

# Workers' Compensation and the Psychiatric IME

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# Types of Mental Stress Claims in WC

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- Physical injury leading to mental stress
- Mental Stress alone
- Mental Stress resulting in physical injury
- Unlike some states, MO WC does not require a physical injury to have a mental stress claim.

# Physical Injury Leading to Mental Stress (Type 1)

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- **Standard of Causation:** Was the work accident the prevailing factor in the development of the medical condition and disability?
- Example: An over-the-road truck driver is in a motor vehicle accident which causes the vehicle to roll over a guard rail and down an embankment. He suffers multiple fractures, and due to chronic pain, develops depression.

# Physical Injury Leading to Mental Stress (Type 2)

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- **Standard of Causation:** Was the work accident the prevailing factor in the development of the medical condition and disability?
- Example: An over-the-road truck driver is in a motor vehicle accident which causes the vehicle to roll over a guard rail and down an embankment. He suffers multiple fractures, and is now afraid to drive a truck.

# Mental Stress Alone (Accident)

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- **Standard of Causation for Mental Injury Resulting from an Accident:** Was the accident the prevailing factor in causing both the resulting medical condition and disability? *E.W. v. Kan. City Sch. Dist.*, 89 S.W.3d 527 (Mo. Ct. App. 2002)
- “The need to distinguish extraordinary mental stress from ordinary day-to-day stress is not applicable to a mental injury arising from a traumatic event, so it is understandable why the legislature did not require proof of extraordinary and unusual stress for compensation of a claim for mental injury resulting from a traumatic incident.” *E.W.* at 536.

# Mental Stress Alone (Occupational Disease)

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- **Standard of Causation for Occupational Disease:** Mental injury resulting from work-related stress does not arise out of and in the course of the employment, unless it is demonstrated that the stress is work related and was extraordinary and unusual. The amount of work stress shall be measured by objective standards and actual events. § 287.120.8.
- Until recently, the stress exposure had to be extraordinary and unusual compared to the occupation.

# Mental Stress Alone (Mistreatment)

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- A mental injury is not considered to arise out of and in the course of the employment if it resulted from any disciplinary action, work evaluation, job transfer, layoff, demotion, termination or any similar action taken in good faith by the employer. § 287.120.9.



# Mental Stress Leading to Physical Injury

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- Less common situation in WC and sometimes overlaps with civil actions for harassment, retaliatory discharge, discrimination, etc.
- **Standard of Causation:** Was the mental stress the prevailing factor in the development of the medical condition and disability?
- Example: The claimant works long hours with many deadlines to meet in a high pressure job as a surgeon, criminal lawyer, air traffic controller, claims rep, etc. and suffers a rash, heart attack, etc.



# The Psychiatric IME

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## **The Clinician**

- First, Do No Harm
- Beneficence
- Confidential
- May seek collateral sources of information to provide good care, but care not withheld if the sources are not available

## **Forensic Examination**

- Medical and psychiatric knowledge required to help answer a legal question
- Collateral sources of information are required
- Non-confidential
- Opinion may be harmful or at least not helpful

# Challenges for Forensic Psychiatry

## IME

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- Diagnostic challenges with manual-based syndromes
- Lack of full longitudinal history
- No laboratory or imaging findings
- Everyone thinks they are a psychiatrist

# First Steps

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- Define the question
- Records, records and more records!
- Engage the expert

# Experts

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- Psychiatrist
- Psychologist
- Neurologist
- Neuropsychologist
- Nurses
- Social Workers

# The Psychiatric IME-History

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- Personal History
- Education
- Work History
- Past Medical/Surgical History/Medication/  
Allergies/ROS
- Past Psychiatric/Substance Use History
- Legal History
- Family History

# The Psychiatric IME-Examination

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- General Appearance and Behavior
- Speech
- Psychomotor Activity
- Content of Thought
- Flow of Thought
- Mood/Affect
- Insight/Judgment
- Sensorium/Intellect



# Common Psychiatric Illnesses in Workers' Compensation

# Personality Disorders

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- Enduring pattern of inner experience and behavior that deviates from one's culture and manifests cognition, affect, interpersonal function and impulse control
- Pattern is inflexible and pervasive across a broad range of personal and social situations
- Pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of function

