Theories of Psychiatric Defense in Workmen's Compensation Cases

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The Development of Compensation for Psychiatric Injury

In most Workmen's Compensation statutes, only work-connected injuries arising in the course of employment which cause disability resulting in temporary or permanent loss of wage earning capacity are compensable. These laws are designed so that industrial employers assume the cost of occupational disablities as cost of production, without regard to any fault involved.[1] Difficulties arise when the line of demarcation between occupational and nonoccupational disability is obscured, as in heart disease, ulcer disease, or psychiatric disorder. Workmen's Compensation statutes were never intended as replacements for pensions or sickness insurance, but it is problematic for a jurist attempting to apply these laws fairly when it is proposed that a disabling mental disorder is caused by conditions in the work place (unassociated with a physical injury).[2] This lack of clinical consensus and diagnostic clarity has resulted in almost any psychological aberration being considered by plaintiff's psychiatric consultant as mental illness caused by the work place. The 1960 *Carter v. General Motors* decision by the Michigan Supreme Court was an important precedent for current policies in many states. The court sustained a compensation award for a machine operator who suffered a psychosis alleged to have resulted from emotional pressure encountered on his job. The ruling was unique in that there was neither a physical injury nor a specific, definable event that precipitated the breakdown. It is arguable that the original intent of Workmen's Compensation laws is undermined by this rationale, that not only work injuries but all illness and injury are becoming a part of the cost of production.[3]

Boredom, alienation, depression, and general life dissatisfaction have also been attributed to the work place as predisposing factors to mental and physical disorder.[4,5] In a carefully designed study, Siassi, *et al.*,[6] found no more evidence of alienation, loneliness, boredom, life

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dissatisfaction, work dissatisfaction, or depression among workers than among their spouses. These phenomena were concluded to be part of a broader pattern of emotional illness characteristic of diagnosed patients drawn from the same population.

Behan and Hirschfeld[7,8,9] have documented amply the ways in which physical injury and subsequent disability may represent a solution to ongoing psychological problems. A similar study by Selzer and Vinokur[10] demonstrated that life change and current subjective stress are significantly related to traffic accidents.

The Post-Traumatic Neurosis Concept

It has been difficult to obtain consensus within the psychiatric profession about post-traumatic emotional disorders as distinct entities, even though this is a common consideration in workmen's compensation cases. In the published glossaries of psychiatric diagnoses, this topic has been debated with each edition. The first edition of the *Diagnostic and Statistical Manual* included "gross stress reactions" to specify stress related reactions. In DSM II, this diagnostic category was deleted. In its place were the various neuroses such as anxiety neurosis, or transient situational disturbance. This vagueness,and lack of reliability among psychiatric experts has fostered much of the imprecision often observed in compensation cases.

In DSM III, the concept of post-traumatic stress disorder is well developed, with diagnostic criteria specified.[11,12] These include the following:

a. A recognizable stresser that would be expected to evoke significant symptoms of distress in almost all individuals.
b. Re-experiencing the traumatic event either by recurrent and intrusive recollections of the event, or recurrent dreams of the event, or suddenly acting or feeling as if the traumatic event were occurring because of an association with an environmental or ideational stimulus.
c. Numbing of responses to or involvement with the external world, beginning sometime after the traumatic event, as shown by markedly diminished interest in one or more significant activities, or feelings of detachment or estrangement from others, or marked constriction of affective responses.
d. At least two of the following (not present prior to the traumatic event):
    1. Hyperalertness or exaggerated startle response.
    2. Initial, middle, or terminal sleep disturbance.
    3. Guilt about surviving when others have not, or about behavior required to achieve survival.
    4. Memory impairment or trouble concentrating.
    5. Avoidance of activities that arouse recollection of the

traumatic event.

6. Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.

It may become more difficult to assert that psychiatric disabilities are job related. The evidence is persuasive that most affective disorders,[13] schizophrenic disorders,[14] and many anxiety disorders[15] have substantial hereditary components. It may thus be argued that the disability would have occurred anyway.

