Behavioral Health Disability

Innovations in Prevention and Management
Pamela A. Warren
Editor

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People have experienced mental health concerns throughout the course of history, as can be seen from the different terms that have been used over the years to describe these concerns, such as “different,” “special,” “touched,” “mad,” and “having a fit,” among others. Of course, for most of history there wasn’t a societal system to provide services to these individuals. Instead, frequently families took care of their members, or the person resorted to begging for daily necessities. As an example, although individuals involved in the westward expansion undoubtedly experienced the mental health conditions we know today, the necessity of providing for the basic human needs of shelter, food, and clothing took priority over the option of not working because of the dire consequences for such actions. This pattern can be observed over each subsequent societal evolution.

In the interim, there have been extensive advances in the understanding and professional treatment of mental health conditions. Moreover, the advancement of technology coupled with the general decrease in the necessity for hard physical labor has, without a doubt, made most aspects of daily living easier, and the overall quality of life has dramatically improved. Yet, despite these improvements, there is still an overall prevalence of mental health conditions ranging from 1 to 20% of the population, depending on the particular concern. Of note, this prevalence rate has been reported to be relatively stable over time. However, this reported stable prevalence rate is in conflict with the current prevalence rate observed in behavioral health (BH) claims. Thus, this book explores some of the factors that contribute to this discrepancy.

The sustained suffering of those with mental health disorders has led to a quest to improve the quality of mental health treatment, which in turn has resulted in the development of a variety of standardized psychological tests, empirically based treatments, and even ways to examine changes within the structures of the brain, with the advent of positron emission tomography and other neuroimaging modalities. Despite these recent developments in professional care, there remains a problematic rate of treatment failure due to how mental health services are provided within the mental health field as well as across other professions, such as primary care medicine. One of the primary issues is the lack of synthesis of current objective assessment and empirically based treatments in the current mental healthcare system. This has resulted in several misperceptions. One of the most prevalent is that
mental health conditions are permanent and typically lead to disability. This is coupled with the lack of understanding that the terms diagnosis, disability, and impairment are not synonymous. When these common misperceptions also occur in other professions, the misconceptions expand exponentially.

Today, mental health conditions and psychosocial issues, such as job dissatisfaction, poor coping strategies, and motivational problems, have been combined in the coined term behavioral health. While the stigma of a current mental health diagnosis has modestly decreased, typically there is no stigma associated with psychosocial issues. It is common for psychosocial issues to be “medicalized” into faux mental health concerns or viewed as the direct result of mental health conditions themselves. Behavioral health issues are now frequently presumed to occur with a negative life event or situation, but without the benefit of a thorough clinical evaluation of the developmental, cultural, and perceptual issues that may make a person more likely to experience emotional distress and potentially develop a mental health condition. However, the fact that many people experience similar situations but do not develop a mental health condition is commonly overlooked. The issue of placing blame and/or cause has resulted in an explosion over the past two decades in behavioral health disability claims. There has been a concurrent explosion in the number of prescriptions for psychotropic medications that coincides with this same period. It is the amalgamation of these permutations in the professional evaluation, assessment, and treatment of mental health that led to this book.

While the term integration has been employed to convey the synthesis of physical and mental health treatment, in reality most systems provide a great deal of guidance pertaining to physical concerns but far less so for behavioral health issues. Consequently, integration as employed currently does not necessarily mean that true integration of the biopsychosocial issues is identified or addressed. Instead, there is a widely held, jaundiced viewpoint across professions and society that most individuals are either exaggerating or faking their mental health conditions. This viewpoint is likely just one factor which results in arbitrary decisions in professional care and disability claim resolution. Moreover, only recently have employers begun to accept that behavioral health concerns occur within the workplace. Yet, few have actual behavioral health policies in place to manage Family Medical Leave Act (FMLA) American With Disabilities Act (ADA) now called: American with Disabilities Act Amendments Act (ADAAA, 2008) workplace absences related to behavioral health issues. Further, the lack of workplace policies may result in inconsistent management decisions, contributing to a potentially perceived adverse work environment. Employers and employees alike are likely to seek legal advice. Thus, the door is opened for possible lengthy legal proceedings. Consequently, the current behavioral health spectrum is fraught with difficulties in how to best proceed.

Until now, there hasn’t been a “road map” of how behavioral health issues should be evaluated across those professions routinely involved in the evaluation and treatment process. Instead, professionals are left to their own devices to evaluate and manage within their particular treatment process, and do not necessarily collaborate with other professionals. Now, for the first time, a book provides direction on the
evaluation of behavioral health across multiple professional perspectives, including the insurance and legal fields, to better address the current problematic aspects and to provide true collaboration and enhanced treatment outcomes. Most importantly, this book provides the means to standardize terminology, to correct misperceptions, and to promote the empirically based treatments into routine clinical practice. With the recent development of these empirically based treatments, the expected outcome is a return to one’s previous level of functioning and a higher quality of life in individuals receiving appropriate professional care than is routinely experienced by those on disability.

Urbana, USA

Pamela A. Warren
Acknowledgments

I wish to thank the contributors for the discussion of current standards to address behavioral health concerns within each profession. This exchange has culminated in the first book that provides direction on appropriate evaluation standards for, potential barriers to, and methods for working around problematic issues. This provides a means for enhanced treatment as well as professional communication and collaboration across professional disciplines. Thus, the model for true integration of behavioral health conditions and concerns is revealed.

In addition, I wish to thank Janice Stern and Ian Marvinney of Springer for their invaluable assistance in bringing this book to fruition.

Lastly, I want to give my sincere gratitude to Bruce and Rachel for informal brainstorming and review.
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Chapter 1
A Critique of the Behavioral Health Disability System

Pamela A. Warren

1.1 Overview of the Explosion of Behavioral Health Concerns

There is an increased recognition of behavioral health (BH) concerns occurring with increasing frequency. However, there is also confusion about what this term encompasses. The behavioral health spectrum is comprised of mental health disorders, such as Major Depressive Disorder (MDD) and also, psychosocial issues, such as job dissatisfaction, workplace conflict, a lack of balance between personal life and work. BH concerns are a huge cost to society as well as to the individual. A review of the empirical literature (Agency for Healthcare Research and Quality, 2009; American Psychiatric Foundation, 2005; Talmage, 2005; Warren, 2005) as well as the actuarial data from federal disability programs, such as the Social Security Administration (SSA, 2008) and insurers (Warren & Hubbard, 2008), have demonstrated 300%+ increases in behavioral disability claims over the past two decades. Based on direct medical costs, such as medical, medication, absenteeism, and short- and long-term disability, the annual costs of mental health disorders total $253 billion (Warren, 2005). However, when indirect costs, such as presenteeism and psychosocial issues are considered, the total costs rise to a staggering $1.265 trillion. In the United States alone, workplace behavioral health disorders cost employers $114 billion per year (DMEC, 2009). These concerns are not isolated to the United States alone. The World Health Organization (WHO) has predicted that by the year 2020, MDD will be the leading cause of disability, globally. Currently, MDD is the second leading cause of disability (WHO, 2004).
1.2 Problematic Factors That Complicate Behavioral Health Care

1.2.1 Comorbid Physical and Psychological Concerns

BH issues have been identified as occurring both as individual concerns and as a comorbidity issue with physical injuries and illnesses (American Medical Association, 2008; American Psychiatric Association and American Psychiatric Foundation, 2006, 2005). The term, “behavioral health” currently is used by professionals to encompass true psychiatric disorders, such as those that meet the Diagnostic Statistic Manual, IV-TR (American Psychiatric Association, 2000) as well as psychosocial issues, such as workplace difficulties or personal life matters (American Medical Association). Moreover, the review of empirical research has revealed that the majority of physical concerns also have a concurrent psychiatric component (Buist-Bouwman, de Graaf, Vollebergh, & Ormel, 2005; Chellappa & Ramaraj, 2009; Dersh, Gatchel, Polatin, & Mayer, 2002; Dewa & Lin, 2000; de Waal et al., 2009; Evans et al., 2005; Fava et al., 2006; Gatchel, 2004; Gros, Antony, McCabe, & Swinson, 2009; Hutter, Scheidt-Nave, & Baumeister, 2009; Kessler, Ormel, Dernier, & Stang, 2003; Ormel et al., 2008; Roy-Byrne et al., 2008; Scott et al., 2007, 2009; Suls & Bunde, 2005; DiMatteo, Lepper, & Croghans, 2000; Gatchel, Peng, Peters, Fuchs, & Turk, 2007; Kessler et al., 2006; Kessler et al., 2005; Kroenke, 2003; Kroenke, et al., 1994; McGlynn et al., 2003; Merikangas et al., 2007; Simon, Grothaus, Durham, Von Korff & Rabiniak, 1996). Thus, it is essential for all professionals involved in the treatment and disability management processes to acknowledge the broader scope of BH concerns, as well as incorporating a biopsychosocial approach across professions. The term biopsychosocial addresses the biological, psychological, and psychosocial factors in a combined manner that better account for the complexity of impairment issues, particularly with comorbid concerns (Bruns & Disorbio, 2005).

The scope of this book will examine the occurrence of BH concerns and how to begin move the past Cartesian duality model that had artificially separated the mind from the physical (Campbell, Clauw, & Keefe, 2003; Wade, 2006). Further, this exploration will also investigate how occurrence of BH concerns typically occur across multiple professions, what are the current problems that occur as well as strategies for the enhancement of treatment outcomes. However, there are multiple present barriers that occur within the treatment and management processes that currently impede the implementation of the synthesis of a more comprehensive approach. One of the primary barriers, despite this knowledge, is the current trend in the medical, mental, rehabilitation health, assessment, treatment, and disability fields to still artificially separate behavioral and physical health concerns. Consequently, this leads to the lack of identification and treatment of BH concerns, an underestimate of the actual prevalence of BH in the professional and disability fields as well as the potential for unwarranted workplace absence and inappropriate labeling an individual as being permanently disabled and unfit to function in everyday life activities indefinitely (Bagenstos, 2000; DMEC, 2009). The current BH treatment and disability systems have been noted to have major contributing factors in the explosion of BH concerns that is presently
occurring (Center for Disease Control & Prevention, 2008; Centers for Disease Control & Prevention, National Center for Injury Prevention & Control, 2006).

1.3 The Systemic Problems in the Treatment and Management of BH Concerns

1.3.1 The De Facto Behavioral Health Care System in the United States

In this time of managed health care, most BH concerns are not addressed from a coordinated and standardized approach. Instead, in the current system, most individuals with BH concerns are initially evaluated by a primary care physician (PCP) (Koike, Unutzer, & Wells, 2002; National Committee for Quality Assurance 2009). Thus, the De Facto BH care system is occurring within the general medical system and does not typically involve the inclusion of BH professionals, at the outset of treatment (Norquist & Regier, 1996). In the typical treatment process, the PCP is likely to prescribe medication only and request that the individual returns for further evaluation at some time in the future, usually around 6 weeks. The individual may or may not be referred to a mental health care professional. Thus, there is little to no follow-up of the individual in terms of the appropriateness of the selected treatment, side effects, and compliance with treatment. Consequently, any type of treatment provided is typically confined to what the PCP can accomplish within a short time span due to time-limited appointments. Empirical research has demonstrated that the amount of time that a physician is able to spend with a patient is very brief. This limited amount of time must address the evaluation of the presenting problem, the development of the treatment plan, and the dictation that summarizes the key points of the appointment and current actions taken by the physician. Not surprisingly, while PCPs can diagnosis and treat BH disorders, such as Major Depressive Disorder, a high percentage frequently will miss recognizing or assessing symptoms and not make the diagnosis altogether (Seelig & Katon, 2008). Thus, the De Facto BH health care system significantly contributes to iatrogenic disability.

Despite the availability of effective treatments for Major Depressive Disorder, rates of appropriate treatment for MDD remain low nationally, particularly in primary care, where only about one-fourth of depressed patients receive appropriate care, including receiving either any diagnosis of a mental health concern or even the correct psychological diagnosis (Kroenke, 2003, 2006). In most instances, the person’s diagnosis is made based solely on the symptoms noted. Thus, this complicates the professional treatment. Moreover, unlike physical concerns which are diagnosed based on a standardized evaluation and treatment process, the same is not true of behavioral health care (Gask, 2005).

Additional issues include the societal stigma of being diagnosed with a BH concern, and obtaining appropriate professional treatment due to the individual’s reluctance to receive care outside of the medical setting. Consequently, a BH
professional may or may not be involved in the care of the individual with a BH
issue. Moreover, after the referral is made to the BH, the PCP’s diagnosis is likely
to be assumed accurate and thus, influencing the professional treatment that the
person receives from the BH professional (Seelig & Katon, 2008).

Although the focus was on the PCP, it is important to realize that these concerns
are not unique to the medical primary care profession alone. Unfortunately, due to
the lack of professional training, the majority of professionals currently involved in
both the treatment and disability management fields have little to no training in
appropriate evidence-based evaluation, treatment, and management of BH concerns
and how to appropriately synthesis this in an effective manner. This is particularly
troubling since this leaves the individual with a BH issue left to navigate the BH
system without strong assistance.

1.3.2 The Contributory Factors of the Behavioral Health
Treatment System and Insurers

The Surgeon General’s 1999 report specifically focused on BH issues and overall
mental health system. It was initially reported that although the United States
spent over $69 billion on mental health services, there was substantial disparity
in the quality of treatment provided. This resulted in abysmal treatment outcomes.
Consequently, there was a call for a complete overhaul of the BH treatment
system. Moreover, the ability to receive treatment was directly impacted by
whether an individual had insurance coverage to provide professional treatment
as well as the ability to navigate of obtaining approval from the insurer for care.
While there has been a substantial increase from previous monetary amounts
spent on the treatment on mental health concerns, the issues of obtaining approval
for treatment and how the amount paid for a specific services differed from payer
and provider. This is of concern since it demonstrates that simply increasing pay-
ment for BH treatment does not necessarily result in improved treatment out-
comes. Instead, there are multifactorial issues that contribute to the current
fragmented treatment and management processes. Thus, the improvement of
increased recognition of BH concerns and subsequent treatment must also address
current barriers that lead to poorly defined and open-ended care and sustained
poor treatment outcomes as well as an astronomical increase in BH disability
claims (Anssea et al., 2004; Kessler et al., 2003; National Business Group on

1.3.3 Federal Agencies and the Incidence of Behavioral
Health Disability

The SSA’s (2008) actuarial data provide ample evidence of the considerable
increase in BH concerns over the past two decades. In 2008, disabled workers
accounted for 87% of SSA disability beneficiaries. The average age for disability benefits as called in the SSA’s Social Security Disability Insurance (SSDI) program is 52. The majority of beneficiaries are male (52%). Slightly over 14% applied and also received SSI benefits as well. When the Supplemental Security Income (SSI) program disability benefits are considered, the percentage of disabled workers increased to 90% of all disability benefits. BH concerns represented 33.4% of all of the SSA’s disability beneficiaries group. Thus, BH disorders represented the SSA’s largest disability beneficiary group.

The second largest disability group within SSA was comprised of individuals with musculoskeletal concerns. Randomized controlled research has consistently demonstrated a high comorbidity prevalence (64% and higher) with BH concerns. Musculoskeletal concerns were SSA’s second largest group of disability beneficiaries (26.4%). Because significant number of chronic physical concerns also have been found to have a concurrent BH concern, it becomes evident the potential impact of BH concerns within the largest public disability program in the US (SSA, 2008). A more in-depth discussion of the SSA data will occur in Chapter 2.

1.4 The Need for Improvement in Communications Among Professionals Involved in the BH Fields to Reduce BH Disability

This brief overview discussed in this chapter notes some of the primary systemic problems that must be addressed to set a different course of action needed to both treat and manage BH concerns and disorders. One of the primary ways in which the system can immediately improve is with enhanced communication among professionals in the treatment fields with those professionals in the disability management fields (DMEC, 2009; Talmage, 2007; Talmage & Melhorn, 2005). The other chapters of this book will explore these problems in a more in-depth manner. Further, the scope of BH concerns will be examined across multiple disciplinary perspectives to provide a unique synthesis of addressing BH concerns in a comprehensive manner and across the entire behavioral health spectrum. Typically, in addition to the PCP, the other professionals involved in this process are: occupational medicine physician, psychologist, psychiatrist, rehabilitation professionals, such as a physical therapist and rehabilitation vocational counselor, attorney, nurse case manager, and insurier. Each of these different perspectives will address factors specific to each professional discipline, explore the determination of psychological and behavioral health functioning specific to the identified concern, gaps into determining functioning and how to foster collaborative communication with other professionals (Talmage, 2007). This type of cross-communication is essential in developing much-needed improvements to bridge the current problems rampant within the BH disability field (Warren, 2009).
References


Chapter 2
Prevalence of Behavioral Health Concerns and Systemic Issues in Disability Treatment and Management

Pamela A. Warren

2.1 Prevalence of Behavioral Health Concerns

In the fields of disability and disease management, the term “behavioral health” (BH) has been coined to encompass both psychological diagnoses, such as Major Depressive Disorder (MDD) as well as psychosocial concerns, such as job dissatisfaction or fear of reinjury. In the recent two decades, there has been an explosion of BH disability claims despite the development of new, empirically based BH treatments that have been demonstrated to quickly and effectively treat psychological disorders to return an individual to one’s previous level of functioning. However, to understand this phenomenon, it is essential to examine the prevalence of BH concerns to better understand some of the current problematic issues that occur in both the treatment and disability management fields. In general, the prevalence of psychological disorders has been found to vary across each type of DSM-IV-TR diagnostic category. The current body of empirical research (Bogner, de Vries, Maulik, & Unützer, 2009; Fichter et al., 1996; U.S. Department of Health and Human Services, 1999) has revealed that there is a general prevalence rate of approximately 20% across all objectively determined mental health concerns (MH) in the U.S. general population. One of the primary psychological disorders that occur Major Depressive Disorder has been found to have a prevalence rate of 10–20% in the clinical population of those diagnosed with a psychological disorder (American Psychiatric Association, 2000; Kessler et al., 1996). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2001, 2007a, 2007b) placed the prevalence rate of a behavioral health disorder much higher, with 30% of the population experiencing a BH disorder in any given year (age group 15–54). Moreover, over the lifetime course, approximately 48% of the population have had at least one BH disorder, while 27% have had two or more BH disorders. SAMHSA (2001) reported that the most common BH disorders were depressive disorders (Major Depressive Disorder and
Dysthymic Disorder), the anxiety disorder spectrum (e.g., Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Social Phobia, etc.), and substance abuse. In those individuals who typically apply for disability benefits, the prevalence rate is estimated to range from a conservative 30% up to a greater estimate of 60–70% when including comorbid physical and psychological concerns (Aronoff et al., 2007; Binder & Rohling, 1996; Buist-Bouwman, de Graaf, Vollebergh, & Ormel, 2005; Campbell, Clauw, & Keefe, 2003; CDC, 2008; Dersh, Gatchel, Polatin, & Mayer, 2002; Dersh, Polatin, Leeman, & Gatchel, 2005; DMEC, 2008; Evans et al., 2005; Gatchel, 2004; Kessler et al., 1997; Kessler, Ormel, Dernier, & Stang, 2003; Kouzis & Eaton, 1997; MacDonald-Wilson, Rogers, & Anthony, 2001). The National Institute of Mental Health (2008) reported that the leading cause of disability in the United States for the age group of 15–44 is Major Depressive Disorder. Consequently, it quickly becomes clear that those individuals who are diagnosed with a BH concern are the very people who have a substantial impact on the initiation of current BH disability claims and attendant costs associated with the claims, particularly those that do not resolve in the anticipated timeframe. It is the astronomic expanse of BH concerns, poor treatment outcomes, and open-ended disability leaves that are of noteworthy interest since these aspects dramatically increase the costs of BH disability (American Psychiatric Foundation, 2005; DMEC, 2008). Therefore, it is imperative for all professionals to both recognize and understand the importance of appropriate management of BH concerns (DMEC, 2009). Moreover, with the anticipated increase of MDD as a leading cause of disability worldwide, it makes clear that BH issues are not merely minor concerns when it comes to professional treatment and assisting the individual in the stay-at-work (SAW) and return-to-work (RTW) processes, but are critical components to be addressed (ACOEM, 2006; Kessler & Wang, 2008; Kessler et al., 2005; Ormel et al., 2008; Reggers & Annseau, 1999; Roy-Byrne et al., 2008; Seedat et al., 2009; Wang, Berglund, & Kessler, 2000; Bruns & Disorbio, 2005; Gask, 2005; Greenberg & Shuman, 1997; Greene, 2007).

Currently, there is a great deal of misperception among all professionals regarding all aspects of BH disability. Many of these issues, such as the lack of the following, are:

- Appropriate training to complete a thorough and competent BH evaluation required to evaluate an individual in a comprehensive manner regarding functioning
- Objective data to support a lengthy BH disability leave
- The medicalization of psychosocial concerns
- Providing treatment that is in line with current empirical research and best practice standards
- A RTW goal in treatment planning, and long-term workplace absences which will be discussed to provide a more thorough understanding of the underlying issues with the current BH evaluation and treatment process (Warren, 2009; Warren & Hubbard, 2006, 2007, 2008)
2.2 BH Professionals Involved in the BH Disability Process and Problematic Issues

There are several different types of BH professionals currently providing professional treatment. A cursory comparison of each professional will be provided. However, it is essential to keep in mind that it is not possible to provide comprehensive information in the scope of a single chapter regarding each profession. Instead, this comparison is provided to understand the basic differences among each profession to be seen at a glance in Table 2.1.

2.2.1 Problematic Inconsistencies in Professional BH Training

When looking at Table 2.1, it becomes evident that there are limitations across each profession in what constitutes usual care as well as the clinical focus with each type of profession. It becomes clear too that there are substantial differences in the breadth of professional training that may result in specific clinical competency in the BH evaluation process, particularly in regards to the types of objective standardized psychological testing that can be conducted to adequately assess an individual’s current functioning. Consequently, an immediate observation regarding this potential lack of additional training specific to the evaluation of objectively determined BH disability is essential for any consumer of such services to be aware. This may necessarily limit what types of clinical services and treatment the professional may offer in regards to BH and the evaluation of permanent impairment (Warren, 2005, 2009).

In addition to training differences for each profession, there are also limitations in what each type of professional is taught as regarding the pertinent diagnosis, evaluation, selection, and determination of appropriate clinical treatment. The evaluation process becomes more complex when the assessment of the individual from multiple domains occurs. Moreover, when the biopsychosocial model that is utilized in current practice is considered, the evaluating professional must take a thoughtful assessment of the physical, psychological, emotional, developmental, and social aspects of the person’s life. While talking with the individual is one way to obtain this information, it is insufficient to consider only what the person has to say since reality can be clouded by an individual’s perceptions of it. Consequently, the evaluating professional must strive to corroborate subjective information (e.g., the person’s perceptions) with more objective information in BH evaluations.

Two types of professionals who tend to have better training in the assessment of individual are clinical psychologists and psychiatrists. A brief discussion of the type of training highlights the differences in training.
Table 2.1 Demonstration of differences in professional training experiences and professional services provided by each type of behavioral health professional

<table>
<thead>
<tr>
<th>Educational degree</th>
<th>Counselors (LCPC, LCP)</th>
<th>Social workers (LCSW, MSW)</th>
<th>Nurse practitioners/Physician Assistant (NP/PA)</th>
<th>Psychologists (Ph.D., Psy.D., and occasionally, Ed.D.)</th>
<th>Physicians (general practitioners, psychiatrists)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice without supervision</td>
<td>Master’s degree and internship</td>
<td>Master’s degree and internship</td>
<td>Bachelor’s degree, plus additional advanced training to obtain the NP/PA title and to become licensed</td>
<td>Doctoral degree, plus practical and internship</td>
<td>Medical doctor (D.O. or M.D.), medical degree, residency, and specialized training for specialty</td>
</tr>
<tr>
<td>Can make a professional diagnosis</td>
<td>Maybe in a few states where a master’s level professional can be licensed as a psychologist</td>
<td>Yes</td>
<td>Maybe. Some states require a physician to oversee the NP treatment, particularly in psychiatric treatment</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Provide professional treatment</td>
<td>Yes, but many states require this is reviewed by supervising professional</td>
<td>Yes</td>
<td>Yes, but some states require a physician to review</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Yes, with supervision in many states</td>
<td>Yes</td>
<td>Yes, but with supervision in some states</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Conduct and interpret objective standardized psychological testing appropriate for evaluation of impairment in functioning</td>
<td>No, except in those states that allow the professional to become licensed as a psychologist. However, many of the tests are restricted to doctoral or MD practitioners only</td>
<td>No, except in those states that allow the professional to become licensed as a psychologist. However, many of the tests are restricted to doctoral or MD practitioners only</td>
<td>No</td>
<td>Yes, particularly clinical and neuropsychologists. Both types of these professionals can typically complete the testing required to determine objective impairment in functioning</td>
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<tr>
<td>Can prescribe psychotropic medications</td>
<td>No</td>
<td>No</td>
<td>Yes, but some states require a physician to review, particularly in a psychiatric setting</td>
<td>Generally, no. However, the states of New Mexico and Louisiana, and the U.S. Territories of Guam and Puerto Rico do allow psychologists with additional professional training to prescribe. This is also true in the U.S. armed forces. Other states are considering allowing psychologists’ prescription rights. Thus, this may change in the future. Warren (2005, 2009)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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Yes, but only if the physician has had appropriate psychological testing training.

Generally, no. However, the states of New Mexico and Louisiana, and the U.S. Territories of Guam and Puerto Rico do allow psychologists with additional professional training to prescribe. This is also true in the U.S. armed forces. Other states are considering allowing psychologists’ prescription rights. Thus, this may change in the future. Warren (2005, 2009)
2.2.2 Clinical Psychologists

Most clinical psychology doctoral programs, particularly those that are APA-approved, have a standardized sequence of 4 years of coursework training, including clinical practica, the completion of a scientific study (dissertation, usually 1–2 year process) for which the student has primary control of designing and conducting, and a required 2-year supervised internship before the professional may sit for a state licensure examination. The American Psychological Association (APA, 2009) is the primary professional organization that governs ethical, and the determination of appropriate professional training and clinical practice. Clinical psychologists traditionally receive professional training to evaluate, diagnosis, and treat a broad variety of psychological disorders and in addressing common problems experienced by most individuals in the course of everyday life. While some counseling psychologists may receive this type of coursework and training, the majority do not, as can be ascertained from examining the typical training programs in Counseling Psychology.

Of note, even if a psychologist is not a member of the APA, it does not necessarily mean that one does not have to follow what is considered to be appropriate clinical practice standards, in particular with regards to appropriate psychological testing. While the breadth of this professional training is essential to practice as a competent clinician, there may be gaps in professional training and real-life application of clinical skills, particularly in regards to professional training regarding the prevention and management of psychological disorders that are primary catalysts for BH disability (APA, 2001, 2002, 2007a, 2007b, 2009).

2.2.3 Physicians

While all physicians receive basic training regarding BH concerns and treatment of them, not all physicians have completed rigorous professional training to treat the complexity of most BH disorders. As noted in Chap. 1, the primary care medicine system is viewed as being the De Facto behavioral health system in the United States. While this type of model has improved medical care access, it has not necessarily improved the quality of care. A typical comprehensive BH evaluation takes approximately 45–90 min to complete. The average time spent in face-to-face patient visits with most primary care doctors is between 15.7-20 minutes (Mauksch et al., 2008; Ming et al., 2007). Thus, it is not surprising that other studies found the substantial variance among PCPs in terms of assessing for a BH diagnosis and the level of accuracy of diagnosis made. It is important to note that significant improvements have been made in diagnosing and treating BH disorders in the primary care setting. But, unless further improvements are made in both the diagnosis and the implementation of current best practice standards as well as close collaboration with BH professionals, then a poor treatment outcome remains a distinct potential outcome.
Those physicians who have trained as psychiatrists have completed medical training and then have undergone intensive supervised training pertaining to the diagnosis of psychiatric illnesses and the medical treatment of such conditions. In Chap. 5, a deeper discussion of some of the issues that impact on psychiatrists providing care is provided. However, it is important to note that because a psychiatrist specializes in the treatment of BH disorders, there is specific training that occurs with an emphasis on the treatment of mental health disorders as a medical condition and the usage of medications to treat them (ACOEM, 2006). Moreover, any consumer in the utilization of BH services and in the disability management spectrum must carefully screen whether the psychiatrist has sufficient training in the evaluation of BH functional impairment.

2.2.4 Lack of Objective Assessment in the BH Evaluation Process

There is frequent confusion among professionals as to why objective assessment must occur as well as what constitutes objective information. The reason for this approach is that it provides a more accurate picture about the person’s actual level of functioning and allows the professional to discuss functioning from an objective standpoint versus a perceptual/subjective one. A professional must attempt to provide as accurate data and facts as possible report regarding functioning. If a professional does not follow this approach, then serious questions regarding the objectivity and accuracy of the professional’s clinical report can be made. Objective documentation pertaining to an individual’s psychological functioning considers physical data (e.g., blood work, X-rays, and MRIs), psychological and psychosocial data which are determined through comprehensive standardized testing. Moreover, any psychological testing must be specific to the reported concern and not simply administered without a particular reason. Otherwise, testing in this manner does not follow current appropriate psychological testing standards set forth by the APA. While a professional may note that one is not a member of the American Psychological Association (APA), all psychological tests, in particular, standardized psychological testing and the administration of such tests are under the APA’s jurisdiction. Thus, all professionals who utilize psychological tests must comply with the rules set forth by the APA, even if not a professional member.

The testing data provide data and information that are synthesized and then examined in a more comprehensive manner to allow the professional to assess the individual from the physical, psychological, cognitive, emotional, development, and psychosocial aspects that may be impacting on the person. This synthesis is considered objective data because the standardized tests are administered in a specific manner each time the test is administered from individual to individual. Moreover, the test user must follow the interpretation protocol set forth in the standardization process in order for the testing results to be considered valid. Unfortunately, many professionals do not follow this step and end up reporting psychological test data that were either nonstandardized or invalid due to the manner in which it was administered and/or interpreted.
Many master’s level clinicians as well as other BH professionals tend to over-utilize subjective tools, such as surveys, questionnaires, and fill-in-the-blank devices (AMA, 2008; Bruns, Mueller, & Warren, 2010). There are three primary issues with these types of tools:

1. Usually, these tools have been validated for research settings, but not clinical settings. This is important because both the AMA (2008) and APA (2001, 2002, 2004) require appropriate psychological test usage in which the test administrator must employ the test in the setting for which it was designed as well as follow appropriate testing administration protocol.

2. These tools have been found to be excellent screening devices to identify potential BH concerns, but that they are inappropriate to use in the actual assessment of psychological functioning because of limitations in their validity (accurately measuring what the test purports to measure) and reliability (consistently measuring the same clinical issue or domain each time the test is employed), and thus do not provide meaningful data about the individual’s current level of functioning.

3. Users of screening tools frequently make changes to address a different clinical issue, but without going through the standardization process (ACOEM, 2008; Bruns et al., 2010; Warren, 2009). Thus, this arbitrary process deviates from mandated psychological testing protocol as noted by the APA (2001, 2002, 2004). When a change in a tool takes place, it is uncertain if the tool still screens for the issues for which it originally designed to assess and because the changes were made without completing the required stringent validation process. American Educational Research Association, American Psychological Association & National Council on Measurement in Education (2004).

### 2.2.5 Problematic Selection of BH Treatment

The type of treatment that is provided by the clinician is likely based on the coursework and professional supervised experience in graduate or medical training. It is important to note that there are different types of treatment associated with different psychological theories, and thus the selection of treatment is likely to be substantially influenced by the clinician’s theoretical orientation. These treatments may or may not be current with empirical research and best practice standards. Consequently, there is the potential that a professional may provide treatment that was learned in clinical training, but is no longer deemed appropriate or effective. Types of professional services are generally determined by two governing bodies (1) the profession itself sets standards regarding what constitutes thorough training and (2) each state has laws that legally limit as to what services a professional is able to provide. Any consumer of BH services should take steps to familiarize oneself with these standards and laws. It is beyond the scope of this chapter to address them here. (Heilburn, Grisso, & Goldstein, 2009; Lerner & Henke, 2008; Merikangas et al., 2007).

Unfortunately, not all behavioral health treatments are effective for the treatment of all BH concerns (Warren, 2009). It is critical to know that there are current scientifically
based treatments for true individual BH disorders (e.g., Major Depressive Disorder) that are the most likely to result in efficient care and the facilitation of the individual’s return to previous level of functioning. Thus, the limitation in professional training that was discussed earlier can have negative implications throughout the diagnostic process, assessment process, the type of treatment provided.

It is important for non-BH professionals to understand the differences in training among BH professionals. Furthermore, it is essential that non-BH professionals become better acquainted with current scientifically based treatments for true psychological disorders in order to both understand typical treatment of the disorder and in order to ask the treating professional (TP) about different aspects of the treatment provided, treatment goals, medications, and transition plans for the RTW process (ACOEM, 2006, 2008; Melhorn & Ackerman, 2008; Warren, 2009). While some BH TPs may balk at a nonclinician asking these type of clarifying questions, in reality, there is nothing inherently wrong with a non-BH professional asking questions pertaining to professional care received. In the age of the Internet, it is common for a person to informally research different topics of interest, including professional care. Thus, BH TPs should recognize this and use asked questions as an opportunity to discuss the current state-of-the-art treatment and to be prepared to discuss any deviations in the care they have provided. Moreover, the TP must also explain how the RTW goal and process are being addressed and will be accomplished as well as the expected timeline for treatment. Any deviations from the above must be grounded in scientifically based standards versus subjective clinical opinion (Warren).

In addition, there is wide variation in the quality of BH health treatment provided currently (APF, 2005; NBGH, 2007; Warren, 2005, 2008, 2009). This has resulted in poor and unpredictable treatment outcomes in the BH treatment process. These poor outcomes have caused some non-BH professionals to become skeptical as to the veracity of the BH impairment in functioning claim, particularly if there is poor documentation provided to support such a claim. Consequently, nonclinicians involved in the BH disability process have come to ask questions of the BH TP regarding treatment for a variety of reasons, including BH disability claim determination. With the advent of HIPAA (Health Insurance Portability and Accountability Act of 1996), new changes were mandated regarding what types of health information could be released and imposed new requirements to protect health information. However, HIPAA also allowed that certain protected health information (PHI) could be disclosed without a signed release by the individual receiving treatment, in some cases, such as the application for disability. Frequently, BH TPs inappropriately use HIPAA as a shield to avoid disclosing essential information, often to the detriment of the person being treated, such as in the case of obtaining disability benefits. It is important to note that HIPAA specifically allows both TPs and non-TPs to exchange information in regards to workers’ compensation (WC) and other disability issues, such as with short-term (STD), long-term (LTD), and Social Security Administration Disability Insurance (SSDI). Moreover, if there is sustained concern about the release of potentially protected health information, any professional may alleviate this by simply asking the person receiving treatment to sign a release of information. This effectively reduces
the potential concern of the person not assenting to the release of pertinent information. Although this is not always necessary with these types of disability disclosures as noted in HIPAA, it provides additional protection to all involved parties (ARRA, 2009; HIPAA, 1996; Warren, 2009).

2.2.6 Problematic Utilization of Inappropriate or Nonevidence-Based Treatment

It is also essential to note that the empirical research is clear that there are evidence-based treatments for the majority of BH diagnoses and that recovery is the norm, not the exception (APF, 2005; DMEC, 2008, 2009; Melhorn & Ackerman, 2008; Messer, 2004; Nathan & Gorman, 1998; NBGH, 2007; Reed, Kihlstrom, & Messer, 2006; Rush et al., 2009; Sing, Hill, & Puffer, 2001; Warren, 2005, 2009). Thus, this is an essential issue for professionals to address throughout the BH evaluation and treatment process. Unfortunately, as the American Psychiatric Foundation’s Partnership for Workplace Mental Health (2005) has noted, there seems to be a professional disconnect between the empirical literature and its application by BH professionals in current common clinical practice. This problem is of great concern since two of the primary reasons empirical research takes place are to develop and identify new or more efficacious ways in which to provide treatment in clinical practice and to improve treatment outcomes. Thus, there are several questions can be raised about the type of professional treatment provided by a BH TP: (1) Has the implementation of best practice standards into current clinical treatment occurred? (2) Has a RTW goal been set as a part of the treatment plan? (3) What are the ethical and professional implications of not providing such treatment to individuals? and (4) What are the inherent problems with providing less-than-excellent care likelihood of leading to poor treatment outcomes? (Warren, 2009).

There are several professional treatment guidelines and best practice standards for physical concerns, such as the American College of Occupational Medicine (ACOEM, 2008), the American Medical Association’s Guides to the Evaluation of Permanent Impairment (AMA, 2008), the Colorado State Division of Workers’ Compensation Chronic Pain guidelines (2007), as well as commercially available guidelines such as the Official Disability Guidelines (ODGs, 2008); and the Reed Group Medical Disability Advisor (MDA, 2008). However, there are relatively few guidelines explicitly for BH concerns: the American Psychiatric Association’s Practice Guidelines for the Treatment of Psychiatric Disorders (2006), the Work Loss Data Institute’s ODG (2008), and the book “The Management of Workplace Mental Health Issues and Appropriate Disability Prevention Strategies” (Warren, 2005). The ACOEM and the AMA both have chapters on mental and behavioral health issues. However, at the time of this chapter, the ACOEM guidelines had not been updated for the inclusion of current empirical research and the AMA guidelines focus more on the assessment of permanent impairment, not the specifics of professional BH treatment. Another considerable concern, at present, is that the importance of providing
current evidence-based treatments are not regularly taught in professional training of BH clinicians nor mandated by professional organizations such as the American Psychological Association or the American Psychiatric Association (Warren, 2009). While it can be appreciated that there are different theoretical bases for treatment, the importance of providing the most efficient treatment to alleviate an individual’s suffering and to greatly facilitate the person’s return to previous functioning is of tantamount concern. This is a professional deficit that must be remediated in order to provide quality BH assessment and treatment processes.

While there are limitations in the professional training of BH professionals that contribute to uneven treatment and poor treatment outcomes, there are also several misperceptions that occur with that all professionals, both BH and non-BH, that will be explored further.

2.3 Common Misperceptions That Occur with All Professionals Involved in the BH Disability Process

There are multiple misperceptions that occur across the BH disability spectrum that contribute to adversarial interactions, arbitrary decision making, and treatment, disability claim, and legal outcomes.

2.3.1 Determination of Functional Impairment Versus Disability

There is a common misunderstanding among professionals regarding the terms of “disability” and “impairment in functioning.” Frequently, many professionals appear to believe that the terms of impairment and disability are synonymous and use them interchangeably. The term disability is a socioeconomic and legal term which varies with each state statute, federal statute, insurance carrier, governmental agency, or organization (Warren, 2009). Because of the variability of the definition of disability across organizations and laws, there is little to no standardization of language and criteria regarding disability. Thus, currently, there is no single set of criteria recognized as to define disability in a standardized manner. Consequently, there is a great deal of confusion about among professionals in using the term “disability” and the belief that using one organization or law’s specific criteria will be sufficient to constitute disability and more specifically, whether an individual has true physical or psychological impairment. However, frequently, the primary issue at stake for clinicians is in the professional determination process of whether the individual can actually work. Thus, this relates directly to ability to function in the workplace (and other settings) versus simply noting that a person is “disabled.” Unfortunately, by using an organization’s disability definition and criteria, such as, for example, the Social Security Administration (SSA, 2008), there is a tendency to refocus the treating
professional to solely address whether the individual’s current concerns meet the organization’s disability criteria. A significant problem with this approach is that the organization’s disability criteria may or may not utilize current clinical practice standards to objectively determine what the individual is and is not objectively capable of doing. Consequently, the question regarding objective impairment in functioning remains unanswered. This creates a dilemma for both the TP and the individual is reported to be disabled since both have moved away from an active treatment model and recovery as an outcome goal and more to declaring the individual is disabled and incapable of recovery, including work. Moreover, once a person obtains disability status through an organization, such as SSA, then there is little to no incentive to help the individual continue professional treatment or to recover and return to one’s previous lifestyle, including work (Warren & Hubbard, 2006, 2008). Thus, this is essential for professionals in the BH disability field to be aware and to ask the following general questions:

- What is the current DSM diagnosis for this individual?
- What is the current best practice standard for this diagnosis?
- Is this actual treatment being provided?
- If yes, Is the person making appreciable progress in treatment?
- If no, What are the barriers to the person making progress that need to be addressed?
- Has a RTW goal been set as an integral part of BH treatment?
- If yes, How will be this addressed?
- If no, How is this supported in the current empirical research?

These questions will quickly help any professional quickly focus on the pertinent issues at hand and to avoid tangential concerns that may be interesting, but have little impact on the clinical issue of functioning. As noted earlier, when the issue of BH disability is examined, it quickly becomes apparent that there are even fewer definitive criteria than can be found with the physical disability criteria. Again, many of the difficulties are related to the nonstandardization of criteria in the initial defining of disability. Thus, disability is a term that is used among professionals to convey a wide variety of psychological diagnoses and BH concerns, but without a sufficient standardized mode in which to note occurrence of objective impairment (Warren, 2005, 2009).

While disability is primarily a nonstandardized term that has little to no meaning, the same is not true for impairment of functioning. Impairment relates to the actual objectively determined functioning of the individual across many different physical systems, such as, for example, cardiac, respiratory, emotional, neurological, and cognitive functioning. Importantly, there are specific means to measure functioning in each of these systems that is both standardized and utilized across different professions and will be discussed more fully in the later chapters. However, in summarization, this objectively determined process provides a means for professionals to discuss if specific deficits exist and how these deficits relate to the individual’s ability to complete daily activities of everyday living as well as in performing a variety of workplace duties (ACOEM, 2006; Warren, 2005, 2009).
2.3.2 A BH Diagnosis Is Automatically Equal to Impairment in Functioning

A common, problematic issue in the field of behavioral health evaluation process is the apparent belief among most professionals involved in the BH evaluation, treatment, and disability process that a mental health diagnosis is equal to a disability. While there is no question that some psychological diagnoses have considerable impact on an individual’s life, there is not a substantial body of empirical research to date, which demonstrates that the majority of the psychiatric diagnoses necessarily result in a permanent inability to function in multiple settings, including work (Alpert et al., 2006; AMA, 2008; APF, 2005; CDC, 2008; Kahn & Langlieb, 2005; Warren, 2005). Yet, this perception permeates across all professional fields involved in the prevention and management of BH disability. Typically, with the treating and case management professionals, the current standard has been to utilize a psychological diagnosis as the means to justify an application of disability. However, starting from this point, it clearly illustrates how strongly it is presumed that a psychological diagnosis is synonymous with impairment. Thus, using this line of reasoning and to continue to its logical conclusion, it would stand to reason that once a psychological diagnosis is made, then all persons with a psychological diagnosis would be both permanently disabled and impaired. Yet, it is clear from casual observation – such as having a family member with a diagnosed psychological condition, empirical research, as well as in clinical practice – that even though some individuals do receive a psychological diagnosis, there are variations in the severity of that clinical concern (Grant, 2005; Warren, 2009). Moreover, many continue to function in all aspects of life, despite receiving a psychological diagnosis. For example, the DSM-IV-TR (American Psychiatric Association, 2000) has a clear system of rating for the severity of MDD. This rating system is to be used to denote milder symptoms of MDD to more severe symptoms that are highly likely to impact on the person’s ability to functioning effectively in life. Thus, while an individual may receive a diagnosis of MDD, it may not currently be impacting on the person’s ability to function. Therefore, despite the diagnosis, the person is likely to be able to participate in everyday life activities. Once an exception to an assumption can be found, such as in this case, then it clearly brings into the question of the soundness of utilizing over-generalities in clinical practice as well as in nonclinical settings (Grant 2005, 2010).

It is incumbent for the TP to evaluate actual functioning beyond a diagnosis. One way to do this is to employ the DSM coding system for the specific psychological condition to denote severity of the current status, but also it can also be used to reflect the positive changes in the individual’s recovery and return to functioning. Consequently, DSM diagnostic system is not a unilateral system, but a bidirectional one. Furthermore, in the review of several thousand psychological disability claims, the change in severity of the DSM diagnosis is rarely seen in follow-up after a disability claim has been approved and even, with professional treatment (Warren, 2005, 2009; Warren & Hubbard, 2008). This does not
necessarily accurately represent that the person is still severely impaired, but begs the questions regarding whether: (1) The TP has made the correct diagnosis initially? (2) Has the diagnosis been confirmed with objective, standardized psychological testing? (3) Has the TP re-evaluated the individual since treatment began? (4) Does the professional treatment provided meet the current best practice standards? and (5) Is the person being treated fully complying with treatment? (Warren, 2009). Evidence-based treatment and best practice standards will be discussed in more depth in Chap. 3 and the usage of objective standardized psychological testing will be examined in Chap. 4.

### 2.3.3 Behavioral Health Impairment in Functioning Is Permanent

Frequently, both BH and disability professionals as well as individuals with true, objectively determined BH impairment tend to believe that this impairment is permanent and recovery requires the individual to avoid those situations that exacerbate one’s symptoms, as well as withdraw from everyday activities, including work. However, this viewpoint is a deviation from the recognition of necessary and appropriate rehabilitation required with most chronic physical injuries and illnesses in the medical and rehabilitation fields. When one is physically ill or injured, the medical standard is to facilitate an increasing activity level in order to keep the person as physically active as possible to preserve and strengthen physical health. Even after cardiac or orthopedic surgery, it is common practice for the individual to be gotten up and moving as soon as it is deemed medically safe to facilitate the healing process and to prevent complications, such as DVTs, bed sores, and muscle atrophy (AMA, 2008). However, unfortunately, there is not an analogous standard in the current BH treatment practice (Warren, 2009). Instead, BH TPs frequently tend to confuse empathy with actual professional treatment and the person is encouraged to recover by withdrawing from life. This is not to say that empathy is not important in the treatment of BH concerns, because it is essential to have professional empathy to the condition of human suffering (Koocher et al., 2005). But, empathy alone is not noted anywhere in the empirical research, as a current stand-alone professional treatment nor does it help the person to maintain a more active lifestyle, make appropriate changes, focus on developing sound coping skills, as well as regroup and re-engage fully in all activities of living, including work.

This observation should not be taken to mean that no person should ever be placed on permanent disability, since there are some BH diagnoses, such as traumatic brain injury, schizophrenia, or dementia (Lee, Lyketsos, & Rao, 2003; Rao & Lyketsos, 2003; Schretlen, Munro, Anthony, & Pearlson, 2003; Schretlen et al., 2007) that may potentially result in permanent impairment in functioning. However, it is essential to note there are serious issues with professionally opining that an individual is completely and totally impaired in all spheres of life, even with the completion of objective determination of impairment in functioning.
Empirical research has demonstrated that the quality of one’s life dramatically decreases when one is unemployed or once placed on disability. Gerdtham and Johannesson (2003) found that one’s social relationships, financial and physical status substantially decreased, so much so, that after 10–17 years the individual became unemployed, that there was a 50% increased probability of committing suicide. This effectively illustrates that being declared disabled is not a panacea for BH concerns and may actually cause or worsen a BH condition. In the field of psychology, this is called learned helplessness (Seligman & Maier, 1967).

2.3.4 Inappropriate Usage of Subjective Information Versus Objective Data for Behavioral Health Concerns

Because of the inherent nonstandardized definition of BH disability, many professionals across the disability spectrum tend to over-rely on subjective information (from either the person being evaluated or the professional) as “evidence” of disability versus utilizing objective data of impairment in functioning in the BH disability determination process. Examples of subjective information are the individual’s self-report of distressing symptoms, family members’ report of symptoms, the clinician’s professional opinion without the inclusion of objective, standardized psychological testing to offset any underlying professional bias, and the usage of screening tools, such as a Beck Depression Inventory (BDI) (which is appropriate for research settings and basic screening, but inappropriate for the comprehensive assessment of individual’s perceived BH impairment), questionnaires, and surveys and the like. This listing is not meant to be all-inclusive, but rather to illustrate common problematic issues that arise across the BH field. This is not to say that this type of information should not be gathered and noted in the assessment and treatment process, but it must be cross-checked with more objective means of confirming or ruling out impairment in functioning. The importance of objective assessment is a critical component of the BH evaluation and assessment process. Some examples of objective evidence are standardized objective psychological testing, blood work, as well as PET scans, MRIs (Melhorn & Ackerman, 2008; Warren, 2009). The process of objective psychological testing will be discussed later in Chapters 3 and 4.

2.3.5 Over-Reliance on Subjective Information in the Diagnostic Process

Frequently, professionals involved in the BH field use psychological symptoms and their clinical opinions as shortcuts to render a clinical diagnosis. Although this certainly is a component of assessment in which professionals are trained, using
this approach alone leaves the professional vulnerable to over-relying on one’s opinion and an underlying apparent assumption of infallibility in one’s professional decision making. Using the physical treatment model, when a person consults with a physician, symptoms are noted and discussed, but then further explored through a variety of more objective measures, such as cultures, blood assays, X-rays, CT, and MRIs and the like. Consequently, the physician is able to quickly narrow the clinical focus and use clinical tools available to confirm or rule out specific diagnoses and to delineate an appropriate treatment for the issue. While BH professionals have similar objective, clinical tools available, they are not regularly utilized so that the person’s subjective report is often viewed as completely accurate and without bias. This is further compounded by the BH professional employing one’s clinical opinion alone as the final arbiter in the ruling out or confirmation of a psychological condition and/or diagnosis. Thus, if the BH diagnosis is based solely on subjective information versus objectively determined data, and the diagnosis is incorrect, then conceivably, the person could receive the inappropriate professional treatment for reported concern. Unfortunately, this can result in lengthy and expensive professional treatment with little to no progress made in facilitating the person’s return to one’s previous level of functioning. The potential ethical and legal implications that could arise with this approach should give pause to all professionals (Hadjistavropoulos & Bieling, 2001; Hamm, Reiss, Paul, & Bursztajn, 2007; Harding, 2004; Warren, 2005, 2009; Warren & Hubbard, 2008).

This more subjective type of approach taken by professionals is frequently observed in the BH disability claims process. Unfortunately, the majority of applications for BH disability have important missing documentation that impedes the claim management decision-making process. For example in the review of a large, national insurer, frequent missing information found in BH claims were: (1) A missing DSM-IV-TR (or current version) diagnosis. (2) A clinical evaluation is missing or is of poor quality. (3) A person’s symptoms are provided as “proof” of impairment. (4) There are no objective data provided to support the reported diagnosis. (5) Treating professionals have not collaborated. (6) A treating professional has noted that the workplace must be changed before the person can return to work. (7) Open-ended workplace leave is reported as being required. (8) The person is reported to have sustained symptoms, even after lengthy treatment; and (9) Evidence of poor quality of treatment provided by the BH professional (Warren & Hubbard, 2008). This type of missing documentation results in a cycle that causes the need for additional documentation, delays in decision making, mistrust, and frustration for all involved parties. Moreover, this increases the costs to the claimant and the insurer since it is necessary to have the claimant request additional information and perhaps, re-evaluation and for the insurer to have the file materials reviewed by a psychologist or psychiatrist trained in disability management. Because of lengthy delays, arbitrary decisions may be made and result in an adversarial stance between the BH professional, claimant, and insurer (Hadjistavropoulos & Bieling, 2001; Hamm et al., 2007; Warren, 2005, 2009; Warren & Hubbard, 2006, 2008).
2.3.6  **Physical Disability Concerns Represent the Majority of the Disability Claims**

As noted earlier, there is a great deal of physical and BH comorbidity occurring in the disability management field. While various organizations may have databases specific to limited populations, by examining the SSA (2007) actuarial data, it can provide clear data to illustrate overall disability patterns in which BH concerns represent the largest group (33.4% or 2,030,612 people) receiving disability benefits. The second largest SSA beneficiary group is the musculoskeletal concerns (26.4%). Of note, empirical research has consistently demonstrated that approximately 64% of individuals with musculoskeletal concerns (1,875,931 beneficiaries) have a comorbid BH diagnosis as well. By employing this information with the SSA data, this results in an additional 16.8% of individuals diagnosed with a musculoskeletal concern who have a concurrent BH diagnosis. Moreover, as noted earlier, empirical research has demonstrated that there is approximately 50–60% prevalence rate of behavioral health comorbidity with other physical concerns, such as, for example, cardiac, stroke, diabetes, cancer, and morbid obesity (Buist-Bouwman et al., 2005; Campbell et al., 2003; CDC, 2006; Chellappa & Ramaraj, 2009; Dersh et al., 2002, 2005; de Waal et al., 2009; Evans et al., 2005; Fava et al., 2006; Gros, Antony, McCabe, & Swinson, 2009; Hutter, Scheidt-Nave, & Baumeister, 2009; Kessler et al., 1994, 1997, 2003, 2006). Using this assumption, of the remaining 40.2% of individuals receiving SSDI benefits, approximately another 20.1–24.12% have a comorbid BH diagnosis. Thus, in taking SSA’s data, and incorporating the empirical research which have demonstrated a high prevalence of physical and BH comorbidity, there are approximately 70.3–74.32% of individuals with a comorbid BH diagnosis within the SSA disability system. Even with the subtraction of 4.8% for a mental retardation diagnosis, which is typically a congenital disorder, there are still 65.5–69.52% of individuals with a BH diagnosis. While these data illustrate the SSA comorbidity issue, it is essential to note that the same issue occurs within the private insurance industry with the STD and LTD benefits. This is known because those individuals receiving STD and LTD disability benefits and who do not experience resolution of their concern typically go on to apply for SSA disability benefits. Consequently, this quickly demonstrates the true scope of the BH disability issue. Therefore, BH disability concerns represent the largest portion of disability recipients across the board of STD, LTD, and SSA (SSA, 2008). Further illustration of the expanse of BH disability issues can be seen by examining the SSA for those 30 states and U.S. territories with higher BH prevalence rates than the overall SSA average in Table 2.2.

Of note, the higher the BH disability percentage of SSA beneficiaries, the lower the second highest category of musculoskeletal concerns, except for three states. This can be observed in Table 2.3.

Table 2.4 demonstrates the overall BH prevalence rates with the SSA actuarial data when the BH and the musculoskeletal concerns only are included. Thus, this provides a clear picture of the extent of BH disability within one federal disability system.
Table 2.2  States and territories with BH disability percentages higher than SSA BH disability percentage of 33.4%

<table>
<thead>
<tr>
<th>State</th>
<th>BH Disability Percentage</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>36.1</td>
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<tr>
<td>Arizona</td>
<td>39.8</td>
</tr>
<tr>
<td>California</td>
<td>38.6</td>
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<tr>
<td>Colorado</td>
<td>33.5</td>
</tr>
<tr>
<td>Kentucky</td>
<td>35.8</td>
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<tr>
<td>Mississippi</td>
<td>33.7</td>
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<tr>
<td>North Dakota</td>
<td>39.5</td>
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<tr>
<td>Hawaii</td>
<td>45.5</td>
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<tr>
<td><em>idaho</em></td>
<td>38.1</td>
</tr>
<tr>
<td>Maine</td>
<td>42.7</td>
</tr>
<tr>
<td>Maryland</td>
<td>35.1</td>
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<td>Montana</td>
<td>33.8</td>
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<td>Nebraska</td>
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<tr>
<td>Oregon</td>
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<tr>
<td>Arizona</td>
<td>39.8</td>
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<tr>
<td>Idaho</td>
<td>38.1</td>
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<tr>
<td>Illinois</td>
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<tr>
<td>Maine</td>
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<td>Massachusetts</td>
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<tr>
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<td>Maine</td>
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<td>Montana</td>
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<td>Nebraska</td>
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<td>Oregon</td>
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<td>Oregon</td>
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<td>Kansas</td>
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</tr>
<tr>
<td>Minnesota</td>
<td>17.6</td>
</tr>
<tr>
<td>New Mexico</td>
<td>27.0</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>25.4</td>
</tr>
</tbody>
</table>

The bold-print states represent over 40% of SSA BH disability in the state.

Table 2.3  States and territories with musculoskeletal disability percentages lower than SSA musculoskeletal percentage of 26.4% (except for 3 states)

<table>
<thead>
<tr>
<th>State</th>
<th>MS Disability Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>24.0</td>
</tr>
<tr>
<td>Arizona</td>
<td>23.5</td>
</tr>
<tr>
<td>California</td>
<td>24.3</td>
</tr>
<tr>
<td>Colorado</td>
<td>25.2</td>
</tr>
<tr>
<td>Kentucky</td>
<td>27.7</td>
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<td>Maine</td>
<td>24.8</td>
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<tr>
<td>Maryland</td>
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<td>Massachusetts</td>
<td>19.2</td>
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<td>North Dakota</td>
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<td>Ohio</td>
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<td>Idaho</td>
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<td>Arizona</td>
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<td>Idaho</td>
<td>25.2</td>
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<tr>
<td>Illinois</td>
<td>19.1</td>
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<td>Maine</td>
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<tr>
<td>Montana</td>
<td>26.5</td>
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<td>Nebraska</td>
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<tr>
<td>Oregon</td>
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<tr>
<td>Arizona</td>
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<tr>
<td>Idaho</td>
<td>54.23</td>
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<tr>
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<tr>
<td>Maine</td>
<td>42.70</td>
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<td>Montana</td>
<td>50.76</td>
</tr>
<tr>
<td>Nebraska</td>
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<td>51.53</td>
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<tr>
<td>Colorado</td>
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<td>Indiana</td>
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<tr>
<td>Massachusetts</td>
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<td>New Mexico</td>
<td>27.0</td>
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<tr>
<td>Puerto Rico</td>
<td>25.4</td>
</tr>
</tbody>
</table>

This demonstrates an overall inverse relationship between the higher BH disability in the state and the lower disability beneficiaries with musculoskeletal concerns.

Table 2.4  The SSA BH disability group and the 64% of psychological comorbidity demonstrated in the empirical research and taken from the SSA musculoskeletal disability group. These percentages are added together for a cumulative total.

<table>
<thead>
<tr>
<th>State</th>
<th>BH Disability Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>51.46</td>
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<tr>
<td>Arizona</td>
<td>54.84</td>
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<tr>
<td>California</td>
<td>54.15</td>
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<tr>
<td>Colorado</td>
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<td>Kentucky</td>
<td>53.53</td>
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<td>Maine</td>
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<td>Maryland</td>
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<td>Ohio</td>
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<td>Washington</td>
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<td>Rhode Island</td>
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<tr>
<td>Puerto Rico</td>
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<td>District of Columbia</td>
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<tr>
<td>Kansas</td>
<td>50.76</td>
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<tr>
<td>New Mexico</td>
<td>53.68</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>62.96</td>
</tr>
</tbody>
</table>

There is not only a higher rate of BH disability in each of these states, but also the inclusion of the 64% of the musculoskeletal concerns that have a comorbid psychological disorder, pushes the BH disability percentage even higher in all states (Dersh et al., 2002, 2005). Thus, it becomes clear the extent that BH disorders impact on federal disability programs. Because the Short-term disability (STD) and Long-term disability (LTD) programs are the stepping stones for SSA disability benefits, it is clear that a similar pattern in the private insurance industry as well (Agency for Healthcare Research & Quality, 2009; National Committee for Quality Assurance, 2009).
Unfortunately, there is not a similar breakdown of data available for the WC system since statutes vary from state to state regarding the allowance of a BH concern as being compensable. For example, the State of Montana does not allow a BH concern under its WC laws. In other instances, some states such as IL may allow a BH claim under its WC law, but if a BH concern is not identified as a part of a physical claim, then there is likely to be an under-reporting of BH issues in the state’s reported WC data. In addition, when a BH concern has been identified, but not confirmed with objective psychological assessment, it is likely that there will be an inaccurate overcounting of BH concerns within the data (Warren, 2005).

2.3.7 Disability Concerns Can Only Be Physical or Behavioral in Nature, But Not Both

By looking at the empirical research, it is abundantly clear that while a impairment issue can be either a physical or behavioral disorder, it is equally probable that a impairment concern can also be a comorbid concern. Thus, it is essential to move from an “either–or” approach and more to the integration of the biopsychosocial issues that have been to occur with all types of disorders and is the current model employed in empirical research. The biopsychosocial model was discussed in Chap. 1.

2.3.8 BH Issues Must Be Treated Differently from Physical Issues

Most physical concerns have clear treatment standards that have been developed to quickly and effectively treat the underlying issue. Thus, a physician does not have to struggle to identify the assessment or treatment process. Instead, the majority of medical treatments are strongly based on the melding of clinical practice with scientifically based research. This type of information is typically taught during medical training as well as with continuing education throughout the professional career. This allows for a standardization of medical assessment and treatment from physician to physician. Consequently, a physical ailment, such as a broken bone, is treated in similar fashion by each professional (Warren, 2009).

While there are similar standards in the graduate and medical training for the evaluation and assessment in the BH field, the same is not true when it comes to the actual provision of professional BH treatment. Instead, it is common for a mélange of BH treatments to be provided without regard to empirical research and its synthesis into clinical practice. The problem with this approach is that appropriate treatment that is specific to the BH diagnosis may or may not be conducted. Instead, each BH professional is left to determine a type of treatment based on the professional’s theoretic orientation, such as, for example, psychoanalysis, humanistic, or behavioral.
While many BH professionals profess to provide eclectic psychotherapy, this is particularly problematic in regards to providing a cohesive treatment from start to finish. Many times, this type of treatment can result in poorly focused treatment that is both lengthy and open-ended. Thus, this type of approach can substantially reduce the likelihood of good treatment outcome, including facilitating the person’s return to the previous level of functioning, if it is not strongly supported by scientific research. Furthermore, the treatment process issue is compounded by the tendency for many BH professionals to believe that BH issues should not be standardized because this is somehow uncaring and that behavioral health care must be treated differently from physical concerns. The problem with this approach is that it ignores/bypasses the biopsychosocial aspect of disability as well as overlooking the current scientifically based treatments available. Thus, this type of approach may result in the unintentional continuation of the individual’s suffering. Most importantly, because many individuals with physical concerns also experience a concurrent psychological disorder, it is imperative to evaluate and treat BH issues in tandem with physical concerns (ACOEM, 2006, 2008; AMA, 2008; APA, 2009).

2.3.9 **Treating Professionals Are the Most Appropriate to Evaluate BH Impairment in Functioning Issues**

There is a tendency among all professionals in the disability field to believe that TPs are the best professionals to evaluate BH disability issues, particularly in regards to those individuals receiving treatment. However, there are several problems with this belief. First, when a TP is in the treating role, most professional organizations, such as the APA’s ethical guidelines (2004), do not permit the professional to have a dual professional relationship with an individual receiving treatment. For example, a TP can be a TP, but cannot later switch roles to that of an objective evaluator, such as a forensic evaluator of the same person and who then purports to re-examine the individual and look current level of functioning. Other organizations, such as ACOEM (2007) and the AMA (2008), have noted similar restrictions for professionals as well. Thus, a professional may be a TP or an objective evaluator in more of a forensic role, but not both simultaneously. The primary reason is that there are conflicting professional responsibilities associated with each professional role (Table 2.5).

Another important issue is that most BH professionals are trained in assessment and treatment, but do not receive professional training in regards to disability prevention and management strategies since these professional skills are not typically taught at the present in most BH graduate programs or medical schools. Thus, while it is true that the TP may have spent more time with the person who is reporting impairment, clinical observation and opinion alone are insufficient to note whether the individual actually impaired. Instead, this must be determined through more objective means, such as with standardized psychological testing (Bruns et al., 2010).
Table 2.5 The differences in professional responsibilities between the treating and forensic roles in psychology

<table>
<thead>
<tr>
<th>Treating psychologist role</th>
<th>Independent or forensic psychologist role</th>
</tr>
</thead>
<tbody>
<tr>
<td>An individual selects the psychologist for psychological treatment</td>
<td>A third party selects the psychologist for an independent evaluation of the individual</td>
</tr>
<tr>
<td>The individual is considered the patient or the client</td>
<td>The third party is considered the client</td>
</tr>
<tr>
<td>The individual’s treatment information is considered PHI</td>
<td>The data collected in the evaluation are not considered PHI. However, the APA restrictions of releasing raw test data only to qualified professionals must still be followed</td>
</tr>
<tr>
<td>HIPAA applies to all information, data, and health care information</td>
<td>HIPAA is not likely to apply to some information or data gathered due to exceptions related to separate disability and workers’ compensation laws and need to have specific information to make decisions. However, the information is limited in scope to what can be provided to a third party</td>
</tr>
<tr>
<td>No information may be released without written consent by the patient</td>
<td>Information gathered may be released to a third party without consent by the individual</td>
</tr>
<tr>
<td>A court order or subpoena is required for release of information in a lawsuit</td>
<td>In the case of some legal and disability procedures, clinical information can be released without consent of the individual</td>
</tr>
<tr>
<td>The state mental health laws apply where the psychologist practices</td>
<td>The state mental health law is likely to not apply due to HIPAA exceptions for the management of disability claims and workers’ compensations laws</td>
</tr>
<tr>
<td>A summarization of diagnosis, treatment, and outcome to date can occur with appropriate signed release</td>
<td>Typically, no release is needed to release only information pertinent to the disability procedures and where the professional is serving as an expert in a legal proceeding</td>
</tr>
<tr>
<td>Test data are considered PHI. Summarizations of testing may occur only with signed release</td>
<td>Raw test data are considered PHI, but a summarization of test results are not. The summarization may be released without signed consent</td>
</tr>
<tr>
<td>The goal of treatment is to alleviate symptoms and teach appropriate coping strategies. Treatment usually occurs for 6+ sessions</td>
<td>The goal of the evaluation is to objectively evaluate the individual’s current cognitive, psychological, and emotional functioning related to (1) job fitness and ability to complete current job responsibilities, (2) disability claim resolution, and (3) legal proceeding</td>
</tr>
<tr>
<td>The patient may be seen in the future, if the need arises</td>
<td>The individual is not typically seen after the evaluation</td>
</tr>
<tr>
<td>The patient may request a copy of the evaluation and treatment records</td>
<td>The individual may not request a copy of the evaluation records or report directly from the evaluating psychologist evaluatee’s. However, records may be obtained by an attorney</td>
</tr>
</tbody>
</table>

All professionals are strongly encouraged to become trained in their individual state laws and in regards to federal laws related to the different disability processes. Moreover, professionals should consult with an attorney regarding the specifics of each law.
The argument of deference being expressly given to the TP’s professional opinion over an independent evaluating professional has not been supported by the U.S. Supreme Court. It held the following:

ERISA does not require plan administrators to accord special deference to the opinions of treating physicians. The “treating physician rule” imposed by the Ninth Circuit was originally developed by Courts of Appeals as a means to control disability determinations by administrative law judges under the Social Security Act. In 1991, the Commissioner of Social Security adopted regulations approving and formalizing use of the rule in the Social Security disability program. Nothing in ERISA or the Secretary of Labor’s ERISA regulations, however, suggests that plan administrators must accord special deference to the opinions of treating physicians, or imposes a heightened burden of explanation on administrators when they reject a treating physician’s opinion…

Finally, and of prime importance, courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant’s physician; nor may courts impose on administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician’s evaluation. (U.S. Supreme Court, Black & Decker Disability Plan v. Nord, 538 U.S., No. 02-469, 2003, pp. 5–11).

In summary, while TP opinions can be provided as some documentation in the disability determination process, the inclusion of an independent evaluating professional’s opinion and evaluation carries the same weight as that of the TP. While there will still be questions raised by professionals regarding whether the TP is the best professional to evaluate the individual regarding impairment in functioning, the specific limitations noted here dispose of those questions.

### 2.3.10 BH Concerns Can Only Be Work- or Nonoccupationally Related

Because of the arbitrary ordinal (work-related, not work-related; event caused impairment, the event did not cause impairment) system that many legal systems, particularly the WC system utilize, a BH professional is likely to be asked to give opinion regarding whether the BH concern is work- or nonoccupationally related. However, because of the complexity of biopsychosocial issues inherent in the BH model of evaluation, this question cannot be easily answered. Instead, it is essential to first examine the issues related to legal causality and the current BH model of evaluation (Warren, 2009).

### 2.4 Causality and Behavioral Health Concerns

Causality is a legal issue related specifically to tort law and the WC system. The legal standard for professional opinions of cause in civil legal settings is based upon “a more probable than not basis” (Kahn & Langlieb, 2005). Specifically, the issue of causality is one that behavioral health professionals are asked to address frequently both the workers’ compensation and tort legal systems. However, the issue of causality, particularly within the WC system, is at odds with the multidimensional behavioral health
which is currently followed in the behavioral health field. The primary reason for the problematic opposition is that the WC standard follows an approach in which all injuries, illnesses, and impairments are considered work-related when they are “caused or worsened by work-related injury, even if the employee is predisposed to the impairment” (Grant, 2005; Kahn & Langlieb; Melhorn & Ackerman, 2008). Therefore, the WC system follows an ordinal means of measurement delineating between only two categories of work-related or not work-related. There are no gradations between the two categories. Moreover, the system does not consider the reported psychological disorder in terms of predisposition toward impairment, past development issues, or biological causes. Consequently, there are many problems with this WC definition and its inability to translate directly to the highly complex assessment models employed with psychologists and psychiatrists. In a greatly simplified overview of the BH assessment model, BH professionals must evaluate the person from multiple aspects of the person’s life, health, psychological, cognitive, emotional, and psychosocial factors to determine the appropriate diagnosis and then, treatment. In addition, BH impairment in functioning is multifactorial in nature. It is this lack of translation of legal terminology and an arbitrary categorization of work- or nonwork-related causation to the application of the BH treatment system that leads to a great deal of frustration and misconceptions (Grant). In order for a BH professional to attempt to answer the issue of causality, it is incumbent upon the other individuals involved in the disability process: employee/claimant, employer, families, coworkers, treating professionals, insurers, and attorneys to recognize:

1. The difference between impairment and disability.
2. What constitutes appropriate roles for the treating and evaluating professional.
4. The expectation of setting RTW as a required treatment goal.
5. The high probability in remission of the majority of psychological disorders and reduction in objectively determined impairment.
6. The ultimate goal of the BH treatment process is to restore the person to one’s previous level of functioning (Warren, 2009).

This last aspect is of particular importance because if the person is to improve to one’s previous level of functioning, then it may potentially reduce the monetary award or benefits paid to the individual. In addition, because the actual cause of a true objectively determined psychological disorder is multifactorial in nature, the majority of BH disorders cannot always be readily connected with a single interaction, setting, event, or person. Moreover, many true objective psychological disorders do not occur/begin directly after a specific event which is often identified as a trigger for a disorder. Instead, the development of true objective psychological impairment in functioning is a complex process comprised of genetic, social, psychosocial, and biological (biopsychosocial) factors that gradually converge across an indeterminate time period before a psychological disorder becomes apparent. Thus, absolute determination from a behavioral health standpoint is not usually possible (Caine, 2003; Grant, 2005; Heilburn, 2001; Heilburn, Marczyk, &

Another issue that arises within legal causality is that all individuals involved in the disability determination process tend to use their own perceptions (accurate or inaccurate) to link a specific event as being the cause of the person’s psychological disorder. This is particularly true in the legal system. The inherent problem with this approach is that it does not always incorporate clear and objective data to support the perception or in some instances, the professional opinion. Consequently, when subjective information is utilized as “proof,” it further muddies the water regarding the causation issue (Grant, 2005; Melhorn & Ackerman, 2005; Warren, 2009).

In order for a BH professional to attempt to answer the legal issue of causality, the clinician must possess a thorough and competent understanding of the diagnostic process, how the correct diagnosis drives the selection of the appropriate treatment, and the emotional meaning that the individual has attached to the subjective symptoms s/he is experiencing. It is important to note that all parties, patients/employees/claimants, treating professionals, and attorneys frequently inappropriately subscribe cause to events and situations without the consideration of the necessary components of development, personality, and biological issues. Thus, this line of reasoning is often overly simplistic, circular in nature, and inaccurate. Most importantly, this ignores the significant complexity of the true development of a psychological disorder and that the majority of individuals with a psychological disorder still continue to function in life, including work (Grant, 2005; Grove, Zald, Lebow, Smitz, & Nelson, 2000; Melhorn & Ackerman, 2008; Warren, 2009; Young, Kane, & Nicholson, 2007).

There are several factors that must be examined and evaluated by the BH professional in order to complete a more thorough evaluation and to rule out potential treatment issues that are not psychological disorders and/or misperceptions, but may negatively impact on treatment outcome. These issues are:

- **Primary gain.** The person experiences relief with the symptom that helps to avoid an unconscious and internal conflict. It provides an acceptable excuse to avoid a situation. For example, a person with a severe headache is excused from going to work. The person has been having some dissatisfaction at work. Thus, the headache allows the person to avoid work. Thus, primary gain is an internalized motivation (Melhorn & Ackerman, 2008; Warren, 2009).

- **Secondary gain.** Any type of disorder may have a secondary gain component. In general, the motivation is externally based and is linked to obtaining or avoiding something. Examples of secondary gains can be increased attention from one’s spouse, avoiding a household chore or a jail sentence, or monetary awards. The key element is that the person is consciously aware of the motivation (Melhorn & Ackerman, 2008; Warren, 2009).

- **Lack of training and/or misperception.** Frequently, person or professional will inappropriately associate an event as a cause of a BH disorder, but without full knowledge of the complex evaluative process. This is not done maliciously or with intent. It is simply due to a lack of knowledge or in the case of the professional, either lack of training or a bias in clinical opinion that is not supported by objective data (Melhorn & Ackerman, 2008; Warren, 2009).
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• **Malingering versus symptom exaggeration.** Malingering occurs when a person knowingly and willingly fakes one’s symptomology for financial gain, such as in a lawsuit. It is not a psychological disorder. Instead, it is fraudulent behavior and one that may be criminal (Aronoff et al., 2007; Barsky, 2002; Iverson, 2007; McCracken & Gatchel, 2000; Mittenberg, Patton, Canyock, & Condit, 2002; Rogers, 1988, 1997; Rogers & Bender, 2003; Thompson, LeBourgeois, & Black, 2004; Warren, 2009; Wiley, 1998; Rohling, Binder, and Langhinrichsen-Rohling 1995; Scott et al., 2007, 2009).

• **Symptom exaggeration is a conscious act.** Although symptom exaggeration can be a component of malingering, it does not automatically equate to malingering. For example, a person may exaggerate one’s symptoms because of wanting assistance with a problem and fearing the concern will not be taken seriously without consciously faking one’s symptoms. Instead, the individual may exaggerate one’s symptoms as a means to ensure help is obtained for the concern. If the concern is objectively determined to exist, then, the professional will need to explore whether the exaggeration is simply an exaggeration or if it is a willful intent to purposely mislead the professional and the concern does not exist. The latter is an example of Malingering. (Aronoff et al., 2007; Barsky, 2002; Iverson, 2007; McCracken & Gatchel, 2000; Mittenberg et al., 2002; Rogers, 1988, 1997; Rogers & Bender, 2003; Thompson et al., 2004; Warren, 2009; Wiley, 1998).

Because empirical research has revealed that there is a higher rate (30–40%) of symptom exaggeration and malingering with disability concerns due to motivation for a favorable outcome, it is imperative that all BH professionals evaluate for these types of issues (Aronoff et al., 2007; Iverson, 2007; Mittenberg et al., 2002; Rogers, 1988, 1997; Rogers & Bender, 2003). Moreover, the AMA’s Guides to the Evaluation of Permanent Impairment (AMA, 2008) require this as a part of the BH evaluation.

• **Denial of a BH disorder.** In our society, there is still a stigma of having a psychological disorder. Thus, it is frequently difficult for some individuals to openly acknowledge the possibility of a psychological disorder. Instead, the person is likely to attribute the symptoms to another, more personally acceptable situation. This is a face-saving mechanism on the part of the involved person (Bagenstos, 2000).

It is essential to note that many BH symptoms are actually defenses used by the person for protection from one’s emotional distress. Because of this, the individual cannot typically provide objective and accurate descriptions, and a factually-based explanation of the psychological concern. Thus, the person’s description is more likely to be subjective in nature and must be corroborated against other types of more objective data (Warren, 2009).

2.4.1 Professional Barriers to Objective BH Causality Determination

There are several additional issues that arise with professionals that further compromise one’s ability to infer with the BH causality determination process. These are:
• Incomplete or cursory evaluation and assessment of the individual. This occurs with the professional that does not follow all of the required components necessary to evaluate the person in a competent and comprehensive manner. Thus, the professional bases one’s professional opinion on incomplete professional data (Warren, 2009).

• Lack of clinical objectivity. In this instance, the professional is influenced by conscious or unconscious feelings. The professional then moves away from professional objectivity (Grove et al., 2000; Harding, 2004).

• Utilization of clinical heuristics. Heuristics represent clinical generalizations or shortcuts that a professional may use in either the evaluation or treatment process that are based upon incorrect assumptions (Harding, 2004).

• Differences in clinical opinion. This commonly occurs when professionals focus on select clinical information or data, while ignoring data that do not support one’s professional opinion or based on the lack of comprehensive synthesis of developmental, social, and biological factors (Grant, 2005).

• Potential loss of insurance. Because some systems such as the WC system only pay for work-related concerns, this may leave a person without health insurance to pay for treatment. Thus, the individual may be inclined to claim that the condition is work-related. At the same time, the professional may feel a quandary either in not treating the person or in opining that the concern is related to the workplace (Grant, 2005).

• A professional desire to not upset patients and referral sources. Most professionals want their patients as well as referral sources to be happy with them. Therefore, the professional may experience a wish to avoid conflict. In this circumstance, the professional may avoid issues and comprehensive evaluation as well as not stating the objective data findings clearly as a means to “keep everyone happy.” However, this greatly decreases the professional’s integrity as well as substantially degrades the credibility of the professional’s opinion (Warren, 2009).

• Lack of routine assessment of symptom exaggeration and malingering. In the evaluation of symptom exaggeration and malingering, many professionals are quick to avoid a comprehensive assessment of these issues because of the distasteful nature of having to note that a person is purposefully misrepresenting the severity of symptoms. It is important to note that the current American Medical Association’s Guides to the Evaluation of Permanent Impairment (AMA, 2008) require the professional to evaluate for symptom exaggeration and malingering as part of the evaluation for any reported BH impairment in functioning. It must be noted that neither symptom exaggeration nor malingering is not something that a professional can simply opine based on clinical opinion alone. Instead, it takes careful, comprehensive evaluation and includes looking at overall patterns across objective, standardized psychological tests (Aronoff et al., 2007; Iverson, 2007; Warren, 2009).

• Medicalization. This occurs when a professional identifies everyday situations, events, and occurrences and inappropriately mislabels them as medical or psychological disorders. Medicalization is at the heart of separating
psychosocial issues from true objectively determined psychological disorders. Examples of psychosocial concerns are “stress,” job dissatisfaction, workplace conflict, and relationship discord, which may aggravate a psychological disorder, but are not actual psychological disorders themselves. The DSM does not have diagnostic criteria for psychosocial concerns. Instead, they are noted in the multiaxial diagnostic system (e.g., Axis IV). Importantly, psychosocial concerns are those issues that the majority of individual experience in the course of everyday life. While they may cause situational distress, they are not currently accepted as being a recognized psychological diagnosis. Moreover, if a professional artificially separates a psychosocial concern from the biopsychosocial model but, ignores the contribution of these other complex aspects then this should be viewed as a deviation from current practice standards (Barsky & Borus, 1995; Warren, 2009, Warren, 2003).

### 2.5 Causes of Iatrogenic Behavioral Health Disability

There are several ways that iatrogenic BH disability can occur through actions of (1) the individual, (2) TPs, (3) employers, (4) attorneys, and (5) insurers. The contributions of each to iatrogenic BH disability will be examined further.

#### 2.5.1 Personal Factors That May Contribute to Behavioral Health Disability

An individual can contribute to one’s perception of being disabled a number of ways. First, a person may have had past experience with a family member or friend who was diagnosed and treated for a BH concern. In talking with the other individual, one’s perception may be shaped by what the individual has noted was experienced and what the TP said. A different way for this to occur is through simply observing other people with the reported concern. By researching a BH concern on the Internet, there is considerable variance in the quality of the information that can be found. While there are many reputable websites that provide a true service with accurate information, there are many others that provide unsubstantiated information that may misdirect the individual in understanding what constitutes appropriate care and in terms of expected recovery. This type of misinformation may contribute to treatment compliance issues and poor treatment outcomes. Thus, the person who seeks treatment is frequently in need of careful assessment of misperceptions and education about the normal course of the condition in order to prepare the individual for treatment and for improved treatment outcomes (Grant, 2005; Warren, 2009; Warren & Hubbard, 2006, 2008).
2.5.2 Treating Professional Causes of Iatrogenic Disability

Treating professional iatrogenic disability is caused by one of two ways (1) injury occurs through overt action by the professional, such as prescribing the wrong medication and a negative reaction is experienced; or (2) by the TP provides information that conveys the message that the person is disabled or that the workplace is the source of the individual’s concerns (ACOEM, 2006, 2008; Aronoff et al., 2007; Norquist & Regier, 1996; Robinson, Gatchel, & Whitfill, 2005; Schultz & Gatchel, 2005; Talmage & Melhorn, 2005).

It is essential that comprehensive mental health professional care must encompass a deeper understanding of how the label of disability generally introduces a clinical bias on the part of the professional that may interfere without considering other types of data that do not support a clinical conclusion of permanent impairment in functioning. Moreover, when a professional conveys to the individual that a diagnosis equates functioning impairment, it is quite possible for this to become a self-fulfilling prophecy, leading the person to strongly identify with the disability role and believing that one is unable to function actively in life. This can lead to iatrogenic disability caused by incorrect information and assumptions. The importance of the professional taking a broad-view approach to facilitate understanding in the individual being evaluated and treated as to what choices the individual can make, how a diagnosis may or may not impact on one’s life, how treatment will be structured to help ameliorate any current impairment, the inclusion of a RTW goal as a required part of the treatment process, and most importantly, how to resume living an active life – despite a psychological diagnosis – are critical components in the treatment of BH health concerns (ACOEM, 2006, 2008; Aronoff et al., 2007; Norquist & Regier, 1996; Robinson et al., 2005; Schultz & Gatchel, 2005; Talmage & Melhorn, 2005; Warren, 2009).

2.5.3 Employer Contributory Factors to Iatrogenic Behavioral Health Disability

The employers also play a role in the creation of iatrogenic disability. Employers need to be aware that without appropriate training, employees, supervisors, and administrators alike are likely to flounder. This can create a workplace where expectations and standards are not conveyed or that there is inconsistency in how employees are treated. Moreover, this stance causes confusion and frustration to occur and without an adequate means in which to address BH workplace concerns appropriately. Thus, job dissatisfaction can quickly occur and impact on work quality and productivity. Moreover, this can be compounded by supervisory evaluation of poor workplace performance (DMEC, 2008, 2009; Kahn & Langlieb, 2005; Warren, 2009).

It is essential for employers to have workplace policy for both physical and BH concerns. It is still common for employers to have a workplace policy for physical concerns only. However, this leaves both the employee and employer in a poor position
to address BH issues when they arise (DMEC, 2008, 2009; Kahn & Langlieb, 2005; Warren, 2009). For example, presenteeism may occur slowly before a person has a fully-developed psychological disorder. Presenteeism occurs when the individual continues to work, but not up to one’s full responsibilities or potential. Over time, the employee’s workplace performance decreases substantially. Initially, this can be difficult to distinguish from job dissatisfaction. Having a workplace BH policy in place and ensuring that employees are aware of the policy encourages employees to obtain professional assistance. In addition, it opens the door for employers and employees to discuss a health concern from a work perspective and to address a temporary workplace accommodation, if necessary. It should be noted that not all BH disorders require a workplace accommodation. As pointed out earlier, there are variations with a psychological diagnosis, with some people experiencing little change in everyday functioning, to some people experiencing moderate impairment, to the most extreme situations where a person is severely impaired. However, as the APF (2005) noted, this constitutes a crisis in which intensive care is required. In the worse cases, an individual may need to be hospitalized in order to be stabilized quickly. If an accommodation is needed, it should be linked objectively determined impairment in functioning as well as linked to specific job duties. Because the normal outcome of BH is recovery, it stands to reason that any accommodation will be temporary only. By having a BH policy within the workplace, both the employer and employee have a means to address a BH concern with consistency, so that all employees are treated in a similar fashion.

There is increased workplace stress occurring in the workplace (Wang, Demler, & Kessler, 2002). This stress as well as interpersonal differences can lead to workplace conflict. While many employers have workplace policy regarding appropriate workplace behavior and the lack of tolerance for any workplace violence, this does not always address issues, such as communication difficulties with a supervisor or a specific coworker, or if the person is attempting to transfer to a different position or department because of these ongoing concerns. It is not always enough to simply have the people involved to sit down and discuss an issue. There are times when, despite taking this action, there are still interpersonal difficulties. A more winning strategy may be to take a commonsense approach in allowing an employee to transfer (if possible) to another department. Moreover, if there are several employees from the same department who transfer in a relatively short amount of time, an employer should address whether there is an issue with the supervisor. It is better for an employer to keep an employee, particularly an employee who has performed well in the past, than to simply ignore the workplace interpersonal conflict (Kahn & Langlieb, 2005; Warren, 2009).

It is important for an employer to address workplace motivation issues and to recognize that not all negative motivation concerns, such as marital distress, lack of autonomy, work burn-out, job dissatisfaction, job security, and disregard for workplace policies, are necessarily representative of psychological disorders. Instead, these can be representative of psychosocial issues. Psychosocial issues usually are feelings, events, or situations that are typical in everyday life. They are not objective psychological disorders. Warren and Hubbard (2006, 2008) found that job dissatisfaction is a primary cause of negative workplace motivation.
It should be noted that inappropriate employee behavior tends to share the trait of workplace conflict. However, there are also instances where some inappropriate employee behavior is frank criminal behavior, such as with a serious threat to do harm to another person, theft, vandalism, or sexual harassment. In most instances, this type of behavior is not related to a psychological disorder and is under voluntary control. Thus, it should be recognized by the employer and the workplace policy dealing with each of these situations must be followed (Warren, 2009).

2.5.4 Attorney Contributory Factors to Iatrogenic Behavioral Health Disability

The discussion of how attorneys can promote iatrogenic disability will be brief since there is an entire chapter devoted to attorneys and BH disability. Defense attorneys can promote disability by denying that the plaintiff has any concerns at all and indicating that the person is faking or greatly exaggerating. This is inherently upsetting to the person reporting problematic symptomology and may cause the person to become more entrenched. Conversely, plaintiff attorneys represent individuals who have been injured. Some plaintiff attorneys in legal proceedings may directly or indirectly note that the monetary value of the case is directly related to the severity of the injury. Thus, the person is encouraged to seek multiple professional opinions to buttress the individual’s claim of serious injury. While both types of attorneys have roles in the disability process, both defense and plaintiff attorneys must take care to practice in an ethical manner, not just to win the case. Long after the case is settled, the person with the reported injury will have to live with both the positive and negative outcomes (Gold et al., 2008; Goldstein, 2003a, 2003b; Heilburn, 2001; Heilburn et al., 2002; Heilburn, Marczyk, et al., 2003; Heilburn, Warren, et al., 2003; Heilburn et al., 2007; Melton, Petrila, Poythress, & Slobogin, 2007; Schultz & Gatchel, 2005; Simon & Gold, 2004; Van Gorp, 2007).

2.5.5 Insurer Contributory Factors to Behavioral Health Disability

The discussion of insurers will be equally brief since a later chapter will examine issues related to BH disability. However, insurers play a role in the iatrogenic BH disability process. There are a number of common issues that occur that serve to increase the probability of an adversarial interaction between the insurer and the claimant (Kemper, Tu, Reschovsky, & Schaefer, 2002; Hamm et al., 2007). These issues are:

- **Lack of appropriate training for the case management of BH disability.** By not providing appropriate training to case management employees and by not becoming educated in appropriate evidence-based treatment, this can directly cause arbitrary
decision-making. This and other factors will be discussed in Chap. 10 regarding the insurance industry and behavioral health disability.

- **A systemic lack of standardization in the types of objective data required to make a decision regarding the BH disability claim.** Each insurer has its own internalized system regarding the types of documentation required for the claim adjudication process. Currently, some insurers request objective data, while others simply request the evaluation and treatment notes and make a determination based on the insurer’s internal criteria. Moreover, many insurers do not require the usage of DSM-IV-TR diagnoses and objective standardized psychological testing in the claim adjudication process. Because of this, frequently arbitrary decisions are made regarding the outcome of the claim, such as paying a claim that is unsubstantiated, but importantly, not paying a claim that may be substantiated with appropriate objective documentation (Hadjistavropoulos & Bieling, 2001; Hamm et al., 2007; Warren, 2009; Warren & Hubbard, 2008).

- **Differences in how BH disability issues are handled versus physical disability claims as well as not recognizing comorbid health concerns.** Frequently, despite changes in laws requiring the elimination of limiting BH treatment to ensure adequacy of care, some insurers still are limiting BH treatment. This is done by indicating that the insurer will only pay for an evaluation and then the TP must send the notes, so that the insurer’s utilization review professional deems whether any further treatment is necessary from the insurer’s perspective. This process is repeated when psychological testing services are requested by the TP. This is a slippery slope for the insurer because while an insurer cannot, by law, make treatment decisions, since this can be perceived as practicing without a license, this may result in this outcome unintentionally (Hadjistavropoulouos & Bieling, 2001; Hamm et al., 2007; Warren, 2009; Warren & Hubbard, 2008).

  Moreover, many insurers do not regularly assess for BH disorders with a physical disability claim. This is because many insurers still do not recognize the high prevalence of comorbid health concerns.

- **Lengthy review process for both treatment and the claim itself.** Some insurers also note that all BH treatment must be precertified. (Again, this is typically by a utilization review professional.) However, only after the TP has sent records and the precertification process has been completed, can any further treatment be given without the person having to self-pay for services. In one instance, this author had called an insurer who then directed the query to a BH claim triage professional (who worked exclusively for the insurer to approve clinicians’ requests for treatment). The BH professional approving treatment requests indicated that it was at least a 2-week process before any decision about beginning professional treatment would be made. It was also noted that the process could take even longer than the 2 weeks. This is an unfortunate process that certainly does not allow for expedient professional care (Hadjistavropoulos & Bieling, 2001; Hamm et al., 2007; Warren, 2009; Warren & Hubbard, 2008).

- **Lack of direct interaction with the TP.** Many insurers require the TP to send records, but do not allow the TP to discuss the pertinent issues with either a case manager (CM) or the medical director to quickly address issues. An example of
this occurred when this author was requested to send all documentation to an insurer pertaining to individual with rapidly progressing Huntington’s disease. The author contacted the insurer directly and asked to speak with the Medical Director to expedite the process. This request was denied the ability to talk by the CM with the medical director to discuss the pressing issues, later the medical director called the author directly. At that point, the disability claim was quickly approved (Melhorn & Ackerman, 2008; NBGH, 2007; Otto, Slobogin, & Greenberg, 2007; Pransky, Shaw, Franche, & Clarke, 2004; Schultz & Gatchel, 2005; Talmage, 2007; Talmage & Melhorn, 2005).

• Lack of incorporation of scientifically based practice guidelines into the treatment and claim review processes. Currently, most insurers have not brought scientifically based practice guidelines into the precertification and claim review processes. This is curious since the insurer is making decisions as part of its internalized system. It would be quite easy to incorporate these types of evidence-based standards as a means both to streamline the precertification and claim review processes and to ensure decision made within the insurance company that were in line with the scientifically based standards (ACOEM, 2006; Melhorn & Ackerman, 2008; Warren, 2009).

• The insurer employs psychologists or psychiatrists, but does not assess whether the professional has received appropriate training in disability assessment, evaluation, treatment, and prevention. Therefore, those professionals may make the same mistakes as other non-BH professionals. A primary issue with this for the insurer is that it makes the organization vulnerable to potential legal challenges, as has successfully occurred in the past several years (Warren & Hubbard, 2008).

2.6 Conclusion

It is clear that BH health issues are a critical component in the multiple disability processes. BH concerns cannot be simply assumed based on opinion or exposure to certain events. Instead, there are multiple factors that negatively contribute across the current BH disability spectrum. In Chap. 3, strong, scientifically based strategies will be discussed in order to positively improve the BH treatment and disability process, and most importantly, to accurately assess the potential underlying BH concerns in order to facilitate the individual’s return to health.

References


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Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law No. 104-191.  


Chapter 3
Effective Psychological Evaluation and Management of Behavioral Health Concerns

Pamela A. Warren

3.1 The Importance of Appropriate Psychological Evaluation of Behavioral Health Concerns

As noted in Chap. 2, there are multiple systemic issues that arise to negative impact on treatment and disability processes. (Chellappa & Ramaraj, 2009; Dersh et al., 2005; Gerdtham & Johannesson, 2003; Schultz & Gatchel, 2005; Otto et al., 2007; Reed et al., 2006; Rush et al., 2009; SSA, 2008; Scott et al., 2007, 2009; Thompson et al., 2004; Trivedi et al., 2006; Van Gorp, 2007; Wang et al., 2000, 2002; Warren, 2005; Warren & Hubbard, 2006; Weber, 2008). Fortunately, many of these issues can be addressed by making multiple changes within the current BH treatment and disability processes. Of note, BH professionals can play a particularly strong role in making substantial changes to serve as a catalyst for other fields to make similar changes. Much of the initial changes within the BH evaluation and treatment model will stem from addressing the current problematic evaluation issues by following the more standardized model that is taught in graduate and medical school. Thus, the focus will shift to address the specific elements of a standardized psychological evaluation. In this chapter, the current model will be discussed and then the efficacy of including additional components, so that the current evaluation model allows for a more thorough evaluation of current functioning of the individual from a biopsychosocial basis (Warren, 2005; Warren & Hubbard, 2006; Warren, 2009).

3.2 Current BH Evaluation Model

The current BH model has multiple standard components that are taught in graduate and medical training to complete a comprehensive and competent evaluation. These components are a comprehensive evaluation of the individual’s current relationship
status, past and current employment status, the presenting problem(s) that brought the individual into treatment, personal habits, coping strategies, social history, education history, psychological history, medical history, medications, mental status evaluation, diagnostic impressions, and summation and treatment recommendations. Additional required components that must be included in the BH evaluation process will be discussed as well. A brief overview of each component will be presented simply to ensure understanding of what is required in each section. However, it is not possible to present a comprehensive discussion of the intricacies of each component within the limited scope of this chapter (Warren, 2009; American Psychiatric Association, 2000; APA, 2009; Caine, 2003).

3.2.1 Relationship Status

This section is designed to gather information about whether the person is single or is involved in a relationship. Moreover, if the person is currently in a relationship, a careful probing of the quality of the relationship is made as well. Inquiries regarding the number of long-term relationships, including past marriages are made to ascertain whether there are chronic issues within personal relationships. This is important because it establishes a potential pattern of difficulties within personal relationships that may mirror similar concerns with workplace communication. It is also important to ask about the person’s current living conditions to establish if other people, including children are living with the person seeking treatment. Thus, the BH evaluator is able to determine if there are problematic issues arising with personal relationships.

3.2.2 Employment Status

The BH professional should also ask about the individual’s current employment status to determine if the person is employed. If unemployed, a thorough probing of the individual’s perceptions of the contributory factors should be gathered. If employed, information regarding one’s current job title, workplace duties, and any past or current workplace concerns is obtained. Moreover, a comprehensive review of the person’s entire work history should be gathered and have the same type of information obtained for each position held. Catalysts for the person seeking a new job should be explored as well to ascertain whether potential concerns existed.

3.2.3 Presenting Problem(s)

A brief appraisal of the primary concerns that brought the individual to seek treatment is conducted. Although brief, the BH professional should try to note all of the concerns that initially brought the individual into treatment. This helps to provide an initial understanding to both the individual and the BH evaluator in
specifying what particular issues are likely to be addressed in treatment. This does not mean that additional concerns cannot be added later, but rather what the individual deems as problematic at the outset. This process also allows the BH evaluator to briefly assess the individual’s insight, logic and reasoning abilities as well as illuminates any deficiencies in recognizing serious, unidentified issues.

### 3.2.4 Personal Habits

With regard to the evaluation of personal habits, any underlying issues, such as sleep difficulties that leave the person feeling fatigued, illicit and inappropriate prescription drug usage which may be demonstrative of the person self-medicating emotional issues or substance abuse, and dependence issues and heavy caffeine usage which may mimic symptoms of anxiety must be explored in order to rule in or rule out these concerns. The number and frequency of meals as well as the quality of the diet, in general, provide important information about whether there is a potential eating disorder, poor diet, or infrequent meals all of which can contribute to symptoms of low blood sugar, which may also mimic symptoms of an anxiety disorder, are important to ascertain. The objective determination of a true psychological disorder will be evaluated later through standardized psychological testing.

Additional areas that the BH evaluator should inquire about are: tobacco usage, alcohol usage, and amount of exercise obtained during a normal week. Heavy tobacco usage can compromise physical health and thus, impact on an individual’s ability to function. Heavy alcohol usage can not only be a sign of abuse problem, but it is disruptive to the quality of sleep that one receives. In addition, the individual should be asked about current coping strategies in managing life stressors and whether these are deemed as effective at present. Deficits in coping mechanisms should be explored to understand the specific problems that the person perceives.

By gathering this type of information, it quickly allows the BH evaluator to identify positive habits and strategies and those are clearly negative, such as alcohol and drug abuse and dependence. By inquiring about this aspect of the person’s life, other salient treatment issues are identified and can be made part of the resulting treatment plan.

### 3.2.5 Social History

An individual’s social history is appraised to learn about the person’s upbringing, whether one’s parents are alive, remained married, or divorced. Moreover, the number of siblings is identified as well. This process is designed to assess the family dynamics, regarding communication, interactions, and problems. Careful probing regarding the demonstration of affection, disciplinary action, and even, how emotions were expressed within the family are pertinent to how the person currently functions. In addition, the BH evaluator should ask for information about where the person
grew up and ascertain if the family moved frequently. If frequent moves are noted, then, the BH evaluator should spend time in gathering information about catalysts that prompted the moves. Finally, the BH evaluator should ask about religious orientation and spiritual beliefs, as well as discern if there are cultural differences that may account for some of the purported concerns or problematic interactions.

### 3.2.6 Educational History

An assessment of the person’s educational history to date is generally obtained by the BH evaluator. This provides a careful review of the person’s scholastic career, particular academic strengths, learning difficulties, and degrees obtained. Moreover, it is a means for the BH evaluator to initially assess past performance in a setting in which one needed to learn new skills. While the information is subjective in nature, in some instances, it may be correlated with school records. The ability to learn and function in the past is a crucial piece of data to ascertain, since past behavior is one of the best predictors for future behavior and functioning (Kahn & Langlieb, 2005).

### 3.2.7 Past and Current Psychological History

The BH professional must determine if the individual has received professional BH care in the past. If so, then information about the purpose of seeking treatment, the type of professional who provided the treatment, what specific treatment was given, and the length of the treatment obtained. Moreover, it is important to assess what new skills were learned in past treatment by the individual to better cope with a stressful situation or event. The BH professional should also ask if the treatment was helpful and if not, identify what were the barriers present to prevent an effective outcome.

Before initiating any professional treatment, the BH professional must also determine whether the person is currently involved in any other BH treatment at present. If so, it is essential to ask the individual to sign a release to permit professional collaboration as well as establish what each BH professional will and will not address in treatment to protect the individual from receiving counterproductive treatment. For example, the American Psychological Association (2002) requires psychologists to maintain appropriate professional boundaries and to take steps to ensure that inappropriate care (in this case, potential duplicate care) is not provided.

The BH professional must also evaluate the person’s past history of physical, emotional, sexual and substance abuse. Each of these instances is an important component to understand how the person has learned to interact in relationships, whether the person was allowed to set appropriate personal boundaries, and the emotional sequelae from an abusive situation. Most importantly, this assists the BH professional in both understanding the individual’s past history and how past behaviors may be impacting on the present, such as relationships and personal interactions with others (Gold et al., 2008; Goldstein, 2003a, 2003b; Melton, Petrila, Poythress, & Slobogin, 2007).
3.2.8 Medical History

A careful review of past and current medical conditions is another essential part of a comprehensive BH evaluation since it provides information about potential comorbid physical concerns that may be currently impacting on the individual’s ability to function (Buist-Bouwman, de Graaf, Vollebergh, & Ormel, 2005; Campbell, Clauw, & Keefe, 2003; Dersh, Gatchel, Polatin, & Mayer, 2002; Dersh et al., 2006; Gatchel, 2004; de Waal et al., 2009; DMEC, 2008, 2009; Evans et al., 2005; Fava et al., 2006; Kessler, Ormel, Dernier, & Stang, 2003, Kessler et al., 1997, 2006; Merikangas et al., 2007; Warren, 2009). This is one means in which a BH evaluator assesses the biological component of the biopsychosocial model. Moreover, while a person may initially indicate that one does not have any health concerns, it is common for these concerns to become apparent when the person is asked about the medications currently being taken. The BH professional should also ask what specific professional is treating each concern and how frequently the person follows up with the TP. The individual should be asked to explain what treatment is being conducted, what is being learned to better manage current problematic issues, and what are the expected outcomes with treatment. Additionally, the BH professional should ask whether the person is complying with all treatment recommendations. At times, a person may pick and choose specific elements to follow, while ignoring other components. This inconsistent compliance can occur for many reasons, but importantly can be a cause of poor treatment outcomes. Thus, a means of cross-checking available to the BH professional is to correlate the person’s verbal statements with other treatment records (ACOEM, 2006, 2008;AMA, 2008; Robinson et al., 2005; American Psychiatric Association, 2000; Caine, 2003).

3.2.9 Mental Status Evaluation

Typically, in the mental status evaluation (MSE), the BH professional asks the individual questions to assess the following, regarding multiple domains of cognitive and emotional functioning:

- **Appearance:** (a) level of consciousness (e.g., awake, sedated), (b) age (whether the person appears to be one’s stated age), (c) posturing, (d) abnormal physical traits, (e) grooming (e.g., the quality of one’s hygiene), and (f) eye contact during the evaluation.
- **Activity:** (a) voluntary movement, (b) involuntary movement, (c) automatic movement, (d) tics, and (e) compulsions.
- **Mood and affect:** (a) mood is the individual’s overall emotional stated at the time of the evaluation, through self-report; (b) affect pertains to the clinical observations of the BH professional and is directly observed. However, it should be noted that an objective evaluation of mood will occur through standardized psychological testing to rule out perceptual bias.
• **Speech and language:** (a) fluency of speech, (b) comprehension, (c) repetition, (d) naming, (e) writing, (f) reading, (g) prosody (e.g., intonation, rate and rhythm of speech), and (h) quality of speech.

• **Thought processes, thought content, and perception:** (a) Thought process directly relates to the spontaneous communication process in the evaluation process; (b) thought content pertains to specific types of spontaneous speech that may reveal delusions. Rumination, suicidal and homicidal ideation, as well as phobias to name a few concerns, and (c) perception pertains to whether the individual is experiencing hallucinations, depersonalization, de-realization, and the like.

• **Cognition:** (a) orientation to time, date, place, and person, (b) attention and concentration, (c) short-term memory, (d) long-term memory, and (e) a brief assessment of executive functioning; and (f) estimation of IQ.

• **Insights and judgment:** (a) insight is the self-awareness that one possesses regarding the full spectrum of reality, and (b) judgment is the process in which the person is able to appropriately assess different components of an issue (Koocher, Norcross, & Hill, 2005, pp. 7–12).

### 3.2.10 Diagnostic Impressions

In this section, the BH professional must utilize the DSM-IV-TR (AMA, 2000, or current version) multiaxial diagnostic model. It is comprised of five axes: Axis I: Clinical disorders and other conditions that may be a focus of clinical attention; Axis II: Personality Disorders and Mental Retardation; Axis III: General medical conditions; Axis IV: Psychosocial and environmental problems, and Axis V: Global assessment of functioning (GAF) (Warren, 2009).

On Axis I, the reported clinical psychological disorder must be an actual current DSM-IV-TR diagnosis, such as Major Depressive Disorder (MDD), for example, and not simply notation of depression, anxiety, or stress. While this may appear self-evident, there are frequent occurrences in file and peer-to-peer reviews completed by the author, where non-DSM-IV-TR diagnoses are reported by professionals. When a BH professional notes a non-DSM-IV diagnosis, it muddies the clinical picture regarding the accuracy of the reported diagnosis as well as the treatment provided, since the diagnosis is utilized frequently to select the appropriate treatment for the concern. Moreover, in the normal course of life, one can experience symptoms of MDD, but without being depressed clinically. In this instance, the person may be experiencing symptoms of MDD, but does not actually meet the DSM-IV-TR full criteria for MDD. This can be further confirmed or ruled out by employing standardized psychological testing. Consequently, in this example, the person would not receive the diagnosis of MDD. This is also true when the BH professional notes “anxiety” as a diagnosis. A cursory examination of the DSM-IV-TR reveals that there are several different types of anxiety disorders, a sampling of these are Generalized Anxiety Disorder, Obsessive-Compulsive
Disorder, Panic Disorder, and Social Phobia. Consequently, the BH professional who had noted that the individual has “anxiety” simply has indicated that the person has symptoms of anxiety, but does not objectively confirm an actual DSM-IV-TR diagnosis of a true psychological disorder (Melhorn & Ackerman, 2008; Warren, 2009).

On Axis II, the BH professional must note whether Personality Disorders exist. This is also where the diagnosis of Mental Retardation is noted. Personality disorders may be thought to exist, but should be confirmed or ruled out with objective standardized psychological testing.

The BH professional who is not a physician should use Axis III to note the medical diagnoses that have been made by medical professionals. A strong attempt to confirm medical diagnoses by corroborating medical records should be undertaken by the BH evaluator.

Psychosocial and environmental problems are noted on Axis IV. Examples of psychosocial concerns are marital difficulties, poor coping strategies, and workplace concerns. These are pertinent issues that may have direct impact on an individual’s level of motivation as well as treatment outcomes. As with Axis III, the BH professional should attempt to corroborate with other records, such as workplace documentation.

On Axis V, the GAF is to be utilized for psychological, social, and occupational functioning only. Any impairment due to physical or environmental concerns should not be included in the GAF score. The GAF has been found to be problematic because it is left to the clinician’s subjective opinion in assigning the specific rating without a means to verify this rating in an objective manner. Although there are directions noted within the DSM-IV-TR, in estimating the GAF score, there are not any objective means to determine the current GAF for the individual at this time. The clinician’s estimation is an attempt to provide some type of measurement of an individual’s current level of functioning. But, the GAF rating system does not have any standardized means to reliably determine an individual’s GAF from one professional to another. Consequently, the GAF rating is of relatively low value in the determination process of an individual’s level of functioning. Thus, when a GAF score is provided as “proof” of impairment by the BH professional, it must be corroborated with other more objective data, such as standardized psychological testing (Warren, 2009).

To illustrate the elemental problem with the GAF score, Warren & Hubbard (2008) completed a pilot study with a large insurer regarding BH disability claims. It was ascertained that the GAF score changed very little throughout the life of the disability claim, and demonstrated no correlation on whether the person received treatment, type of treatment, length of treatment, or even reported a treatment response to whether an individual or the person’s TP. This is puzzling since the GAF score should be reflective of the individual’s basic ability to function in life across a number of settings. Thus, if a person has reported to have a response to treatment, it stands to reason that the GAF should reflect this positive change and increase to reflect an improvement in functioning. Instead, the GAF was not observed to change based on the report of both the claimant and the TP(s).
3.2.11 **Summation and Treatment Recommendations**

This portion of the BH evaluation provides a summarization of the salient clinical concerns and issues to be addressed in the treatment process. While the individual should be asked about desired end goals for treatment, the BH professional must also note whether there are potential issues such as motivation and compliance; inability to come regularly to treatment which will negative impact on the treatment process and outcome. A specific initial treatment plan should be outlined and tailored to treat the identified DSM-IV-TR (2000) diagnosis(es). It is the DSM-IV-TR diagnosis that determines the type of professional treatment conducted since there are many scientifically based treatments that effectively facilitate the return to the previous level of functioning (APF, 2005).

By presenting the standardized model (APA, 2009) that is taught in graduate or medical training, it allows both other BH clinicians as well as other non-BH professionals to understand the typical process that should occur. Moreover, this permits a means to note deficiencies in the BH professional evaluation process when a more superficial evaluation or even no evaluation is completed. While many BH professionals do follow such an evaluation process, there are a considerable number who do not. Unfortunately, this creates problems within the BH treatment and disability processes, in terms of poor quality of professional treatment, increased costs, and potentially, unnecessary and inappropriate identification of an individual as being disabled.

In a greatly simplified overview of the BH assessment model, BH professionals must evaluate the person from multiple aspects of the person’s life, health, psychological, cognitive, emotional, and psychosocial factors to determine the appropriate diagnosis and then treatment. This type of evaluation corresponds with the biopsychosocial model accepted in the medical and BH fields. In addition, BH impairment in functioning is multifactorial in nature (Gatchel, 2004; Grant, 2005). Consequently, the evaluation must appropriately evaluate each aspect of salient functioning with this comprehensive evaluation model. When this is not done by BH professionals, it further compounds the lack of translation to biopsychosocial functioning and makes the process vulnerable to indirect professional conclusions being drawn regarding the person’s ability to function, legal causality, and an arbitrary categorization of work or non-work related causation to the application of the BH treatment system. This leads to the current problems of frustration and misconceptions about appropriate BH treatment (Bruns & Disorbio, 2005). In order for a BH professional to attempt to answer the issue of causality, it is incumbent upon the other individuals involved in the disability process: Employee/claimant, employer, families, coworkers, treating professionals, insurers, and attorneys to recognize:

1. The difference between impairment and disability
2. What constitutes appropriate roles for the treating and evaluating professional
3. The essential criteria of an accurate diagnosis, appropriate best-practice standard-based treatment
4. The expectation of setting return to work (RTW) as a treatment goal
5. The high probability in remission of the majority of psychological disorders and reduction in objectively determined impairment
6. The ultimate goal of the BH treatment process is to restore the person to one’s previous level of functioning. This last aspect is of particular importance because if the TP is to treating the person to restore to one’s previous level of functioning, then it may potentially reduce the monetary award or benefits paid to the individual from either a legal procedure, the workers’ compensation, or the disability claim systems (Kahn & Langlieb, 2005; Melhorn & Ackerman, 2008; Warren, 2009).

3.3 Additional Assessment Components to Add to the BH Evaluation

3.3.1 Military History

Information about an individual’s military history is another means to assess the person’s ability to function in a highly structured setting and in which teamwork is the norm. A careful evaluation of the length of time in the military, beginning and ending rank, special distinctions or awards, as well as the manner in which one terminated one’s career in the military (e.g., retirement, honorable or dishonorable discharge) are all meaningful aspects to address in the psychological evaluation. Because military service, typically, is organized with numerous supervisors, sustained difficulties should be noted since this may be an example of previous communication or behavioral difficulties.

3.3.2 Legal History

The BH professional should inquire about the person’s past legal history. For example, information about lawsuits, arrests, and imprisonment are quite important to know before beginning professional treatment. For example, if the person is involved in a Workers’ Compensation claim, the BH clinician must be aware of this since the probability of the professional’s records being requested by the individual’s attorney and/or being asked to give professional opinion in a deposition is high. Moreover, the BH professional should make note of the name of the person’s attorney to ensure that records are released to this professional and not to the attorney defending the business or insurer. A careful evaluation of the reasons behind any legal concerns to address what prompted the legal action as well as the outcome should also be obtained.

3.3.3 Disability History

A review of the individual’s current disability history is important to ascertain how long the person was off work, how the RTW, and any accommodations were addressed. The BH evaluator must ask about current barriers that the person
perceives to either staying at work (SAW) or returning to work (RTW) (ACOEM, 2006). Coupled with this, it is important to ask about how the person spends a typical day to reveal if any significant portions of the day are spent in which the person is inactive. Moreover, this allows the BH professional a chance to compare activities of daily living (ADLs) to similar workplace responsibilities. This is essential because with reported BH impairment issue, if a person is able to complete a set of cognitive activities in one setting, then it is exceedingly rare for the individual to not be able to do so in another setting (Grant, 2005).

The BH evaluator must also ascertain whether the person has a past disability history. Aspects such as the reason for the disability leave, length of the leave, types of treatment obtained, and how the RTW process was addressed is essential to note. Frequently, if the person is in the midst of a disability claim that is protracted, the individual may have obtained an attorney for legal representation. The professional evaluator should collect the person’s attorney’s name for future reference, in case the evaluator’s records are requested. This helps the evaluator to avoid inappropriately releasing potential protected health information (PHI). In all instances for release of information, it is critical that the professional obtain a signed release from the person to be evaluated. While HIPAA (1996, 2009) does allow for information to be released to insurers for the claim management process, this does not necessarily release the BH professional from all legal responsibilities (both state mandated and HIPAA related) to release minimally required information. Thus, a signed release ensures that the individual being evaluated is aware and gives permission for the evaluation and treatment information to be released and to a specific party (Lerner & Henke, 2008; MacDonald-Wilson, Rogers, & Anthony, 2001; Melhorn & Ackerman, 2008).

3.3.4 Evaluation for Potential Medicalized Issues, Malingering, and Symptom Exaggeration

The BH evaluator should also take note of potential issues that may contribute to the individual’s perception of impairment, such as self-report of excessive stress, job dissatisfaction, job security, workplace conflict, marital discord, workplace performance, motivational concerns, and inappropriate workplace behavior, such as harassment of others, or criminal action. While all of these psychosocial issues may negatively impact on a true psychological disorder, none are actual DSM-IV-TR diagnoses. Instead, these common occurrences are in everyday life, with the exception of criminal action which is dealt with by the legal action and procedures. Consequently, the BH evaluator should note each type of psychosocial issues without rendering an opinion, until objective standardized testing has confirmed or ruled out the concern noted (Barsky & Borus, 1995).

It is essential to note that the AMA (2008) has stipulated that the assessment of symptom exaggeration and malingering must occur as a routine component of the evaluation of an individual, in particular when it is related to disability assessment. Therefore, this must occur by all professionals evaluating BH disability issues as a required component in the assessment process. Moreover, because empirical research
3.3.5 Collaborative Communication and BH Referrals

The BH professional should make every effort to obtain the TP(s)’ evaluation, assessment, and treatment records. This will require a signed release from the person with the reported BH concern, indicating the approval for the release. As with the workplace documentation, information obtained should be noted in the finalized report as well as any unfulfilled requests. The BH professional should note whether there is clear evidence of active collaborative communication among all TPs and note any deficiencies in that regards. It is important for TPs to collaborate with the evaluating BH professional so that if treatment will occur, it can be coordinated and optimized. Moreover, this ensures that TPs understand what specific concerns are being treated by other TPs. This also allows TPs to discuss any differences in a DSM-IV-TR diagnosis(es) since the diagnosis drives what type of professional treatment will be given. Further, it allows for observation whether a RTW goal has been set and if the individualized transitional RTW plan has been discussed with the individual and the workplace. Lastly, this allows a BH professional to ascertain whether the person appears to have complied fully with treatment recommendations or if issues of noncompliance may exist (Pransky, Shaw, Franche, & Clarke, 2004; Talmage, 2007; Warren, 2009).

Questions that an evaluating BH professional should ask of other TPs are

1. What are the specific reasons that you are providing treatment to this individual?
2. What is the specific DSM-IV-TR diagnosis(es) that you have made?
3. What sources of corroborative information and documentation have you used to verify the individual’s perceptions?
4. Have you completed any psychological testing?
5. If so, what tests were employed and what were the results, including validity indices, base rates, and T-scores?
6. If not, why?
7. What specific treatment are you providing?
8. How long have you been treating the individual?
9. Has the individual to whom you’re providing treatment made progress? If so, how has this been determined? If not, how has this been determined?
10. If so, what is the anticipate goal? If not, why not?
11. Are there other TPs who are providing concurrent treatment?
With regard to referrals, if the TP is the referring professional, it is important to discuss with the TP the reasons for the referral and what specific issues the TP views will be assisted by the referral. The BH evaluator should note the discussion as well as what issues will be addressed and what specific questions regarding psychological functioning will be answered (APA, 2001, 2002, 2007a, 2007b).

If the referral source is not a treating professional, but an employer, attorney, or insurer, then a discussion to delineate the appropriate professional boundaries, types of information to be explored and gathered, and limitations of information that may be obtained, and if treatment will be needed, and the anticipated length of treatment should be noted (both are determined only after the BH evaluation has taken place), (Heilbrun, 2001; Heilbrun, Marczyk, & DeMatteo, 2002; Heilbrun, Marczyk, et al., 2003; Heilbrun, Warren, & Picarello, 2003; Heilbrun, Marczyk, DeMatteo, & Mack-Allen, 2007; Heilbrun, Grisso, & Goldstein, 2009; Kahn & Langlieb, 2005; Talmage, 2007; Talmage & Melhorn, 2005).

In conclusion, there are specific questions that the BH professional should ask of referral sources:

1. What are the specific reasons that you are referring this individual?
2. What are the specific questions that you want to have answered regarding current level of functioning?
3. Can you send corroborative documentation or data? If yes, what types and how will it be sent? Whether or not corroborating documentation is sent, it should be noted in the professional records.
4. Who are the TPs from whom the individual has already received professional treatment for the reported concern?
5. Can the TP’s records (both medical and psychological) be sent for review? If not, the BH professional should note this in the records. If yes, then the BH professional notes the type of records to be received.
6. Can workplace documentation be sent for review? The BH professional should note if workplace documentation is to be received and the types of information being provided. The lack of workplace documentation must also be documented.
7. Are there potential legal issues concerning this referral?
8. If so, has the individual obtained an attorney?
9. If so, who is the attorney representing the referral source?
10. Is the purpose of the requested referral for the professional evaluation strictly for treatment or will an independent evaluation be completed? This allows the BH professional to set clear professional boundaries and expectations at the beginning of contact as to what role the BH professional will take.

3.3.6 Corroborating Documentation and Data

It is essential for the BH evaluator to obtain as much collaborative information as possible regarding the issues that the person with the reported BH concern has noted. Examples of collaborative information are workplace documentation, review
of other TPs’ treatment records, and medical records. Workplace documentation and medical records will be discussed further (ACOEM, 2006; AMA, 2008; Lerner & Henke, 2008; Melhorn & Ackerman, 2008).

Workplace documentation is simply the documentation of current job title, written job responsibilities, current supervisor, length of employment, internal departmental transfers, name of the current department, job performance evaluations, workplace attendance records, past and current disability records, workplace disciplinary records, workplace advancement and recognition, and if legally allowed, direct communication with the employer. It should be noted that this listing is not all-inclusive nor is always possible to obtain all workplace documentation. Despite this, it is important to request as much information and documentation as possible. In addition, requests that were not fulfilled should be noted in the finalized report (ACOEM, 2006, 2008; Grant, 2005; Lerner & Henke, 2008; Warren, 2009).

A trend that has been ascertained has been the aspect of the BH professional utilizing one set of standards to determine treatment when the individual presents with personal issues and a different set of professional standards when the workplace is the primary issue. Interestingly, Weinstein (1969) observed a trend of some psychiatric patients improving, while others did not. He called this the “illness process.” Weinstein noted a series of discrete steps that led from the individual’s subjective distress (e.g., anxiety and depression) which led to the “emergence of stress-related sanctioned disability.” An example of this would occur if the patient/applicant presented with personal difficulties and a troubled life situation; this typically was viewed in Weinstein’s model as an unacceptable cause of disability. The rationale was it was viewed that the individual could conceivably make changes to better one’s life. However, Weinstein observed that if the person presented with personal difficulties, a troubled life situation, and either alcoholism, an illness, injury, or as the result of an accident, then the BH professional tended to label the person as disabled. Weinstein held that BH health professionals must help the individual seeking assistance in learning positive coping strategies in either instance, not just the second example. In this way, the individual is taken out of the sanctioned disability model and taught to return to life and all of its challenges fully (Table 3.1).

When BH clinicians do not assist their clients or patients in learning to adapt to life and work situations or to problem-solve effectively, then the professional is utilizing one’s own subjective opinions versus appropriate clinical evaluation protocol, standardized, diagnostic criteria, and evidenced-based treatment (Grove, Zald, Lebow, Smitz, & Nelson, 2000; Harding, 2004). This results in questionable clinical opinions and inappropriate psychological care (NBGH, 2007; Surgeon General’s Report, 1999). Weinstein opined that BH professionals have contributed to the development and persistence of disability in the manner in which clients or patients were facilitated through the disability process, with being placed on permanent disability as the ending point. It is a major cause of iatrogenic BH disability (AMA, 2008).

<table>
<thead>
<tr>
<th>Table 3.1</th>
<th>A 40+ year old recognized formula from psychiatric literature Weinstein, 1969</th>
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<tbody>
<tr>
<td>a)</td>
<td>Personality difficulties +</td>
</tr>
<tr>
<td>b)</td>
<td>Troubled life situation =</td>
</tr>
<tr>
<td>c)</td>
<td>Unacceptable disability</td>
</tr>
<tr>
<td>d)</td>
<td>Accidents, illness, alcoholism, etc. =</td>
</tr>
<tr>
<td>e)</td>
<td>Acceptable disability</td>
</tr>
</tbody>
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There are several ways to avoid this problematic approach. First, it is important to remember that in both instances of acceptable and unacceptable disability that Weinstein noted the primary role of the BH professional is to help the individual to learn to cope with the situation and how to live life as active as possible in order to preserve physical and emotional functioning. Second, it is essential to ensure that the appropriate psychological diagnosis is made and is documented in the records. If the professional does not note this information than the lack of appropriate documentation leaves the BH professional vulnerable to legal issues, such as insufficient documentation to support the resulting psychological services, and makes it likely that the applicant will have a disability claim denied because of poor documentation. This results in unnecessary increased costs and leaves the BH professional vulnerable to legal challenges of misrepresentation and malpractice. Third, the BH professional must be clear as what the precise professional role that the professional is in during the BH disability process. Specifically, the BH professional avoids being in the dual role of TP and evaluating professional simultaneously. When the BH professional takes this approach, then s/he has a strong sense of the legal implications of causation of disability, makes the distinction between impairment and disability, and to thoroughly understands the complexities of the biopsychosocial evaluation and treatment model for psychological disorders. A simple means to point the BH professional in the right direction is to remember that psychological impairment must meet two criteria: (1) Psychological impairment is the objective loss of psychological function; and (2) It may represent a limitation. Limitation is (a) something an individual cannot do because of functional loss or (b) something a person should not do because of realistic harm to self or others as determined by the comprehensive BH evaluation and standardized psychological testing. This is called psychological determination (Gold et al., 2008; Grant, 2005; Heilbrun, 2001, Heilbrun et al., 2002, 2003, 2007, 2009; Young, Kane, & Nicholson, 2007).

On the other hand, BH disability is a non-standardized term loosely employed by various organizations and laws as is taken generally to mean the loss of the ability to perform a defined role (e.g., a work role) because of medical or psychological circumstances as noted in Chap. 2. This issue of disability is one that all BH professionals are asked to answer during their careers. However, it is important to keep in mind that ability to function, in this case, ability to work primarily represents contractual and legal constructs. Importantly, it is not an issue decided by the BH professional, but a legal and contractual agreement between the employer and the employee, in some instances and in legal procedures in other situations. Therefore, in most instances, BH professionals will not be deciding the issue of psychological disability, but instead will be evaluating whether objective impairment actually exists and if so, in what capacity is the individual limited in functioning. However, in those instances where the BH professional attempts to answer the BH disability question on a BH disability application, one should be aware and consider the risks of the legal consequences for practicing beyond one’s area of professional competency, such as not being licensed as an attorney (Gold et al., 2008; Grant, 2005; Heilbrun, 2001, Heilbrun et al., 2002, 2003, 2007, 2009). Medical records, both past and present, should be obtained in order to evaluate the types of professional who provided treatment, diagnoses provided, types of treatment conducted, MRI, CT, and blood work, and other test results. This allows the BH evaluator to understand the biological component of the issues that may
3. Effective Psychological Evaluation and Management of Behavioral Health Concerns


3.3.7 Objective, Standardized Psychological Testing

As was noted in Chap. 2, it is common among TPs to administer screening tools, such as the Beck Depression Inventory, surveys, or fill-in-the-blank questionnaires to gather information from an individual with a reported BH concern. However, these current standards in the evaluation of impairment in behavioral health functioning specifically note that this is inappropriate because of the limitations in such tools to fully and objectively evaluate current functioning (AMA, 2008; Warren, 2009). Instead, objective standardized psychological and in many instances, psychological test batteries are the current gold standard to complete this type of objective evaluation of the person. Moreover, at present, there is no single standardized psychological test that evaluates all psychological, cognitive, and emotional domains related to functioning at this time. Instead, the current practice standard is to administer a minimum of two standardized psychological tests specific to the deficit being reported. There is a more complete discussion of psychological testing in Chap. 4 that will address specific types of standardized tests to employ, how these types of tests are useful in the evaluation of malingering, symptom exaggeration, and in separating psychosocial issues from true psychological disorders. However, it was important to note the required component of objective, standardized psychological testing as a part of the BH evaluation to more objectively evaluate the individual’s reported concerns in a comprehensive manner. By doing so, this helps to overcome the issues of the professional and the person’s biases regarding the diagnosis and impairment (Grove et al., 2000; Harding, 2004).

It is important to note that any reporting of test data must include a synthesis of all test data, not just the data that appear to support a reported concern. This is following appropriate reporting of psychological testing data that is in compliance with the American Psychological Association (APA)’s The Standards for Educational and Psychological Testing (2001, 2002, 2004, 2007a, 2007b). All professionals who conduct psychological testing, including those who are not members of the APA, are still bound to follow these standards. Psychological testing is generally under the auspices of the American Psychological Association. This organization determines the general standards for appropriate psychological testing. Moreover, most objective, standardized psychological tests have strict limitations in who may purchase and administer them. Furthermore, all standardized psychological tests must be developed and administered in accordance with these rules.

3.3.8 Appropriate Documentation Regarding Potential Limitations in Objective Impairment in Functioning

psychological testing to report all scores in the finalized evaluation report. The specific questions regarding the individual’s current level of functioning are answered at this point. Any reported impairment must be supported by objective psychological testing results, not simply by clinical opinion because of the inherent bias that occurs with clinical opinion. By following this process, any psychological disorder or impairment in functioning is either confirmed or ruled out through more objective means.

Many professionals tend to report individual test scores as “proof of impairment.” However, all test scores are required in order to make a careful and balanced professional summarization regarding functioning. The APA (2004) also requires all professionals to write the finalized report in language that avoids professional terminology and jargon and more in a manner so that the average layperson can understand it. Any noted diagnosis must be an actual DSM-IV-TR diagnosis since this is the current practice standard and has specific criteria to be met that will be understood across all BH professionals. Furthermore, it is the DSM-IV-TR diagnosis that determines the appropriate treatment, particularly the specific evidence-based treatment (Warren, 2009). Lastly, it is important to be mindful that a diagnosis does not necessarily equate an impairment (American Psychiatric Foundation, 2005).

3.3.9 Drawing on the Strength of Scientifically Based Treatments of BH Concerns

It is important to note that the majority of psychological disorders have not been found to result in permanent impairment in functioning. Grant (2005) noted that most individuals with true objective psychological disorders are able to and actually do continue to work. The American Psychiatric Foundation’s Partnership for Workplace Mental Health (2005) came to the same conclusion independently and noted that the reported inability to work must be considered a crisis and requires immediate, intensive treatment by all TPs. The APF also pointed out there are currently multiple professional treatments that have been empirically supported to quickly restore the individual to one’s previous level of functioning. For example, Major Depressive Disorder (MDD), one of the most common psychological disorders that may cause temporary impairment in functioning, has been examined through two well-known series of empirical research, STAR*D (Sequenced Treatment Alternatives to Alleviate Depression, 2009) and TIMA (Texas Implementation of Medication Algorithms, 2008). The results of STAR*D research in which individuals were treated for 16 weeks, revealed: “In conclusion, about half of participants in the STAR*D study became symptom-free after two treatment levels. Over the course of all four treatment levels, almost 70% of those who did not withdraw from the study became symptom-free.” The TIMA series of research demonstrated similar results and emphasized intensive care, including hospitalization if the person was unable to function. Thus, this briefly demonstrates just one psychological disorder that can be treated effectively in order to restore the individual to one’s previous level of functioning. The key aspects emphasized are quick intensive treatment that is focused on optimizing medication levels quickly over a short period
of time. It is important to note that there are similar scientifically based treatments for many other psychological disorders. Thus, if an individual is not improving over time, it may be necessary to examine whether medications should be increased, patient compliance, and perhaps, supplementing the current medication with other appropriate medications to positively augment the response to treatment.

### 3.3.10 Appropriate Treatment Goals (Including RTW)

If professional BH treatment is provided, then the RTW goal must be set as a required part of treatment. The APF (2005) emphasized that with the current empirically based treatments the likelihood of permanent impairment with an objectively determined psychological disorder is rare and that a RTW is the norm. Therefore, it is essential to set the expectation from the start of treatment, including in the evaluation that the anticipated treatment outcome is either SAW or RTW, if true impairment in functioning is found.

As a part of treatment, it is important to educate the individual about a diagnosis after it has been objectively confirmed or ruled out. For those individuals with an objectively determined diagnosis, the BH professional should discuss what constitutes the current state-of-the-art, scientifically based treatment, what are the particular components involved in the treatment, that the individual will need to take an active role in treatment, including homework assignments and increasing physical activity, anticipated treatment milestones so that progress can be noted, and if there needs to be additional collaboration with another BH professional, such as a psychiatrist to prescribed medications, if necessary (ACOEM, 2006; Warren, 2009).

The APF (2005) also noted that although most individuals who have been off work may experience anxiety about returning to the workplace, this is a normal reaction, and the TP should not take as a reason for the individual to not return to the workplace. Instead, the BH professional can note this ahead of time to desensitize the individual and so that it is understood that this is a normal response and to better help the person to identify ways in which to cope with the return.

### 3.4 The Behavioral Health Return-to-Work Process

After an individual has received appropriate, evidence-based treatment and is ready to return to the workplace, the BH professional can help in guiding the person through the process by first obtaining a signed release to talk with the Human Resource (HR) department. Most BH professionals do not follow this step and it can make for an uneven transition by lack of communication to clarify the process and to have the employer become involved. Instead, by the BH professional talking with the HR, a clear line of communication is obtained. This allows for the development of a short-term, graduated RTW plan to be put into place. Moreover, the HR department can discuss the specifics of the RTW plan with the individual’s
supervisor as a means to ensure that all parties understand the proposed process. This alleviates the full burden of the RTW transition being placed on the individual who is returning to work and also helps the BH professional address any questions that the employer may have (Warren, 2009).

A common graduated RTW program that the author has successfully employed is outlined in Table 3.2.

### 3.4.1 Workplace Accommodations for Behavioral Health Concerns

There are times when workplace accommodations may greatly facilitate the individual’s RTW sooner. However, it is still important to be aware that simply asking for accommodations does not necessarily ensure that accommodations will be provided by the employer. Frequently, well-meaning professionals and individuals will cite the Americans with Disabilities Amendments Act (ADAAA, 2008), which went into effect on January 1, 2008 and protects individuals against discrimination in the following areas of age, disability, equal pay, genetic information, national origin, pregnancy, race, retaliation, sex, and sexual harassment, as the basis for accommodations. But, it is important to know that although there are changes in the Act to allow for broader coverage, there are still limitations in requiring employers to make accommodations.

The US Equal Employment Opportunity Commission (EEOC, 2009) provides this brief guidance:

The law, (ADAAA) requires an employer to provide reasonable accommodation to an employee or job applicant with a disability, unless doing so would cause significant difficulty or expense for the employer.

A reasonable accommodation is any change in the work environment (or in the way things are usually done) to help a person with a disability apply for a job, perform the duties of a job, or enjoy the benefits and privileges of employment. Reasonable accommodation might include, for example, making the workplace accessible for wheelchair users or providing a reader or interpreter for someone who is blind or hearing impaired.

An employer doesn’t have to provide an accommodation if doing so would cause undue hardship to the employer. Undue hardship means that the accommodation would be too difficult or too expensive to provide, in light of the employer’s size, financial resources, and the needs of the business. An employer may not refuse to provide an accommodation just because it involves some cost. An employer does not have to provide the exact accommodation the employee or job applicant wants. If more than one accommodation works, the employer may choose which one to provide.

<table>
<thead>
<tr>
<th>Name of employee, HR representative, and immediate supervisor</th>
<th>Return to work at 2 hours a day for approximately 1 week</th>
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<tbody>
<tr>
<td>Return to work at 4 hours a day for approximately 2-3 weeks</td>
<td>Employee will work 4 hours a day for approximately 2 weeks</td>
</tr>
<tr>
<td>Employee returns to working a full-day</td>
<td>Employee will work 6 hours a day for approximately 2-3 weeks</td>
</tr>
</tbody>
</table>

Table 3.2  Example of a return to work program for behavioral health concerns
The ADAAA’s current definition of disability is

“In order to be protected, a person must be qualified for the job and have a disability as defined by the law.”

A person can show that he or she has a disability in one of three ways:

- A person may be disabled if he or she has a physical or mental condition that substantially limits a major life activity (such as walking, talking, seeing, hearing, or learning).
- A person may be disabled if he or she has a history of a disability (such as cancer that is in remission).
- A person may be disabled if he is believed to have a physical or mental impairment that is not transitory (lasting or expected to last six months or less) and minor (even if he does not have such an impairment).

It is important to be cognizant that based on the current body of empirical research regarding scientifically based treatment, most true psychological disorders do not result in permanent impairment in functioning, thus most requested accommodations are likely to be temporary in nature. Some exceptions to this are likely to occur with those individuals who have diagnosed with Schizophrenia, Traumatic Brain Injury (moderate to severe), and Bipolar Disorder that is unresponsive to treatment (Schretlen, Munro, Anthony, & Pearlson, 2003, 2007). Examples of accommodations related to true psychological disorders, as defined in the DSM-IV-TR (2000), are (1) Working part time until medication has been optimized; (2) working in a different department with reduced work demands, until the disorder has been stabilized; and (3) taking breaks that allow the individual to take a walk in order to obtain some physical exercise during the workday as a means to reduce physiological symptoms of an Anxiety Disorder. It must be emphasized that the ADAAA is still very new and it will be shaped over time by various legal challenges. Moreover, there are some situations where the Family and Medical Leave Act (2009) will be more appropriate to utilize than the ADAAA. Each Act has its own set of rules and regulations. Thus, it is important for all professionals to become educated regarding the specific requirements and limitations with each law. Moreover, when there is a question pertaining to a specific issue with an employee, an employer should seek legal consultation to ensure appropriate guidance in sound decision making in the workplace.

3.5 Conclusion

While this chapter provides guidance about appropriate evaluation of objectively determined psychological impairment in functioning, there are several other groups of professionals typically involved in this process. Other professionals are typically, physicians, such as Occupational Medicine, psychiatrists, rehabilitation clinicians, nurse case managers, insurers, and attorneys. Each type of professional has a unique role in the BH disability process. The remaining chapters will discuss how BH concerns usually occur within each profession, how they are identified and managed, common problems that arise, as well as how to better address these issues.
to bring positive change (National Center for Injury Prevention and Control, 2006; Centers for Disease Control and Prevention, 2008).

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Chapter 4
Assessment of Psychosocial Contributions to Disability

Daniel Bruns and Pamela A. Warren

4.1 Introduction

Disability has traditionally been defined in terms of a largely biomedical model, where an individual’s limitations were seen as being the product of objectively verifiable physical problems. More recently though, disability has been redefined in terms of functionality within a social context (Pledger, 2003). The emphasis of new conceptualizations of disability is that in addition to the individual’s physical limitations, disability is also influenced heavily by the ecology of the psychosocial environment. “This disability paradigm maintains that disability is a product of the intersection of individual characteristics (e.g., conditions or impairments, functional status, or personal and socioeconomic qualities) and characteristics of the natural, built, cultural, and social environments” (U.S. Department of Education & Rehabilitation Research, 2009, p. 2). Consequently, determining that a person is disabled cannot be made by assessing the person in isolation, without consideration of the social environment (Jette & Badley, 2000). Thus, disability is best understood as a biopsychosocial phenomenon that combines biological, psychological, and social elements.

4.1.1 Biopsychosocial Aspects of Disability

Biopsychosocial disorders arise out of an interaction between biological and psychosocial forces in a patient’s life (Gallagher, 2004; Gatchel, 2004; Grace, 2000; Hyams, 2004; Ong & Keng, 2003; Turk & Okifuji, 2002). Although biopsychosocial disorders have often been discussed as if they were a single condition, more recently these disorders have been described as occurring in distinct forms, and as having an identifiable natural history (Bruns & Disorbio, 2005). Consequently, the
goal of the psychological evaluation of an individual with disability is to (1) review the individual’s medical findings, with particular attention to any biological factors that may be a direct cause of impairment, (2) understand the individual’s perception of and emotional reaction to the medical condition, (3) identify any psychological contributions to symptoms or disability, and (4) understand the meaning of this condition in the social context in which it occurs.

The fact that objective physical conditions can lead to disability is readily understandable. If a person’s hand is traumatically amputated in an accident, the disabling consequences of this are obvious. In contrast, the psychosocial aspects of disability are often more difficult to assess, with the assessment of subjective psychological variables generally being the most challenging. Despite their inscrutable nature, however, psychosocial variables have a strong influence on disability.

Some psychosocial risk factors are objective in nature. For example, race has been found to predict outcomes from treatments for cancer (Terplan et al., 2009) and heart disease (Greene Jackson et al., 2009), presumably because race is associated with the quality of care received. Perhaps for similar reasons, low education has been found to be predictive of poor outcome from lumbar surgery (den Boer, Oostendorp, Beems, Munneke, Oerlemans, et al., 2006). Other behaviors that bear on a person’s health, such as smoking and diet, are also in principle objectively verifiable activities. However, a complication here is that in practice, the evaluator is dependent on patient reports to determine the presence of many of these risk factors, and unfortunately, patient self-reports are not always accurate. Consequently, many psychosocial variables that would appear to be objective in nature, in practice, are not. Because of this, one of the goals of the psychological evaluation of disability is to determine the extent to which a patient’s self-reports might be inaccurate or biased.

