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I. Introduction

This chapter will provide an overview of the concept of disability, describe approaches to evaluating disability, and discuss some special challenges particular to disability evaluations. Disability, for the purpose of this chapter, will be narrowly defined as the inability to perform one or more of an individual's usual life activities such that the individual can no longer function in the workplace. In short, we shall focus on the evaluation of an individual's ability to work following injury or illness.

First we shall describe the social and political aspects of disability, examining societal attitudes and their impact on the disabled individual. We will then examine the meaning of disability for the disabled individual, paying particular attention to the mechanisms by which depression develops in combination with comorbid anxiety and pain disorders.

We explore role of the psychiatrist in disability matters in two iterations:

- a) As a treating psychiatrist
- b) As an examining psychiatrist

Special considerations that obtain in both treatment and evaluations roles are enumerated. Particular attention is devoted to the avoidance of conflicts of interest by careful attention to the different duties that accompany each role. A detailed discussion of the disability evaluation is presented, with liberal use of case examples.

We then examine malingering and lack of motivation as factors that sometimes complicate both the evaluation and treatment of disabled individuals.

We conclude with a brief discussion of the Americans with Disabilities Act and the policy and professional challenges that it presents.

II. Overview of disability

Disability is a multidimensional, emotionally laden concept. The word itself can be used to refer to an individual's functional capacity to engage in certain activities, e.g. learning disability. It can also be used to describe a person's status relative to the world of work, e.g. "He's not working; he's out on disability." With either usage, disability is associated with bias and much conflicted feeling.

Psychiatrists may be asked to participate in the disability process in several

ways, but within a framework of two very separate roles: treating clinician vs. independent evaluator. (Schouten, 1998) Most commonly, psychiatrists, like other treating clinicians, may be asked to fill out forms in support of their patients' claims for disability resulting from mental illness. Psychiatrists, and occasionally psychologists, may be called upon to perform independent evaluations of disability in connection with such claims. Psychiatrists may be asked to evaluate and treat patients disabled from work. Finally, psychiatrists may be called upon to provide independent evaluations of individuals who have filed disability claims based on medical or surgical illness. These roles can be broken down into the following categories:

- The treating psychiatrist asked to certify the disability of his or her patient in order for the patient to receive disability insurance benefits
- The treating psychiatrist asked to opine as to his or her patient's ability to work in spite of a mental disability, e.g. after a leave of absence or in a fitness for duty context
- The consulting psychiatrist asked to evaluate and possibly treat a medical-surgical patient seeking disability
- The psychiatrist asked to perform an independent assessment of an individual's fitness for duty or disability status.

Disability has often been a basis for discrimination in the form of exclusion of individuals with disabilities from the workplace. It is for that reason that the federal government enacted the Americans with Disabilities Act (ADA, 1990) and many states passed their own disability discrimination laws. The false assumption underlying this discrimination is that individuals with mental or physical illnesses are necessarily disabled from working. It is important for laypersons and clinicians alike to keep in mind the distinction between disabilities and impairments. Impairments are the cognitive and affective abnormalities associated with disorders. Disabilities are the restrictions that are imposed by impairments in function, including work and relationships. Thus, an individual with a disorder may or may not have an impairment, and that impairment may or may not amount to a disability. The ADA prohibits discrimination against individuals who have disabilities, or who are perceived as having disabilities, if they can perform the essential functions of the job with or without reasonable accommodation. (Langer, 1996; Zuckerman, 1993) Public and professional sentiments are often aroused when disability from work, and those seeking disability status, are considered. On the one hand, society has developed insurance plans, both public and private, which insure workers against the possibility that they will no longer be able to earn a living. The systems established to provide financial and emotional support for individuals who become disabled from work as the result of illness or injury represent major social advances. Yet, while we have established and endowed these systems, those who utilize them may find themselves the objects of scorn and derision. After all, ours is a society that values work and the work ethic. Those who ask to be relieved of the obligation to work often elicit disdain from caretakers, co-workers, and family members. The growth of attention to disabilities and the disabled is no doubt related to the increasing numbers of disabled individuals in the workplace and a growing number of disability claims. Some authors have predicted that the combined impacts of the Americans with Disabilities Act and aging of the baby boom

generation will result in a significant increase in the number of disabled workers in the next decade (Zwerling, et al, 1997)

The loss of workers to disability has been a growing problem in the United States during the 1990s. Insurance companies that insure against disabilities saw claims rise sharply during this period. Claims for disability resulting from disorders that were relatively unknown during the previous decade appear to have grown most quickly. Between the first quarter of 1989 and the first quarter of 1994, disability insurers saw claims for the following diagnoses rise more than 100%. (Quint, 1994)

<u>Claimed</u>	<u>Percent Increase</u>
Carpal Tunnel Syndrome	467%
Epstein-Barr Syndrome (Chronic fatigue)	320%
Back and intervertebral disk pain	215%
Psychiatric disorders	205%
AIDS	195%

Table I: Adapted from: Quint M: New Ailments: Bane of Insurers. The New York Times, November 28, 1994. Page D1-2

The apparent costs of work-related injuries, defined as injuries or illnesses that cause loss of time from work, have grown tremendously. In 1992, there were 13.2 million non-fatal injuries and 862,200 illnesses in the American workforce. There were approximately 6500 job related deaths due to injuries and 60,300 deaths due to disease. The estimated total direct and indirect costs of these injuries and illnesses were \$171 billion. (Leigh, et.al, 1997)

Depression is both an important cause and consequence of disability, both as a primary disorder and in combination with other medical illnesses. In both roles, it has significant economic consequences. Judd, et al (1996) found an important significant association between self-reported functional impairment and the presence of sub-syndromal depression and major depression. Greenberg, et al (1993) reported the total estimated workplace costs of absenteeism and impaired working ability associated with depression to be \$24 billion per year.

The Experience of Disability

While many people are injured or become ill at work, only a small proportion of those goes on to become permanently disabled. The meaning of a disability to an individual can influence its severity and the individual's adaptation to it. The meaning of any given impairment to an individual, and the degree to which he views himself as disabled depends on the interplay of a number of factors. The consequence is that individuals with similar impairments may experience widely varying degrees of disability. For example, the meaning of a physical injury that prevents standing for long periods is different for a surgeon than it is for a psychiatrist.

