KAPLAN CONSULTING AND COUNSELING
(216) 766-5743

Summer 2006

Volume 1, Issue 4

Insights.... On Psychological Disability

Inside this issue:

Prepared by

Kaplan Consulting and Counseling, Inc.
Robert G. Kaplan, Ph.D.
3401 Enterprise Parkway
Suite 340

Beachwood, Ohio 44122
Call: (216) 766-5743
RKapan@KaplanCC.com

Expertise in

Forensic Psychological Evaluation
Posttraumatic Stress Disorder
Workers' Compensation
Disability Evaluation
Workplace Violence
Sexual Harassment

Settlement Issues

In litigation involving psychological disability, the following variables can increase the strength of a claim:

- No preexisting psychological impairment
- Severe stressors that are documentable and indisputable
- Evidence of normal or superior premorbid functioning
- Little or no discrepancy among sources of information
- Level of injury clearly evident from standard medical and psychological procedures
- No delay in seeking help (exceptions in Posttraumatic Stress Disorder, sexual harassment and assault, and discrimination cases)
- No social support available immediately after the traumatic event and later
- Very young or very old victim
- Very high demands on the victim

Conversely, the following variables can decrease the strength of a claim of psychological disability:

- Severe preexisting psychiatric history
- Weak stressors that are vague or difficult to document
- Evidence of poor premorbid functioning
- Large discrepancy among sources of information
- Level of injury inferred or not clearly evident from extraordinary medical or psychological procedures
- Long delay or no seeking of help (exceptions in Posttraumatic Stress Disorder, sexual harassment and assault, and discrimination cases)
- Much social support available immediately after the traumatic event and later
- Middle-aged victim
- Few demands on the victim

Treatment Considerations Relevant to Settlement

A combination of factors determines the length of treatment needed for psychological problems. Included among the more salient of these are:

- Preexisting level of adjustment or impairment
- Amount of available social and material support
- Competence of treatment provider
- Severity of condition
- Degree of complication (e.g., other physical, financial, psychological, or social stressors)
- Effectiveness of medication
- Presence of self-medication with alcohol and/or drugs
- Motivation for recovery

Included among the age and life course factors that impact the length of treatment are:

- Chronological age of the victim (i.e., young or old)
- Arrest or intensification of life-course development

Several issues contribute to the potential for long-term damages, including:

- Adverse characterologic and personality changes
- Decreased occupational potential or increased occupational changes
- Long-term effects on relationships (e.g., marriage)
- Potential for recurrence or relapse
- Greater vulnerability to stress
- Emotional "scars" (e.g., extreme cynicism, apprehension, distrust, etc.)

Insights is a newsletter published by Kaplan Consulting and Counseling, Incorporated as a free service to legal professionals. Comments regarding this issue, suggestions for future issues, and requests for additional copies can be directed to the attention of Thomas A. Moran, J.C.D., B.C.E.T.S., Senior Litigation Analyst. Call (440) 225-4614 or e-mail thmoran@comcast.net.

AMA Guides to the Evaluation of Permanent Impairment

The American Medical Association's *Guides to the Evaluation of Permanent Impairment*, currently in its fifth edition, are widely used to determine permanent, partial, or total disability. These guidelines are similar to those used by the Social Security Administration and other federal agencies (e.g., Department of Veteran Affairs). The Guides focus on four areas of consideration:

- Activities of daily living (bathing, dressing, feeding, etc.)
- Social functioning
- Concentration, persistence, and pace (intellect)
- Adaptation (problem solving, planning, judgment, and stress tolerance)

The Guides distinguish five levels of impairment:

- Class I: No Impairment
- Class II: Mild Impairment (compatible with *most* useful functioning)
- Class III: Moderate Impairment (compatible with *some*, but not all useful functioning)
- Class IV: Marked Impairment (*significantly impedes* useful functioning)
- Class V: Extreme Impairment (*precludes* most useful functioning)

Unlike physical conditions, the guides assign no percentages of impairment for psychiatric disorders. However, some sections of the Guides and customary practice suggest the following ranges:

- Mild Impairment: 0-14%
- Moderate Impairment: 15-29%
- Severe Impairment: 30-49%
- Extreme Impairment (i.e., severe limitation of almost all daily functions): 50-70%

It should be noted that disability and impairment are not synonymous. Disability is an administrative/legal concept. Impairment is a clinical/medical concept. Impairment must be related to specific work activities in order to determine disability. Consequently, impairment does not necessarily disable one from all occupations. Depression, for example, may disable an individual from one occupation, such as accounting, but not another, such as custodial work.