### 4.1.2 Subjective Risk Factors for Disability

In contrast to objective risk factors, many psychological variables are inherently subjective in nature. Even so, these variables can have a profound influence on disability. Research by the World Health Organization (WHO) has used the concept of disability-adjusted life years (DALY) to assess the burden of disease, where one DALY represents 1 year of healthy life lost either to death or disability. Using DALY, WHO determined that in 2004, worldwide, the three disease states with the highest burden of disability were (1) respiratory infections, (2) diarrheal diseases, and (3) Major Depressive Disorder (MDD) (World Health Organization, 2008). This study ranked the disabling burden of depression worldwide as being greater than heart disease, HIV/AIDS, malaria, diabetes, and many other conditions. Furthermore, WHO projections are that by 2020, Major Depressive Disorder will be the second greatest source of disability (Murray & Lopez, 1997), and the most disabling condition by 2030 (World Health Organization, 2008). Unlike the other conditions though, the diagnosis of depression relies heavily on patient self-reports of subjective feelings and behavior.
Pain is also a subjective experience, which cannot be directly assessed. Pain is one of the most common reasons why people see physicians, with one study finding that 80% of patients presenting in office-based care had complaints of pain (Koch, 1986). Not surprisingly, chronic pain has been found to be one of the most expensive conditions in managed care (Disorbio et al., 2006). Several studies have found that pain also tends to be associated with other unpleasant subjective experiences, such as depression (Fishbain et al., 1997; Polatin et al., 1993; Campbell et al., 2003) and anxiety (Gureje, 2008; Roy-Byrne et al., 2008; Gureje, 2007).

While most painful conditions are easily treated and resolve quickly, a small number of painful conditions are extremely expensive to treat. With regard to back injury, one study found that 10% of all cases accounted for 79% of all costs (Spengler et al., 1986), while another study concluded that 5% of cases led to 75% of all costs (Frymoyer & Cats-Baril, 1991). Similarly, a study in Quebec found that 7% of injured patients accounted for 76% of costs. As only 14% of the costs in the Quebec study were for medical care, though, it was concluded that these high costs were not driven by medical complexity, but rather by psychosocial complications (Spitzer et al., 1987).

When objective, biomedical impairments are present, it would seem a reasonable assumption that they would be the primary determinants of disability, with psychosocial variables making a smaller contribution. However, this is often not the case. For example, depression is commonly associated with serious illness and injury. When depression co-occurs with a serious disease, such as heart disease or diabetes, it would be natural to assume that the physical disease state is the primary cause of disability. However, an international study performed by WHO found that disability was more closely associated with psychopathology than physical disease severity. Overall, it was concluded that impairments of emotion, motivation, and cognition were more powerful determinants of functional disability than the physical disease status itself (Ormel et al., 1994).

If we consider patients with spinal injuries, MRI imaging studies are often used to assess objective pathophysiology. However, a number of studies have shown that positive MRI findings are common in individuals who are symptom-free (Jensen et al., 1994). In contrast, psychological testing has been found to be more predictive than MRI with regard to predicting future disability (Carragee et al., 2005; Carragee et al., 2004). Another study found that physical pathology accounted for only 10% of disability one year after the evaluation while psychosocial variables could account for 59% of the disability. (Burton et al, 1995). Consistent with this, a prospective study showed that patients who were satisfied with their care were significantly more likely to go on to have a good treatment outcome (Butler & Johnson, 2008). These findings have led the American Medical Association to conclude the following in its Guides to the Evaluation of Permanent Impairment (Rondinelli et al., 2008):

The traditional and outdated biomedical approach assumes that all pain symptoms have a specific physical cause, and attempts to eradicate the cause directly, by rectifying the presumed pathophysiology. However, chronic pain can rarely be understood by linear, nociceptive mechanism . . . There is often an absence of a documentable relationship between pain and pathophysiology (p. 32).
Research on the relationship between pain and disability has found that pain levels were more closely associated with disability and patient satisfaction with care than were objective physical impairments (Chiu et al., 2005). Other studies have also found strong correlations between subjective pain reports and disability (Koho et al., 2001; Fejer & Hartvigsen, 2008), and that pain was associated with a decreased willingness to use muscles forcefully, which potentially could impact one’s overall level of disability (Ylinen et al., 2004). Lastly, research has also shown that the tendency to seek medical care is strongly impacted by societal attitudes and patient demands (Proctor et al., 2004; Barsky & Borus, 1995).

Given this biopsychosocial nature of pain, it has been recommended that treating physicians should more strongly consider the conservative, multidisciplinary treatment approaches that include medical management, physical therapy, and behavioral interventions, and avoid unnecessary surgical procedures when possible. Given that surgery always carries a certain degree of risk, it was concluded by one study that by taking a conservative approach, the level of physician-caused disability could be reduced (Aronoff & Livengood, 2003). Consistent with this, a recent study found that intensive multidisciplinary rehabilitation was as effective for nonradicular back pain as was a lumbar fusion (Chou et al., 2009), while other studies have shown that using case managers to address psychosocial and other complications can improve return to work (Butler et al., 2007; Tompa et al., 2008). Overall, multidisciplinary treatment is widely regarded as a first line treatment for chronic pain.

4.2 The Assessment of Psychological States Leading to Disability

The assessment of subjective psychological states is inherently difficult. Of course, one can simply ask the patient how he or she feels and record the answer, but there are two general problems with this. First of all, patients may lack insight into their psychological status, and are thus unable to answer certain questions. If patients do not know what depression is, they cannot say if they are depressed. Second, even if patients do have adequate insight, they may be motivated somehow to bias their reports of information. In some cases, out of guilt or shame, patients may minimize their psychological difficulties. In other cases, however, especially when there are incentives to do so, patients may magnify their symptomatic complaints.

The AMA Guides to the Evaluation of Permanent Impairment (Rondinelli et al., 2008) discusses the dilemma that disability ratings in the past have been too dependent on the subjective impressions of the patient, and have suggested instead that disability be assessed by physician ratings. However, this is not much better, as when performing these ratings, the professional is still heavily dependent on patient report. For example, consider the assessment of depression. According to the DSM IV (American Psychiatric Association, 2000), Major Depressive Disorder (MDD) consists of the daily or almost daily the presence of five or more of following symptoms: depressed moods, markedly diminished interest in activities, decrease or
increase in appetite, insomnia or hypersomnia, fatigue, feelings of worthlessness or guilt, indecisiveness, or diminished the ability to think. Furthermore, diagnosis of MDD requires that the above subjective difficulties give rise to either significant distress or impairment in social, occupational, or other functioning. Thus, a professional performing disability rating continues to remain heavily dependent upon patient reports to make many determinations.

It could be argued that in theory, the above determinations about depression could be made primarily by the objective observations of a professional. In reality though, this is not possible. The diagnostic criteria of depression require that the patient have some of the above symptoms for much of the day, almost every day. This would require a degree of professional observation that is completely impractical. If for some reason though, it were economically warranted to pay a professional to observe a patient for days at a time, this would still not resolve the problem. A professional could try to assess a feeling such as appetite by observing eating behaviors. However, these behaviors are largely under the voluntary control of the patient, and could be altered as desired. Intensity of libido might be judged by sexual behaviors, but observing this is not ethically allowed. Thus, for a myriad of reasons, we must turn to patient report to assess important subjective variables, such as appetite, libido, pain, depression, and anxiety. Unfortunately, patients may be unable or unwilling to accurately report these subjective states. In some cases, the patient may be motivated to intentionally supply false information. While the subjective contributions to biopsychosocial disorders and to disability are so important that they cannot be dismissed, the assessment of these subjective traits remains challenging. Fortunately though, there is a means of addressing this problem.

4.3 Psychometric Assessment and Disability

Psychometrics is the scientific method used to measure subjective psychological human abilities, traits, and experiences. This includes inferred traits such as intelligence or personality, subjective experiences, such as emotions, thoughts, and memories, and physical symptoms, such as pain or fatigue. Psychometrics involves the systematic analysis of overt human behavior as a means of assessing unobservable psychological attributes (Furr & Bacharach, 2008). The observed behaviors may include memory tasks, problem solving, verbal reports, responses to paper-and-pencil questionnaires, or motor behaviors (e.g., drawing a picture). From a careful scientific analysis of the data gathered, underlying attributes can be inferred and measured.

Although psychometrics sounds mysterious, it is a science that Western society has come to rely on heavily. Perhaps the most common example of this is that on almost every edition of the news on television, the results of a poll are reported. Scientific surveys, which employ psychometric principles, have an established ability to accurately predict the sentiments of a population, with a known degree of error. In a manner analogous to the way that scientific questioning of voters can
assess their subjective opinions and predict voting behavior, standardized psychometric instruments can assess subjective states that predict disability in patients. Psychometric tests are often employed to assess psychological (e.g., depression or personality) or neuropsychological (e.g., memory or reasoning) constructs. Additionally though, they can also be used to assess a patient’s perception of physical abilities, health behaviors or symptoms (e.g., measures of physical functioning like the Oswestry Disability Index (Fairbank & Pynsent, 2000), or the Dialysis Symptom Index (Weisbord et al., 2004)). Overall, psychometric tests can be used for a variety of purposes. These uses include: (1) diagnostic classification; (2) description of patient traits or characteristics; (3) intervention planning; (4) tracking changes in symptoms, beliefs, or behaviors over time; and (5) prediction of future thoughts, feelings, behaviors, or events, including satisfaction with care or treatment outcome (Turner et al., 2001).

One of the important contributions of psychometric assessment is not only to measure whether or not a condition like depression is present, but also to assess the degree to which it is present. For example, the National Comorbidity Study found that between 2001 and 2003, 20% of the population from 18 to 54 years of age had received some sort of treatment for an emotional disorder. However, only about half of those that received treatment had disorders that met the diagnostic criteria for a mental disorder (Kessler et al., 2005). This research suggests that a low level of psychological distress and other conditions is common in the healthy population. Consequently, during a disability evaluation, it becomes important to determine (1) whether or not depressive or other symptoms are present, and (2) whether or not these symptoms are indicative of commonly occurring mild adjustment difficulties, or a more serious psychological condition that could contribute to disability. The advantage of a psychometric measure of depression is that it can return a percentile rank, thus more precisely and reliably quantifying the degree of depression that is present.

Despite the advantages of the biopsychosocial model, integrating psychological concepts into the biomedical model can be daunting. Those who do not adopt an integrated biopsychosocial model of disability, though, are at risk for oscillating between biomedical and psychological reductionism. On one hand, using biomedical reductionism, it could be argued that depression or anxiety can “really” be reduced to a purely physical disease state, defined by aberrant levels of serotonin, norepinephrine, or other neurotransmitters and that the subjective experience is irrelevant. Alternately, for those patients who complain of disabling symptoms that are medically improbable, psychological reductionism can be employed: “Your symptoms aren’t real. They are all in your head.” Neither type of reductionism though can fully explain the full spectrum of variables that lead to disability. In contrast, the strength of the biopsychosocial approach is that it attempts to bring together these disparate biological, psychological, and social aspects of the human condition under one umbrella, and in this manner, can achieve greater explanatory power.

The biopsychosocial assessment of patients is a challenging task. Despite this, multiple evidence-based medical guidelines recommend a biopsychosocial approach (American College of Occupational and Environmental Medicine, 2008a; Colorado Division of Workers’ Compensation, 2009; Work Loss Data Institute, 2009).
With regard to performing the best possible assessments of the psychosocial aspects of disability, the following suggestions are made.

**4.4 An Introduction to Psychological Testing Concepts**

Psychometric questionnaires vary greatly with regard to what they are intended to assess, and the degree to which they have met accepted psychometric standards. While there are a very large number of psychometric questionnaires available, not all measures are equal, and many are not appropriate for clinical assessment. Standardized psychometric tests differ substantially from informal questionnaires. The definitive standard for determining whether or not a questionnaire can be regarded as a “standardized test” is a work called *The Standards for Educational and Psychological Testing* (American Educational Research Association, American Psychological Association, National Council on Measurement in Education, Joint Committee on Standards for Educational and Psychological Testing (U.S.), 1999). In addition to meeting the criteria specified by the *Standards*, others have suggested that a standardized psychological test should also have been reviewed by the Mental Measurements Yearbook (American College of Occupational and Environmental Medicine, 2008b; Mitrushina et al., 1999), and have generated publications in peer-reviewed journals (Mitrushina et al., 1999).

How good are psychometric tests? A systematic review of the literature reviewed 125 meta-analyses on test validity, and 800 samples used for multimethod assessment (Meyer et al., 2001). This study reached the following conclusions:

1. There is strong evidence that psychological tests can validly measure their intended constructs
2. Psychological test validity is comparable to medical test validity
3. Psychological tests are a distinct assessment method that can provide a unique source of information
4. Psychological tests can provide information that cannot be gained by interview alone

The Meyer study concluded that psychometric tests are the scientific equal of medical tests. Beyond this, however, in some studies, psychometric tests were better predictors of medical outcome than standard medical assessment techniques. For example, as noted previously, studies have found that psychological variables were (a) better than either MRIs or discography in predicting future back pain disability (Carragee et al., 2005); (b) stronger contributors to disability than was disease severity (Ormel et al., 1994); and (c) able to predict delayed recovery without using medical diagnostic information (Gatchel et al., 1995).

Overall, standardized tests offer an efficient means of gathering information about psychological, social, and medical variables. Standardized psychometric tests can help the disability evaluator by: (a) providing a means to quantify a patient’s subjective reports in a manner that an interview cannot; (b) helping to
control for a patient’s tendency to exaggerate or minimize symptoms; and (c) evaluating
the individual in a standardized way that reduces the effect of biases on the part of
the professional. Thus, psychometric tests can be an important part of a thorough
assessment and facilitate the evaluation of the patient in a comprehensive manner.

4.4.1 What Is a Standardized Test?

The defining features of a standardized test are listed in Table 4.1. While this
information is known by psychologists, it is offered here as it is not common
knowledge among members of other professions. It is important to recognize that
many commonly used questionnaires (such as the Oswestry and the Zung
Depression Scale) are not standardized. The Standards indicate that while such
measures may work well in research settings, only standardized tests should be
used for clinical assessments. It could be countered, “How can you say that Test
XYZ should not be used clinically? It has been used in numerous research studies.
Isn’t that enough?”

To illustrate the effects of lack of standardization, consider the 0–10 pain rat-
ing scale. It has been noted that this scale has literally thousands of variations,
with no agreed upon definition of what a pain level of 10 is, no agreed upon time
frame (e.g., pain right now versus usual pain or worst pain), or pain location
(overall pain versus back pain or headaches) (American College of Occupational
and Environmental Medicine, 2008b). Because of these problems, Turk and
Melzack (1992) stated:

The appropriateness of norms of tests has rarely been considered in the pain literature. In
the absence of normative information, the raw score on any test is meaningless. To observe
that a patient with a migraine headache scores a 10 on a Visual Analog Scale (VAS) of
intensity conveys little or no information.

Another problem with nonstandardized measures is that users sometimes modify
them. For example, the Oswestry Disability Index has been modified multiple
times. Further, some of the modifications have been done carelessly, as some
published versions of the Oswestry contain misprints, and others omit the scoring
system altogether (Fairbank & Pynsent, 2000). The practice of modifying question-
naires serves to create nonequivalent forms of the measure, and this negates any
standardization a test may have had.

The lack of standardization is compounded when a test is informally translated
into a different language. For example, one unauthorized Spanish translation of the
Beck Anxiety Inventory in use with Spanish speakers translated the item “Dizzy or
light-headed” as “Dizzy or light on hooves.” This poor translation is worsened by
the fact that the phrase “light on hooves” is a figure of speech in Spain and Puerto
Rico that implies promiscuity (Artiola i Fortuny & Mullaney, 1997). This type of
mistranslation would be comical, if not for the fact that this measure was used for
clinical decision-making.
It would be a mistake to say informal or nonstandardized questionnaires are without value. In research settings, nonstandardized questionnaires are frequently used and modified to address particular research questions. This is a perfectly acceptable practice in research, where the task at hand is to compare groups of patients. In contrast, clinical assessment is fundamentally different. In clinical assessment, the scores of one individual are assessed to determine if they are unusual enough to cause concern or suggest alterations to the treatment regimen. This is a much more challenging task. As noted in Table 4.1, this cannot be accomplished unless we know that the test (1) is a valid measure of what we want to assess;
(2) is a reliable measure; (3) has standardized materials and scoring methods; and (4) has standardized scores based on norms that will allow the identification of unusual scores.

### 4.4.2 Validity Assessment

Part of human nature is that for a variety of reasons, patients may sometimes answer questions or respond to test items in aberrant ways. During a disability evaluation, a patient may be consciously or unconsciously incentivized to provide distorted or blatantly false information, and in so doing, invalidate the results. These incentives could include the presence of primary gain (e.g., a person enjoys being a patient or being in a hospital), secondary gain (e.g., the patient will receive monetary rewards for being disabled or opioids for being in pain), or tertiary gain (e.g., the patient realizes with somewhat misguided altruism that being disabled would make it possible to spend more time with one’s child, which would benefit the child). Beyond the effects of these sorts of incentives, there are a number of other types of aberrant responding that could also invalidate a psychometric test’s results. These include a reluctance to reveal private information, confusion, illiteracy, careless responding due to fatigue, lack of motivation, or response sets.

A response set is a tendency to respond to a psychometric test in a manner that is independent of the test items. For example, the response set of acquiescence involves the tendency to agree with anything, regardless of content. In contrast, social desirability is a response set where a person is always prone to choose the most socially desirable response, while a response set called “primacy” involves a tendency to choose the first alternative that is presented. Overall, subjects prone to response sets are not really responding to the content of the test item, but rather to an incidental feature of the test or test administration, and this undermines the validity of their test results.

To control for various sorts of threats to validity, many psychological tests employ validity indices. When validity indices are lacking, the test administrator may not be able to determine if the test taker is underreporting or exaggerating responses, responding randomly, influenced by a response set, or responding in other aberrant ways. The use of validity measures is an important control when assessing the subjective reports of patients in the clinical setting. Through the use of these measures, it is possible to better assess the accuracy of the patient’s self-report of abilities and subjective experiences.

In general, there are two types of validity measures: psychological and neuropsychological. Psychological validity measures assess traits such as the tendency to conceal embarrassing information (defensiveness), exaggerate positive traits, or aberrant responding due to response sets, illiteracy, or random responding. Psychological validity scales assess the validity of symptom reports related to subjective psychological difficulties, such as depression, post-traumatic stress disorder or pain. In contrast, neuropsychological validity scales assess the motivation to give best effort during the assessment of challenging mental tests, such as the measures
of reasoning and memory. Neuropsychological validity scales assess the validity of symptom reports related to mental functions, such as cognition, memory, and perception, especially with regard to brain injury or disease.

An interesting study employed a factor analytic method to mathematically identify the patterns of biased reporting while taking psychological tests. This method identified four patterns of biased reports, which were (1) the underreporting of psychological symptoms; (2) the overreporting of “neurotic” and vague illness symptoms; (3) insufficient cognitive effort; and (4) the overreporting of psychotic or bizarre symptoms (Nelson et al., 2007). Biased reporting may go beyond the reports of current symptoms. Studies have shown that in addition to exaggerating present symptomatology, biased reporting can also involve exaggerating how much better one was in the past (Greiffenstein et al., 2002; Mittenberg et al., 1992).

All major psychological tests, such as the BHI 2, MBMD, MCMI-III, MMPI-2, and PAI include multiple measures of validity (see Appendix 1). In contrast, brief psychological tests generally do not have validity measures. The exceptions to this are the P3, which has a measure of bizarre responding, and the BBHI 2, which includes assessments of exaggerating, denial, random responding, and psychosis. In a nutshell, validity measures on these tests are looking for statistically implausible reports. This could involve implausibly low reports of emotional distress (e.g., patient claims to have never been mad or had sad feelings), implausibly high levels of bizarre psychological symptoms (e.g., patient complains of a far higher level of bizarre symptoms than do patients with paranoid schizophrenia), or high levels of diffuse physical symptomatology that are difficult to explain medically.

The psychological test that has generated the most research on malingering is the MMPI 2. The current MMPI 2 computerized report incorporates nine separate validity measures, each of which has specific purposes, strengths, and weaknesses (Arbisi & Butcher, 2004). The new MMPI-2-RF (revised form) has similar, shortened versions of eight of the MMPI-2 validity scales (Ben-Porath & Tellegen, 2008), but has to date only limited research on this topic. While the MMPI tests include the measures to assess a wide variety of invalid test protocols, much attention has focused on the Fake Bad Scale (FBS), which has been extensively researched (Nelson et al., 2006). However, others have been critical of this scale, saying that the scale is “likely to classify an unacceptably large number of individuals who are experiencing genuine psychological distress as malingerers” (p. 473) (Butcher et al., 2003). This underscores the fact that a score on any single psychometric measure of validity, while useful, is not sufficient to declare a person to be a malingeringer, but rather needs to be interpreted within the context of other test scores, clinical observations, and the patient’s history.

Assessing validity for neuropsychological conditions is somewhat different than psychological conditions. In general, it is not possible to fake good on a neuropsychological test (e.g. an individual with dementia cannot pretend to be intellectually gifted). In contrast, neuropsychological tests are very vulnerable to faking bad: All a patient has to do is to not try very hard, or say, “I don’t know.” To control for this, symptom validity tests (SVTs) are used to assess motivation during neuropsychological test administration.
The Word Memory Test (WMT) is a commonly used SVT. The WMT is called a “forced choice test,” and it operates in the following manner. A testing subject is first shown a list of words. After a delay, the subject is shown two words, and asked to choose which one of these was seen previously. Using this method, a person with no verbal memory ability at all would be expected to get about 50% correct just by guessing. In theory, to get a score below chance levels such as 25% correct, a subject must remember the right answer, and choose the opposite one. The Test of Memory Malingering (TOMM) is similar to the WMT, but has the patient choose which of two pictures was previously seen, while the Computerized Assessment of Response Bias uses a similar procedure using the memory of numbers. Of these, research suggests that the WMT may be the strongest single measure (Gervais et al., 2004).

In contrast, the Validity Indicator Profile (VIP) takes a somewhat different approach to validity assessment using a performance curve (Frederick et al., 2000). On the VIP, the test subject is given both vocabulary and math items of varying difficulty in random order. In theory, a test subject who is capable of performing at the ninth grade level should score highly on items up to that level, and progressively worse on items with a 10th, 11th, and 12th grade difficulty. This pattern of progressively increasing error rate is difficult to fake, however, and subjects who fail a large number of easy items while getting much harder items correct obtain profiles suggestive of poor motivation to perform (Frederick & Bowden, 2009; Frederick & Crosby, 2000).

Overall, psychological and neuropsychological tests employ a variety of validity measures intended to assess how a particular test subject approached the testing. There are a variety of reasons why a particular test may not be valid, though. Consequently, multiple measures of validity should be used (Lynch, 2004). When multiple measures of validity are administered, though, some of them may suggest that the results are valid, while others do not. This is not a contradiction, though, as each of these measures may assess a different aspect of valid test performance, and together these provide for a more accurate assessment of a patient’s symptoms and abilities.

### 4.4.3 Malingering, Exaggeration, and Denial

Sometimes, there are incentives for a patient to appear disabled. In disability settings, one of the principal uses of test validity measures is to detect malingering or exaggeration. Malingering is defined by the DSM-IV-TR as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs” (p. 739). According to the DSM-IV-TR, probable malingering exists when two or more of the following four conditions are present: (1) The patient presents in a medical/legal context; (2) There is a marked discrepancy between claimed disability and objective
findings; (3) The patient exhibits a lack of cooperation with testing or treatment (a malingering may avoid diagnostic evaluations that would fail to support the symptomatic complaints; or treatment for which a genuine condition might respond); and (4) The patient has an antisocial personality disorder (American Psychiatric Association, 2000).

Studies have shown that psychological conditions can be easily faked (Hall, 2007) and that compensation for disability is associated with increased reports of symptoms (Binder & Rohling, 1996; Rohling et al., 1995). Despite this, the prevalence of malingering remains controversial. The most extensive review to date of pain-related malingering reviewed 68 studies and estimated that malingering was present in 1.25% to 10.4% of patients with chronic pain (Fishbain et al., 1999). In contrast, some more recent studies have suggested that there may be a 30–40% incidence of malingering of pain, emotional distress or cognitive symptoms in patients who were litigating or seeking benefits (Aronoff et al., 2007; Mittenberg et al., 2002). Variations in estimates of the prevalence of malingering may be explained in part by the fact that a recent study found that the prevalence of malingering was observed to increase along with the degree of potential for financial gain. Consequently, in situations where a high potential for financial gain was present, such as in federal litigation, the prevalence of malingering could be significantly higher. This phenomenon could help to explain wide variations in estimates of the prevalence of malingering (Bianchini et al., 2006).

The DSM-IV-TR notes that prior to diagnosing malingering, other psychiatric explanations must be ruled out. These alternative explanations include factitious disorders, somatoform disorders (e.g., somatization, conversion disorder, pain disorder), or psychosis with somatic delusions (American Psychiatric Association, 2000). In contrast to malingering, where symptoms are feigned in the pursuit of some kind of external reward or secondary gain, in factitious disorders, symptoms are produced for primary gain. As noted above, in factitious disorders, a patient reports symptoms without any intent of external reward such as a disability settlement. Instead, in factitious disorders, the individual reports symptoms because he or she wants to be a patient (Wise & Ford, 1999). Thus, while a healthy patient may aspire to have a career, a factitious patient wants nothing more than to be a patient, even to the point of turning down a monetary settlement if it would jeopardize patient status. In some cases, factitious symptoms are feigned. In other cases though, patients with factitious disorders may actually self-induce a medical condition (such as by drinking a toxic substance or rubbing fecal material into a wound) in order to gain patient status (Mailis-Gagnon et al., 2008).

Malingering must also be distinguished from Somatoform Disorders. Somatoform Disorders are psychiatric conditions, where psychological difficulties are expressed in a somatic form. In Somatoform Disorders, the individual is typically unaware of any relationship between physical symptoms and his or her psychological status, and is not in voluntary control of the physical symptoms (American Psychiatric Association, 2000). Significantly, Somatoform
Disorders may involve both the exaggeration of physical symptoms, and the simultaneous denial or minimization of psychological distress or dysfunction. This, in fact, is the core of somatizing: denied psychological difficulties unconsciously manifest themselves as inflated complaints of physical symptoms (Ford, 1986). An example of this would be a patient who denies being anxious, but continues to interpret a pounding heart as a deadly sign of a heart attack, even after this has been medically ruled out. In other cases, the patient may actively conceal psychological difficulties, out of the fear that if they were reported, the physical symptoms would be taken less seriously. Malingering must also be distinguished from psychophysiological disorders, as stress and physiological arousal can sometimes lead to objective medical difficulties (Bruns & Disorbio, 2005; Bruns & Disorbio, 2009) such as stress-related hypertension (Pickering, 2001).

Finally, malingering must be distinguished from exaggerating. Patients with objective physical difficulties may exaggerate the report of associated symptoms for a variety of reasons. Exaggeration can be related to personality type, depressive negativism, a cry for help, or out of a patient’s perception that the physician is trivializing the reported symptoms (Iverson, 2007). Cognitive styles such as catastrophizing may also increase symptom reports (Sullivan et al., 2001). Further, one of the effects of litigation is that both sides may make biased or exaggerated statements as part of the adversarial process (Bornstein et al., 2002). While malingering involves the intentional report of information that is either a gross exaggeration or patently false, mild exaggeration is common and can occur for many reasons other than malingering.

Even when malingering is not judged to be present, environmental incentives can affect the treatment outcome. For example, research has shown that patients are less likely to recover from a back injury if they are in a lawsuit for that injury (Rohling et al., 1995). Similar studies have found that litigation is associated with poor outcome from treatment for head injury (Binder & Rohling, 1996), and for vocational rehabilitation (Lysgaard et al., 2005). Similarly, if a patient receives insurance compensation for disability (such as from the workers’ compensation system), this has also been found to be associated with a poor prognosis from care (Bernard, 1993; Deyo et al., 2005; Epker & Block, 2001; Greenough et al., 1994; Groth-Marnat & Fletcher, 2000; Mannion & Elfering, 2006; Glassman et al., 1998; Klekamp et al., 1998; Taylor et al., 2000). In general, research suggests that when patients are paid or hope to be paid for having symptoms, their symptoms are less likely to get better.

Overall, malingering is not a medical or psychiatric condition. In the case of disability determinations, malingering is an illegal, fraudulent act, which has consequences under both criminal and civil law. Thus, for a medical professional to label someone a “malingering” is not an act of diagnosis, but is rather rendering a verdict. As stated by Mendelson and Mendelson (Mendelson & Mendelson, 2004), “In our view, the ultimate issue of the veracity of the plaintiff is for the Court to decide, and epithets such as “malingering” have no place in reports prepared for legal purposes by health care professionals” (p. 423).
4.4.4 Psychosocial Predictors of Poor Treatment Outcome and Disability

Research has shown that psychosocial variables can predict the outcome of certain medical treatments. In clinical settings, the practice that has received the most attention is the use of psychological evaluations prior to a variety of invasive procedures and other treatments for pain and injury. This practice has been judged valuable enough that in several jurisdictions, laws and regulations mandate the use of the biopsychosocial model, and that psychological evaluations are performed prior to various medical procedures (Colorado Division of Workers’ Compensation, 2009; California Division of Workers’ Compensation, 2009).

A substantial body of research has focused on predicting the outcome of invasive procedures such as spinal cord stimulation (SCS) (Heckler et al., 2007; Giordano & Lofland, 2005a; Burchiel et al., 1996) and spinal surgery (den Boer et al., 2006; Epker & Block, 2001; Boersma & Linton, 2005; DeBerard et al., 2003; den Boer et al., 2006; Gatchel & Mayer, 2008; Gatchel et al., 2006; Hagg et al., 2003; LaCaille et al., 2005; Block et al., 2003; Block et al., 2001; Gatchel, 2001; Schofferman et al., 1992). Several studies have found that psychosocial factors were successful in predicting the results of invasive surgical procedures correctly 80–85% of the time (Block et al., 2001; Giordano & Lofland, 2005b). Psychological evaluation prior to various invasive procedures is now recommended by multiple evidence-based medical guidelines (American College of Occupational and Environmental Medicine, 2008b; Work Loss Data Institute, 2008; Colorado Division of Workers’ Compensation, 2007). With regard to outcome from back surgery, a systematic review found nine variables that were consistently associated with poor surgical outcome. These variables were depression, anxiety, somatization, pain, job dissatisfaction, functioning, days away from work, low education, and passive coping (den Boer et al., 2006).

The psychological assessment of patients is often portrayed as a counterpoint to biomedical assessment. For example, prior to various invasive procedures, a patient may be referred for both a medical opinion and a presurgical psychological evaluation as well. More recently though, one study noted that this approach is not consistent with the biopsychosocial perspective, as this type of evaluation should be approached as a single multidisciplinary assessment process (Bruns & Disorbio, 2009). This study proposed what it called the “Convergent Model” of biopsychosocial assessment. The term “Convergent Model” was intended to reflect that while at this time the field has yet to achieve a consensus about how to perform biopsychosocial assessments, evidence and opinion are beginning to converge.

In the Convergent Model, risk factors were classified as either extreme “exclusionary risks” (Table 4.2) or less severe “cautionary risks” (Table 4.3). This approach identifies statistically unusual complaints of problematic symptoms, which in past research were found to be associated with poor treatment outcomes. The identified risk factors were then assessed using standardized psychometric measures, the Battery for Health Improvement 2 (Bruns & Disorbio, 2003), and the shorter Brief
Battery for Health Improvement 2 (Disorbio & Bruns, 2002). The US national norms for the prevalence of these risk scores were obtained, with the subjects being both community members, and injured patients with a variety of diagnoses being treated in a variety of treatment settings. The norms obtained from these samples allowed the calculation of a risk score percentile rank, which was used to establish empirical benchmarks for patient reports of behaviors and subjective symptoms (Bruns & Disorbio, 2009).

Using this approach, extreme exclusionary risk factor scores that were observed in less than 1% of a national sample of patients in rehabilitation were developed.

<table>
<thead>
<tr>
<th>Type of Risk</th>
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<tbody>
<tr>
<td><strong>Affective</strong></td>
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<td><strong>Other psychological risks</strong></td>
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<td><strong>Social</strong></td>
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<td><strong>Biological</strong></td>
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</table>

Table 4.2  Exclusionary risk factors

Adapted from Bruns and Disorbio, 2009. Used with permission
Table 4.3 Cautionary risk factors

<table>
<thead>
<tr>
<th>Type of risk</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affective</td>
<td>Depression</td>
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<tr>
<td></td>
<td>Anger</td>
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<td></td>
<td>Anxiety (fears, phobias, PTSD, etc.)</td>
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<tr>
<td>Psychological vulnerability</td>
<td>History of substance of abuse</td>
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<td></td>
<td>Personality disorder</td>
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<td></td>
<td>Cognitive disorder or low education</td>
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<td></td>
<td>Poor coping</td>
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<td></td>
<td>Diffuse somatic complaints</td>
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<tr>
<td>Social</td>
<td>Conflict with Physicians</td>
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<td></td>
<td>Job dissatisfaction</td>
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<td>Family dysfunction</td>
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<td>Hx abuse</td>
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<td>Worker compensation</td>
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<td>Compensation focus</td>
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<td>Represented by attorney</td>
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<tr>
<td>Biological</td>
<td>Pain &amp; disability</td>
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<tr>
<td></td>
<td>Extreme pain</td>
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<td>Dysfunctional Pain Cognitions</td>
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<td>Pain sensitivity</td>
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<td>Pain invariance</td>
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<td></td>
<td>Diffuse pain</td>
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<td>Pain &gt;2 years</td>
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<td></td>
<td>Unexplained disability</td>
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<td>Degree to which patient does not meet</td>
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<td>medical criteria for procedure</td>
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<td></td>
<td>No medical necessity of procedure to</td>
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<td></td>
<td>preserve life or function</td>
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<tr>
<td></td>
<td>Destructive/high risk elective medical</td>
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<tr>
<td></td>
<td>procedure</td>
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<td></td>
<td>Procedure specific risks: Smoking, diet,</td>
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<td></td>
<td>attitude toward implant, etc.</td>
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<td></td>
<td>Similar procedure failed previously</td>
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<td></td>
<td>No response to any treatment</td>
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<td></td>
<td>History of no adherence to conservative care</td>
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<tr>
<td></td>
<td>No objective medical findings</td>
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<td></td>
<td>Insufficient evidence that the proposed</td>
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<td></td>
<td>medical treatment would be effective</td>
</tr>
</tbody>
</table>

Adapted from Bruns and Disorbio, 2009. Used with permission

In contrast, less extreme cautionary risk factor scores that were observed in only 16% of the national sample of patients in rehabilitation (one standard deviation above the mean) were developed. These risk scores demonstrated a test-retest reliability of 0.85–0.90, with no significant race or gender bias. Evidence of validity was based on the analyses of both community subjects and ten patient groups.
The community norms allowed for the comparison of a patient’s score to healthy persons in the community, which makes possible an assessment as to the degree to which a particular patient’s condition differs from that of the typical healthy person. In contrast, the patient norms allow the identification of unusual patients, who report a level of symptomatic complaints that differs from that of the typical patient (Bruns & Disorbio, 2009).

The Convergent Model was then applied to multiple patient groups, which were back surgery patients, upper extremity surgery patients, patients with head injuries, patients with acute injuries in physical therapy, patients in multidisciplinary treatment, and patients with chronic pain. Across these multiple groups, elevated levels of the exclusionary and cautionary risk factors were found to be consistently associated with subjective dissatisfaction with care and with an objective outcome measure: unemployment (Bruns & Disorbio, 2009).

Although it was initially defined primarily by the chronic back pain literature, supportive results from the other groups in this study suggest that this method may have broad applicability. This assumption has some intuitive appeal: Regardless of a patient’s medical condition, if the patient is reporting the presence of exclusionary risk factors (e.g., active suicidality, chronic intoxication, psychosis, or violent tendencies), it seems reasonable to assume that such traits could potentially compromise a patient’s ability to adhere to a broad range of medical treatments. Similarly, if the patient reports the presence of cautionary risk factors, such as depression or job dissatisfaction, it seems reasonable to assume that this could potentially impact the patient’s ability to return to work. Overall, this approach demonstrates how the careful application of psychometric methods can begin to contribute to the scientific assessment of psychosocial variables that contribute to disability (Bruns & Disorbio, 2009).

4.4.5 When to Administer Psychological Tests

Like a medical test, psychological tests should not be used indiscriminately, but should rather be used as indicated by specific clinical findings. Typical reasons that individuals are referred for psychological testing are:

- Suspected current psychological disorder
- Known history of psychological disorder
- Physical symptom complaints continue in the absence of supportive medical findings
- Extreme or impossible symptomatology is reported
- Lack of motivation in treatment is observed or suspected
- Low treatment adherence or motivation
- Medically unexplained levels of disability
- Psychosocial issues appear to be impeding progress in treatment
- Assessing primary, secondary, or tertiary gain issues
- Psychosocial concerns or conflicts at home, work, or in the medical setting
4.4.6 Test Selection

When psychological tests are used, the clinician (usually a psychologist) is responsible for the selection and use of appropriate test instruments that adequately and objectively assess the desired clinical concerns. As readers may not be familiar with commonly used psychometric tests, an appendix of commonly used tests is attached (Appendix 1). The goal of this appendix is to provide information that will promote the understanding of the psychometric assessment process. The tests listed here consist of psychometric tests commonly used to assess a variety of concerns that occur with disability, and which are also used to assess patients prior to certain medical procedures. A caveat that should be noted here is that while disability is widely regarded as being a biopsychosocial phenomenon, the interrelationships among biological, psychological, and social variables are very complex, and high quality research demonstrating the relationship between medical variables and specific psychometric test scores is lacking. Ultimately, the selection of appropriate psychological tests must be left to the examiner.

Standardized psychological tests are developed and normed for specific clinical populations and concerns, and the instruments listed in Appendix 1 are grouped with similar tests for comparison, and basic information about each test is provided. With regard to test selection, no single psychological test adequately measures all psychological or cognitive domains of functioning. Consequently, some have recommended the use of a minimum of two standardized tests to measure the targeted clinical concerns (American College of Occupational and Environmental Medicine, 2008b). If two psychometric measures developed in different ways produce the same findings, this provides a higher degree of confidence in the results. However, multiple psychological tests should not be given without consideration of the referral questions to be answered or psychological concerns that need to be ruled in or ruled out.

Lastly, in the evaluation of disability, distinguishing an enduring trait from a temporary state is an important determination, as it cannot be assumed that the findings of an evaluation held true in the past, or will continue to hold true in the future. Instead, the meaning of the test scores must be interpreted in the light of the referral questions, patient history, other test findings, the interview, and behavioral observations.

4.5 Conclusions

Disability is a complex biopsychosocial phenomenon, which is determined by objective medical tests, by patient behavior and by subjective psychological variables, such as pain, depression, and cognition. Of these, patient behavior and self-reports are strongly influenced by psychosocial variables. Consequently, when evaluating patients for disability, psychosocial aspects of the condition must be assessed. The assessment of these psychosocial aspects relies, to a considerable degree, on the self-reports of the patient and the patient’s willingness to perform on testing.
Consequently, it is important to establish the veracity of the patient’s subjective reports and the motivation to perform, especially when there are incentives for a patient to appear disabled. To this end, the inclusion of validity measures should be an integral part of the disability evaluation.

In the clinical setting, it has been said, “To have great pain is to have certainty. To hear that another has pain is to have doubt” (p. 7) (Scarry, 1985). This creates a dilemma for the disability evaluator, who is left with the responsibility of listening to a patient’s reports, and discerning the extent to which a disabling condition is present. To address this, perhaps the best advice is to follow the Russian maxim cited by President Reagan to General Secretary Gorbachev at the end of the Cold War: “Dovorey no provorey; Trust, but verify” (Reagan, 2009).

When properly performed, psychological testing can play a critical role in biopsychosocial assessment, by screening for psychiatric diagnoses and identifying psychosocial contributions to disability. This increases the chances of developing an effective multidisciplinary plan for addressing the totality of the patient’s concerns, removing roadblocks to recovery, and decreasing disability. In this way, psychological testing can make a significant contribution to the assessment and treatment of patients with disabling conditions.

Appendix: Psychometric Assessment Tools

The tests listed below are for informational purposes only, and this is not an exhaustive list. The final decision about which tests to use must be left to the evaluator. Within each section, tests are listed in alphabetical order.
<table>
<thead>
<tr>
<th>Assessment Task</th>
<th>Test</th>
<th>Notes(^a)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Assessments of Emotion</strong></td>
<td></td>
<td></td>
<td><em>These tests are useful when the assessment of a patient’s emotional status is desired.</em></td>
</tr>
<tr>
<td>BDI II</td>
<td>S J B G</td>
<td></td>
<td><strong>Beck Depression Inventory II:</strong> Well-researched measure of depression, widely used clinically and in research. A brief measure that assesses a broad range of cognitive, affective, and physical depressive symptoms. 21 items, 1 scale, no validity measures. 5 min, hand scoring, computerized scoring and report</td>
</tr>
<tr>
<td>BSI 18</td>
<td>S J B G N</td>
<td></td>
<td><strong>Brief Symptom Inventory 18:</strong> Brief measure of depression, anxiety, and somatization. Community and cancer patient norms. 18 items, 3 scales, no validity measures, computerized scoring and report, and hand scoring. 2–3 min</td>
</tr>
<tr>
<td>CES-D</td>
<td>J G</td>
<td></td>
<td><strong>Center for Epidemiological Studies Depression Scale:</strong> Brief measure of depression that has been widely used in research. Assesses depression without reliance on physical symptoms, reducing the risk of false positive findings. No norms. 20 items, 1 scale, no validity measures, 3 min, hand scoring</td>
</tr>
<tr>
<td>HDI</td>
<td>J G</td>
<td></td>
<td><strong>Hamilton Depression Inventory:</strong> Brief measure of depression, widely used in research. Assesses a broad range of cognitive, affective, and physical depressive symptoms. Uses community norms. 23 items, 1 scale, fifth grade reading level, no validity measures, 5 min. A variation of this is the Hamilton Rating Scale, which is a 17 or 21 item measure filled out by the professional</td>
</tr>
<tr>
<td>STAI</td>
<td>S J B G N</td>
<td></td>
<td><strong>State-Trait Anxiety Inventory:</strong> Well-researched measure of both anxious states and anxious tendencies. A brief measure that assesses a broad range of cognitive, affective, and physical anxiety symptoms. Community norms. 40 items, 2 scales, no validity measures, 8–10 min</td>
</tr>
<tr>
<td>Zung</td>
<td>J G</td>
<td></td>
<td><strong>Zung Depression Scale:</strong> Brief measure of depression that has been widely used in research. A brief measure that assesses a broad range of cognitive, affective, and physical depressive symptoms. Uses cutoff scores, not norms. 20 items, 1 scale, no validity measures, 5 min, hand scoring</td>
</tr>
</tbody>
</table>

(continued)
### Brief Assessment of Pain and Functioning

*These tests are useful when the assessment of a patient's ability to function is desired.*

<table>
<thead>
<tr>
<th>Assessment Task</th>
<th>Test</th>
<th>Notes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Pain Inventory Short Form</strong></td>
<td><strong>BPI-SF</strong></td>
<td><strong>S J G</strong></td>
<td><strong>Brief Pain Inventory Short Form</strong>: Assesses pain, pain variation, and pain distribution through drawing. Also assesses degree to which pain interferes with functioning. Used in pain research, no norms. 20 items, multiple measures, no validity measures, 4–6 min</td>
</tr>
<tr>
<td>Oswestry Low Back Pain Disability Questionnaire</td>
<td>Oswestry</td>
<td><strong>J G</strong></td>
<td>Oswestry Low Back Pain Disability Questionnaire: Commonly used measure of functioning in research studies is known to be sensitive to assess change. Original version has been shown to be an effective research outcome measure, multiple modified versions, and no norms. 20 Items, 1 scale, no validity measures, 4–5 min</td>
</tr>
<tr>
<td><strong>Pain Disability Questionnaire</strong></td>
<td><strong>PDQ</strong></td>
<td><strong>J G</strong></td>
<td><strong>Pain Disability Questionnaire</strong>: Brief tool that appears to be a sensitive measure of disability associated with pain. 15 items, 1 scale, no norms, no validity measures, 3–4 min</td>
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<tr>
<td>Roland and Morris Disability Questionnaire</td>
<td>Roland and</td>
<td><strong>J G</strong></td>
<td>Roland and Morris Disability Questionnaire: Commonly used measure of functioning in research studies is known to be able to assess change in functioning. Original version is a frequently used research outcome measure. 24 items, 1 scale, no norms, no validity measures, 4–5 min</td>
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<td></td>
<td><strong>Morris</strong></td>
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<td>Translated into Arabic, Chinese, Croatian, Czech, Danish, Dutch, English, Flemish, French, German, Greek, Hindi, Hungarian, Iranian, Italian, Japanese, Kannada, Korean, Marathi, Norwegian, Polish, Portuguese, Romanian, Russian, Spanish, Swedish, Tamil, Telugu, Thai, Tunisian, Turkish, and Urdu, 3–4 min</td>
</tr>
<tr>
<td>Short Form 36 Questionnaire Version 2</td>
<td><strong>SF 36 – V2</strong></td>
<td><strong>S J G N</strong></td>
<td><strong>Short Form 36 Questionnaire Version 2</strong>: Overall assessments of physical and mental health, Function scale is the strongest and it assesses subjective reports of impairment. Has scoring software. Original SF 36 is less well standardized. SF 36-V2 has an improved administration format, norms, and standardized scores. 36 items, 8 scales, no validity measures, 6–8 min</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Translated into English, Spanish, German, French, Chinese, Japanese, and for persons from the following countries: Armenia, Bangladesh, Brazil, Bulgaria, Cambodia, Croatia, Czech Republic, Finland, Greece, Hungary, Iceland, Israel, Korea, Latvia, Lithuania, Poland, Portugal, Romania, Russia, Singapore, Slovak Republic, Tanzania, Turkey, Wales (UK), and Vietnam</td>
</tr>
<tr>
<td><strong>McGill Pain Questionnaire Short Form</strong></td>
<td><strong>MPQ-SF</strong></td>
<td><strong>J B G</strong></td>
<td><strong>McGill Pain Questionnaire Short Form</strong>: Assesses sensory, affective, and evaluative dimensions through the use of verbal descriptors of pain experience as opposed to pure pain intensity, no norms. 15 items, 2 scales, no norms, no validity measures, 3–5 min</td>
</tr>
</tbody>
</table>
Translated into Amharic (Ethiopian), Arabic, Chinese, Czech, Danish, Dutch, English, Finnish, Flemish, French, German, Greek, Hungarian, Italian, Japanese, Norwegian, Polish, Portuguese, Slovak, Spanish, and Swedish.

<table>
<thead>
<tr>
<th>Test</th>
<th>Description</th>
<th>Length</th>
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<tbody>
<tr>
<td>NRS</td>
<td>Pain Numerical Rating Scale: Ubiquitous pain rating scale is recommended by JCAHO. Extremely easy to use, usually administered verbally. Unstandardized test, with unknown number of variations. No agreement on scaling (e.g., 0–10 vs. 1–100), location (e.g., rating whole body vs. one body part) or time (e.g., right now vs. typical). No norms.</td>
<td>&lt;1 min</td>
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<tr>
<td>VAS</td>
<td>Pain Visual Analog Scale: Sensitive measure of pain used extensively in research. Unstandardized test, with unknown number of variations. No agreement on graphic format of test (e.g., length of line; does the line have numbers on it), location (e.g., rating whole body vs. one body part) or time (e.g., right now vs. typical). No norms.</td>
<td>&lt;1 min</td>
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</tbody>
</table>

### Intermediate Length Assessments of Pain and Disability

<table>
<thead>
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<th>Test</th>
<th>Description</th>
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<tr>
<td>BBHI 2</td>
<td><strong>Brief Battery for Health Improvement 2</strong>: Assesses depression, anxiety, somatization, pain and function. Also has validity measures for minimizing, exaggerating, and random responding. Pain measures include pain intensity, distribution, and tolerability. Normed on both community sample and a rehabilitation sample. Computer scored. Has Spanish version. 63 items, 6 scales, 15 critical items, 1 validity measure, fifth grade reading level,</td>
<td>8–10 min</td>
</tr>
<tr>
<td>BPI</td>
<td><strong>Brief Pain Inventory-Long Form</strong>: Assesses pain, pain variation, and pain distribution through drawing. Also assesses degree to which pain interferes with functioning. Includes demographic and medication short answer questions.</td>
<td>15–25 min</td>
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<tr>
<td>BSI</td>
<td><strong>Brief Symptom Inventory</strong>: Brief assessment of a broad range of psychopathology, including somatization, depression, anxiety, hostility obsessive-compulsiveness, paranoid ideation, and psychoticism. 53 items, 12 scales, no validity measures, computerized scoring and report,</td>
<td>7–8 min</td>
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<tr>
<td>P3</td>
<td><strong>Pain Patient Profile</strong>: Measure of depression, anxiety and somatization with chronic pain patient and community norm groups. Validity measure checks for random or bizarre responding. Has Spanish version. 44 items, 3 scales, one validity measure, computerized scoring and report,</td>
<td>12–15 min</td>
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</tbody>
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(continued)
### Comprehensive Assessment of Psychopathology

<table>
<thead>
<tr>
<th>Assessment Task</th>
<th>Test</th>
<th>Notes</th>
<th>Description</th>
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<tbody>
<tr>
<td>These tests are useful for the comprehensive assessment of psychopathology and were designed primarily for psychiatric patients</td>
<td>MCMI III S J B G N</td>
<td>Million Clinical Multiaxial Inventory III: Scales keyed to the DSM IV. Also has scales for DSM IV diagnoses of affective and psychotic disorders, and for each form of personality disorder. Base rate scoring attempts to adjust test findings to approximate the actual base rates of psychological disorders in the psychiatric population. Has Spanish version. 175 items, 25 scales, three validity measures, critical items, computerized scoring and report, eighth grade reading level, 25–30 min</td>
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<tr>
<td>MMPI-2 S J B G N</td>
<td>Minnesota Multiphasic Personality Inventory-2: Most researched psychological test, with well-established strengths and weaknesses. Over 100 scales and indices to assess a wide range of psychological conditions. Extensive validity assessment is valuable to assess conscious or unconscious exaggeration of reports. Has Spanish version. 567 items, 100+ scales and indices, critical items, computerized scoring and report, hand scoring, sixth grade reading level, 70–90 min</td>
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<tr>
<td>MMPI-2-RF S J B G N</td>
<td>Minnesota Multiphasic Personality Inventory 2 – Revised Form: New version of MMPI 2 that has undergone radical revision to correct perceived MMPI 2 deficiencies. Extensive validity assessment is valuable to assess conscious or unconscious exaggeration of reports. May be stronger at psychiatric assessment, but some studies found it to be less capable when assessing somatoform disorders. (Butcher et al, 2006; Thomas &amp; Youngjohn, 2009) 338 items, 50 scales including 8 validity scales, critical items, fifth grade reading level 45–50 min</td>
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<tr>
<td>PAI S J B G N</td>
<td>Personality Assessment Inventory: A comprehensive personality test that is significantly shorter than the MMPI 2. Assesses a broad cross-section of affective, characterological, and psychotic conditions. Multiple validity measures. 340 items, 22 scales, including 4 validity scales, critical items, fourth grade reading level, 50–60 min</td>
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### Comprehensive Assessment of Medical Patients

**Battery for Health Improvement 2 (BHI 2)**
- *Description*: These psychological tests are designed specifically for the comprehensive assessment of medical patients. They assess a broad range of psychological symptoms, characterological risks, social conflicts, coping, and physical symptoms, such as pain and disability complaints. Pain measures include pain intensity, pain distribution, pain intolerance, and dysfunctional pain cognitions. Normed on both community samples and a rehabilitation sample, plus has eight other reference groups, including chronic pain, head injury, and fake bad. Has three validity measures for minimizing, exaggerating, and random responding. Spanish version. 217 items, 18 scales, including 3 validity measures, 30 content areas, 25 critical items, computerized scoring and report. Sixth grade reading level, 30–35 min.

### Assessment of malingering

**Computerized Assessment of Response Bias (CARB)**
- *Description*: Used to assess whether an individual is falsifying symptoms of memory impairment. No norms.

**Hare Psychopathy Checklist – Revised (Hare)**
- *Description*: The assessment can be used to help assess the degree to which an individual exhibits severe antisocial traits, in the form of a prototypical violent psychopath. May be useful if assessing patients who are making threats.

**Structured Inventory of Malingered Symptomatology (SIMS)**
- *Description*: Used for both malingered psychopathology and neuropsychological symptoms.

**Test of Memory Malingering (TOMM)**
- *Description*: Used to assess whether an individual is falsifying symptoms of memory impairment. No norms.

**Validity Indicator Profile (VIP)**

**Word Memory Test (WMT)**
- *Description*: Used to assess whether an individual is falsifying symptoms of verbal memory impairment. No norms.

(continued)
### Assessment Task Test Notes

<table>
<thead>
<tr>
<th>Assessment of Cognitive Ability</th>
<th>Test</th>
<th>Notes</th>
<th>Description</th>
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<tbody>
<tr>
<td>These tests are measures of intelligence, memory, and cognitive processing ability.</td>
<td>GAMA S J B G N</td>
<td>Global Assessment of Mental Ability: Culture-free measure of general intellectual ability. Based on the scores on four subtest scales: Matching, Analogies, Sequences, and Construction. Community norms. <strong>25 min timed test</strong></td>
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<td>RBANS S J B G N</td>
<td>Repeatable Battery for the Assessment of Neuropsychological Status: Measures neuropsychological status and cognitive decline in individuals who have experienced stroke, head injury, dementia, or neurological injury or disease. Community norms. <strong>Less than 30 min</strong></td>
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<td></td>
<td>WASI S J B G N</td>
<td>Wechsler Abbreviated Scale of Intelligence: An abbreviated measurement of adult intelligence in short and very short forms. <strong>15 min for 2 subtests IQ. 30 min for 4 subtest IQ</strong></td>
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<td></td>
<td>WAIS-IV S J B G N</td>
<td>Wechsler Adult Intelligence Scale – IV: Common measure of adult intelligence assesses cognitive strengths and weaknesses. WAIS-IV and WMS-IV are the only conormed ability-memory instruments. <strong>60-90 min</strong></td>
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<td></td>
<td>WMS-IV S J B G N</td>
<td>Wechsler Memory Scale – IV: Measures visual and auditory memory, immediate versus delayed memory, and free recall versus cued recall as well as recognition. Normed on older adolescents and adults. <strong>30–35 min</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>WRAT-4 S J B G N</td>
<td>Wide Range Achievement Test – 4: Achievement test assesses basic academic skills of reading, spelling, and math, with norms to age 94. The test has been validated against multiple other cognitive psychological tests. <strong>35–45 min</strong></td>
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*Notes: S Standardized test materials; N Norms; J Peer reviewed journal publications; B Reviewed by Buros Institute; G Noted in Treatment Guidelines*
References


5.1 Epidemiology and Prevalence of Psychological and Behavioral Health Concerns in Psychiatry

5.1.1 Psychiatry as a Medical Specialty

Psychiatrists are physicians (Doctors of Medicine or Doctors of Osteopathy) who specialize in the prevention, diagnosis, and treatment of mental, addictive, and emotional disorders, for example, psychoses, depression and other mood disorders, anxiety disorders, substance abuse disorders, developmental disabilities, sexual dysfunctions, and adjustment reactions (Reed, 2005). Psychiatrists have received specialized training in the biological, psychological, and social components of illness, and can order laboratory tests and prescribe medications, as well as evaluate and treat psychological and interpersonal problems. Psychiatrists also intervene with individuals and families who are coping with crises and other problems. Psychiatric training includes broad skills in psychiatric and medical diagnosis, formal psychotherapies, and psychopharmacology. Some psychiatrists have received further training in more specialized areas such as psychoanalysis, alcohol and substance abuse, geriatrics, neuropsychiatry, or forensic psychiatry.

In real practice, many individuals with treatable mental disorders do not necessarily receive specialty psychiatric or other mental health evaluation and care. A study of a large national sample (n=77,183) examined the healthcare visits made by individuals who self-reported significant symptoms of depression, and found that only 14.3% of their total healthcare visits were to specialty mental health professionals, such as psychiatrists, psychologists, or mental health social workers (Druss, Rosenheck, Sledge, 2000). Another study of general medical, high-utilizing patients in primary healthcare clinic (patients who made an average of 15 visits and 15 telephone calls to the clinic during the course of a year) found that at some point in their lives, 83.5% of those high utilizers had suffered from a psychiatric condition for which they had not received appropriate diagnosis or treatment. The most common disorders were Major

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Disability Research and Consulting, LLC, Atlanta, GA, USA
e-mail: drbettina@att.net
Depressive Disorder, Dysthymic Disorder, Generalized Anxiety Disorder, and Somatization Disorder (Katon et al., 1990). Some researchers have estimated that half of all visits to primary care doctors result from symptoms unexplained by a physical illness but often associated with a psychiatric condition, most frequently a mood or anxiety disorder (Kroenke & Mangelsdorff, 1989). Even after extensive medical evaluation, mental disorders are not often diagnosed or treated (Barsky et al., 1999).

5.1.2 Psychiatry and Behavioral Health Disability

Each year, millions of American workers develop health problems that may prevent them from re-entering the work force, temporarily or permanently. In most cases, employees are able to stay at work or return to work after a brief recovery period. However, approximately 10% of these workers incur significant work absences and/or life disruptions that can lead to prolonged or permanent withdrawal from the work force (ACOEM, 2006). During this non-working period, these individuals are described as “disabled,” and many become involved in one or more of the existing disability systems and laws, for example, sick leave, workers’ compensation, short-term disability, long-term disability, Social Security Disability Insurance, or the Americans with Disabilities Act (ADA). The estimated cost of disability benefits paid under all these systems exceeds $100 billion (ACOEM, 2006). As noted earlier in this book, mental health issues are involved in the largest portion of disability claims made.

The National Institute of Mental Health estimates that one in every 20 adults will be depressed in any given year, and the World Health Organization predicts that Major Depressive Disorder will be the second leading cause of disability by 2020 (NIMH, 2001). A study using the National Survey Replication estimated that approximately half of Americans will meet the criteria for a mental disorder at some point in their lives (Kessler et al., 2005).

The economic, social, and quality-of-life burdens of untreated or undertreated mental disorders are tremendous. Without appropriate intervention, mental disorders can be as debilitating as any chronic major illness (Lepine, 2002; Simon, 2003). Some rank Major Depressive Disorder as the third leading cause of loss measured in quality-adjusted life years (QALYs), after arthritis and heart disease and ahead of chronic lung disease, diabetes, stroke, and cancer. In particular, Major Depressive Disorder that co-occurs with a non-psychiatric medical illness is a significant “compounder” of debility (Lecrubier, 2001; Simon et al., 2000; Unutzer et al., 1997). Major Depressive Disorder can significantly increase the rehospitalization rate and mortality rate of cardiac patients (Allison et al., 1995). It is associated with poor glycemic control and increased risk of complications in diabetics (Egede, 2004; Lustman et al., 1997).

The economic costs of mental disorders go well beyond the direct cost of treatment for them, their compounding of direct healthcare costs for co-occurring medical conditions, and the costs of disability claims paid. Psychiatric disorders generate substantial indirect costs related to unemployment, absenteeism, and lack of
productivity at work. Major Depressive Disorder (MDD) is one of the top five issues associated with work loss and presenteeism (an ill employee working at less than full capacity) (Kessler et al., 2001; Rossi, 2001). American employers spend at least an estimated $33 billion yearly related to indirect costs of MDD alone (Greenberg et al., 1996).

For the psychiatrist, the extent and impact of mental disorders, co-occurring conditions, disability issues, and economic and other costs have significant implications. By providing effective and collaborative treatment, aimed at maintaining and restoring function, the psychiatrist is in a position to improve an individual’s overall health function by many measures, increase quality of life for mentally ill individuals and families, and impact the multidimensional costs of mental illness.

5.2 The Usual Treatment Process and the Role of the Psychiatrist

5.2.1 The Traditional Treatment Approach and the Paradigm Shift

Traditional medical thinking is that recovery from illness or injury requires work and withdrawal from work. Traditional psychiatric thinking has been consistent with this approach, particularly if the psychiatrist thinks his or her patient needs to “be away from” the demands of a stressor, such as his or her work situation, in order to recover from a mental illness. In recent years, this paradigm has begun to shift, as psychiatrists and other medical professionals recognize that people recover better and faster if they stay active and engaged in life as much as possible during episodes of illness, including period(s) of mental illness (Gerdtham & Johannesson, 2003; Harris et al., 2005; Krause et al., 2001). Disrupting a worker’s daily life with unnecessary prolonged work absence can cause unnecessary and significant harm to his or her well-being and detract from robust recovery. While on extended disability status, many individuals lose social relationships with coworkers, the self-respect associated with earning a living, and a major part of their identity – their occupation or vocation. Recent research confirms that workers receiving disability benefits recover less quickly and with poorer clinical outcomes than those with the same conditions who do not receive disability benefits, and that people who never lose time from work have better outcomes than people who lose some time from work (Bartley, 1994; Harris et al., 2005; Jin et al., 1995).

5.2.2 The Usual Treatment Process

As noted below (see Sect. 5.4.1), an individual may enter the psychiatric treatment process in a number of ways. If another provider, such as a primary care physician or non-physician mental health provider, has already seen the patient, he or she
may intend that the psychiatrist provide consultation or that the psychiatrist is to be the (new) primary source of mental health treatment. It is important that the psychiatrist have a clear understanding of his or her intended role. For example, if the psychiatrist is the primary mental health-care provider, will the psychiatrist be the only provider prescribing psychotropic medications? Will the primary care physician enforce this if the patient misses psychiatric appointments but contacts the primary care physician for medication refills? If the referral source is a psychotherapy provider, does he or she plan to continue the patient’s participation in psychotherapy with him or her?

The psychiatrist may spend 60–90 min on an initial clinical evaluation. The purposes of a general psychiatric evaluation (see Sect. 5.3.1) include establishing a psychiatric diagnosis and formulating a treatment plan, taking into account other professionals who may already be involved in the patient’s treatment. To reach these aims, several evaluative sessions may be needed.

Once the psychiatrist establishes a diagnosis, the treatment plan should include determining the treatment setting, establishing and maintaining a therapeutic alliance, monitoring the patient’s psychiatric status and safety, providing education to patients and families, enhancing treatment compliance (see Sect. 5.7.3), and working with patients to address early signs of relapse (American Psychiatric Association (APA), 2006). The APA has developed, updated, and published evidence-based guidelines specific to many mental disorders (APA, 2006). The presence of a co-occurring substance abuse disorder, personality disorder, or medical condition impacts the treatment planning for any mental disorder.

“Split treatment,” in which a psychiatrist’s primary role is medication management while another mental health provider serves as a psychotherapist, is frequent in mental health treatment. This offers the advantage of enhanced monitoring of issues such as malingering, compliance, etc.; gives each provider another set of “eyes and ears” for observations; and gives clear definition to the psychiatrist’s role. However, the prescription of psychotropic medications carries with it psychotherapeutic implications and vice versa, making it critical that in a “split” treatment context, psychiatrist and psychotherapist are in agreement on their approaches and goals. “Split” treatment has the potential disadvantages of mixed communication to the patient and inconsistent (and therefore ineffective) treatment, especially if the psychiatrist and psychotherapist do not see themselves as a team. If more than one clinician is involved in providing the care, it is essential that all treating clinicians have sufficient ongoing contact with the patient and with each other to ensure that relevant information is available to guide treatment decisions.

For many disorders, especially if the psychiatrist is prescribing psychotropic medications, he or she will see the patient more frequently during the initial phase of treatment. For example, many antidepressant medications take 4–8 weeks to achieve moderate to full response. During this time, the psychiatrist may see the patient every 2 weeks to monitor response and side effects. If the patient has not responded or cannot tolerate side effects, the psychiatrist will re-evaluate the treatment. Once a patient is responding to medication, the frequency of visits often decreases to once monthly or
less often, while the psychiatrist makes further adjustments and then transitions the patient to a maintenance treatment schedule of once every 2–3 months.

The usual treatment process does not necessarily take into account that inability to work is a psychiatric crisis, one that demands an immediate and focused response from mental health providers (see Sect. 5.4.3) (American Psychiatric Foundation, Partnership for Workplace Mental Health, 2005). As do other psychiatric crises, inability to work due to mental disorder requires immediate and intensive treatment to prevent or minimize loss of function and/or to restore function. Immediate and intensive crisis-oriented treatment, rather than treatment every few weeks or months as per the usual treatment process, is indicated until the crisis is resolved and work function is stable or restored. Specific treatment considerations are discussed in Sect. 5.9.

5.2.3 Avoiding Dual Roles

If an individual has filed a disability or workers’ compensation claim, a non-clinical third party, such as the Social Security Administration, insurer, or an attorney representing the individual (“claimant”), may ask a psychiatrist to evaluate the person independently (to perform an independent medical examination or “IME”) at some point during the adjudication of the claim. Any claims payer may also ask a psychiatrist to review available records for the purpose of determining the extent of functional capacity and/or impairment the records support, and/or answering other specific questions. When he or she is acting in any of these situations, the psychiatrist is applying his or her scientific and clinical expertise in a legal context and by definition is acting in a forensic role (AAPL, 2005).

Psychiatrists who take on a forensic role for the patients they are treating may adversely affect the therapeutic relationship with them. There are multiple reasons why a dual treatment and forensic relationship are not advisable. Psychiatry has delineated the conflicts inherent in the dual role to a greater extent than have other medical and surgical specialties (Morgan, 2006; Reid, 1993; Starsburger et al., 1997). The purpose and goals of the treating psychiatrist are fundamentally different from those of the psychiatrist in a forensic role.

The treating provider has fiduciary and ethical obligations to the patient, which demand that he or she place the patient’s interests before all else. In a treatment relationship, the patient has a right to rely on this attitude in the healthcare provider during (and after) the treatment relationship. The patient has the right to expect a single, private treatment role from his or her psychiatrist. This right is a cornerstone of the patient’s ability to engage in treatment fully, free of concerns about future divulging of confidences, betrayal, or exploitation. On the contrary, the forensic consultant’s responsibilities are to objectivity. Both the law and professional ethics demand that the forensic professional be objective in both commission and omission; he or she has no obligation to the claimant, litigant, or “evaluatee” (and does not refer to that person as his or her “patient”) (Starsburger et al., 1997).
A treating psychiatrist who endeavors to fulfill the conflicting duties to the primacy of the patient’s interest and the objectivity that the forensic role demands is attempting an extraordinarily difficult, if not impossible, task. Having spent many hours (perhaps dozens or hundreds) working with a patient, sometimes quite intimately, a psychiatrist, understandably, often feels a personal affinity for that patient’s viewpoint. There is thus a danger of intentional bias toward the patient. Separate from the psychiatrist’s conscious awareness of a duty or wish to act in the patient’s interest, he or she should be keenly aware of the obligation to “do no harm” to the patient. Even if a psychiatrist attempts to be objective in forensic reports or testimony, there is a danger of unintended bias toward the patient.

On a practical level, forensic evaluations often require examination of corroborative information and/or interview of corroborative sources, exposing information to third party or public scrutiny, or subjecting the evaluatee and the treatment process itself to cross-examination. The conflicts inherent in the differing clinical and forensic roles may also undermine the credibility of the forensic evaluation and the practitioner. For these reasons, treating psychiatrists should generally avoid performing forensic evaluations of their patients, or acting as expert witnesses for their patients (AAPL, 2005, italics mine).

5.2.4 The Treating Psychiatrist as “Advocate”

Serving as an advocate, especially for rights of the mentally ill and the destigmatization of mental illness, has long been a part of the traditional role for the psychiatrist in many settings. The treating psychiatrist may see his or her role in relation to the disability claimant as one of advocating on behalf of the claimant against a system or insurer who is “denying benefits” to which the claimant is “entitled,” “discriminating” against the claimant, etc. In fact, the psychiatrist’s duty is to his or her patients, for whose health and interests he or she must advocate. However, advocating for the claimant’s health and interests does not equate to advocating for benefit payments and need not involve an adversarial posture. It also does not mean advocating for whatever the claimant wants. Frequently, being a mental health advocate means promoting full participation in work and in other life activities, in the patient’s interests.

5.2.5 Defining “Disability”

When dealing with a psychiatric disability claimant, the treating psychiatrist’s understanding of his or her role can impact the course of treatment significantly. A narrow working understanding of “disability” may limit the treating psychiatrist’s ability to evaluate and treat the claimant in a way that maintains and/or restores his or her functional capacity.

In real terms, disability is complex and involves far more than the presence of symptoms and findings that the psychiatrist treats. Beyond the presence of an illness that the psychiatrist can diagnose and treat, disability is a complex psychoso-
cial process to which many factors contribute. These include but are not limited to an individual’s values and beliefs, the role of illness in the individual’s childhood and family experience, the meaning of mental illness to the individual, the individual’s relationship to his or her employer, occupational alternatives available to the individual, the individual’s financial situation, economic issues (such as the local economy and incentives associated with illness and disability), the motivation and ethics of the treating healthcare professional(s), the quality of mental health treatment and case management provided, workplace accommodations made by the employer, and the employer’s policies, practices, culture, and values. From the perspective of the disability systems and insurers, contractual or rule definitions of disability are also complex, and represent some attempts to capture the complexity of disability by including specific definitions of terms such as “total disability,” “continuous disability,” “own occupation,” “any occupation,” “gainful employment,” etc.

Because of the multifaceted nature of disability and also for practical reasons, it is not helpful or appropriate for either the treating psychiatrist to “determine disability.” The full complexities of disability and contractual and rules determination are beyond the skills and training of most psychiatrists. The primary role for the treating psychiatrist is to engage the claimant in treatment that facilitates functional recovery.

5.2.6 Challenges for the Treating Psychiatrist

Few physicians, receive substantive training in disability prevention and management. And most medical schools and residency specialty training programs have not integrated evaluation and restoration of function into their curricula. Yet the average psychiatrist who treats working age adults may be asked to complete multiple forms and letters to employers and payers on a monthly or even weekly basis, and is by definition a participant in the behavioral health disability process. The treating psychiatrist is often time pressed and wishes to focus on “treating the patient” rather than devoting time (for which he or she is not usually compensated) and energy to a process he or she does not fully understand. The following sections will clarify important aspects of the process for the treating psychiatrist and will provide some foundation and practical information to help the treating psychiatrist in his or her work in empowering maintenance and restoration of function for mentally ill patients.

5.3 Determining Current Psychiatric Functioning

5.3.1 The General Psychiatric Evaluation

While others may have evaluated an individual prior to him or her seeing a psychiatrist (see Sects. 5.4.1 and 5.4.2), it is vital that the psychiatrist, who has both general medical and specific mental health skills, performs a full psychiatric evaluation.
Domains of the psychiatric evaluation include reason for the evaluation; history of the present illness; past psychiatric history; history of alcohol and other substance use; general medical history; developmental, psychosocial, and sociocultural history; occupational and military history; legal history; family history; review of symptoms; physical examination; mental status examination; functional assessment; diagnostic tests; and observations derived/observed during the interview process (APA, 2006).

A general psychiatric evaluation has as its central component a face-to-face interview with the patient. Although medical technology has advanced tremendously and has increased the amount of laboratory and neuroimaging information available to assist psychiatrists in making more accurate diagnoses and developing more specific treatment plans for patients, these tests cannot supplant the importance of gathering critical data via the traditional psychiatric interview (Hales et al., 2008).

One of the primary aims of the psychiatric evaluation is to establish a psychiatric diagnosis. The current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, Fourth Edition, Text Revision) is a categorical classification that divides mental disorders into types based on defining features (APA, 2000), and many of the defining features are symptom based and time defined. For example, the criteria for a Major Depressive Episode include the presence of five or more specific symptoms during the same 2-week period, and the essential feature of Generalized Anxiety Disorder is excessive anxiety and worry (apprehension and expectation), occurring more days than not for a period of at least 6 months. Therefore, the psychiatrist may spend much of the interview time obtaining the history of present illness – a detailed history of specific symptoms and their severity and time course – from the patient. Information related to the other historical domains help the psychiatrist to place the patient’s symptoms in cultural, medical, and environmental context.

A review of systems helps the psychiatrist to identify whether the patient has symptoms that suggest an undiagnosed medical illness that may be causing or contributing to psychiatric symptoms, or whether the patient is experiencing side effects from medications or other treatments. Whether the psychiatrist or another medical professional performs the physical examination, the presence of abnormalities, especially in the patient’s general appearance, vital signs, skin, or neurological status, should prompt further investigation. It is important to detect non-psychiatric disorders that present with psychiatric symptoms. For example, thyroid disorders, anemias, other endocrine and metabolic abnormalities, neurological disorders, other illnesses, or medication side effects can cause symptoms that masquerade as a depressive, anxiety, or thought disorder.

The mental status examination (MSE) is a core skill of psychiatrists and qualified mental health professionals, and is a key part of the initial psychiatric assessment in any setting. MSE is a systemic collection of data based on the observation of the patient’s behavior during the interview and before and after the interview while the patient is in the psychiatrist’s view. Responses to specific questions are an important part of the MSE, particularly in the assessment of cognitive function (Trzepacz & Baker, 1993). Analogous to the physical examination for non-psychiatric conditions, the purpose of the MSE is to obtain evidence of current mental disorders that the patient may be experiencing. Furthermore, the MSE
provides evidence of the patient’s insight, judgment, and abstract reasoning, which informs decisions about treatment choice and setting. The core elements of the MSE are general appearance and behavior, characteristics of speech, mood and affect (including stability, range, congruence, and appropriateness of affect), thought processes (including the presence of recurrent or persistent themes, and whether the thought processes are coherent), thought content (including the presence of abnormalities such as delusions, ideas of reference, overvalued ideas, ruminations, obsessions, compulsions, and phobias), thought of harm directed to self or others, perceptual disturbances (the presence of hallucinations, illusions, derealization, or depersonalization), sensorium and level of cognitive function (orientation, attention, concentration, registration, short- and long-term memory, fund of knowledge, level of intelligence, drawing, abstract reasoning, and executive functioning), and level of judgment and insight.

It is vital that the psychiatrist distinguish between the patient’s symptoms (the patient’s self-report) and the psychiatrist’s findings and observation. For example, a claimant may self-report forgetfulness or difficulty paying attention or concentrating (symptoms), and/but may or may not complete specific MSE tasks of attention, concentration, or memory (such as serial arithmetic or object recall) well (findings). Beyond the MSE, additional observations derived from the interview process include whether the patient is exaggerating symptoms, whether he or she appears to provide accurate information, and whether particular questions evoke hesitation or signs of discomfort (Hales et al., 2008). Instruments such as the Beck Depression Inventory (BDI), the Beck Anxiety Inventory (BAI), Hamilton Depression Scale (HDS, HAM-D, HRSD, or HDRS), and the Hamilton Anxiety Scale (HAS, HAM-A, or HARS) are validated self-report inventories that may help the clinician assess the severity of depressive or anxiety symptoms, but are not findings and observations. Findings and observations (sometimes referred to as “objective data”)¹ are the foundation from which a psychiatrist can begin to build an occupational functional assessment. These include the results of properly interpreted psychological tests apart from those based on self-report, as discussed elsewhere in this book (the chapter 4 on psychological testing).

5.3.2 The Psychiatric General Functional Assessment

Although treating psychiatrists in general understand the psychiatric evaluation process and the mental status very well, very often they do not understand, or they have not been trained to understand, functional status. In practice, neither

¹Often in relation to mental health disability, entities distinguish between “subjective” data (what the patient or claimant reports) and “objective” data (clinician findings and observations, as well as laboratory and imaging data.) This can connote minimizing the “subjective” data as “less real” than objective data. Therefore this author and others prefer the distinction of “self reported” data (for which the patient or claimant is the source) and “findings and observations (for which the mental health professional is the source).
a general functional assessment nor an occupational functional assessment is a consistent domain of an initial psychiatric evaluation (American Psychiatric Foundation, Partnership for Workplace Mental Health, 2005). If a psychiatrist performs a functional evaluation, often it is limited to evaluating the degree to which the patient can perform the physical activities of daily living (such as eating, toileting, transferring, bathing, and dressing) or can perform the instrumental activities of daily living (such as driving; using public transportation; taking medications as prescribed; shopping, managing finances; keeping house; communicating by mail, phone, or email; and caring for dependents) (Hales et al., 2008). The multiaxial system of psychiatric diagnosis in DSM-IV-TR facilitates comprehensive and systematic evaluation with attention to the various mental disorders and general medical conditions, psychosocial and environmental problems, and level of functioning that might be overlooked if the focus were on a single presenting problem. The multiaxial system of DSM-IV-TR includes an axis of assessment for global assessment of functioning, Axis V, which is “for reporting the clinician’s judgment of the individual’s overall level of functioning.” The Global Assessment of Functioning (GAF) Scale may be particularly useful in tracking the progress of individuals in global terms. It is to be rated with respect to psychological, social, and occupational functioning only; the instructions specify, “Do not include impairment in function due to physical (or environmental) limitations.” The description of each 10-point range in the GAF scale has two components. The first part covers symptom severity (usually based on self-report) and the second part covers functioning (usually based on clinician judgment; may include self-report to varying degrees). In situations where the individual’s symptom severity and level of functioning are discordant, the final GAF always reflects the lower of the two (DSM-IV-TR). For example, the GAF rating for an individual who is a significant danger to self but is otherwise functioning well would be below 20, and the GAF rating for an individual with minimal symptomatology but whose excessive preoccupation with substance use has resulted in loss of job and friends would be 40 or lower. The GAF Scale is useful in planning treatment and measuring its impact (by change in GAF rating). However, it gives significant weight to symptom severity and other patient self-report, it is general and not specific to an individual’s occupation or job, and it emphasizes a global degree of function and impairment, rather than focusing on the specifics of what the claimant is able and not able to do.

The proposed Social and Occupational Functioning Assessment Scale (SOFAS) may be useful to assess social and occupational function and impairment independent of the severity of the psychological symptoms. The SOFAS is derived from the GAF Scale and is included in an Appendix in DSM-IV-TR. Similar to the GAF Scale, the SOFAS rates overall psychological functioning on a scale of 0–100. The instructions for SOFAS are “Consider social and occupational functioning on a continuum from excellent functioning to grossly impaired functioning. Include impairments in functioning due to physical limitations, as well as those due to mental impairments. To be counted, impairment must be a direct consequence of
mental and physical health problems; the effects of lack of opportunity and other environmental limitations are not to be considered” (DSM-IV-TR). In contrast to the GAF, the SOFAS is not (or should not be) directly influenced by the severity of symptoms. It also includes in its ratings any impairments due to non-psychiatric condition and remains a general assessment and scoring of function and impairment; therefore, it is not a focused occupational functional assessment.

5.3.3 The Psychiatric Occupational Functional Assessment

As noted previously, psychiatrists should consider it a crisis when an individual leaves work due to a mental health condition. A crisis situation requires that the psychiatrist must secure an assessment of the scope, range, and severity of the patient’s functional abilities and impairments as they pertain to the claimant’s occupation as the basis for treatment and return to work planning. The starting point for this assessment is the psychiatrist’s findings and observations, as opposed to the patient’s self-reported symptoms, as described above. An understanding inherent in the development of the SOFAS (described above) and established as one of the principles for the Partnership on Workplace Mental Health is that symptoms are not impairments. Furthermore, while accurate diagnosis is vital to appropriate treatment, the presence of a diagnosis is not itself an impairment (Christian et al., 2006).

Once the psychiatrist has identified and defined findings and observations, the psychiatrist should identify the individual’s specific functional capacity. Based on the findings and observations, what can the person do today? What functional abilities are intact and which are limited? Which findings and observations, support the capabilities and limitations? (For example, are there findings that indicate impairment in cognitive function? In affective stability? In basic functioning or social ability?) Has the patient’s psychiatric condition made him or her so ill that he or she cannot maintain any focus and concentration, or organize information, or communicate appropriately socially in appearance, speech, or actions? If not, what can he or she do in his or her current condition? Can he or she comprehend and follow instructions, organize complex information, make effective decisions, organize and sustain energy, maintain stable relationships, and solve routine problems? What can the individual not do now that he or she could do previously? Are there any medically based restrictions – activities in which the patient should not engage because specific harm might occur? (For example, the individual has voiced credible threats toward self or others, or based on findings and observations, the psychiatrist has concerns about the safety of the patient’s coworkers, the public, or the employing business.)

Next, the psychiatrist compares the demands of the patient’s usual job with the individual’s current functional capacities, limitations, and medically based restrictions with the demands of his or her usual job. To make this comparison, the psychiatrist must know the functional demands of the job, including what cognitive
and social skills the job requires. For example, how important to the patient’s work is his or her ability to comprehend and follow directions, perform simple and repetitive tasks, maintain a work place appropriate to a given workload supervise others, and interact with the public or with others internal or external to the business? Access to the person’s job description is critical for this analysis. The end result of the occupational functional analysis is a definition of job duties the psychiatrist thinks the patient can perform, those which he or she thinks the patient cannot perform, and the specific findings and observations (taking into account the observations of the patient’s function in job like tasks such as managing finances; interacting in person, by phone, or in writing; working on a computer; organizing a daily plan, etc.) that are the basis for finding whether the patient is able to function or is impaired in each area.

In 2005, the Partnership for Workplace Mental Health, alongside the APA, convened the Taskforce on Disability and Return to Work to evaluate current clinical and employer practices; identify barriers; and develop a methodology that would routinely include treatment to preserve function, enhance stability, and facilitate return to work for employed individuals. As part of this work, the Taskforce developed a set of assessment tools and recommendations that are currently being pilot tested with a large employer in the Pacific Northwest.

For the psychiatrist, the occupational functional assessment forms the basis of incorporating a return to work plan into the overall treatment plan for the patient. If the psychiatrist performs an appropriate occupational functional assessment based on findings and observations and corresponding impairments — and does not base the occupational functional assessment solely or primarily on self-report of symptoms or on diagnosis — there may well be a difference between what the patient says he or she can and cannot do, and what the psychiatrist believes that the patient can or cannot do. When this is the case, it is important that the psychiatrist consider the possibilities of medicalization (identifying every day or life issues as medical concerns) or symptom exaggeration or malingering, which can complicate the mental health disability process. Section 5.5 addresses these issues.

### 5.4 The Psychiatric Referral and the Occupational Referral

#### 5.4.1 The General Psychiatric Referral Process

An individual may enter the psychiatric treatment process in a variety of ways. Some individuals self-refer for evaluation and treatment. Other sources of referral include the primary care provider, a non-physician mental health provider (such as a psychologist or a social worker), or a clergy member. Entry into psychiatric evaluation and treatment related to a concern for mental health disability may also originate from the workplace.
5.4.2 The Occupational/Workplace Psychiatric Referral

Co-workers, managers, human resources personnel, and occupational health workers might notice signs of a potential mental health issue (Kahn, 2008). An employee may seem sad, withdrawn, angry, anxious, unmotivated, tired, or “out of it.” His or her personality may change, and he or she may seem much more exaggerated, restrained, passive, or angry. He or she may express pessimistic, obsessive, overly insistent, or unrealistically positive or negative thoughts. Performance may have deteriorated, with errors or erratic behavior. Work relationships may have become more distant or difficult. Observations such as these should prompt thoughtful consideration and supportive conversation (Kahn, 2008). Where there is any question, or further concern, referral to appropriate resources is in order.

Occupational nurses and physicians, employee assistance program mental health specialists, psychologists, and social workers usually perform initial workplace-driven mental health evaluations. They may also formulate a differential diagnosis and provide treatment for mental disorders (Kahn & Aidinoff, 1999). Urgent psychiatric referral is indicated when there is evidence of risk of suicide or self-harm; risk of violence to others; marked symptoms of anxiety, depression, or psychosis; cognitive disorganization or acute cognitive changes; substance abuse; child abuse (for which appropriate notification of legal authorities is also required); and life issues or emotional crises requiring rapid and integrated management. Psychiatric referral may also be important in other situations, including the presence of a significant co-occurring medical condition, longer term life issues, interpersonal or personality issues, inadequate response to non-psychiatric treatment, need for reconsideration of or better definition of the diagnosis, need to re-evaluate the treatment plan, the presence of heightened confidentiality issues, or the need for consultation on overall management (Kahn, 2008). The psychiatrist’s combined medical and mental health skills and experience improve the likelihood of accurate diagnosis and effective treatment, and the psychiatrist can have more impact when referral occurs earlier in the process (Langlieb & Kahn, 2005).

5.4.3 The Occupational Psychiatric Referral in Practice

In practice, an occupational referral (and other referrals) may not occur promptly and/or the psychiatrist may not receive all of the information he or she needs to initiate a general psychiatric evaluation or psychiatric functional assessment. The reason for the referral may be nonspecific, such as “psychiatric information” or “medication management.” The historical information with regard to the domains of the general psychiatric evaluation (below) may not be included, in which case the psychiatrist spends much of the initial evaluation reconstructing the patient’s history and then must spend additional or follow-up time on an occupational functional assessment. The referral may not include a job or occupational analysis
or description, which is critical to the performance of the occupational functional assessment, discussed in detail below. The Partnership for Workplace Mental Health has identified inability to work as a psychiatric crisis, one that demands an immediate and focused response from mental health providers (American Psychiatric Foundation, Partnership for Workplace Mental Health, 2005). In order to provide an appropriate response to an individual in this psychiatric crisis, the psychiatrist must be able to perform an occupational functional assessment readily, and a job description is critical to this effort (see Sect. 5.3.3).

5.5 Medicalization

5.5.1 The Process of Medicalization and Psychiatric Context

“Medicalization (literally “to make medical”) describes a process by which nonmedical problems become defined and treated as medical problems” (Conrad, 2007). There is an extensive body of analysis of medicalization; for nearly four decades, sociologists, anthropologists, bioethicists, physicians, and others have written about medicalization. Much writing about medicalization has been critical of the “overmedicalization,” of life processes such as menstruation, birth control, infertility, childbirth, menopause, aging, and death. But it is important to note that medicalization is a two-way process, in the sense that there can be both medicalization and demedicalization. For demedicalization to occur, the problem must no longer be described in medical terms, and medical treatments must no longer be deemed appropriate medical interventions (Conrad, 2007). In psychiatry, a classic example is homosexuality, which was officially demedicalized in the 1970s by APA. In a somewhat different vein, the disability movement has advocated, with partial success, for a demedicalization of disability and a reframing of it in terms of access and civil rights (Conrad, 2007).

During the past century, the trend has been to expand medicalization. Many social factors have encouraged this process, including the diminution of religion, and abiding faith in science, rationality, and progress (strengthened by medicine’s “great discoveries” of late nineteenth and early twentieth centuries, including the “cause and effect” understanding of disease and the discoveries of insulin and penicillin), the American penchant for individual and technological solutions to problems, and a general humanitarian trend in Western societies (Conrad, 2007).

In psychiatry, there is controversy as to whether medicalization has gone too far in defining what mental illness is. In the early post-World War II years, psychiatrists began to “remedicalize” psychiatry in an attempt to extricate it from the prevailing attitude among psychoanalysts, who looked on a medical (non-psychodynamic) identification of mental illness with disdain (Chodoff, 2002). Successive editions of the DSM are the result of (re)medicalization, in which an atheoretical, symptom-based, and unpsychodynamic approach to diagnosis (and treatment) has
become central to psychiatry. There is general acknowledgment that remedicalization has had a positive and invigorating effect on psychiatry and has led to more effective treatments. However, some believe that American psychiatrists “are running the risk of trying to medicalize not only psychiatry but the human condition itself…to apply a diagnostic label to various unpleasant or undesirable feelings or behaviors that are not readily distinguishable from the range of experiences that are often inescapable parts of being human” (Chodoff, 2002). The controversy has continued during the current process of development of DSM-V, with concern that the inclusion of new categories to capture the subthreshold versions of existing official disorders (such as minor depression or mild cognitive disorder) will result in a “wholesale … medicalization of normality that will trivialize mental disorder and lead to a deluge of unneeded medication treatments” (Frances, 2009). There is also concern that creating a new series of “so-called behavioral addictions to shopping, sex, videogames, the Internet, and so on” will lead to the consequences of “inappropriately medicalizing behavioral problems, reducing individual responsibility, and complicating disability, insurance, and forensic evaluations” (Frances, 2009). On the contrary, as the APA and DSM-V task force note, “Clinicians complain that the current DSM-IV system poorly reflects the clinical realities of their patients. Researchers are skeptical that the existing DSM categories represent a valid basis for scientific investigations, and accumulating evidence supports this skepticism. Science has advanced, treatment has advanced, and clinical practice has advanced since … work on DSM-IV. The DSM will become irrelevant if it does not change to reflect these advances” (Schatzberg et al., 2009).

5.5.2 Overmedicalization in the Mental Health Disability Process

In the psychiatric disability process, the tendency of patients and many psychiatrists is toward “overmedicalization” – specifically the medicalization of “stress” or of issues such as job dissatisfaction, conflict at the workplace, marital difficulties, and non-work-related family care or other demands. It is essential that the psychiatrist be acutely aware of and avoid this tendency. While these issues have importance for treatment approaches, the psychiatrist should not identify these as functional mental health impairments.

“Stress” is a highly variable self-reported experience and not an objective finding. Both the workplace and the medical community overuse and underdefine the concept of “stress.” “Stress” in and of itself is neither good nor bad. At its root, “stress” refers to the physiological reactions the human body makes in the face of a physical or mental challenge to the human body or mind, and therefore, can result from everyday life and workplace challenges. “Stress” is not a psychiatric condition or identified diagnosis.

With regard to the workplace, a “stressful” job means different things to different people. One individual may find the demands of a job overwhelming and feel that
he or she cannot handle them; this person is likely to use absence from work as a way of coping. Another person may build healthy resistance to the demands of the same job. The former is more likely to seek “going on disability” as a way of dealing with “stress.” It is very important that the psychiatrist not consider this as a mental health impairment. In my experience, I have seen psychiatrists complete “disability” forms identifying the claimant’s impairment as “unable to handle stress” and recommend a restriction or limitation of “no work involving stress.” In medicalizing stress, the psychiatrist is not acting in the patient’s best interests. As noted already (Sect. 5.2.4), the mentally ill patient is more likely to recover more fully more quickly if he or she is active and engaged in life (and work) as much as possible. Furthermore, unless we return individuals with mental illness such as depression and anxiety to the workplace, they will not build resistance to everyday stressors and learn to cope and offset the impact of stressors on the body and mind (Sleeth, 2009). The psychiatrist may conclude that the stressors inherent in the patient’s job are a poor fit for the patient’s cognitive, emotional, and behavioral makeup – in which case the primary issue is poor job fit. Poor job fit is neither a psychiatric condition, nor a psychiatric impairment. A mismatch between an individual’s skills or temperament does not mean that the person is unable to work at his or her or another job. Also the mismatch does not respond to medical treatment; it may warrant human resources and/or vocational and career counseling efforts.

Other issues, such as job dissatisfaction, conflict at the workplace, marital difficulties, and non-work-related family care or other demands, may detract from an individual’s enjoyment of work and/or his or her perception of what he or she is able to do. A dissatisfied worker is more likely than a fulfilled one to seek absence from work, including “going on disability.” An individual may feel, understandably, that he or she does not have the physical or emotional energy to work and to deal with marital or family conflict, or care taking or other responsibilities at home. In many of these situations, the issue is not psychiatric impairment, as the patient may be able to engage in many activities requiring abilities similar to those he or she needs at the workplace, including engaging in socially appropriate interaction with others; maintaining a schedule of activities; performing tasks needing intact cognition; completing written, verbal, and email communication; handling interruptions and unexpected demands; etc. The issue may well be that the other demands consume the time, energy, and emotional resources that a person usually dedicates to the work place; non-work activities in essence become the individual’s “job.” This issue, too, is not a psychiatric condition responsive to medical treatment; it may warrant human resources or similar efforts.

The assessment tools developed by the Taskforce on Disability and Return to Work, currently being pilot tested (Sect. 5.3.3), separate the duties the psychiatrist believes the patient cannot do from the duties the patient says he or she cannot do. If there is no specific impairment that the psychiatrist can define associated with the latter, the psychiatrist is asked to note whether the patient’s self-report represents distress, time needed for other problems, or job conflict, thus separating these issues from impairment – and demedicalizing them.
5.6   Symptom Exaggeration and Malingering

5.6.1   Malingering and the Disability Process

According to medical anthropologists, individuals take on the “sick role” after becoming ill or injured (Twaddle, 1979). The sick role exempts people from their normal obligations, such as work, school, or parenting, while it also elicits care and concern from others. The mental health disability system provides the financial incentive of paid benefits, while at the same time exempting the person in the sick role from work responsibilities. Given the multidimensional incentives involved, the psychiatrist should consider the possibility of malingering any time a patient claims psychiatric disability (Samuel & Mittenberg, 2005).

It is estimated that malingering occurs in 7.5–33% of disability claimants (Binder, 1993; Frederick et al., 1994; Rogers et al., 1993; Trueblood & Schmidt, 1993). The financial costs of malingering are high. In USA, “fraud that broadly includes malingering costs the insurance industry $150 billion annually, increasing the cost of insurance by $150 billion (Garriga, 2007). The DSM-IV-TR defines malingering as the intentional production of false or grossly physical or psychological symptoms, motivated by external incentives such as avoiding work or military duty, obtaining drugs or financial compensation, or evading criminal prosecution. The DSM-IV-TR further suggests that the mental health professional should suspect malingering strongly in the presence of any combination of the following: medical context of the presentation (for example, a disability evaluation or claim), a marked discrepancy between patient claims (self-report) and findings, lack of cooperation with evaluations or treatment, or presence of antisocial personality disorder. Antisocial personality disorder is not usually found in disability claimants, especially those with private disability policies – most likely because individuals need good employment capabilities and histories in order to obtain jobs in which they are eligible for such policies. However, the other three factors occur often (Samuel & Mittenberg, 2005).

5.6.2   Malingering and Psychiatric Disorders

Psychiatric disorders are notoriously easy for persons to malinger, as they are often defined by self-reported symptoms and histories. Additionally, malingering can co-exist with psychiatric disorders. Individuals can have one psychiatric disorder and malinger by faking or exaggerating symptoms of other disorders. Likewise, an individual can have a psychiatric condition and exaggerate or fake the symptoms of that condition, or the impact of the condition on his or her functioning. Any one of these constitutes malingering.

Studies have shown that the psychiatric interview is not an effective tool for detecting malingering. Psychiatrists detect approximately 50% of lies in interviews,
which is no better than the percentage that would be discovered by chance (Ekman, 1985; Rosen et al., 2004). While lying or simulation do not equate directly to malingering, the studies indicate that psychiatrists cannot distinguish between genuine, fake, or exaggerated reports on the basis of the patient’s demeanor. Techniques used to increase the accuracy of detecting malingering include using multiple sources of data, prolonged interviews, and psychological tests that assess effort or “faking” during test taking.

The primary mental disorder to consider in the differential diagnosis of malingering is Factitious Disorder, a Somatoform Disorder that DSM-IV-TR defines as the “intentional production of physical signs or symptoms” in order to assume the sick role. In Factitious Disorder, there is an intrapsychic need rather than an external incentive. According to the DSM-IV-TR definitions, the presence of external incentives negates the diagnosis of Factitious Disorder and suggests malingering. Clinical research has identified other factors suggesting the presence of malingering in the mental health disability claims process, including financial incentive, disability payment as the solution to a socioeconomic problem or “financial crunch,” unethical or illegal behavior, career dissatisfaction, work conflict, end of career, participation in treatment for “documentation purposes,” a change in claim diagnosis to better fit benefit policy requirements, unusual or atypical symptoms, and a claim of future decompensation in the presence of current lack of symptoms (Samuel & Mittenberg, 2005). Factors that argue against malingering include participation in aggressive treatment, significant findings consistent with self-reported symptoms, and self-defeating or truly dangerous behavior (Samuel & Mittenberg, 2005).

The psychiatrist may consider some other Somatoform Disorders, defined in DSM-IV-TR, in the differential diagnosis. The essential feature of Somatoform Disorder is a pattern of recurring, multiple, somatic complaints without corresponding medical findings. Conversion Disorder involves unexplained symptoms or deficits affecting voluntary motor or sensory function, which suggests a neurological or other general medical condition. Pain Disorder is characterized by pain as the predominant focus of clinical symptoms. Psychological factors are judged to have an important role in the onset, severity, exacerbation, and maintenance of both Conversion and Pain Disorders. In both the latter disorders, the symptoms are not intentionally produced (as in Factitious Disorder) or intentionally exaggerated or feigned (as in malingering).

5.6.3 Psychiatric Response to Suspected Malingering

The psychiatrist may attribute suspected malingering to poor motivation or poor effort, and/or medicalize it as part of the claimant’s illness. This can occur for a variety of reasons, including fear of litigation, concern about error, and the pejorative nature of the term “malingering.” However, misattribution of malingering is not in the patient’s best interest. Malingering is not an illness or clinical
disorder; therefore, evidence-based guidelines for its treatment have not been established. A malingering patient is less likely to experience iatrogenic symptoms and illness (e.g., side effects from medications), and more likely to engage in appropriate treatment for any accurately diagnosed conditions present if the psychiatrist presents to the patient the possibility of malingering in an empathetic, non-judgmental, non-accusatory manner (Purcell, 2002). It is appropriate for the psychiatrist to include this possibility in a targeted discussion with the patient, which focuses on the psychiatrist’s findings, observations of discrepancy between the claimant’s self-report and the psychiatrist’s findings, and the psychiatrist’s emphasis on the importance of identifying and removing any and all barriers to the claimant’s improved function. Many psychiatrists may suspect malingering but may lack the skills to evaluate malingering accurately. In those cases, it is appropriate for the psychiatrist to refer the patient for psychological testing and/or specialized psychological or psychiatric evaluation to address the concern, with honest discussion of the referral with the patient.

5.7 Patient Compliance Issues

5.7.1 Compliance and the Psychiatric Patient

The concept of “compliance” or “adherence” is highly important in all fields of medicine (Horwitz & Horwitz, 1993; Lerner et al., 1998). Psychiatrists deal with complex compliance situations, which may involve non-compliance with specific therapy approaches (either in therapy with the psychiatrist or in split treatment), failure to keep appointments, and varying degrees of compliance with psychiatric medications. There is no universal definition of compliance, and even the language itself is somewhat controversial (Weiden & Rao, 2005). While most clinicians are comfortable with the term “noncompliance,” some consider it to highlight a power imbalance between doctor and patient and to emphasize obedience in a way that is pejorative to patients. “Adherence” is used widely as a synonym for compliance. The proponents of “adherence” and “nonadherence” assert that these terms are free from the connotations of power imbalance and coercion that may freight “compliance” and “noncompliance.” In view of the wider familiarity with “compliance” (Weiden & Rao, 2005), I use the terminology of “compliance” here. For the psychiatrist, noncompliance with psychiatric medications is one of the most common causes in “non response to treatment and is often not recognized by the psychiatrist (Johnson, 1979), so this is the focus of this section. It is worth noting that according to some research, noncompliance may be the single greatest modifiable risk factor for unfavorable outcomes in psychopharmacology. For example, medication noncompliance is associated with significantly higher rehospitalization rates for Depressive Disorders, Bipolar Disorders, and Schizophrenia (Pampallona et al., 2002; Sajatovic et al., 2004; Weiden & Olfson, 1995).
The most common definition of noncompliance is a deviation from or cessation of a treatment recommended by the provider (Haynes et al., 1979; Weiden & Rao, 2005). Noncompliance with treatment is not a mental disorder (DSM-IV-TR). However, it is a barrier to achieving desired treatment outcomes and as such warrants clinical attention when it occurs. “Noncompliance” assumes that the psychiatrist is prescribing the medication accurately and appropriately. In proposing a residency training curriculum for compliance, Reizen and Rao emphasize that when dealing with a “non-compliant” patient, the first question the psychiatrist should ask himself or herself is, “Is my treatment effective in the first place?” (Weiden & Rao, 2005). Misattributing the lack of adequate or expected response to a medication to noncompliance may prevent the psychiatrist from trying and finding – more effective treatment for the patient. A good second question is, “Is the patient experiencing a relapse?” In some psychiatric conditions, such as mood and thought disorders, a patient’s insight and participation in treatment can deteriorate abruptly. A previously stable patient can become noncompliant, even if noncompliance is not the cause of the relapse.

5.7.2 Identifying Noncompliance

It has been estimated that the noncompliance rate for medication treatments of psychiatric disorders is well over 50% (Reizen & Rao, 2005). Furthermore, clinicians underestimate the extent of noncompliance in patients they are treating (Norell, 1981). Since the psychiatrist can expect noncompliance, it is appropriate for him or her to ask the patient about medication compliance in a routine and nonjudgmental manner. If the psychiatrist in non-threatening and curious, asking for example, “Can you tell me about stopping your medication?” he or she makes it easier for the patient to respond truthfully. The psychiatrist should heighten his or her concern about possible noncompliance if there is an increase or decrease in reported side effects without any change in the psychotropic medication(s) or dose(s).

Beyond the clinical interview, other assessment methods can help the psychiatrist to determine whether the patient has been noncompliant. The psychiatrist may ask the patient to bring all medications, in their containers, to the appointment to facilitate a detailed review of the patient’s medication practices. The psychiatrist may pursue other sources of information. These include interviewing those close to the patient (with the patient’s consent), requesting pharmacy records, and/or considering blood levels when applicable. The psychiatrist should be aware of situations associated with noncompliance, which include changes in treatment environment (particularly when a patient is transitioning to a less structured setting), change in mental health provider(s), loss of a significant family or other personal relationship, and beginning or ending an important relationship (Reizen & Rao, 2005; Blackwell, 1976; Perkins, 2002; Fenton et al., 1997). Most of us who have been prescribed medications to take three or four times daily know how easy it is to forget one or more doses. It is critical that the psychiatrist distinguish between a
patient’s “inadvertent noncompliance” and a patient’s intentional decision to “adjust” a dose or frequency of medication or to stop taking it altogether.

5.7.3 Treatment Approaches to Improve Compliance and Prevent/Reduce Noncompliance

There are a variety of theoretical perspectives that underlie approaches to improve compliance as an outcome (Barofsky, 1978; Eisenthal et al., 1979; Fishbein & Ajzen, 1975; Goldfinger et al., 1984; Hall & Dorman, 1988; Moran et al., 1984; Palardy et al., 1998; Soumerai et al., 1994). On a practical level, the two major areas of intervention likely to prevent or reduce noncompliance are maintaining the therapeutic alliance when addressing noncompliance and tailoring the medication treatment to the needs of the patient (Weiden & Rao, 2005).

In maintaining the therapeutic alliance, the psychiatrist should be aware that the patient’s personal beliefs have a major influence on his or her compliance behavior. It is vital that the psychiatrist seek to understand the patient’s point of view – what does the patient believe about the prescribed medication? Rather than “correcting” these, it is much more helpful for the psychiatrist to make an active effort to ensure that he or she understands the patient’s beliefs and biases, and to discuss them in a non-blaming way. It is important that the psychiatrist considers noncompliance as a treatment failure and not a patient failure, and engages with the patient as a partner in achieving a good outcome.

When discussing the specifics of medication treatment with a patient, a psychiatrist is more likely to improve compliance if he or she offers information in the context of reducing the patient’s distress (however the patient understands or experiences distress) rather than emphasizing decreasing target symptoms. The psychiatrist should consider the cognitive, social, time, and economic impact of the medication regimen as well as its impact on the patient’s care/social network. The more “user friendly” and less complex the medication routine is, the more likely the patient is to follow it. In selecting a medication, the psychiatrist should make every attempt to minimize the side effects that would be of the greatest distress to the patient (for example, drowsiness, “jitters,” and weight gain) and should discuss this thoroughly with the patient – who may well be more concerned about side effects than about clinical efficacy.

5.8 Appropriate Documentation of Impairments and Limitations in Functioning

The psychiatric functional assessment, including identifying impairments and limitation in functioning, particularly occupational functioning, is discussed at length above (see Sect. 5.3.3). It is essential that the psychiatrist document the findings
and observations, abilities and impairments that the findings and observation support, and occupational limitations based on the impairments – in one place for each visit. This allows the psychiatrist to track a patient’s functional status regularly, and facilitates both patient’s and psychiatrist’s focus on the goal of restoring function. Additionally, maintaining focused documentation enables the psychiatrist to communicate clearly with others involved in the patient’s treatment.

Beyond being a helpful clinical tool, concise, focused functional documentation from the treating psychiatrist is immensely valuable to a psychiatrist involved in a forensic role in the patient’s disability claim (see Sect. 5.2.3). As already noted, the psychiatrist in the forensic role has a duty to objectivity and, therefore, will appropriately give more weight to an analysis of impairments and limitations based on findings and observation than he or she will to self-report information or opinions based on self-report. For example, a psychiatrist completing a focused file review to determine whether the available records support occupational impairment will be highly focused on findings and observations, and whether they are consistent with the impairments and restrictions/limitations proposed by the treating physician. It is in the patient’s best interest for the treating psychiatrist to document this clearly and accurately. If the information is neither clear nor sufficient, it is likely that the review psychiatrist cannot determine what, if anything, the information supports in terms of functional and occupational capacity and impairment.

5.9  Treatment Outcomes: Strategies for Addressing Return to Work

The preceding sections have underscored the importance of the psychiatric functional assessment (see Sect. 5.3.3), coordination of treatment (see Sect. 5.2.2), avoiding medicalization (see Sect. 5.5.2), identifying and responding to malingering (see Sects. 5.6.2 and 5.6.3), and enhancing compliance (see Sect. 5.7.3). This chapter also emphasizes that true inability to work due to a psychiatric illness is a crisis warranting immediate and intensive intervention (see Sects. 5.2.2 and 5.4.3). While a psychiatrist may take all these to account and determine that the treatment of a patient follows evidence-based guidelines and is effective for that patient (see Sect. 5.7.1), it is not likely that the patient’s return to work will occur solely as a result of these efforts. Treatment should include an explicit and clearly communicated goal of return to work. Because inability to work is a crisis, return to work function should be a top priority goal.

It is very important for the psychiatrist to understand that illness and impairment can co-exist with adequate occupational function (American Psychiatric Foundation, Partnership for Workplace Mental Health, 2005). That is, a patient does not need to be 100% free of psychiatric symptoms, findings, or impairments in order to work. As many disability case managers have found that “People may feel they need to be 100% in order to return to work. But in reality, they can’t really be 100% until they are back to work 100%” (Parker, 2009).
My colleagues and I have found several strategies helpful in achieving a return to work goal. When appropriate, we communicate to patients our belief that return to work is in the patient’s best interests and clarify that it is our duty to advocate for those best interests. We engage patients in activities focused on the return to work goal, such as work hardening, communicating with the employer and human resources, etc. Work hardening, as defined by the American Physical Therapy Association, is a highly structured, goal-oriented, individualized intervention program designed to return the patient/client to work. Work hardening uses real or simulated work activities designed to restore physical, behavioral, and vocational functions (American Physical Therapy Association, 2009) (see Chapter 7). The psychiatrist can incorporate work hardening principles into mental health treatment by having a patient read successfully more challenging and technical material, complete email on a regular basis, or perform other tasks using the same abilities as those needed for his or her job. In discussing return to work, it is essential that the psychiatrist and the patient remain solution focused rather than barrier focused. For example, if a patient says that he or she cannot return to work until he or she feels 100% better, the psychiatrist can ask, “Did you ever work at less than 100%? What helped you then?” If a patient does not feel that he or she can return to the same boss or the same workload, the psychiatrist can engage the patient in a conversation on what the patient can do differently in terms of managing interactions, prioritizing the load, communicating his or her needs appropriately, etc. As a regular practice, we devote some of the face-to-face time to completing any forms required, to engage the patient in this process and as a practical time management approach.

While the psychiatrist can have significant impact on a patient-by-patient basis, and can play a role in improving the mental health disability process, he or she is one part of a much larger system that includes employers, insurers, and many others, all of whom can help to build a better system and processes. It may help the psychiatrist to know that he or she is not alone in improvement efforts. Toward this end, the American College of Occupational and Environmental Medicine adopted a guideline in 2006, based on the work of the College’s Stay-at-Work and Return-to Work Process Improvement Committee (ACOEM, 2006). The Committee examined current stay-at-work and return-to-work processes, made recommendations to improve the processes, and examined current best practices and initiatives. Recommendations for insurers and employers included the following: revamp disability benefits systems to reflect the reality that restoring function is an urgent matter, given the short window of opportunity to normalize life; whenever possible, incorporate mechanisms into the stay-at-work and return-to-work process that prevent or minimize withdrawal from work; provide or pay for employee assistance and condition management services; inquire routinely into workplace social realities; develop and disseminate screening issues that flag workplace and social issues for investigation; perform prompt psychiatric assessments of workers with slower than normal recoveries; make payment for psychiatric treatment depending on evidence-based treatments with demonstrated effectiveness; educate healthcare providers about the financial aspects that can distort the disability process; compensate physicians for their time and effort in managing the stay-at-work and
return-to-work processes; encourage programs that allow employees to take time off work without requiring a medical excuse; encourage employers, insurers, and benefits administrators to use communication methods that respect physicians’ time; and standardize key information and processes.

Specific to psychiatry, in 2005, the Partnership for Workplace Mental Health convened a series of conferences with practicing psychiatrists, psychologists, employers, health plan representatives, members of the Social Security Administration, researchers, and other experts in the area of work disability/mental disorders to discuss the problem psychiatric occupational disability (American Psychiatric Foundation, Partnership for Workplace Mental Health, 2005). The Task Force made recommendations for clinicians and employers. Recommendations for employers included the following: establish policies and procedures to ensure that employees secure an accurate diagnosis and appropriate treatment plan, with an emphasis on a solid and objective assessment of the scope, range, and severity of functional impairment; require that their health/behavioral health/disability plan vendors use standardized functional assessment clinical tools (currently under pilot study; see Sect. 5.3.3); design their benefit plans in conjunction with their medical and disability providers to ensure that psychiatric conditions and disabilities, and physical disabilities with underlying psychiatric conditions, are treated by the appropriate mental health professional; intervene early in an employee’s disability absence; and use a team-based approach to work (including the employee, treating provider(s), employer, EAP, and disability plan representatives).

Currently, active discussions are taking place at the grass roots level. For example, The 60 Summits Project brings together physicians and other providers, employers, insurers, and others across traditional boundaries – to build a team approach to and to agree on specific new ways to collaborate – because they now see that the goal is to minimize the disruptive impact of illness and injury on life and work for employed people as well as their employers. Summit participants hope to increase the well-being, diversity, availability, and productivity of North America’s workforce by reducing avoidable lost workdays, presenteeism, benefit costs, job loss, and withdrawal from the workforce (60 Summits, 2009).

Acknowledgments Each of us has the privilege of leaning on the shoulders of others. In formulating this chapter, I have drawn deeply from the well of extensive research by many scholars and practitioners, to whom I am in great debt. Special thanks to Jennifer Christian, M.D., President and CMO of Webility Corporation, and Founder of 60 Summits Project and Jeffrey P. Kahn, M.D., CEO, WorkPsych Associates, Inc. for providing a wealth of foundational research; and to Jeffrey Segal, M.D., J.D., F.A.C.S., CEO of Medical Justice, for invaluable assistance in defining and articulating the forensic psychiatric role.

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Chapter 6
The Occupational Medicine Perspective on Behavioral Health Concerns

James B. Talmage

6.1 Epidemiological and Prevalence of Psychosocial and Behavioral Health Concerns

In occupational medicine, the main problem with psychological and psychosocial issues is the treatment of workers with injuries or illness attributed to work and thus treated in the workers’ compensation system.

Workers’ compensation is a state or province program, and each state or province has its own laws and rules, although these are somewhat similar. Even when workers present with seemingly clear cut medical issues, psychological and psychosocial factors still have a large impact.

Harris et al., (2005) reported a meta-analysis comparing the results of surgical treatment for conditions treated in a compensation setting (usually workers’ compensation) to the results of treating the same condition in a noncompensation setting (health insurance). Two hundred and eleven studies met the inclusion criteria, and 175 found worse treatment results (outcomes) in the compensation patients compared to the noncompensation patients. Thirty-five studies found no difference. For surgeries commonly performed in the workers’ compensation system like shoulder acromioplasty, lumbar spine fusion, lumbar discectomy, and carpal tunnel release the odds of a poor or unsatisfactory result were four times greater in the compensation patients.

Similar findings have been reported in more recent studies on other diagnoses, like anterior cruciate ligament reconstruction in the knee (Barrett, Rook, Nash, & Coggin, 2000; Mobbs, Gollapudi, & Chandran, 2001). These studies do not show that the patients receiving workers’ compensation had more severe injuries or illness prior to surgery, and they did not find worse objectively measured outcomes in range of motion, neurologic deficit, etc. These studies did not document mental disorders or psychosocial stressors, but logically, the reason for the poor outcomes in these studies of workers’ compensation patients is that the outcomes were assessed by questionnaires.

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on which the patients self-report symptoms and function. While these questionnaires (Oswestry Disability Index, DASH, Knee Society rating scale, SF-36, etc.) have been validated in populations not seeking compensation, their use in compensation patient populations has not been scientifically validated. Thus, something (psychosocial issues) other than biomedical issues causes the treatment results to be worse, as assessed by patient self-report, in workers’ compensation patients.

Many workers’ compensation patients do not have significant psychosocial confounding issues, and these patients recover like the noncompensation patients. There is no postulated biological reason for delayed or poor recovery in these compensation patients; therefore, logically, those patients with psychosocial confounders are those who have delayed recovery and poor outcomes.

Compensation status also affects the outcomes of vocational rehabilitation efforts (Drew et al., 2001).

This conclusion is supported by studies on the prevalence of psychosocial issues in compensation patients. Dersh found that 64% of 1,595 patients in a tertiary rehabilitation program had major (Axis I) disorders (other than pain disorder associated with psychological factors), compared with 15% of the general population (Dersh, Gatchel, Polatin, & Mayer, 2002). In addition, 70% had a recognizable Axis II personality disorder, compared with a literature estimate for the general population of 6–14%. Psychological and personality factors are an important issue in those with upper limb work-related disorders. Ring and colleagues found that compared to patients with specific diagnoses, those with idiopathic arm pain had a much higher prevalence of psychological issues, and that upper extremity ill-health correlated with depression (Ring, Kadzielski, Malhotra, Lee, & Jupiter, 2005; Ring et al., 2006).

In summary, psychosocial confounders are common in occupational medicine in workers’ compensation patients, and these issues seem to explain the poorer outcomes noted in treating these patients. This has recently been reviewed with a conclusion that comprehensive biopsychosocial treatment is more effective than isolated traditional biomedical treatment (Vranceanu, Barsky, & Ring, 2009).

6.2 Discussion of Usual Care Treatment Process: Strengths and Weakness Within Occupational Medicine

Many physicians manage musculoskeletal disorders within the biomedical model, as this was how they were trained. Most orthopedic and neurosurgeons, who provide the majority of specialist care for workers’ compensation injuries, did not have a psychiatric rotation during residency training, and psychologists and psychiatrists are not part of the traditional teaching faculty in these residency programs. Most orthopedic and neurosurgeons have strong obsessive compulsive personality traits, which makes them perfectionists who are very detail oriented (critical for surgeons), good with differential diagnosis, and hardworking/goal oriented. However, this personality style is uncomfortable with emotions – their own, their significant others, and their patients’ emotions (Oldham & Morris, 1990). Thus, the same personality traits that
make many orthopedic and neurosurgeons good surgeons give them “blinders” to the psychological makeup of their workers’ compensation patients. While this “unemotional” personality hinders their perception of psychosocial issues, it allows them to remain calm while treating critical medical illness and in surgery.

Occupational Medicine physicians vary. Some have been residency trained in occupational medicine, and some of these may have had exposure to psychologists and psychiatrists during residency training. The majority of private practice occupational medicine physicians were residency trained in some other field, and evolved into an occupational medicine practice over time after their formal medical education was complete. Most occupational medicine physicians, however, have done multiple “fitness for duty” exams for employers in which the issues were psychiatric or psychosocial, so as a group they may be more perceptive in recognizing and more comfortable dealing with the psychosocial issues of workers’ compensation patients.

In addition, occupational medicine physicians may allot more time per patient visit compared to surgeons, since their hourly practice overhead is less. There is evidence that spending additional time with back pain patients can significantly improve outcomes (Indahl, Velund, & Reikeraas, 1995).

6.3 Determining Current Psychiatric Functioning: Strengths and Weakness Within Occupational Medicine

One barrier to the recognition of psychosocial issues within the workers’ compensation system is the workers’ compensation system itself. Most states have “fee schedules” that determine how much physicians are paid for seeing patients in the office. For a practice to be economically viable, physicians must budget appointment time commensurate to what they are paid for the visit and the expenses to the practice of providing the care. Exploring psychosocial issues takes time to build the necessary rapport, and this exploration of psychosocial issues is in addition to the time required for the purely biomedical aspects of injury or illness treatment. The expense to the practice to treat a workers’ compensation patient is considerably higher than the expense incurred by the practice to treat any other type patient (Brinker, O’Connor, Woods, Pierce, & Peck, 2002). This is because of extra paperwork detailing causation and work status, obtaining treatment authorization, resolving collection disputes, rebilling, etc. Thus, workers’ compensation patients really need more physician time to permit the biopsychosocial issues to be addressed, and yet these are the very patients for whom the physician has the greatest economic incentive to limit the time spent in the exam room. There is evidence that insurers paying physicians more to provide quality care improves outcomes (Atcheson et al., 2001).

A second issue in the workers’ compensation system is that workers’ compensation insurance companies many times have a strong bias against having any psychiatric diagnosis recognized. In the workers’ compensation system, diagnoses that are recognized as work related are eligible for free medical treatment (possibly lifetime medical treatment), and in many systems they are also eligible for lump sum or
monthly payment financial awards for diagnoses that are permanent impairments. Thus, workers’ compensation insurers may have a financial interest in directing cases to doctors who do not recognize psychological issues. In addition, in some states workers’ compensation systems do not recognize “mental-mental” claims (psychological disorders with psychosocial stressors, but no physical workplace injury). This may predispose both the patient and the physician to “medicalize” stressors, by labeling them as if they were physical disorders.

A third issue is that patients in a compensation setting have been shown to fail to accurately reveal their past history of psychiatric/psychological illness. Don and Carragee (2009) found that 68% of motor vehicle accident victims seeking care for neck or back pain denied having any preexisting history of spine pain, drug or alcohol abuse, and psychological diagnoses, but these problems had been documented in their prior medical records. In those seeking compensation for the motor vehicle accident, the rate of false reporting of preexisting problems was 80%.

Lees-Haley, Williams, and English (1996) found that workers’ compensation claimants describe their preinjury function on questionnaires as significant superior to average individual’s function, again suggesting that being in the compensation system changes patients in a way that makes it harder for physicians to obtain the needed information about psychosocial issues to be able to deal with these issues. (Lees-Haley et al., 1996 and 1997). The reluctance of patients to admit to preexisting psychological or alcohol or drug use disorders makes the use of self-report questionnaires problematic in detecting these issues. Nonforensically oriented psychologists and psychiatrists may have trouble detecting these issues if they use the traditional nonforensic mental health professional approach of accepting whatever the patient says and trying to work within the patient’s conception of reality.

Thus, the current system incentivizes the patient to conceal, consciously or unconsciously, the existence of psychosocial factors so that the injury or illness is accepted as compensable; the current system incentivizes the physician to spend less time with the patient than with patients with other funding sources; and the insurer has financial incentives to steer patients to doctors who ignore the psychosocial issues.

Obviously, one way to determine current psychiatric or psychological functioning is to refer the patient for formal evaluation by a mental health professional. Simpler ways to screen for psychosocial issues exist.

Physicians frequently note symptoms and exam findings that are out of proportion to the objective findings (e.g., Waddell’s signs and Waddell’s symptoms for back pain patients) in cases of biologically unexplained delayed recovery (Waddell, 2004). This should suggest the need for the assessment of psychosocial issues. Waddell developed these signs and symptoms lists to help physicians recognize when a psychosocial problem exists in addition to a biological problem. These signs may also be present in malingering, but malingering is much less common than are psychosocial confounders that delay or prevent recovery.

When recovery is occurring as predicted by the biologic model, the exploration of psychosocial factors is usually neither done nor needed. When recovery or outcome is inconsistent with the biomedical model and tolerance for symptoms, not risk of
harm or objectively documented lack of capacity is the issue (Sect. 6.8), physicians should recognize that unevaluated and untreated psychosocial issues are present.

Asking open-ended questions that screen for psychosocial issues may reveal “yellow flags” suggesting that psychosocial issues are present (Kendall, Burton, Main, & Watson, 2009). Examples of these questions would be:

- What do you think is the cause of your pain?
- Do you worry that something bad is causing your pain, but has not been found?
- When your pain increases, do you think you are harming yourself, and you must stop what you are doing?
- Do you think you will never get better?
- Have you been feeling stress or depressed lately?
- What tasks do you do at work?
- What do you like about your job, and what do you dislike about your job?
- Are there parts of your job you fear you will never be able to do again?
- When do you think you will return to work?
- What could your employer do to help you return to work?

Another method of assessment is to have the physician’s office staff to have patients complete pain drawings or questionnaires that screen for psychosocial issues. Pain drawings that show symptoms in places that are not easily explained biomedically are an indication for the assessment of psychosocial factors (Mooney, Cairns, & Robertson, 1976). A fear avoidance beliefs questionnaire (FABQ) (Waddell, Somerville, Henderson, Newton, & Main, 1993) and Distress Risk Assessment Method (Main, Wood, Hillis, Spanswick, & Waddell, 1992) are questionnaires the patient can complete before the physician enters the exam room. These are easily scored, and they help make physicians aware of psychosocial issues. Another “yellow flag” questionnaire is contained in the New Zealand Acute Low Back Pain Guide (http://www.nzgg.org.nz/guidelines/0072/acc1038_col.pdf).

### 6.4 Referral and Coordination of Treatment Considerations: Strengths and Weaknesses in Current Processes

Again, the main weakness in the current workers’ compensation system is that physicians are economically incentivized not to find the psychosocial issues, and that once discovered, many workers’ compensation insurers seem to deny the treatment authorization for these issues. Some jurisdictions do not recognize mental health issues accompanying physical work injury claims (only the “accepted condition” can be mentioned in reports and treated), so any referral to a psychologist or psychiatrist in those jurisdictions has to be done by using the employee’s health insurance. Employees who are out of work with a work-related injury are generally very reluctant to spend their own money to see mental health professionals for what they perceive as purely an injury that is the employer’s fault.
Many larger employers have an Employee Assistance Program (EAP) that enables employees to see a mental health specialist for a limited number of confidential visits (outside the workers’ compensation system with its lack of doctor patient confidentiality). Physicians can suggest the workers’ compensation patient with apparent psychosocial issues access the employer provided EAP. Most EAPs are not organized to deal with the complex psychological and psychosocial issues that impede the Stay-at-Work/Return-to-Work process, but they may recognize the issues, convince the injured worker that these issues need to be addressed, and then refer the worker to a psychiatrist or psychologist for more intensive treatment. This may be the only access to mental health services available to many injured workers. Unfortunately, many employees do not have access to an EAP as a benefit of employment.

In general, the mental health professionals (psychiatrists and psychologists) are the strength in the current system, but the strength that is underutilized. As previously mentioned, nonforensically oriented mental health professionals may not recognize the psychosocial issues hindering recovery. Some mental health professionals fail to appreciate work as a source of emotional support, and the importance of keeping people at work (American Psychiatric Foundation, Partnership for Workplace Mental Health, 2005). These mental health workers may inappropriately keep patients off work with open-ended medical leave recommendations.

Another weakness in the current mental health system that has not been systematically researched is the recurring pattern of the mental health professional that is employed by, or frequently used by, pain clinics that want a normal psychological exam before undertaking pain procedures that usually do not work well. There is a pattern of consistent reports from these mental health professionals that the patient has no Axis I or Axis II disorder, and that depressive symptoms are appropriate to the chronic pain for which the pain procedure has been proposed. Despite the literature finding a high rate of Axis I and Axis II disorders in these patients, some mental health providers seem rarely to diagnose these disorders in chronic pain patients referred for psychological “clearance” for invasive procedures.

### 6.5 Medicalization

Medicalization is defined as physicians transforming the events of life (job dissatisfaction, workplace conflict, marital strife, parenting problems, etc.) into diseases. This occurs frequently with neck, back, and upper limb symptoms being considered as diseases in the absence of clear pathology. The physician thought process may be that if there are musculoskeletal symptoms, there must be musculoskeletal pathology to explain the presence of the symptoms. Yet, the English language contains these idioms “My neighbor is a pain in the neck” (meaning my neighbor’s obnoxious behavior makes my neck hurt) and “My boss is a pain in the butt” (meaning my boss’s behavior makes my low back and buttocks hurt). Despite these idioms being universally used, many times physicians medicalize neck and back symptoms from such sources as “degenerative disc disease” or upper limb “tendinitis” with no objective findings on examination and only
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age appropriate degenerative findings on imaging studies. Linton’s review found that psychological factors are associated with the reported onset of back and neck pain, and that psychosocial variables are clearly linked to the transition from acute to chronic pain disability (Linton, 2000). Hoogendoorn’s review identified multiple work and private life factors as risk factors for low back pain (Hoogendoorn, van Poppel, Bongers, Koes, & Bouter, 2000). These psychosocial factors probably do not change the spine, but rather, when normal human minor spinal pains occur, physicians transform these common innocent symptoms into diseases by medicalization.

The two keys to prevent medicalization are for physicians to diagnose, and code office visits as symptoms until there is a clear objective pathologic basis for a disease or injury diagnosis, and for physicians to realize what normal aging looks like on imaging studies. The diagnoses “pain in the limb, ICD-9 729.5,” “low back pain ICD-9 724.5,” and “neck pain ICD-9 723.1” are acceptable for charting and billing, and these indicate that the source of the symptom is not yet scientifically established. This leaves the physician room to explore psychosocial issues and leaves the patient open to suggestion that symptoms may not be due to serious disease. Conversely, if marital distress is labeled by a physician as “degenerative disc disease,” the patient becomes convinced there is a medical disease present that needs medical treatment.

6.6 Symptom Exaggeration and Malingering

Patients with psychosocial issues commonly exaggerate symptoms and have medically unexplainable exam findings. The previously mentioned Waddell’s symptoms and Waddell’s signs are the examples. Dr. Waddell has been clear in pointing out that these symptoms are common while true conscious malingering is rare (Main & Waddell, 1998). Malingering is difficult to diagnose with absolute certainty (Aronoff et al., 2007). Aronoff’s review shows that literature estimates of malingering in claimants vary from 1 to 67%. This is because malingering can simulate many different symptoms, illnesses, or injuries, and because of the difficulty of proving malingering is actually present. Most physicians will not be comfortable in diagnosing malingering based on proposed criteria, and will insist on personal observation of intentional production of physical exam findings or video surveillance that unequivocally documents the patient lied. Thus, malingering will continue to be underdiagnosed. Malingering is not a biopsychosocial issue, but rather is usually a crime, in that the claim of injury or illness is to obtain financial benefits to which the individual is not entitled.

6.7 Patient Compliance Issues

The workplace may pose psychosocial issues that hinder patients’ return to work and symptom abatement. If there is low job satisfaction, conflict with supervisors or coworkers, or the perception of high job demand and low probability of return
to work by the patient, these issues are best addressed by open communication between the employer and the employee/patient. Physicians do not have the time, or generally the knowledge of the workplace to contribute to this dialog other than to explain the medical issues. The medical issues can be communicated in reports, or better yet by the combination of medical reports and the presence of a case manager (many times a Registered Nurse, or Certified Case Manager) at the meeting of the employer and the employee/patient. The Cochrane review found some evidence (five randomized controlled trials) that this type workplace intervention is effective compared to usual care to reduce sickness absence due to musculoskeletal disorders (van Oostrom et al., 2009).

Unrecognized alcohol or drug abuse can be a medical issue that masquerades as a workplace issue hindering return to work, and physicians should screen for this possibility with urine testing, interviews of the family, validated screening instruments for assessing alcohol misuse, etc.

6.8 Appropriate Documentation of Limitations in Objective Impairment/Functioning

Physicians are typically expected to provide employers guidance on every workers’ compensation patient as to the employee’s work abilities and restrictions. Unfortunately, almost no medical school and very few medical residency programs teach how to determine appropriate work restrictions and limitations, so it is not surprising that physicians have very different assessments of patients’ work ability (Rainville, Pransky, Indahl, & Mayer, 2005).

Most “return to work” forms physicians are asked to fill out do not define the terms “restrictions” and “limitations.” Many of these forms do not differentiate between these two concepts or the concept of “tolerance.” These terms have been defined (Talmage, 2007; Talmage & Melhorn, 2005).

Risk refers to what the individual clearly can do, but should not do, because of significant risk to self or others. Significant risk is the basis for physician-imposed work restrictions. Most work status certification forms contain a line on which physicians are to enter work restrictions based on risk. If there is no significant risk of substantial harm, physicians logically would leave this line on work ability forms blank. However, many physicians do not understand work ability terminology and thus they inappropriately enter comments about tolerance on this line.

Capacity is a misnomer. Actually, “current ability” is usually what is intended. The current ability can increase up to capacity with exercise or training, or decrease with inactivity (“use it or lose it”). Most work status certification forms contain a line on which physicians may enter work limitations based on capacity issues. Current ability can usually be measured to some degree. For example, if a strenuous job requires the ability to do sustained work at four METs with frequent exertion to a peak workload of eight METs, and if a prospective employee can only exert to six METs on treadmill testing, the employee does not have the current capacity to do
that job. Similarly, if a job requires working with hands overhead, and if a prospective employee has a stiff shoulder, the individual lacks the current capacity for that job.

Tolerance is the basis for an individual patient’s or worker’s decision to do or not to do a specific task, like work, based on the rewards available for doing the task (like wages) and the cost of doing the task (symptoms like pain, numbness, etc). Tolerance is unique to every individual. Tolerance is not scientifically measurable. Tolerance is not predictable by objective findings. Some patients with severe objective pathology express symptoms, but remain fully functional while others with minimal apparent pathology refuse to function due to symptoms that seem to be out of proportion to the objective findings. Many individuals are not willing to tolerate mild pain from an easy job for a low rate of pay, but are willing to tolerate much more pain from a physically demanding job for a high rate of pay. This dramatizes that tolerance is not a scientific concept that physicians can measure or determine. Most work status certification forms for physicians from employers and insurers have no line on which physicians can comment on tolerance issues. One reason for this is that tolerance is a subjective issue for a patient decision, but is not an issue for physician-imposed restrictions or physician-described capacity limitations.

When two patients have seemingly similar pathology, and yet very different self-reported ability to tolerate symptoms and work, psychosocial factors probably explain the discrepancy, since again the pathology is the same.

Physicians can assess pathology, and based on scientific studies or known consequences make statements about risk and capacity. The only way to attempt to measure tolerance is by Functional Capacity Evaluation (FCE) conducted usually by a trained physical therapist or occupational therapist. This testing shows what a patient is willing to do on the day tested. FCEs have not been shown to correlate with the risk of reinjury if the patient is reemployed (Gouttebarge, Wind, Kuijer, & Frings-Dresen, 2004; Gross & Battié, 2005, 2006). Thus, they yield some information about whether the patient is likely to return to work (tolerance), but not whether the return to work is safe.

In summary, physician statements on return to work forms should be recognized as “educated guesses” unless the physician can clearly articulate a logical significant risk of substantial harm or an objectively measured deficit (loss of range of motion, loss of a body part, reduced exercise capacity due to coronary artery disease, etc.).

6.9 Treatment Outcome: Strategies for Addressing the Individual’s Return to Work

The key issues in addressing the patients return to work are:

- For physicians to realize that symptoms not clearly explainable by objective pathology and that unexplained delayed recovery may be due to psychosocial issues
- For physicians to screen such patients with questionnaires to further document that psychosocial issues are a problem
• For physicians to involve mental health professional in the care of these patients, however that is possible within the constraints of the workers’ compensation system
• For physicians to realize that work is good for people, and that being out of work actually causes medical disease and premature mortality; (Talmage & Melhorn, 2005; Waddell & Burton, 2006).
• For physicians to properly assess risk and capacity, and leave tolerance decisions to the patient
• For physicians to communicate with employers and case managers so that workplace issues are addressed as part of the psychosocial treatment

References

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Chapter 7
Physical Therapy Treatment and the Impact of Behavioral Health Concerns

Jill S. Galper

7.1 Epidemiological and Prevalence of Psychological and Behavioral Health Concerns in PT

Physical therapy “is a dynamic profession with an established theoretical and scientific base and widespread clinical applications in the restoration, maintenance and promotion of optimal physical function” (Guide to Physical Therapist Practice, 2001). Physical therapists (PTs) and physical therapist assistants (PTAs) are involved in the treatment of people with movement dysfunction and pain, and also provide services to promote health and wellness in order to prevent injury and the progression of symptoms, impairments, and activity limitations in a person with an illness or injury. In the United States, the practice of physical therapy is regulated by the state in which the PT and the PTA practice.

Musculoskeletal injuries and disorders affect many Americans, and the incidence is increasing (Woolf & Akesson, 2001). In 1996, 54 million Americans reported having at least one musculoskeletal condition (Yelin, Hermdorf, Trupin, & Sonneborn, 2001). The prevalence of physical disabilities caused by musculoskeletal conditions has been estimated at 4–5% of the population (Reynolds et al., 1992). There is considerable expense associated with these conditions, with the total cost amounting to more than $250 billion per year (Lidgren, 2003), with 50% more spent on medical care for people with musculoskeletal conditions compared to nonmusculoskeletal conditions (Yelin et al.). Work-related musculoskeletal disorders cost $20 billion per year (Bernard, 1997). In addition to the economic burden associated with musculoskeletal conditions, there is the human cost of pain and suffering. It is therefore important that the PTs and PTAs who treat patients with musculoskeletal dysfunction do so effectively.

Although training includes class(es) in psychology, educational programs for PTs and PTAs emphasize the science and clinical techniques related to physical function. In their textbook Psychology in the Physical and Manual Therapies, Kolt and...
Andersen (2004) state that practitioners would like more education in psychology in their training program. This is understandable since a patient’s participation in treatment is essential for a positive outcome. A practitioner who is able to communicate, understands his or her patient’s barriers to program adherence and participation, and has tools to overcome these barriers has a better chance of success than one who does not. Barriers to treatment success in physical therapy include physical, psychological, social, and environmental factors. Psychological factors include preexisting mental health or behavioral health conditions such as depression and anxiety disorders, which may be comorbid with each other. Psychological factors may also include a person’s stress response, depression, and anxiety following injury. Although it is beyond the scope of physical therapy to diagnose and treat these conditions, recognizing that nonphysical factors are impacting a person’s recovery from illness or injury and responding appropriately is critical to optimize treatment outcome and avoid unnecessary or ineffective treatment.

The purpose of this chapter is to discuss how a PT can recognize when recovery is impacted by these psychological and behavioral conditions and what options can be used to effectively address them in the context of physical therapy treatment. Physical therapy intervention can be provided in a number of different settings. The setting most common for the treatment of musculoskeletal injuries is the outpatient setting. Physicians and therapists may be located within the same facility, but often are not.

7.1.1 Discussion of Usual Care Treatment Process

The majority of patients are referred to PTs by a medical practitioner, usually a physician. Regulations regarding referral or prescription for physical therapy vary by state. In some states, direct access permits the patient to see a PT without a referral or prescription. At the initial physical therapy visit, the therapist performs an evaluation in order to ensure that there are no contraindications for treatment, identifies the patient’s symptoms and clinical findings, and establishes a physical therapy diagnosis, treatment goals, and a plan of care. Physical therapy treatment is started, the patient’s response to treatment is monitored and the program is progressed. Treatment frequency may be reduced and the home program emphasized to prepare the patient for discharge. The therapist usually sends written progress notes to the referral source regarding the patient’s progress with treatment. These progress notes include information regarding the patient’s response to treatment and recommendations regarding the need for ongoing care and any assistive devices or equipment the patient may need. If the patient does not require further treatment, discharge or discontinuation of treatment is recommended.

In general, PTs are very good at performing musculoskeletal evaluations and identifying a diagnosis, short- and long-term treatment goals, and a plan of care. Childs et al. (2005) investigated PT’s knowledge in managing musculoskeletal conditions by administering an examination to PT students and existing practitioners.
of varying experience levels. The examination is one that is used by medical students, physician interns and residents, and across a variety of physician specialties. The results showed that experienced PTs had higher levels of knowledge than all groups with the exception of orthopedists (Childs et al.).

PTs spend a significant amount of time with their patients, with most treatment sessions lasting between 30 and 60 min, often two to three times per week. Therapists are therefore in a position to develop a caring therapeutic relationship and bond with patients, and often learn details regarding his/her patient’s work and personal life. This therapist–patient relationship can positively impact the patient’s response, since trust in the clinician can positively impact the recovery process. The American Physical Therapy Association’s (2009) tag line, “The Science of Healing, The Art of Caring,” reflects the interaction of art and science that has attracted many people to the physical therapy field.

However, just as the therapist–patient relationship can be positive, there are occasions when the opposite may occur, and a positive therapeutic relationship does not develop, or the relationship is such that patient independence is not fostered. A patient may complain that his/her therapist does not “care” about him/her or what he/she is experiencing, and develop negative feelings about the therapist, and generalize those negative feelings to physical therapy in general. The following will identify several factors or scenarios that can negatively impact treatment outcome because of the PT’s behaviors or beliefs:

- The PT does not have the expertise to either diagnose or treat the patient’s problem. While this can be corrected through referral to another practitioner, the therapist may not recognize this and continue to treat the patient despite the poor result. Another example is the clinician who does not keep his/her skills and knowledge base current, and may not be aware of more optimal treatments for the patient’s problem. For example, a PT who recommends bed rest for a patient with subacute or chronic nonspecific low back pain is probably not aware of current evidence-based treatment recommendations.

- The PT may unwittingly encourage the patient’s dependence on physical therapy treatment. This may occur if the PT feels his or her “hands-on” or manual treatment is required in lieu of educating the patient in self-management techniques. This is not intended to imply that hands-on or manual therapy is inappropriate or unnecessary, but ongoing manual therapy for people with chronic symptoms who do not demonstrate functional progress is not necessary in the majority of cases.

- A PT’s bias, beliefs, and attitudes may negatively impact treatment. For example, a therapist who has fear-avoidant beliefs may counsel his/her patient to stop any activity that hurts, and fail to teach the patient to distinguish between hurt and harm (Vlaeyen & Linton, 2006). The patient will likely maintain a low activity level. The PT may become frustrated if his/her patient does not respond to treatment as expected, or if the therapist feels the patient is exaggerating symptoms or malingering. Therapists who treat patient with chronic pain or other syndromes such as chronic fatigue or fibromyalgia should understand the psychological, environmental, and social considerations involved.
• The PT may fail to communicate with other healthcare providers (e.g., physician or medical case manager) when his/her patient is not recovering as anticipated. Some therapists will continue to treat a patient on the basis that there is a referral for treatment, even when there is an absence of subjective and objective improvement. The therapist may not want to directly confront the referral source regarding their difference of opinion regarding the need for continued therapy, especially if the therapist relies on referrals from that provider. In other instances, therapy is continued on the basis of the patient reporting temporary symptom relief. Continuing physical therapy in the absence of demonstrated benefit is not consistent with the APTA’s Guide for Professional Conduct, Principle 4.1.H (Guide for Professional Conduct, 2009).

• The patient, rather than the PT, may control treatment content and continue to request ongoing treatment, even when there is no functional progress. Discussions with patients about stopping physical therapy can sometimes be difficult, especially if the patient shared intimate emotional and physical information with the therapist, because the termination process involves breaking a bond. In other cases, the patient and therapist may not agree on the need to continue therapy. Some therapists may continue treatment and avoid the difficulties associated with terminating treatment.

• Some therapists may continue treatment based on the financial rewards for doing so.

A patient’s response and progression during physical therapy is also affected by a number of other factors or considerations in addition to the ones discussed above. These include physiological, psychological, social, and environmental factors. Examples of physiological factors include the severity and extent of the injury or illness and the presence of comorbid conditions (complete discussion of these is beyond the scope of this chapter). Psychological, social, and environmental factors include preexisting psychological disorders such as anxiety and depression, depression, anger or anxiety following the injury or illness, job dissatisfaction or work performance issues, stress or conflict in relationships at home and/or work, insufficient social support, and lack of modified work or the ability/willingness of the employer to accommodate the patient’s functional limitation(s). These factors may manifest in one of the following ways during a physical therapy program: poor attendance or punctuality for scheduled appointments, poor availability for PT appointments, limited or poor participation in the PT program at the clinic and at home, the patient’s focus on symptoms, a negative or pessimistic outlook, and dependent or passive behavior, where the patient is looking to the therapist to “fix” the problem. The PT needs to be aware of these factors since they impact the patient’s recovery and lengthen the episode of care beyond what would be anticipated based on physical considerations and the natural history of the injury or illness. The therapist also needs to attend to any negative feelings he/she may have about the patient, such as frustration over the patient’s lack of progress. Effective response and management by the PT is important in order to prevent and/or manage delayed recovery and disability.
7.2 Determining Current Psychiatric Functioning and/or Behavioral Health Concerns, such as Fear of Reinjury: Strengths and Weaknesses in the Current Process

When a patient is not progressing as the PT had anticipated, the therapist should reevaluate the patient to determine if something was missed in the initial evaluation. Reevaluations should be done at least monthly, or more often if the patient reports a change in status. It is reasonable to anticipate improvement after several therapy sessions, and specific objective parameters are customarily monitored by the PT at each session, in addition to asking the patient about his/her symptoms. For example, if the area of injury is the cervical spine, and limited neck motion was identified at the initial evaluation, the PT should assess neck motion before and after a treatment session, since it is reasonable to expect improvement following treatment. In the absence of improvement, the therapist should modify the treatment regimen to determine if another approach will be more effective for the patient. It is unreasonable to continue with the same treatment regimen in the absence of objective or functional improvement.

In addition to measuring “objective” parameters (motion, strength, endurance, etc.) during an evaluation, there are a number of condition-specific pain and disability questionnaires that can be used to determine how the patient perceives his/her pain and function. A comprehensive review of these various questionnaires is beyond the scope of this chapter. Examples of condition-specific questionnaires include the Oswestry Disability Index (Fairbank, Davies, Couper, & O’Brien, 1980) and Neck Disability Index (Vernon & Mior, 1991). These questionnaires can be scored and used to monitor the patient’s progress. The therapist can compare the observations he/she made of the patient during evaluation and treatment with what the patient identified on the questionnaire. This can provide useful information regarding the patient’s perceptions of ability and function, which the PT monitors during the treatment episode in addition to other objective parameters. In addition, some questionnaires, like the examples given above, have scoring criteria. Significantly elevated scores will clue the therapist to consider that nonphysiologic factors are probably involved.

Pain can be monitored through verbal or visual pain scales. Significantly elevated pain ratings that persist beyond the initial injury or illness phase (e.g., pain ratings of 8–10/10 on a pain scale) and discrepancies between the patient’s perception and the therapist’s observations should be noted and addressed.

In addition to the condition-specific questionnaires and pain ratings, the patient’s fear of activity or (re)injury can be assessed and monitored via questionnaires. The Fear Avoidance Beliefs Questionnaire (FABQ) (Waddell, Newton, Henderson, Somerville, & Main, 1993) and Tampa Scale of Kinesiophobia (Vlaeyen, Kole-Snijders, Boeren, & van Eek, 1995) can be used to determine whether the patient has fear-avoidant beliefs or fear of (re)injury. Identifying whether a patient has fear-avoidant beliefs or fear of (re)injury is important since evidence suggests that a different treatment approach is recommended for these patients (George, Fritz,
Treatment for patients classified as having fear-avoidant beliefs generally includes education and graded exercise, which has been endorsed as a potential treatment for individuals with fear-avoidant beliefs (Crombez, Eccleston, Vansteenwegen, & Lysens, 2002; George, Bialosky, & Fritz, 2004; Sullivan, Adams, Rhodenizer, & Stanish, 2006; Vlaeyen, de Jong, Geilen, Heuts, & van Breukelen, 2001). In addition, the use of this approach for low back pain patients who do not have fear-avoidant beliefs has been shown to slow recovery (George et al., 2003). It is therefore important for PTs to be aware of fear-avoidant beliefs in both themselves and their patients.

The FABQ includes 16 statements regarding the nature and presumed cause of the patient’s pain, and the degree to which the patient believes the pain to preclude physical activity and return to work. The questionnaire has two sections, a physical activities (FABQ-P) section and a work activities (FABQ-W) section. Each section is scored separately. Elevations in the scores on the FABQ-W section have been shown to negatively correlate with return to work in patients with acute low back pain, with scores exceeding 29 predictive of poor outcome (Fritz et al., 2001). A recent study suggested that scores as low as 20 are correlated with disability as measured by the Oswestry Disability Index at 6 months (George, Fritz, & Childs, 2008). The association of work disability and fear-avoidant beliefs, determined by the FABQ for patients with neck pain, is less clear (George, Fritz, & Erhard, 2001).

The Tampa Scale of Kinesiophobia (Vlaeyen et al., 1995) is a questionnaire that consists of 17 questions that is scored on a four-point Likert scale where higher scores reflect greater fear of movement. It has not been used as frequently as the FABQ in the physical therapy literature, but can be used by PTs as an alternative to the FABQ.

Cairns, Foster, Wright, and Pennington (2003) wrote that distress (a term that represents a composite of psychological distress, depressive symptoms, and depressive mood) associated with low back pain is common, and investigated the use of The Distress Risk Assessment Method in conjunction with the Roland Morris Disability Questionnaire for the management of recurrent low back pain. They found that increased levels of distress markedly increase the risk of poor outcome. How to most effectively manage distress, and what additional support and training PTs need to provide this management has yet to be definitely determined.

In addition to the use of the types of questionnaires discussed above, the identification of yellow flags has been suggested in order to identify potential psychosocial barriers to recovery. These have been outlined and discussed in detail by the New Zealand Guidelines Group (2004). Yellow flags consider the patient’s attitudes, beliefs, and behaviors regarding the injury and subsequent symptoms, the patient’s social circumstances and support, whether the injury is compensable, history of prior injuries, and items pertaining to the beliefs, behaviors, and actions of the health professionals involved in treatment.

These and a number of other such tools are available for use by PTs and do not take much time for the patient to complete (generally less than 10 min). It is recommended that PTs use them during the episode of care since they provide valuable information that can assist the therapist in effectively treating the patient. Therapists should not use these tools to negatively label or judge their patient, but
rather should regard them as an additional source of information about the patient that can help guide selection of the appropriate intervention.

7.3 **Referral and Coordination of Treatment**

PTs work as part of a healthcare team. The members of that team will vary, depending on the circumstances and healthcare setting. Frequently, the team will consist of the physician who referred the patient for therapy, the patient, and the therapist (and the therapist’s staff involved in treatment). Additional individuals involved in treatment include medical case managers, vocational experts, and medical specialists treating the patient (e.g., physiatrist, orthopedist, neurologist, etc.). Interdisciplinary treatment programs frequently include occupational and recreational therapists, a social worker, and a psychologist. When a patient is referred to a PT for treatment, it is helpful for the physician to identify his/her medical diagnosis and next follow-up appointment. When the injury is work related, and the patient is not able to work, information from the employer regarding the patient’s essential job functions and the ability to modify or accommodate work is needed. While this can be provided at least in part by the patient, verifying the information with the employer is important to ensure accuracy of the information. A medical case manager involved with the patient can be a helpful source of information for the therapist.

The early identification of patients who may be at risk for developing chronic pain or work disability is important since there is “an important window for preventive intervention” (APG-Chronic Pain, 2008, p. 2). Because PTs are often involved in the treatment of a patient in the acute or subacute stage of recovery, the identification of any barriers to recovery exhibited by a patient and the prompt effective response by the therapist can be instrumental in preventing progression to chronic symptoms, prolonged activity avoidance, and work disability. This requires that the therapist is actively involved in the patient’s evaluation and intervention, is using the various tools and questionnaires discussed previously, and is regularly communicating with the other healthcare providers involved in the patient’s care. It is therefore problematic if a treating PT lacks the knowledge, awareness, time, or willingness to identify these factors and information during treatment, and the therapist may unwittingly contribute to the problem (delayed recovery) rather than the solution. That said, even when a PT takes all these steps in the treatment of his/her patient, positive outcomes are not assured, since there are multiple factors from a number of sources that can impact outcome. In cases when the physical therapy treatment goals are not met, the PT who took all the possible steps discussed can be secure in the knowledge that he or she acted in the best interest of his/her patient, relied on the best clinical evidence during treatment, and communicated clearly with all relevant parties.

In circumstances when a patient has received prior physical therapy treatment at another location, and there has not been any interval change in reported symptoms, objective findings, medical diagnosis, or surgery, it is helpful for
the therapist to obtain permission from the patient to either receive records from or speak with the previous therapist regarding the patient’s prior treatment. This communication should prevent duplication of treatment that was not effective. Unfortunately, this is not frequently done, based on this author’s experience.

During the episode of treatment, the therapist should be communicating with the physician and other team members (e.g., physician, occupational therapist, medical case manager) in regard to the patient’s attendance, participation, and progress in therapy. In addition, the therapist should provide the physician (and other team members) with information regarding the patient’s physical abilities relative to home and work activities, and recommend relevant accommodations. In clinical settings where the team members work together on-site, communication may be easier given the on-site presence of the parties involved. There may be regular team meetings to discuss patient progress. This occurs regularly in most interdisciplinary programs. In circumstances where team members are not physically present at the same facility, communication can become more challenging, and frequently occurs via written progress reports sent to the physician by the therapist. When progress is not occurring as expected, or the patient is not attending or participating with therapy, the therapist should clearly communicate this. If the therapist believes referral to another practitioner is indicated, he/she should contact the referring physician to discuss this.

Communication between all relevant members of the healthcare team is therefore essential, but unfortunately does not always occur. If a PT receives another referral for physical therapy treatment despite his/her recommendation to stop therapy, the therapist should contact the physician (or other referral source) to discuss the need for ongoing treatment. The physician may have rationale to continue therapy that the therapist has not considered, the physician may have misunderstood the therapist’s request to stop therapy, or the physician may have requested additional therapy based on request of the patient.

This author has heard complaints and frustration voiced from all parties regarding the lack of communication or response from another party involved in treatment. Complaints voiced by therapists have included ongoing treatment referrals from the physician despite lack of progress, lack of a specific medical diagnosis, inability to obtain results of diagnostic tests, absence of modified duty by the employer, and lack of insurance coverage for “wellness” or fitness programs that would allow the patient to continue to exercise in a less supervised (and costly) setting.

Complaints voiced by physicians have included lack of, illegible, or unclear communication from the therapist, lack of information regarding physical abilities, and a lack of specific recommendations regarding the need for continued therapy. The need for a good working relationship and clear communication between team members is critical to positive treatment outcomes. This should help ensure that the patient does not receive conflicting information and that treatment is well coordinated between team members.
7.4 Medicalization

Medicalization may occur by the patient, PT, physician, or other healthcare providers. In regard to physical therapy, the following may occur:

- The patient medicalizes his/her condition despite medical opinion to the contrary, and is unwilling/unable to participate in a rehabilitation program because he/she is searching for a definitive answer to his/her symptoms.
- The therapist focuses on identifying a physical explanation for the patient’s symptoms, and does not attend to the yellow flags or other indicators of psychosocial factors that are impacting recovery. An example of this includes focusing on postural asymmetries or muscle tightness that most likely existed prior to the current injury/illness and does not affect the current condition or underlying functional limitation.
- The physician or referrer to physical therapy continues to refer the patient for PT, and maintains work disability based on the patient’s symptoms. In some cases the patient may doctor shop, which may lead to repeated diagnostic tests, additional episodes of physical therapy treatment and possibly result in invasive treatment.

Physical therapy management of the patient can be difficult in these situations. Treatment may involve confronting the patient or physician regarding the requested treatment. In regard to the patient, the PT should review his/her examination findings and recommendations for treatment. It is important that the therapist listens to the patient’s concerns and feelings and addresses them respectfully. The therapist and patient should collaboratively develop treatment goals and a plan of care, because this should improve patient compliance and participation.

In regard to the physician, the therapist should contact the physician to discuss the requested treatment if he/she does not feel therapy is indicated, or believes that a different intervention might be more effective. The therapist should be prepared to discuss his/her examination findings with the referral source, including any yellow flags that were identified and the results of the pain and disability questionnaires, and the rationale for or against physical therapy treatment. As discussed earlier, this is difficult for many therapists to do because of fear of impacting future referrals from the physician or angering the physician. If the therapist has reason to suspect job-related factors are impacting the patient, the therapist can either discuss this with the physician who would communicate with the employer, or the PT might contact the employer directly. If a medical case manager is involved in treatment, the therapist can discuss his concerns with him/her, and develop a plan for the patient.

7.5 Symptom Exaggeration and Malingering

During the course of physical therapy treatment, most therapists form an opinion about the patient that is based on the severity of the injury or illness and body regions involved, the presence of comorbid conditions, the patient’s subjective reports,
Therapists compare the patient’s subjective reports with objective findings. When pain and disability questionnaires are used as part of the assessment process, the items reported as difficult on the questionnaire can be compared with the patient’s performance during functional testing and treatment. When a patient reports high levels of pain and disability and is significantly limited by pain, but has little evidence of objective impairment on clinical examination and diagnostic tests, many therapists refer to the patient as being pain-focused or exaggerating his/her symptoms. Elevated scores on condition-specific questionnaires can be interpreted as indication of symptom exaggeration. For example, an Oswestry Disability Index score of 90% is noted to be indicative of someone either bed-bound or exaggerating symptoms.

It is important that the clinician not use an isolated result as the basis for his/her opinion, but rather considers a combination of results, observations, and behaviors. In addition, symptom exaggeration and pain behavior does not equate with malingering. How a patient expresses his/her pain experience is influenced by culture, upbringing, and social/work circumstances in addition to injury severity. Malingering refers to one who intentionally misrepresents or feigns symptoms for the purpose of secondary gain (e.g., to obtain money or medications). An individual who experiences a high degree of pain is therefore not necessarily consciously feigning symptoms, even if there are discrepancies between what that patient perceives and what he/she does.

Fiore, Keeley, and Mayer (2009) discuss the difficulty an evaluator has in differentiating between an individual with chronic pain who is limited by symptoms and a malingering during functional capacity evaluation (FCE), a test process performed to identify a person’s physical abilities. Part of the difficulty is because the pain behaviors identified with both may be similar, although Fiore et al. suggest that “Malingers are typically less likely to show the usual psychological manifestations of chronic pain,” such as being overwhelmed (Fiore et al., p. 305). Therapists should use caution when labeling patients, particularly when there is the possibility of negatively impacting treatment or financial benefits.

A patient’s level of effort and performance consistency is assessed by the FCE evaluator, but there is controversy regarding some of the methods currently used to do so. Sindhu and King (2009) discuss this in detail in the Guide to Evaluation of Functional Ability. Because of the consequences that can occur from labeling a patient as a symptom exaggerator or symptom magnifier, these labels should be used with caution.

Therapists can manage patients with pain-focused behavior by using the following strategies that are sometimes referred to as a cognitive behavioral approach. At the core of these recommendations is communication with the patient, expressed in a caring manner, along with suggestions that should help empower the patient by providing techniques for self-management:

- At the first visit (and as often as needed thereafter), the therapist should communicate the expectations for treatment, including anticipated response to treatment, adherence to the schedule, and participation by the patient. Collaborate with the
patient regarding treatment goals and the plan of care. Provide the rationale for treatment and answer the patient’s questions. Perform regular evaluations, and identify the areas of improvement. Identify reasonable short-term goals. While symptom reduction is frequently identified as a goal of therapy, the focus on activity or functional goals is preferred.

- Directly communicate with the patient regarding his/her fears and pain. Help the patient differentiate between hurt and harm. This is particularly important when the patient has been inactive due to pain and believes that activity will result in pain. Listen carefully to the patient’s complaints, and do not minimize or ignore them.
- Use graded activity that addresses the activities that are of concern to the patient. Break down the activity into manageable components that can be progressed. Start the exercise program at a level that will not evoke symptoms, and build the intensity and duration of activity over time. When appropriate, instruct the patient in alternative movement strategies that allow the patient to more comfortably, safely, and/or effectively perform an activity. The use of visualization may be helpful to allow the patient to mentally practice the movement prior to physically doing so.
- Encourage the patient to maintain an activity diary and establish activity quotas and goals for the patient. The therapist should review the diary on a regular basis, and provide positive reinforcement when the goals are achieved. When the goals are not achieved, explore why they were not without negativity.
- Encourage self-management by educating the patient regarding techniques, postures, and exercises that can be performed independently. This may include instruction in relaxation techniques or imagery, recommendation regarding home equipment or assistive devices, and instructing family members, friends or significant others in massage or stretching techniques that can be performed at home.
- Communicate the therapy findings and plan of care with the physician and other providers involved in the patient’s treatment so they are aware of the treatment approach and can support it. If the patient is not able to progress, discuss with the physician referral to a psychologist who may be better able to address the patient’s fears and pain focus.

In instances where the therapist suspects or has evidence that the patient is malingering, communication with the physician and other healthcare providers involved in treatment is imperative since treatment is not warranted.

### 7.6 Patient Compliance Issues: Limitations and Strategies for Improved Management

Brewer (2004) discusses patient adherence to rehabilitation, and notes that adherence refers to the patient’s attendance and active participation in the rehabilitation program. Indicators of good adherence include the following:

- The patient is on time for his/her scheduled visit.
- The patient participates fully in the program.
• The patient follows instruction regarding activity limitations.
• The patient uses prescribed devices (orthotics or assistive devices).
• The patient follows instruction for home management, including exercise and/or other recommendations, like the use of ice/heat.

Adherence is frequently measured by attendance, but this fails to account for the patient’s participation in therapy. Therapists make assessments about adherence based on patient observation during treatment, and judgments regarding the patient’s knowledge regarding what was taught to him/her during treatment and by the patient correctly demonstrating the exercises given as a home program. Attendance can be measured by the Sport Injury Rehabilitation Adherence Scale developed by Brewer, Van Raalte, Petitpas, et al. (2000).

Adherence is affected by the patient’s beliefs about his/her prognosis and pain, social support, and physical environment (Medina-Mirapeix, Esolar-Reina, Gascon-Canovas, Montilla-Herrador, & Collins, 2009) Low adherence is more likely to occur when a patient perceives barriers, such as lack of time to fit exercise into a daily routine, fatigue, forgetting to exercise, or associating exercise with adverse effects and symptoms. A physical environment may contribute to decreased adherence to home exercise if there is not enough room at home. Social support appears to improve adherence, whether provided by a spouse at home or in a clinic setting (Medina-Mirapeix et al.). Adherence has been associated with self-efficacy, with improved adherence to home exercise associated with better self-efficacy (Medina-Mirapeix et al.).

Therapists can positively impact adherence by doing the following:

• Understand the patient’s beliefs about his prognosis, perceived credibility of the treatment, and his/her expectations. Therapists can reinforce positive factors and offer balance between perceived barriers or other problems.
• Reinforce verbal instructions with written and illustrated materials (Medina-Mirapeix et al., 2009).
• Establish a confidence-based partnership with the patient that includes empathy, listening, and respect (Slade, Molloy, & Keating, 2009).
• Provide understandable information regarding the patient’s problem and the rationale for treatment (Slade et al., 2009). Kolt and McEvoy (2003) found decreased adherence in patients receiving compensation as compared with those who were not, and suggest that the therapist may need to spend more time educating patients receiving compensation regarding the importance of physical therapy sessions. Establishing a contract between the therapist and patient was also recommended.

In regard to the patient’s ability to stay at or return to work, the PT should be aware of the patient’s physical work requirements and whether modified duty is available. This will probably require the therapist to contact the employer. The therapist should assess the patient’s ability to perform his/her work tasks. While the need for this assessment may seem obvious, it is not routinely performed during outpatient treatment during the subacute stage of recovery. Instead, either no functional testing
is performed or is performed only in the context of a formal FCE. In this author’s opinion, functional testing relative to the job demands should be performed routinely during treatment, since this provides important and relevant information to the treating physician/clinician, and will help the therapist recommend appropriate accommodations for the patient.

In instances where there is job dissatisfaction or the patient has indicated that there is interpersonal conflict between coworkers or a supervisor, and the therapist finds that this is impacting the patient’s participation in therapy, communication with the physician, medical case manager, and possibly the employer is warranted because of the impact this may have on return to work.

### 7.7 Appropriate Documentation of Limitations in Objective Impairment/Functioning

PTs routinely send the referring provider information about his/her patient. This is almost always done after the first visit, and progress reports thereafter are usually timed to coincide with the physician’s visit. This requires that the therapist is aware of when the physician’s appointment is scheduled. Copies of these reports may also be sent to the medical case manager and in some cases to the insurer. The report should include:

- **Subjective data**
  - The patient’s reported symptoms.
  - Results of pain and/or disability questionnaires – the therapist should indicate if the scores meet the criteria for minimal clinical important difference.

- **Objective data**
  - Range of motion, strength, etc. compared with previous findings.
  - Functional abilities – what can the patient do relative to work and home activities?
  - Functional limitations – what work and home activities are limited because of the health condition? Can these limitations be accommodated? The therapist should provide specifics.

- **Assessment (the therapist’s interpretation of the data)**
  - Discuss the overall findings and their meaning. When reevaluating the patient, report the areas of improvement. Improvement includes change in both impairment and function. Barriers to improvement should be discussed in detail.
  - Discuss the patient’s attendance and participation in therapy.
  - If relevant, provide an assessment about the patient’s work ability – either full or modified duty. If the therapist feels that the patient cannot work full time, objective rationale for his/her opinion should be included.
Discuss the need for further treatment. The therapist should identify specific short- and long-term goals with time frames. If no further treatment is required, this should be clearly stated.

**Plan of care**
- What treatment is recommended?
- What is the treatment duration and frequency? It is reasonable to decrease treatment frequency during the episode of care, as the patient improves and can do more at home.

Problems frequently noted in documentation include:
- Use of esoteric abbreviations that no one but the therapist understands.
- Illegible handwriting.
- Subjective assessment does not include pain scales or validated disability questionnaires. The inclusion of these tools has been previously discussed, and is recommended because it provides a more objective method of documenting the patient’s symptoms and perceived function, and allows therapist to monitor scores over time.
- Lack of functional data – unfortunately, this information is frequently not assessed as part of the therapy program, even though the patient may be out of work due to a work-related injury. Barriers to including this information include the therapist’s inability to perform functional assessment and/or allowing the time to perform the assessment.
- Unclear treatment recommendations – rather than the therapist clearly identifying a recommendation (usually to discontinue therapy), some therapists write something akin to “per physician.” It is this author’s opinion that this type of recommendation is insufficient. As the functional expert, the therapist should be able to provide recommendations regarding the need for further treatment, work, and home abilities, etc., and provide reasonable treatment goals. When therapy is no longer needed, either due to attainment of goals or due to lack of progress, the therapist should clearly indicate this.

### 7.8 Treatment Outcomes

As noted earlier, PTs are well qualified to treat patients with musculoskeletal problems. When treating patients with work-related injuries, there are additional considerations therapists should consider to facilitate return to work. These include:

- The patient’s work demands
- Whether modified work is available and whether the employer can accommodate functional limitations
- What, if any, constraints exist in scheduling therapy appointments

The therapist may need to contact the employer to obtain this information.
At the first physical therapy visit, the therapist should establish treatment and return to work goals and timeframes. The therapist’s expectations for the patient’s attendance and participation in treatment should be discussed and agreed upon by the patient. Validated pain and disability questionnaires and functional testing should be used as part of the assessment process. The therapist should provide all relevant parties with information regarding the patient’s progress, and recommendations for continued therapy and return to work, and communicate any barriers to progress that have been identified.

In most instances it is reasonable to expect significant functional progress in 4–6 weeks. If the patient has demonstrated fear-avoidant beliefs, fear of (re)injury or exhibited other yellow flags associated with delayed recovery, and a cognitive behavioral approach (as discussed previously) was used by the therapist but the patient has not made significant progress, therapy should be stopped and another treatment approach, such as referral to a psychologist, should be considered by the physician/clinician. If the patient is later better able to participate in a physical therapy program, the patient can be rereferred for therapy.

In order to facilitate a patient’s return to work, therapists need the following information from the employer:

- Detailed job description that includes the essential job demands and their associated physical requirements. If the physical requirements have not been identified previously, it would benefit the employer to have this done. Physical and occupational therapists and/or ergonomists can go to the job site and obtain this information. A common barrier to obtaining job analysis is the employer’s unwillingness to reimburse for them. Because this information is essential to the therapist for treatment planning and job-specific functional testing, and to the physician/clinician in order to make informed return to work decisions, information regarding the patient’s job is needed.
- Modified work – is it available and are there time constraints? Are there limits to how work can be modified? This information helps the therapist and physician make informed and practical recommendations.
- If the patient is working in some capacity while attending therapy, what is the employer’s policy regarding scheduling appointments? For example, can the employee leave work to attend therapy or does treatment have to be scheduled before or after work?

If the employer frequently works with the same health professionals, inviting them for a tour of the facility is helpful to provide the clinicians with more information regarding the employer’s procedures, operations, environment, and equipment.

In this author’s experience, psychologists are frequently not involved in the treatment of patients with delayed recovery. Having qualified psychologists or mental health professions involved in the treatment of these patients would be beneficial when psychosocial factors are impeding recovery.
More open and regular communication between all health professionals should facilitate return to work by ensuring that the patient is given consistent information regarding his/her medical problem and treatment regimen.

7.9 Summary

While the focus of physical therapy treatment is on management of movement dysfunction, PTs need to be aware of the psychosocial and environmental factors that can lead to delayed recovery and chronic pain syndromes, and have tools to effectively address them. This chapter has discussed these tools, and the need for effective communication, which is critical to effective patient management.

References


Chapter 8
Vocational Rehabilitation Considerations for Mental Health Impairments in the Workplace

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8.1 Introduction

One professional discipline that works with employment-related issues for persons with disabilities is the field of vocational rehabilitation. Vocational rehabilitation counselors obtain advanced degrees in vocational rehabilitation and work in both the public and private sector to evaluate the needs of persons with disabilities in terms of work. Vocational rehabilitation counselors are professionals who aspire to a professional code of ethics and standards and are accredited by the Commission on Rehabilitation Counselor Certification. The commission defines the scope of practice as follows:

“Rehabilitation counseling is a systematic process which assists persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the counseling process. The counseling process involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social, and behavioral interventions” (Code of Professional Ethics for Rehabilitation Counselors, 2009).

Vocational rehabilitation is provided in a variety of environments including but not limited to workers compensation (WC), short-term disability benefits (STD), and long-term disability (LTD). Vocational rehabilitation counselors may also work in state or federal vocational rehabilitation programs, or in litigated environments. Each environment has its own eligibility requirements, boundaries to what services are permitted, and how money can be expended. The diversity and complexity of each environment are too complicated to describe fully in this chapter. This chapter will present many of the more common factors and tools that the profession of vocational rehabilitation relies upon to assist individuals with mental and physical disabilities obtain and maintain suitable employment.

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8.1.1 Prevalence of Psychological and Behavioral Health Concerns in Vocational Rehabilitation

The National Institute of Mental Health cites: “Mental disorders are common in the United States and internationally. An estimated 26.2 percent of Americans ages 18 and older – about one in four adults – suffer from a diagnosable mental disorder in a given year. When applied to the 2004 U.S. Census residential population estimate for ages 18 and older, this figure translates to 57.7 million people. Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion – about 6 percent, or 1 in 17 – who suffer from a serious mental illness. In addition, mental disorders are the leading cause of disability in the U.S. and Canada for ages 15–44. Many people suffer from more than one mental disorder at a given time. Nearly half (45 percent) of those with any mental disorder meet criteria for 2 or more disorders, with severity strongly related to comorbidity” (The Numbers Count: Mental Disorders in America, 2010).

Mental health conditions exist in every employer community at one time or another. The Chartbook on Mental Health and Disability in the United States (2004) data suggest, “3.5% of the adult U.S. civilian non-institutionalized population is estimated to have a mental health disability (6.7 million people). In comparison, 15.4% of the population is estimated to have a physical health disability without a co-occurring mental health disability (29.3 million)” (Jans, Stoddard, & Kraus, 2004). More recent evidence suggests much higher rates of mental health disorders in USA. The Partnership for Workplace Mental Health, Facts for Employers sites a 2005 Harvard study, which estimated that over 35 million persons (14% of the US adult population) suffer from a moderate or serious mental disorder in a given year Fig. 8.1 (Facts for Employers: Mental Health Parity Law, 2010).

“In four nationally representative surveys conducted between 1989 and 1998, people with any mental illness had lower employment rates (48–73%) than people who did not report mental illness (76–87%). Employment rates for people who reported serious mental illness were even lower, ranging from 32 to 61%. Among those with serious mental illness who had Schizophrenia and related disorders, employment rates ranged from 22 to 40%” (Jans et al., 2004).

Analysis shows that “employed people with mental illness worked in a range of occupational categories similar to those of people with no mental illness. Among people with mental illness, as in the general population, educational attainment was the strongest predictor of employment in high-level occupations” Fig. 8.2 (Jans et al., 2004).

“The National Comorbidity Survey Replication (NCS-R, 2001–2002) estimates that 32.6–35.1 million adults (16.2%) experience Major Depressive Disorder at some point in their lives. Major Depressive Disorder is a serious disorder that is different from normal temporary feelings of sadness. An estimated 13.1–14.2 million adults (6.6%) experience Major Depressive Disorder within a given year” (Jans et al., 2004). A 2003 study sited by The Partnership for Workplace Mental Health
estimated that 18 million Americans are affected specifically by depression on an annual basis. The study further found “only severe heart disease to be associated with more disability and interruption of daily functioning than depression” (Facts for Employers: Mental Health Parity Law, 2010).
8.1.2 The Mental Health Conundrum: Impairment Versus Disability

The prevalence is in stark contrast to the current state of the art of defining how mental health conditions affect the ability to work. To understand how mental health impairments affect employment and the provision of vocational rehabilitation services, it is important to describe the differences between impairment and disability. Inconsistency in the definitions of what mental health impairments are is part of what creates confusion for vocational rehabilitation professionals. Treating mental health professionals struggle to describe the effects of mental health conditions on an individual’s capacity to work. There is also incongruence between legislative definitions of disability as it pertains to work, and clinical descriptive information as is utilized by mental health professionals creates a unique problem for vocational rehabilitation professionals and employers. Employers and rehabilitation professionals must be mindful of all the considerations of the Americans with Disabilities Act (ADA) as amended in their decision-making process about an individual’s ability to work and in what capacity.

The ADA defines impairment as a physiological or mental disorder. Impairment is a “disability” under the ADA only if it substantially limits one or more major life activities. “An individual must be unable to perform, or be significantly limited in the ability to perform, an activity compared to an average person in the general population. The determination as to whether an individual is substantially limited must always be based on the effect of an impairment on that individual’s life activities” (The Americans with Disabilities Act, 1990). This is at the foundation of vocational rehabilitation and is consistent with rehabilitation process and practice.

There is no one agreed-upon definition of mental health impairments. A mental health impairment is a disease that causes mild to severe disturbances in thought and/or behavior, resulting in an inability to cope with life’s ordinary demands and routines. There are more than 200 classified forms of mental illness. Some of the more common disorders are Major Depressive Disorder, Bipolar Disorder, Dementia, Schizophrenia, and Anxiety Disorders, such as Posttraumatic Stress Disorder (PTSD), Panic Disorder (PD), Obsessive-Compulsive Disorder (OCD), and Generalized Anxiety Disorder (GAD), to name a few. Symptoms may include changes in mood, personality, personal habits, and/or social withdrawal. An estimated 54 million Americans suffer from some form of mental disorder in a given year” (Duckworth, 2008).

A mental impairment is defined by the ADA as “[a]ny mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities” (The Americans with Disabilities Act, 1990).

According to the US Department of Labor (USDOL), Office of Disability Impairment Policy, “A mental health disability is a mental impairment that substantially limits a major life activity. There is not one agreed upon definition of a mental health impairment Neither the statute nor the regulations list all diseases
or conditions that make up ‘physical or mental impairments’, because it would be impossible to provide a comprehensive list, given the variety of possible impairments.”

The Diagnostic Statistical Manual of Mental Disorders (DSM-IV 4th ed., text revision) indicates, “when establishing the existence of a ‘mental disorder,’ ‘mental disability,’ ‘mental disease,’ or ‘mental defect’ additional information on an individual’s functional impairments and how these impairments affect their abilities is usually required beyond that in the DSM IV. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability…The problem raised by the term mental disorder’s has been much clearer then its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute. The concept of mental disorder lacks a consistent operational definition that covers all situations” (American Psychiatric Association, 2000).

Physical disabilities are well differentiated in the language of work and job demands. By comparison, mental health conditions are not typically described in the language of work. As evidenced here, in the mental health disciplines, the word “impairment” means something different from that in the physical medicine arena. Employees, employers, and treating professionals struggle to determine if and how a mental health condition affects the person’s abilities to work. All too often, the decision becomes a guess as therapists rarely seek objective evidence about the job and its demands.

8.2 Vocational Rehabilitation: The Treatment Process

Vocational rehabilitation is typically the program of last resort for individuals with disabilities. It is neither an acute care service, nor is it required when there is a clear path back to an individual’s regular work assignment. While vocational rehabilitation can be helpful early on after an injury or illness, it is more likely to be considered later in the recovery process. Some disability programs preclude the consideration of vocational rehabilitation until after acute medical care has been completed. This delay in referral results in lower success rates and increased costs. Inclusion of a vocational rehabilitation counselor in a treatment plan does increase costs for services, but becomes justified as cases age. The Pareto Rule or Pareto Principle applies here (Hafner, 2001). In total, 20% of cases result in 80% of the program costs. This is the marketplace for vocational rehabilitation. Due to the high cost of these claims and the potential future exposure, vocational rehabilitation becomes justifiable to try to resolve these more difficult claims. The Workers Compensation Research Institute determined that the optimal time for claims to be referred for vocational programming in New York State was about 3 months from injury (Gardner, 1986). While this is an older study, it is generally accepted as being relevant at the present time.
Vocational rehabilitation counselors may work in a facility setting providing direct services, or in a case management role within a government agency or an insurance company, or for a private case management firm. Vocational rehabilitation counselors engage in a variety of activities to assist the individual in achieving his or her employment goals. The process itself is a time-intensive effort that is best performed within the community. Clients are seen by vocational rehabilitation case managers in their homes or within their community where they are more comfortable.

From referral for services to return to work, to understand the typical vocational rehabilitation planning process is to better understand how it can be effective in assisting individuals with mental health impairments return to or remain at work. Vocational rehabilitation is considered a behavioral approach. Its’ stepwise process allows vocational rehabilitation counselors to coordinate individualized services with the objective of assisting a person in adjusting to the effects of their disabilities while increasing overall function. Although services are individualized to meet an individual’s needs, the treatment process does not typically vary based upon the type of impairment(s) (mental or physical) an individual faces.

8.2.1 Assessment and Appraisal

Vocational Rehabilitation Counselors start with an initial evaluation and interview of the individual requesting or being referred for services. This includes review of the pertinent medical/psychological records and history, how the presenting condition is inhibiting the person’s ability to achieve his or her goals, who are the treating providers and what is the course of treatment, what is the progress, and what goals are planned for further intervention. In addition, there is a review of the individual’s education, training, and work history along with discussion about family and psychosocial considerations.

This phase of the process is a strength of vocational rehabilitation as it identifies the individual’s view of his or her limitations and needs. It also focuses on how the individual perceives the limitations affect his or her ability to work. For persons with mental health conditions in particular, it is very important to understand how they view their own limitations and potential to work. Since most vocational rehabilitation environments are regulated by laws or insurance policy language, these aspects of the assessment are well regulated. They become the platform from which the vocational rehabilitation plan is developed and should be detailed in the plan justification for services. This justification and plan are many times necessary for the expenditure of money.

“Effective rehabilitation that enables individuals to function effectively in their job often involves the interdisciplinary efforts of many types of medical and non-medical professionals to conduct assessment, evaluation, therapy, and vocational guidance” (Falvo, 1991). Vocational Rehabilitation Counselors can administer
some standardized tests, but others will require referral to an appropriate professional. Some examples of the tests used are described later in this chapter under the section “The Vocational Rehabilitation Tool Box.” Additional diagnostic tests may be required to address unanswered questions about the individual’s abilities and limitations, as well as how they affect the person’s ability to achieve employment or an independent living goal. A psychological assessment by a clinical psychologist may be required to determine the correct diagnosis, degree of mental impairment, prognosis, recommended treatment, and readiness to participate in an active vocational rehabilitation program. Clinical psychologists should describe how the mental health condition affects the person’s work capacity and do so in work terms. “Avoid stress” is a common description used. A more appropriate description of the specific work temperaments modeled from the Dictionary of Occupational Titles (DOT) would be: “The patient should avoid: Performing a VARIETY of duties, attaining precise set limits, TOLERANCES, and standards, working UNDER specific instructions, and DIRECTING, controlling, or planning activities of others.”

Another consideration is that individuals with impairments will not recover spontaneously. Typically, they will show gradual improvement over time. They should be able to begin to perform some activities earlier than others and increase their skill over the course of their treatment. Initially, they may be limited to working ALONE or apart in physical isolation from others. Then they will progress to giving and taking instructions and performing repetitive activities. Finally, they may be able to DIRECT, control, or plan activities of others and INFLUENCE people in their opinions, attitudes, and judgments (descriptive terminology from the worker trait descriptions of the DOT and USDOL).

Without this level of specificity of function in work terms, Vocational Rehabilitation Counselors are forced to use other time-consuming and very expensive methods to acquire that information.

### 8.2.2 Career (Vocational) Counseling

Depending on the environment of and reason for the referral, the goal will likely be suitable employment (though some cases will focus on increasing the person’s ability to live as independently as possible). Career counseling will help the individual to integrate his or her work history, interests, aptitude, education, and limitations into a realistic and viable vocational goal. Labor market research about the career choices and informational interviewing are also helpful to assure that the vocational goal meets the individual’s expectations. While this step in the process is described prior to the development of a plan of services, there are some program environments where career counseling is incorporated into the Individual Written Rehabilitation Plan (IWRP).
8.2.3 **Vocational Rehabilitation Plan of Service**

This is the foundation of vocational rehabilitation. Once the vocational assessment process is complete and a vocational goal is determined, an Individualized Written Rehabilitation Plan (IWRP) is developed. Rehabilitation plans have two main parts. First, the justification provides a narrative rational for the services planned, how they will help the individual achieve their goal, who will provide those services, and how the vendors will be selected. The justification also includes an explanation about how the vocational goal was established and the viability of successful completion. Potential threats to success or obstacles to completion are also explored.

The second part of the rehabilitation plan includes a plan grid (See end of chapter for an example of a rehabilitation plan) outlining the services required to achieve the goal. Vendors are included along with start and completion timeline for coordinated services. Costs may also be included depending on the environment of the referral. The plan is signed by the individual in need of services and often by the vocational rehabilitation counselor. It is used as a method of outlining the responsibilities of each party and as an agreement for participation. Employers, insurers, and/or payers may also sign the plan. Rehabilitation plans are developed collaboratively, so that by the time the plan is presented to the individual with a disability for signing, the agreement of the other parties should have been secured. Failure to do so could erode the individual’s confidence in the plan and the vocational rehabilitation counselor.

During the implementation of the plan, the vocational case manager continually monitors progress and identifies problems that may interfere with successful completion. Periodic progress reports address how the individual is progressing toward his or her goals. These are shared with the payer and other parties as necessary, including treating professionals. As needed, plans are amended to include more time in programming, a change of vendors, or additional support services to adjust for or navigate unforeseen obstacles to success. The feasibility of successful completion is always present in the case monitoring. If an individual is making progress, this becomes highly reinforcing and tends to motivate the person further. If there is concern about the individual’s efforts to follow through, counseling and use of a behavioral contract may help the individual to get back on track and move toward a successful return to work.

8.3 **Other Considerations in Vocational Rehabilitation**

8.3.1 **Malingering and Compliance with Services**

Since vocational rehabilitation is primarily reserved for the more difficult cases, there is often a concern about compliance with services. “Is the individual motivated?” “Are they putting forth enough effort?” These are difficult questions to
answer. According to Donna R. Falvo, “The individual’s capacity to function at a job can depend on cognitive, psychomotor, and attitudinal factors, as well as on the physical aspects of illness or disability. An accurate assessment of an individual’s capacity to return to work consists of more than evaluation of physical factor’s alone. Success or failure at work is often determined by factors other than physical skill or ability…” (Falvo, 1991). There can be many reasons why a person does not perform or comply with services. If there is no medical or psychological evidence to preclude participation, then the individual may be malingering. Sometimes there is fear of re-injury, rejection, loss of benefits, failure, or some other variable that the individual does not readily present.

Falvo points out, “Some individuals readily adjust to the challenges, limitation, and associated behavioral changes necessitated by illness or disability. Many individuals, however, actively sabotage treatment and recommendations- to their own detriment. In such instances, professional’s goals should attempt to understand the underlying problems and motivations of individuals and to help them make necessary adjustments and adaptations in order to maximize functional outcomes. Rather than criticizing those who are ill or disabled for disinterest, a lack of motivation, or failure to follow recommendations, it is important to identify the barriers that prohibit adherence and to recognize that such reactions may indicate difficulty in accepting the condition or adapting recommendations in the individual’s own unique way of life” (Falvo, 1991). If vocational rehabilitation counselors identify less than full effort, case management can initiate discussions about the cause with the treating mental health or medical professionals as well as the individuals themselves. If the issue is related to the mental health condition, the discussion moves to how the therapist and the vocational rehabilitation counselor can help the patient overcome these obstacles. If the problem is unsolvable, then termination from the vocational rehabilitation effort must be considered. If the cause is not specific to the mental health condition, then the use of a behavioral contract can be helpful to identify specific areas of noncompliance. When problems are identified, the treating professionals are consulted as to the cause and how to overcome the performance problem. This results in a discussion addressing how the mental health or psychosocial condition is producing the specific work-related barriers. Regardless of the etiology, several decisions need to made. Does the psychosocial or mental health condition result in a material limitation in the ability to work? Did the condition predate the onset of disability? If it did predate the onset of disability and at the time did not present itself as a disabling factor, it would be difficult to argue that it now limits the ability to work. An important distinction in the field of vocational rehabilitation is that vocational rehabilitation does not engage in the diagnosing of disabilities, but focuses only on the individual’s vocational strengths and limitations and his or her potential to engage in substantial gainful employment. Vocational rehabilitation takes the person as a whole and must consider all aspects of the individual, including psychosocial condition, basic educational levels, age, and work history as part of determining the whole person’s ability to function in the work place.

Some programs require compliance for continued benefits, while others may suspend payments. Vocational rehabilitation is almost never the enforcer of consequences
for failure to comply. Working all day long in a treatment program provides many opportunities to observe inconsistencies in performance if there is an effort to hold back. While some individuals will present a sick role for a few hours, few people are capable of a sustained presentation for full-time activity. If the individual is genuinely apprehensive or fearful, the work simulations reinforce performance and increase confidence. Incremental increases of their time and days progress the individual toward the goal of full time by the end of the program.

One advantage to intense observation in a work adjustment program is the ability to gather objective data on behavior. This information allows the treating professional to address how the individual’s mental health condition is producing the observed behavior. If unexplainable, an independent medical/psychological examination may be recommended. In some cases, the decision is made to interrupt the program for a brief period while the treating professional addresses specific issues that may have arisen.

### 8.3.2 Job Descriptions

Occupational information has been standardized since the 1930s. The USDOL first published the DOT in 1934. There were periodic revisions of the DOT until 1991. The DOT provided the first effort at quantifying job demands in the physical, cognitive, and behavioral domains, which will be described in more detail later. In the early 1990s, the USDOL convened the Advisory Panel on the DOT (APDOT), to look at updating the DOT and its content. After a rigorous review, the APDOT determined that research had confirmed there were structural problems with the DOT and recommended a totally new database of occupational information called the Occupational Information Network (O*NET). The new O*NET had some similarities to the DOT and initially relied on the DOT for content. In other ways, there were significant content differences that are still debated today.

O*NET was not developed for disability determinations, but neither was the DOT. Since both the DOT and O*NET were not designed to assist with disability determinations, caution must be used when relying on job information derived from their data. This leaves administration of disability benefit programs at a disadvantage as well. The Social Security Administration (SSA) administers the federal governments’ disability benefits for American citizens and is the largest provider of those benefits in the world. The SSA must determine if and how a disability affects a person’s ability to work. Their regulations still require the use of the DOT. However, they are currently evaluating alternatives due to the problems with the DOT’s structure and its age since last being updated. Jobs have changed and new ones have evolved, thus reliance on the DOT can no longer meet their needs. The SSA has also determined that O*NET, as currently designed, cannot meet their needs. Even if the SSA designs a new system, it will be many years before it would be completed and validated.

In the midst of all this confusion and uncertainty, persons with mental health conditions are returning to work and employers are figuring out how to accommodate
their impairments. Not all employers use the DOT or O*NET as their job descriptive platform, even though they are the most well known. So, how is it done? How do employers make determinations while avoiding potential litigation? Do employers have resources/professionals to help them in the process? How do they bring back the employee at the right time, neither too early, nor too late in his or her recovery?

Due to the limitation in the behavioral health field regarding quantifying job demands, especially the impact of a specific mental health condition on a person’s capacity to work, many employers are left frustrated about how to consider a candidate/employee who presents with a mental health condition. One solution begins with well-developed job descriptions, which consider not only the physical demands, but also the cognitive, judgment, environmental and behavioral demands. The value of using the DOT data or O*NET data as a reference is obvious. Employers can be more confident about their job descriptions and document any variations from the standard descriptions.

Detailed job descriptions become the foundation for any return-to-work planning. Vocational rehabilitation counselors can prepare a job description for employers who do not have one, if it is not up to date, or when the current job description is not specific enough to the functional demands of the position. Most counselors utilize the format of the DOT. A sample Job Analysis is found at the end of this chapter. Not all vocational rehabilitation counselors are as well skilled, by training or experience, in job analysis as others. Some may prefer to rely on an Occupational or Physical Therapist to complete an analysis. It is advisable to secure samples of their work to assure that they have the direct knowledge of how to perform a functional job analysis. With a good job description/job analysis, the medical professional can quickly see the job demands without guessing at how much bending, sitting, decision making, or other job demand is required. The treating professional can make an in-depth analysis of how their patient can or cannot address the job demands. When presented with more detail about a person’s job expectations, treating professionals will respond to the specifics, thereby providing a more detailed response. The result is a more definitive and accurate response.

Since vocational rehabilitation focuses on the employment of individuals with impairment, rehabilitation counselors rely heavily on job descriptions to identify job demands and then connect that to the impairments of the individual. Rehabilitation counselors have a strong base in occupational information and job demands. While vocational rehabilitation counselors can reference national data, the best information is based on a specific job. The ADA as Amended addresses the need for good job descriptions that define job demands to help in the placement of a person with a disability. However, even with this new emphasis on the importance, job descriptions vary greatly in content, completeness, and even use by employers. Some employers prefer vague descriptions with little information. Others rely on proprietary systems to develop and maintain comprehensive job descriptions. While some update their descriptions regularly as frequently as once every year, others use descriptions developed many years ago and have decided that they are “good enough.”

Assuming an individual has a condition interfering with their ability to work, with what work obstacles do they struggle? Construction of strong usable job
descriptions is a key component of navigating the broad spectrum of disabilities and their effect on employment. These job descriptions must define job requirements clearly (physical, environmental, cognitive, and knowledge skills and tasks) using standardized language.

Professionals in the job analysis and organizational development industries debate with passion which system best represents the job demands of work. It is not the purpose of this chapter to analyze any specific job analysis database, system, or tool(s) but to provide a general understanding of how these systems can assist employers and mental health professionals discern what components of a job may be impacted by an individual’s impairment(s). Therefore, we will address two job databases developed by the USDOL, the tools of which are also embroiled in debate.

Where does an employer begin in developing a usable job description? There are general work demands essential to all forms of employment.

Since vocational rehabilitation professionals look at things from a more behavioral approach, it is important to identify or be aware of the behavioral issues that affect individuals with mental health impairments in the work setting. Duckworth identifies the following general work demands as those requiring special attention for individuals with mental health impairments (Duckworth, 2008).

- Maintaining stamina during the workday
- Maintaining concentration
- Staying organized and meeting deadlines
- Dealing with memory deficits
- Working effectively with supervisors
- Interacting with coworkers
- Handling stress and emotions
- Maintaining attendance
- Dealing with change

General work demands should be discussed with any person with a mental health condition. If considering a new hire, a post-offer evaluation of these work demands should be obtained by a mental health professional. Under the ADA, “A covered entity may conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site. A covered entity may make inquiries into the ability of an employee to perform job-related functions” (The ADA: Your Responsibilities as an Employer- Addendum, 2008).

The next major component of developing a strong job description is the determination of the essential job functions of a job. Essential job functions are functions for which the job exists. The ADA, as Amended in 2008, approaches the issue of job demands with the definition of who qualifies as a person with a disability. “The term ‘qualified individual’ means an individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires. For the purposes of this subchapter, consideration shall be given to the employer’s judgment as to what functions of a job are essential, and if an employer has prepared a written description before advertising or interviewing applicants for the job, this description shall be considered evidence
of the essential functions of the job.” (Note: The strikeovers relate to the changes made to the ADA by the new ADAAA.) (The ADA Amendments Act, 2008).

The EEOC provides more guidance on defining essential functions in its publication, The ADA: Your Responsibilities as an Employer – Addendum.

8.3.3 How Are Essential Functions Determined?

Essential functions are the basic job duties that an employee must be able to perform, with or without reasonable accommodation. You should carefully examine each job to determine which functions or tasks are essential to performance. This is particularly important before taking an employment action such as recruiting, advertising, hiring, promoting, or firing.

Factors to consider in determining if a function is essential include the following:

- Whether the reason the position exists is to perform that function;
- The number of other employees available to perform the function or among whom the performance of the function can be distributed; and
- The degree of expertise or skill required to perform the function (The ADA: Your Responsibilities as an Employer- Addendum, 2008).

Your judgment as to which functions are essential, and a written job description prepared before advertising or interviewing for a job will be considered by EEOC as evidence of essential functions. Other kinds of evidence that EEOC will consider include the following:

- The actual work experience of present or past employees in the job;
- The time spent performing a function;
- The consequences of not requiring that an employee perform a function;
- The terms of a collective bargaining agreement (The ADA: Your Responsibilities as an Employer – Addendum, 2008).

The guidance from the EEOC clearly encourages an employer to develop accurate job descriptions with significant detail. It also speaks to the essential functions of the job. While there are many proprietary job analysis systems available, where do employers go to get the background material to help assure they are addressing the job dimensions properly? There are two good sources from the USDOL. The first is the “original” database of job information called the DOT and the second is the USDOL’s “new” O*NET.

8.4 The Dictionary of Occupational Titles

DOT was the first attempt at quantifying work into tasks and job demands. The DOT defines over 12,000 job titles and quantifies 73 distinct worker traits for each job title. The Revised Handbook for Analyzing Jobs describes in detail how to measure
each worker trait. The USDOL developed this document to act as a guide for users developing job descriptions using the DOT traits. While revised periodically, the DOT was last published in 1991 and was replaced by O*NET. With the decision to replace the DOT, its companion book *The Revised Handbook for Analyzing Jobs* is no longer published by the USDOL. This book provided detailed descriptive information about how to measure each of the worker traits found in the DOT.

Since this book focuses on issues of mental health in the work place, there are several key areas of DOT worker traits that relate more specifically to those limitations.

### 8.4.1 Temperaments

“The category Temperaments is one of the components of job analysis because different job situations call for different personality traits on the part of the worker. Experience in placing individuals in jobs indicates that the degree to which the worker can adapt to work situations is often a determining factor for success. A person’s dissatisfaction or failure to perform adequately may be attributed to an inability to adapt to a work situation rather than to an inability to learn and carry out job duties.”

The 11 temperament factors are defined below. Following each definition are examples of worker activities, which illustrate the Temperament Table 8.1.

### 8.4.2 Procedure for Rating Temperaments

Evaluate the work activities of the job for applicability of the temperament factors by referring to the definitions of the factors. Select the factors that are considered important in relation to the kinds of adjustments that the worker must make for successful job performance. Do not assign temperaments based on incidental work activities. Some simple jobs may require the worker to adjust to only one temperament factor, while other jobs may require adjustment to several. In Item 9 of the JAR, enter the letter designation(s) of temperament factor(s) considered to be important in relation to the kinds of adjustments that the worker must make for successful job performance (Hillsdale, 1992).

The DOT is now 18 years old and some of the descriptive information about jobs was last revised in 1977. Additionally, the DOT was not designed for disability determination purposes. However, the SSA still relies on the DOT for disability determinations. They have created Occupational Information for Disability Advisory Panel (4) to evaluate solutions for SSA to replace the DOT. They have just begun their work and have not yet published even preliminary findings. Looking at the development time for O*NET, the SSA solution is many years off.
The USDOL no longer supports the DOT and advises users to be cautious because of the age of the DOT data. Expert users of the DOT job data will still use the DOT recognizing the limitations because of its global use and that many other professionals are familiar with its terms. Sedentary, medium, light, heavy, and very heavy work are the recognized terms describing work by medical professionals, workers compensation systems, and the courts.
8.5 The O*NET

The O*NET was first released in 1995. Version 1 was more of a beta demonstration model. It relied on DOT data to describe work. Where the DOT was a “Task base” system, O*NET was a “Worker-oriented” system. The USDOL relied on the recommendations of APDOT (5). O*NET identifies about 900 job titles. The USDOL change from the DOT’s 12,000 distinct job titles to the O*NET’s 900 necessitated significant clustering and aggregation of many DOT titles into one O*NET title. The reduction from 12,000 to 900 was intentional to assist with helping displaced workers transition into other similar work, with minimal retraining. While the clustering may help in assisting displaced workers transition to other jobs by relying on similar skills/knowledge, it presented another problem to those working in the disability arena.

First, the 900 O*NET job titles show a large variability in the job demands for the physical, cognitive, and temperament demands when the DOT codes included within each O*NET title were examined. Second, where the DOT used 73 worker traits to define jobs demands, O*NET uses over 400. Compounding the complexity, the terms used to describe work in O*NET are significantly different from those in the DOT. This lack of familiarity with the terms presents a new problem to medical professionals opining on a persons’ capacity to perform work. O*NET’s worker traits appear to be better developed for cognitive and behavioral skills, and should be considered as a resource tool for any employer revising job descriptions.

“The Content Model was developed using research on job and organizational analysis. It embodies a view that reflects the character of occupations (via job-oriented descriptors) and people (via worker-oriented descriptors). The Content Model also allows occupational information to be applied across jobs, sectors, or industries (cross-occupational descriptors) and within occupations (occupational-specific descriptors). These descriptors are organized into six major domains, which enable the user to focus on areas of information that specify the key attributes and characteristics of workers and occupations” (The O*NET Content Model, 2010).

Worker Characteristics: enduring characteristics such as abilities, interests, and work styles that might influence both a worker’s performance and the capacity to acquire knowledge and skills required for effective work performance.

Worker Requirements: work-related attributes acquired and/or developed through experience and education related to the occupation. Knowledge refers to acquired facts and principles pertinent to a job. Skills are the application of knowledge in a work setting and may be divided into basic skills (such as reading, which facilitates the acquisition of new knowledge) and cross-functional skills (such as problem solving, which extends across several domains of activities).

Experience Requirements: qualities related to previous activities and specific types of work activities. This category includes information about the typical experiential backgrounds of workers in an occupation or group of occupations, as well as certification, licensure, and training.
Occupational Requirements: O*NET identifies generalized work activities and detailed work activities that may be performed within multiple occupations. Using this framework, a single set of descriptors can be used to describe many occupations.

Work context descriptors (the physical, social, or structural context of work) that may impose specific demands on workers are also included in this category.

Occupation-Specific Information: descriptors that apply to a single occupation or a narrowly defined job family. This information includes occupation-specific tasks and machines, tools, and software – referred to as Tools and Technology. This category is particularly important for specific human resource applications, such as training, developing job descriptions, or redefining jobs.

Workforce Characteristics: “general characteristics of occupations that may influence occupational requirements, including the occupation’s social and economic contexts. Labor market information defined by industry or occupation also falls within this category. O*NET provides this information through links from O*NET OnLine to statistical labor market information including compensation and wage data, employment outlook, and industry size information” (O*NET).

Similar to the DOT temperament discussed previously, the O*NET Work Styles subcategory best addresses worker traits as they relate to mental health in the work place. “The O*NET Database provides occupational information within the following categories:

Work Styles – Personal characteristics that can affect how well someone performs a job.

- Achievement Orientation – Job requires personal goal setting, trying to succeed at those goals, and striving to be competent in own work
  - Achievement/Effort – Job requires establishing and maintaining personally challenging achievement goals and exerting effort toward mastering tasks.
  - Persistence – Job requires persistence in the face of obstacles.
  - Initiative – Job requires a willingness to take on responsibilities and challenges.

- Social Influence – Job requires having an impact on others in the organization, and displaying energy and leadership
  - Leadership – Job requires a willingness to lead, takes charge, and offer opinions and direction.

- Interpersonal Orientation – Job requires being pleasant, cooperative, sensitive to others, easy to get along with, and having a preference for associating with other organization members
  - Cooperation – Job requires being pleasant with others on the job and displaying a good-natured, cooperative attitude.
  - Concern for Others – Job requires being sensitive to others’ needs and feelings and being understanding and helpful on the job.
– Social Orientation – Job requires preferring to \textit{work with others rather than alone}, and being personally connected with others on the job.

• Adjustment – \textit{Job requires maturity, poise, flexibility, and restraint to cope with pressure, stress, criticism, setbacks, personal and work-related problems, etc.}

– Self Control – Job requires \textit{maintaining composure, keeping emotions in check, controlling anger, and avoiding aggressive behavior, even in very difficult situations.}

– Stress Tolerance – Job requires \textit{accepting criticism and dealing calmly and effectively with high stress situations.}

– Adaptability/Flexibility – Job requires \textit{being open to change (positive or negative) and to considerable variety in the workplace.}

• Conscientiousness – Job requires dependability, commitment to doing the job correctly and carefully, and being trustworthy, accountable, and attentive to details

– Dependability – Job requires being \textit{reliable, responsible, and dependable, and fulfilling obligations.}

– Attention to Detail – Job requires \textit{being careful about detail} and thorough in completing work tasks.

– Integrity – Job requires being honest and ethical.

• Independence – Job requires developing one’s own ways of doing things, guiding oneself with little or no supervision, and depending on oneself to get things done.

• Practical Intelligence – Job requires generating useful ideas and thinking things through logically

– Innovation – Job requires \textit{creativity and alternative thinking} to develop new ideas for and answers to work-related problems.

– Analytical Thinking – Job requires \textit{analyzing information and using logic to address work-related issues and problems}” (O*NET).

*The worker traits mentioned above are italicized to illustrate those that could be affected by mental health impairments (The O*NET Content Model, 2010).

At the end of this chapter is a sample job description that includes many of the job demands addressed here. This is only one sample type of many and relies on a DOT-based model. Note that each worker trait references the specific tasks performed. This is very helpful in identifying the “essential job demands” where a person with distinct limitations may have trouble or require accommodation. It is important to point out that no analysis would be complete if it addressed only the worker traits we have described here. All worker traits must be reviewed for secondary impact. The mental health condition may affect other aspects of physical function, such as medication’s side effects, reaction time, balance, etc., that could limit job performance.
8.6 The Vocational Rehabilitation Tool Box

Vocational rehabilitation professionals are well versed in standardized occupational information and the associated worker traits that are used to describe job demands. Medical professionals routinely describe physical limitations utilizing the specific standard terminology. Routinely, mental health professionals do not provide descriptive information about the functional limitations of mental health conditions. Vocational rehabilitation professionals commonly accept vague and ambiguous descriptions without challenging the mental health professional to provide more definitive information utilizing standardized worker trait terminology and are, therefore, forced to try to find a best fit with the standardized occupational information. This process is a subjective best-guess estimate of the rehabilitation professional. Some rehabilitation professionals will then utilize other rehabilitation tools to firm up the vague worker trait information.

Outside the planning process, there are many services and tools that vocational rehabilitation counselors utilize/implement to assist individuals adjust to their disabilities effectively, and return to or remain at work. We will not outline all services offered under vocational rehabilitation, but will highlight those that are specifically helpful/beneficial in working with individuals with mental health impairments.

8.6.1 Case Management

Effective rehabilitation case management can increase an individual’s chances of success and reduce cost and time off work. Specially trained vocational rehabilitation professionals coordinate the recovery and act as a liaison between the employer, individual with a disability, and treating professional(s). They provide encouragement, answer questions that have not yet been asked, coordinate information, and reduce the anxiety about the return-to-work process. The key role of an effective case manager is to act as an advocate on behalf of the individual with a disability. It is important to be sure that the case managers are skilled in dealing with mental health return-to-work issues. While rehabilitation professionals’ core training provides some orientation to mental health counseling and personality theory, the core curriculum revolves around the vocational aspects of disability and the impact on work. Although vocational rehabilitation counselors understand the demands of jobs and associated worker traits, most are not professionally qualified to diagnose, treat, or opine on how a specific mental health condition would affect the individual’s ability to perform those job demands. They must, therefore, rely on other licensed mental health professionals to assist them.
8.6.2  Situational Assessment/Work Adjustment

In some cases, it is unclear how the incumbent may respond to a work effort. She or he may have doubt about one’s ability to attend work on a regular basis, or in how to meet work expectations. A Situational Assessment or Work Adjustment program involves the placement of the incumbent in a work simulation, outside of one’s regular place of employment. The program location may be a not-for-profit agency, hospital, school, or rehabilitation facility, where trained professionals work closely with the incumbent to help her or him to assume general work demands. Based on the individual, he or she may begin simulations of one’s regular work activities. An example would be a clerical work adjustment program, where the incumbent initially works at one’s own pace and gradually increases one’s productivity and work tolerances.

During the program, the trained professionals work closely in navigating disability-related limitations and coach the incumbent on how to address specific behavioral issues. Regular progress reports apprise the medical or rehabilitation professionals of problems, so they can help the incumbent and the facility staff to overcome work obstacles. As confidence, coping skills, and performance improve, the incumbent can transition back to one’s regular job with minimal difficulty, and many times without other employees being aware of any issues.

A common problem that can arise is when one of the treating professionals engages in a plan of action or change of plan that is either not communicated or coordinated with the other treating professionals. This can result in the playing of one professional against the other, and can considerably jeopardize the potential for success. It becomes important at that point for the rehabilitation professional to act as an advocate for the injured person and their rehabilitation plan, and promptly address the failure to cooperate by the noncompliant treatment team member. Rehabilitation professionals may even solicit the support of the rest of the team to negotiate an alternative plan that will lead to a successful outcome. While this may be the only viable course of action, this approach can lead to further discourse and without a change of a team member, the program may doomed to fail.

8.6.3  Adjustment Counseling

Significant consideration should be given when determining if the presenting psychological symptoms are the result of a mental health condition or psychosocial issues. It is also important to ask, did these mental health or psychosocial issues exist while an individual was successfully employed? Obtaining additional information from the employer such as the individual’s personnel file, including disciplinary or performance issues, might provide insight into other issues that would affect work and would, therefore, need to be addressed as part of any therapeutic work program. Individuals may experience a temporary exacerbation of symptoms or stressors because of a disability or injury. These only become relevant if they manifest themselves in a functional way that would be described as a general or specific work behavior. For example, if an individual is feeling
more anxious, one day this may be manifested by poor attendance, withdrawal from or refusal to follow instruction, decreased productivity, increased error rate, etc.

Adjustment to disability counseling is a tool that is usually brief and combines with other services, leading toward the eventual goal of employment. It does not replace psychotherapeutic treatment dealing with the clinical aspects of a disability and is routinely coordinated with the treating clinician’s therapy. The goal of adjustment to disability counseling is to assist an individual to better understand the implications of his or her impairments and/or psychosocial factors that may be interfering in his or her successful return to and to develop coping strategies to all for better functioning.

8.6.4 Transferable Skills Analysis

If a mental health condition precludes placement in a specific position, the worker trait profile can identify other potential job titles that remain within the individual’s work capacities. The transferable skills analysis process is typically done by a trained vocational rehabilitation professional. It involves the codifying of relevant work history into standard job database codes. Please see Job Analysis example at the end of this chapter for more specific information. The standard has been a reliance on the DOT database, but others are in early development using different job data information. Once all the relevant jobs history has been categorized, the associated worker traits can be gleamed from the work history, to determine a combined worker trait profile. This profile can be adjusted based on known disability-related limitations, or from tested data. Test data may decrease or increase a worker trait capacity. Using computer software such as OASYS and Skill Tran, the residual worker trait profile can be compared to other jobs in the database to fund a favorable match or matches. Matches are classified based on how similar the job titles are to the past work experience. This allows for the identification of other potential work where previous work skills and experience could be relied upon as employment assets. Last, the listing of residual job titles is used to search for vacant positions both within a business and in the labor market at large.

8.6.5 Return to Work Services

Vocationally related activities are the primary differentiators between vocational rehabilitation counseling and other health-related professions. Vocational rehabilitation counselors direct their focus toward the work capacities of the person and the job demands of work. While it is important to have a correct diagnosis, to the rehabilitation counselor, it is even more important to know the functional capacities of the person in work terms. If a specific vocational goal has been established and job demands are clearly defined, readiness may occur prior to full recovery.

Job-Seeking Skills Training and Job Placement services are an intense training program to teach individuals how to find job leads, interview, and secure employment. For a person with a mental health disability, there are unique issues. Most important,
has the mental health condition resulted in any absence from work, or has it resulted in discipline or firing? While this may not be hidden from a new employer (i.e., gaps in the employment history and reference checks), individuals can be taught how to best present themselves as qualified candidates. This is not an easy fix as they may still experience significant rejection. Intense support and coaching by the vocational rehabilitation counselor and the rest of the treating providers become critical.

The most costly part of any job search is finding potential employers. Utilizing the Internet can help to identify large numbers of opportunities for most of the candidates. If the individual has a limited work history and significant work limitations, job finding may become unlikely. Vocational rehabilitation professionals know that increasing work skills open up more job opportunities. The provision of training in a vocational or academic setting can be used to compensate for specific weaknesses or limitations. This is a two-edged sword as the longer the training, the longer they are removed from the work force, ultimately increasing the risk of failure.

A major limitation to the job search process for persons with mental health impairments is how to filter jobs based on the job demand limitations presented by the mental health condition. Use of job description databases such as the DOT or O*NET as described earlier in this chapter can help, but each employment opportunity has unique issues that cannot be gathered from standard information. This problem is further compounded by the mental health profession’s lack of functional limitations in work terminology.