Some impairment, such as colorblindness, constitutes only narrow functional restrictions, and little psychiatric morbidity results. Other impairments, such as complete

sightlessness result in greater limitations, although substantial community support and having an identity within the community may lessen the impact.

The patient with a psychiatric disability suffers directly from the symptoms associated with the psychiatric disorder, including depression, anxiety, panic, and pain symptoms. Indirect suffering, resulting from the damage to the patient's self esteem, may cause greater distress. Persons judged disabled frequently voice statements like "I feel like I am no good to anyone" and "I am a failure in life." A sense of powerlessness and hopelessness form part of a vicious circle with the preceding direct symptoms, causing the circle to become a downward spiral. Avoidance of social interaction because of shame and embarrassment frequently lead to panic and agoraphobia.

A thought experiment may aid the clinician in better appreciating the consequences of physical and mental disabilities. Much has been written regarding the trauma of corporate restructuring and the resulting layoffs that occurred throughout the late '80's and early '90's. That these processes have a major impact on affected individuals has been taken for granted. Those affected receive some social understanding and support. By contrast, the patient with a psychiatric impairment secondary to a job related injury must contend not only with the impact of loss of employment, but also with both mental and sometimes physical pain. The sense of being "different", coupled with the devaluation that usually occurs within the community, adds to their narcissistic injury. Loss of the "breadwinner" role within the family, or loss of a feeling of being able to "contribute" to the family's financial well being, as well as being a "drain" on familial financial and emotional resources, contributes to lessened self esteem and depression.

The duration of disability influences the degree of trauma. A rapid return to work results in little emotional distress. Major depression usually results from prolonged disability and unemployment.

Real economic hardship is another consequence of disability. All disabled people experience economic anxiety. For many families, loss of "everything I worked for" including formal bankruptcy, is the outcome. In turn, a number of factors help determine the meaning of the disability to the individual. These factors provide a context for the injury or illness, define its consequences, and provide support for either recovery or chronicity.

These factors are listed in Table II.

1. Gender
2. Age of onset
3. Whether congenital or acquired
4. Severity of disability
5. Presence / absence of compensatory skills
6. Single or multiple disabilities?
7. Presence of pre-existing mental illness
8. Effect on vital functions, e.g. work, sex
9. Prognosis of recovery
10. Financial impact
11. Prior level of functioning
12. Family and social support
13. Pain distribution, quality, and intensity
14. Quality of medical/rehabilitative services

Table II: Factors affecting the meaning of disability to an individual

The most common psychiatric finding after disabling injury is Mild to Severe Major Depression. Major depressive symptoms typically develop within eight and fourteen months from the date of the injury. Anxiety and pain disorders typically appear after the depression is well established, and secondary reactions to the loss come into play. The relationship between psychiatric disorders, including depression, and disability is well established. The presence of psychiatric disorders has been shown to have a significant positive correlation with disability ratings. Walker, et al (1996) found that when compared with other inflammatory bowel disease patients, those with psychiatric disorders had a higher number of lifetime psychiatric diagnoses, higher prevalence rates of sexual and physical trauma, and a higher number of gastrointestinal and other medical symptoms. Bruce, et al, (1994) found that the presence of depressive symptoms in otherwise healthy elderly patients increased the risks of physical disability. Finally, Duckro, et al, (1995) showed a direct relationship between depression and perceived disability associated with chronic headache.

Depression following injury can be a response to multiple causes, including:

1. Loss of role status, both in the family and in the community
2. Loss of hope of recovery
3. Activation of pre-existing low self-esteem previously compensated for through having a successful work role identity
4. Loss of self-esteem based on the apparent disparity between the damaged "real self" and the internalized pre-injury self-representation
5. Chronic pain
6. Loss of work as a means of sublimating aggression

Shame, blame, depression and anger are near universal reactions to the loss of the ability to work. The risk of suicide should never be underestimated and should always be assessed when treating the disabled worker. It is higher in the presence of substance abuse, in single males without a social support system, and for those with co-morbid psychiatric disorders with psychotic and/or impulse disordered features. The loss of sublimatory outlets for aggression, typically work and recreational activities, contributes to morbidity, as does sexual dysfunction which may result directly from depression, from medication, or from co-existing injury.

III. The Role of Psychiatrists in Disability Matters

Assessments of disability are requested under a variety of circumstances. These include: fitness for duty evaluations, workers' compensation claims, personal injury claims, Social Security Disability claims, private disability insurance claims, and claims arising under statutes which prohibit discrimination against the disabled.

Fitness for duty

It may be necessary to determine whether a person who is impaired as a result of a psychiatric disorder is capable of fulfilling the responsibilities of a particular position. For example, a nurse's aide may develop a major depressive illness accompanied by markedly increased irritability, crying spells, and impaired concentration and memory. The evaluator may conclude that until the major depressive episode has resolved that it would be unsafe for this individual to be providing patient care, and judge them to be temporarily disabled for that position.

Example: Sally, a 39-year-old divorced white female living with her daughter and a boyfriend, worked as a paralegal. Two years previously she had suffered a shoulder injury in another job, which led to two surgeries, with a poor result. Her supervisor noted deteriorating work performance, with mistakes in letter writing, and failure to remember instructions regarding case management. She suggested Sally undergo a psychiatric evaluation for possible depression. Sally agreed, and began treatment. She was able to continue to work for several months, but her short term memory and concentration became sufficiently impaired to require that she be placed on medical leave. Sally communicated most of the findings directly to the employer. The psychiatrist approved medical leave based on her impaired functioning, and with Sally's permission communicated this to her employer.

Causality

Workers' compensation programs require a determination whether a psychiatric condition is *causally related* to a workplace injury on "a more probable than not basis" to determine whether treatment should be paid for by the workers' compensation plan, and whether compensatory "time-loss" income benefits are due the worker. In this type of assessment *causality* is defined as meaning that the diagnosed psychiatric condition(s) is (are) judged to be the result of the workplace injury in question with a 51% or greater degree of probability. The forensic psychiatrist will note that the level of required certainty is less rigorous for workers' compensation causality determinations than for the determination of guilt in a criminal matter. Nevertheless, the determination of causality regarding psychiatric conditions is often complex and controversial. It is usually adversarial because of the economic consequences to the contending parties. For

example, consider a case in which a maintenance supervisor with a 15-year work history and a history of severe physical abuse and neglect by alcoholic stepfathers is injured. He becomes depressed when the physical injury does not resolve quickly. Self-esteem plummets rapidly, shame and embarrassment set in, and a panic disorder develops. Is the depression and panic disorder causally related greater than 50% to the childhood abuse, or to the injury and the loss of the structure and self esteem support that work provided? When multiple factors are involved in causation, when they are intangible and subject to debate, and major financial liability is involved, disputes frequently arise which must be referred to a judicial process.