The Real Burden of Proof in Personal Injury Cases

In any civil suit, the plaintiff must prove by "a preponderance of evidence" that he has been wrongfully damaged by defendant and is entitled to equitable compensation. In most aspects of Workmen's Compensation litigation this principle is equally true. But in the case of alleged psychiatric injury, a paradoxical reversal of this burden of proof exists because environmentalist theories of psychopathogenesis are so uncritically accepted in our culture, by laymen and mental health professionals. It is not uncommon for a plaintiff's psychiatrist after a half-hour interview with plaintiff to conclude in effect, "patient was not nervous before the accident but has symptoms now; the industrial accident is the obvious explanation for the onset of psychiatric complaints." The court takes such reports seriously, so defendant insurance company is forced to prove the error of such flimsy allegations; in effect the real burden of proof lies with the defense.[3]

To discover the correct etiology of psychiatric complaints, defense psychiatrist must spend many hours interviewing the patient, his family and friends, prior physicians, employers and other associates. He must obtain old records, medical, military, scholastic, employment, *etc.* Sometimes he must see the patient outside his office in other environments. Frequently a trial of treatment is necessary because the true psychopathology does not become clear until the patient takes certain drugs or carries out certain assignments. If defense psychiatrist does not do thorough work, the chances are that the case will never be properly studied.

The very nature of the litigation process is long and complicated and often contributes to prolonged disability.[16] Thus, both the assertions of the plaintiff and the complexities of the litigation process may contribute to the case against the defense. In a previous paper[17] technical skills were discussed which aid in meeting this challenge: thorough work-ups, trials of treatment that emphasize the patients responsibility for his health, intervention in the system on behalf of the patient, clear, well-documented reporting. The purpose of this communication is to describe theories of psychiatric defense that have proven useful in these cases.

Theories of Psychiatric Defense

Psychiatric defense theories will depend upon the laws and regulations of specific jurisdictions. The Workmen's Compensation Code of California is typical of those in other states:

A. The employer takes responsiblity for the employee "as he finds him." If an employee becomes disabled from any job-related cause, employer is responsible to restore him to his state of function at the time of hiring, and to compensate him for any temporary and permanent loss of earning power.
B. In cases where a previous compensable injury has resulted from industrial causes, the present employer is responsible to compensate only for the portion of disability incurred on the present job, and the previous employer must compensate for the other portion.
C. Disability is non-industrial if it would be present without the occurrence of the industrial exposure of the instant employment. Employer is not responsible for disability that would have occurred anyway.
D. Medical Probability and not Medical Certainty is the level of proof required.
E. Client's denial of preexisting disease or disability does not necessarily supercede medical probability in finding apportionment that is looking to a previous employer for payment of a portion of the disability compensation.
F. Reasonable limitations of function preexisting the instant injury may be accepted as cause for apportionment; what work limitations would have been advised before the injury if subject's condition had been known at that time?

Theory I: In spite of the history of a physical injury client never was actually mentally disabled as alleged.

Case Example: A 33-year-old married carpenter, father of four children, fell from a scaffold and broke his arm, causing him to be physically unable to continue his job for two months. When he complained of "nervousness" during this convalescence, his lawyer referred him to a psychiatrist for evaluation. Plaintiff's psychiatrist reported that he had a post-traumatic neurosis because he worries, is irritable, is sensitive to noise and is depressed.

More careful study by the defense psychiatrist put quite a different light on the situation. Plaintiff worries when his bills are unpaid because his disability check arrives ten days later than his paycheck would. While being home during the day plaintiff noticed himself becoming irritable toward his children especially when they are noisy, causing him to be startled. His wife was surprised to hear him say this and explained

that he had the same reactions when the children were noisy after he came home from work before the accident; she therefore arranged their noisy play for the hours when the plaintiff would be at work. So this complaint is not hyperacusis as the plaintiff's psychiatrist implied but is rather an adjustment disorder to the requirement that he remain at home instead of going to work. His "depression" only occurred on Sunday mornings when he had usually played golf; careful questioning revealed that his true feeling at those times was restlessness and boredom, (not depression, discouragement, loss of hope or self-esteem, or suicidal thoughts or acts). Far from losing sexual ability or interest as one might expect from a depressed person, plaintiff used part of these golfless Sunday mornings to entertain his wife in bed, much to her increased satisfaction. These symptoms did not interfere with any of his routine social or other activities, so social withdrawal was not involved.

Thus the syndrome of post-traumatic neurosis asserted by plaintiff's psychiatrist proved, under careful study, to be incorrect. Plaintiff had some nervous symptoms but these were related to unemployment and should resolve easily when he returns to work.

Comments: The basis for the diagnosis of post-traumatic neurosis is now substantiated after careful evaluation when one considers diagnostic criteria for post-traumatic stress disorder.[11] The patient experienced some mild discomforts that could not be called a mental disorder.

Theory I applies also to cases of malingering. It is usually best not to flatly label a plaintiff as a malingerer because one cannot really know whether a person is consciously feigning illness. If malingering is suspected one can give the data and simply conclude that no mental disorder exists, allowing the reader to draw his own inferences.

Theory II: Plaintiff has a mental disorder but it is not due to industrial experience.

Case Example: A 37-year-old cafeteria worker twisted her back and stopped work for a year because of intractable pain, diagnosed "functional" by the orthopedist, and called a hypochondriacal neurosis by plaintiff's psychiatrist. Three months after the orthopedist recommended return to work she had her first appointment with defense psychiatrist. Careful history-taking from the patient and family members revealed that five months after the work injury her whole family had been shocked and bereaved by the murder of her nephew. This initial interview with defense psychiatrist resulted in her immediate return to work, taking Melleril 25 mg at bedtime as needed for sleep.

After three weeks back on the job, she worked the same schedule as before the injury (four hours per day). Her low back pain radiating down the right thigh was present for only the first three days. She needed no medicine the second week. She declined a second appointment when defense psychiatrist contacted her by telephone two weeks after their first appointment, saying that further psychiatric interviews were not necessary.

Comment: The possibility is granted that her prolonged recovery from back injury was related to psychological factors. However, she did not appear to be traumatized emotionally at the time of injury but rather by a non-industrial incident five months later. It could have been argued by plaintiff that she was actually affected mentally by both incidents and that the death of her nephew only aggravated her original mental disorder. Her mental problems are now resolved, regardless of the cause (see Theory IV, below).

Case Example: A 40-year-old engineer, married, with two children was referred to a psychiatrist privately by his work supervisor who was also a family friend. The patient persisted in working many overtime hours despite the warnings of his cardiologist and the documented orders of his work supervisor. One year before while playing handball he had a myocardial infarction, his first experience of illness or disability in life. While recovering, he failed to follow medical advice about activity restrictions, returning to full time (and overtime) employment before medically released to do so. He stopped playing handball, his only recreational interest, working extra hours instead.

The psychiatrist learned that two blood relatives had died suddenly of heart attacks in their early forties several years before. He also discovered that there were conflicts between the patient and his wife, and she was drinking heavily. Treatment was broken off inconclusively, by the patient, after about three months.

A year later the psychiatrist's records were subpoenaed by the Workmen's Compensation Appeals Board because the patient had died of a second myocardial infarction and his widow was claiming the prescribed death benefits for industrially caused fatality. Her psychiatric expert testified that overwork had aggravated the patient's coronary artery disease, contributing to his demise. He cited abundant medical literature about the relationship between such work patterns and coronary thrombosis.

Defense psychiatrist argued that his employment was incidental to his heart disease, which was actually caused by other factors; his familial tendency to heart disease, his compulsive need to overwork at any pursuit, his unresolved fears of death, and his unhappy marriage.

Comment: There are many variations of the typically middle-aged employee who develops chronic psychiatric disability following a more or less traumatic industrial incident. The usual inference is that the disability was industrially caused because of the temporal relationship when a variety of other dynamics may be operating. Absent a careful psychiatric study (usually by defense psychiatrist or not at all), such inference will become a financial award and a diagnosis of industrial injury, often to the disabled patient's ultimate disadvantage, when rehabilitation might have been possible by facing the real causes of distress. Commonly these real causes are depression, fears of approaching illness or death, financial insecurity, marital discord no longer tolerable

at this stage in life because children are leaving the family. Character traits or habits that are no longer tenable commonly cause patients consciously or unconsciously to seek the sick role with honor when it can be attributed to one's job. Examples of these untenable habits are alcoholics who know they will soon be exposed at work, persons who have lost their vigor or their will to strive because they are no longer handsome (beautiful), or no longer promotable or able to change jobs when bored, or no longer able to change wives, or no longer able to hold two or three jobs at once. Such persons are ready to attribute their sense of weakness and hopelessness to a timely industrial accident.