Areas of Consideration:

Activities of Daily Living

Social Functioning

Concentration, Persistence, and Pace

Adaptation to Stress

Factors that Complicate Psychological Disability

In addition to the cause of action, other factors can contribute to the severity of a psychological disability. These factors include:

- **Preexisting mental disorders** that begin early in life or have biological causes including Bipolar Disorder, Major Depressive Disorder, Recurrent, Schizophrenia, Attention Deficit Hyperactivity Disorder, and Paraphilias (sexual perversion).
- **Transient side-effects of certain medications** like hormones and corticosteroids (depression and psychosis), depressants (depression), antipsychotics (anxiety) and antianxiety drugs (depression and fatigue).
- **Physical conditions unrelated to the cause of action**, such as thyroid problems (depression and anxiety), cancer (depression), heart disease (depression), and premenstrual syndrome (depression and anxiety).
- **Unrelated or "non-proximate causes."** Symptoms attributed to psychological disability may be due to non-proximate causes when: the date of the claim coincides with the termination of benefits for physical injury or the termination of employment; there are excessive conflicts with claim representatives or employers; claims are made long after the date of injury; or the symptoms are the result of unrelated stressful or traumatic events (e.g., death, divorce, family problems, previous injury or illness, other traumatic events).
- **Delays in seeking treatment**. In legitimate cases of psychological disability, appropriate treatment typically is sought and provided within a reasonable amount of time. Consequently, one should be cautious of purported psychological disability when: there is non-compliance with psychiatric medications; or there is non-compliance with counseling schedules, or poor attendance. However, claimants may delay seeking treatment due to Posttraumatic Stress Disorder, sexual harassment and assault, discrimination, cultural beliefs and stigma about mental health treatment, financial limitations, or a lack of community resources.
- **Symptoms of psychological disability may be due to alcohol or substance abuse**. Data indicate that substance abusers are five times more likely to file workers compensation claims than their sober counterparts. Furthermore, anxiety and depression can directly be caused and/or aggravated by alcohol and substance abuse. Anxiety and depression also can be caused by the legal, medical, family, and marital problems often associated with substance abuse.
- **Malingering**. The primary motives for malingering are money, attention, a desire to assume the role of a patient, and the avoidance of unpleasant consequences (e.g., punishment, work, compelled service).

Complicating Factors:

Preexisting Mental Disorders

Side-effects of Medications

Unrelated Physical Conditions

Delays in Seeking Treatment

Substance Abuse

Malingering

What is a Mental Disorder?

The *Diagnostic & Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* of the American Psychiatric Association (DSM-IV-TR) and the *International Statistical Classification of Diseases and Health Related Problems, Ninth Edition* of the World Health Organization (ICD-9) are the two major classification systems used by mental health clinicians to make diagnoses of mental disorders.

In order to use these publications properly, one must distinguish a mental disorder from ordinary reactions to stress. A disease is a specific syndrome (i.e., set of symptoms) with a specific etiology (i.e., cause). When the symptoms and the impairment presented do not meet any empirically determined syndrome and etiology, the patient does not have a mental disorder. Rather, the patient's reactions to a stressor are those that normally would be expected. A mental disorder is a dysfunction in some type of psychological process, not just an intense emotional reaction to a stressor.

A mental disorder is a dysfunction in some type of psychological process, not just an intense emotional reaction to stress.

According to the DSM-IV-TR, a mental disorder is a behavioral or psychological syndrome that causes significant distress (i.e., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning), or a significantly increased risk of suffering death, pain, or an important loss of freedom. The syndrome is considered to be a manifestation of some behavioral, psychological, or biological dysfunction in the person.

The designation *Mental Disorders Not Otherwise Specified* typically is utilized when symptoms match no criteria found in the DSM-IV-TR or the ICD-9. According to the DSM-IV-TR, this diagnosis is to be utilized only when:

- The presentation conforms to general guidelines within a diagnostic class but the symptoms are below the threshold for the diagnosis of a specific mental disorder, or there is an atypical or mixed presentation;
- The symptom pattern causes clinically, significant distress or impairment;
- There is uncertainty about the etiology (due to medication, substance abuse, etc.);
- There is insufficient opportunity for complete data collection but enough information to place it within a particular diagnostic class.

When the symptoms and the impairment presented do not meet any empirically determined syndrome and etiology, the patient does not have a mental disorder

Each diagnostic class represented in the DSM-IV-TR and the ICD-9 has specific criteria for the application of this diagnosis (e.g., *Anxiety Disorder Not Otherwise Specified*).

Mental disorders that commonly arise in civil litigation include:

- Posttraumatic Stress Disorder
- Major Depressive Disorder
- Dysthymic Disorder (mild depression)
- Adjustment Disorder
- Specific Phobia
- Panic Disorder

Criminal litigation not only includes these mental disorders, but also commonly involves:

- Schizophrenia
- Bipolar Disorder
- Personality Disorders (e.g., Anti-Social Personality Disorder)
- Dissociative Identity Disorder (Multiple Personality Disorder)
- Substance Abuse

The Psychiatric Evaluation

Physicians, attorneys, and other legal practitioners commonly refer claims of psychological disability or distress to a psychologist for an evaluation. A thorough evaluation and the accompanying report on psychological disability or distress should include the following elements:

- Reason for the evaluation
- A listing of records reviewed and sources of information
- An extensive history of injury, treatment, and the onset of symptoms with pain assessment, if indicated
- An extensive background history including:
  - General medical history (previous injuries, surgeries, hospitalizations, review of systems, medications, allergies)
  - Past psychiatric history
  - Substance abuse history
  - Personal history
  - Family of origin history (family dysfunction, history of mental illness, substance abuse)
  - Social history (current living arrangements, relationships, involvement with social agencies or courts)
  - Sexual and marital histories (childhood abuse, deviance, rape, problems related to spouse or children)
  - Education and work histories (educational level, certificates, number of jobs, terminations, disciplinary actions, awards)
  - Criminal history (arrests, convictions, incarcerations)
  - Functional assessment (pre- and post-injury personal activities, including activities of daily living, domestic activities, social activities, and hobbies and interests)
- A mental status examination covering:
  - Appearance, cooperation, speech, and language
  - Anxiety symptoms
  - Emotional status (range, appropriateness, etc.)
  - Mood symptoms
  - Current thoughts and perceptions (psychotic symptoms)
  - Cognitive status (level of consciousness, orientation, attention and concentration, intellectual functioning, judgment)
- Psychological testing:
  - Use of widely accepted, standardized tests that have validity measures
  - Comments on the validity of the test results
- Clinical analysis:
  - Five-axis DSM-IV-TR diagnosis
    - ⇒ Axis I Mental Disorders
    - ⇒ Axis II Personality Disorders
    - ⇒ Axis III Related Health Conditions
    - ⇒ Axis IV Psychosocial Stressors
    - ⇒ Axis V Current Global Assessment of Functioning Rating on a scale of 0-100 (a rating of 50 or below if the individual cannot work due to mental disorder)
  - Integrative explanation of history, records, mental status, and psychological testing to:
    - ⇒ Support the diagnosis
    - ⇒ Identify causes of the diagnosis
    - ⇒ Rule out alternative diagnoses or causes
    - ⇒ Address any other referral questions (e.g., extent of disability, extent of improvement, treatment recommendations, etc.)
- Opinions must be expressed with reasonable psychological certainty