### 8.6.6 Transitional Work Programs

Recovery from a condition causing impairment is never instant; also it does not progress evenly across all the limitations a person may be experiencing. Some limitations will improve while others will remain constant. Additionally, there are many times during which unknown issues surface at the point of work re-entry, derailing the effort. Utilizing the process described here, the participants and the helping professionals can plan a return to work to occur during recovery. For example, while the full recovery might allow a person to supervise a staff of 20 employees, one may be able to return to work initially as a co-worker in the same department while continuing treatment.

Many companies utilize Transitional Work programs, which are specially designed to identify work within a company where the individual could resume working in a lesser demanding job during recovery. Over time, one can begin to transition into performing some of one’s original job duties, gradually assuming more of his or her regular work tasks over several weeks or months. Transitional Work may involve part-time work, where the incumbent gradually increases one’s work hours to full time. Some more robust programs include the use of on-site therapists to coach the incumbent in how to perform the job duties safely.
Transitional work programs can be successful in both union and non-union work environments. To avoid abuse or labor relations issues, clear written policies are established for these programs. Transitional Work policies are often developed by a vocational rehabilitation counselor with the assistance of the employer. Transitional work programs must be time-limited, with the expectation that the incumbent must be placed in regular work at the completion of the program or placed in a leave status. These programs are most successful where a trained rehabilitation professional assists the employer in coordinating the medical approval with the actual job placement. Transitional work programs can help alleviate apprehension on the part of the treating medical professionals to agree to an early release to work while treatment continues.

8.7 Summary

Vocational rehabilitation professionals work with individuals who present with a variety of disabilities. They seek to match the person’s abilities and limitation to the demands of their job or vocational goal. Mental health impairments present unique problems due to the lack of definitive descriptors in work terminology about how the mental health condition affects work capacity.

Occupational data for disability determination purposes do not yet exist. While the SSA is attempting to address this problem, the solution will likely be many years away. Reliance on existing databases will be helpful but will not provide a clear solution for the employment needs of persons with mental health impairments. Some tools can help to alleviate the uncertainty. Care needs to be exercised to assure compliance with the myriad of laws and government regulations at both the state and federal levels.

The use of detailed job descriptions that include behavioral dimensions is a critical factor to successful re-employment of individuals with mental health disabilities. Detailed job descriptions can also help the mental health-treating professionals to be more diligent in their evaluation of return-to-work limitations. Employers need to appreciate that treating professionals are not familiar with the world of work and will respond more appropriately if presented with detail about work expectations. Even with the added specificity, other tools such as work simulations may better evaluate work capacity and help design programs of treatment to overcome work obstacles.

References


9.1 Epidemiological and Prevalence of Psychological and Behavioral Health Concerns

Behavioral health disability claims have been reported more frequently over the past several decades (Warren, 2009). This has led professionals to question whether there is an actual increase in actual behavioral health disorders or if there are other issues that are driving this increase (American Medical Association (AMA) 2008; Gatchel & Schultz, 2005; Melhorn & Ackerman, 2008).

9.2 Co-morbid Behavioral Health and Physical Concerns

A study by Van Korf (1992) ascertained that approximately two-thirds of individuals who utilize a high level of medical care were found to have some type of true psychiatric disorder that met the Diagnostic and Statistical Manual-IV, text revision (DSM-IV-TR, 2000). Twenty-three percent of these individuals were diagnosed with Major Depressive Disorder. Another 22% of these individuals had a diagnosis of some type of anxiety disorder, while yet another 20% had a diagnosis of somatization disorder. Importantly, this type of high utilization of medical care continued throughout these individuals’ lives. This finding was later supported by Härter, Baumeister, Reuter, Jacobi, Höfler, et al. (2007) who determined that the most common behavioral health diagnoses were those related to the depressive, anxiety, and somatoform disorders spectrum.

Importantly, behavioral health concerns tend to have a high comorbidity with physical concerns. The empirical literature has consistently demonstrated that many physical concerns, such as chronic pain, musculoskeletal, cardiac, stroke, obesity, diabetes, as well as different types of injuries have a great deal of concurrent...
psychological concerns (Dewa & Lin, 2000; Härtter et al., 2007; Kessler, Merikangas, & Wang, 2007; Kroenke, 2003; Laitinen-Krispijn & Bijl, 2000; Linton, 1993; Merikangas et al., 2007; Ormel et al., 2008; Roy-Byrne et al., 2008). The prevalence rates for comorbid behavioral health disorders are quite high, averaging 42.2% for individuals with physical concerns. Thus, the empirical research has demonstrated the importance of appropriate evaluation and diagnosis of potential behavioral health concerns when treating an individual for a physical issue (Adler, 2007; Evans et al., 2005; Gatchel & Gardea, 1999; Gatchel et al., 2007; Goetzel et al., 2004; Heidel et al., 2007; Jorm et al., 2000; Katon et al., 1982; Kavan, 2009; Kessler et al., 2005; Kessler and Wang, 2008; Krause et al., 2001; Langlieb and Kahn, 2005; Lee et al., 2009; Leopold, 2003; Lerner et al., 2005; Reggers and Anseau, 1999; Seedat et al., 2009; Suehs et al., 2008; Disability Management Employer Coalition, 2008; Waeher et al., 2004).

9.3 Defining Disability in the Behavioral Health Context

While the prevailing view among professionals is that disability is primarily a physical issue, the greater prevalence of behavioral health concerns in the majority of disability claims is typically overlooked. Dr. Brundtland, the previous Director General of the World Health Organization (World Health Organization, 2004), noted in 2001 that mental health disorders account for 30% of all years lived with disability (YALY) on a global basis. Specifically, major depression disorder was reported to be the fourth leading cause of disability. Moreover, it was projected that major depression disorder would be the second leading cause of disability by 2020. Moreover, within the USA, a similar trend can be observed in the number of individual filing for behavioral health disability with the Social Security Administration (SSA, 2008).

Because of the lack of clarity in the definition of disability, case management (case manager) professionals tend to rely on subjective information for “evidence” of disability rather than relying on objective data of functional impairment in the disability determination process. Thus, from the initiation of the claim, the stage is set for adversarial process between the treating professional, case manager, and insurer (Hadjistavropoulos & Bieling, 2001; Talmage, 2007). While it is unrealistic to expect all treating professionals to be fluent in the multiple definitions of disability, it is essential that all treating professionals understand the basic requirements for the objective evaluation and documentation when an individual files a disability claim. Unfortunately, there is a current lack of professional training for all professionals in understanding the difference between disability and impairment, appropriate evaluation, and evidence-based treatment to facilitate an individual’s return to work (ACOEM, 2006a).

It is essential for case managers to recall that impairment in functioning pertains directly to the actual functioning of the individual across multiple physical, emotional, and cognitive domains. Importantly, case managers should focus on the specific, standardized measures of functioning in each of these systems. This provides a means for case management professionals to discuss specific deficits and how these deficits relate to the individual’s ability to perform a workplace duty.
This provides a framework in which the case manager can request information from a treating professional such that he or she can understand and be able to provide the precise information requested (ACOEM, 2006a; Warren, 2005, 2009).

In case management, there is misperception about how impairment in functioning relates to behavioral health concerns. This general lack of understanding of the nuances of impairment in functioning is shared not only by the treating professionals but also by the majority of case managers who are involved only on the healthcare side of case management.

Case management involves a wide range of professional knowledge, functions, and responsibilities. Unfortunately, the claimant’s work status may not always be a consideration by the case manager. For example, when the case manager is involved on the healthcare side in non-integrated case management, the focus is often more towards reducing healthcare utilization and cost containment. This type of stance may not always be compatible with optimal treatment and return to work efforts. Moreover, it tends to promote an overly-simplistic case management style in which important and often complex behavioral health disability decisions are made in regards to reducing the number of professional visits with the treating professional and minimizing the cost of care. Reduction of healthcare utilization and costs are not the sole motivating factors in the case management process. Often, treating professionals are unaware of how a good case manager, with a thorough understanding of both the case manager and behavioral health treatment process, can actually help the treating professional better navigate the behavioral health disability process and reduce the time taken for the documentation process (Powell & Tahan, 2007).

### 9.3.1 Types of Disability Benefits

It is important to note there are multiple types of disability benefits that an individual may receive. Each type of disability has its own definition as well as required criteria and documentation that must be submitted to receive disability benefits. It is also possible that the claimant may be applying for benefits under two or more programs. This is commonly seen when an individual applies for short-term or long-term disability benefits and simultaneously applies for Social Security Disability Insurance. The processes may be similar but will demand different application forms and potentially, different clinical documentation. Thus, there are issues related to standardization of definitions and requirements across each type of disability. Each type of disability has its own type case managers who manage disability claims. This can result in multiple case managers involved in a claimant’s disability claim. Alternatively, different case managers may interact with one case in a sequential fashion. Frequently, commercial and private insurers have clauses that limit behavioral health disability to specific periods of time. A typical period is 2 years. After this period of time, the claimant is not typically longer eligible to

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1Behavioral health disability in the contexts of workers’ compensation and personal injury law is discussed in detail elsewhere in this volume and will not be discussed here.
receive further disability benefits from the private insurer, based on common insurance practices. A claimant may either file for private disability or simultaneously file for public disability benefits, such as Social Security Administration (SSDI) disability insurance. Moreover, a claimant may also file for Workers’ Compensation (WC) disability benefits if the claimant and treating professional believe the workplace caused the purported impairment.\(^2\) If the reported behavioral health concern is not work related, then the claimant (if covered at the time the disability occurred) may file for short-term (STD) or long-term (LTD) disability benefits from commercial disability insurer. Typically, STD and LTD insurance benefits are paid either in part or in whole by the employer (Powell & Tahan, 2007).

In STD or LTD, the types of disability are usually broken into two separate categories. These are often termed “Own Occupation” (“Own Occ”) or “Any Occupation” (“Any Occ”). “Own Occupation” refers to the claimant’s ability to perform the essential tasks of one’s own occupation or job. “Any Occupation” refers to the inability to perform any type of gainful employment. STD/LTD contracts may further refine this to mean unable to perform the usual tasks of any gainful occupation for which the claimant is reasonably suited by training, education or experience sufficiently to procure and retain employment (Powell & Tahan, 2007).

In many ways, “Any Occupation” is similar to the criteria for Social Security Disability Insurance (SSDI). The primary difference is that under SSDI, it is permissible for an individual to have limited employment under a “trial work period” and/or “extended period of eligibility” as defined below.

**Trial work period:** The trial work period allows a claimant to test one’s ability to work for at least 9 months. During the trial work period, the claimant will receive their full social security benefits regardless of how much they are earning as long as they report their work activity and continue to have a disabling impairment. In 2009, a trial work month is any month in which the total earnings are $700 or more, or, if self-employed, earn more than $700 (after expenses) or spend more than 80 h in one’s own business. The trial work period continues until the claimant has worked 9 months within a 60-month period.

**Extended period of eligibility:** After the trial work period, the claimant has 36 months during which he or she can work and still receive benefits for any month if the earnings are not “substantial.” In 2009, earnings of $980 or more ($1,640 if one is blind) are considered substantial. No new application or disability decision is needed for the claimant to receive a social security disability benefit during this period (Social Security Administration, 2004, 2007).

The STD/LTD “Any Occupation” criteria may not provide for limited or part-time employment and require the claimant to be totally disabled. Many STD policies related to “Own Occupation” do, however, have provisions that permit part-time or limited duty and do not require the claimant to be “totally disabled” even from one’s own occupation. There are hybrid forms of STD/LTD policies which provide that if the claimant is not able to perform the essential tasks of one’s work, the claimant is considered to be “totally disabled”. Under such a policy, the claimant is generally not permitted to be employed in any other capacity during the time the individual is on disability.

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\(^2\)Statute of limitation issues may complicate workers’ compensation claims initiated after mental health disability coverage periods have run out.
Unless the STD/LTD plan provides rehabilitation incentives or alternative duty programs, the benefits are likely to act as a disincentive for the individual to request accommodations or to request transferring into another position at the workplace. Another concern is that the claimant continues to receive benefits for being disabled from one’s usual occupation. This creates a dilemma for the claimant in that one of the primary incentives to return to work is minimized or eliminated altogether. This is especially true in the case where the individual’s employment has been terminated, such as when the disability has exceeded the Family Medical Leave Act (FMLA) period. In such a case, should the individual wait until his or her STD/LTD “own occupation” benefits terminate before seeking other employment, the individual may become unemployable due to the gap in work history, loss of job-related skills, and mental attitude. At such a point, the individual and/or treating professional may begin to view the STD or LTD as unemployment insurance and the claimant may become strongly entrenched in the disability role (Hadjistavouropoulos & Bieling, 2001).

Unfortunately, many treating professionals continue to see the claimant on a periodic basis only. At these visits, the claimant will typically note continued symptoms. A common response of many treating professionals is to rubberstamp the claimant’s disability to leave without the benefit of referring the claimant for psychological evaluation and evidence-based treatment to better address both true psychological concerns and psychosocial issues. True psychological concerns are not under the claimant’s voluntary control.3

9.3.2 Issues that Arise with Disability Benefits and Objective Evidence of Impairment

A particular problem arises when the claimant experiences a serious illness or injury that will permanently prevent return to work within one’s own occupation (Bruns & Disorbio, 2005; Dersh, Gatchel, Polatin & Mayer, 2002; Gatchel, 2004). Except for certain cases of disability, such as workers’ compensation, where the claimant may be required to accept light or alternative work, such requirements do not apply to the majority of STD/LTD disability policies. Moreover, if the individual has applied and has received SSDI benefits, there is no mechanism in place to facilitate the individual’s return to the workplace.

It is common for the claimant to develop strong affiliation with a disability role and to not attempt activities of daily living, let alone returning to work. In the field of psychology, this is called “Learned Helplessness” (Bandura, 1986; Chang & Sanna, 2007; Peterson, Maier, & Seligman, 1993). If and when the disability policy definition changes to “any occupation” (which often occurs in the transition from

3Moreover, true psychological concerns can cause impairment in functioning and require professional treatment to ameliorate. On the other hand, psychosocial concerns are issues that are likely to occur with most people in life. Examples of psychosocial concerns are: job dissatisfaction, workplace conflict, and work performance issues, to name a few (Warren, 2009).
STD to LTD) and if the claimant is capable of lighter or alternative work, he or she often experiences a “loss of face” resulting from the expectation that they will return to a role that they believe is impossible for them. The claimant, who was previously viewed as being totally disabled, is now faced with a change in disability definition that requires treating professionals, case managers, and the claimant to consider the prospect of other work (ACOEM, 2007; AMA, 2008). Because the claimant is highly likely to have become entrenched in the disability role, it is particularly difficult for the claimant to consider transition back to the workplace (Anssea et al., 2004; Aylward, 2001; Aylward, 1995; Bigos et al., 1991; Bigos & Battie, 1991; Brundtland, 2001; Waddell, 2006; Waddell & Burton, 2001; Waddell & Burton, 2004; Waddell et al., 2007; Waddell et al., 2008; Waddell et al., 2003; Waddell et al., 1993).

In many instances, the treating professional and claimant are unfamiliar with the nuances of disability benefit structures (Warren & Hubbard, 2007). For example, an individual may be denied additional disability benefits after a certain period of time has passed or if the claimant is not receiving regular professional treatment. In addition, there is a misconception among the majority of professionals and claimants that behavioral health concerns are permanent in nature and thus require long, open-ended leave from the workplace. Empirical research has consistently demonstrated that the majority of psychological concerns respond quickly to treatment that has been shown empirically to be effective (Warren, 2005). Thus, while the claimant may continue to experience some symptoms, it is imperative for the treating professional and the case manager alike to not assume that they are evidence of impairment. American Psychiatric Association (2006a), American Psychiatric Association (2006b), American Psychiatric Foundation, Partnership for Workplace Mental Health (2005a). The American Psychiatric Foundation (2005b) has noted that an individual can receive treatment and work simultaneously, and stressed the points that the majority of individuals with mental health concerns are able to return to the workplace, and that extended workplace leave is the exception, not the norm. The common failure to recognize this capacity to work while receiving treatment can lead to iatrogenic disability.

9.3.3 Family Medical Leave Act

Under the Family Medical Leave Act (FMLA), an employee is eligible for job protection for up to 12 weeks of unpaid leave per year when either the employee or a family member suffers from a “serious health condition.” The year is frequently interpreted to be a rolling year so that if the individual has taken 12 weeks off in 1 year, then another 52 weeks of work must be accrued before the individual is eligible to take an additional 12 weeks of FMLA leave. The condition must either prevent the worker from performing his or her job, or require the worker to care for a family member. There are three different ways in which FMLA leave can be utilized:

1. Continuous FMLA leave: an example is when an employee is absent for more than three consecutive business days and has been treated by a doctor.
2. **Intermittent FMLA leave**: in this instance, the employee is taking time off in separate blocks due to a serious health condition that qualifies for FMLA. Intermittent leave can be in hourly, daily, or weekly increments. Intermittent FMLA is often taken when an employee needs ongoing treatment for one’s physical or behavioral health concern.

3. **Reduced schedule FMLA leave**: an employee needs to reduce the number of hours one works per day or per week, often to care for a family member, to reduce stress or to facilitate reconditioning by easing the employee back into the workplace.

When an employee has used up his or her FMLA, he or she loses the FMLA job protection, which can result in the loss of the individual’s work position.

FMLA is not a type of disability insurance. While this may seem self-evident, it is frequently confused by treating professionals with some type of insurance. Alternatively, treating professionals may believe that it affords the employee unlimited leave from the work and protects the employee’s job indefinitely. This is an issue to which all case managers should be aware so that they can help educate the treating professional, address appropriate workplace leave absences, and assist the return to work process more effectively.

### 9.4 Case Management Roles and Requirements in the Context of Treatment

The American Psychiatric Foundation, a branch of the American Psychiatric Association, has taken a role in raising consciousness about the issue of disability by defining the inability to work as a “crisis”. Moreover, it has been noted that most treating professionals do not provide intensive care that is comparable to a mental health crisis. Typically, when a person is said to be unable to work, it means that the individual is truly unable to care for one’s self on an independent basis. This is because many work activities are similar in nature to personal life activities. Consequently, if a person is truly unable to function at work, it is highly probable that the person cannot function in other life activities as well. For severe mental health concerns, inpatient hospitalization is the most effective means of quickly stabilizing the individual and ensuring the person’s safety (Warren, 2005). However, as noted earlier, many treating professionals simply see the claimant on a non-urgent and non-emergent basis (AMA, 2008; Talmage & Melhorn, 2005; Melhorn & Ackerman, 2008; Oyebode, Cantley, & Schroeder, 2008).

### 9.4.1 General Problems Arising Within the Behavioral Health Claims Process

The relationships between case characteristics, adequacy of care, and claim outcome were examined by Hamm, Reiss, Paul, & Bursztajn, 2007. They found that
only 22% of behavioral health disability cases had comprehensive psychological evaluations, while 48% of these claims had superficial evaluation and 30% of individuals who had filed a behavioral health disability claim had no evaluation of the reported concerns. This is troubling because it means that the majority of behavioral health disability claims are submitted without the individual being evaluated in a comprehensive manner to even determine whether any type of objective impairment exists before filing for a disability claim (Hamm et al., 2007).

When professional treatment was evaluated in regards to adequacy of care, an alarmingly low 11% of individuals had received appropriate professional care that was sufficient to help the person regain functioning. This is in contrast to 67% of claimants who had received superficial care and the remaining 22% had received no professional treatment at all. Moreover, it was determined that when behavioral health claims related to a physical injury, the claims related to psychosocial stressors were more often to have undergone a superficial diagnostic evaluation and treatment. In general, those behavioral health claims with superficial treatment were less likely to have their claim granted (19.3%) than those with adequate treatment (36.8%) (Hamm et al., 2007). Thus, when the case manager is reviewing a claim, it is important to ask whether the superficial treatment is reflective of the actual severity of the symptoms or reflective of inadequate treatment.

The quality of the documentation submitted to substantiate the claim is typically quite poor; the documentation that is submitted by the claimant is usually highly subjective and demonstrates a pattern of poor communication of the underlying issues with the treating professional. Documentation generated by treating professionals frequently lacks a Diagnostic-IV-TR diagnosis and objective data to support both the diagnosis noted and the reported impairment (Barth, 2005, 2006; Melhorn & Ackerman, 2008; Schultz & Gatchel, 2005). Diagnoses are rarely confirmed, or ruled out, with objective, standardized psychological testing. There is also a pattern of poor collaboration with other treating professionals involved in the claimant’s care.

Warren & Hubbard (2008a) completed a study regarding behavioral health claims with a large insurer that confirmed these issues were commonplace and that they directly impacted on the claim outcome. Specifically, claims that had even one of the problems noted were more likely to result in extended workplace absence.

### 9.4.2 The Impact of Poor Documentation on Disability Claims

While it may appear self-evident that sufficient documentation is required to make a sound decision regarding the approval or denial of a behavioral health disability claim, it is quite common for the case manager to receive incomplete or poor documentation. Examples of this are: the treating professional reports a nonexistent diagnosis, such as “Stress-related Depression”. All clinical diagnoses provided by the treating professional must be in the form of an actual DSM-IV-TR (or current version). Failure to comply with this requirement leads to non-standardized terminology being utilized. Thus, this leads to confusion about the diagnosis and raises doubt about the accuracy of the treating professional’s diagnosis and proposed
treatment of the claimant. Moreover, the precise criteria for a non-existent “diagnosis” are unclear to the case manager and treating professionals alike (Talmage, 2007; Warren, 2009). Other examples of poor documentation are: (1) the treating professional not completing all of the forms sent by the claimant and/or case manager; (2) the treating professional refusing to release treatment records, even with the appropriate signed release by the claimant; (3) the treating professional sending incomplete records (which has the same result of not sending the records at all); and (4) the treating professional conducting psychological testing that is either not specific to the claimant’s reported impairment or reporting invalid testing. In this latter case, since a case manager is not typically trained in objective psychological testing, the case manager is left in the position of attempting to decide whether the psychological testing is an appropriate evidence. Many times, due to the lack of training, case managers simply accept the psychological testing, valid or not, as “proof” of documentation for the claimant’s reported impairment.

### 9.4.3 Objective Psychological Testing

The issue of appropriate psychological testing and its application in the case manager process warrant further discussion. The appropriate testing procedures regarding test administration and interpretation are under the direct auspices of the American Psychological Association (APA). All individuals who utilize psychological tests are required to follow the appropriate testing standards as addressed by the APA and other professional organizations (American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education, 2004). A particular problem in the case management process for behavioral health disability claims is either the absence of objective, standardized psychological testing or the reporting of invalid test results that were reported by the treating professional as being valid (AMA, 2008; Barth, 2005; Warren, 2009).

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4Although the majority of physicians are members of the American Medical Association, rarely does a physician follow the AMA’s Guides to the Evaluation of Permanent Impairment (6th edition, 2008). The Guides provide professional instruction to other professionals as well who profess to evaluate and treatment individuals with impairment in functioning. Chapter 14 provides detailed information regarding the appropriate evaluation of individuals with behavioral health disability concerns. Case managers should obtain training in the appropriate utilization of the methods discussed in the Guides. By doing so, this will help the case manager to better understand the fundamentals of appropriate professional evaluation of impairment in functioning.

5Although a signed release is not technically required under the federal Health Insurance Portability and Accountability Act (HIPAA, 1996), other state mental health laws may supercede the HIPAA law. Most behavioral health professionals are instructed by their professional organizations to follow the more restrictive law in order to provide protection to their patients/clients. Thus, although the case manager may send a signed release, the treating professional may not honor the insurer’s release. This leaves the case manager in the difficult situation of trying to obtain information from the treating professional to make an initial decision regarding the behavioral health disability claim.

6Testing that cannot be utilized for specific reasons related to the testing process.
The need for objective, standardized testing is taught to psychologists during doctoral graduate training. However, a Licensed Clinical Psychological Counselor or a Licensed Clinical Social Worker is unlikely to have received extensive psychological test training required in the disability assessment process as part of their Masters Degree training. Specifically, many Master’s level professionals cannot complete the necessary objective, standardized testing, such as in the case of neuropsychological or intelligence testing (Warren, 2009). Thus, this means these types of treating professionals are limited in the types of documentation and depth of testing that they can provide to a case manager.

Generally speaking, the case manager should look for objective testing that is specific to the reported concern. Typically, a savvy case manager will work with a clinical psychologist trained in Disability Management to review the submitted testing to ascertain whether the testing: (1) is valid and thus can be utilized as documentation; (2) confirms or rules out the reported psychological diagnosis; and (3) utilizes at least two or more objective psychological tests specific to the reported concern (American Medical Association, 2008). Failure to conduct these reviews eliminates the possibility of the case manager exercising independent judgment.

A major concern with the failure to test appropriately is that many individuals had not received the intensive treatment consistent with the diagnosis and severity of symptoms that would have been disclosed had they been properly tested (American Psychiatric Foundation, 2005b; McGlynn et al., 2003; Seelig & Katon, 2008; Wang, Berglund, & Kessler, 2000; Warren, 2005). It is quite possible that an individual does have true psychopathology, resulting in substantial functional impairment, but is receiving only minimal treatment. It is also possible that an individual’s concerns are not as severe and the treatment is at an excessive level for the concern. However, in either instance, the treating professional has not provided the necessary documentation for the case manager to form a judgment (Hamm et al., 2007).

9.4.4 Subjective Information

Another common issue is the utilization of the claimant’s subjective information as a substitution for the necessary objective documentation. Although all treating professionals rely, at least initially, on the individual’s self-report of symptoms and concerns, the actual treatment process must include a more objective approach that confirms or rules out the perceived issues.

Moreover, the treating professional must utilize objective tools, such as blood tests, CT/MRI scans, and objective, standardized psychological testing to fully evaluate an individual. The empirical literature has demonstrated that treating professionals, as a whole, are not immune to bias in the evaluation process. Furthermore, clinical observation alone is insufficient to confirm or rule out a behavioral health disorder that causes impairment. When the treating professional has simply listed the claimant’s concerns, but has not objectively evaluated them, the case manager should be alerted to request additional information in the case management process (Barth, 2005; Melhorn & Ackerman, 2008; Short et al., 2009).
The most appropriate means in which to make a diagnosis is based on the diagnostic criteria in the DSM-IV-TR (DSM-IV-TR, 2000), as well as employing the multiaxial diagnosis model. The purported purpose of the multiaxial approach is to note different psychological concerns, Personality Disorders and Mental Retardation, medical conditions, psychosocial and environmental concerns, as well as a “Global Assessment of Functioning” or GAF. This multiaxial system is a subjective diagnostic model that all behavioral health professionals are trained and should be expected to provide the minimal level of information pertaining to a psychological status of a claimant. The GAF is a subjective estimate of function by the treating professional. The failure to provide such information is a yellow flag for a case manager to request the missing information.

9.4.5 Assessment of the Behavioral Health Disability Claim

Case managers are often placed in the role of making a judgment about whether a claim for disability based on behavioral health concerns should be accepted by the benefit payer. The role of the case manager is not to form or interpose an independent clinical judgment concerning the claimant, but to determine whether the claim is properly substantiated and documented in the first instance, and properly treated if the claim is accepted.

In the typical behavioral health disability claims process, the individual initiates the claim by noting that s/he cannot work in one’s current job. Usually, each insurer has its own forms that must be utilized. The individual will use these forms and sign a release so that the insurer may request treatment records. Once records are received, they are reviewed to ascertain whether sufficient objective documentation has been submitted to support the claim (Warren & Hubbard, 2008b). A common misconception is that once the documentation has been submitted, the evidence is sufficient because a treating professional has said that an individual is unable to work (ACOEM, 2006b; Melhorn & Ackerman, 2008; Schultz & Gatchel, 2005). However, because of the wide variance in care, a careful review of all documentation must be completed by the case manager.

Moreover, if the case manager is receiving a claim, and a non-specific diagnosis such as “depression” is noted, this represents another yellow flag since depression is simply a symptom and not an actual clinical diagnosis (Warren, 2009; Warren & Hubbard, 2008b).

9.4.6 Assessment of the Treatment Being Provided

The case manager must evaluate whether the treatment being provided by the treating professional(s) is consistent with the reported diagnosis and severity of symptoms noted. For example, a diagnosis may be given Major Depressive Disorder (MDD), single episode, with a global assessment of functioning (GAF) of 40. This type of information is a normal part of the clinical evaluation of an individual with a behavioral
health concern. In this case, the diagnosis of Major Depressive Disorder denotes a severe mental health concern. The GAF rating of 40 indicates a poor level of independent functional ability. Thus, it is reasonable to expect that this individual is receiving intensive care that is consistent with reported concern.\textsuperscript{7} With this low GAF, it is likely that the individual should be hospitalized since it is unlikely that she or he can care for her or himself or others. However, if the claimant is receiving care every 2 weeks or greater, then this can be a yellow flag for further investigation by the case manager since it denotes a lower intensity of care than is typically noted for a severe concern.

When the treating professional is a primary care physician who has provided all care to date, this is also a significant yellow flag since primary care physicians typically prescribe medication and are likely to see the individual about every 4–6 weeks (Kroenke et al., 1994; Oyebode et al., 2008; Pransky, Shaw, Franche, & Clarke, 2004; Seelig & Katon, 2008; Teutsch, 2003; Waddell & Burton, 2007). This type of care is not consistent with a health crisis. If this type of documentation is submitted, it is essential for a case manager to contact the primary care physician to ask for additional information. The contact should not be adversarial in nature, but rather coming from the direction of wanting to educate both the claimant and the primary care physician any necessary remedial steps to help provide the appropriate documentation for the claim decision-making process.

Case managers can use best practice standards or treatment guidelines as a tool to evaluate treatment plans.\textsuperscript{8} Many of these have undergone extensive peer evaluation of empirical research as well as reviewed by other professional organizations to provide an external peer evaluation of the guidelines. However, it is important for a case manager to become familiar with the characteristics of strong practice guidelines and not simply use a guideline in an indiscriminate manner. Bruns, Mueller, & Warren (2010) noted that when a guideline is mandated in some states, the user of the guideline must be aware of the limitations of the guideline whether making clinical, case manager, or legal decisions.

For those behavioral health claims that do not resolve as anticipated, it will be important for the case manager to periodically re-evaluate the continuing claim. In these instances, the case manager will need to request and review additional copies of treatment records from the treating professional(s). Careful attention should be paid to whether the individual is experiencing any improvement from the last review. This is especially important in behavioral health claims because the majority of these concerns have evidence-based treatments that help the individual return to the previous level of functioning quickly. Consequently, the fact that an individual is not improving after a significant number of weeks of treatment should raise a yellow flag for closer evaluation (Warren & Hubbard, 2008b).

\textsuperscript{7}While the GAF is a subjective measure of function, it has assigned values that become important to the case manager when performing subsequent or serial reviews of those claims that have extended beyond the anticipated time denoted by the treating professional. Serial GAF scores provide the case manager with a means to examine and question the treatment plan, especially when there is a lack of improvement noted.

\textsuperscript{8}For a more extended discussion of this issue, see Sect. 9.6 below.
The following are basic tips for case managers to utilize in the case assessment process:

1. Objective, standardized testing must be performed in strict accordance with the testing manual for each test. Moreover, the testing professional must follow the current American Psychological Association’s testing standards. These testing standards are called “The Standards for Educational and Psychological Testing.” A testing professional may not deviate from the prescribed administration for each test. If this is done, then the validity of the testing is compromised, or in some cases invalidated completely.

2. No single objective psychological test can provide a comprehensive assessment of an individual’s reported concerns (AMA, 2008; Warren, 2009).

3. It is essential that the case manager understand the difference between subjective screening tools and objective standardized testing. Thus, the case manager is better able to discern those screening tools that are only subjective and are not appropriate for documentation of impairment in functioning.

4. Many psychological reports used by testing professionals are computer generated in that the professional simply uses the scores from the computerized report. In some instances, the computerized program attempts to interpret the testing results even if they are invalid. Thus, it is important for the testing professional to report that the testing results are, in fact, valid.

5. Many tests have validity indices or base rates. Most case managers do not have the professional training to evaluate these validity indices and should work with a clinical psychologist who is trained in disability management for assistance in making sense of the submitted documentation.

6. When the case manager plans to send psychological tests results out for an independent review by a clinical psychologist, it is essential that the testing professional has provided copies of all the raw data for the independent reviewing psychologist to analyze. When the claimant has signed a release, both Masters’ level and other psychologists may release the raw test data and copies of the answer sheets to an independent reviewing psychologist. This independent reviewing psychologist is most typically a clinical or neuropsychologist.

9.4.7 Psychosocial Concerns Versus True Psychological Disorders

Warren & Hubbard (2008a) found that a high level of job dissatisfaction (88%) was associated with behavioral health claims. While it can certainly be understood how one may dislike a job, this does not necessarily mean that a person cannot perform the job. Instead, this is typically noted as a psychosocial concern in the empirical research (Drukteinis, 1997; Lelliott et al., 2008; Melhorn & Ackerman, 2008; Waddell, 2005; Waddell, Burton, & Aylward, 2008a, 2008b; Warren, 2009; Warren & Hubbard, 2007, 2008a, 2008b). Another common psychosocial issue that arises is
that of workplace conflict. Warren & Hubbard (2008a) found that many behavioral health claimants (81%) reported workplace conflict as a primary reason for filing the disability claim. Unfortunately, the majority of treating professionals did not ask about the workplace conflict and did not note this in their documentation. Other common psychosocial concerns that occur in behavioral health disability claims are the claimant noting: (1) excessive workload; (2) a lack of balance between work and home life; and (3) issues related to childcare. Thus, the case manager should be aware of psychosocial concerns noted and be aware of the possibility of medicalization of those concerns.9

In the research examining behavioral health disability claims, Warren & Hubbard (2008a) explored the occurrence of psychosocial issues and objectively determined psychological concerns. There was a pattern of poor communication between the treating professional and the claimant regarding specific issues, such as job dissatisfaction and workplace conflict. In 72% of the examined claims, there was typically no objective psychological testing completed to support the reported concern. The concern with this statistic is that the treating professional typically had been conducting treatment for at least 1 month before the claim was filed. This time frame is typically adequate treating professional to conduct objective, standardized psychological testing. Moreover, in those instances where objective psychological testing was completed, 94% of testing results reported by the treating professional were invalid. Consequently, the issues in appropriately differentiating between a true psychological concern and a psychosocial issue are often exacerbated by poor quality documentation. When psychosocial concerns exist,10 these can be discerned from objective DSM-IV-TR diagnoses with the usage of psychological testing.

Warren & Hubbard (2008a) developed a set of tools to quickly gather information specific to behavioral health concerns that can allow a case manager to identify potential psychosocial concerns that may be underlying issues related to the reported claim. One set of tools was specific to the claimant, while the other set was directed to the claimant’s treating professional(s). The tools are typically utilized at the claim initiation, as well as follow-up tools to gather accruing documentation over the life of the claim. The tools allow a case manager to evaluate the comprehensiveness of the treating professional’s evaluation of the claimant, to pinpoint the claimant’s report of psychosocial issues, document types of medication prescribed, evaluate treatment compliance, and to examine the consistency of the treatment plans. Of

9See Sect. 9.4.12, below.
10With behavioral health disability claims, when a psychosocial concern arising from work is the primary catalyst for filing for disability, it is important to recognize that this represents a belief by the claimant that s/he must be completely satisfied with one’s job or that one will never experience any workplace conflict. With changes within the workplace, it is highly likely that one will experience job dissatisfaction or conflict at some time during one’s employment (ACOEM, 2006a). Instead, it is the claimant’s coping style that comes into play in these situations. Coping style is shaped by a number of aspects, for example, childhood upbringing, stress management techniques, social support, and one’s personality.
equal importance, the tools provide an opportunity for the case manager to examine medication compliance as well and identify medications prescribed by all treating professionals. Specifically, the tools served to identify those behavioral health claims that were likely to have a high probability of a variety of issues that extended the life of the claim for extremely lengthy periods of time. The tools are designed to assist the case manager in working with the claimant and the treating professional.

### 9.4.8 Utilizing the Expectation of Consistency in Objective Impairment and Functioning

Sufficient and appropriate documentation is typically a problem with behavioral health disability claims (Barth, 2005; Ertel, Koenen, & Berkman, 2008; Melhorn & Ackerman, 2008; Warren & Hubbard, 2008b). A common problem is that many professionals take what the claimant says at face value without benefit of verifying the information through other sources, such as workplace evaluations or even in direct contact with the claimant’s Human Resource department (Short et al., 2009). Without this type of verification, the results of the evaluation and development of a treatment plan are jeopardized. Reliance on the claimant’s subjective report alone is inherently risky. Frequently, the claimant will report an inability to continue a situation at work that is inconsistent with behavior in other aspects of life. Typically, limitations in functioning occur consistently, regardless of the setting. Evidence of this type of inconsistency is a yellow flag to a case manager for further investigation and may require obtaining additional information from both the claimant and the treating professional(s).

**11 An example of contradictory information that Warren & Hubbard (2008a) noted was when a claimant who was a Customer Service Representative was diagnosed with Major Depressive Disorder. The treating professional noted that the claimant was not able to perform her job due to an inability to concentrate and interact with the customers or to respond to their requests for assistance in resolving concerns. The claimant was described as being unable to cope with a full day’s work and could not manage many activities of daily living, such as traveling in a car, paying bills, or preparing meals, among some of the noted limitations. When the submitted documentation was examined, it was found that the claimant was a single mother with children less than 10 years of age. One child needed to have prescribed medications given at specific times. It was the claimant’s responsibility to ensure this occurred. Of significance, the claimant was completely responsible for caring for herself and her children on a daily basis. The treating professional reported that the claimant was unable to concentrate sufficiently to answer customer calls and unable to complete most activities of daily living. Clearly, this is at odds with what the claimant was actually doing. She was able to care for herself as well as her children, including ensuring that prescribed medication was taken at appropriate times by her child. Moreover, the treating professional also went on to note that the claimant was able to drive a vehicle. The inherent problem with the treating professional’s assertion is that driving is an activity that requires complex functioning across multiple cognitive domains, including sustained concentration and attention, visio-spatial skills, and short and long-term memory. Consequently, because driving a vehicle requires similar cognitive skills to those in the workplace, it is unlikely that the claimant was not able to function in the work setting with lesser demands, but could function in driving a car, which takes multiple cognitive skills.**
9.4.9 Patient Compliance Issues Within the Behavioral Health Disability

The prevalence of noncompliance with treatment ordered by the treating professional has been found to range from 20 to 50% in a review of the empirical literature. The issue of noncompliance is critical for both the treatment and case management processes (Becker & Maiman, 1975; DiMatteo, Lepper, & Croghan, 2000; Jensen, Albertsen, Borg, & Nabe-Nielsen, 2009; Warren, 2009). There are several forms that noncompliance might take: (1) outright refusal to follow treatment recommendations; (2) agreeing to follow the treatment plan in consultation with the treating professional, but outside of the treatment milieu, not following the treatment plan; (3) following parts of the treatment plan, but not the entire treatment plan; (4) repeatedly canceling appointments and so, the person is receiving sporadic care; and (5) not taking medication as prescribed.

Noncompliance is a serious issue that negatively impacts on treatment outcome. It is almost always under the individual’s voluntary control as well. Some exceptions to this are when an individual has had a serious mental health concern, such as a psychotic break, or with a head injury in which memory is impaired. With valid behavioral health impairment, there are several instances of noncompliance that can result in poor treatment outcomes. Examples include failure to engage in an exercise program with Major Depressive Disorder (since physical activity has been found to be an important variable in the improvement of that condition) and failure to take medication as prescribed. Noncompliance is not an evidence of objective impairment in most cases, but rather a decision to not follow a recommended course of action. Thus, noncompliance is a yellow flag pertaining to a potential psychosocial issue.

The issues of primary and secondary gain are also usually involved when noncompliance occurs in some form. Primary gain occurs when the person experience a positive internal motivation. It is usually not a conscious. It usually allows the person to save face or to avoid a negative situation. For example, a person may develop physical symptoms without any identifiable physical causes, such in the case of Conversion Disorder. Conversion Disorder is an extreme instance where the

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12 When the claimant is out of work and additional factor may create noncompliance, the claimant may no longer have insurance to provide the recommended care. If the claimant wished to have insurance after one’s employment terminates, one must obtain it for oneself. Such insurance is typically covered by the Consolidated Omnibus Budget Reconciliation Act (COBRA, 1985). COBRA had allowed employed people and their families to opt to continue to receive group health benefits that are provided by their current group plan. This is typically for a limited period of time (18 months). The costs associated with COBRA are quite high. For example, those who are qualified are usually required to pay the entire healthcare premium to 102% of the cost of the plan. This can result in another form of noncompliance due to the claimant’s inability to pay for ongoing treatment, diagnostic procedures, and medications. However, with the institution of the American Recovery and Reinvestment Act of 2009 (ARRA), an individual who is eligible for assistance will pay only 35% of the premium needed to obtain COBRA coverage. Thus, this change should help to ameliorate some of the financial burden and serve to remove one barrier to noncompliance.
person may develop physical symptoms such as stroke-like symptoms, after a hospital visit to a relative who had heart surgery. In this case, the internalized emotions coupled with the stressor produce the physical symptoms (Warren, 2009).

In the case of secondary gain, the behavior is usually linked to an external motivator, such as (1) avoiding an unpleasant task or situation, (2) receiving attention and sympathy from others regarding the physical concerns, (3) receiving monetary benefits because of the physical issues, such as with a lawsuit or with disability benefits, and (4) identification with a “sick or disabled” role. The person may or may not be aware of the motivation. However, when a person is consciously producing or exaggerating symptoms for personal gain, then the person is malingering. If secondary gain is suspected, then the issues of non-compliance and possible malingering should be considered as separate issues, and the case manager should not indulge any assumptions.

Regardless of the reason for noncompliance, the case manager must evaluate whether the claimant is complying with the prescribed treatment. One way to do this is to compare treatment records with the claimant’s reports regarding medications prescribed and how the medication is being taken. To further complicate the case management process, the case manager must complete this evaluation process for each treating professional who is treating the claimant. It is especially important with psychotropic medication for the claimant to fully follow the prescription directions to help restore the claimant’s health to the previous level of functioning. Consequently, the case manager should pay close attention to medication compliance in the behavioral health disability claims process.

9.4.10 Symptom Exaggeration and Malingering

Although many professionals believe they possess the professional ability to discern if the claimant is exaggerating symptoms or malingering, this has not been supported in the empirical literature (Iverson, 2003, 2007). Instead, the empirical research has consistently demonstrated that the majority of professionals are simply not able to reliably differentiate between a claimant who is exaggerating or malingering versus one who is not. The AMA (2008) and others (Aronoff et al., 2007; Iverson, 2007; Wiley, 1998) have indicated that all professionals must evaluate for symptom exaggeration and malingering as a normal part of the evaluation process. With behavioral health concerns, this is typically done with the employment of standardized objective psychological tests in addition to other medical tests, such as blood assays. Furthermore, there are specific objective psychological tests to evaluate both types of symptom exaggeration or malingering issues. Without the benefit of objective psychological testing, the case manager is left to “eyeball” the claim and to make basic case management decisions based on subjective information versus objective data about the veracity of the claimant’s self-reported symptoms (Warren & Hubbard, 2008b).

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13 See discussion of malingering in Sect. 9.4.10 below.
14 Also sometimes referred to as “symptom magnification”.
It is important to note that symptom exaggeration, although a component of malingering, is not sufficient alone as “proof” that an individual is malingering. A person can exaggerate one’s symptoms in situations where she or he believes the treating professional is not taking a concern seriously. However, if the symptoms are related to an actual valid physical concern, then the individual is not malingering. In addition, a person can exaggerate one’s symptoms without being aware of the action. The key distinction between symptom exaggeration and malingering is that the person who malingers is conscious of one’s actions. Malingering is fraudulent in nature. It is useful to note that malingering has been found to occur at a higher prevalence rate in disability situations. The empirical research has noted the malingering prevalence rate to range from 30 to 40% in many disability cases for pain, emotional, and/or cognitive symptoms. These rates of malingering occur in those seeking disability benefits and in litigation cases (Mittenberg, Patton, Canyock, & Condit, 2002). Thus, the treating professional must routinely evaluate whether symptom exaggeration or malingering is occurring. Unfortunately, Warren & Hubbard (2008b) ascertained that this rarely occurs with behavioral health disability claims.

### 9.4.11 Collaboration Among Treating Professionals

When several treating professionals are providing treatment to the claimant, it is imperative for each of them to collaborate to ensure continuity of care. In addition, this affords the treating professionals the opportunity to discuss the specific diagnosis that each has made in regards to the claimant. Unfortunately, this does not occur as regular part of the treatment process. As a consequence, it is common to see conflicts of diagnosis in the file review process. Diagnosis plays an important role in selecting the treatment that is implemented. Therefore, if there are different diagnoses, it raises significant concern about the consistency, and therefore the appropriateness of the selected treatments being provided that may contribute the potential detriment of the claimant (Warren & Hubbard, 2007).

Warren & Hubbard found that the diagnosis provided differed frequently among treating professionals, and that the majority of treating professionals did not collaborate with each other (95%).

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15 The DSM-IV-TR (2000) noted malingering as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs”. Moreover, there are four specific criteria that must be met before malingering is reported by the professional. Aronoff et al. (2007) completed an extensive meta-analysis and found specific behaviors and concerns associated with malingering. In general, the more of these that were identified, the more the potential for malingering is raised. In addition, Iverson (2003, 2007) reported additional factors that serve as catalysts for symptom exaggeration and malingering.
9.4.12 Medicalization of Psychosocial Issues

It is important for the case manager to consider the possibility of a psychosocial concern being the primary issue. In many instances, the treating professional has used the information provided by the claimant to make a decision regarding a potential behavioral health diagnosis. However, if the claimant notes issues such as job dissatisfaction, conflict with one's coworkers, or simply “stress”, then it increases the probability that the underlying concern is a psychosocial issue rather than a true mental health disorder. Typically, psychosocial concerns do not meet the DSM-IV-TR criteria for an actual psychological disorder. When psychosocial concerns are noted as the primary catalyst for the claimant filing for disability, the case manager should take steps to carefully evaluate the treating professional’s records to ascertain how this is addressed. If the psychosocial concerns are noted as the reason for the claimant’s reported concerns, this is known as “medicalization” (Dworkin, 2001; Melhorn & Ackerman, 2008; Waddell, 2005; Warren, 2009; Warren & Hubbard, 2008b).

To fully evaluate the behavioral health disability claim, it is necessary to obtain documentation from all treating professionals who have treated the claimant. The documentation obtained from the treating professional should then be compared to the documentation submitted by the claimant with special attention to psychosocial issues that are reported. This process allows the case manager to ascertain whether there are discrepancies between what the claimant is reporting in the disability claim, what the claimant has discussed with the treating professional, and what the treating professional has noted to be the primary clinical concerns, and addressed in the treatment plan, and the anticipated return to work date (Warren, 2009; Warren & Hubbard, 2008b).

9.5 The Return to Work Case Management Process in the Context of Behavioral Health

Waddell and Burton (2006a, 2006b) explored the relationship between working and health. They concluded that the activity of work is strongly associated with good physical and mental health. Moreover, they noted that working is therapeutic and it literally reverses the negative health effects associated with unemployment. The one proviso that they noted is that the quality of work, as well as being safe when working, is essential. Their final finding was that the beneficial effects of work far outweigh the risks of work and the even greater effects of extensive unemployment and/or workplace absence.

Empirical research has found that those who do not work experience a 50% risk of dying in the next 10–17 years after unemployment begins. Moreover, the quality of life regarding physical, emotional, and financial health declines sharply (Gerdtham and Johannesson, 2003; Jin, Shah, & Svoboda, 1995).
The longer an individual is off work, the less likely s/he will ever successfully return to work (ACOEM, 2006a). Within as little as 12 weeks, the chances of successfully returning to work may be reduced to as little as 50%. The longer the individual remains out of the workplace s/he loses work relationships with co-workers, who may have been absorbing the work not being performed by the disabled individual while off work. This has the potential for creating strained work relationships when the employee returns to the workplace. The individual who was once a member of the team may perceive oneself or the team may perceive her or him as now being an outsider. The individual also can lose job skills or missing out on changes in the workplace. In some cases, significant changes may be instituted even in a relatively short absence from the workplace. This may result in the need for the employee to undergo retraining to be able to complete workplace duties once more (Waddell & Burton, 2006a, 2006b; ACOEM, 2006a). Frequently, the individual experiences a sense of anxiety in returning to the workplace. The American Psychiatric Foundation (2005b) noted that this is not at all unusual, but the norm. This anxiety itself is not a sign that the individual cannot work, but simply a part of the return to work process.

Warren and Hubbard found that treating professionals did not consider return to work at a level consistent with its importance for the overall wellbeing of the claimant. Eighty-one percent of treating professionals did not address the return to work issue with the claimant. Thus, most claimants did not understand that return to work was an expected treatment goal. Moreover, 81% of treating professionals did not address the workplace accommodation issue with employers. Interestingly, the majority of behavioral health claimants felt that they could return to work with an accommodation. However, if this is not addressed by the treating professional and discussed with the employer, the likelihood for a meaningful discussion, as well as the opportunity for assisting the claimant back to work, is lost.

9.5.1 Workplace Accommodations and Return to Work Planning

In regards to behavioral health concerns, although an individual may be unable to fully return to work for one’s own occupation, it is quite common that the individual can either return to work with temporarily reduced work expectations or return to work in another position. Both of these examples are types of workplace accommodations that should be explored by both the treating professional and the case manager. This requires that the case manager be supplied with and utilize objective information from the treating professional(s). When case managers make decisions without sufficient input, from the treating professional they are seen as advancing an agenda other than the claimant’s welfare, and this fosters distrust. These issues arise across the case management spectrum, including the behavioral health disability management process (Pransky, Shaw, Franche, & Clarke, 2004; Talmage, 2007; Talmage & Melhorn, 2005; Warren & Hubbard, 2007, 2008a, 2008b).

Workplace accommodations, particularly with regard to behavioral health concerns, must be addressed as part of the return to work process. Often, the viewpoint
among treating professionals is that this is somehow unsympathetic, harsh, and employer-oriented. The failure to provide the employee with behavioral health concerns with appropriate accommodations leaves him or her more vulnerable to being placed on open-ended disability leave, to his or her long-term detriment.

It is important to recognize that there are gaps in communication between treating professionals and case managers. A necessary component of the case management process is to adequately address time away from work in a comprehensive manner, including addressing the return to work process as an integral part of the claimant’s treatment plan. Consequently, it is important that both types of professionals understand the usual communication issues and strive to overcome them to accomplish the common goal of helping the claimant obtain adequate assistance and restore the claimant’s previous level of functioning (Pransky et al., 2004; Warren & Hubbard, 2007, 2008b).

**9.5.2 Appropriate Roles for the Case Manager**

Case managers can help to educate treating professionals regarding insurance policy limitations, an issue about which treating professionals are often unaware. Moreover, case managers can and should provide information to treating professional about the empirically documented problems with long-term workplace absence, particularly related to behavioral health concerns. Unfortunately, most treating professionals are not taught about disability management, federal and states laws regarding disability, or even, appropriate return to work strategies (AMA, 2008; Melhorn & Ackerman, 2008; Warren, 2005, 2009). Instead, most medical and graduate school programs over-emphasize treatment alone.

There are other areas in which the case manager can assist in obtaining the best result for the claimant. The issue of professional liability is of great concern in the current environment. There is a mind-set among many treating professionals to err on the side of lengthy workplace absences than to open oneself to the potential of inadvertent harm to the claimant. This is particularly true when treating professional has provided professional care to an individual with behavioral health concerns (ACOEM, 2006b, 2006c; AMA, 2008; APF, 2005b; Dasinger et al., 2001). Zinn (1996) revealed that 56% of treating professionals report having limited confidence and knowledge in their ability to determine whether an individual was disabled. More disturbing, the same percentage of treating professionals was willing to exaggerate clinical data to “help” an individual who the treating professional thought was “deserving” of receiving disability benefits. Proactive case management, with a heavy emphasis

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16Talmage and Melhorn (2005) wrote a book for physicians regarding the RTW process. They noted three primary constructs in looking at an individual’s ability to work. These constructs are:

1. **Risk**: This is defined as the potential of harm to the individual or others, if the individual engages in a type of specific work
2. **Capacity**: This is regards to the physical, mental, and psychological ability to perform the specific tasks of the job
3. **Tolerance**: This is noted to be the individual’s ability to tolerate the specific activity, such as work.
on education, claimant advocacy, appropriate workplace leave, and objective documentation of impairment with a treatment goal of returning to work are essential to addressing this issue. The case manager must also emphasize to the treating professional how the case manager can simplify the process, providing additional benefit to the treating professional and the claimant and how the treating professional can help in this interactive process (Warren & Hubbard, 2008b).

Another professional role in case management is to work with the employer to discuss appropriate workplace accommodations that can be made to assist in the return to work process (Powell & Tahan, 2007). Frequently, employers take an all-or-none stance that either the claimant returns fully to work or does not return at all (ACOEM, 2006b). There are many problems with this approach:

1. The employer may be in breach of the current American Disability Act Amendments (that afford new protections to the employee that are much farther reaching than the previous version of the ADA law);
2. The all-or-nothing position may be counterproductive for the employer. It is often more cost-efficient for the employer to allow the employee to return part-time or on accommodations than to incur the administrative costs of replacing the worker and training a replacement. Accommodations also may reduce overall disability costs, by eliminating instances of needless disability caused by prolonged work absence and is also helpful in keeping the employee for whom eventual return is anticipated current in workplace duties; and
3. Specific to behavioral health concerns, employers are frequently in the dark regarding what are appropriate accommodations as well as how long should these accommodations should exist.

The Disability Management Employers Coalition (DMEC) survey (2008) of employers found that most understand that behavioral health concerns exist, but do not feel confident in developing behavioral health workplace disability policies or in making accommodations. Thus, the case manager has the opportunity to discuss appropriate workplace accommodations with the employer and assist them in understanding that the employee may still be receiving treatment, but is, nonetheless, still able to work.

9.6 Strategies to Address Weaknesses Occurring in the Behavioral Health Disability Case Management Process

In case management, precise and accurate information is the most critical component. In some contexts, such as the STD/LTD case management process, the case manager does not have the ability to attend the claimant’s appointments treating professional. In other contexts, the case manager may be prevented by statutory or regulatory prohibitions from engaging in direct, hands-on, information gathering or simply may not have a caseload allowing for that intensive level of involvement. This potentially creates a gap in the available information, with effects that are
potentially detrimental to the case manager’s role and the claimant’s outcome. In such instances, needed information is usually gathered over the phone or from the office notes. A primary problem with this approach is the case manager’s need to obtain information in a timely manner from a source (the treating professional) who has a crowded clinical schedule does not allow for long chats with the case manager. In this situation, the treating professional often views the case manager as a nuisance. An alternative to this approach is to provide the treating professional with a concise list of questions that address the issues pertinent to the claims decision process. If possible, the case manager should try to frame the questions in a yes/no or checkbox answer format to minimize writing by the treating professional. This speeds up the process for the treating professional and also reduces the likelihood of the case manager needing to interpret a treating professional’s handwritten comments. Without the necessary documentation from the treating professional, the case manager will eventually need to take some kind of action. This is likely to result in a claim denial due to insufficient documentation to support the claim (Powell & Tahan, 2007).

In the behavioral health process, the STD/LTD case management process is hindered by both state and federal laws regarding confidentiality (HIPAA, 1996; Gold & Metzner, 2006). All states in the USA have privacy laws regarding mental health treatment as well as confidentiality requirements applying to anyone who may seek to obtain mental health information regarding another person. Because of the perceived stigma in the USA regarding mental health treatment, most individuals do not wish others to know of given diagnoses or received treatment. Releases signed by claimants, when available, are not always honored by treating professionals, who are often concerned with avoiding any approbation or liability attached to improper release of information. This leaves the case manager in the position of needing to tell the treating professional that the behavioral health disability claim will be denied absent the necessary documentation. At this point, the case manager is viewed as an adversary who is only concerned about the insurer and not the claimant. An option in this situation is to discuss with the claimant that the treating professional is unwilling to provide the required information. By doing so, the claimant can then request the treating professional to comply. It is an unfortunate circumstance that most treating professionals do not understand the crucial nature that their documentation plays in assisting both the claimant and the case manager.

It was previously noted there are specific issues that occur uniquely within the case manager process applicable to behavioral health claims. Unfortunately, as discussed, most case managers do not have specific training regarding behavioral health issues and yet it is the case manager’s responsibility to sort through issues related to the claimant’s care and documentation. Many case managers learn on the job about how to address these concerns. While such training is considered the norm for many such positions, it does not provide the in-depth understanding and knowledge of complex behavioral health and co-morbid concerns. Thus, a

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17 While HIPPA technically does not cover workers’ compensation claims, treating professionals routinely demand HIPPA compliance measures to ensure that they limit their liability exposure.
beginning case manager’s training is only as good as the training of the more experienced case manager from whom s/he learned.

It is common to see case managers take a simplistic view of behavioral health disability claims. Moreover, behavioral health co-morbidity with physical concerns is typically not addressed, even though empirical research has consistently demonstrated a strong relationship between serious or chronic physical concerns and behavioral health diagnoses. Consequently, all case managers should be aware of limitations in training and take steps to remedy this. There are a number of avenues to address this:

1. reviewing current empirical literature regarding best practice standards;
2. attending professional conferences in training regarding behavioral health disability issues are addressed; and
3. seeking consultation with a clinical psychologist or psychiatrist trained in disability management to receive individualized instruction regarding evidence-based strategies to be applicable to the circumstances of the case.

Case managers should also use disability guidelines that are available commercially. Each set of guidelines is developed by the specific company or organization. One such organization, ACOEM utilizes professional multidisciplinary panels of experts to review empirical research. The guidelines are then sent for external review to different experts and organizations to ensure independent accuracy of the guidelines and the recommendations made. Moreover, many states legally mandate the usage of certain guidelines. Thus, case managers should be aware of current laws in the state(s) where they work. The usage of professional guidelines permits behavioral health disability claims to be expedited, minimizing delays in starting the disability benefits and minimize the need to obtain copies of the medical records and the associated costs.

It should be noted that disability guidelines are not meant to represent an absolute prescription for the duration of a disability nor the only acceptable plan of treatment. Instead, most of the guidelines usually provide multiple “critical points”. This provides the case manager and claims adjusting personnel with an indication of expected costs and treatment modalities used for a given diagnosis, and/or for the recovery period and anticipated return to work date. Depending upon an insurance carrier’s internal policies and procedures, these “critical points” may be used to signal when to refer the claim on to the case manager or for a physician review should the claim exceed the anticipated resolution time frame. It is essential to keep in mind that disability and treatment guidelines are also only as good as the empirical research on which they are based. Case managers who use professional guidelines are well advised to become educated

18 There are several available guidelines. The most commonly used are the case manager process of the Work Loss Data Institute’s (2008) Official Disability Guidelines (ODGs), the Reed Group’s (2009) Medical Disability Advisor (MDA) and MDguidelines which are complementary, the American Medical Association’s Guides to the Evaluation of Permanent Impairment, 6th edition (2008), and the American College of Occupational and Environmental Medicine’s (ACOEM, 2008) Practice Guidelines.
about the evidence criteria utilized, and to never over-rely on the guideline as an absolute decision-making instrument.

The case manager should also pay close attention to whether the treating professional has discussed return to work directly with the claimant. Frequently, treating professionals do not discuss the process of return to work as a part of the treatment plan. The American Psychiatric Foundation (2005b) has noted that “The belief or policy that one must be fully recovered before returning to work is iatrogenic and inappropriate except in rare, safety-sensitive occupations. Even in these situations, accommodations often make clinical sense for early phases of return to work” (Dasinger, Krause, Thompson, Brand, & Rudolph, 2001). ACOEM (2006a) ascertained that a treating professional’s discussion and encouragement of a return to work within 1 month after an acute illness or injury were associated with a higher return of work rate. After 1 month, however, momentum is lost, and the interaction of physical, psychological, and psychosocial issues come into play, typically resulting in longer workplace absences.

The case manager also has a critical role in communicating with the employer about the claimant’s return to work. Aside from the workers’ compensation disability realm, few employers strive to encourage a quick return to work and in many cases, lack a formal Behavioral Health return to work policy. The employer may, at times, actually act as an impediment in the return to work process. One reason is that an employer may fear the returning employee, who is not fully recovered, may be disruptive to business. Consequently, the case manager can educate the employer regarding the benefits of facilitating the claimant’s return to work. Without the case manager’s intervention, the claimant frequently faces daunting barriers to returning to the job. Moreover, many employers simply do not know the types of accommodations that could be made for a claimant with a behavioral health concern. A superior case manager can help the employer address requests for accommodations and help create a win–win scenario for treating professionals, claimants, and employers alike.

### 9.7 Conclusion

The case management process for behavioral health concerns is a system that has several distinct functions. The basic case management process involves getting information from the claimant and from the treating professional. This information is central to making a well-formed decision regarding the acceptance of the claim, the appropriateness and coordination of treatment, and the planning for return to work and job accommodations. The case manager is responsible for:

1. ensuring that all critical information is obtained and that it is objective and valid for the purposes intended;
2. monitoring to ensure that the treatment plan is developed appropriately to the severity of the presenting behavioral health concern;
3. facilitating collaboration among all treating professionals;
4. ensuring that a return to work planning has occurred, that accommodations have been considered, and that date has been set, when appropriate;

In addition, a superior case manager is skilled in both educating and treating professionals regarding potential insurance issues as well as deficits in the documentation, treatment plan, and return to work planning processes.

In this regard, the case manager is rather like the coach of a baseball team: The coach is not on the field hitting, throwing, and catching. The coach works toward getting the most out of all the players on the team by working together and making sure that they have a winning attitude. The coach collects useful information about team members and the challenges they face, and provides them with needed resources. Most important, the coach makes sure the right player is doing the job that one is best suited to do to accomplish the overall goal. With the baseball coach, the goal is winning the game. With the case manager, the goal is the claimant’s return to a full and productive life, to the greatest extent possible.

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Chapter 10
Behavioral Health and Disability Insurance: A Perspective

Kenneth Mitchell

10.1 Important Definitions and Behavioral Health Disability Claims

10.1.1 A Simple Concept?

Impairment is the objective and measurable loss of function. Disability is the subjective impact of that loss across the person’s work and life activities (Brehm & Nagi, 1989). An employee breaks his femur; the medical condition is validated by physical exam and X-ray. Mobility, as well as such specific tasks as lifting and standing, is measurably diminished. Current physical capacities do not meet job demands during a clearly prescribed period for healing and rehabilitation. The individual is affirmed as eligible for benefits, determined to be disabled and benefits are paid. The disability decision is designed to be a transparent, timely transaction.

This is not true with behavioral health (BH) claims. The ambiguous characteristics of psychological impairments begin with the basic differences between impairment and disability. For BH claims, impairment and disability are equally dependent on the individual’s report of subject symptoms with little to no objective evidence available. The degree of difference between impairment and disability is dependent on a range of changing conditions in play at any given time.

In most instances, the behavioral disability claim starts with symptoms that are reported by the individual to their employer or physician to disrupt his or her ability to work. Does the diagnosis of the behavioral impairment equal disability? Not typically, but this in the case of dementia or severe psychopathology, such as Schizophrenia an accurate diagnosis, may be a disability. Another issue that must be addressed is the reported limitations by the claimant. For example, “Are the limitations presented by a severe depression equal to a compound fracture or a heart...

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attack?” There are some instances where this may be true. There are other issues to address when a behavioral health claim is filed. Frequently, a question that must be answered is: Does the definition of the impairment, e.g., a Major Depressive Disorder, by the Diagnostic and Statistical Manual of Mental Disorders, IV (DSM-IV-TR, 2000) offer a clear and reliable picture of the person’s functional capacity? Typically, the answer from both the insurer’s definition and from the treating profession’s definition is usually no. Yet another question to ponder is, “Can a person be clinically depressed with diminished skills, yet continue to work?” The current research on presenteeism would suggest yes (Kessler, Ormel, Demler, & Stang, 2003; Lerner & Henke, 2008).

At first glance, BH impairments do not typically offer clear, objective, and observable symptoms such as a loss of a range of motion, reduced strength, or reduced mobility at first glance. Or do they? We may be looking in the wrong places? There are innovations within both the insurance industry and behavioral health fields that will be discussed, which illustrate how these types of concerns can be evaluated more objectively.

Timing becomes a valuable element in the disability determination process for the insurer, as well as the claimant. There are specific questions that are asked at the initiation of the claims process:

- When did the impairment start and when did the disability begin?
- When will the disability be over?
- How severe is the condition right now?
- How does the severity of the condition compare to the recent past and what can be anticipated in the future?
- Are the symptoms just a passing complaint, or a long standing personality trait with a recent decline in function?
- Do societal biases or stigmas make a fair and accurate disability assessment unlikely?

This chapter explores how the business of disability insurance approaches the complex work and productivity predicaments created by behavioral health impairments.

10.2 Overview of Social Security Administration Disability

10.2.1 Big Problem? Little Problem?

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10 Behavioral Health and Disability Insurance: A Perspective

approximately 5% each year for the past 3 years with the percentage to overall SSDI claims holding relatively constant over the same period (Annual Statistical Report on the SSDI Program, 2008).

SSDI mental disorders and musculoskeletal claims account for an estimated 50% of all SSDI claims in the most recent (2008) reporting period. Musculoskeletal disorders are typically one of the most well-defined, easily measured impairments with mental disorders being one of the least well defined and most subjectively measured. We have the Ying and the Yang of disability claims.

The SSDI mental disorder claims and age patterns compared to musculoskeletal claims are presented in Table 10.1.

While age is not a disability and aging is not a disease, age does make a difference. BH claims initiation tends to decrease with age. Moreover, musculoskeletal claims tend to increase (average age is 52), and with the increase in these types and other physical claims, there is a substantial underestimation of the true occurrence of BH claims or the impact of BH comorbidity.

The coupling of BH impairment with musculoskeletal disorders offers an important connection for the disability insurer. Recent studies described this connection to be pervasive. For example, a number of researchers (Dersh, Gatchel, Polatin, & Mayer, 2002; Gatchel, 2004; Halligan, Bass, & Oakley, 2003; Katon, Sullivan, & Walker, 2001; Warren & Hubbard, 2008) offer compelling research that individuals with anxiety and depressive disorders report more physical symptoms such as chronic pain. Likewise, they reported that as the physical musculoskeletal disorder symptoms increase, so does the likelihood of anxiety or depressive disorders.

Functional somatic syndromes such as fibromyalgia and irritable bowel syndrome were reported to be closely connected to Panic Disorder, Major Depressive Disorder, and Somatoform Disorders. Is depression the disabling condition or the chronic pain? Or a little of both?

Seventy-six percent of SSDI mental disorder claims are submitted by individuals under the age of 50, with the under age 30 cohort the largest (47.5%). Depression appears to be a young person’s disease with significant implications for work and career development. Disability determination becomes a critical fork in the individual’s career path.

The percentage of the total group of SSDI claimants over the age of 50 filing a mental disorder claim has declined from 13.2 to 11.8%, a 10.6% decrease over the past 4 years. It appears as the work force ages fewer SSDI mental disorder claims are being

<table>
<thead>
<tr>
<th>Mental disorder</th>
<th>Musculoskeletal disorders</th>
</tr>
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<tbody>
<tr>
<td>47.5% Under age 30</td>
<td>4.1% Under age 30</td>
</tr>
<tr>
<td>44.4% Age 30–39</td>
<td>11.5% Age 30–39</td>
</tr>
<tr>
<td>36.7% Age 40–49</td>
<td>20.9% Age 40–49</td>
</tr>
<tr>
<td>26.9% Age 50–59</td>
<td>29.5% Age 50–59</td>
</tr>
<tr>
<td>18.6% Age 60 to FRA</td>
<td>34.7% Age 60 to FRA</td>
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</tbody>
</table>

*Full retirement age
submitted. The estimated comorbidity figures suggest the links between musculoskeletal claims and BH impairment are significant and need to be considered in any disability determination related to chronic pain and long-term musculoskeletal disorders.

It is valuable for employers to understand age-related lost time and diminished productivity patterns within their respective workforce. This is especially true in understanding the nature of age-related musculoskeletal disorders, which in combination with a behavioral health impairment may create an accumulated impairment resulting in a profound impact on productivity. The Social Security Administration (SSA) reported that 23% of the female and 18% of the male SSDI claimants submitting mental disorder claims also reported receiving workers’ compensation claim. This suggests the real potential for a significant connection between BH claims and musculoskeletal impairment in the disability determination process.

Stress-related behavioral health claims reported by workers’ compensation Commissions typically are less than 1% of cases filed during any given year (California Worker’s Compensation Institute, 2008). The US Bureau of Labor Statistics (US BLS) 2008 reports a similar low percentage of work-related lost-time behavioral health claims. This number does not include cases where a physical injury occurs and there is a comorbid or accompanying depression. Several studies suggest this number may be over 60%.

Dersh et al. (2002) completed a review of an estimated 1,500 individuals who were entering into a physical rehabilitation program based on a work-related disability for a musculoskeletal impairment (pain). The analysis reported that 64% of individuals were diagnosed with some type of BH disorder as compared to 15% in the general population. All of the individuals were not working. The critical question is: Is the current inability to work a continuation of the musculoskeletal impairment, the BH impairment, or some combination?

The reported low number of true work-related behavioral health claims illustrate a huge misperception that stress is a viable reason to file a claim. Stress is not a disability. Stress is a physical, mental, or emotional tension beyond the norm. Stress is almost always described as a negative, but eustress or good stress suggests that various types of mental and physical stress can, in fact, be positive. The disability involved in stress is the lack of coping skills to manage the excessive levels of tension or friction that may arise in threatening situations. While most common sense individuals can agree on what is threatening, threat, indeed, is subjective, personal and is defined differently by each person. The inability to manage various degrees of life stress is the difference between day-to-day psychosocial predicaments vs. a true BH pathology.

In addition, many states, such as Montana and other state legislatures, do not allow for the filing of mental–mental or physical–mental claims, and thus Workers’ Compensation numbers also tend to underestimate the true prevalence of BH concerns. The BH epidemiology research notes rates as high as 30% for pure BH concerns alone and even higher for comorbid concerns (50–60%).

The relative impact of behavioral health impairments goes beyond formal lost time claims and the replacement of income. Recent studies on depression in the workplace (Kessler et al., 2003; Kronke, 2003; Lerner & Henke, 2008; Parry, 2009) illustrated the nature and scope of Major Depressive Disorder both as a claims issue, but as a silent saboteur of productivity. These trends complicate how an
insurer must account for the fluidity between absenteeism and presenteeism, pre- and post-claim. The BH productivity threshold indeed may move back and forth based on the resources that may be available to minimize the progression from presenteeism to absenteeism.

The percentage of the total group of SSDI claimants over the age of 50 filing a mental disorder claim has declined from 13.2 to 11.8%, a 10.6% decrease over the past 4 years. It appears that as the work force ages, fewer SSDI mental disorder claims are being submitted. The estimated comorbidity figures suggest the links between musculoskeletal claims and BH impairment are significant.

It is valuable for employers to understand age-related lost-time and diminished productivity patterns within their respective work force. This is especially true in understanding the nature of age-related musculoskeletal disorders that in combination with a behavioral health impairment may create an accumulated impairment resulting in a profound impact on productivity. The Social Security Administration reported (Annual Statistical Report on the Social Security Disability Insurance Program, 2009, September) that 23% of female and 18% of the male SSDI claimants submitting mental disorder claims also reported receiving workers compensation claim. This suggests the real potential for a different view of the connection between BH claims and true impairment that may be present.

Stress-related behavioral health claims reported by workers’ compensation commissions typically are less than 1% of cases filed during any given year (US. Bureau of Labor Statistics, 2009). The US BLS reports a similar low percentage of work-related lost-time behavioral health claims. This number does not include cases where a physical injury occurs and there is a comorbid or accompanying Major Depressive Disorder. Several studies suggest this number may be as high as 30% (Gatchel, 2004; Halligan et al., 2003).

This apparently low number of true behavioral health claims illustrate a huge misperception that stress is a viable reason to file a claim. Stress is not a disability. Stress is a physical, mental, or emotional tension beyond the norm. Stress is almost always described as a negative, but eustress or good stress suggests that various types of mental and physical stress can, in fact, be positive. The disability involved in stress is the lack of coping skills to manage the excessive levels of tension or friction that may arise in threatening situations. While most common sense individuals can agree on what is threatening, threat, indeed, is subjective and is defined differently by each person. The inability to manage various degrees of life stress is the difference between common psychosocial predicaments vs. a true BH pathology.

10.2.2 Workers’ Compensation (WC) and Behavioral Health Disability

In addition, many states, such as Montana and others, do not allow for the filing of mental–mental or physical–mental claims, and thus WC numbers too tend to underestimate the true prevalence of BH concerns. The BH epidemiology research notes rates as high as 30% for pure BH concerns alone and even higher for
comorbid concerns (50–60%). Therefore, the workers’ compensation system may not accurately account for those individuals with BH impairment.

The relative impact of behavioral health impairments goes beyond formal lost-time claims and the replacement of income. Recent studies on depression in the work place (Mitchell, 2008a, b; Mittenburg, Patton, Canyock, & Condit, 2002) illustrated the nature and scope of depression both as a claims issue, but as a silent saboteur of productivity. These trends complicate how an insurer must account for the fluidity between absenteeism and presenteeism, pre- and post-claim. The BH productivity threshold indeed may move back and forth based on the resources that may be available to minimize the progression from presenteeism to absenteeism.

A review of a large private disability insurance data base shows that behavioral health claims account for an estimated 4 and 7.5% of short-term and long-term disability claims, respectively (Mitchell, 2008b).

### 10.2.3 A Private Insurer’s Overview of Behavioral Health Disability Trends

Unum’s 2008 behavioral health productivity illustrated the distribution and impact of behavioral health claims experienced in a large private disability insurance book of business in the USA (the Unum database included 25 million individuals covered across 100,000 employers).

The Unum Behavioral Health Productivity Study (Mitchell, 2008b) offered the following observations across 25,000 short-term disability (STD) <6 months off work) and long-term disability (LTD) >6 months off work) behavioral health disability claims submitted from 2001 to 2006.

STD demographic patterns
- Sixty-nine percent of BH claims are filed by women
- The distribution of BH claims by age was:
  - 50.5% age <40
  - 30.5% age 40–50
  - 19% >50
- Major Depressive Disorder was the most common short-term BH claim (40%)
- Bipolar Disorders claims were 2 (22%)
- Bank/Finance employers reported the highest BH claim incidence rate per 1,000 employees with Education reporting the lowest number of claims per 1,000 employees
- Employers with <250 employees reported the highest STD BH incidence rate

Short-term disability return to work (RTW) patterns
- Manufacturers had the highest RTW rates; Education, the lowest STD RTW rate
- There were no RTW differences based on gender
- STD RTW rates varied little across BH diagnoses
Dysthymic Disorders had the highest RTW rate. Major Depressive Disorder was the lowest RTW rate

**LTD demographic patterns**

- Major Depressive Disorder was 1 LTD claim (49.4%) – Bipolar Disorder claims were 2 (23.5%)
- Females under the age of 40 were the single largest LTD BH claims group (27%)
- Public sector employees reported highest BH LTD incidence rates
- The employer with <250 employees reported the highest LTD BH incidence rates

**Long-term disability RTW patterns**

- Bipolar and Dysthymic Disorders had the highest BH LTD RTW rates
- Individuals under the age of 30 had the highest BH RTW success
- Education employers had the highest RTW rates with Business/Finance with the lowest
- Thirty percent of the LTD BH claims closed with SSDI benefits. This interesting finding may suggest that with the 24-month LTD limitation of benefits, 30% of the cases were significantly impaired to be approved for SSDI
- Nine percent of LTD cases closed as “not disabled” received SSDI benefits. Correspondingly, this cohort of the BH LTD claims closed as not disabled met the definition of disability to be approved for SSDI. This may suggest different definitions or an erosion of function from the time the private insurer closed the case and the individual filed for SSDI
- There was a seven-point increase in RTW outcomes when STD and LTD claims were managed in an integrated fashion

These patterns provided useful insight to the scope of what the insurance industry needs to respond to related to Major Depressive Disorder, Anxiety Disorders, and Bipolar Disorders. The following data illustrate specific patterns within a private disability insurer’s behavioral health claims.

Figure 10.1 illustrates the top five short- and LTD behavioral health claim types along with the RTW outcomes. Major Depressive Disorders lead the list with Bipolar Disorders in second position for both short- and long-term disability.

Individuals with Dysthymic Disorders had the most success in returning to work with +3 and +2 points above the mean in RTW rates. Individuals with Major Depressive Disorder were below average (−1 point) for STD and individuals with Adjustment Disorders had the least success (−2) in returning to work in the LTD group.

Work force size appeared to make a difference regarding both incidence of claims and RTW outcomes. Figure 10.2 illustrates the incidence patterns for STD claims. The small employer, <250 employees, had a 16 plus point difference of BH claims incidence than the larger employer (EE >2,000). Interestingly, the mid-size employers had greater success in RTW outcomes than either the large or small employers.

These data elicited several interesting questions: (1) Does this pattern suggest that employer work force size makes a difference in the determination of disability?; and
Does the data suggest that employees working for a smaller employer may have less access to treatment that may reduce the needs for disability benefits?

Several possible answers to these questions are: (1) Work force size would unlikely impact the disability determination process, but the lack of behavioral health services in the form of Employee Assistance program (EAP), BH treatment covered under an employee health plan may play into the higher incidence. (2) It may also suggest that the small employer with a work force under 250 EE’s has less flexibility to adapt the work place encouraging an earlier and longer separation from the employer.
Figure 10.3 illustrates the patterns for LTD and employer size. Similar patterns occur for the long-term cases but tend to return to the mean.

Figures 10.4 and 10.5 offer a view of behavioral health claims incidence and RTW outcomes by industry. For STD cases, Education employers had the lowest incidence and the lowest RTW rates, with healthcare and financial groups with the highest incidence. While manufacturing had a close to the mean incidence rate, its RTW rates led the industry groups. The higher RTW rates served as the foundation for its lower LTD incidence rate.

The financial industry and public sector employers led with the highest BH LTD rates. Both industries reflect a historically rigid policy on work site accommodation and returning individuals back to work. This is changing dramatically for the financial industry with the current turmoil in the financial sector. The lack of short disability management will increase LTD rates. Historically, public employers, e.g., municipal/
state governments, typically have a negotiated pension program that creates significant incentives to retire on disability until full retirement can be achieved at age 65.

### 10.2.4 A Closer Look at Major Depressive Disorder

**Depression costs!** Both the direct and indirect costs of Major Depressive Disorder offer a reference point on the relationship between disability insurance and behavioral health claims. The 2009 Integrated Benefits Institute (IBI) cost of Depression Study (Parry, 2009) offered a unique look at the complex relationship between work, Major Depressive Disorder, presenteeism, and comorbidity. The most significant point is the differences between a single disability with BH impairment and one that was compounded by a comorbid condition.

The IBI study reported that Major Depressive Disorder related to lost productivity while at work (i.e., presenteeism) is the highest cost contributor (63%). Depression-related sick days were reported as the second most costly group (18%). Those individuals on disability claim with another impairment (such as heart attack, stroke, and chronic pain) with Major Depressive Disorder as a comorbid condition (13%) and those individuals on a disability lost time claims just with Major Depressive Disorder (6%) accounted for the remainder of the lost productivity. This pattern suggested the pervasiveness of the behavioral health impact on work function, but once again draws attention to that line between symptoms, impairment, work performance, and disability (Fig. 10.6).

Correspondingly, a recent comparison of the cost of medical care within the workplace reported Major Depressive Disorder as the most costly impairment group when medical, pharmacy, absenteeism and presenteeism costs were combined (Loeppke et al., 2009). Anxiety Disorders conditions rounded out the top five

<table>
<thead>
<tr>
<th>Percent of Claims by Lives</th>
<th>Return to Work</th>
<th>Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank/Finance</td>
<td>-3</td>
<td>-15</td>
</tr>
<tr>
<td>Manufacture</td>
<td>-2</td>
<td>-14</td>
</tr>
<tr>
<td>Education</td>
<td>-2</td>
<td>-3</td>
</tr>
<tr>
<td>Healthcare</td>
<td>-1</td>
<td>Other</td>
</tr>
<tr>
<td>Retail</td>
<td>-1</td>
<td>Services</td>
</tr>
<tr>
<td>Healthcare</td>
<td>4.7%</td>
<td>13%</td>
</tr>
<tr>
<td>Trans/Utility</td>
<td>12.5%</td>
<td>Trans/Utility</td>
</tr>
<tr>
<td>Other</td>
<td>10.3%</td>
<td>Education</td>
</tr>
<tr>
<td>Public sector</td>
<td>17%</td>
<td>Public sector</td>
</tr>
<tr>
<td>Retail</td>
<td>4.7%</td>
<td>Public sector</td>
</tr>
<tr>
<td>Services</td>
<td>-3</td>
<td>+3</td>
</tr>
<tr>
<td>Trans/Utility</td>
<td>-4</td>
<td>+3</td>
</tr>
<tr>
<td>Education</td>
<td>-4</td>
<td>+4</td>
</tr>
</tbody>
</table>

**Fig. 10.5** LTD Incidence and RTW by industry (Mitchell, K. (2008). Behavioral health productivity study. Unum US, White Paper, Chattanooga, TN)
behind obesity, arthritis, and back/neck pain. This study presented a valuable picture for employers and useful information for insurers making choices in applying limited resources. Once again, these data illustrated the fluidness between working and not working with behavioral health impairment (Fig. 10.7).
10.2.5  Disability Insurance and Disability Management: 
The Odd Couple

Disability insurance and disability management are not natural partners. In their purest form, there are competing self-interests between the insurer, the claimant, and the employer policy holder. The self-interests, such as profit motive, expedient claims closures can offer substantial barriers to the integration and successful outcomes of claims administration, as well as mitigating the impact of the behavioral health impairment. This requires the disability insurer to make a measurable commitment to offer an approach supported by resources that reduce the competing interests.

The principle goals of disability insurance (public or private) are to assess the claim in a fair and timely manner and, if approved, pay the benefit as directed by the contract or legislation. In the private insurance world, reducing risk and achieving a measurable profit are expected and appropriate. Income that is generated by the insurance premiums are invested creating sufficient funds with reserves to pay the agreed to benefit throughout the life of the claim. In the public disability insurance program, profit is not a motive, but financial sustainability is. Programs such as the SSDI Program, Supplemental Security Income (SSI), and Federal and State Workers’ Compensation program have well-developed trust funds with investment programs to cover the respective costs of the insurance program. When these investments do poorly or are impacted by mismanagement, the funds become in danger of operating with a deficit and threaten the sustainability of the insurance funds.

The principle goal of disability management is to mitigate the impact of an injury, illness, or chronic disease. The claims managers (private or public) are prepared to administer the claims process in a fair, timely manner as defined by the contract or legislation. Claims managers are not prepared as disability managers by design. This lack of preparation and focus in disability management is based on the singular mission of the respective insurance groups.

Disability management functions are appropriately developed and provided by individuals who possess the specialized skills and information required to minimize the impact of the injury or illness. Disability management is an additional service provided by the private insurer directly or in concert with a collaborating disability management organization.

There is a growing trend by the private disability insurer to offer a more sophisticated range of interviewing skills that invite the disability claims professional to take a broader role in guiding the claimant to pursue work options. Indeed, this is a true blending of the disability claims and disability management process. A critical issue is blending the management of the terms disability contract with the needs of the claimant. This can be a sensitive and challenging task. The blending of these two functions has not yet become a focus of the public sector claims administrators.

Competing interests (e.g., closing or keeping a case open) can create friction between claims administration and disability managers. Managing the disability is typically a secondary or even tertiary task of the insurer. Disability management is one of the several risk management functions that are applied in various forms on top of the benefit administration process.
Timing becomes a critical factor and an internal barrier to successful management of the impairment. Disability management works best when it is applied early, typically during the first 30–60 days, within the disability period. Within the insurance business, disability management will not occur until the claim is approved. A timely claim decision offers timely disability management. A delayed decision almost always means a delay in the management of the disability. This is particularly relevant in the public program (SSA) that has a record of many months to years involved in the claims adjudication process.

Active management of the claim or the disability is not part of public disability insurance (SSDI) program for Behavioral Health claims or for that matter, any claims. Award and ignore is the operative position. If any risk management controls are applied, they are embedded in the disability determination process to sort out true disability according to the current SSA’s definition of disability.

Frequently, the SSDI applicant will be turned down several times due to either inadequate or incomplete information. SSA has acknowledged that this is one means of slowing entry into their system and that some people may simply go away. SSA may also do this for “cost management” purposes. Again, this is a rudimentary and ineffective means to keep costs stable without regards to immediacy. Thus, SSA has generated a large industry of SSDI Advocates who offer legal advice on navigating the SSDI process.

Federally legislated RTW incentives are a patch work of good intentions as after thoughts of the public disability insurance program. The Federal Ticket to Work (TTW) program offers financial incentives to employers, SSDI recipients, and RTW providers encouraging engagement in re-employment activities. The origins of the TTWP were generated by various disability advocacy groups who felt that employment opportunities for individuals with disabilities, specifically on SSDI, were poor to nonexistent.

The TTW legislation offered a menu of incentives that were designed to enhance employment opportunities. Correspondingly, various features as trial work programs, rehabilitation benefits are made available to reduce the inherent work disincentives of the federal disability benefits.

State vocational rehabilitation agencies offer RTW planning and retraining services to assist an SSDI claimant secure enhanced skills and eventually re-employment. These programs are passive at best and do not result in significant successes in work resumption. All too often such assessment services are made available too far down the road (9 months to 1 year) from the initial onset of the impairment and the approval for disability. Such delays impact both the public and private insurer with inadequate evaluation and inaccurate recommendations. Incomplete and inaccurate evaluations place the insurer in a very difficult position as they make a decision on the degree of disability that is reported to be in place.

The length of time between the onset of impairment and the evaluation of work disability is a clear disincentive and major factor in the public disability insurance as it is in the private insurance world. Lag time is commonly referred to be the time between the onsets of the injury, illness or work disrupting symptoms, and the filing of the claim. Time gaps from 10 to 90 days are not uncommon. Recent research
illustrated that with effective integration of benefit programs, lag times can be reduced dramatically, creating more positive outcomes for all the stakeholders. Figure 10.8 identifies common characteristic that influences the private and public disability insurance approach to behavioral health impairments.

10.3 Common Problems that Occur with Behavioral Health Concerns

10.3.1 Bureaugenic Disability

The policies and practices of the employer or insurer shape the disability benefits for a BH claim. Bureaugenic disability is lost time created by corporate or insurer policies and practices. A narrow or more inclusive definition of BH disability and how it is managed changes the nature and scope of the benefit and experience for the individual. The scope of disability can be expanded or limited based on the plan design, legislation, or an employer practice. The simplest form of bureaugenic disability is when an employer does not respond to minor impairments with a timely work site accommodation. The impairment quickly becomes an unnecessary disability.

The varying definitions of BH disability enhance the complexities of adjudicating and managing behavioral health lost-time claims especially in the public sector. For example, the definition of disability under SSA is different from that used by private disability programs. SSA pays benefits only for total disability; it does not pay benefits for partial disability or STD. Correspondingly, SSA uses different terminology and definitions then treating professions as well.

To be eligible for SSDI benefits, a person must:

- Be insured for benefits, i.e., sufficient contributions into the fund
- Be younger than full retirement age
- Have filed an application for benefits
- Have a social security-defined disability

Meeting the insured’s social security eligibility requirement means that a person must have worked long enough – and recently enough. The number of work credits (quarters of coverage) a person needs to qualify for benefits depends on the individual’s age when he or she becomes disabled. Section 223(d) (1) of the Social Security Act defines disability as an
inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Private insurer definitions of BH disability also present a complex set of guidelines. For example, the definition of disability for private or public disability insurance industry is based on a contractual relationship between the policy holder (e.g., employee, employer) and the insurer. All parties enter into an agreement based on an individual- or group-benefit plan that states the conditions under which one is eligible for benefits, the scope of the benefits, criteria for approval, and how the benefits are to be paid out.

In either private program, the decisions are based on:

1. The determination of eligibility for benefits
2. Objective medical evidence that can demonstrate measurable impairment exists
3. That, in fact, the impairment measurably impacts the individual that they are unable to meet the demands of their job or occupation either temporarily or permanently

Each insurer may have a different level of specificity and focus on defining what a BH disability may be.

A fourth element is added for workers compensation claims, i.e., the notion of causality. Does the condition (BH impairment) arise out of or during the course of the work itself? In many cases, this is extremely difficult to determine in total or in any proportion. While the legal profession defines causality, it plays a critical issue for the worker’s compensation claims administrators direction.

10.3.2 Claims Adjudication

The private disability insurance programs excel at timely claims adjudication. It is recognition of the impact of consumerism. Due to the sheer number of claims submitted per year compared to the resources at the state disability determination operations and the number of Administrative Law Judges (ALJ), the public disability insurance program (SSA) does not represent the most efficient claims management. To illustrate the volume, 877,226 impaired workers were awarded disability benefits, e.g., in 2008 from an estimated three million claims submitted. An estimated 23% (200,007 claims) were behavioral health related.

A poignant illustration of the impact of untimely claims adjudication with a less than ambiguous impairment, cancer, was presented at the 2007, SSA Compassionate Allowance Hearing. In a review of LTD claimants with a cancer diagnosis within a private DI program, 53% of LTD claimants who were approved for SSDI received their award after their death. The wait time for the SSDI award was on the average of 14 months post claim submission (Mitchell, 2008). These data were used to support the revisions in the SSDI’s compassionate allowance program to expedite the approval of claims highly likely to be awarded, such as cancer, quadriplegia, and severe psychopathology.
Typically, the claims submission programs are based on proven customer services strategies with a clear movement to Internet and telephonic claims submission. Reducing lag times between the point of injury and impairment is a critical factor both in claims decision making and RTW outcomes (Mitchell, 2008a). This occurs in the private insurance process, but not in the public programs.

Extending time between the submission of the claim and the final decision appears to work on behalf of the public disability insurance programs. The process assists in testing the validity, as well as tenacity of the claimant. Whether this is by design or a residual of a process has been a significant area of discussion for years with little intent to change.

The inherent nature of behavioral health claims offers significant lag times over an acute injury. The BH experience is more likely a percolating chronic disease. Any claims determination delays are most likely related to:

1. The gathering and receiving appropriate objective medical information
2. The vacillating nature of the impairment, i.e., “Good today, not so good yesterday and who knows about tomorrow”

The private disability insurance programs and the SSA are working on innovative electronic claims and medical information sharing protocols to insure both timely and accurate sharing of medical information. Current demonstration projects sponsored by the Social Security Administration (SSA), America’s Health Insurance Plans (AHIP), and its member disability insurance groups are designed to test out methods to expedite claims review, secure electronic medical files, as well as the gathering and sharing of medical information. AHIP in its recent January 2010 Innovations in Disability Insurance describe the emerging and current projects to increase effective management of disability across the private and public sectors.

10.3.3 Disability Deception?

By whatever name it is called, disability deception, fraud, or malingering is an intentional effort to create a false belief to gain an advantage or avoid a task, activity, or responsibility by pretending, making up, or creating fraudulent illness or symptoms. Research indicates that fraudulent claims occur in an estimated range of 1–5% of workers’ compensation and STD claims (California Workers’ Compensation Institute, 2008; Halligan et al., 2003).

Attempts to deceive employers are perpetuated by individuals who are clearly looking for quick personal gain, possibly retribution or some other manner of taking advantage of the employer. This person’s scam typically has clear gaps and inconsistencies in behavior.

Private insurers are effectively addressing these types of concerns by reducing the ambiguity around RTW considerations. By offering a clear set of RTW expectations coupled with accurate and objective assessment of the individual’s functional capacity with a demonstrated commitment to employ timely and fair, legal action creates a reliable strategy for dealing with fraud.
Because of the occurrence of malingering, employers have frequently come to believe that all or a large segment of its work force’s injured or impaired employees are involved in some form of deception. This appears to be especially relevant for this individuals with a self reported, less than objective set of symptoms.

This type of automatic assumption can and does result in the costly disability dance of adversaries. The immediate assumption of an adversarial position invites the employer to become unnecessarily entwined in an unproductive relationship with the impaired employee, the healthcare and insurance partners. Such entanglement creates a complex, self-perpetuating, unsolvable health and productivity predicament. The ability to separate real fraud from those employees caught in this adversarial dance is to the mutual benefit for all involved.

Symptom exaggeration, a more commonly reported event than disability deception, is often misrepresented as fraudulent behavior as well (Mittenburg et al., 2002). Twenty percent to 30% of medical and disability claims with certain impairment types, e.g., fibromyalgia, chronic pain, and mild head injury, were reported to experience symptom exaggeration. Symptom exaggeration is most likely an unintentional enhancement of the impact of a real injury, illness, or medical symptoms. Although symptom exaggeration is an integral part of real malingering, this alone is not fraud or absolute faking.

Symptom exaggeration can be a poorly learned adaptive response, an ineffective coping style, the product of misaligned rewards and reinforcements, or a prominent feature of a comorbid condition, such as depression.

Symptom exaggeration is characterized by real impairment with disproportionately high subjective disability. Secondary gains are present, but usually include benefits other than money. For example, the exaggerated symptoms may serve to:

- Reduce anxiety symptoms
- Support a dependent relationship
- Exempt a person from expected social roles, such as spouse, parent, or worker
- Reward a highly choreographed dysfunctional relationship in a family or workplace

Symptom exaggeration can be fueled by a high level of comfort with the status quo highlighted by vacillating feelings of ambivalence and resistance to change. While the resistance may be strong, it will typically be a more benign type than observed with a person engaging in disability fraud. Resistance may be more related to habit, fear, or avoidance of higher levels of anxiety generated by change. When confronted with the discrepancies, the individual will most likely agree, but will have little to no insight.

10.4 Strategies for Superior Management of Behavioral Health Disability Claims

10.4.1 Work Capacities and Job Demands

At the heart of the disability determination process is the objective and accurate assessment of the temporary and/or permanent gap between the workers’ capacities and the job demands. Both private and public disability insurance programs are
built on the concept of medical evidence. This is both a strength and weakness. Objective medical evidence vs. medical opinion becomes an important differentiator in determining the nature of the disability in question.

Recent studies completed by the American Psychiatric Associations Foundation’s Partnership for Workplace Mental Health Taskforce on Disability and Return to Work (2005) (American Psychiatric Association, 2007) suggested that determining the work capacity for an individual with a behavioral impairment was deficient in both professional training and in practice.

To this end, the development of a pilot study that created a formal training program to prepare psychiatrists to assess work capacity and connect with the patient’s job demands was a high priority. The APA Foundation recently reported on the demonstration project that began, May 1, 2008, with a leading US retailer, based in the Northwest. This study offered a well-defined model for assessing worker capacities and job demands. Sample evaluation tools can be found at the end of this chapter. The sample tools do not represent APA policy. Correspondingly, the testing of the forms is not complete. The forms should be used in conjunction with the larger process posited by the APA taskforce on disability and return to work to include: early intervention, recognition of the inability to work as a crisis warranting commensurate levels of attention.

The models developed were supported by the work of Lerner and Henke, (2008) who conducted an extensive review of the studies related to the impact of depression on presenteeism and absenteeism focusing on the links between work capacity and job demands. The review accurately illustrated the role depression plays across specific work tasks and functions.

The review suggested that individuals who reported depressive symptoms had significantly greater work performance deficits. This resulted in greater absenteeism specifically related to the inability to manage mental, interpersonal responsibilities, low energy to complete physical activities, time management with memory and output deficits. Employees reporting depression while continuing their work (presenteeism) estimated that Major Depressive Disorder symptoms limited their physical performance on the job 20% of the time. The critical question is, “at what levels of lost productivity does disability or rather the impairment in functioning begin, e.g., 30, 50, or 75% lost function?”

The AMA Guides to the Evaluation of Permanent Impairment (6th ed.) noted that questionnaires are sufficient only as screening devices to note symptoms, but are NOT adequate to assess true objective disability. Thus, this is a continued problem with the research that is conducted. Moreover, it is at odds with what is found clinically. Most individuals reports more deficits, but these are NOT found to occur when measured with objective standardized psychological testing. This gap between research and clinical practice has to be noted and addressed.

Correspondingly, a more critical question is: To what level of work disruption can the employer accept prior to the person filing for a disability benefit? In this case, the employer’s work site flexibility or lack thereof may be the true disabling factor, not the behavioral health impairment itself.

Other research has found that many individuals complain of the workplace or experience workplace inflexibility, but that these are psychosocial issues vs. a psychological impairment. There is no getting around the psychosocial issues in the
workplace. It has been ascertained that many psychosocial issues are overmedical-
ized and said to be a psychological concern, when it is not so when measured
objectively. Legal and contractual issues or what is referred to as “Bureaugenic
Disability” such as benefit plan design and access to employee assistance services
become a workplace issue as well.

Lerner & Henke’s (2008) comprehensive review suggested that the ability to
measure specific functions of a job for an individual reporting BH impairment
needs to be multifactorial of not only the physical capacities, but a representa-
tive sample of the job’s cognitive and psychological functions. This includes time manage-
ment, short-term memory tasks, interpersonal demands, planning and concentration
critical to both continuing at work, as well as returning to work.

While this is true, unfortunately, SSA simply utilizes a checklist that the claim
adjudicator uses to make the decision. The primary issue is that it is a continuation
of the same problem that is already occurring in the private insurance sector. There
is too much subjective information that is utilized as “proof” of impairment.
Checklists, surveys, and questionnaires will never be able to measure impairment
since there are no validity indices, base rates, and these tools are not reliable.

Employers, such as JP Morgan Chase, have focused on the practical notion of
connecting job demands and worker capacities as a way of defining the relationship
between job demands, impairments, and degree of disability. By applying a simple
work capacity to demonstrated impairment matrix based on data gained from interview
and clinical information coupled with worksite analysis, they are able to illustrate
the connection between BH impairments and job demand, the employer, employee,
and the healthcare provider are able to determine gaps and mismatches. Disability
insurers have yet to move in this direction.

The notion of proportional or partial BH disability creates a very complicated thresh-
old to consider as job demands and worker capacities are considered. The complications
are generated within the language of the employee benefit plan, the reality of work site
accommodations, as well as the EAP that may be made available to the employee.

Partial disability invariably invites the notion of partial ability. This introduces
the half-empty/half-full glass metaphor. Is the glass half-full or half-empty? Is the
employee partially disabled or partially able? The answer to the glass half-full or
half-empty depends on whether you are drinking or pouring. In the behavioral
health case, the employee who is trying to prove disability, or loss is doing the
drinking, partial disability and the employer/insurer who is trying to protect
productivity and recognize remaining ability is the pourer, partial ability. The decision
of disability becomes very complex.

Proportional disability is offered by private insurers and state workers’ compen-
sation programs. The Federal SSDI program does not recognize proportionality;
instead, the disability is viewed from an all or nothing point of view.

10.4.2 Controlling Risk

All public and private disability insurance programs have well-defined claims
processes that are designed to efficiently gather information related to eligibility,
scope of impairment, and effect on work capacity. These processes are applied across all forms of impairments.

The process begins with a statement of medical evidence by the attending physician to be reviewed by a professional claims specialist who determines the awarding of the disability benefit. The adjudication process takes a current snapshot of medical information and functional capacity applied to well-defined guidelines to determine whether job demands exceed work capacity both currently and in the future.

10.4.3 BH Risk Management Strategy 1

The practice of the 24-month mental and nervous (MN) benefit limitation is standard under private group LTD contracts. This benefit design establishes limits on the payout for a mental and nervous (behavioral health claim) to a 24-month period. Following the 24 months, the claim is closed as the end of benefits. The claimant no longer receives payment and must RTW, if the job no longer exists or must seek other employment options.

The public disability insurance program does not have this feature. In fact, one of the weaknesses of the public program is the lack of follow-up or benefit milestones as to improvement or increased function. Thus, once an individual is receiving disability benefits from a public program, they continue until retirement age (65 years of age). Both the insurance program and the individual view the disability as permanent.

MN limitations under disability income replacement policies have not been challenged or altered by federal or state mental health parity laws bearing on medical expense insurance coverage. However, the limitations have been challenged/altered through other state regulatory mechanisms (only to a limited extent thus far).

In 2008, the State of Vermont issued a bulletin requiring mental health parity under disability income policies. Although the Vermont Legislature has acted on mental health parity for medical expense insurance repeatedly over the past decade and more, the Legislature never did enact provisions bearing on disability income. The Vermont Insurance Department asserted that general insurance statutes required mental health parity for disability income policies. This puts Vermont in a unique position and offers an opportunity to view the impact of changing the MN limitation approach.

The MN limitations became a standard provision of group LTD policies as a compromise between offering meaningful disability income protection and the need to manage the financial risk presented by disabilities arising out of ambiguous and self-reported conditions. As presented earlier, disabilities arising out of mental and nervous conditions are accompanied by a much greater degree of subjectivity (on the part of the “disabled” individual) and much more limited ability to test/diagnose through objective medical tests.
With this ambiguity and an unspoken lack of confidence in the diagnosis and treatment of mental and nervous conditions, the insurance provider defines these cases as one accompanied by a special kind of moral hazard or unacceptable risk. All too often, an adversarial relationship is developed to thwart would-be deceivers. While a clear sentinel effect has value, individuals who are genuinely in need of the benefit may be discouraged to apply.

The benefit of MN limitations under group disability policies is that they create some level a balance between offering meaningful, affordable insurance coverage and risk management without corresponding underwriting guidelines. The MN limitation policy also strikes a balance between giving a claimant time to deal with/recover from a mental and nervous condition (with the help of appropriate medical intervention) and motivating a claimant to RTW. The end of a benefit period always seems to encourage some individuals to reconsider a RTW that may have chosen to continue on disability for an unlimited period.

However, not all individuals do RTW. Instead, many have applied for SSDI disability benefits simultaneously, and while they no longer receive private disability benefits, they continue to receive SSDI benefits. This creates a quandary for the individual in attempting to look for and obtain a job, which will result in certain loss of SSDI benefits.

The rationale for the MN limitations is not understood by laypersons, consumers, most therapists, and some regulators. The policy strikes many as unfair and artificial. It is a form of negotiated disability. In reality, all disability is negotiated to some degree or other. It just depends on the stakeholders who are doing the negotiation.

A critical issue in the working within the 24-month benefit limit is; do you wait until 24 months to begin treatment or work planning or do you use the 24 months as the planning. The common sense point is that you use the 24 months to move forward. Yet, there can be a claims administrator practice to “manage to the limit,” meaning that with well-defined limited benefits the insurer and employer might not pay as much attention to make sure to continue to validate ongoing impairment and/or help the individual RTW.

Those insurers and employers who have made a commitment to manage the disability have individuals RTW within 6–8 months making the 24-month BH an inconsequential issue. This can unintentionally contribute to friction between the claimant and the insurer. There is also some difficulty in defining what does (e.g., depression) fit within the limit, and what does not (e.g., dementia), even though both are within the DSM-IV-TR diagnostic system.

Finally, the notion of disability shifting is invited. The individual in the position that if they have been out of work for 20+ months and their BH disability benefits are ending, and may not ready or able to RTW may “look for” or be coached to shift to a physical reason to continue the benefits. This may be particularly an issue for the individual over the age of 50 who may have a well-defined musculoskeletal impairment, but is not disabled by the conditions. The addition of the musculoskeletal impairment and the possible comorbidity of the BH impairment to the mix may offer a less ambiguous condition to support the continuation of the claim.
10.4.4 BH Risk Management 2: Transitions In and Out

Disability insurers apply various levels of case or condition management as a risk reduction program. Case management that simply monitors the individual can have a minimal, but measurable, sentinel effect. Effective case management includes real planning with clear expectations based on targeted incremental goals. This incrementalism or transitional work fits nicely with the treatment process for BH impairments. Transitional work is not passive and open-ended light duty but a series of defined steps leading to full productivity.

Transitions and the subsequent connections over time offer the claimant and the treating professionals’ a collective snapshot of behavior. The approach provides feedback to the treatment team to adjust medication or refocus on new behaviors. This approach pays measurable dividends for the claimant, insurer, as well as the employer.

An essential part to case management focused transitional work program is the RTW plan. The RTW plan offers the insurer, employer, claimant, and the healthcare provider a well-defined path to determine the changing impact of the impairment, adjust the path based on the outcomes of treatment with job demands and worker capacities in the balance.

Transitional work programs engage the employer in a process that invites reasonable, timely accommodation and provides continuous reinforcement of incremental success for the claimant. Maybe most importantly, the transitional work program offers the healthcare provider accurate, real-time functional data on how his or her patient is doing in concert with the treatment plan. Modifications can be made to enhance success.

The development of a transitional work process through a well-defined work return plan integrated with the treatment plan with an incremental continuation or resumption of work. Such a plan is offered as an illustration in Fig. 10.9.

Correspondingly, a BH return to work plan is best applied with a team approach that brings together assessment, treatment, and work site accommodation.

Several employers, such as Costco and AOL, have developed such programs that offer collaborative innovation with the disability insurer in linking BH assessment and case management. Both employers, one in the Internet industry and the other a large retailer, recognized that BH lost time was both a chronic productivity and cost problem. Correspondingly, the BH claims were the leading claims in their respective workforces.

Both employers partnered with their respective disability and healthcare insurer. The respective programs provided a unique evaluation process for BH claims with corresponding treatment to employees who submit STD claims for behavioral health conditions (e.g., Major Depressive Disorder and Anxiety Disorders). The intent was to promote a RTW in a timely manner. While the programs were focusing on individuals who left work on claim, both employers have moved the services to those employees still at work with reported behavioral health and productivity concerns.

The project teams designed a process to ensure that employees who were diagnosed with behavioral health conditions participated in diagnostic evaluations by behavioral
health specialists within 2 days of submitting STD claims. To participate in the program, employees were required to sign authorizations allowing healthcare practitioners to provide summary information about their conditions.

In the retailer’s program, a special assessor training program was initiated. The assessor training program prepared community-based psychiatrists to use specific tools for determining current levels of pathology, impairment, and to offer a recommendation of not only the loss but also what the person could do. Likewise, the assessor was able to provide a recommended treatment plan that would align with and balance the needs of the employee and the employer’s ability to offer work site accommodations.

### 10.4.5 Return-to-Work Planning

After assessing employees’ conditions and receiving their authorizations, behavioral health professionals provided a clear statement as to the individuals’ BH diagnoses, functional limitations, prescribed medications, and projected return-to-work dates. Program participants also received regular phone calls from the vocational rehabilitation and nurse case managers, who provided them with information about their conditions, answered questions, helped them follow physicians’ treatment plans, and linked them with needed services, such as support groups and

---

**Prescribed Restrictions & Limitations: 8 weeks off work – Call Center Position**

- Reduce exposure to targeted stressors which includes full duty work load, answering complaint calls and reduce phone time initially.
- Reduce work hours which means begin halt time and increase to full time over a 2 week period

<table>
<thead>
<tr>
<th>Time</th>
<th>Strategy</th>
<th>Application</th>
<th>Outcome</th>
<th>Adjustments</th>
</tr>
</thead>
</table>
| Week #1 | • Modify work schedule  
• Computer Training  
• Listening to Mentor  
• Phone time with Mentor |  
| 2:00 PM to 8:00 PM  
| 2 Hours per day  
| 2 Hours per day | Full  
Partial  
Marginal |
| Week #2 | • Modify work schedule  
• Listening to Mentor  
• On phone with Mentor  
• Full Phone Time |  
| 11:00 AM to 8:00 PM  
| Reduce by 1 Hr.  
| Reduce by 1 Hr.  
| Mentor available as needed | Full  
Partial  
Marginal |
| Week #3 | • Full Phone Time |  
| Return to full duty | Full  
Partial  
Marginal |

**Fig. 10.9** In *No More Light Duty as a Career Path! Building Transitional Work Programs*: Unum US, WorkRx Group, Ltd, 2010
transportation to doctor visits. During the 3-year program, the following results were achieved for the Internet company:

- Overall number of STD Claims submitted – 25% decrease
- Average length of duration – 34% decrease
- Behavioral Health STD Cost – 73% decrease

The outcomes from the retailer program are currently being assessed.

10.4.6 Incentives and Disincentives

All disability insurers, public or private, recognize the value of providing incentives to RTW. With limited follow-up by the public disability insurance program, the SSDI claimant is invited to take advantage of a number of incentives to consider employment options. The “Disability Riddle” comes into play. The Disability Riddle asks: will a person, who has committed time and energy to demonstrating that they cannot work, be interested in and make an effort to go back to work following the disability award. The paradoxical answer is yes, but with support and guidance.

The public program RTW incentives require the claimant be aware and understand the incentives, as well as have the skills and energy to apply the available resources. The incentives become faux motivators if the claimant is not able to move forward.

The SSDI program offers a number of incentives that line up with the private industry incentives as well. The following SSDI work incentives have the clearest symmetry with the private insurance programs:

- Ticket to Work and Self-Sufficiency Program
- Expanded Availability of Health Services
- Expedited Benefits
- Disability Review Postponed
- Proportional reduction of benefits based on earnings

The Ticket to Work and Self-Sufficiency Program offers a voucher or resource ticket to obtain the various employment support services offered by private and public vocational rehabilitation service providers, education centers, etc. This program was slow to start in 2002 and has recently been revised to realign the incentives for employers and vocational service providers to participate. The private DI programs offer comparable services directly to the claimants with a more timely and focused follow-up.

The expanded healthcare services extended Medicare Part A premium fee coverage for 93 months after the trial work period for those beneficiaries who are able to work. The private sector DI programs does not have this incentive. This incentive has shown to work well in European countries with a national health programs.

Expedited benefits offer a quick resumption of disability benefits to an individual who has returned to work and has exceeded the earnings level but the impairment and resulting disability has returned within 60 months. This benefit removes the barrier of having to reapply for disability benefits. The private DI program offer similar benefits.
Postponed Disability Reviews offers a mixed message to the claimant. Go to work and we will pay less attention to you. The SSDI program offers to postpone regular reviews of the claims (usually every 6–9 months) if the claimant uses the TTW program. Inherent in the success of the private insurance programs is the regular review of the claim (every 2–3 months) to assist the individual in moving forward. In complex cases, the private DI insurer may be working with the claimant on a weekly basis.

Proportional reduction in benefits based on earnings offers an incremental support for a RTW. In the SSDI case, the insurance provider reduces the benefit $1 for every $2 earned. This prevents the rapid reduction or elimination of the benefit that may be a disincentive to attempt a work return.

The private insurer has a vested interest in encouraging the claimant to participate in all incentives offered, but the public disability program does not.

### 10.4.7 Rehabilitation Benefits

Such awards that reinforce the individuals’ efforts to RTW can be exceptionally effective for individuals with behavioral health impairments. First, the rehabilitation benefit protects income while reinforcing increased participation in RTW planning. The traditional rehabilitation benefit offers an increased percentage of benefit as the person moves toward work. This increased benefit may range from 10 to 25%.

The rehabilitation benefit recognizes that individuals do improve but not at either traditional or expected schedules. The potential danger of the rehabilitation award is that when it is assigned as a temporary benefit, it may become permanent both in the mind of the claimant and the employer, i.e., the comfortable status quo and may no longer serve to protect or move the person forward to full productivity.

### 10.4.8 Appropriate Determination of Impairment in Functioning

*What can you do and how often?* Determining the line between impairment and disability is both an art and science when it comes to behavioral health claims. The problem is that there are very few professionals who know how to do this appropriately. Consequently, it is essential to examine what can be done to make better decisions regarding determination of behavioral health disability.

The degree of subjectivity and ambiguity in a self-reported impairment creates a complex process for determining the current severity, receptivity to treatment, and future impact of the disorder. The traditional method to gather medical evidence has been requesting the attending physician to offer an opinion of diagnosis with corresponding restrictions and limitation. The question is, “can this person do one’s job with the impairments s/he has”. The commonly asked question is, “can this person do his or her job with the impairments s/he has?”. The less common, but more practical
question is, “can this person continue to work if the limitations produced by the impairment are minimized?” When a discrepancy arises between the noted impairment and the unlikelihood of continued employment a functional capacity evaluation (FCE) or an independent medical exam (IME) may be called for. These are typically done independent of a behavioral health job analyses. Neither may offer relevant information on what a person can do within the specific nature of one’s current work tasks. For a person who is disconnected for one’s employer as she or he applies for SSDI, this element of the determination is completely absent.

10.5 Protecting Productivity: A New BH Business Model

The prevention of disability has now moved past the notion of managing disability. Occupational health and wellness organizations are promoting the notion of the health and productivity continuum from wellness, prevention to management of chronic disease (Loeppke et al., 2009). This new model can be effectively applied for BH impairments as well.

Preventing disability does not mean not allowing or discouraging the individual to apply for disability benefit, but rather assisting the employee to continue to be productive through the combination of work site accommodation integrated with timely care. While such a program may not prevent a disability claim, it has a high probability of reducing the long-term impact of the impairment.

The following elements serve as the foundation of a BH disability prevention program connecting the employer, the employee, the healthcare provider, and the insurer:  

- Corporate policies and benefit plans that minimize “Incapacity”:
  - Early validation of impairment
  - Rule out the presence of organic disease
  - Do not rule out well-defined psychiatric disorders:
    - Major Depressive Disorder, Panic Disorder, medication conflicts
  - Support active management of impairment:
    - Treatment quality – Multi-modal approach
    - Treatment planning and focus
    - Critical timing and application of strategies
  - Limit assurance for a pure medical solution
  - Recognition of chronic, LTD and that some individual with a BH impairment will simply be unable to work

Develop Stay at work (SAW) and RTW policies in coordination with performance management strategies:

- Create plan design that supports productivity
- Create linkages to behavioral health treatment networks
• Apply internal RTW planning function
• Invite collaborative rather than commodity BH care
• Support conservation of functional capacity
• Create accommodation pathways (work transitions)
• Monitor RTW and lost-time indicators correlated with supervisory practices

Provide active absence tracking and management to include:

• Develop skills to manage the employee who is ambivalent and resistant to RTW
• Separate impairment from poor performance
  – Accurate medical/FCE information
  – Job performance data
• Move to develop SAW plan tied to functional capacity conservation plan
• Provide partial disability and SAW benefits
• RTW transition incentives for employee
• Insure access to care with behavioral health benefit parity
• Provide incentives for supervisors supporting RTW
• Apply practical eligibility and elimination periods to minimize treatment applications

### 10.5.1 Employer Education

Inviting and preparing the employer to be an effective disability management partner is good, smart business for the disability insurer. Poorly informed, isolated employers can become less than engaged in supporting a continuation of work or a RTW for the BH claimant. When employers become partners, the individual with a behavioral health claim reduces the competing interests that may become barriers. Both employers and insurers need to accept an appropriate role in the disability determination and management process.

Private insurers are expanding the role employers play in providing precise job demand information, as well as pathways back to work during the treatment process. A glaring weakness that is inherent in the public disability insurance program is the isolation of the employer from the process. Based on the definition of disability for the public program, i.e., off work for >6 months, it is highly likely that the claimant will have been disconnected from the employer.

### 10.5.2 A Corporate Health and Productivity Strategy

Managing behavioral health impairments should be considered an emerging best practice through collaborative innovation by employers, insurers, and healthcare provider, alike.
The following health and productivity prescription illustrates the integration and coordination of the various elements in such a business strategy. The prescription can be portioned across four general areas of action, such as:

1. Benefit Design and Product Alignments
2. Health and Productivity Program Development
3. Management Education
4. Medical and Insurance Vendor Coordination

At the heart of solving a behavioral health predicament are the incentives and disincentives embedded in the benefit and compensation programs offered by employers. Benefit programs define the employers’, as well as the employees’ response to injury, illness and the impact of a chronic disease on continued productivity. Benefit program connect health with productivity in the work force.

Figure 10.10 outlines the key connections and incentives that need to be aligned to support continued productivity while protecting the economic stability of the employee.

The dramatic move to employer use of voluntary benefits suggests the future of dealing with employee choices and motivation to RTW will be embedded in the respective benefit plan design.

Guiding the employee through the health and productivity maze increases the likelihood that an individual will not get stuck. Figure 10.11 offers a set of well-defined steps for SAW or RTW program that creates clear pathways. Creating a work prescription links the healthcare treatment with the job demand and corporate practices. Pathways offer direction while reducing the chances of going in the ditch.

- Connect family medical leave, short term, and long term disability claims administration.
- Reduce the potential for disengagement by either the employee or the supervisors.
- Coordinate with safety/wellness incentives.
- Link workers compensation, disease management, and employee assistance utilization.

**Fig. 10.10** Benefit design and incentive alignments

- Create stay-at-work, as well as return-to-work pathways. Such pathways define how a person can stay at work or return to work with impairments.
- Require a return to work plan rather than restrictions and limitations as part of a work decision. The RTW plan connects the employee's medical treatment with the job demands and emerging worker capacities.
- Review and adjust the work prescription at appropriate increments.

**Fig. 10.11** Health and productivity program development
Ignorance is not bliss. Ignorance of best practices invites the employer and impaired employee to become stuck. Figure 10.12 outlines key education steps to prepare senior management and day-to-day managers to be effective partners. The education programs focus on the influence of personal agendas, bias, and misinformation that guide both the employer and employee's efforts to maintain and protect productivity.

It is critical for the employer to coordinate the work of its health and productivity partners. Figure 10.13 highlights key coordination points creating a cohesive response reducing the potential gaps an injured or ill employee may fall into. “Mind the Gap” has practical value for vendor coordination. Employees become lost in the “gaps.”

10.6 Summary

Behavioral health impairments are real, not imagined. People are functionally impaired either through a paralysis by emotion or a faulty thinking process. Often they are engaged in a perpetual mental health and productivity collision. They are, indeed, disabled. Individuals get better, recover, yet some do not. Some go back to work, others never will and a few choose not to.

The disability insurer, public or private, plays a critical role as an economic safety net for those who are unable to work. While behavioral health impairments can be confusing to the claimant, the employer, family, and friends, they can be managed by reducing the ambiguity surrounding the ambiguous impairment.

References

### Assessment of Illness and Function Form – Current

**Employee Name:**

**Date:**

<table>
<thead>
<tr>
<th>Current Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include Psychological, Somatic, or Substance Abuse?</td>
</tr>
<tr>
<td>Severity</td>
</tr>
<tr>
<td>(1) Mild</td>
</tr>
<tr>
<td>(2) Moderate</td>
</tr>
<tr>
<td>(3) Severe</td>
</tr>
<tr>
<td>(4) Severe &amp; Serious</td>
</tr>
<tr>
<td>Observations of Symptom Impact</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complicating Indicators of Illness Severity – Check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last 3 months</td>
</tr>
<tr>
<td>Background</td>
</tr>
<tr>
<td>History of racing thoughts, going days without sleep, unusual spending</td>
</tr>
<tr>
<td>Family history of severe mental illness or social disruption</td>
</tr>
<tr>
<td>History of black-outs, DUI, or experienced need to cut back on alcohol</td>
</tr>
<tr>
<td>Early onset and resulting lack of education/skills &amp; supports</td>
</tr>
<tr>
<td>There has been a recent change in symptoms</td>
</tr>
<tr>
<td>Repeated lost relationships</td>
</tr>
<tr>
<td>Multiple unexplained physical symptoms</td>
</tr>
<tr>
<td>History of multiple jobs, employment gaps</td>
</tr>
<tr>
<td>Frequent/severe episodes of illness</td>
</tr>
<tr>
<td>Learning/school problems</td>
</tr>
<tr>
<td>There is evidence of exaggeration/inconsistency</td>
</tr>
<tr>
<td>History of trauma (Loss/Abuse)</td>
</tr>
<tr>
<td>Behavioral or social problems</td>
</tr>
<tr>
<td>History of arrests or pattern of criminal behavior</td>
</tr>
</tbody>
</table>

### Other Complicating Indicators

| Are there any current criminal, legal or financial issues? |
| Are there any family issues? |
| Is the employee contemplating retirement? |
| History of failure to finish programs, and/or education changes, and/or job shifts |
| Have there been big changes in external social or personal life factors? |
| Are there any other Non-Work Issues? |

### ADDITIONAL COMMENTS:

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Employee Work/Job Task Evaluation Form – Assessor

Name: 
Job title: 
Assessment Date: 

To be filled out by the evaluator with the employee

Please describe in detail the patient’s report of all the things they do in a day and in a week at work - time, relationships, changes, the hours they work, extra hours, and demands.

Usual Work Schedule: Maximum hours/day Overtime (>50 hr/wk). Usual maximum hours/week Permanent 3rd Shift?

Ask patient to describe what (s)he likes and does not like about their job (persons, problems at work, history of any difficulties, etc).

Please identify all of the elements of the employees current job, identify the specific areas and importance of work tasks (functions) that are part of the job.

<table>
<thead>
<tr>
<th>Employee's Specific Work Tasks (Functions)</th>
<th>Work Task Scale</th>
<th>What tasks can the employee do</th>
<th>Assessor Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interacts with coworkers</td>
<td>1: Almost essential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deals with the public</td>
<td>2: Sometimes essential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interacts socially with customers</td>
<td>3: Almost essential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appearance and behavior within normal limits</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Required to meet tight deadlines for work completion</td>
<td></td>
<td></td>
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<tr>
<td>Can follow complex written/verbal instructions</td>
<td></td>
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<tr>
<td>Work product is useful and reliable is within normal bounds</td>
<td></td>
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<tr>
<td>Makes independent judgments about decisions/solving problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Must meet deadlines despite usual stresses</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Interacts with supervisors - makes reports in meetings</td>
<td></td>
<td></td>
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<tr>
<td>Must take the initiative in instructing others &amp; solving problems</td>
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<tr>
<td>Manages, instructs or gives feedback to others</td>
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<tr>
<td>Required to plan new work or processes</td>
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<tr>
<td>Must monitor legal or regulatory issues</td>
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<td></td>
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<tr>
<td>Job requires unusual hours, overtime or availability after hours</td>
<td></td>
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<tr>
<td>Job involves operating a motor vehicle</td>
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<tr>
<td>Job requires specific math or language skills</td>
<td></td>
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<tr>
<td>Works around chemicals, unprotected heights, machinery, danger (Explain)</td>
<td></td>
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<tr>
<td>Job requires specific technical skills or licensure</td>
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<tr>
<td>Has additional responsibilities related to the job (such as union rep) (Explain)</td>
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<tr>
<td>Job has a safety risk (explain)</td>
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</table>

Assessor: 
Date: 

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## Work Function Assessment

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Assessment as of:</th>
</tr>
</thead>
</table>

### Assessment of Work Functions

Please provide your opinion on the employee's level of impairment, taking into consideration impairment in daily functioning & job-like functions according to the following scale:

- **None**
- **Mild**
- **Moderate**
- **Severe**

<table>
<thead>
<tr>
<th>Functional Impairment Scale</th>
<th>None 1</th>
<th>Mild 2</th>
<th>Moderate 3</th>
<th>Severe 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can the employee?</td>
<td>Yes</td>
<td>Usually</td>
<td>Occasionally</td>
<td>Rarely</td>
</tr>
<tr>
<td>Cognition</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Comprehend and follow instructions?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Maintain work focus/concentration in spite of usual disruptions?</td>
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<tr>
<td>Organize complex information?</td>
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<tr>
<td>Remember processes &amp; details without repeated reminders?</td>
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<tr>
<td>Remember and adhere to the usual workplace rules?</td>
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<tr>
<td>Learn &amp; retain new information timely?</td>
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<tr>
<td>Maintain focus/concentration despite usual stressors?</td>
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<tr>
<td>Take responsibility for completing routine work tasks?</td>
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<tr>
<td>Mood</td>
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<tr>
<td>Attend work regularly &amp; timely?</td>
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<tr>
<td>Sustain realistic energy through a regular workday?</td>
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<tr>
<td>Appropriately follows through &amp; complete tasks timely</td>
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<tr>
<td>Gets along with peers &amp; relates to others without undue irritability?</td>
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<tr>
<td>Affect</td>
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<tr>
<td>Capable of working on his/her own much of the time</td>
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<tr>
<td>Maintain stable relationships in the face of usual stressors?</td>
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<tr>
<td>Sustain thinking and focus in the face of usual stressors?</td>
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<tr>
<td>Contain behavior despite frustration with negative or supervisory feedback?</td>
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<tr>
<td>Maintain appropriate work pace; remain on task until completion</td>
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<tr>
<td>Maintain performance despite significant organizational stress/change?</td>
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<tr>
<td>Engage &amp; motivate others effectively</td>
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<tr>
<td>Insight</td>
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<tr>
<td>Appearance, speech, and actions are socially appropriate?</td>
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<tr>
<td>Take responsibility for solving routine work problems?</td>
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<tr>
<td>Understand their role in errors and omissions?</td>
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<tr>
<td>Take responsibility for effect of behavior on productivity &amp; on others?</td>
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<tr>
<td>Deal realistically with others errors and demands?</td>
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<tr>
<td>Make realistic use of supervisory feedback?</td>
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<tr>
<td>Judgment</td>
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<tr>
<td>Make effective independent decisions?</td>
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<tr>
<td>Maintains appropriate boundaries on their authority &amp; relationships</td>
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<tr>
<td>Effectively organize completion of multiple tasks at the same time</td>
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<tr>
<td>Anticipate barriers to task completion</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Delay responses when appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Organize and manage projects and/or processes independently</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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Mitchell, K. (2008). Beyond the disease: Analysis of cancer survivors and awarding of SSDI Benefits, Testimony at Social Security Administration, Compassionate Allowance Hearing. Harvard University School of Medicine, Boston, MA.


Chapter 11
The Legal System and Behavioral Health

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Behavioral health concerns arise in diverse legal contexts and under a variety of legal theories and specific laws. The effects of the legal system on persons experiencing the symptoms of behavioral health concerns vary according to the context in which they interact with the system, the specific law governing the cause of action giving rise to their legal claim, and to their treatment by the lawyers on both sides of the dispute. Yet there are significant and recurring issues arising in the interaction between those experiencing behavioral health concerns and the legal system in which they sometimes find themselves. This chapter will focus on those issues and some possible systemic solutions.

11.1 Causes of Action and Their Prevalence

The prevalence of behavioral concerns in our system of legally-based dispute resolution (henceforth, “the legal system”) is not well known. One of the reasons for this lack of information is the diversity of contexts in which the person experiencing behavioral health concerns can interact with the legal system. Any dispute submitted to legal resolution involves the claimant and defendant in a bewildering maze of unfamiliar rules and demands, subjugation of control of various aspects of one’s life to external authority, and the stress of having a matter of great personal concern winding, sometimes interminably, through a system that is

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1 It is beyond the scope of this chapter to examine the practices and causes of action available in all jurisdictions and under all laws. Rather, the purpose of this chapter is to acquaint the reader with general concerns that arise more or less frequently. Of necessity, individual variations in practice are excluded from this discussion and no criticism of any individual’s legal practice or of any specific class of practitioners is intended or implied.

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opaque to him or her. These more general impacts of the legal system will be dealt with elsewhere in this analysis.

At the same time, some issues within the legal system focus directly on the behavioral health challenges of the litigant. A basic tenant of American law is that there must be a case or controversy over which the court-like entity has jurisdiction for the legal system to be invoked. The shorthand term for the recognized case or controversy is “cause of action.” The causes of action in which behavioral health issues are most likely to be in issue include workers’ compensation claims, enforcement of rights under both the Americans with Disabilities Act (ADA) (as amended) and under federal and state laws against violation of civil rights, in tort claims of various types, and in the enforcement of disability insurance provisions and claims for Social Security Disability Insurance (SSDI). There are also several factors affecting our knowledge of the prevalence of behavioral health claims that cut across most or all of the various causes of action and affect many of such claims.

11.1.1 Workers’ Compensation

Workers’ compensation is the generic name given for the 53 state and territorial programs that provide medical treatment and indemnity benefits to workers covered under the provisions of the specific law for injuries and occupational illnesses occurring in the course and scope of work.

In addition, the Federal government has a general program for governmental employees and several specific programs for specialty populations. The SSDI program covers long-term disability. Some sovereign tribal entities have adopted their own tribal workers’ compensation provisions.²

Each of the statutory schemes in these jurisdictions is different and provides different benefits and procedures for the perfection of rights. The differences include very significant variation in the extent to which claims are brought to the attention of a centralized record keeper and variations in the manner in which centralized records of claims made in the system are recorded. There is no central collector of standardized workers’ compensation statistical data; although several organizations do research across many or all jurisdictions to an extent,³ no research quantifying the prevalence of behavioral health concerns across all jurisdictions has been published.

² For a general, but much more detailed description of the scope of these programs, see American Bar Association 2009.

³ The National Academy of Social Insurance, Workers’ Compensation Research Institute, and National Council on Compensation Insurance provide special studies of workers’ compensation issues based on data available to them. See, for instance, NASI Research Summary: Workers’ Compensation Benefits, Coverage and Costs Fall, 2009.
Moreover, the extent to which behavioral health concerns are compensable under the various workers’ compensation laws (2009) varies widely. Some states allow claims for workers’ compensation based solely upon the behavioral impacts experienced in the workplace, some states limit claims based upon behavioral concerns to those that are resultant from a sudden, discernable trauma or the direct or indirect result of physical trauma, and some states purport to ban such claims altogether. In this environment, many behavioral health concerns are not separately reported from the physical injury to which the claim is attached. Accordingly, the prevalence behavioral health concerns in workers’ compensation can only be estimated (Warren, 2009).

### 11.1.2 Americans with Disabilities Act

The ADA provides protection against employment discrimination for persons with physical and mental limitations or challenges. The ADA requires covered entities, including certain private employers, to provide reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless such covered entity can demonstrate that the accommodation would impose an undue hardship.⁴ Two crucial issues under the law are the definition of disability and the concept of “essential functions” of the job. A covered worker is disabled under the act if one has a physical or mental impairment that substantially limits one or more of the major life activities of an individual, have a record of such impairment, or are regarded as having such impairment.⁵ A worker with a disability who can perform the essential functions of his or her job is disabled under the act and entitled to its protections. Under the definitions in the original act, workers with behavioral health concerns were seldom afforded protection because of failure to qualify as a protected disabled person.

The ADA was amended in 2008⁶ (effective January 1, 2009), and the amendments appear to have greatly expanded the effective definition of disability with respect to behavioral concerns. The definition of disability itself remained unchanged, but the effects of mitigating measures (except for vision correction lens) are not to be considered when determining the extent of interference with the major functions of everyday life. Under the new amendments, virtually any condition that can interfere with work and is subject to control with medication, treatment, or assistive technology is likely to be covered, including common behavioral health concerns. The definition of major functions of everyday life has been expanded to cover bodily functions. Episodic conditions or conditions in remission are to be considered active.

There is insufficient history under the amendments to predict their effectiveness in protecting the rights of persons with behavioral “disabilities”, but the intent of

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⁵ 42 U.S.C. 12102(2).
the framers was to expand the protections afforded under the definitions present in the original act, as the courts had interpreted them. It appears that the ADA amendments will only be applied prospectively to cases arising after January 1, 2009.

11.1.3 Civil Rights Enforcement Under 42 U.S.C. 1983 and Under State Civil Rights Laws

After the Civil War, Congress passed remedial legislation intended to keep the states from perpetuating the discrimination against persons of color. The complaining person must prove two critical issues: a “person” subjected the aggrieved party to acts “under color of state law”, and the acts deprived the aggrieved person of rights, privileges, or immunities guaranteed under federal law or the U.S. Constitution. The state itself is not a “person” within the meaning of the section, and the requirement for action “under color of state law” refers to an action taken in the context of the authorized duties of the accused. Thus, if state law authorizes law enforcement officers to conduct traffic stops of suspected violators, the officer is a person acting under the cover of state law when he makes such traffic stops. If the reason for stopping a person is related to, say, the ethnicity of the person stopped, rather than to the driving behavior, the claim under Section 1983 may be complete.

Certain groups are afforded a heightened standard of judicial protection. These groups are called “suspect classifications” and claims of actions against such groups may go forward with a lower standard of evidence of discriminatory intent. Persons with behavioral health concerns are not considered a “suspect classification” under the law. As a result, successful claims under Section 1983 for discrimination based upon the aggrieved person’s behavioral health have been rare. The effects of the alleged discrimination in causing or exacerbating behavioral conditions are sometimes offered as an element of harm for which monetary compensation is sought. Many states have a parallel remedy under state law, subject to similar limitations. Some states have specific antidiscrimination laws pertaining to people with behavioral health concerns.

Because of the nature of the claims under federal and state antidiscrimination laws, and the fact that records are seldom kept with respect to the nature of the allegations of damage in such claims, the prevalence of behavioral health concerns in such claims is not well documented.

11.1.4 Psychological Torts

There are a number of causes of action for the redress of personal injuries, and they are generically referred to as “torts”. Several of them pertain to injuries to the behavioral health of the aggrieved person, and collectively they may be described as psychological torts. An essential feature of traditional tort law is the notion of fault. An act must be intentionally done, or done negligently, in violation of a duty to avoid harm, to be actionable (at least in the absence of some special “no-fault” statutory
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Of necessity, these claims are difficult to prove, and of varying degrees of success, because of the inherently hidden nature of the harm. Even with a competent diagnosis, some jurors tend to discount behavioral health injuries either because of perceived lack of objectivity associated with them, or because of a tendency to separate emotionally from the possibility that they could similarly be harmed.

11.1.4.1 Intentional Infliction of Emotional Distress

Intentional infliction of emotional distress is a cause of action utilized for the redress of intentional psychological harm. The harm complained of is a change in the behavioral health status of the plaintiff. Therefore, the plaintiff is subject to examination with regard to both current and past behavioral health. Since the cause of action is predicated on an adverse change of condition, the cause of action forces the plaintiff to prove that he or she has been the victim of wrongdoing, and that as a result, his or her behavioral health has suffered.

The change in behavioral health status is relatively hard to prove and the cause of action requires the plaintiff to attach the public stigma of behavioral health concerns to themselves in a public manner. Given these concerns, juries do not generally respond well to these actions. They are not commonly asserted as stand-alone grounds for recovery.

11.1.4.2 Hostile Working Environment (Sexual Harassment)

Sexual harassment lawsuits may precede under one or more of three available theories. The case might allege that the plaintiff was actually subjected to unwanted physical contact, that he or she was given or offered benefits in exchange for sexual concessions or threatened with adverse consequences if such concessions were refused, or that he or she was subjected to a hostile working environment that contained unwanted sexual content. The nature of this last theory for claiming sexual harassment places the behavioral health of the claimant into issue in the case, as the unwanted nature of the content must be proven, as well as any harm for which damages are sought.

These lawsuits are reasonably common, and some of the successful ones have been highly visible. Persons subject to sexual harassment are readily seen as “victims” for whom much of the stigma of public assertion of behavioral health concerns may be diminished.

11.1.4.3 Posttraumatic Stress Disorder and Other Psychological Claims Rising from Traumatic Events

When a traumatic event causes damage, psychological injuries are often claimed as an element of the damages. The claims themselves are based upon the negligence or intentional act that caused the damage, such as an assault or a failure to maintain proper
control of an automobile. An element of any tort action is that it caused damage and the size of the damage award is based, at least in part, on the extent of the damages that are proven. Accordingly, a change in the plaintiff’s behavioral status is often alleged as part of the damages in the case. The assertion of that element of damages places the plaintiff’s psychological state in issue in the lawsuit, subjecting him or her to examination, testimony, and cross-examination concerning both prior and present behavioral health concerns. Posttraumatic Stress Disorder is a common example of this element of damages. The diagnosis, which was originally developed to describe the effects of the incredible brutality and stress of warfare, has been (often inappropriately) generalized by enterprising plaintiff attorneys (and mental health practitioners looking for their business) to apply to the emotional aftermath of almost any unpleasant experience.7 Tort claims are most often filed in at the state court level where record keeping is not detailed and often is only generally tabulated as to the nature of the claim. Detailed central tabulation at the state level is rare and multistate tabulation of records is hampered by inconsistent record keeping formats. Details such as the elements of damage asserted are often not available for study absent specific examination of individual files. Moreover, when a jury awards damages, it often does not specify the specific harm for which the damages were awarded. Accordingly, little is known about the prevalence of the assertion of these elements of damages, or about the success associated with such assertions, except in connection with local studies in a specific jurisdiction.

11.1.5 Disability and Health Insurance Claims

Insurance for disability has at least two incarnations: some states, such as California, have mandatory short-term employer-based disability insurance programs for most workers. The majority of states do not have such programs, and disability insurance is available as a private purchase insurance option or as part of an employee benefit program. In most instances, insurance-based disability programs contain provisions for the settlement of disputes outside of a traditional legal framework. Provisions requiring arbitration, or other alternative dispute mechanisms, are common in disability insurance contracts.

Health insurance has similar dynamics, with most health insurance available on a private purchase or employee benefit basis. Public-based health insurance options are more prevalent among the states, but often cover specific populations, rather than the broad spectrum of workers in general. Use of mandatory alternative dispute resolution procedures is quite frequently a feature of such insurance contracts.

In this context, disputes concerning care for behavioral health concerns seldom find their way into the formal court system. Rather, disputes over whether the insurer has met the obligations of the insurance contract in good faith are sometimes

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7 It should be noted that the negative effects of “medicalization” of the claim upon the claimant (see Sect. 11.5, below) are sometimes inadvertently caused by the desire to find a diagnosis to support an enhanced claim for damages.
asserted as a cause of action in state courts. The behavioral health concerns of the plaintiff sometimes find their way into such lawsuits as elements of the damages alleged, but for the reasons stated above in connection with psychological torts, the prevalence of such allegations is not well documented across broad populations.

The SSDI system also has a captive dispute resolution protocol involving its own specialized judges and criteria for proof. Importantly, the criterion for receipt of benefits is proof of the inability to do any kind of work. Thus, in this context, the claimant must consider himself or herself completely disabled to get benefits, and model a lifestyle consistent with that expectation. SSDI reports that 36% of its claims are for behavioral health concerns, but additional claims present a combination of physical and behavioral reasons for disability (Warren, 2009; Annual Statistical Report on the Social Security Disability Insurance Program, 2007).