The defense here is that the mental illness had already occurred or was in the process of occurring at the time of the accident, and that the apparent relationship to the accident is illusory. Sometimes the data will support this theory handsomely and carry the day; sometimes the data will be unconvincing, but this is the best available defense theory.

A special ethical dilemma is posed to defense psychiatrist by sociopathic personalities or other character disorders whose life histories are marked by arrests, convictions, nefarious activities, instability, irresponsibility, and lying. Such persons might have a real industrial injury, but not be duly compensated because they have little credibility when they testify. Defense psychiatrist may be the only witness qualified to say that the sociopathic plaintiff also has an industrially caused disability.

The defense of *contributory negligence* has no formal place in workmen's compensation law because the employer is fully liable if employment caused the condition to any degree. In personal injury cases where contributory negligence is a valid defense, the defense would want to show how plaintiff's bad habits, irresponsibility, neglect, or personality disorder contributed to the resultant disabling mental illness in question, to diminish defendant's liability. Even though the concept of contributory negligence is *technically* irrelevant in workmen's compensation cases, courts tend to consider such data in the overall picture; such data can be included in the report without formal mention of contributory negligence. Such data must be reported when treatment results are affected by the underlying character disorder.

Theory III: Client has an industrially related mental disability that will be relieved by return to work.

Case Example: A 30-year-old bartender was shot in the abdomen by youths in a passing car. After leaving the hospital he continued to experience a daily fever which was very upsetting. "Everything scared him, noises, strangers, annoyances," according to his wife. He lost 30 pounds and returned to the hospital when an abscess ruptured while being irrigated by his wife, another truly frightening experience for him. When the surgeon declared him fit for duty three months after the attack, he complained of pain and immobility of the back and neck, shortness of breath, explosive temper, nightmares, despair, fear of

another attack by the same assailants, poor sex life,marriage problems. He worked in a radio station and he wanted to make this his career,but the pay was inadequate. For two months he picked grapes, and during this time his symptoms were not disabling and greatly reduced. He is ready to resume work in a bar but cannot find a job.

The opinion of the defense psychiatrist in this case was that the patient was suffering from a post-traumatic stress disorder following the shooting. The best remedy would be for him to return to full employment of which he is capable, as evidenced by his improvement during his grape-picking job. Further, his recovery would be enhanced by early conclusion of litigation.

Comment: An important variant of Theory III is the case where plaintiff has been experiencing psychological problems before an industrial accident and these become more severe when he is forced to leave work because of a disabling *physical* injury. Careful history-taking will produce the data supporting the conclusion that plaintiff's work is therapeutic for him, not a hardship. This theory is so contrary to the mental set of those who equate work with hardships that it sometimes wins by its surprise effect. This theory is seldom considered in plaintiffs' psychiatrists' reports, and it is difficult for them to refute when the supportive data is present.

Theory IV: Client's pre-existing mental disability was aggravated by the industrial trauma but it has subsequently returned to its pre-trauma level.

Case Example: A 55-year-old domestic worker accidentally splashed cleaner into her eyes. In the emergency room superficial lesions were found, but in the excitement she thought she overheard the doctor saying she would be blind. She was stunned by this news. Six days later she could read for 20 minutes and her vision gradually returned to its pre-trauma status. Ten days after the injury she returned to work but had to stop after a week because of dizziness on bending down, and depression. Plaintiff's psychiatrist diagnosed depression caused by her industrial injury.

Defense psychiatrist commenced treatment. Her depression was relieved on a regimen of Elavil and Premarin prescribed by her family doctor, and three months post-injury she again returned to work. At first she was so exhausted by her employment that she slept almost all of her non-working hours. Defense psychiatrist required her to plan each day in advance, and to include pleasant after-work activities at least three times per week instead of simply going to bed each night after work.

At the next treatment session a month later she was nicely groomed, witty, and exuberant. She no longer took Elavil daily and felt no need for it.