When a claim is being closed administratively, an opinion regarding the degree of impairment attributable to the injury compared to pre-existing conditions may also be required. These factors are taken into account in arriving at the financial settlement, which may take the form of a pension (in the case of total disability), a permanent partial disability settlement, or no award.

Example: Henry, a 38 year old divorced white male grocery checker, developed a repetitive motion injury following 13 years on the job. His productivity suffered, and he was threatened with termination. His chiropractor referred him for psychiatric evaluation and treatment under a worker's compensation claim. Henry responded well to antidepressant medication and group therapy, and his productivity reached a new high. Treatment was terminated. Henry relapsed, and a resumption of medication was recommended. The insurance company managing the claim denied treatment, and requested an independent medical evaluation.

Causality and amount of damages

Personal injury claims require both a determination of causality and the degree of impairment resulting from a named event to determine damages. A psychiatric assessment may be requested by a defense attorney representing an insurance company, or by a plaintiff's attorney in a personal injury claim. For example, someone hit by a car with a resulting head injury may be unable to return to work because of psychiatric sequelae to the head injury. Estimates of the extent of the injury as well as the need for and future costs of care related to the injury are requested. These must be supported by reference to data gathered in the evaluation with a supporting rationale.

Example: Bertha, a 45-year-old mini-mart chain supervisor was driving from one site to another when she was rear-ended by another driver. Initially diagnosed only as having low back strain, she was treated essentially as a malingerer by all but her family physician, who had known her for 10 years. When she was referred for psychiatric evaluation, she was diagnosed as having a Major Depressive Episode, severe. There was a history of alcohol abuse of several years' duration subsequent to a divorce 15 years previously. The patient was referred to a specialist group in a major city, and three level disk injury was diagnosed. Because it was so extensive, it could not be treated surgically. However, with antidepressant medication and group therapy, the patient's depression steadily improved. When her complaints were determined to have a physical basis, she improved even more. Litigation regarding her automobile accident yielded only a minimal settlement related to her mental status, because she had nearly recovered to her prior level of functioning; the damage was temporary, and no long term need for treatment was projected.

Degree of disability assessment *without* consideration of causality

Social Security Disability evaluations focus on the determination of degree of impairment. Although diagnoses are requested, the focus is on the degree to which the impairment(s) interfere with the normal day to day functioning of the individual. A "Listing of Impairments" is published by the Social Security Administration (SSA,) and defines the extent to which activities must be limited by different disorders, such as affective disorders, mental retardation, anxiety disorders, and personality disorders in order to satisfy the threshold requirements to qualify for benefits. The responsibility of the evaluator is to provide specific information as requested. The SSA personnel assemble the information and render a decision. Their decisions are subject to a three-step review and appeal process, ending with a live hearing before an administrative law judge.

Example: Hank, a 49 year old divorced and homeless Viet Nam veteran presented with a history of alcohol abuse in early complete remission and Post Traumatic Stress Disorder. He was receiving group therapy and medication through a local Veteran' Administration facility. His history revealed two tours of duty where he was involved in heavy combat as a landing zone preparer. His drinking began in Viet Nam, and continued after discharge. He had continuous symptoms of PTSD, and was never able to sustain continuous employment as a roofer because of initiating frequent fights and a general inability to get along with co-workers because of his high level of irritability. The issue to be decided was whether the alcohol dependence was the primary disorder that would disqualify Hank for benefits, or whether it was secondary to his PTSD.

Degree of disability assessment and treatment recommendations without causality

Private insurance companies which underwrite group or individual disability insurance policies primarily rely upon the reports of treating clinicians when determining disability claims. These reports are then reviewed by claims managers and in-house medical reviewers. Based upon those reviews, the insurer may request confirmation of the findings and a review of treatment provided. The goal of the insurance company is to minimize disability claims that result from substandard care, to insure that accurate diagnoses are made, and to determine whether the terms of the policy's coverage are being satisfied. For example, some policies were written that allowed for full benefits if the policyholder became unable to perform the tasks of his own occupation, where other policies provide benefits only if the insured is unable to perform the tasks associated with any job. The entity requesting the evaluation typically provides a specific list of questions to be answered and requires a comprehensive evaluation. The evaluator is instructed to release the information only to the requesting entity, much as an evaluation requested by an attorney goes only to the attorney.

Example: Patricia, a 53 year old former nursing supervisor had been receiving disability benefits for 3 years following an unsuccessful recovery from an abdominal surgery that resulted in many complications because of a retroperitoneal abscess that escaped detection for several weeks. Ultimately she was diagnosed as having restrictive lung disease. She was treated initially by her colleague physicians in the clinic where she was employed. No one physician was in charge. She attempted to return to work, but lacked the stamina to walk across the parking lot, in part because of her lung disease. Her physician recommended that she "go on disability." She and her disabled spouse

moved to another community, where she was treated by an internist with antidepressant medication. The insurance company asked the following questions:

- 1) Based on her history, do you feel she meets the criteria for a Somatoform Disorder as classified in DSM IV?
- 2) If you do not feel the patient has a Somatoform Disorder, do you feel the patient has any other psychiatric diagnoses?
- 3) Is the patient impaired, and if so, what is the primary impairing condition?
- 4) Is the patient receiving appropriate treatment? If no, what would you recommend?
- 5) Please complete a mental functional capacity evaluation in full.

She was found to have an anxiety disorder and mild depression, but not a somatoform disorder. She was impaired, but less so than the insurance company had surmised, and was willing to attempt part time employment. An internist had reported dyspnea at rest, but the patient denied this symptom, and did not display it during the interview. She performed poorly on portions of the mental status examination dealing with memory and concentration, and psychological testing was recommended to differentiate anxiety and organicity as an etiology. Medical treatment was found to be appropriate, but it was recommended that a psychiatrist be assigned to the management of the psychotropic medications, and that brief treatment focused on restoration of function be instituted. She was not a candidate for insight therapy.

The Differing Roles of Clinician and Independent (Forensic) Evaluator

There are two types of evaluations to be considered, *forensic* and *clinical*. (Schouten, 1993, 1998; Strasburger, et. al., 1997) These two types of evaluations have separate goals, and whenever possible should be conducted by separate psychiatrists, although this may sometimes be difficult to achieve in actual practice. A clinical evaluation is undertaken to formulate an effective treatment plan, and is properly undertaken by the treating psychiatrist. A forensic evaluation addresses the issues that must be considered in order to render an opinion with regard to causality. Although there is overlap between the two types of evaluations, there is a difference in emphasis, and indeed there are core conflicts between the two roles.

Role Distinctions

- Clinician--Duty to determine the "truth"
- Clinician--Duty to patient to "cure"
- Forensic--Does not advocate for patient
- Clinician--Patient "advocate"
- Forensic--Uses collateral information to determine objective reality
- Clinician--Psychological reality for patient is of primary importance
- Forensic--Provides reports to third parties as essential role
- Clinician--Reporting to third parties may undermine therapy relationship
- Forensic--Empathy to examinee not material
- Clinician--Empathy for patient essential
- Forensic--Evaluation explicitly not confidential; report provided to third party
- Clinician--Confidentiality primary duty to patient to allow effective treatment

At the heart of this conflict is the fundamental notion that the clinician and the independent evaluator serve different masters. The clinician has a fiduciary duty to act only in the best interest of the patient. While "best interest" is open to interpretation, many clinicians take the view that they are obligated to be advocates for the patient's preferences. Thus, if the patient is distressed and unhappy at work, the clinician should assist him in staying out of work until the causes of the distress have been addressed

and corrected. The independent evaluator has an obligation to provide an objective, scientifically based opinion.

Another major difference between the clinician and the independent evaluator is the information used. Under the traditional psychotherapeutic model, the treating clinician attempts to see the world through the eyes of the patient; historical accuracy is less important than individual perception. As a result, the treating clinician may or may not review prior medical records. In addition, the treating clinician rarely looks to outside sources to corroborate the patient's story. Even contact with family members may be controversial. The independent evaluator, in search of an objective, accurate assessment, must evaluate the medical records as extensively and closely as possible. The independent evaluator will also evaluate other sources of information, including court records, reports of private investigators, and personnel records. None of these materials serve any purpose in the treatment of the patient, yet they can make a crucial difference in the assessment of disability. Finally, the treating clinician who fills out forms or gives testimony in a manner contrary to what the patient sees as being in his or her interest, may find that the treatment relationship is destroyed.

It is prudent for clinicians to resist both the external pressures emanating from the attorney or patient or both and the internal pressures from the therapist's felt allegiance to the patient. The legal process is directed toward the resolution of disputes; psychotherapy pursues the medical goal of healing. Although these purposes need not always be antithetical and may even be congruent, the processes themselves typically create an irreconcilable role conflict. In essence, treatment in psychotherapy is brought about through an empathic relationship that has no place in, and is unlikely to survive the questioning and public reporting of a forensic evaluation. (Strasburger, et al, 1997) Institutional policies often force treating psychiatrists to function in both roles in disability determinations, as for example by requiring either concurrence or non-concurrence with Independent Medical Evaluations (IMEs). Even court testimony is frequently required in administrative law hearings when disputes arise, and by law the testimony of the treating psychiatrist is given more weight than that of the forensic evaluator, on the grounds that the treating psychiatrist is more knowledgeable about the patient. When the treating psychiatrist must participate in the disability evaluation process, the following principles should be kept in mind:

1. Obtain and document informed consent from the patient to disclose information provided during the course of the treatment.
2. Have a clear understanding of the job duties.
3. Be honest about the limitations on the sources of information used.

Example: The following example illustrates fairly common difficulties encountered when the treating clinician fulfills the role of independent evaluator. Ms. A is a 45 year old married mother of two who presented to an emergency room with complaints of acute confusion and memory loss. She was employed as a floor supervisor in a manufacturing company, Widget, Inc., where she had worked for the last 18 years. The owners of Widget took good care of Ms. A, paying her even when she was out of work for several months with Graves' Disease. All was well at work until new owners bought into the business and brought along new managers. Several new production engineers, all college educated, came to Widget to manage operations. One of them took over a number of Ms. A's duties. Ms. A, who had only a high school diploma, felt inferior and began hating work. She began having trouble concentrating and made a

number of uncharacteristic calculation errors that caused significant waste. Her boss, who had been a father figure to her since she joined Widget, criticized her mercilessly over these mistakes. The engineers began double-checking her calculations and work. Two months later, she presented to the emergency room.

Ms. A was referred for extensive neurological and neuropsychiatric evaluations; no abnormalities were found. She continued to complain of severe memory disturbance, including not recognizing her own home when she awakened in the morning. She continued to drive, against the instructions of her physicians, and had a number of serious near misses and several minor accidents. Ms. A was adamant that she was suffering from a major medical illness as the cause of her memory problems. She was originally sure that she had a brain tumor, but when that was ruled out, she and her husband expressed their beliefs that this was all a side effect of her radioactive iodine treatment some years before. They were both dismayed, and angry, when Ms. A was referred to a psychiatrist, Dr. C, for further evaluation and treatment.

Ms. A presented to Dr. C with classic neurovegetative signs and symptoms of depression, and possessed no insight into her situation. She acknowledged being depressed, but attributed it to her memory problems and frustration at being out of work. Her anhedonia and other symptoms were prominent, but she attributed them to her "thyroid problem." She reluctantly agreed to take antidepressant medication and begin psychotherapy. Dr. C had no reservations about signing the form necessary for Ms. A to begin receiving short term disability benefits, which provided her with 75% of her former income, tax-free.

Six months after beginning treatment with Dr. C, Ms. A brought in a form for long-term disability. Dr. C reviewed the form with her, asking specific questions about each of the categories of activities and her limitations. Eligibility for disability payments was predicated upon her inability to perform duties of her former position. Ms. A insisted that she could not possibly go back to work because of all of her symptoms. She asked Dr. C to indicate that she was suffering from a thyroid disorder and became angry when Dr. C entered a diagnosis of Major Depression and Anxiety Disorder NOS. Dr. C did sign the disability form, however.

After one year of treatment, Ms. A's mood and overall level of function had improved significantly. Dr. C had signed disability forms periodically at Ms. A's request, largely because Ms. A insisted that she could remember nothing about her old job duties. She also maintained that she would be a safety hazard at work due to her forgetfulness with everyday activities and anxiety. When Dr. C urged her to take a job with lower wages, Ms. A refused, saying that she wasn't going back to work until she could earn what she had previously. Ms. A's depressive symptoms had resolved, but her anxiety symptoms persisted. These symptoms, which contained elements of Panic Disorder and Social Phobia, were exacerbated under stressful conditions, such as work.

During the second year of treatment, Ms. A attempted to work part-time at a job largely unrelated to her previous job. She obtained the job through a family member, and she was paid "under the table" so there was no impact on her disability payments. Ms. A periodically reported errors that she made at work, some of which resulted in minor injuries. Several months after she had started this job Ms. A brought in another disability form for Dr. C to sign. This time, however, the form asked whether Ms. A was substantially disabled from performing any work for which she was reasonably suited. Dr. C reviewed the form with Ms. A and indicated that while she was able to perform some work she remained at risk of injury. Ms. A began spreading out her therapy appointments, eventually to once a month. Eventually, she obtained a job similar to what she had had at Widget.

The Role of the Treating Psychiatrist

The role of the treating psychiatrist is to do exactly that: treat the patient. Dr. C's challenge was to break the self-sustaining cycle of Ms. A's depression, anxiety, objective impairment, and perceived disability. The difficulties of this task were compounded when the issue of long-term disability was introduced. While Dr. C explored each of the specific elements of the disability form with Ms. A, as her treating psychiatrist he was limited to Ms. A as his primary source of information. She made clear her view that she was not fit to return to work, and she had no desire to do so. As her treating clinician, Dr. C felt that Ms. A would be better served by returning to work as soon as possible. On the other hand, he knew that he could not force her to return to work, and he was aware of her tendency to become symptomatic under stress. As in the majority of cases, the patient would be the final arbiter of whether or not she could or would return to work. At most, the clinician can treat the symptoms, support and encourage the patient, and provide guidance.

Dr. C found himself in a more conflicted position when Ms. A began working "under the table." On the one hand, she had followed Dr. C's advice to get back to work as soon as possible. Yet, she was doing so illegally and asking Dr. C to endorse her as still being disabled. She continued to tell Dr. C of accidents and near accidents at work, so that Dr. C felt comfortable indicating that she was at risk of injury if she returned to her previous work with complicated machinery. Dr. C continued to feel uncomfortable with Ms. A's status, wondering whether her disability was now sustained entirely by the secondary gain of avoiding conflict at work and her substantial disability benefits. It was a combination of factors that eventually got Ms. A back to work: successful treatment of her depression and anxiety, as well as expiration of her long-term disability benefits, appear to have been especially important factors.

An independent evaluator called in to assess Ms. A's disability would have approached the situation quite differently. The independent evaluator would have reviewed all available medical records as well as collateral sources of information. These collateral sources could include conversations with co-workers and supervisors of Ms. A and surveillance materials. In some cases, surveillance materials gathered by insurance companies show the claimant engaged in activities inconsistent with the claimed disability. Finally, the independent evaluator would likely conduct a clinical evaluation involving several hours of clinical interview as well as a full psychological testing battery. Thus, the independent evaluation uses broader, more detailed, and more objective sources of information in preparation of an assessment of disability. Such information is simply not available to treating clinicians under normal conditions. The independent evaluation is not a panacea from the clinical standpoint, however. Independent examiners may face subtle pressures to issue opinions deemed to be favorable to the insurance company in an effort to secure repeat assignments, and may in their own way be subject to bias. An independent evaluation concluding that secondary primary gain is was the primary motivation for disability might result in a premature termination of benefits, a return to work, and subsequent further injury or illness. A comprehensive evaluation can help avoid such a negative outcome, however.

IV. The Disability Evaluation

Psychiatric Disability Evaluation Outline:

A. General considerations

1. Reasons for a disability evaluation
 - a) Employer request
 - b) Insurance company request
 - (1) Private disability coverage
 - (2) Second opinions re: treatment
 - c) Physician request for psychiatric assessment as adjunct to general medical care – treatment rather than causality issues central (e.g. orthopedist requests psychiatric consultation for depressed patient)
2. Role and boundary issues
 - a) Confidentiality is waived
 - (1) This is made explicit to the examinee, who is advised to whom the report will be provided
 - (2) The examinee is advised that examination does not constitute nor is a substitute for medical treatment
 - b) Role of the independent psychiatrist evaluator
 - (1) No follow-up treatment responsibility
 - (2) Potential adversarial relationship to patient
 - c) Role of the treating psychiatrist
 - (1) Follow-up reports are often required by statute or insurance carrier, so patient must be informed
 - (2) Some confidentiality limitations: make explicit to patient
 - (a) Information usually confined to diagnoses, medications, and general impression regarding progress in treatment or lack thereof.
 - (b) Advise patient that second or independent opinions may be requested in ambiguous situations.
3. Consequences of psychiatric disability for the patient
 - a) Suffering from a psychiatric condition: both psychiatric symptoms (e.g. depression, anxiety, panic, pain symptoms, phobias, etc.) and damage to self-concept
 - b) Work life and love life similar/equivalent in importance for individual fulfillment
 - c) Consequences of loss of work role
 - (1) Devaluation within the family
 - (2) Loss of community prestige
 - (3) Economic loss, insecurity
 - (4) Loss of sublimations for the expression of aggression

B. The psychiatric evaluation procedure

1. History
 - a) Medical and collateral record review
 - b) Reason for the evaluation
 - c) Presenting problem in patient's own words
 - d) History of the presenting problem
 - (1) New or recurrent problem?
 - (2) Static or changing?
 - (3) Impact on home and work functioning?
2. Social history
 - a) Family's socio-economic status

