This project was his main

source of pride and he was totally invested in it. T.N. also had numerous personal problems, including grief over his father's recent death, concern over a son who was incarcerated, marital conflicts, and a number of musculoskeletal injuries acquired during the construction of his cabin.

Was this patient lying to the treating psychiatrist? Was the treating psychiatrist falsely supporting the claim? Was the treating psychiatrist incompetent? The answer is that most likely none of these occurred. Rather, the subjective nature of mental disorders, coupled with known contaminants to the patient's history, created the distortion:

1. All psychiatric histories provided by a patient are in some sense a mythical narrative. Research has shown that memories are influenced by decay over time as well as by a number of interfering factors. Biological processes, of course, play a major role so that brain deterioration through aging or other conditions can affect memory. Psychological processes also distort memory. For example, people are known to create personal myths in which they tell their story in light of how they want to see themselves, or how they have learned to see themselves over time. This can be an idealized, inflated self-view; or a self-deprecating one. Also, there is a process of memory reconstruction which takes place with or without a theme, and that is influenced by numerous factors. Among these factors are post event misinformation, suggestibility, biases, and environmental influences. Surprisingly, these distorted memories have been shown through research to be expressed with a great deal of confidence by people, even though there may be significant inaccuracies.
2. Human nature is such that people are always interested in finding causes for unpleasant or painful experiences. Social psychologists recognize this, labeling it attribution theory. This essentially means that by identifying a cause for their distress, human beings can see themselves as less vulnerable - even if that cause is erroneous. Throughout primitive cultures, unpleasant experiences were typically attributed to those forces which were mysterious and seen as most threatening. Spiritual and supernatural causes of distress were relegated to be understood and manipulated by which doctors and medicine men. In spite of our advances in science, much in medicine and psychiatry is still not well understood, but the need to attribute distress to some cause remains. This can lead to finding reasons where no reason exists, or ignoring the real reasons, or identifying reasons that are convenient.
3. Mental as well as physical symptoms can be maintained by a process known as secondary gain. This refers to those perhaps unexpected environmental responses to symptoms or impairment that sustain the disorder by reinforcing it. Examples include financial reimbursement, attention from the family, or avoidance of less than satisfactory work conditions. Secondary gain not only influences the symptoms themselves, but the reporting of those symptoms in the patient's history. The history can, therefore, have elements of exaggeration and distortion. This is not necessarily a conscious process, but can be a powerful one.

**B. Treating psychiatrists.**

Treating psychiatrists often have intimate knowledge of their patient's psychological and emotional functioning, strengths and vulnerabilities, defense mechanisms, symptom complexes, and response to

treatment. Inevitably, they have also made a diagnosis of their patient's condition which has served as the foundation of the therapeutic work. In addition, they often have seen the patient over an extended period of time, which can include many hours of personal contact - the inference being, again, that they would naturally know the patient the best. Furthermore, their involvement has frequently been initiated outside of the context of the legal arena so that their observations are somehow thought to be more pure and not contaminated by pressure from a hiring insurance company or law firm. For these reasons, treating psychiatrists are usually sought by claimants' lawyers, who represent them as the most credible witnesses to the claim.

However, there are serious drawbacks that must be considered with treating psychiatrists which can only be understood by examination of the nature of the psychotherapeutic relationship. The most important of these is that treating psychiatrists generally accept the reality of the patient's presentation and historical narrative. This does not mean if a patient's account is delusional or grossly distorted, that a treating psychiatrist would not confront it. Similarly, over time and with the development of trust, the treating psychiatrist may be able to present alternative perspectives on even more subtle distortions which the patient may harbor. But, for the most part, a plausible perspective of the patient is accepted. The patient's reality and the meaning attributed to it are more important than actual reality. For example, if a patient is expressing emotional pain because of a mother's abuse, it may not be important, at least at the outset, to determine how often the abuse occurred, what were the particular circumstances, or whether or not it has been misrepresented. The patient can still be comforted and helped to work through this pain in the absence of a completely accurate historical account. Treating psychiatrists, after all, are not lie detectors and are not in the business of doing detective work. Yet, if the plausible perspective of the patient is brought to a Labor Board as fact by the treating psychiatrist, it may be erroneous and misleading.

Treating psychiatrists are also limited in the scope of information to which they have access. Again, they typically rely on the patient's account. At times, they may ask for earlier mental health records or, more likely, summaries of records, but they do not perform exhaustive corroborative searches. They will usually not have access to accident reports, complete medical records, other witness statements, employee files, school records and so on. Those are not essential for psychotherapeutic work to continue, even though they may be critical in a hearing decision. If treating psychiatrists do receive corroborating information at some later point in order to prepare for testimony, they may face information that is not compatible with their earlier clinical formulation. Yet, modification of their opinion could threaten the therapeutic alliance.