## Antisocial Personality Disorder

- Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- Deceitfulness, repeated lying, use of aliases or conning others for personal profit or pleasure
- Impulsivity or failure to plan ahead
- Irritability and aggressiveness, as indicated by repeated physical fights or assaults
- Reckless disregard for the safety of self or others
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations

## Borderline Personality Disorder

- Pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Identity disturbance: markedly and persistently unstable self-image or sense of self
- Impulsivity in at least 2 areas that are potentially self-damaging (spending, sex, substance abuse, reckless driving, binge eating)
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- Affective instability due to a marked reactivity of mood
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger
- Transient stress-related paranoid ideation or severe dissociative symptoms

# Posttraumatic Stress Disorder

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A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

# Posttraumatic Stress Disorder

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B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

Note: in children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

Note: In children, there may be frightening dreams without recognizable content.

3. Dissociate reactions (flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring

Note: In children, trauma specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

# Posttraumatic Stress Disorder

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C. Persistent avoidance of stimuli associated with the traumatic events(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic events(s).

# Posttraumatic Stress Disorder

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D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, of the world.
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state.
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions.

# Posttraumatic Stress Disorder

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E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance.



# Other Anxiety Disorders

# Panic Disorder

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- Panic Attacks-4 of the following:
  - Palpitations, sweating, shaking, short of breath, choking, chest pain, nausea, dizzy, chills or hot, numbness, derealization/depersonalization, losing control, fear of dying)
- One month or more of worry about having attacks/ change in behavior
- Isolated panic attacks can be seen in other disorders

# Generalized Anxiety Disorder

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- Excessive anxiety/worry more days than not for over 6 months
- Difficult to control worry
- At least 3 of the following:
  - Restless
  - Easily fatigued
  - Difficulty concentrating/mind blank
  - Irritable
  - Muscle tension
  - Sleep disturbance

# Somatic Symptom Disorder

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- A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.

## Significant

Consulted health care professional

Required work up or treatment

Symptoms interfered with life or activities

# Somatic Symptom Disorder

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Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:

1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns

# Major Depressive Disorder

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- Five or more of the following present during a two week period, representing a change from previous functioning.
  1. Depressed mood most of the day, nearly every day
  2. Markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day
  3. Significant weight loss or weight gain
  4. Insomnia or hypersomnia

# Major Depressive Disorder

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5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive or inappropriate guilt
8. Diminished concentration or indecisiveness
9. Recurrent thoughts of death or suicidal ideation or plan

Symptoms must cause clinically significant distress or impairment.



# Psychiatric “Testing”

# MMPI-2

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- Minnesota Multiphasic Personality Inventory
- 10 clinical/personality scales
- 4 validity scales
- Can only be given by a psychologist trained to administer
- Best for correlation with clinical interview, possibly suspicion for exaggeration

# Neuropsychological Testing

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- IQ
- Attention, memory, comprehension, processing speed, etc.
- Best for suspected intellectual disabilities or brain injuries

# Other Measures

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- Hamilton Depression Rating Scale
- Hamilton Anxiety Rating Scale
- Montgomery-Asberg Depression Rating Scale
- Y-BOCS
- PCL5: Posttraumatic Check List

# Opinion

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- Psychiatric illness
- Work injury as prevailing factor
- Contributing factors?
- Treatment if necessary
- Maximum Medical Improvement
- Disability

# Treatment Recommendations & Long Term Prognosis

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- What treatment currently receiving? Meds, Psychotherapy, Specialized treatments.
- Is it working? Why not?
- How often?
- How long will be needed?
- What happens if not received?

## ■ Prognosis

Based on duration and severity of symptoms, response to treatment, compliance with treatment recommendations



## *Bowman v. Central Missouri Aviation, Inc.*, 497 S.W.3d 312 (Mo. App. W.D. 2016)

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- In 2007, the claimant was assaulted by a pilot after refusing to immediately do what he was asked. He suffered no physical injury from the incident, but indicated he felt scared, confused, and helpless. The claimant sought psychological treatment after a request from the employer was denied. The claimant was previously involved in a robbery/kidnapping incident in 2003, which resulted in the development of PTSD.
- The Commission denied his claim for psychiatric disability, affirming the ALJ's conclusion that the claimant did not establish a compensable psychiatric injury as a result of the incident.