- b) Role of work in family life
- 3. Educational history
 - a) Detail elementary, middle, and high school
 - b) Strong and weak subject areas
 - c) Relationship with teachers
 - d) High school drop outs at increased risk
- 4. Employment history
 - a) Job types
 - b) Performance level
 - c) Length of employment
 - d) Reasons for prior changes in employment
 - e) Job satisfaction at the time of injury
- 5. Current income sources: impact of illness
 - a) Evaluate for primary gain in maintaining disability if receiving benefits
 - b) If no benefits, motivation to forgo treatment and return to work prematurely, inviting further injury
- 6. Past medical history
- 7. Current medical problems and names of physicians
- 8. Medications
- 9. Substance use/abuse history
- 10. Legal problems
- 11. Past personal psychiatric history
 - a) Hospitalizations: Complaint, dates, hospital, duration, outcome
 - b) Outpatient history: Complaint, dates, treating professional, duration, and outcome
- 12. Family psychiatric history
 - a) Suicide attempts
 - b) Depression
 - c) Anxiety Disorder
 - d) Alcohol and substance abuse
- 13. Developmental history
 - a) Family structure
 - (1) Parents together or divorced; stepparents
 - (2) Nature of patient-parent relationship
 - (3) Birth order; relationships with siblings
 - (4) Neglect or abuse history; duration and severity
 - b) Work role models: Parent work history
 - c) Age when patient began work: Premature responsibility increases disability risk
 - d) Illness history in family or patient
 - e) Relationship with authority figures
 - f) Peer relationships: Best friend?
 - g) School experiences
 - (1) Academic performance level through grades
 - (2) Last grade completed
 - (3) Strong and weak subject areas
 - h) Dating experiences; marital history
- 14. The "typical day"
 - a) Narrative description of how the day is spent
 - b) Time of arising; napping; time of retiring

- c) Activities of daily living: who performs, changes since illness onset
 - (1) Bill paying
 - (2) Meal preparation
 - (3) Laundry
 - (4) Housecleaning
- 15. Mental status examination
 - a) Appearance and behavior
 - b) Mood and affect
 - c) Speech and thought content
 - d) Preoccupations, suicidal or homicidal ideation
 - e) Cognitive functioning: orientation, fund of knowledge, memory testing, abstract thinking, judgment, insight
- 16. Psychological testing
 - a) MMPI-2, MCMI-3, Rorschach, TAT
 - b) When should testing be requested?
 - (1) To clarify ambiguous or complex diagnoses
 - (2) To compare with previous test results
 - (3) To assess for neuropsychological impairment
 - (4) To help resolve diagnostic disagreements between clinicians
 - (5) To assess for malingering
- 17. Summary and discussion
 - a) Logically synthesize all information obtained
 - (1) Present explanation of symptom/illness development
 - (2) Developmental psychodynamic factors which may be re-enacted
 - (3) Neurobiological and genetic factors
 - (4) Environmental factors
 - b) Temporal relationship between events and illness; degree and duration of impairment; use of appropriate rating systems
- 18. Multi-axial DSM IV diagnoses
 - a) Current standard for psychiatric diagnosis
 - b) Utilize 5 axis format for listing diagnoses, important psychosocial and environmental problems, and GAF
 - (1) Valuable as a means of measuring change over time between evaluations
 - (2) Changes in degree of disability

Discussion:

The psychiatric disability evaluation is conducted in a context that sets it apart from routine treatment evaluations. The evaluating psychiatrist does not owe the same duty to the patient as a treating psychiatrist. Different situations in which a psychiatric evaluation might be requested were outlined earlier in the chapter. It is important that confidentiality limitations and roles be clearly explained to the patient before undertaking the evaluation. Without such information it is impossible for the patient to give informed consent to the evaluation process. (Grant and Robbins, 1993)

When the evaluation is being conducted at the request of a third party, the patient is told that there will be no follow-up treatment relationship with the examining psychiatrist, who may find himself in an adversarial role *vis a vis* the patient. If the evaluation is for treatment purposes (as might be the case when a treating physician refers the patient for evaluation), the patient and psychiatrist may choose to enter into a treatment

relationship. The patient should be allowed to choose from other treatment providers as well, however. This is of particular importance in disability treatment situations since there is often an adversarial quality to the claims administration process, and for therapy to be effective the patient must have trust and confidence in the treating psychiatrist. In workers' compensation treatment settings, regular reports to the administrative agency are required, and the patient should be informed that the confidentiality is limited. Sensitive material not necessary to the administration of the claim should be excluded from reports that should primarily document diagnoses; treatment modalities employed, and progress in treatment. It is a good practice to advise the patient that the patient, the treating psychiatrist, or the administrative entity, may request second or independent opinions.

After determining who is requesting the evaluation, the clinician should perform a review of available records. Much of the evaluation process is identical to a standard psychiatric evaluation. Only aspects particular to a disability evaluation will be discussed in this article.

Ask how the patient experienced the development of impairment and resulting disability. Define whether it is a new or recurrent problem, and whether it is static or changing. What is the impact on home and work functioning? What are the economic consequences of the disability?

The role of work in the family's life is important as it relates to the nature of the work ethic that has been formed. An early forced entry into the labor market often results in an early burnout. Such individuals may have developmental histories marked by deprivation, neglect, and abuse that exert a major influence on their response to injury. School adjustment and performance correlate positively with recovery from injury and return to work. High school dropouts fare poorly in comparison with college graduates. Strong and weak academic subject areas should be defined.

Employment history includes jobs held and their sequence, performance level, and satisfaction. Gaps in employment may reflect commitment to work, level of job skills, flexibility and adaptability. Reasons for changes in employment should be described, and patterns identified.

Example: Ted had worked as a forklift driver for a distributor for the last 17 years. His employer indicated that he had been a good employee, and that the company would modify the forklift controls so that he could operate it with his uninjured hand.

Example: Henry provided a history of frequent job changes. Most of his jobs lasted for only a few months. He was vague about the reasons for job changes. The typical gap in employment was about 6 months, during which period he would collect unemployment.

The economic consequences of disability are described in the evaluation; typically they include loss of income, but occasionally may yield income close to that earned while working, as in the case of Ms. A. In a situation where the work was particularly high stress, this may be experienced as a good trade, and constitutes primary gain. Secondary gain is unconscious in its nature. It occurs when assuming the sick role

gratifies dependency needs unmet in earlier development. However, in lower socioeconomic class families, the loss of role status both within the family and the community can be extremely adverse to the individual, who is treated as a freeloader—someone little better than a welfare cheat.