This leads to the next important drawback in the use of treating psychiatrists, namely, that their therapeutic alliance with the patient can preclude objectivity. Treating psychiatrists, by their very role, rely on the treatment relationship in order to provide their healing. That relationship must be one of trust and confidence, and belief on the part of the patient that the psychiatrist is there for them. If the psychiatrist ex-presses an opinion that is contrary to the patient's claim, resentment can inevitably form and the relationship is damaged. It would be naive to think that the authority and opinions of the psychiatrist would be accepted by the patient without such a consequence. More likely, the psychiatrist and patient would become adversaries, with the patient perhaps even seeking other professional help. Instinctively, treating psychiatrists know this, and especially where there has been a long-term relationship, they will not compromise the patient's interests. For example, if a psychiatrist has been in a treatment relationship for many years with a patient who has hypochondriacal tendencies, would the

psychiatrist refuse to support a recent claim of whiplash symptoms even if exaggerated? It is unlikely. This does not mean that the psychiatrist would purposely give a false opinion, but there would be the inclination to soften the impact of hypochondriasis on the patient's current distress.

Another potential conflict faced by treating psychiatrists is payment for their services. Although private health insurance carriers will be responsible for payment of most therapy with or without some copayment on the part of the patient, this is not always the case. For example, in worker's compensation claims, payment to the psychiatrist will be directly related to a favorable opinion that the patient's symptoms arose out of and in the course of employment. The typical scenario in these cases occurs after an initial interview between the psychiatrist and the patient, when the patient announces that all the bills will be covered by worker's comp. The psychiatrist is next handed an insurance form or asked to provide documentation which validates the work connection. This decision is often made after a relatively brief interview with little in the way of corroborating information. Later, as treatment has progressed and a more formal opinion is requested, is it really possible for the psychiatrist to be objective and say that the symptoms are not work related, when fees have been collected over a period of time on that basis? Again, this does not mean that the psychiatrist will falsely provide an opinion in order to be paid, but that conscious or unconscious factors will certainly influence the psychiatrist's ability to be objective.

C. Independent psychiatrists.

Independent psychiatrists would appear to be a better choice to gain an objective opinion, and using them would avoid many of the potential conflicts and issues around credibility just described. Independent psychiatrists can provide opinions which do not affect the therapeutic alliance with the patient. They are in a position to consider all the data and give it proportional weight. They usually have access to more corroborating information and, by virtue of their experience, should be asking for complete records and background data which provide a more complete understanding of the patient's history. If properly trained and certified, independent forensic psychiatrists are more knowledgeable in the legal process, rules of evidence, the legal standards to which their opinions are being applied, and the limitations of psychiatric testimony.

On the other hand, independent psychiatrists may not always be objective either. In the first place, the concept of objectivity is probably an illusion. There is always a tendency for bias in every opinion and in every testimony, this goes for both treating psychiatrists as well as independent psychiatrists. Bias can come from basic philosophical positions or allegiance to a theoretical stance; in psychiatry, for example, there are a number of schools of thought, one or more of which may dominate the independent psychiatrist's thinking. There is also potential bias based on agency, i.e., whose agent is the psychiatrist? The insurance company? The law firm's? The State's? Can the independent psychiatrist really maintain neutrality with regard to agency? Therefore, recognition of potential bias is necessary for the independent psychiatrist so that this element can be neutralized as much as possible.

Money, too, can affect objectivity because there may be an inclination to provide favorable opinions to whoever is hiring the independent psychiatrist. This has led to the use of the term hired gun. No doubt this occurs, and lawyers may, indeed, rely on predictable opinions of their frequently used experts. However, independent psychiatrists may, at times, be incorrectly labeled as hired guns due to widely conflicting testimony observed in the courtroom. It should be noted that legitimate differences can exist in clinical opinion and in the adversarial process itself, where favorable aspects of an opinion are

emphasized and unfavorable aspects are downplayed. This happens, of course, with any expert opinion, not just that of an independent psychiatrist. Considerable differences are seen among other medical specialists, economists, arson and ballistics experts, engineers, etc. These reasonable differences should not imply that opinions are by a hired gun. But, if very similar sets of facts lead to two different opinions by the same independent psychiatrist, or if the psychiatrist routinely swings in his or her conclusions, then it may be suspect.

**III. Worker's compensation claims for mental injury.**

Work and stress are almost synonymous. The very nature of work creates forces and pressures on an individual, either from external events or internal drive, that require adaptation. At the outset, stress comes from having to be at work at a particular time, remaining there for a prescribed number of hours, accepting the physical demands and requirements, meeting deadlines or quotas, achieving a level of quality or accuracy, and interacting with coworkers and superiors. In the real world, it also includes tolerating personality differences, facing one's own shortcomings, dealing at times with unreasonable authority, facing overwhelming tasks, and answering to the excessive demands of clients or customers. These factors are inherent in work and are not pathologic. Even the distress or discomfort that flows from those obligations is not pathologic. After all, few individuals are completely satisfied with their work, and most feel distress on a regular basis. The issue then is not whether there was stress or even distress, but how adaptive or maladaptive was the individual in the face of it. More importantly, did a maladaptive process lead to an actual stress related illness, and how can it be defined or measured when there may be no observable injury? From its inception, worker's compensation law recognized this difficult question and tried to find ways of establishing objectivity. There are three general categories of mental claims, which differ in their degree and form of objectivity.

1. Physical-mental
2. Mental-physical
3. Mental-mental

Traditionally, most worker's compensation acts have required as a part of their coverage formula a personal injury by accident or accidental injury. Emotional or stress related illness was viewed skeptically because of its subjective nature. Objectivity was established by requiring that stress related illness have a physical connection. Two types of claims are found using that connection: physical trauma leading to a mental disorder, and mental trauma leading to a physical disorder. These are respectively known as physical-mental and mental-physical.

In the physical-mental cases, there is a clear precipitating injury with psycho-logical consequences, e.g., a laborer falls off of scaffolding, injuring his back, and later develops a major depression, claiming it is due to his newly acquired limitations. In the mental-physical cases, some emotional or stress circumstances leads to an objectively measured physical disorder. Originally, the circumstances needed to be clearly identified such as from a nervous shock, e.g. witnessing a disaster at work leads to a heart attack. However, the nature of the emotional stress has expanded to include prolonged or cumulative work stress, and there has been a trend to compensate for many conditions including hypertension, asthma, peptic ulcer, etc., which are claimed to be a result of that stress. Again, although the stress

related illness or the stress circumstances may be subjective, the physical connection is thought to give these claims an objective credibility.

The more controversial category of stress claims is that of mental trauma leading to a mental disorder, also known as the mental-mental claim. The difficulty in evaluating these claims is to a great extent due to the difficulty in defining a personal injury when it consists primarily of an intangible force producing a more intangible effect. When the injury represents a single or limited sequence of events, then it might be easier to identify its traumatic potential, e.g., a fire at a plant or a robbery in a bank can be objectively described by the worker or other observers so that the magnitude of the threat, the proximity to the worker, and the likely alarm created can be independently scrutinized. It is quite a different task to attempt to measure the cumulative effects of exposure to some harmful aspect of the total work environment, where the perspective of the individuals involved can widely differ. For example, how do we measure the degree of pressure a boss was placing on an employee that is claimed to have led to an anxiety disorder? Adding to the problem, from principles of the eggshell skull rule in tort law, are stress related claims that are based only on an aggravation of a preexisting condition. In effect, this opens the door to a multitude of potential claims because someone with an emotional disorder can invariably say that any work stress at least made it worse.

Many jurisdictions have attempted to limit these mental-mental claims by narrowing the scope of allowable claims or by using more restrictive language. In Vermont, for example, to be compensable, the employee alleging that the work stress has caused a mental injury must demonstrate:

1. Some condition of work created an actual stressful situation. This need not be sudden or immediate but may take place over a period of time (gradual onset); it cannot be a reaction to normal employment events such as a job transfer, a disciplinary action or job termination; and, the stressful situation must actually exist and not merely be the employee's subjective impression or perception.
2. The work situation is the proximate cause of the mental injury rather than some other stress in the claimant's life (e.g., divorce, financial ruin, legal problems, family illness or death, etc.).
3. The work situation/stress was greater than the day-to-day stress and tensions which all employees must experience and/or greater than that experienced by employees in a similar occupation.

In New Hampshire, as another example, if an employee has a preexisting (mental) weakness, there is no recovery unless the stress of the workplace contributed something substantial, i.e., the employment connected stress or strain must be greater than is encountered in normal non-employment life.

**IV. Gathering information**

**A. Diagnostic issues.**

In mental claims, complete and accurate information is necessary in order to both make the correct diagnosis as well as to determine what employment factors played a role. The lack of complete and

accurate information is the number one problem for the treating psychiatrist, and can be for the independent psychiatrist if the information is not available. There is a great difference, therefore, between psychiatric opinion and medical opinion with regard to how much information is necessary. For example, if a worker has crushed the fingers of his hand in a machine, only a limited amount of information will be necessary to establish the accidental injury. If a worker has injured her back while picking up a filing box, slightly more information may be necessary, especially if there are not good diagnostic tests to confirm the injury. On the other hand, if a worker claims that he has become depressed because he was mistreated by his supervisor, a great deal more information is required to objectify the claim.

The peculiar challenge with mental disorders can be seen by comparing how diagnoses are generally made in medical conditions, and how the presence of any medical condition can be defined. The traditional ways of making a diagnosis are through:

1. Structural pathology, e.g., a biopsy finding of cancer
2. Etiology, e.g., an infectious bacteria identified in the blood
3. Deviation from some physiological norm, e.g., abnormally high fever, or elevated blood pressure
4. Observable signs, e.g., a physical examination finding of a rash, or heart murmur
5. Symptoms, e.g., complaints of pain or fatigue

The more a diagnosis relies on observable signs or symptoms only, the more it is subjective and difficult to verify. Almost all mental disorders rely only on observable signs, such as how the person appears and sounds, or symptoms which the person describes. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders IV-TR (DSM-IV-TR) helps provide various criteria for mental disorders. But even those criteria are constantly being changed, revised and expanded. It is possible today to find a diagnosis for almost any type of human distress or behavior. The DSM-IV-TR has been criticized as creating the false impression that more people suffer with a mental disorder than actually do. For example, one of the most serious types of depression, major depressive disorder, can be diagnosed if an individual for a two-week period has depressed mood, diminished interests, poor sleep, tiredness, and difficulty with concentration - symptoms that are frequently found in someone who is just distressed. Furthermore, a diagnosis of a mental disorder cannot be made only by looking at a particular point in time or by what a patient is saying the symptoms are today. The diagnosis must be made by looking at the entire life of the person and the kind of stresses and conflicts that person has undergone throughout his life. Some mental disorders are chronic, even though the person may be coming to a psychiatrist for the first time. Others are cyclical and recurrent. Still others represent long-standing personality traits that lead to maladaption. Without information about the patient's entire life history, the correct diagnosis cannot be made.

Mental disorders, by their very nature, interfere with an individual's social and occupational functioning. Of course, mental disorders can have many possible sources, including biological defects, psychological conflict, or environmental stress totally unrelated to the job. But, when the disorder becomes full-blown, it may invade all aspects of the individual's life, including his or her family, friendships, recreation, and work. As the individual's coping mechanisms deteriorate, every demand at work also becomes an overwhelming burden. Often, the work becomes too much. The more work performance is affected by illness, the more desperate an individual may become, seeking to blame what is convenient

for the distress. This typically and erroneously can include family, friends, or the workplace itself. With time, poor work performance actually creates a new burden in life, the threat of financial hardship, loss of self-esteem, or personnel action as a response to the poor performance. Information about the life history and previous mental problems of the patient becomes critical to identify if the mental disorder preceded the claimed workplace stress or was a result of it.

**B. Corroborating information.**

Corroboration can come from various sources. It can be either internal, i.e., within the history of the person being evaluated and mental observations of the person; or external, i.e,, from outside sources such as reports of family, friends, employers; or other witness observations. Medical and psychiatric records both from the current treatment, as well as past seemingly unrelated treatment, may be necessary to properly chronicle a mental disorder. Similarly, medical and psychiatric records, employment files, and IRS returns can help chronicle a person's functioning before and after the claimed disability. The reliability of all sources of information must be taken into account. For example, family members may be as equally vested in a worker's compensation claim as the person asserting it, and may distort the history in support of the claim. On the other hand, an employer may provide misleading information about the functioning of the employee to show that the claim of disability is fabricated. The inherent bias of all informants, as well as the consistency of reported information, must be scrutinized. Not having sufficient information leads to opinions with a poor foundation, and may be embarrassing when that information later surfaces.

Surveillance is a controversial area for obtaining corroboration. Even in instances of alleged physical injury, surveillance pictures or films within a discrete period of time may not accurately reflect an individual's overall functional ability. By necessity, many disabled people must exert themselves briefly beyond their actual capability, and then pay the physical consequence afterward. With mental disorders, it is even more difficult to assume that a discrete period of surveillance is representative of total functioning ability. A surveillance camera cannot capture internal emotional states. In some instances, however, if a person has represented that certain activities are impossible or never performed, then a surveillance camera may be able to disprove this representation. Surveillance is a limited tool, though, which should not be overly credited with importance.

**C. Nature of the work stress.**

Understanding the nature and severity of the work stress or trauma is important, as well as ascertaining whether stress even occurred as claimed. A percentage of claimants will grossly misrepresent or fabricate a workplace stress situation. More commonly, though, individuals may embellish or exaggerate a claim. It is important therefore to obtain verification of what actually occurred at work. Employer records, reports from supervisors, and witness statements may be extremely informative in this regard. Some of the thornier issues in worker's compensation claims of mental injury have to do with administrative or personnel actions by the employer. For example, if an employee is given a warning or reprimand for poor performance, it is understand-able that this would cause stress. Should that be considered a personal injury arising out of employment conditions? What if the employee was engaged in deliberate misconduct or criminal activity for which the employee was sanctioned or even terminated

by the employer? Surely, this would be stressful, too, but does it fall under worker's compensation law? What of the stress of a layoff or termination with our without a cause? Are these properly considered employment stressors? Labor Boards have been divided on these issues. In Vermont, the law seems to address the problems by excluding personnel actions as compensable. However, there must be room for consideration of unreasonable employer behavior as a source of stress.

D. Nature of the work.

Impairment from a mental disorder generally falls under one of four categories:

1. Temporary partial
2. Temporary total
3. Permanent partial
4. Permanent total

An understanding of that impairment must always be in relationship to the nature of the work the employee was performing, or could still perform. At times, the nature of the work can clearly show that the employee cannot or should not continue performing those same duties, e.g., a firefighter who has posttraumatic stress disorder from a near-death experience becomes too anxious to go into a burning building; or a flight attendant whose plane dropped 1000 feet in an air pocket becomes too frightened of flying. At times, even mild symptoms of a mental disorder can compromise the essential aspects of the job, e.g., a correctional officer who is beaten by inmates no longer projects confidence, thereby becoming vulnerable to further assaults. Some types of work may require a higher degree of mental acuity and energy which can be lost with a mental disorder, e.g., a sales manager in a high-powered position cannot motivate his employees because of a depressive disorder. The employees in all of these examples may be suited for some other work if their mental disorder does not appear to be amenable to treatment. Claims, on the other hand, that an employee can no longer work for any employer or in any setting should be scrutinized carefully and accompanied by objective evidence of a serious mental disorder and significant impairment.