Three days before Mothers' Day she collapsed at home and missed two days work. Defense psychiatrist discovered that she was terribly

upset because her daughter had not mentioned coming to visit on Mother's Day. He arranged for friends to take her to her daughter instead. Next day she returned to work.

Careful study by defense psychiatrist revealed a long history of alcohol and barbiturate abuse, and nervous symptoms remitting and returning over the years. Three years before the industrial injury her husband suddenly divorced her, leaving her shocked and grief-stricken. Shortly before the industrial injury she had abruptly stopped her mourning over the divorce and resumed a full schedule of social and athletic activities and started her present job, similar to her pre-divorce routine. Apparently the shock of possible blindness renewed her previous depression. Treatment helped by urging her to resume full activity, including employment, once again. She undoubtedly continues to be predisposed to develop acute psychiatric reactions, but the treatment returned her at least to her pre-trauma level of function.

Comments: Particularly valuable in this case was the participation of her daughter and two current peer friends, a man and a woman who helped to bring out very important information and cooperated in the formulation and administration of the treatment plan. The case was resolved in the context of her real life space and her significant others instead of the relatively esoteric atmosphere of the court.

Theory V: Plaintiff's mental disability was not caused by industrial experience but actually relieved by it until he stopped working.

Case Example: A 56-year-old correctional counselor was granted medical retirement from his eight-year employment at the prison for addicts six years ago. His heart disease was attributed to job-related emotional stress so he was awarded *unlimited* psychiatric treatment and referred to defense psychiatrist. History revealed that client had been subject to a variety of psychosomatic complaints and seven years ago suffered a myocardial infarction. Further history revealed his father's and his own severe alcoholism. After leaving the U.S. Air Force he made several unsuccessful attempts to work in forestry, from which he ws terminated because of alcoholism. He managed to control his alcoholism during the years he worked in the prison. The last three years of his correctional career he had his first successful lengthy relationship living with a woman. Shortly before his medical retirement they separated because he refused to marry her. Thereafter his alcoholism became much worse. He refused to accept treatment for alcoholism and insisted on living alone. He also declined to take an antidepressant even though he recalled this to be helpful. After several treatment sessions it became apparent to him and significant others that he was not interested in self-improvement at this time and treatment would not help. Defense psychiatrist challenged the assertion that his work experience was a traumatic stress when in fact he functioned at his best during his years at the prison.

Comment: Frequently the possible success of psychiatric treatment

cannot be predicted and a trial of treatment is necessary. In this case the subject was a willing patient until he realized there is no magic in psychiatry to change him without either his personal effort to establish a constructive pattern of life excluding alcoholism, or even his willingness to take medicine he found helpful.

This case also illustrates how the right job can be therapeutic in that it draws the subject into a higher level of function that is more gratifying. The real cause of the exacerbation of alcoholism was not his heart attack but rather the separation by his girlfriend when he refused to marry her. Until referral to defense psychiatrist, the true facts of his personal life were unknown; several conferences with his girlfriend in a reconciliation effort were most revealing of the psychodynamics. Defense psychiatrist's willingness to serve as a marriage counselor allowed the full and correct picture of the case to emerge.

One of the questions asked by referees in evaluating these cases is "What limitations or prescription would have been given to the patient on the day before the accident or illness in question began?" In this case there obviously would have been no limitations, and the question is used to bring out the absence of work trauma. In other cases the question is used to identify pre-existing disability levels.

Conclusion

Early in our experience as defense psychiatrists it seemed in fairness that it might be necessary to eliminate or circumscribe the types of psychiatric cases that should be allowed for trial. The applicant appeared to have an unfair advantage in the system because widely held psychiatric theories seemed to have been adopted by lawyers and judges as medical certainties. Prevailing notions that mental illness is caused by environmental adversity had made society the cause of mental illness, so justice called for social compensation to those afflicted; such theories seemed unaware of heredity, constitution, and factors of unsound personal choices in etiology. Perhaps in an abstract sense all causes could be attributed to a society that does not control bad heredity or teach good judgment to all citizens; however, it seems unlikely that workmen's compensation or tort law is intended or best fitted to solve such problems.

Skillful psychiatric defense can considerably equalize the legal contest, and offer alternative ways of understanding and resolving industrially related mental illness to the benefit of patients and society as a whole.

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