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The evolution of workers' compensation began in Germany in the 1880's as an attempt to arrest the spread of social discontent and to bolster a new national government. The fairness of the law caused most industrial-democratic nations to adopt similar laws. Initial coverage for physical injury progressed to include disorders which encompass the interaction between physical, psychological and neuropsychiatric illnesses. Clear precedents exist in state law for injuries where noxious mental stimuli produce a physical injury such as peptic ulcer disease or myocardial infarction, and where a physical injury is causally related to the onset of a psychiatric disorder such as depression. A third category of work related disorders also exists where a negative emotional antecedent induces a psychiatric disease. This third category of psychiatric work related illness has yet to gain universal acceptance or clear definition, although there has been a gradual realization by the courts of the causal relationship seen so frequently by mental health professionals.[1]

The Diagnostic Statistical Manual (DSM III) of the American Psychiatric Association has attempted to define the phenomenology of psychiatric disorders including post traumatic stress disorders. Frequently, the criteria of the DSM III is either ignored or stretched beyond plausible limits in order to label a number of complaints presented by the patient which do not comply with a recognized syndrome. This inability to encapsulate patient syndromes often reflects the complexity of human behavior and psychiatric illness. There is often a reluctance on the treating professional's part to see that the present conflicts are related to pre-existing or co-existing factors and are not directly related to the injury. Most people prefer to think in reductionalist terms. In dealing with all psychiatric work-related disorders, no matter what the cause, it is imperative that the therapist be aware of the following principles:

1. Is the traumatic event proximally related to the disorder?
2. Does the injury or stress constitute a substantial factor in causing the disorder or aggravating a pre-existing one?
3. Are there pre-existing and/or co-existing factors affecting the disorder?
4. What role does secondary gain play in continuing factitious complaints or malingering?
5. What is the patient's understanding of his entitlement?[2]

Given the aforementioned considerations as constraints on our thinking, an examination of the Stress Burn-Out Syndrome seems appropriate. Hans Selye, the author of *The Stress Of Life* and one of the original researchers on stress in the work place, described the stress syndrome during the early 1950's aptly characterizing the disorder as a "fight-flight" phenomenon where the organism under real or perceived threat responds in a predictable manner. The response has numerous biological models and is considered an adaptional resource for survival. It is not necessary to list the various stages of the response, but suffice it to say that the response becomes pathological when it occurs inappropriately or over a long period of time. The end stages of the disorder (exhaustion) appear as lethargy, depression or as various psychophysiological disorders. Selye and later thinkers felt the exhaustion phase was a period of conservation-withdrawal where the organism retreats in order that it may heal itself. The contemporary theories of psychophysiologic disease (peptic ulcer disease, asthma, colitis, migraine, dermatitis) and depressive disorders support the premise that prolonged stressful stimuli may in certain individuals produce either physical or psychiatric illness. The theories do not claim to be able to predict which persons will succumb to an illness or which form the illness will take. Some individuals will initially develop one set of symptoms during a period of stress and during a later period switch symptoms to another organ system.[3]

The causative factors of the classic stress disorders resemble a three-legged stool. Each leg if severely enough damaged can cause the stool to fall but most frequently the stool's collapse follows a series of repetitive challenges to the integrity of its structure. The three determining factors in human disease are: environmental, i.e., those events and surroundings either acute or chronic in the patient's life which affect his health; intrapsychic, i.e., those learned and preferred adaptive mechanisms used by the patient to help him control his internal milieu and interpersonal relationships; and constitutional, i.e., those genetic and/or congenital pre-dispositions to physical or psychiatric disease.[4] It is the role of psychiatrists to understand the integration of these causative factors in determining the genesis of psychiatric illness. Too frequently practitioners view their patients from only one perspective ignoring the role pre-existing or co-existing factors play in the disease. Treating professionals often err in fully assessing these factors. In forensic cases, for example, environmental determinates all too often become the sole causative agent. Compensation issues as well as the human need for simplistic answers make single factor understanding of illness popular. Patients and their therapists often lose sight of the complex interactions of human genetics, psychodynamics and experience in the formation of disease.[5]

To qualify for compensation, a work-related disorder must be accidental or occupational. In some states, such as Maryland, stress does not qualify as an unusual condition of employment and therefore, without a manifest physical injury, is not compensable. Many attorneys now assert that the consequences of stress may be an occupational disease. Occupational disease is an ailment or disorder which is expected under the working conditions and inherent in the employment. Typically, the course of the disease is slow and insidious.[6] The disease must be a natural result of the employment and not a consequence of extrinsic factors. For stress to qualify as a causative factor in an illness or syndrome the practitioner must isolate the stressful agent or agents and assess their environmental impact on the constitutional and intrapsychic constructs of the patient.

Loosely applying Selye's theory and accepting the notion of occupational disease, let us now look at the Stress Burn-Out Syndrome. The syndrome is a collection of

symptoms which include any number of the following:

1. Decision making becomes difficult;
2. Excessive day-dreaming or fantasizing about getting away from it all;
3. Increased use of cigarettes and/or alcohol;
4. Increased use of tranquilizers and stimulant drugs;
5. Thoughts trail off when speaking or writing;
6. Excessive worry about all things;
7. Sudden outbursts of temper and hostility;
8. Paranoid ideas and mistrust of friends and family;
9. Forgetfulness of appointments, deadlines, and dates;
10. Frequent spells of brooding and feelings of inadequacy;
11. Reversals in usual behavior.

There is insidious onset to this syndrome which may explode in violent behavior or lead to psychophysiological and psychiatric disease. Stress Burn-Out Syndrome may be a compensable disorder even if it does not progress to a clearly defined clinical illness. To qualify for benefits, the individual shows symptoms that cause him severe impairment at work.[7]

Paradoxically, most claimants of stress related disorders are not lawyers, physicians, or other high pressure professionals. The individual is usually in a low pay scale job, has limited job training, and no control of his working situation. Commonly, the complaints consist of perceptions of work overload, work underload, ambiguous job descriptions and repetitive tasks, nonreceptive management styles and excessive changes in daily routines. The effect of employee discontent is devastating to productivity and safety. Organized labor, among others, believes that a more humanitarian approach to employment would decrease stress and thus increase productivity and safety. Labor sees a predominant need for the employee to have control of his work environment. Labor would require: 1) a safe and healthful environment; 2) recognition of personal and family needs in scheduling work; 3) avenues for social interaction at work; 4) restructuring of work to allow workers to use their own initiative in decision making; 5) participatory management; and 6) a reduction in monotonous tasks. Not all workers would be able to take part in such a system due to lack of ability or interest. Also, the system would not answer the question of entitlement which motivates many employees to seek compensation.[8]

Entitlement issues complicate many compensation cases. Psychiatric office experience indicates that when the patient believes he has paid enough symbolic dues to his employer and that his injury should provide him with an annuity or a fantasized solution to his present difficulties, entitlement becomes a serious impediment to rehabilitation. Generally, the patient has worked for many years for his firm and is over 50 years old, although more dependent personalities and those with greater psychopathic tendencies seek to manipulate the compensation system earlier in their lives. Co-existing factors of spouse retirement, marital difficulty, chronic nonwork related disease, unrealistic legal counsel, previous compensation settlements, and job boredom influence the tenacity with which the patient clings to his right to be entitled. Work-related injuries legitimize the patient's unconscious desire to regress to a dependent mode.[9] Often the same patient who now claims disability protests that he was an independent, self-sufficient person who cared for himself and others. Whenever a patient without adequate anatomical or demonstrable psychiatric disease believes it is his time to become a recipient of compensation, entitlement must be considered as a primary motivation.