# *Bowman v. Central Missouri Aviation, Inc.*, 497 S.W.3d 312 (Mo. App. W.D. 2016) [2]

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- The Commission noted their analysis did not turn on the simple either/or question of whether the 2003 or 2007 event caused the claimant to suffer the medical diagnosis of PTSD because it is possible for the claimant to have suffered psychiatric injury from both events.
- The Commission differentiated between "medical condition" and "medical diagnosis," noting the two terms are not necessarily synonymous.
- The Commission added that once an employee has met his burden of proving an accident was the prevailing factor causing a resulting medical condition and disability, evidence of a preexisting condition of ill-being and/or disability may be relevant to the issue of SIF liability, and/or the nature and extent of compensable disability, but does not defeat the claim. To the contrary, it is well-settled in Missouri that where a work accident is the prevailing factor causing aggravation or exacerbation of a preexisting disabling condition, the resulting aggravation is compensable; this is true even following the 2005 amendments.

# Pre-existing Mental Conditions

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- Have to determine whether there were prior diagnoses, treatments, and recovery from mental health conditions.
- Relevant to know the claimant's functional capabilities prior to the work injury.

# *Mantia v. MODoT*, 2016 WL 3269890 (Mo. App. E.D. 2016)

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- The claimant experienced horrific things while working for the Missouri Department of Transportation.
- The ALJ denied the psych claim because she did not present evidence of similarly situation employees as required under the old law.
- The Commission reversed, noting strict construction requires the Court to use objective standards in determining whether a claimant's work-related stress was extraordinary and unusual.
- The Court of Appeals affirmed the Commission, setting the precedent that the extraordinary and unusual standard is to be viewed in comparison to other employees, in general, not other employees in the same employment as the claimant.

# Implications of *Mantia*?

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- It can probably be presumed that, over time, there will be an influx of psychiatric claims stemming from generally stressful occupations
- Doctors?
- Nurses?
- EMTs?
- Claims Representatives?
- Judges?

## *Charles Jinkerson* (Inj. No. 11-008697, Mo. Lab. Ind. Rel. Comm., May 1, 2017)

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- Dr. Bassett (the claimant's psychiatric expert) opined the accident was the prevailing factor causing employee to suffer a recurrent depressive episode that manifested thereafter.
- Dr. Pribor (the employer's psychiatric expert) opined in her report that the accident was the prevailing factor “in the *initiation* of the exacerbation of the particular major depressive episode in [employee], but it is not the prevailing factor in the overall episode and persistence of his clinical depression.”

## *Charles Jinkerson* (Inj. No. 11-008697, Mo. Lab. Ind. Rel. Comm., May 1, 2017)

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- The Commission felt the accident caused employee to suffer the resulting medical condition of a recurrent depressive episode, with associated permanent disability. They agreed with the ALJ's award of 5% PPD BAW for the psychiatric condition.
- But what about future medical?

# *Charles Jinkerson* (Inj. No. 11-008697, Mo. Lab. Ind. Rel. Comm., May 1, 2017)

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- Dr. Bassett opined that the claimant needs ongoing treatment with antidepressant medication as a result of the accident.
- Dr. Pribor felt the claimant might benefit from ongoing psychiatric medications and therapy, but felt this need did not flow directly from the work injury, because the claimant suffered from preexisting bouts of recurrent major depression, and was more likely to need treatment as a result of this recurrent preexisting condition, rather than any psychiatric effect of the work injury.
- In rejecting Dr. Pribor's opinion, the Commission noted:
  - As the courts have made clear, ...“the question of whether or not [employee] may have needed future treatment even if the injury did not occur is irrelevant to the analysis of whether the future medical care flows from the injury that actually occurred.” *Stevens v. Citizens Mem'l Healthcare Found.*, 244 S.W.3d 234, 238 (Mo. Ct. App. 2008).