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Daniel J. Freedenburg M.D.
University of Maryland Medical School

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UPDATE ON OCCUPATIONAL STRESS DISORDERS

Daniel J. Freedenburg, M.D.

The frequency of psychiatric stress and occupational disease claims has rapidly increased over the last several years. In some jurisdictions such as California, which formerly relied upon the subjective rule in determining the validity of a claim, 50% of workers' compensation claim dollars were paid out for psychiatric/psychological stress or occupational mental diseases. In response to industry-wide pressure, the California legislature mandated that the claimant demonstrate that at least 10% of the stress claim or psychiatric occupational disease is employment-related before a claim may be considered valid. The subjective rule was revoked and it became incumbent on the treating professional to supply objective data to confirm both the diagnosis and its causal connection to the claimant's occupation.

As California was limiting emotional claims, other jurisdictions, including the state of Maryland, were broadening the concept of occupational mental disease by allowing "mental" disorders to become compensable. Maryland had previously recognized physical-mental and mental-physical claims as being compensable. In Belcher v. T. Rowe Price, the Court of Appeals of Maryland utilized the tort law concept of psychiatric physical injury to espouse psychiatric personal injury when awarding workers' compensation benefits. In doing so, the court concluded that there must be an objective determination of psychiatric injury in order to ensure that the claim is not spurious and insisted that the mental distress appear real.

Objective v. Subjective Testing

It is obvious that applying tests of objectivity to psychiatric claims is difficult. This is not to say that a trained professional cannot note, through history taking, mental status examination, and observation of behavior, classic signs and symptoms of a mental disorder. Psychological testing has proven particularly useful in objectifying psychiatric complaints. The caveat, however, is that the test must have validity scales, e.g., it must be normed against a controlled data base, and it must not rely exclusively on the individual's self-report.

There is a marked contrast between the approach an individual takes in completing a psychiatric evaluation for purposes of treatment when there is no potential for either primary or secondary gain and completing a forensic psychiatric evaluation. In the latter, all subjective complaints of the patient must be questioned, investigated, and verified. Objective testing is frequently essential. Reviewing previous medical records and reports of witnesses of the traumatic event are extremely helpful in reaching the appropriate diagnosis.

In the former case of evaluating a patient for treatment where there are no forensic parameters, it is generally common for the therapist to believe the individual's subjective report and provide comfort and support as well as proper medical management. The therapist relies on the patient's subjective perception of his complaints and causality of the disorder. Therapy frequently becomes a task in educating the individual in a proper understanding of his symptomatology and the nature of the causality of the illness.

Because workers' compensation claims are always clouded with issues of primary and secondary gain

About the Author: Dr. Daniel J. Freedenburg graduated from the University of Maryland Medical School. He specializes in occupational and forensic psychiatry and is president of NeuroPsych Associates, Inc. in Glen Burnie, Maryland.
(psychological and monetary), an objective evaluation is difficult to obtain. There is frequently a lack of cooperation between the individual and the examiner, and the possibility exists that the claimant may have been educated into reporting the proper symptoms by his treating therapist.

Acquired v. Developmental Disorders

It is imperative that the evaluating mental health professional keep in mind the difference between acquired and developmental mental disorders. Acquired disorders are the result of a disturbance in neurophysiology or neurochemistry, traumatic injury or toxic phenomenon, or infectious disease or mass occupying lesions. There is also the possibility of degenerative disease. Psychiatric disorders often result from a traumatic environment or a disturbed and abusive childhood. Acquired conditions imply that the individual was not born with the disorder but acquired it secondary to a pathological process alien to the individual. In contrast, developmental disorders reflect genetic and congenital diseases such as mental retardation and developmental learning disorders. From a psychiatric perspective, developmental personality disorders associated with problematic, lifelong, pervasive behaviors play a significant role in workers’ compensation and tort claims.

Distinguishing between these two disorders and apportioning impairment is the responsibility of the mental health professional. The mental health professional should be aware of what acquired disorders preexisted the occupational stress claim. It is not uncommon for the patient and the therapist to indulge in reductionist thinking -- assuming that the patient’s myriad problems are directly attributable to the one cause, generally the injury.

Stress claims

The court’s ruling in the Belcher case opened the door for post-traumatic stress disorder and acute stress disorder claims. While the court of appeals has been reluctant to accept mental disorders as compensable diseases, they held out the possibility that some gradually evolving, purely mental diseases could be compensable as occupational diseases. However, it remains incumbent upon the claimant to prove that the mental disorder was due to the nature of his employment in which the risk of stress existed.

One of the most common forms of work related psychiatric disorders is the stress claim. The stress is generally divided into chronic and acute disorders. Occupational psychiatric diseases are generally classified under the chronic stress versus post-traumatic stress disorder. Acute stress disorder is usually secondary to a single unexpected traumatic event, although continued exposure to traumatic events may also produce the condition.