The vague criteria of the Stress Burn-Out Syndrome, which I previously discussed is quite different from the DSM III description of Post-Traumatic Stress Disorder, whose validity is questioned by some practitioners. The criteria for Post Traumatic Stress Disorder are as follows:

1. Existence of a recognizable stressor that would evoke symptoms of distress in almost everyone;
2. Re-experiencing the trauma either in intrusive memories, recurrent dreams, or sudden feelings associated with an environmental stimulus;
3. Numbing of responsiveness to the outside world beginning after the trauma as shown by either feelings of detachment, constrictive affect, or diminished interest in activities;
4. Possessing two of the following symptoms not present before the disorder: Hyperalertness; sleep disturbance; guilt that others may not have escaped the trauma; memory impairment; avoidance of activities; and worsening of symptoms by exposure to symptoms symbolizing the event.[10]

The DSM III then describes sub-groups, natural history and differential diagnosis of the disorder. It is important to emphasize the role of a significant stressor that can provoke similar responses in most individuals. This criterion is not present in the Stress Burn-Out Syndrome. The epidemiological studies of the Stress Burn-Out Syndrome indicate a more sporadic, imprecise and incidence pattern, and does not imply that the work stress would affect most people in the same manner.

Examination of the stress syndrome reveals that it is a vague disorder with an inexact onset and an uncertain course. At best, it is a syndrome that is a natural human response to a variety of environmental pressures which may cause particular individuals to respond in a stereotypical manner. Their response is a warning that the person has reached his limit and should amend his way of living and/or working. The syndrome most often is claimed as an occupational disease in the environment where the worker has little control, low pay, poor training and a perceived antagonistic management. The fact that higher level workers experience the same symptoms but do not seek compensation indicates that either their expectations of their job are different or their characterological development enables them to continue despite the discomfort inherent in their position. Because of the newness of the syndrome, there is no statistical evidence to support the aforementioned conjectures.

How should we then consider the Stress Burn-Out Syndrome? It is not a disorder defined by the DSM III, yet the disorder has been promoted as a compensable occupational disease. There are many subjective symptoms and few objective signs. There is no anatomical or physical abnormality. The syndrome does not fit any designated psychiatric illness. The ailment paradoxically incapacitates more often the repetitive, low skill worker than the executive decision maker. Regardless of the contradictions, most of humanity has experienced some elements of the syndrome in their lives. [This author was unable to find any studies which demonstrate the response rate of sufferers to change in their work environment, psychiatric treatment, or financial compensation.] There are many techniques touted as ways to treat and prevent the syndrome; most are more precise than the definition of the disorder. Often, it is a treatment technique in search of the disease. A concerted effort by labor and management could design a work place where stress could be reduced, communication improved, productivity increased, and safety enhanced. Counseling and treatment are ways of assisting in that effort.

From a psychiatric-medical perspective, clarification of the definition of the disor-

der is needed. The definition must allow the examiner to determine where the normal human response ends and the disease process begins. As physicians we can rely on changes in function, anatomy, and behavior as we have in the past. There must be an analysis of the pre-existing and coexisting factors. Entitlement issues must be addressed with equal scrutiny. Questions of how long a stress response must be present to qualify for compensation and how global the disorder must be in affecting the patient's life are also pertinent. Also pertinent is the question of whether the patient should be required to undergo treatment and industrial counseling as a prerequisite to a physician's certification of the syndrome as chronic and incapacitating.

In the ideal, one could use the life change chart developed by Holmes and Rahe for assessing stress.[11] These authors ranked life change events, (i.e. death of a spouse, mortgage, marriage, etc.) assigning each event a numerical value. If an individual exceeded a crucial number of points in one year, the result was a greater risk of physical or mental illness. However, such a chart did not allow for individual personality structure and pre-existing factors. I suspect stress in the work place will continue, and there will be additional pressure to have it classified as an occupational disease. Owing to this reality, more research both prospective and retrospective is necessary to help mental health professionals evaluate and treat stress syndromes.

Notes

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[10]*Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association, (Washington, D.C., 1980).

[11]Rahe, R.H., "Subject's Recent Life Changes and Near Future Illness Susceptibility" In *Advances in Psychosomatic Medicine*, vol. 8, (Basil: Krager, 1972).

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