**E. Timing.**

The timing of when symptoms began in relationship to the claimed work stress is an important area of consideration, in order to objectify the claim. Patients often relate their history in a generalized or impressionistic way which may or may not be consistent with the actual history in the work setting or in their personal life, e.g., an employee claimed that an incident at work triggered posttraumatic stress disorder, when records showed that symptoms of mental problems were evident in the month or two prior to the incident. Establishing a careful timetable that is corroborated by records and other outside information can help show the consistency or inconsistency of a patient's account. Claims of persistent unrelenting symptoms and permanent impairment must also be weighed against the efforts at rehabilitation. Did the person ever try to return to work? Did he or she participate in vocational rehabilitation efforts, retraining, or educational opportunities? Is there evidence of compliance with treatment? What has been the motivation to recover?

**F. Alternative explanations.**

When a person claims to have a mental disorder and impairment from work stress, but cannot adequately demonstrate it, there may be alternative explanations. Some individuals are malingering, but this is probably a small percentage. On the other hand, exaggeration, inconsistency, or lack of objective measures of either the mental disorder or impairment, are all quite common. These are not necessarily overt fabric-cations, because individuals can honestly believe that their work has created the problem. But, the same individuals may have found difficulty in functioning due to a number of unrelated or accumulating factors in their lives, e.g., social consequences of personality disorders, substance abuse, economic hardships, or personal and family stressors. Outside of the work setting, many personal life crises can present unresolvable conflicts for which a face saving solution through a worker's compensation claim is sought. Additionally, if individuals feel that they have been mistreated at work, they may have a sense of entitlement, which, to them, justifies the claim as a substitute for dealing with a personal crisis, e.g., a woman operated on for breast cancer claims dis-ability from relatively minor work related stress, denying the catastrophic effects of the cancer on her life. A thorough personal history, together with adequate corroborative background information, may show the inconsistency in the claim and uncover alternative explanations. Such evaluations are difficult for the psychiatrist since the person making the erroneous claim may generally be suffering. However, a thorough under-standing and elimination of these alternative explanations is necessary in order to validate the claim.

**V. Conducting the IME.**

Following complete review of the records, which hopefully has provided a sufficient database from which to understand the claimant, the IME itself can be conducted. This consists of a personal interview and mental status examination, and possibly psychological testing.

**A. The psychiatric interview.**

The length of the psychiatric interview can vary. Up to several hours may be necessary to trace a complex history. The interview itself is not merely an opportunity to gather information, even though that is also one of its tasks. It serves as an opportunity to formally observe the claimant's emotional state as he or she discusses their current complaints and past history. The setting should be one that provides an opportunity for the claimant to reveal intimate aspects of emotional life and to express the feelings that surround them. In contrast to a treatment interview, the claimant is warned that material to be discussed will not have the same confidentially that would normally occur in a treatment relationship.

Typically, a claimant will be asked to describe his or her current symptoms, and will be questioned about the presence or absence of symptoms that help formulate a diagnosis. Past history, family history, school performance, marital history, drug and alcohol history, employment history, and medical history are also explored in consider-able detail. Of course, the employment situation that allegedly has led to the mental disorder is also reviewed thoroughly.

**B. Mental status examination.**

Throughout the interview or interviews with the claimant, emotional observations are being made by the psychiatrist and eventually recorded as a mental status examination. This is an extremely important part of the evaluative process, since the psychiatrist's skills will help confirm or call into question the presentation that the claimant is trying to make. Although the recording of this examination is in a particular order, organized according to categories, this need not be the order in which the examination itself is conducted. That usually depends on the circumstances under which the claimant and the psychiatrist meet, the degree of cooperation, and the psychiatrist's own judgment about which parts of the mental status examination are to be emphasized. The following is a description of the typical categories of the mental status examination:

1. General Appearance, Attitude and Behavior:
   What kind of relationship did the claimant have with the psychiatrist? Was he cooperative, indifferent, or withdrawn? Was there open hostility or assaultiveness? Was he dressed with normal neatness? What was his clothing and grooming like? Were there any purposeless movements, such as hyperactivity, motor agitation, or tremor? What was the posture, gait, and facial expression? Were there any unusual or inappropriate motor movements?
2. Stream of Thought:
   What was the quality of the voice and speech? What of its intensity and pitch? Was the rate of speech unusually rapid or overly delayed? Was the speech spontaneous or hesitant? Was there any speech impediment? Was the flow of thought logical and organized, or was it tangential, loose, and disconnected? Was there a flight of ideas or repetitive speech?
3. Mood and Affect:
   What was the claimant's mood throughout the interview? Was it fearful, happy, sad, despondent? Did the claimant's facial expressions show anxiety or worry? Was there tearfulness? Was there any inappropriate mood, such as unusual silliness, giddiness, or laughter? Was the mood consistent with the content of what was being discussed?
4. Perceptions:
   Did the claimant describe or appear to have any unusual perceptions? Did she seem to be responding to voices or sounds that were not present, or did she describe such? Was there any sign of seeing strange things or reacting as if something was visible to the claimant that was not really there? Were there any strange smells or tastes described? Was the claimant mumbling or appearing to converse with a third person when no one else was present?
5. Content of Thought:
   What is the claimant speaking about spontaneously? Does he describe being persecuted or feeling that enemies might be out to harm him? Are there other paranoid thoughts? Was there any sign of false beliefs or bizarre thinking? Was there any grandiosity or exaggerated sense of self-importance? Does the claimant describe unusual physical symptoms, fears, or compulsions? Is there suicidal thinking expressed? Could the claimant speak in abstract terms or was his thinking overly concrete? On proverb testing, could he extract correct meanings? What were his work values, expectations, attitude?
6. Orientation and Memory:
   Does the claimant know her whereabouts? Is she able to properly identify the time, place, who she is, and who the examiner is? How easily is the claimant able to recall recent or remote events? Is there a problem with number calculations that reflects confusion?

The form of the mental status examination can vary to some extent from one examiner to another, but generally, the above types of information should be in constant observation by the psychiatrist and an integral part of the overall assessment.

**C. Psychological testing.**

In addition to the psychiatric interview and mental status examination, psychological testing may be used to provide further information on the psychological functioning of an individual. In many cases, this is not absolutely necessary, but can be an added tool to validate clinical impressions. Typically, psychologists conduct such testing, but a number of tests are now available in formats that can be used by psychiatrists as well, if they have experience with this modality. Today, literally hundreds of different psychological tests are used to measure a whole array of intelligence, personality, and other psychological functions. Some of the more common areas of psychological testing are listed here:

1. Intelligence
   e.g., Wechsler Adult Intelligence Scale (WAIS); Slosson Intelligence Test; Kauffman Brief Intelligence Test; Shipley Institute of Living Scale, etc.
2. Clinical symptoms and personality traits
   e.g., Minnesota Multiphasic Personality Inventory (MMPI); Millon Multiaxial Clinical Inventory (MMCI); Personality Assessment Inventory; Beck Depression Inventory; Beck Anxiety Inventory; Rorschach Inkblots, etc.
3. Psychological factors in pain problems
   e.g., Millon Behavioral Health Inventory (MBHI); Wahler Physical Symptoms Inventory; Pain Drawing Test; Chronic Illness Problem Inventory; Dallas Pain Questionnaire; McGill Pain Questionnaire, etc.
4. Brain functioning:
   e.g., Halstead-Reitan Battery; Wisconsin Card Scoring Test; California Verbal Learning Test; Luria-Nebraska; Complex Figure Drawing; Booklet Category Test, etc.

It is impossible to even begin to outline the number of psychological tests that are used as part of an evaluation of mental disorders. It is important, however, to note that no test should stand alone as a final conclusion about a person's mental disorder, or the level of impairment. Psychological tests cannot make a diagnosis; they are merely an aid for a clinician making the diagnosis. At times, the tests are quite valid, but at other times they are misleading and produce both false positive and false negative results.

**D. The psychiatric report.**

At the conclusion of the IME, there is usually a report that summarizes the findings and opinions of the psychiatrist. Those who have read a number of psychiatric reports will probably agree that they are frequently mysterious. They can be brief and mysterious, or long and mysterious. In the former case, opinions may be briefly stated, but without apparent substantiation, leaving the reader to wonder what will be the basis for the opinion at a hearing. In the latter instance, it may be so long and convoluted that it is difficult to discover what the actual opinion is. An adequate report should have enough

substantiating data that the reader can follow the reasoning and conclusions, but it should not be so lengthy and laden with psychiatric jargon that the essence is lost or is unintelligible. The report serves as a useful aid during the pre-hearing process. A strong, well-stated report may also have significant weight at a hearing. Finally, the psychiatrist must be able to translate, at the time of testimony, the report and opinion in a simple and meaningful manner.

**VI. Common psychiatric diagnoses.**

**A. What did he say?**

Perhaps in more than any other field of medicine, psychiatric diagnoses can be quite baffling and misconstrued. In part, this is because the words contained in the diagnoses are commonly used in a lay context, but may mean something very different in a diagnosis. So, for example, when a rheumatologist diagnoses fibromyalgia, lay people recognize that this condition is not known to them and they must look it up or get a professional interpretation. However, when someone is diagnosed with depression, the average person has some feeling of what that might be. Unfortunately, however, that feeling may be far from what the particular diagnosis represents. In addition, when psychiatrists begin to explain the sources of a mental disorder, they frequently weave a complicated tapestry that is difficult to follow, and one that leaves the lay person more confused than not. While a deeper analysis of causation, psychological conflict, and unconscious dynamics may have meaning between one professional and another, it may totally lose the lay person. Even among professionals, there is often ambiguity in terminology. The DSM-IV-TR is an attempt, now in its sixth version, to provide common language and definition of mental disorders. Because it reads more like a cookbook, it has been welcomed by attorneys and often referenced in hearings. There is no question that it is a useful manual, but in an attempt to simplify, it may unwittingly give the impression that it has exclusive title as a psychiatric text. This is far from the case, since the manual only serves as a guideline and is in a constant state of change, subject to committee vote and even political influence. So, the problem of confusing psychiatric terminology has not yet been solved. Many of the diagnoses contained in the DSM-IV-TR are subject to interpretation and modification based on individual circumstances, as well as the unique characteristics of the patient. It is impossible to outline all areas of the DSM-IV-TR, but the following are groups of diagnoses frequently encountered in worker's compensation claims:

**B. Depressive disorders.**

Depressive disorders constitute a wide range of possible conditions. Certainly, in a basic sense, they involve a state of sadness or loss of interest and pleasure in life. However, this can be only as a very mild form, adjustment disorder with depressed mood, in which a specific stress causes a maladaptive reaction that is generally of short duration and usually mild in severity compared to other conditions; or it can be in the form of a major depressive disorder that includes marked disinterest in life, weight loss, insomnia, lack of energy, and other symptoms that could represent a severe illness. In some cases, there can be psychotic features, where the person has false beliefs or perceptions about the world and has clearly lost contact with reality. Careful scrutiny as to which symptoms are present helps distinguish between the mild or the major form. Simply looking at how depressed someone says they feel is not enough. Depression can often have a biological or physical cause, with recurrent episodes. During these

spells, an individual may be unable to function at work or otherwise in life. Therefore, it is extremely important to discover which came first, the difficulty in functioning or the work-related problems, since when a person cannot function due to depression, job performance is bound to be affected and the problems at work could be a consequence.

**C. Anxiety disorders.**

Anxiety disorders are also a frequently seen problem that can have a number of forms. In panic disorder, there are periods of intense fear or discomfort, often with physical symptoms such as shortness of breath, dizziness, trembling, hot flashes and pain. When the individual experiences these in a particular setting in which he or she feels trapped and unable to escape, it is known as panic disorder with agoraphobia. In phobias, generally, people avoid the place or thing that they feel is the source of their anxiety, and so can be quite limited in their functioning. These and other anxiety-related problems, such as generalized anxiety disorder and adjustment disorder with anxious mood, can often present themselves in a work setting. Whether the setting was the actual precipitant or a significant aggravating factor can only be determined by a very careful history survey and assessment of the psychological makeup of the individual. Because some anxiety disorders take a chronic course, the impact to a worker's long-term functioning can be significant.

**D. Posttraumatic stress disorder.**

One of the most common disorders seen in worker's compensation claims, and litigation generally, is posttraumatic stress disorder. This is most likely due to the fact that it is one of the few diagnoses that actually refers to trauma within its very nature. For this reason, it has been quickly adopted by attorneys seeking damages for negligence and worker's compensation remedies. The original diagnosis, however, evolved from the experiences of people in combat situations. Originally, it was known as traumatic neurosis or battle fatigue. The stress that is thought to produce the disorder is usually an extreme life-threatening one, such as a disaster situation, a fire, airplane crash, military exposure, or any circumstance where an individual faces the threat of death or serious injury. The need for such an impact is necessary because the features of this disorder are that the person repeatedly re-experiences that horrible event in the form of intrusive recollections, nightmares, or avoidance behavior, so as to allow his or her psychological state to regroup. It is doubtful, therefore, that minor accidents and the normal stresses of life would produce such a reaction. Claimants often utilize this diagnosis, confusing bad memories with intrusive, involuntary recollections. The expansion of this diagnosis is probably inconsistent with psychiatric principles of trauma.

**E. Somatoform disorders.**

One of the most difficult areas in psychiatry is psychosomatic illness, now renamed somatoform disorders. In the past, people were termed as hypochondriacs when they suffered with physical complaints and yet had no known medical illness. We now recognize a number of physical presentations that have, in fact, a primary psychological disturbance. The complicating factor here is that, at least unconsciously, an individual may blame a traumatic event as being the source of physical discomfort, rather than recognizing psychological conflicts or needs that are actually the cause. One type of

somatoform disorder is known as conversion disorder, in which a person has a loss of physical functioning, such as paralysis or blindness, which is totally based on psychological reasons. At times, there has been a minor physical trauma, which may have no bearing on the actual dysfunction, but serves as a face-saving mechanism for the claimant. Another commonly seen problem is somatization disorder, which presents as a long-standing history of physical complaints covering many organ systems of the body, e.g., gastrointestinal, pain, cardiac, sexual, reproductive, but with no recognizable medical disease. This is a disorder that can almost become a way of life for a person. Another condition in this group is undifferentiated somatoform disorder, where there is inadequate medical explanation for a set of physical symptoms that can include both pain as well as loss of physical functioning in a mixed pattern of symptoms. Many of the new wave of syndromes can at times fall into this category, including, for example, chronic fatigue syndrome, fibromyalgia, multiple chemical sensitivity, etc. Again, psychological conflicts can be involved, and the claimed medical basis or environmental factor is simply a convenient target to blame, and may be totally unrelated.
Very often, there are emotional and psychological symptoms that accompany physical disease or injury, and chronic pain. These types of disorders, known as pain disorders with psychological factors and a general medical condition, are seen where the psychological effects of pain can aggravate or complicate the course of recovery.

**F. Psychosis.**

This class of disorders implies a major disruption in psychological functioning in which an individual has lost contact with reality. A common type of psychosis is known as schizophrenia, which is a disease that usually includes false beliefs or perceptions, hallucinations, incoherent thinking, bizarre behavior, and marked social and personal dysfunction, and that often takes a chronic course. It represents a major world health problem today. The causes of schizophrenia are not well understood but include strong biological factors. Other types of psychosis are bipolar disorder (formerly known as manic-depressive illness), delusional disorder, and schizophreni-form disorder. While these psychotic conditions may have some precipitant or aggravating stress factor in their onset, they are usually thought of as having a strong biological cause.

**G. Traumatic brain injury.**

A common type of claim that can have associated psychological factors is that of traumatic brain injury. Certainly, an individual who has undergone a traumatic brain injury may have emotional and behavioral changes from the brain insult itself. The person may also have psychological complications from being injured, in the form of depression, anxiety, or other nonspecific distress. The more troubling area, however, is in claims of mild traumatic brain injury which may occur with little or no impact to the head and which have no clear diagnostic evidence that the brain has received an insult. This is a controversial area because claims of mild traumatic brain injury are increasing dramatically. In some case, careful evaluation of the individual's history reveals preexisting psychological factors that preceded the accident, for which a claim of traumatic brain injury can serve as a convenient resolution. When this dynamic occurs, these claims actually are based on a somatoform disorder.

**VII. Conclusion.**

The increase in claims for stress-related illness and mental disorders in the workplace is not explained by one set of factors alone. Complex social and cultural trends are responsible. In the early history of America, a self-sufficient and stoic attitude promoted individual responsibility. For right or wrong, mental illness and disability were considered a weakness. Of course, this stigma disadvantaged the unfortunate individuals who suffered from such illness, artificially segregating them from the rest of society. Advances in medicine and psychiatry over the last 100 years have helped identify biological and psychological disorders which have scientifically identified origins and characteristics. To reject this is to place us back at an earlier, unenlightened, blame casting mentality. Modern psychiatric and psychological treatment has offered new hope to emotional distress and the favorable resolution of mental illness states as a regular feature of therapeutic practice. However, progress in mental health treatment, as in many new scientific technologies, is accompanied by dangers and abuse. The subjective nature of some mental disorders and the overlap between illness and ordinary distress create a problem in definition that has facilitated that abuse. As discussed earlier, this trend for finding disorder where none exists is by no means limited to psychiatry, since our society as a whole has become increasingly medicalized. As the stigma of mental illness is leaving, the attention to health rather than illness is disappearing. The range and relativity of health, based on individual variants, social and cultural differences, is lost in favor of narrow stereotypes. Growing numbers of psychiatric diagnoses with indefinite criteria which label the continuum of human behavior inadvertently promote this process and help validate mounting worker's compensation claims.

In addition to increased medicalization within our society, a number of other trends within society in general, and industry in particular, may be instrumental in the rise of worker's compensation claims. Not the least of these is the increasingly litigious nature of our society. Growing numbers of lawyers, higher damage awards, and flexible theories of liability are testament to this. Litigation is fueled also by changing attitudes toward and mistrust of our institutions. Legal, medical, religious, govern-mental and corporate institutions are the constant object of criticism within our media, and the average person sees them as self-serving and exploitive. Employees are no longer as loyal to the organization, since they see employers no longer as protective. Job instability created through layoffs and downsizing, decreased buying power of wages, the disappearance of many types of jobs, and the lack of guarantees for a career within an organization have resulted in a workforce that is shaken and insecure. It is no wonder that worker's compensation claims could be a vehicle for self-preservation.

Finally, there may be, in fact, greater pressures in the workplace with the higher demands of technology and specialization. Today's faster pace, more rapid transportation and communication put greater demands on the worker both in skills and performance. In order to compete, many companies have become lean and mean, expecting more than is often possible from their workers. Adding to this is the phenomenon of Americans working long hours for higher income while spending almost everything they earn beyond life's necessities on consumer goods. This cycle of work and spend over the past 50 years has increased the amount of goods workers produce in an hour. But rather than create greater leisure, the number of hours worked has also increased. Through debt and habit, each higher level of material achievement appears to become a necessity, which creates even a greater need to work and spend. Whether this leads to greater stress in the workplace and therefore more work related mental disorders, or simply blaming the workplace unjustifiably, needs to be evaluated on a case-by-case basis. The subjective nature of many mental disorders, coupled with subjective and vague standards for compensability, can provide either a needed safety net for injured workers or an opportunity for abuse.

Psychiatric IMEs must strive for as much objectivity as possible by widening the scope of inquiry to more than the subjective distress of the worker.

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