11.1.6 General Considerations Concerning Reporting of the Prevalence of Behavioral Health Claims

There are several reasons to believe that behavioral health claims are significantly underreported (Warren, 2009). These include the stigma attached to behavioral health claims and the tendency for them to be swept up in general privacy protection requirements, the concentration of the legal system of the documentation of physical ailments, and the failure to properly diagnose and document elements of harm that are based on behavioral health issues.

11.1.6.1 Stigma

Notwithstanding the remedies outlined above for redress of discriminatory treatment of persons with behavioral health concerns, stigmatization of such persons is widespread. Responses vary from overt discrimination to social disadvantage, and the subtle value judgments of persons with such challenges are even imbedded in our language. Thus, we are taught from a young age that such challenges are shameful and should be hidden from view. Emphasis is placed in privacy policies, especially those concerning health records, to especially safeguard records concerning behavioral health issues. A recent television public service campaign was aimed at overcoming this stigma utilizing a celebrity to encourage persons with Depressive Disorders to come forward and seek help. These phenomena evidence the degree to which behavioral health concerns are regarded as something to be hidden from public view. As a result, it is reasonable to assume that some percentage of the affected population

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8 We have no lack of derogatory terms for people with behavioral health challenges. “Crazy”, “whacko,” and “nut case” are not complementary terms when used to describe a person. “Special” takes on a whole different meaning in the phrase “special education”.

self-selects avoidance of any activity that could “label” them, and therefore that the reported prevalence of such claims is artificially suppressed.

11.1.6.2 Concentration on Physical Ailments

The legal system operates on the presumption that the complaining party has the burden of proving the harm claimed. That proof must be made to skeptical claims examiners, or to a judge or jury with no personal stake in the outcome. In that context, the natural tendency is to seek and concentrate upon elements of claims or damages that are objectively verifiable and demonstrable. Subjective claims concerning conditions that have no obvious physical manifestations are simply harder to prove, since they require the person or group delegated the authority to determine facts in the dispute to accept the word of an expert or the assertion of an interested party. As a result, there is a natural tendency for advocates in the system to focus first on the objectively demonstrable harms and damages, and to throw additional issues in for whatever they are worth. In the traditional assessment of the value of a tort claim, for instance, the presumptive measure of damages is some multiple of “actual” damages (medical expense, lost wages, property damages) and “special” damages (including most behavioral harms such as Depressive or Anxiety Disorders arising from the physical harm) may or may not be included in the calculation. As a result, especially given the stigmatization associated with such claims and the tendency for assertion of such damages to generally place the behavioral health of the claimant into issue in the case, assertion of such claims is likely artificially suppressed, or is often hidden as a secondary element of damages. In addition, treating physicians usually do not look for behavioral harm resulting from a physical injury (American Medical Association, 2008a, 2008b) and therefore often miss them when they are present, due to lack of training or awareness, time pressures, or lack of a behavioral baseline from which differences can be noticed.

11.1.6.3 Failure to Diagnose Behavioral Health Concerns

Since advocates tend to focus on physical harms and claimants have a tendency to minimize or keep secret behavioral health concerns, symptoms are often not brought to the attention of the examining health care providers. The health care provider diagnoses and treats the conditions brought to his or her attention, and may or may not delve into behavioral health issues. Even if the health care provider who is treating the claimant for his or her physical symptoms both notices and understands the significance of presenting signs or symptoms of behavioral health issues, they are often inadequately equipped, by training and experience, to diagnose or treat such conditions. Referral to an appropriate mental health specialist is an extra step, for which there is little reinforcement. As a result, behavioral health concerns often go undiagnosed, further suppressing the reported prevalence of such issues in the legal system.

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And attempts to treat behavioral health concerns by someone untrained and inexperienced often result in less-than-optimal outcomes.
The legal system is a complex and unintuitive dispute resolution mechanism. Navigation of the intricacies of that system is possible for the persons who do not have legal representation, but such litigants are often at a substantial disadvantage in utilizing (and defending against) the procedural and evidentiary requirements of a lawsuit and in understanding the development of the law with respect to their particular cause of action and its requirements.

To understand the impact of the legal system on participants with behavioral health challenges, it is necessary to closely examine the roles played by the advocates upon whom they rely for guidance through the unfamiliar processes of the legal system. The lawyer for the claimant (plaintiff) in an action has a substantially different role than the lawyer for the person or entity against whom the claim is filed (defendant). Understanding those roles and the underlying economic motivations is crucial to understanding the impact of participation in the system. It is also helpful to understand the issues that are created by the health care professionals upon which either side relies.

11.2.1 Plaintiff’s Lawyers

There are two distinct varieties of plaintiff’s lawyers, operating under different economic models and therefore subject to differing sets of motivations. The private plaintiff’s lawyer is generally compensated by the plaintiff, either out of the plaintiff’s resources or (most often) out of the proceeds of the recovery from the case.

The public attorney is paid a salary by an entity for which he or she works and provides services to the plaintiff without expecting compensation from the plaintiff. Regardless of the role and source of compensation, the role of the plaintiff’s lawyer is to win the case before him. The lawsuit is, to the plaintiff’s attorney, a classic “zero sum” game where one party wins and the other loses.

11.2.1.1 The Private Plaintiff’s Attorney

The private plaintiff’s attorney is most often compensated on the basis of a “contingent fee” arrangement whereby the attorney invests his or her time in the perfection of the case without compensation, in exchange for a contractual right to a percentage of the proceeds of the claim. The percentage of the ultimate recovery can vary widely, but most often is between 25 and 33% of the award of damages to the plaintiff. This arrangement creates two motivations: the attorney is unlikely to accept cases on this basis that are unlikely to generate a substantial award (and thus a substantial fee) either because the case is unlikely to be successful or because the
case has too little at stake by way of economic outcome to generate a fee that will compensate the attorney at the rate they desire. The calculation of the assessment of the case is complex and subject to both economic and noneconomic influences. A case that “develops the law” in a new and untested direction might be accepted if the potential for the eventual outcome is high enough or if the attorney particularly believes in the direction of development for which he or she is advocating.

Private plaintiff’s attorneys may also accept cases on the basis of payment at a predetermined hourly rate. The rates charged by attorneys vary quite widely, depending on the market in which they operate, their experience, and overhead. Typically, a claimant is asked to deposit a “retainer” in such cases, against which the attorney draws periodically at the specified hourly rate. If the retainer is depleted, the plaintiff is usually required to deposit further funds before the attorney invests additional time in the case.

The private plaintiff’s attorney is often caught between two paradigms. On the one hand, he or she often feels that they are advocates for the disadvantaged and the champion of the little person. On the other hand, the economics of practice, particularly under contingent fee arrangements, require them to reduce all claims to monetary value, prioritize their representation choices based on the potential size of the award, and focus their resources on the maximization of that award.

The economics of practice under contingent fee arrangements also dictate that a percentage of cases will fail to generate fees or will generate fees that are insufficient to adequately compensate the attorney for the time invested. This creates a motivation to keep the volume of open cases large enough to generate an income stream and to file all cases under every conceivable legal theory that is available or that can be imagined as an extension of existing law. The long pendency of lawsuits exacerbates the tendency to keep high volumes of cases presenting multiple theories of relief. It is not unusual for a case to persist for over a year from the initial filing of the complaint that initiates it until judgment after trial that resolves it, and this period can be substantially extended by appellate proceedings. The long resolution times combined with the economics of contingent fee practice also create a substantial pressure to settle pending lawsuits by agreement, and the urge to settle sometimes puts the attorney into conflict with the client who wants one’s “day in court”.

In cases of certain rights violation allegations, and many cases involving workers’ compensation, the defendant may be required to pay some or all of the claimant’s attorney fees, subject to order of the court adjudicating the case.

11.2.1.2 The Public Plaintiff’s Attorney

There are public advocacy organizations that employ attorneys to provide free representation to qualifying individuals. Most often, cases that have the potential to generate a fee through a monetary award to the plaintiff are excluded from these services upon the presumption that a private plaintiff’s attorney can be found to provide representation. Where the remedy sought is the enforcement of a right, or
the development of the law in a particular direction, the public plaintiff’s attorney may become involved.

Since the public plaintiff’s attorney is paid a fixed (and often, comparatively low) salary, there is no motivation to maximize the monetary value of the claim. Rather the motivation comes from the choice to represent the population and the political, philosophical, and social agenda of the employing organization. Cases are sometimes determined to be worthy by the organization, and plaintiffs are then recruited to allow the organization to go forward and seek development of the law in a particular direction. The concerns of the particular litigants in such cases are not necessarily the attorney’s primary focus.

Public plaintiff’s attorneys are often regarded as possessing inferior skills, based upon perceptions of their chosen role. This is often inaccurate, as these attorneys often develop superior knowledge and skills in a focused area of law and possess strong internal motivation. It is also true that public plaintiff’s law is used as a training ground for inexperienced attorneys, who eventually move on to more lucrative practice.

11.2.2 The Defense Attorney

Defense attorneys also come in various incarnations. Private defense attorneys may be employed to defend an insurer who is potentially liable for damages on the claim or by the defendant directly. Governmental attorneys defend public agencies from claims against those entities. In either case, the defense attorney may be directly employed by the client or may work for a private firm of attorneys representing the client. The defense role is also to win the case brought to them. Since contracted attorneys are in a purely reactive mode, responding to claims that have already been asserted, they are in a modified zero-sum game. Reduction of a liability below the expected level may be considered a “win” since the attorney had no choice concerning the acceptance of the claim and entered the case too late to have free reign to defend as he or she sees fit. In-house counsel sometimes has the opportunity to avoid claims by proactive intervention.

11.2.2.1 Defense Attorneys Who Are Compensated According to Contract

Defense attorneys who contract with insurers, private entities or persons, or governmental agencies for defense of claims against them are usually compensated on the basis of an agreed hourly rate (although a flat rate per case defended is occasionally utilized). The motivation set for such attorneys is a balance of efficiency in claims resolution (to please the client) and a desire to aggressively defend the claim (to accumulate the greatest number of billable hours). The defense attorney is not in primary control of the overall approach to litigation, however. The employing entity most often decides the litigation approach either on a case-by-case basis, or
as an overall policy, and finds an attorney who will acquiesce in the strategy. Depending on the willingness of the paying entity to fund aggressive litigation, the behavior of the contractual defense attorney may range from a desire to quickly settle every claim to an aggressive procedural and substantive defense. Strategy in such aggressive defenses includes tactics designed to delay resolution of the claim and “starve out” the claimant and procedural manipulations designed to sap the litigation resources of the plaintiff through multiplication of expensive preliminary procedures such as extensive discovery and motions practice. These tactics are successful when the willingness of the plaintiff and one’s advocate to invest further time and energy is impacted. The ultimate goal of this “scorched earth” defense is to encourage the plaintiff to give up his or her claim, or force settlement at a fraction of the value of the claim.

11.2.2.2 Salaried Defense Attorneys

The salaried defense attorney, whether working for a governmental agency or as in-house counsel for either the defendant directly or for one’s insurer is less motivated by the economic ramifications of practice and more by the management of risk for their employer. Typically, such defense counsel are motivated to minimize the damages in particular cases, as an overall measure of their effectiveness. In-house noninsurance and governmental defense attorneys may also take action within their organization to prevent similar claims from arising in the future. However, when given direction to do so, salaried defense attorneys are also capable of utilizing the considerable resources of their organizations to engage in aggressive defense practices.

11.2.3 Treating Professionals

Both the plaintiff and defense bars rely on behavioral health professionals in making their cases between more attractive and saleable in court. When there is a relationship between a court advocate and a health care professional that is habitual in nature, it is likely that economic motivations influence both, although that influence may not be recognized at a conscious level. The advocate is searching for an opinion that suits the needs of the theory of the case. The health care provider gets a referral for an evaluation and potentially for treatment after the lawsuit. If the opinion does not match the needs of the attorney then the health care provider does not get more referrals. Even without conscious intent, the defense bar and plaintiff’s bar develop, over time, their stables of “reliable” health care providers, and the health care providers tend to nurture that relationship. Even where the relationship is entirely innocent of opinion influence, the tendency for attorneys to choose health care providers with known tendencies friendly to the position their position is common. Bias in determining the individual’s psychiatric disability status can result (Harding 2004).
11.2.4 What Works, and Does Not Work, in the Legal System?

It is important to understand that, despite popular misconceptions, the legal system in the United States is not designed to necessarily produce a just result, but rather is designed as a decision generation engine. At the end of the day, when the legal system is done with a claim, there will be a decision. The parties may or may not find it satisfying, but there will be finality, and there are extensive rules designed to preclude re-litigation of the same issue after the legal system has processed it completely. This production of finality is one of the chief functional successes of the legal system.

Access to attorneys for representation is generally not a significant problem, but there are notable exceptions in particular circumstances. There is no national shortage of attorneys, and as evidenced by lawyer advertisements, there is competition among attorneys for clients. Most fee generating cases can be matched with an attorney hungry enough to take them on, albeit not always the most experienced attorney for the case at hand.

However, plaintiffs with certain classes of cases that will not generate a fee commensurate with the work involved in perfecting the claim may experience difficulty in finding representation. This phenomenon is particularly evident with respect to workers’ compensation claims where the benefit in issue is limited to treatment for medical or behavioral concerns. In such cases, the usual measure of compensation is a percentage of the benefit obtained by the services of the attorney. If the value of the benefit sought is sufficiently low and the difficulty in perfecting the right is sufficiently high, the plaintiff’s attorney is unlikely to accept the case. Defense lawyers know this and discourage representation by threatening aggressive defense that will require a substantial investment of time to overcome. The result is that some workers’ compensation clients seeking treatment only for medical or behavioral concerns (or seeking only modest levels of other benefits) are effectively denied representation by the structure of the system. Some states have developed public advocacy attorney organizations to manage this phenomenon. The phenomenon is also present in other claims where there is a contingent fee arrangement and the potential damages (and therefore the attorney’s fee) are relatively low.

Public advocacy attorneys, and encouragement of representation on a pro bono basis by bar organizations, is widespread and available to qualifying individuals with appropriate claims. Representation on this basis may not be as available in rural areas, although the special needs of disadvantaged populations are a particular emphasis of many public advocacy organizations. As noted earlier, the representation of individuals may sometimes be compromised by the overall social, philosophical, or political agenda of the organization.

Contingent fee arrangements allow plaintiffs to pursue claims without the necessity of placing large sums of money on retainer for their attorney, when such resources are often not available. This allows claims to be freely brought. The consequences of such fee arrangements include crowding of the courts, “strike suits,” and subsidization of dubious claims by claimants with more conventional claims. Success in litigation generates fees, and therefore claimant’s attorneys are encouraged to pursue the
reduction of claims to an economic value through the legal process, often to the exclusion of other remedies. This creates expectations in the public (fed by lawyer advertisements) that perceived wrongs are a potential source of monetary awards. The courts then experience demand for their dispute resolution services based upon the expectations of the public and long delays are the result, as demand outstrips judicial resources. While some courts have resorted to alternative dispute resolution techniques to manage their caseload, delay in litigation resolution remains a problem.

The ultimate extension of this trend is the “strike suit”. A claim of dubious merit may be filed with the knowledge that the cost of defending the claim exceeds the value of a small settlement to make the claim “go away”. While there are court rules designed to control this behavior, most judges are former practicing attorneys and some are reluctant to enforce the intent of such rules, whether by reference to their own former practices or because of continuing relationships with the attorneys against whom such enforcement would fall.

As a practical matter, contingent fees usually compensate attorneys at a level that is disproportionately high for the effort expended. This is regarded as justified because of the risk of failure of the claim and the resultant risk that the attorney will be uncompensated for his or her efforts. As a practical matter, the practice results in systemic subsidization of dubious claims, and efforts to extend the law, by claimants that have routine claims that generate fees without substantial risk of uncompensated work. It also results in a lack of willingness to take on anything but routine low-risk claims by some attorneys, potentially affecting access for people with unique circumstances.

On the defense side, privately contracted defense attorneys get paid to defend claims and not to find solutions for problems or prevent their recurrence. The image of a “junkyard dog” is given grudging admiration as a model for behavior. The task of managing risk exposure and return to work efforts is most often delegated to other personnel.

In general, the legal system stops when the claim is resolved. There is no follow up to see if the litigants have resolved their issues and moved on with their lives. While economic provision for future medical care is made in workers’ compensation cases and some tort cases, litigants are often left to seek resources for the resolution of their behavioral health concerns on their own. The advocate for the claimant has no systemic motivation to assist him or her after the claim is completed, depriving the claimant of what may have been their only support system during the pendency of the litigation. Planning for functional adaptation and treatment after the dispute is resolved is often lacking. Once the projected future costs of functional recovery are reduced to a monetary figure and an award is made, the claimant is most frequently left to one’s own devices with regard to actually obtaining services.

Some practices in the legal system overcompensate for harm. The doctrine of “punitive (or exemplary) damages” allows a litigant with actual damages to seek an additional award in many tort (but not workers’ compensation) cases. This award is not designed to compensate the claimant, but rather to punish the defendant for wrongdoing and/or serve as an exemplar for others to avoid the behavior that formed the basis for the complaint. Punitive damages exacerbate the tendency for the system to cast the claimant in the role of “victim” and encourage “legalization”
of the claim. They are also quite popular with attorneys who work on a contingent fee basis, as the attorney gets their percentage of these awards.

The process of litigation is itself highly stressful on the litigants. The claim is submitted to a dispute resolution forum that has its own (often counterintuitive) rules that require professional help to navigate. The claimant's personal behavioral health may be placed in issue, depending on the nature of the claim, and his or her privacy invaded. Loss of a sense of personal control is frequently experienced, as is enhanced focusing on the wrong suffered or condition experienced. The process is long, invasive, and uncertain in outcome. The stress of litigation can exacerbate the harm that gave rise to the claim or create new behavioral concerns. These facts are sometimes used by the defense as part of a strategy to discourage claimants from pursuing their rights.

11.3 Determining Current Behavioral Functioning in the Legal System

The determination of harm in the legal system arises from a simpler time when the issues presented were less complex. The legal system, with its reliance on prior precedent for future guidance, has been slow to adapt to the demands of more complex case presentations. This weakness of the system in its adaptation is particularly evident with respect to behavioral health concerns. As behavioral health effects have gained recognition as elements of damage, the issue of correctly assessing the mental aspects of the harm from the physical or other elements of damages has become difficult. So too has the issue of causation, where the ability to attribute the onset of behavioral health concerns to a specified event is critical to the establishment of the requirement that the event complained of caused the harm for which damages are sought. This issue of causation particularly applies to tort and workers' compensation cases. Thus, the determination of the level of current behavioral functioning and the determination of the causal connection between prior events and the current behavioral health status are issues of importance in the legal system, even though the current status of scientifically-based determination of behavioral health functioning sometimes cannot keep pace (Melhorn and Ackerman 2008). This can lead to further complication of the already complicated relationship between lawyers and behavioral health practitioners discussed earlier in Sect. 11.2.3 and result in more unpredictability and variation in diagnosis and impairment rating than would be desirable.

11.3.1 The Legal Standard of Proof Concerning Scientific Evidence

For testimony concerning the degree of harm, or the causal link between the acts giving rise to the legal claim and the harm, to be considered by the entity in the legal system that will decide the facts (the judge or the jury, depending on the cause
of action, the tactical choices of the parties and the requirements of applicable statutes) the testimony must be determined to be reliable. The general rule of law is that reliable evidence will (with exceptions not usually relevant here) be considered in the determination of the case, and unreliable evidence will not. In general, for evidence of a scientific nature to be considered (“admissible”) the reliability of the evidence is determined by a rule of evidence.

With respect to scientific evidence, the Circuit Court of Appeals for the District of Columbia announced, in 1923, a standard of evidence still used in some states in a case that has become known as the Frye opinion. In that opinion, the court announced a standard for reliability of scientific evidence that was based upon the general acceptance of the basis of the scientific testimony in the particular field of scientific inquiry. This standard is conservative when it comes to the acceptance of new or novel theories, definitions, or (importantly for behavioral concerns) diagnoses. If a new behavioral diagnosis is not “generally accepted” in the behavioral health community, it cannot form the underlying basis of testimony that a particular claimant does or does not suffer from it.

In 1993 the U.S. Supreme Court announced a new standard and overruled the Frye case. In Daubert v. Merrell Dow (henceforth, “Daubert”) the court rejected the inflexibility of the Frye test in favor of an independent judicial assessment of the reliability of the evidence. Factors to be considered by the court reviewing scientific evidence reliability include the degree to which the scientific theory has been empirically tested, the extent to which it has been peer reviewed and published, and the qualifications and professional stature of the witness presenting the testimony. Because of the procedural footing of the case, it did not become binding on the states, and at present approximately one third of the states still follow the Frye standard, one third follow Daubert, and the remainder have developed their own standard or a hybrid between Frye and Daubert. Thus, the legal standard for admissibility of scientific evidence, and therefore the admissibility of testimony that a particular person has a particular behavioral health concern, is subject to state-by-state variation and uncertainty.

This is particularly true when a plaintiff is attempting to “extend” the law by establishing that a novel, or newly discovered or described, behavioral health concern is an appropriate basis for an award of damages. Testimony about the objective existence of the “new” behavioral health concern can become the principle litigated issue in some cases. The plaintiff in such a setting may be subjected to unusual systemic pressures to internalize the purported diagnosis.

In the context of this uncertainty, the presence on the Diagnostic and Statistical Manual, version IV-TR (American Psychiatric Association, 2000), stands as a point of predictability and relative stability. Presence of a diagnosis in the (APA, 2000) DSM-IV-TR is almost always accepted as sufficient under that Frye or Daubert standards for establishing the definition of a behavioral health concern. The criteria for determining the presence of behavioral health concerns in a particular case is also

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10 Frye v. United States, 293 F. 1013 (CADC, 1923).
established by the DSM-IV-TR to the standard demanded by the court for admissibility determination. In the absence of a DSM-IV-TR diagnosis, there is a substantial likelihood that the admission of testimony about the condition of a particular claimant will be preceded by a protracted “mini-trial” on the issue of the reliability of the science underlying the proposed testimony.

With respect to testimony concerning the degree of impairment of function caused by a behavioral health concern, the same legal considerations apply to expert opinion, but there are sometimes other modes of approaching the issue. The law of evidence allows a nonexpert to give one’s opinion about one’s own experience or about matters for which special expertise is not regarded as necessary, such as matters within the general knowledge of the average person. Thus, the person with a behavioral health concern generally can testify as to what s/he experience and how it affects her or him. To translate the experience of the plaintiff into a quantified measure of impairment of his or her functioning usually requires the assistance of a behavioral health expert.

The sixth edition of the AMA Guides to the Evaluation of Permanent Impairment incorporates a chapter on “Mental and Behavioral Disorders” (American Medical Association, 2008a, 2008b) that relies heavily on the DSM-IV-TR for its diagnostic underpinning. The chapter provides, unlike prior editions of the Guides, numerical ratings for some selected and well-documented major mental illnesses. Even where applicable, the majority of states have not adopted the sixth edition of the Guides for purposes of workers’ compensation cases, although its use for tort cases may be more widespread. No other document with the credibility of the Guides that provides numerical impairment guidance is available. This deficit in objective impairment guidance leaves the determination of impairment of function due to behavioral health concerns largely unconstrained from the legal perspective, opening the door to vigorous litigation of the issue.

This litigation usually takes the form of “dueling experts”. The plaintiff and defense arrange for opinion evidence to support higher or lower assessments of impairment. Both sides examine the plaintiff to assess the impairment claimed. The plaintiff is subjected to a process that has a tendency to entrench existing impairment and may create additional behavioral health concerns (see, Sect. 11.5, below).

The assessment of impairment in a legal context is usually limited to the assessment of current impairments of functioning for the purpose of determining and quantifying liability. Little or no analytical energy or emphasis is placed on the prospective restoration of functioning in this process, and the plaintiff may incorporate the message that his or her recovery of functionality is of little importance to the legal system.

A judge or a jury will be put into the role of making a determination concerning the relative weight to be given to the evidence presented in the case. In workers’ compensation cases, juries are seldom utilized. In tort cases, the use of juries as the “trier of facts” is much more common. With respect to determination of the degree of impairment caused by a behavioral health concern, the trier of facts must make

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11 The reliability of such evidence can be suspect, however (Wiley, 1998; Brennan et al., 2007).
determinations concerning the basis of testimony and credibility of experts discussing a highly technical and specialized area of knowledge. The degree to which most judges, who have not institutionally received any special training in the interpretation of such evidence, can reasonably understand and distinguish credible testimony about behavioral health concerns can reasonably be questioned. The expectation that a jury of people with wide variations in education and experience could make accurate determinations in this area is naïve.

11.4 Case Coordination and Coordination of Care

With regard to cases involving monetary compensation for a harm, people go to lawyers when they feel aggrieved as to their rights or feel that they are unable to comfortably perfect their rights without professional assistance. If the lawyer feels that it would assist in making a claim, he or she may attempt to steer the client to a health care provider that, from prior history or reputation, is likely to support the claim. For an interesting study of the outcome of this behavior, see Victor, Barth, & Neumark, 2005. The defense bar also often has its stable of sympathetic health care providers to whom the defense advocate will turn when a sympathetic opinion about the case is desired. The Model Rules of Professional Conduct (American Bar Association, 1993) for attorneys are silent on the issue of referrals to or from other professions, except for a general prohibition against receiving payment from another to represent a client without the client’s informed consent (American Bar Association, 1993, Rule 1.8). These practices are reportedly widespread, but not meaningfully quantified.

Such referrals as do exist, in either direction, are generally for the development of a particular position in the case rather than for the purpose of advancing the care of the party. The greater the harm demonstrated to the judge or jury deciding the facts, the greater the compensation, and the greater the plaintiff’s attorney’s fee. The less harm shown, the more successful the defense, and the greater credit to the defense attorney, resulting in a continuing stream of case referrals. Accordingly, the focus of referrals in a litigation context is the demonstration (or questioning) of disability and its quantification, rather than the restoration of functional ability.

Follow up services provided by the advocate to the client after the end of the case are relatively rare, and focused attention on the restoration of client’s functional ability is usually lacking. There is no economic incentive for such follow up impacting either the plaintiff or defense bar, and services provided for such coordination are often uncompensated. Orders from the resolving adjudicatory body to continue jurisdiction over a case after its resolution, for the purpose of ensuring functional restoration of the claimant, are generally not permitted. In the legal

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12 For an interesting study of the outcome of this behavior, see Victor, Barth, and Neumark 2005.
system, once the decision is made in the case in front of them, the advocates and adjudicator move on to the next case.

In litigation to resolve the rights that have been alleged to be violated, it is more common for the advocate of the claimant to continue involvement, if only to be on the lookout for retaliation against the claimant by the employer, which may give rise to another cause of action. Moreover, in that context it is more common for the remedy to involve restoration of some sort of relationship between the parties, rather than simple monetary award. The remedy that is fashioned may be monitored concerning its success and the good faith of the parties in implementing it.

Coordination of care between various health care providers may or may not be a priority during litigation, depending on which party is being considered. The plaintiff’s advocate has no economic motivation to expend time and effort on the coordination of care, other than that needed to ensure that a consistent message is presented to the judge or jury deciding the case. There is sometimes a motivation for the claimant’s advocate to seek assistance in client control during the process, especially where behavioral health concerns make controlling the client’s behavior problematic. The defense advocate has greater motivation in seeking coordination between health care providers, but usually for the purpose of limiting the overall expenditures for services, discovering inconsistencies between the representation made by the claimant to various health care providers, or discovering inconsistencies with the statements or behavior exhibited by the claimant generally. Although individuals vary in their behavior, neither the plaintiff’s or defense’s advocate is institutionally concerned with the outcome of care, as they will have moved on to the next case before care issues are resolved. Accordingly, coordination of care is most often delegated to other professionals.

### 11.5 Medicalization of Claims

The legal system unintentionally encourages “medicalization” of a claim. Diagnosis, particularly diagnosis supported by some authoritative reference, tends to fulfill the *Frye or Daubert* criteria for admissibility of evidence concerning the behavioral concern that is connected with the plaintiff’s claim. By giving it a name, the diagnosis demonstrates the general acceptability of the assessment of disability or adds weight to the independent assessment of the court, creating conditions that allow the admission of evidence of disability. Without such evidence, the cause of action or the limitations that give rise to an award of damages under the cause of action cannot be proven. Thus there is significant pressure created by the legal system to find a diagnosis for the plaintiff as part of the process of bringing a claim. These pressures impact the behavior of the attorneys as well as the attending behavioral health professionals. Even without improper economic motivation, the attorney seeks to win, and the strength of the case is improved by the appending of an established diagnosis to the symptoms.
Once the diagnosis is determined, individual variations among claimants for development of disability really come into play. Research has demonstrated that psychosocial factors are good predictors of the development of disability after injury (Fayad et al., 2004; Jellema et al., 2006; Main, Sullivan, & Watson, 2007; Van der Windt et al., 2008; Bruns & Disorbio, 2009). Many claimants recover fully and are not affected adversely by the dynamics of the legal system. For some, the outcome is much more difficult.

The claimant hears the diagnosis and sees it being built into the litigation strategy of the attorney. There is discussion of the claim for damages, and through questioning about the limitations experienced, the claimant quickly learns that the more disabled he or she is, the larger the claim for damages is likely to be. The attorney begins to refer to the plaintiff as a disabled person, and the perceptions of both shift to match the requirements of the task at hand – proving the disability. Claimants may hear and internalize the subtle messages imbedded in the language commonly used in the system and may start identifying with the role of the “injured worker”, “accident victim,” or “person whose rights have been violated”. Surveillance and other documentation of daily activities becomes a factor, particularly in workers’ compensation cases, and claimants understand that they may not do things that are inconsistent with their claim. Normal movement and activities of daily life are curtailed and the physical effects of inactivity exacerbate the already existing symptoms of injury. The process of incorporating chronic limitations into daily life begins. As this process extends over time, the probability of the worker ever returning to one’s pre-injury employment is significantly diminished (Bartley, 1994; Bellamy, 1997; Gerdtham & Johannesson, 2003; Guirguis, 1999; Harris et al., 2005; Jin, Shah, & Svoboda, 1995; Johoda, 1983; Martikainen & Valkonen, 1998; Mathers & Schofield, 1998; McGill, 1968; Nachemson, 1983; Sander & Meyers, 1986; Stewart, 2001; Strang, 1985; McKee-Ryan et al., 2005).

In the process of presenting the best possible case for a large award of damages, the natural tendency is for attorneys to project the worst possible case into the future, for the purpose of creating motivation for the award of maximized future damages. When an individual projects the worst case scenario into the future, behavioral health experts are likely to refer to the phenomenon as “catastrophic thinking” and take therapeutic steps to assist the person in recasting one’s thinking into more useful directions. When the same behavior takes place in the courtroom, litigators consider it good advocacy, and seem unconcerned that the claimant may internalize the characterization, engage in his or her own catastrophic thinking about one’s condition and prospects, and create behavioral conditions conducive to one’s failure to restore full functioning (Horwitz & Wakefield, 2007; Barsky & Borus, 1996). Indeed, conversations with plaintiff attorneys about their clients are usually scattered with reference to lives that have been irretrievably shattered, with no hope of meaningful restoration and only a large award as solace. If the guide to this mysterious process has given up hope for the claimant’s recovery, the claimant’s opinion is likely to follow.

The legal process is one where the claimant is almost always subject to a loss of sense of control. Control is lost to the lawyers and judges running the process of dispute resolution, a health system that casts the patient in to the role of passive
recipient and claims examiners who may control the means to obtain the basic needs of day to day living. This loss of control may combine with increasing focus on physical limitations, resulting in the litigant becoming increasingly identified with their cause of action and diagnosis. The claimant may change one’s perceptions to fit one’s new identity. When the new identity is entrenched, it is difficult for the worker to regain a sense of wholeness and independence. This is a systemic variant of “medicalization” of a claim, involving the larger actions of the entire medico-legal system in the process. The resulting encouragement of an identity as a disabled person, internalization of limitations consistent with that role, and change of perceptions so that experience in the world is interpreted to reinforce those limitations has been sometimes called “attorneyogenic disability”. The legal system has shown no conscious awareness of the impact of this “medicalization” on the plaintiff’s long-term well being, although there is a tendency for the plaintiff’s advocate to assert that the diagnosis, once established, is a permanent condition. Unfortunately, the legal process itself may help fulfill this prophecy.

11.6 Professional Enabling

Lawyer audiences, and individual practitioners, inevitably assert that the behaviors described elsewhere in this chapter are certainly not the way they personally conduct business. Often they will protest that it is wrong to generalize with regard to the lawyers at all, and certainly that it is unfair to characterize the entire profession as motivated solely, or even primarily by personal gain.

The criticism is justified, to an extent. Legal education in the United States has been focused, during much of the last 50 years, on training students to “think like a lawyer”. The term is often used as shorthand for the process of training someone to take any side of an argument, without regard for one’s personal beliefs. While the socialization of students to disassociate from one’s personal values has been widespread, there are certainly many individuals who make career choices that allow them to feel a personal sense of comfort with the positions that they take. These positions are often taken without regard to the remunerative nature of the representation. However, the attorney who avoids the trap of being influenced by pecuniary gain should not be secure in the belief that one’s actions do not contribute to the disability of one’s clients.

“Enabling” is a term applied, often in the context of alcoholism, or other issues involving familial dysfunction, to describe the behavior of protecting someone from the consequences of their actions. An alcoholic’s enabler might make excuses to the alcoholic’s work supervisor to keep him or her from getting fired, create explanations to friends and family, and deceive him or herself into thinking that everything is normal, or at least a reasonable response to abnormal stressors. The enabler does so in the belief that one is helping keep the family together and providing for stability and normalcy (Wegscheider-Cruse, 1989).
Professionals can also take the role of an enabler. When a lawyer acts as an enabler, he or she may act to save the client from the consequences of one’s actions. The most obvious example of this behavior is the defense of criminal matters. If the aim of defense is to help the client “get off” with respect to the charges, then the professional role is to spare the client the consequences of one’s actions. This enabling behavior often separates the client from the resources needed to address the underlying behavioral health issues. Indeed, the archetypical criminal defense lawyer only resorts to treating the underlying problem as a less onerous outcome to incarceration in cases where the guilt of the client can clearly be proven such that a plea bargain is advised under the circumstances. Similar kinds of services are performed in assisting the client deal with employment difficulties, marital and familial situations, economic obligations, and other aspects of everyday life.

Other types of professional enabling are subtler and more pervasive. The ads on television loudly proclaim that “you may be entitled to a cash award”, or a similar phrasing. The message to clients is that they are owed something by the world – that is that they should focus, not on their own choices, options and empowerment, but rather on the notion that “fairness” demands that they receive something in compensation for what has been done to them by someone else. This focusing of the client on an outside agency as the source of one’s problems, and one’s ultimate salvation, protects the client from having to take psychological responsibility for one’s circumstances. This enabling behavior allows the client to become “stuck” in the identity of a victim. It is not hard to conjure up examples of individuals who became controlled by their identity as a victim to the extent that they psychologically foreclosed the possibility of change in their circumstances. In this context it is not surprising that Dr. Christopher Brigham refers to attorneys as “the victim makers” in *The Crippling of America* (Brigham, in press).

Interestingly, when offered the opportunity to write himself or herself a check for any amount of money in exchange for accepting a disabling injury or condition, virtually no one indicates that one would find the exchange acceptable. Terms used by the legal system to refer to the payment at the end of the case are interesting in that context. The term “cash award” is often used – including the connotation of an award as recognition for some achievement. The term “settlement” is often used, implying that once the money is paid, the whole matter is settled, notwithstanding the fact that the client still has to live with the disability thereafter. Sometimes the reference is just to “cash” or “money”. In all these cases the concept that a payment is the appropriate mechanism for compensation has the tendency to objectify the client’s condition and divorce the client from the consequence of choosing to be disabled rather than making the best of the life available to a person in one’s present condition. This form of enabling distracts the client from one’s power to make

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I have asked approximately 50 audiences in the U.S. and Australia the following question during the last 3 years: “Imagine that I have a blank check, guaranteed to be honored for any amount that you decide to write in. How many of you would accept a life altering injury in exchange for the ability to write this check to yourself for any amount of money that you chose?” I am yet to have a single person volunteer to accept the check.
meaningful choices concerning the life one leads and saves the person from the emotional and psychological consequences of those choices. In this sense, the reduction of behavioral health disability to the product of an outside agency for which pecuniary compensation is the only appropriate redress has insidious consequences and may combine with or exacerbate the underlying behavioral health issues in ways that may be difficult to predict.

11.7 Symptom Magnification and Malingering

The issue of symptom magnification and malingering is one that varies substantially depending on the point of view of the parties. Not surprisingly, these terms are frequently used imprecisely, giving rise to confusion in discussion of the phenomena.

11.7.1 The Importance of Language

What we say about people with behavioral health concerns in the legal system has an impact on their future recovery and reintegration. The goal of the zero-sum game of litigation is to obtain the largest possible award, or defeat the claim entirely. In this context, both sides utilize language that has a tendency to force the claimant into the position of defending and rendering habitual, the behavior that underlies the behavioral health claim.

In the process of making the best possible case for a large award, the claimant’s advocate seeks the most inflammatory description available, because that will likely result in the largest award (and fee). The claimant hears that description and understands that his or her job is to ratify the description with his or her behavior and model the description credibly as a witness. See discussion of “Medicalization of claims”, in Sect. 11.5. The description of a behavioral health concern becomes a role that the claimant plays during the (often extended) pendency of the claim. Behaviors practiced over time become habitual. Thus the attachment of terminology to a set of symptoms in the context of litigation has consequences that tend to increase the possibility of needless, iatrogenic disability.

At the same time, the claims examiner and defense counsel question the credibility of the diagnosis, as part of the process of opposing each item of liability or damages. Attacking the diagnosis either requires the attorney to attack the qualifications or methods of the examining behavioral health practitioner or to attack the validity of the behavioral data on which it was based. This second form of attack looks, sounds, and feels to the claimant like an attack on one’s personal credibility and integrity. In response, the claimant has a natural tendency (sometimes encouraged by plaintiff’s counsel) to defend one’s status, and make one’s behavior more obvious and pronounced so that it will not be questioned. This behavior, in turn, may occasion claims of symptom magnification, or malingering from the defense.
This overt attack on credibility results in further defense of the behavior that is being questioned (Lippel, 1999; Guthrie & Monterosso, 2009).

This might be seen as an inevitable result of the litigation process, present whenever less confrontational dispute resolution measures are not availing. The trouble is that language is misused frequently in litigation contexts, and that this misuse exacerbates the long-term harm to the claimant (Talmage, 2007). One of the most egregious examples of this phenomenon is in the use of the terms “symptom magnification” and “malingering”.

### 11.7.2 Symptom Magnification

“Symptom magnification” as used in legal context is a habitual focus on physical symptoms that exceeds “normal” expectations, but “normal” is in the eye of the beholder. Most people have had the experience of finding a cut or bruise and being unable to recall the circumstances of acquisition of the injury. Most people can recall instances when a minor incident caused completely focused attention on the immediate physical sensation and an overreaction to the objective harm incurred. “Normal” perception of symptoms falls within that rather broad range of experience. Symptom magnification occurs when the range of perceptions shifts toward the focused attention end of the spectrum. The person experiencing this shifted focus often experiences concurrent expectations of sensation and/or fear of sensation that reinforces the focused attention. Over time, focus upon one’s sensations, and the emotional content associated with them, has a tendency, through normal processes of habit formation (the neuroscientists would refer to “brain plasticity” as the mechanism for this phenomenon), to become habitual and entrenched (Strang, 1985; Oakley & Halligan, 2009; Duffau, 2006; Kolb & Whishaw, 1998). Symptom magnification is established.

### 11.7.3 Malingering

“Malingering” is generally a more value-loaded concept in the law. The term is usually used to describe someone who emphasizes or extends his or her sensations or limitations in the expectation of secondary gain (Arnoff et al., 2007; Mittenberg, Patton, Canyock, & Condit, 2002; Conroy & Kwartner, 2006; Reid, 2000). “Secondary gain” is a neutral term that describes the seeking of external reward for behavior (Schultz & Gatchel, 2005). Secondary gains range from increased sympathy and attention from loved ones, through permission to avoid disagreeable tasks, to increased experience of disability in expectation of enhanced awards of damages. The seeking of secondary gains (at least at the lower levels of the continuum) is a natural behavior that is experienced by most of us in everyday life. The seeking of secondary gain can become destructive, however. The behavior can lead to avoidance of the activities and
responsibilities of everyday life. When that happens, interference with normal activity and relationships can cause secondary physical or behavioral health harms.

Malingering is properly defined as the intentional display of behavior in the calculated attempt to obtain external benefits (secondary gain) that would not be otherwise forthcoming. Malingering is a species of fraud, involving an intentional misrepresentation of condition, known to be a misrepresentation when expressed, with the intent and for the purpose of obtaining a benefit to which the person would not otherwise be entitled.

### 11.7.4 Other Reward Seeking Behavior

There is another species of behavior that occurs quite frequently and is often mistaken for, or confused with, malingering. People learn to get what benefit they can out of conditions and circumstances with which they are presented. We say, “When life hands you lemons, make lemonade”. All of us have learned that “feeling bad” sometimes gets us out of unpleasant activities. We may actually experience the stomachache that gets us out of going over to dinner with relative who is a dreadful cook. When we are ill or hurt we often get extra nurturance and attention. We do not stop and think of the causal connection, but sometimes “make a fuss” and get a little extra warmth from those close to us. These behaviors are part of our everyday primary (internal) reward seeking behavior (Schultz & Gatchel, 2005), established over time by classic operant conditioning. Most of the time, the mechanism operates without our conscious direction or decision. We might call this class of behavior “reward seeking” in the absence of an established term. But in the context of the law, there is a tendency to treat any reward seeking behavior as evidence of malingering. Since both the focus of the behavior (primary vs. secondary gain) and the intention (unconscious vs. premeditated) distinguish “reward seeking” from “malingering”, this is error. The mislabeling of reward seeking behavior as malingering forces the reward seeker to defend and focus upon behavior, entrenching it and magnifying the perceived intensity. Thus the mislabeling of innocent normal behavior as malingering increases symptom magnification behavior and the probability of unnecessary disability.

### 11.7.5 Control of Symptom Magnification and Malingering by the Plaintiff’s Advocates

As discussed above, it is unsurprising in the legal context that some claimants intentionally adopt behaviors or limitations that enhance the probability of success of their claim. Since in the legal system disability is rewarded and ability is not, these adopted behaviors are often inconsistent with activity that would assist them in regaining function. Malingering and symptom magnification work contrary to the regaining of full function. Thus, control of those behaviors is a legitimate systemic concern.
The question of control of symptom magnification and malingering by the plaintiff’s advocate is really a question of motivation. The greater the apparent disability of the plaintiff, the greater the award in fee generating cases and the greater the emotional appeal of the case in causes of action that are intended to perfect or secure rights. In this paradigm, there is no institutional reason to suppress these behaviors.

As noted above, *symptom magnification* has a tendency to become an entrenched behavior. Such behaviors are more likely to be consistently displayed to treating health care providers and be employed to subjectively support a diagnosis. The existence of a diagnosis is highly useful in establishing the admissibility of evidence of harm, which is particularly important in cases where the harm is not visible or objectively verifiable to the judge or jury. Typically, a diagnosis is buttressed by the plaintiff’s overt display of symptoms to the jury. Behavior on the witness stand is often coached, and the plaintiff’s lawyer may speak to the claimant in terms that objectify and reinforce his or her sense of disability. In these ways, symptom magnification is often intentionally or unintentionally encouraged by the plaintiff’s advocate.

An ethical attorney will not intentionally encourage malingering. Moreover, symptom magnification and malingering can make the attorney’s job more difficult and less efficient by making the client more demanding or more logistically difficult to deal with. The legal system does not provide plaintiffs attorneys with financial compensation, resources, or training for the purpose assisting their clients with behavioral health concerns that bring them to the legal system or that are exacerbated by the inherent stressors in the system.

### 11.7.6 Control of Symptom Magnification and Malingering by Defense Advocates

When defense of cases is treated as a zero-sum game, there is a natural tendency to look for any possible “pry point” in which to get leverage to limit or avoid liability. In this context, questioning the objective existence of the symptoms claimed by the claimant is a popular approach to case defense. The defense directly, and through its experts, often question the veracity of the symptoms claimed. The claimant is put into a position of “defending” his or her symptoms from an adverse judgment. This requires the claimant to focus more attention upon those symptoms. This situation is exacerbated by accusations of symptom magnification or malingering, which bring the claimant’s character and integrity into issue as well as one’s behavioral symptoms. The claimant often feels that she or he is under personal attack. This dynamic forces the claimant to focus on the continuation and justification of one’s symptoms, rather than upon symptom resolution and reintegration into normal life. Thus, defense against a behavioral health claim may extend or exacerbate it inadvertently.
11.8 Facilitating Return to Work and Stay at Work Behaviors

Attorneys involved in the process of litigation are not generally overly-concerned about the process of returning the injured person to work (or keeping him or her at work in the first instance). The tendency is to focus upon the zero-sum game of litigation, and move on to the next case as soon as the current case is resolved. The principle exception to this phenomenon arises when the claimant’s work activity affects the damages that may result from the case. It is not uncommon to hear workers’ compensation claimants complain that their attorney “won’t let them”, return to work, despite current economic hardship caused by the discrepancy between disability benefits and wages before the work stoppage. It is likewise common for such claimants to complain that the employer, defense doctors, or the defense counsel is trying to force the worker back to work prematurely. This dynamic arises primarily in those causes of action that seek monetary compensation as a remedy.

In civil and employment rights litigation, there is more opportunity built into the system for the parties to engage in pre-litigation attempts to mitigate or avoid the claim. In this context, it is possible for behavioral health issues to be raised in a more informal pre-litigation context and for them to be addressed as a problem to be solved rather than as an item of damages. If an attorney is employed prior to the initiation of a claim, the attorney may accept a private retainer, or a promise of future payment by the offending governmental entity or private employer, to represent the claimant in an effort to avoid litigation. In this role, the claimant’s attorney seeks to encourage the cooperation of the employer and to resolve the issue prior to (threatened) litigation. In this context, return to work and specific accommodations in the workplace to facilitate staying at work are commonly negotiated. This procedural posture allows negotiation about work conditions and accommodation of behavioral health needs that is often unavailable once the party’s positions are solidified by the pendency of litigation.

This kind of interaction carries its own psychosocial dynamic. The claimant may feel a sense of personal immunity from discipline and a sense of empowerment to make demands upon the employer for special treatment in the workplace, due to the backing of the attorney and the continuing threat of litigation. In the alternative, or at the same time, the worker may feel a sense of alienation due to one’s unique status and the reaction of management and one’s co-workers to his or her special status.

The employer in this situation may feel like he or she constantly has a “gun to the head” and may seek to find ways to make the claimant want to leave, may ignore the claimant, or may give in to every demand. The response may be similar to the response of an employer to being given a political appointee (in governmental service) or a relative of the boss (in private industry). Employers tend to mix injury

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14 In many jurisdictions, the liability of the employer (or insurer) is reduced or limited when the worker has returned to work.
and personnel issues inappropriately. An injury becomes an excuse to get rid of a troublesome employee rather than facilitate their return to the workplace. The worker’s time off for recovery may be seen by the employer as a vacation from the stress of supervising someone who is less than fully compliant or controllable, and early return to work may not be seen as a virtue in such cases. Contact with the employee, which is crucial to keeping them engaged in their identity as a worker, may be avoided. Even enlightened employers, who realize that prolonged absence from work increases the chances of permanent disability, can fall into inappropriate avoidance behaviors, and inadvertently or intentionally encourage iatrogenic disability.

Excellent attorneys are aware of these dynamics and seek to heal the relationship between the employer and worker, before moving on to the next case. The healed relationship is more likely to be valued by both sides, resulting in more opportunity and willingness to return to work. The attorney may proceed by addressing the emotional components of the underlying experience of each through mediation, team building, and other conciliatory exercises. These efforts may emanate from either the plaintiff or defense advocate.

11.9 Appropriate Documentation of Objective Impairment and Limitations of Functioning

The process of determining what is reliable evidence of impairment and functioning is of great significance in the fashioning of an enlightened approach to behavioral health in the workplace. The responsibility for providing and coalescing such information falls on several parties in the system. The employer has the responsibility to provide accurate information concerning the functional demands of the job. The physical health care provider has the responsibility for assessing the current physical condition of the worker and to obtain an accurate assessment of the duties of the job before making an assessment of duty limitations. The behavioral health professional has the duty of determining whether there are limitations based directly or derivatively on the injury. Optimally, the attorney advocates have the role of coordinating all these sources of information and bringing them together in a sensible manner. Regrettably, the dynamics of litigation (or even the threat of litigation) undermine these optimal roles by introducing outcomes that influence the behavior of the parties.

11.9.1 Distinguishing Between Objective and Subjective Evidence

In the context of claims of injury, the documentation of objective evidence of impairment and functional limitations begins substantially before the report of a behavioral health concern. It is important to have the actual job duties and performance standards
documented and available for review. Often, when a health care provider attempts to make a decision concerning the ability of a worker to return to work, they will interview the worker as to the nature and requirements of the job and seek no further information. The worker’s view of the job is likely to be affected by one’s perceptions, the interpersonal relationships between them and one’s supervisor and co-workers, one’s perception of their current health status, and other psychosocial issues, such as symptom exaggeration. Provision of an existing objective description of essential job functions, working conditions and production demands, as well as other medical records, including mental health, to the examining health care provider may create increased accuracy in the prognosis concerning return to work.

Similarly, prompt and thorough investigation and documentation by the employer concerning the circumstances of the injury can be important, although it is usually seen as being of greater significance in physical injuries than in behavioral health concerns. If it is well known how the behavioral health concern is reported to have occurred, there is a much better chance of distinguishing whether the concern is related to an event or if it was a pre-existing concern. Investigation and documentation by the employer of the circumstances where the behavioral health concern arose may also help establish when harm was caused in a manner related to the workplace (workers’ compensation) or by the actions of the defendant (other tort claims).

The objective assessment of impairment and limitations on functioning is dealt with elsewhere in this volume. It is important for the parties to be aware of the history of judicial acceptance with respect to scientific evidence in their jurisdiction. If the creation of objective evidence of impairment and limitations of function is based upon a methodology that has not been previously judicially tested, then much of the benefit associated creating the documentation may be lost. If the results of a novel testing protocol are not accepted by one party or the other, litigation under the applicable admissibility standard is likely to follow.

Attempts to reintegrate the person with a behavioral health concern into the workforce should also be carefully documented. The issue of good faith by the employer in accommodating the limitations of the worker in an employment context can give rise to its own cause of action for “retaliation” against the worker for the act of making a claim. Objective recording of the placement, efforts to make the worker successful, and actual performance of the worker are critical to avoiding inappropriate claims. Accurate recording of the actual performance of the worker in the placement will also give guidance to managers.

11.9.2 Impact of Objective and Subjective Evidence

When the parties focus upon subjective evidence of impairment and limitations, such as the worker’s self-reporting of physical conditions or job duties, the possibility of greater variations in the outcome changes the litigation dynamics. If subjective evidence is introduced into the litigation process and treated as credible,
then the possibility of a much larger award is created for the plaintiff. If the plaintiff relies on subjective evidence and is unsuccessful in establishing its credibility, then the defense has a better chance of defeating the claim outright, or sharply limiting the liability exposure. Thus advocates for both sides have strong motivation to focus their attention on the subjective evidence, as its presence in the case creates a “risk-reward” calculus that makes their involvement in the case valuable. It is this “risk-reward calculus” that makes the adversarial process so difficult for injured workers and employers. The definition of “winning” has changed from rehabilitation and reintegration of the worker to maximizing or minimizing the extent of the award, and the possibility that the legal system will create disability that was avoidable becomes significant.

In contrast, when only objective evidence of behavioral health concerns (such as testing results verified for reliability and validity and diagnoses based upon clear causal evidence and objective criteria) is present in the case, there is little role for traditional litigation approaches. Based upon a rational analysis of the objective evidence, the “winner” of the case is usually easy to determine. If objective evidence determines that the plaintiff has a valid claim, then it can be paid appropriately and the energy and expense that would have been spent upon litigation can be devoted to return to work efforts and prevention of future harms. If objective evidence shows the claim to be invalid, then the probability of it being brought by the attorney relying on a contingent fee for compensation is diminished.

It would be naïve to think that the presence of objective evidence in a case will persuade parties to rely upon it exclusively. However, the presence of well-documented objective evidence of impairment and loss of function will inform the parties of what the likely outcome of the claim will be and the likely range of liability exposure and allow better choices concerning allocation of resources to be made. The addition of empirically based practice guidelines for the treatment of behavioral health concerns only increases the predictability of the outcome and reduces the costs associated with dispute resolution. When the outcome is predictable, there is less economic gain to be had by pursuing a dispute and rational resolutions are encouraged.

11.10 Dispute Resolution Outcomes

When considering dispute resolution in the legal system, formal litigation is the model that most often comes to mind. This is true despite the fact that the overwhelming majority of cases are settled before the parties ever present their cases to a judge or jury. The reasons for this misperception probably arise from popular entertainments – settlement of cases does not make for good drama, in the way that a good confrontation in the courtroom does. The litigants are not unaffected by this dynamic. The desire for a “day in court” probably arises from the conditioned expectation that “justice” is the product of court proceedings. As noted previously, the law is not a justice engine, but rather a dispute resolution engine. It is not nearly as important to society that an
individual dispute be resolved fairly as it is that the dispute be resolved finally, allowing society (if not the individuals) to pick up the pieces and move on in relative peace. Thus, the outcomes of dispute resolution after traditional litigation are not often stories of successful restoration of function and reintegration into the pre-harm lifestyle. The litigants are left in much the same (or worse) behavioral health circumstances as they were in before, except now the plaintiff may or may not be richer and the defendant (or his insurer) has spent money to defend the lawsuit and perhaps to pay damages.

If resolution of claims is the ultimate outcome, then approaches other than formal litigation can also achieve the desired results. The possibility exists to view disputes as an opportunity to fix problems, improve the system in which the problem occurred, and prevent future occurrences of harm. This role, in a legal context, has been called “counselor at law”.

When a lawyer adopts the role of “counselor at law” the focus shifts from winning disputes to the prevention and solving of human problems in a legal context. The purpose of the counselor at law in a case is not to gain advantage for one side at the cost of the other, but to find solutions that enhance the outcomes of both. The role of litigation advocate is not consistent with the role of counselor at law, and the roles tend to attract different personalities. However, some attorneys have developed the capability of switching between roles, as the needs of the situation dictate.

The advantages of the counselor’s role to the plaintiff interest in the ultimate outcome of the case are evident. In traditional litigation, dispute resolution is defined by one party winning and the other losing. The aftermath of this system is not conducive to the recovery of the parties, particularly in the context of behavioral health concerns. The complaining party has had to adopt the role of victim to pursue their claim. This attitude may become internalized and persistent. Especially in behavioral health claims, this may be the beginning of iatrogenic disability. The defendant has been placed into the role of denying the claim and questioning the veracity and character of the plaintiff. Mutual distrust after the system has finished with one is common. The distrust may create or exacerbate a behavioral concern. Each blames the intractability of the other for the need to expend the psychological energy and economic resources needed to reach a resolution. The threat that one side or the other will find a way to retaliate for an unfavorable outcome casts a pall on the continuing relationship. The claim is resolved, but the parties may not be able to resume their previous lives.

In a counselor’s role, the outcome for the plaintiff is much better. Objective assessment of the case keeps expectations realistic in many cases. The stresses of litigation may be avoided altogether, or the litigation may be limited to a few unresolved issues, allowing the behavioral health client to avoid some of the rigors of the process. There is a recognition that an economic settlement will not really make the plaintiff whole, and the focus thus changes to what is needed to give the plaintiff an opportunity to regain as much of one’s former life as is possible. The risk of an “all or nothing” outcome is reduced, as the approach allows the defendant to reallocate some of the resources originally devoted to defense of the claim to improvement of the situation that gave rise to it. The possibility of reintegration between the plaintiff and defendant is preserved, as the search for a mutually acceptable solution inherently engages both parties and is optimally designed to help them
each achieve an improved situation. The parties tend to see each other in less extreme terms when neither wins at the expense of the other, and the possibility of a sense of peace that would allow the rebuilding of their relationship is created.

One difficulty for the adoption of the counselor’s role by plaintiff attorneys is the lack of any formal mechanism for compensation of them in that role. Particularly in workers’ compensation and tort claims work, the tradition of compensation by contingent fee is strong, and the tradition is reinforced by the relative inability of litigants who have already suffered harm to finance attorney intervention in their cases out of personal resources.

The defense side of the case also has much to gain from the counselor’s approach. The defense is usually in reactive mode. When the defense lawyer is engaged in a case, the harm has usually occurred and the possibility of avoiding it or mitigating it significantly has often been lost. Moreover, the defense is at the mercy of the cause of action chosen by the plaintiff and the theory, evidence, and experts the plaintiff chooses to pursue. The defense must respond to the plaintiff’s case or face the possibility that it will be regarded as meritorious simply because it has not been confronted. This task is all the more difficult when the theory of recovery or the evidence of harm is unique or novel, as is more likely in behavioral health claims. A perfect defense to the cause of action that the plaintiff ought to have brought for the harm complained of may fail miserably if the plaintiff’s case proceeds on a different theory. This reactive mode does not allow the defense advocate to help the parties avoid foreseeable harm, or to mitigate the effects of harm before they are irretrievable. Prevention of a problem through early intervention is almost always more cost effective than resolution of a problem in reactive mode, when the claim has been left to mature. Resources spent mitigating present, and preventing future, behavioral health claims are almost always more cost effective than “rolling the dice” in court. However, the mechanisms are lacking for compensating attorneys who serve outside of an “in-house counsel” role for these kinds of services in workers’ compensation and insurance defense environments.

11.11 Some Possibilities for an Improved Systemic Approach

The current legal system contains systemic features that tend to exacerbate, and in some instances create, behavioral health issues for the litigants who find themselves cast into the system for the purpose of resolving a dispute. There are two kinds of approaches to these challenges. One approach looks to the attorneys involved to change the way that they practice, while the other suggests peripheral changes to the structure of the legal system to assist needed changes in behavior.

11.11.1 Changes Lawyers Can Make

The role of counselor at law has been discussed above. The advantages to both sides in a behavioral health concern dispute run to increased possibility of recovery and reintegration and decreased risk of iatrogenic disability. The role is not often taught
in law schools, and is not always encouraged by clients, who have been conditioned to expect a more aggressive model of dispute resolution. Yet the benefits, particularly in behavioral health cases, are undeniable.

Barriers to this role include mechanisms for compensation, client education, inexperience and lack of training, and personal disinclination. Of these, compensation is the easiest to address. An alternative to normal contingent fee pricing structures should be offered to plaintiff seeking this kind of approach. For the plaintiff’s side, a diminished fee percentage is already often used for settlements prior to litigation. A third tier of pricing, or an hourly rates for exploring reconciliation before filing litigation could be established. Successful resolutions can contain a provision for payment of the fee of the counselor at law, and unsuccessful attempts at resolution will simply move on to the existing system.

The legal system is structurally designed to compensate with cash awards for harm that has been done. Even disregarding the emotional and psychological toll of injury, this system is inadequate to completely compensate the disabled person for the loss of one’s productivity. Nonpunitive awards virtually never replace the income that a person would have made had she/he kept working, and in workers’ compensation cases, statutory limits on compensation are clearly not even designed to “make the victim whole”. Clients need to be reeducated to understand that a cash award and permanent disability is almost always economically a worse financial outcome than return to productive life (Biddle, Boden, & Reville, 2001). In the absence of that kind of information the client cannot truly make an informed choice about his or her litigation options; so the provision of this information has an ethical component as well (American Bar Association, 1993, Rule 1.2).

Lawyers need to become skillful in the basic recognition of existence of behavioral health concerns, the evaluation of the professional qualifications of behavioral health professionals, and the interpretation of the objective testing and other output of such evaluations. They need to become familiar and comfortable with the practice of the counselor’s role and the use of the tools particular to that role. The tools of the counselor at law are often the tools of the counseling arts: listening, seeing the larger picture, finding commonly held values and goals, helping people to find agreed solutions. In particular, true mediation, where a neutral facilitator assists the parties in an effort to voluntarily come to a mutually acceptable resolution, is a valued approach. Most importantly, counselors need to learn to look for solutions that allow both sides to “win” during the resolution process, instead of focusing on zero sum outcomes.

Some law schools currently offer postgraduate programs in specialty areas of law, such as the law of taxation. A postgraduate specialization in the skills of a counselor at law would assist in the recognition of the role, and perhaps lead to the kind of acceptance enjoyed in the British legal system for the separation between barristers and solicitors. Such a specialization would likely be embraced by law schools (whose faculty, after all, opted out of the traditional legal role) and over time would become an accepted part of the legal framework. The recent flourishing of so-called “alternative dispute resolution” techniques is indicative of a readiness of the public to accept a less expensive and less confrontational method of solving our legal problems. Behavioral health concerns, especially where they are imbedded in traditional legal disputes, would particularly benefit from separation and separate processing in this more gentle and constructive paradigm.
Some attorneys will not accept this role. They choose, for whatever reasons, the adversarial nature of courtroom litigation. Such lawyers should look to the British model of barristers (who try cases before the court) and solicitors (who do nearly all other legal work) and associate lawyers who can take referrals of cases that can be settled, while accepting referrals of cases where settlement was attempted unsuccessfully.

11.11.2 Disengagement of the Profit Motive from the Litigation Process

As seen earlier, the mechanism for the compensation of attorneys in the tort and workers’ compensation system creates an incentive for attorneys to seek the largest possible awards for their clients, without regard to the unintentional adverse consequences to litigant behavioral health created in the process. When the incentive is to reduce the human problem to the largest possible monetary award, “medicalization” of the presenting condition, internalization of catastrophic thinking about the future, the creation of identity as a disabled person, and alteration of perceptions to reinforce that identity are outcomes affecting far too many litigants.

It is, perhaps, unrealistic to think that plaintiff’s attorneys, who may earn millions from a single settlement, will willingly change their ways. Attorneys do, however, change their practice patterns in response to the demands of clients. As the public has become more aware of the nature and impact of litigation upon the individual and society as a whole, alternative dispute resolution has become more popular.\textsuperscript{15} A key issue in achieving these changes is the education of the public. Scholarly study of the economic impact of attorney involvement is only recently being published.\textsuperscript{16} As the public becomes aware of the real impact of litigation in our society, and the practical alternatives such as alternative dispute resolution, their taste for the

\textsuperscript{15} Witness the burgeoning, during the last 20 years, of the role of the attorney-mediator and attorney-arbitrator. Those roles were nearly unheard of in the early 1990s, but it would be a rare issue of a State Bar newsletter that did not carry multiple advertisements for such services today.

\textsuperscript{16} Swedlow, A. – citations on the way, Bernacki, E. – citation on the way.

The Workers’ Compensation Research Institute is scheduled to publish one or more studies on the topic by the end of 2009.

Data mined from the Delaware Rating Bureau’s workers’ compensation claims payment data base indicates that, over the course of two claims years (2005 and 2006), cases with attorney representation had 11 times higher medical expenses and 30 times higher indemnity expenses than cases in which their was no attorney representation. Although it was claimed at the time that the differential was a combination of increased severity and effective representation in the cohort that had attorney representation, the explanation does not explain the relative difference between the results for medical and indemnity benefits. A more plausible explanation involved the fact that attorneys were compensated by a combination of contingent fees and additional payments for attendance at hearings that was in effect in Delaware at the time.
courtroom may be reduced. A few peripheral changes in the structure of the legal system could help reeducate the public and create an acceptable level of lawyer participation in changes that will help prevent “attorneyogenic” disability.

Defense counsel generally charge fees on an hourly basis. Attorney motivation to “churn” a case with excessive and time-consuming research, motions, discovery, and other activity is often suppressed by scrutiny from sophisticated clients. Nonetheless, systemic incentives are not designed to reward efficiency.

Attorney compensation on the basis of contingent fees for plaintiff’s advocates and hourly fees for defense advocates is not the only possible model. We do not assume that doctors are unmotivated to do the best for their patients because they are paid on the basis of the work they complete. Certainly, the diagnosis of ailments of the human body and the restoration of health is as challenging as legal practice, and the stakes are as high or higher. Some jurisdictions have adopted fees schedules for attorney work that compensates them by the task completed, rather than by the outcome or the hours consumed in workers’ compensation cases.\(^\text{17}\) While studies are still ongoing,\(^\text{18}\) indications are that claimant outcomes are not adversely affected, and that overall systemic costs are reduced.

It might be argued that a fee schedule based upon work completed is a compensation system that is more available in workers’ compensation than in tort, because in workers’ compensation proof of fault is not part of the cause of action and therefore the risk of nonrecovery is diminished. The contingent fee mechanism is also justified on the grounds that many injured people do not possess the resources to fund litigation except out of the recovery. It should be noted that the “American system” of attorney compensation, which presumes that the litigants will pay their own attorneys, is not universally followed even in the United States. Civil rights and employment cases (including those that enforce the rights of those with behavioral health concerns) and divorce cases are examples of decisions, as a matter of public policy, to allocate the cost of representation to the losing party. Reevaluation of the “American system” of attorney compensation should be undertaken in light of the unintentional harm to the litigants caused by the economic motivation the system imparts to the advocates.\(^\text{19}\)

\(^\text{17}\) Massachusetts and Western Australia are examples of two jurisdictions utilizing this system.

\(^\text{18}\) See reference Biddle, Boden, and Reville, 2001. The author is also aware that research into the impact of the recent change from a contingent fee system to a schedule of payments for services rendered in Western Australia is scheduled for Fall of 2009.

\(^\text{19}\) Wollschlager, 1998. The USA has a litigation rate of 74.5 cases per 1,000 population, while England and Wales has a reported rate of 64.4 cases per 1,000 population. Although the reasons for relative differences in litigation rates internationally are not well understood, it seems safe to say that the barrister/solicitor system in the United Kingdom is insufficient as a sole step to reduce unnecessary litigation. The estimated ranking of the USA in this study is fifth in the world and the ranking of the UK is sixth. Interestingly, Germany’s rate of litigation is more than 1.5 times that of the USA (123.2 per 1,000 population) and Sweden’s is nearly 1.5 times (111.2 per 1,000 population). Israel (96.8 per 1,000 population) and Austria (95.9 per 1,000 population) are also higher than the United States or the United Kingdom.
Punitive damages also deserve a closer look. It might be advantageous to society to encourage an individual litigant to act as societal champion in an effort to create an economic deterrent to future wrongdoing. The resulting individual overcompensation of the successful claimant in such cases is hard to justify. When the defendant is a corporate entity with vast economic resources, the “punishment” must be large enough to get the corporation’s attention to have the desired impact. But then a single litigant, who has already been compensated for one’s actual damages, is the recipient of a massive redistribution of wealth unrelated to their personal harm. The plaintiff’s lawyer, of course, gets a percentage of the award, which explains the popularity of the damage category. Arguably, it would be better to fashion the remedy requiring expenditures to undo the damage the defendant has done to others, or to make the punitive award a donation to a worthy cause, rather than to enrich one particular litigant and one’s attorney. Appropriate compensation for the work actually done could be paid to the attorney for seeking the punitive award, removing motivation based upon the expectation of a multimillion dollar fee.

11.11.3 Beyond Professional Enabling

Lawyers should be aware of the role that they play as professional enablers. It may not be possible to entirely avoid this role. Members of the general public do not generally engage lawyers unless there is a specific situation with which they need assistance. The resolution of the presenting situation is the reason the lawyer is involved in the first place. Yet a responsible lawyer must recognize that the client may not have his or her own best interests at heart. Sometimes “getting off” of charges or getting the largest settlement possible is not the solution that will lead to a life untainted by the continuing identity as a victim. Sometimes additional services, beyond those needed to resolve the presenting crisis, may provide the best hope for regaining a full and healthy life. A responsible attorney should look to the whole client and make referrals to other professionals and services. Just as doctors take the Hippocratic Oath, perhaps it is time for attorneys to adopt the mindset with regard to their clients to “first, do no harm”.

11.12 Conclusion

The legal system causes unnecessary disability for many classes of claimants. Those suffering from behavioral health concerns are particularly vulnerable to the impact of structural and behavioral components in the system. Structural components include the win–lose nature of the dispute resolution system, the emphasis on reduction of all harms to a monetary award, and the mechanism for attorney compensation. Behavioral components include the effects of imprecision of language used in the process and the unintentional discouragement of recovery and reintegration that goes with making the claimant with a behavioral health issue defend the
existence of the concern to obtain any recompense. These problems are deeply entrenched, but there are several examples of more enlightened dispute resolution approaches available as a guide.

What would the world look like under such a system? Litigation rates, estimated as of 2000 at 74.5 cases per 1,000 population (Wollschlager, 1998) would likely fall, as more disputes are resolved prior to litigation. More persons with behavioral health concerns would resolve the issues that gave rise to their claims, resulting in fewer lives broken by the process of dispute resolution itself. Some attorneys would make less money and others will flourish as they learn to help others solve their problems rather than merely resolving their disputes.

Behavioral concerns in the legal system are less often resolved by simple determination of rights and liabilities than by planning for the restoration of function and the healing of broken relationships. Flexibility in the way that we think about the law can open the possibility for roles and approaches that are more helpful in encouraging behavioral health.

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