“I feel like I can't be around anybody—nobody wants to talk to me. I avoid people; I don't go out of my house. My father in law asked me when I was going to go back to work.”

Litigation, or retention of an attorney, is frequently cited as contributing to chronic disability. This belief has not been borne out by prospective studies, however. (Dworkin, et.al., 1985; Modlin, 1986) What indisputably contributes to morbidity and chronicity is denial or delay of appropriate treatment. Correctable conditions worsen, with both physical and psychological negative consequences. (Gallagher, 1996) Since substance abuse correlates nearly 100% with negative treatment outcomes, it is particularly important to explore this area thoroughly, both with the patient directly and by collateral record review. A prior arrests history for minor offenses, although not favorable, is less prognostically negative than active substance abuse. When substance abuse is present, concurrent treatment for this comorbid condition is a requirement. Regular compliance reports should be requested from the facility providing such care. A dual diagnosis treatment orientation is essential, as pharmacotherapy is usually required for such individuals.

The patient's family psychiatric history and past personal psychiatric history are explored in a standard manner. Severe character pathology is significantly correlated with protracted if not negative treatment outcomes. Patients with bipolar disorders and histories of psychoses confront more obstacles to recovery. Depressive disorders with psychotic features are more common than generally appreciated. (Dubovsky and Thomas, 1992)

Example: A 53-year-old nurse's aid fell and injured her back and shoulder while transferring a patient. She was tearful and nearly mute when she first presented for treatment. After 9 months of aggressive pharmacotherapy and psychotherapy she admitted that she was having command hallucinations that were telling her to commit suicide. She had been too embarrassed and ashamed to admit to these symptoms when first evaluated. The addition of antipsychotic medication produced some immediate improvement.

The patient's developmental history provides the major clues to character formation, and the ease or difficulty of coping with later adversity can be predicted by these influences. Abused and neglected children are likely to become maladjusted, brittle, and angry adults. Depression, substance abuse, panic disorder, and pain disorders find fertile ground in this population. Premature work responsibility interferes with the developmental tasks of childhood, and the price is paid later. For women, an excessive caretaking responsibility for younger siblings while still a small child themselves is as destructive as being sent into the fields at 7 or 8, and contaminates and shapes attitudes towards work in adult life.

Sexual or physical abuse trauma resonates with difficult work situations encountered as an adult, and renders appropriate responses to workplace conflict more difficult, as well as complicating relationships with health care givers and other authority figures. (Johnson, et al 1994) ,and Indvik, J: The impact of unresolved trauma on career management. International Journal of Career Management, 1994;6(2):12-18)

The details of family structure are set forth, and standard psychiatric concepts are employed in their incorporation into the final impression.

Example: Peter was 41 and married for 14 years when he slipped and injured his back after working as a foreman in a manufacturing concern for 8 years. His only prior employment was in a similar capacity, and was of 7 years duration. When he failed to recover and return to work quickly as he had expected, he began to become depressed and paranoid. He blamed his former employer for spreading “rumors” about him within the community, and began to drive by the plant with a gun. He actively fantasized about “going in with the gun blazing” to exact revenge. He experienced command hallucinations telling him to “get even.” Panic disorder symptoms developed. Inquiry regarding his developmental history revealed 7 alcoholic physically abusive stepfathers, and a mother that ignored him and his 5 siblings. He recalled frequent beatings with wood two by fours. He left home at 16 and joined the Navy. He remembered always being angry during those years, although he earned an honorable discharge and was never the subject of disciplinary proceedings. He remembered making a conscious decision at the time of his marriage to “set my anger aside and not think of it.” He worked 12-18 hours a day for his employers, burying himself in his work, and deriving a sense of self worth from being productive. He admitted to being distant from his family because of his long work hours. He complained of feeling “betrayed” by his employer, even though there was no evidence to support that contention. Group therapy, individual therapy, and aggressive pharmacotherapy produced gradual improvement over several years.

A specific description of a patient’s “typical day” is valuable because it is specific, and represents actual behavior on which to base clinical conclusions. Bill paying, meal preparation, laundry, housecleaning, and social interaction patterns on a day to day basis yield important clues as to the patient’s current level of functioning, as well as regression that may have occurred. Sleep patterns, particularly including naps, may indicate avoidance and withdrawal.

When questions arise regarding complex or ambiguous diagnoses psychological testing should be considered. This is often useful when organic brain impairment is suspected. It may also establish a baseline that will permit comparison with later findings, when assessing response to treatment. Diagnostic disagreements between clinicians can sometimes be resolved by reference to such testing.

The summary and discussion should be a biography from a psychiatric perspective—one that tells the story of the individual from a work perspective, drawing upon their developmental history, neurobiological and genetic factors, environmental factors, and current life circumstances. The time sequence of events often provides further insight into the patient’s condition. The function, meaning, and role of the current disability should be explored. Treatment recommendations are based on current psychiatric knowledge, taking all known factors into consideration.

DSM IV diagnoses are to be included, as part of the standard format, but their limitations should be borne in mind.

Treatment recommendations are based on the integrated assessment of the patient, one that takes into account both Axis I and Axis II conditions. Personality trait disturbances or full disorders are present in a majority of affected patient in some sub-populations, and require sophisticated clinical skills. (Azima, 1993; Oldham, 1995) The importance of chronic and acute pain on psychological functioning should not be overlooked. One series of patients referred to a pain clinic found 67% of chronic pain patients had

undiagnosed medical conditions that were responsible for some or all of their complaints. (Hendler and Kozikowski, 1993) Every effort should be made to assure that these and other potentially undiagnosed medical conditions are receiving necessary attention from appropriate specialists.

Effective treatment may include group, individual, and marital psychotherapy, along with appropriate pharmacotherapy. (Williams, 1997) The treatment plan must take all conditions into account, and the clinician's awareness of comorbid disorders is critical to successful outcomes. (Oldham, et. al., 1995) Patients with personality disorders require particular skills, and the treatment of this group requires substantially longer treatment than solitary Axis 1 disorders. A bio-psychosocial treatment approach will yield the best results.

V. Special Problems in Disability Evaluations

Malingering

Questions of disability provide fertile ground for concerns that the claim of disability is the result of malingering. While many insurers and evaluators focus on the detection of malingering, research data shows that the incidence of malingering is less than anticipated. (Minnesota Department of Labor and Industries, 1995) Nevertheless, the possibility of malingering should be considered and evidence for its presence or absence noted in the record.

Neurological disabilities are subject to malingering. False or exaggerated claims of memory disturbance, or confusion, can be difficult to detect. The evaluator must be careful to distinguish between those symptoms that are malingered and those arising from undetected illness or psychiatric disorders such as depression, anxiety, and somatoform disorders. Psychiatric disorders are also the subject of malingering efforts, largely because so much of psychiatric diagnosis is based on self reported symptoms. It is sufficient to note that malingering must be considered in every disability evaluation. The evaluator who does not address the issue, as part of the evaluation is likely to find the evaluation challenged at some point. The treating clinician can aid his or her patient by making an objective determination as to whether or not the patient's claims are exaggerated. Such a determination, with documentation, can ease the patient's path to deserved insurance coverage.

A detailed discussion of techniques for the detection of malingering is outside the scope of this chapter. There are several excellent texts on this subject (Forensic Deception Analysis; Rogers: Clinical Diagnosis of Malingering and Deception) The authors make extensive use of psychological testing, conducted by qualified psychologists, to assist in diagnosis, assessment of cognitive functioning, and evaluation of possible malingering. The Minnesota Multiphasic Personality Inventory Second Edition, the Rorschach Inkblot Test, and the Structured Interview of Reported Symptoms are all useful in this regard. Disabled by Disease or by Lack of Motivation? The Secondary Gain Question Disability evaluations often present difficult problems reminiscent of the time honored question: "Which came first, the chicken or the egg?" The following is a typical example of situations in which these problems can arise.

Example:

Mr. B, a well-known attorney in his community, was brought before the Board of Bar Overseers in his state on charges that he had embezzled funds from his clients' accounts. His license to practice was suspended immediately. Mr. B was devastated by these charges, developed symptoms of a limited depression, and filed a disability claim on the basis that he was no longer able to practice law because of his depression. His insurer initially granted limited benefits, but then suspended benefits after Mr. B lost his license, pending an independent evaluation. The insurer argued that Mr. B's inability to practice was not the result of depression, but the consequence of his having violated the Code of Professional Responsibility. Any depression he experienced, the insurer argued, was secondary to his own misdeeds.

The challenge of these evaluations is to focus on the individual's ability to function in a certain job. Whether or not the individual being evaluated is allowed by the relevant licensing authority to engage in the previous occupation is largely irrelevant. The authors have evaluated cases such as this involving lawyers, physicians, and financial services professionals.

Even in the absence of a governmental prohibition against working in a specific field, individuals may find the desire to work waning as their industries undergo major change. This concern is heightened when economic downturns or changes in certain industries make work in those areas undesirable. Such changes may lead to feelings of sadness and other symptoms suggestive of depression. With a diagnosis of depression from a supportive clinician, the individual may be successful in obtaining disability benefits. Thus, the evaluator is left with this question: Is the claimant disabled from working because of depression, or is he depressed because he no longer likes the job? As with the disbarred lawyer, the question is whether the individual could perform the job if he chose to do so.

Disability and the Americans with Disabilities Act

Individuals with disabilities are protected against discrimination by the Americans with Disabilities Act and similar state statutes. (Langer, 1996) Those same individuals may require disability insurance benefits to cover living expenses during periods when they cannot work. Some individuals have filed suit alleging disability-based discrimination by their employers, while at the same time filing claims for disability benefits. The courts have differed as to whether both claims can be made simultaneously. Some have rejected such claims, cf. *Cleveland v. Policy Management Systems Corp.*, 120 F. 3d 513, (5th Circuit 1997). Others, noting that claims for disability benefits do not involve the question of reasonable accommodations, allow both claims, C.f. *Swanks v. Washington Metropolitan Transit Authority*, 116 F. 3d 382 (D.C. Circuit, 1997) They noted that the heart of the anti-discrimination claim is that an individual with a disability is able to perform the essential functions of the job, with or without some accommodation, but is being subjected to disparate treatment because of the disability. The disability insurance claim, however, is based on the fact that the individual is disabled and unable to perform the essential functions of the job. The two claims, by the same individual during the same time period, are mutually exclusive. One cannot claim that one is entitled to benefits due to an inability to work and then claim that one is able to work for the purpose of the discrimination claim.

Discrimination against those with mental and physical disabilities is a real phenomenon. The bias may be overt or subtle, it may be based on actual experience or, more commonly, on stereotypes. Clinicians treating those with mental and physical disabilities can make a major contribution to getting their patients back to work and helping them overcome the bias. They can do so by conducting objective evaluations of the patient's

specific abilities to function in different settings, and by being willing to cooperate with the employer's request for information. Such cooperation and sharing of information must only occur with the patient's permission, of course. The treating clinician should be clear with those requesting the information that the evaluation is not an independent evaluation, and that it is based on more limited information.

While treating clinicians can serve as the patient's advocate in getting back to work, they can also put their patient and the patient's co-workers at risk. It is essential that any clinician that opines that a patient is able to return to work after a period of disability has a clear sense of the nature and responsibilities of the job, as well as his clinical condition. (Maffeo, 1990) For example, one treating social worker opined that his patient, a research chemist who conducted high pressure liquid chromatography with hazardous materials, was no longer disabled by her depression and was fit to return to work. Upon inquiry by an independent evaluator, the social worker indicated that he had no idea of the duties and the potential dangers. In a similar case, a treating psychiatrist argued that his psychotic patient could return to her job in government, in spite of her active paranoia and lack of compliance with medication, because he felt that no one could force her to take the medication.

VI. Conclusion

The evaluation and treatment of individuals with work-related disabilities provide a number of challenges to those clinicians that undertake these tasks. The importance of work to individual and societal well-being, the moral valence we attach to it, and the diverse motivations for entering and leaving the workforce all combine to make this an emotionally charged area with many clinical challenges. As in all clinical matters, the clinician and patient are best served when the clinician is honest with him or her self and the patient about the limitations on knowledge and ability and the constraints these limits impose. Attention to detail, understanding of the task involved and the techniques for completing it, and a willingness to resist the multiple elements of bias in the disability process are likely to lead to a positive outcome.

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