Post-Traumatic Stress Disorder

In 1994, the American Psychiatric Society released the DSM-IV. This reworking of the diagnostic and statistical criteria for the classification of psychiatric disorders has further defined post-traumatic disorder and acute stress disorders.

The diagnosis of PTSD in the DSM-III-R was based on the “A” and “B” criteria. Under the previous guidelines, the individual had to experience an event so far outside of normal human experience that almost anyone who experienced such a trauma would have a similar psychological reaction. If the stressor met the sufficient level of severity, the individual also had to show that he or she developed specific symptoms associated with the disorder.

Examples of sufficient stressors included rape, physical injury, natural disasters, wartime experiences, concentration camp internment, or watching a family member be assaulted, maimed, or killed. Minor physical injuries and automobile accidents were excluded from the criteria. Symptoms of the diseases consisted of nightmares, flashbacks, reliving, emotional numbing, survivor guilt, and avoidance of real or symbolic events reminiscent of the trauma. One of the problems with the diagnostic criteria was the ability of individuals to learn
the symptoms and repeat them by rote. It was often essential that the psychological testing be completed to assist in verifying the complaints.

The criteria for PTSD in the DSM-IV is in some ways a looser definition and, in other ways, it is a more specific definition of the symptoms. Specifically, to meet the “A” criteria, the person must be exposed to a traumatic event in which two conditions are present. First, the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others. Second, the person’s response involved intense fear, helplessness, or horror.

Furthermore, the traumatic event must be persistently re-experienced in one or more of the following ways: recurrent and intrusive distressing recollections of the event including images, thoughts or perceptions; recurrent distressing dreams of the event; acting or feeling as if the traumatic event were reoccurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening); intense psychological distress on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event; and physiological reactivity on exposure to internal or external cues.

There should be persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness not present before the trauma, as indicated by three or more of the following: efforts to avoid thoughts, feelings or conversations associated with the trauma; efforts to avoid activities, places, or people that arouse recollections of the trauma; inability to recall an important aspect of the trauma; markedly diminished interest or participation in significant activities; feeling of detachment or estrangement from
others; restricted range of affect; and a sense of foreshortened doom.

Lastly, there should be persistent symptoms of increased arousal not present before the trauma as indicated by two of the following: difficulty falling asleep or staying asleep; irritability or outbursts of anger; difficulty concentrating; hypervigilance; and exaggerated startle response. To qualify for PTSD the condition must have lasted for more than one month. It is not uncommon for the condition to produce significant distress or impairment in social, occupational, or other important areas of functioning.

The DSM-III-R “A” criteria was analogous to the reasonable man analysis used in tort claims in that the event should be so far outside of normal human experience that almost anyone who experienced the event would develop symptoms. The new criteria, though specific in stating that the person experienced, witnessed, or was confronted with threatened death, serious injury, or threat to the physical integrity of self or others, does not say that almost anyone experiencing this event would have similar symptoms.

The symptoms of the disorder are much more finely honed and specifically point out that the behaviors must be new and not have been present prior to the trauma. This is significant since many of the symptoms are also associated with personality disorder (developmental). However, the new criteria do not significantly help in distinguishing between real or feigned PTSD. This is not surprising since the prevalence of the disease in combat veterans who were at risk for developing the disorder varies in reports from 3-58%. In the general population, the disease is reported as varying from 1-14%. These figures indicate there is little specificity and considerable difficulty in identifying the disorder.

Acute Stress Disorder

The DSM-IV adds a new diagnosis of Acute Stress Disorder. The essential feature of this diagnosis is the development of characteristic anxiety, dissociative, and other symptoms that occur within one month of exposure to an extremely traumatic event. Stressors should be similar to those seen in PTSD, and the individual should develop at least three of the following dissociative symptoms: a subjective sense of numbing; detachment or absence of emotional responsiveness; and a reduction in awareness of his or her surroundings including derealization, depersonalization, or dissociative phenomenon. The event may be persistently re-experienced with the individual avoiding stimuli resembling the trauma. There should be symptoms of anxiety and increased arousal, and the symptoms must cause significant distress. The disturbance must last longer than two days and persist not longer than four weeks.

The differential diagnosis for these stress disorders includes: mental disorder due to general medical condition; substance-induced disorder; brief psychotic episode; major depression; exacerbation of a previous mental disorder; adjustment disorder; and malingering.

Conclusion

It is difficult to make generalized statements about stress disorders because of the vagueness of their symptoms, the subjectiveness of the complaints, and the difficulty in verifying the level of distress. A proper evaluation is done on a case by case basis utilizing clinical history, behavioral observations, mental status examination, and psychological testing. For those practicing in Maryland, there may be an extension of the concept of post-traumatic stress disorder to include other psychiatric conditions including depression, paranoia, and generalized anxiety. The concept of occupational psychiatric disease has yet to have been fully defined.

ENDNOTES: