Mental and Emotional Injuries in Employment Litigation

Second Edition

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Mood Disorders
Major Depressive Disorder
Dysthymic Disorder

Anxiety Disorders
Panic Disorder
Generalized Anxiety Disorder
Posttraumatic Stress Disorder

Adjustment Disorders
With Depressed Mood
With Anxious Mood
Mixed

wife unexpectedly miscarried the couple's first child at five months. A large investment went sour. Seven months after Mr. D's father's death, Mr. D's mother succumbed to an (apparently intentional) overdose of her antidepressant medication. Not long after his father's death, Mr. D's work product began to deteriorate. Assignments were not completed or were completed sloppily. Usually social and outgoing, Mr. D was noted to be uncharacteristically irritable around peers, and snappy and aggressive with colleagues and clients alike. His personal hygiene deteriorated, as did his judgment. One customer reported Mr. D for spontaneously sharing with her how "it was I who had to identify my father's maggot-ridden body when he blew his brains away."

Finally, things reached a head when Mr. D complained that a cherub painted in the unisex restroom admonishing the user to "please put the toilet seat down after use" was actually meant to be a mean-spirited personal attack upon Mr. D's masculinity. Mr. D complained to management, demanding that a "reasonable accommodation" be made to his needs by converting all twenty-two of the company's unisex restrooms into male-only or female-only versions.

When the company refused, Mr. D resigned and initiated a lawsuit claiming constructive termination. Later, violation of the Americans with Disabilities Act was added to the lawsuit, based upon Mr. D's subsequent diagnosis of Major Depressive Disorder.

Major Depressive Disorder is the "Great Imitator" of psychiatry, in that the psychopathology may present itself in so many variable ways. Certainly, Major Depressive Disorder's hallmark symptom is a marked alteration of mood that does not vary over time, but that altered mood may be sadness, anger, irritability, apathy, guilt, or despair. The depressed person may first note physiological changes such as inability to sleep beyond a specific predawn hour (early morning awakening) or decrease in appetite, or their exact opposites (hypersomnolence and/or appetite increase). There may be changes in cognition—difficulty with concentration, memory, or attention. There may also be diffuse, nonspecific physical discontent—aches and pains or chronic fatigue. Psychotic symptoms may even develop.

As suggested by the name, however, the classic, core abnormality in Major Depressive Disorder is an alteration of mood—a marked period of sadness, despondency, or despair, or of tenseness, irritability, or anger. Such uncharacteristic, uncomfortable, pervasive mood state is typically accompanied by "neurovegetative" symptoms of depression: changes in physiologic regulation such as altered sleep, altered appetite, altered motor activity ("psychomotor retardation"—a literal slowing down of ambulation and body movements). Superimposed upon all these symptoms may be cognitive changes, psychotic changes, and a morbid preoccupation with death that can lead, most extremely, to violence in the form of suicide, homicide, or both.

Major Depressive Disorder is one of the most commonly encountered of the Axis I diagnoses. It is believed to occur with a prevalence of 5 to 10 percent in the population at large. Lifetime risk appears to be between 10 and 25 percent, with a slightly higher likelihood of occurrence in females than in males. Episodes may begin at any age, with average age of onset in the mid-20s.

Major Depressive Disorder is episodic, with circumscribed, acute major depressive episodes reoccurring throughout the lifetime. Individual episodes

are typically time-limited, with symptoms receding naturally and even without treatment after one to two years. Between individual episodes, the disorder is said to be in remission. The affected individual is often returned to his or her psychological baseline entirely symptom-free.

Major Depressive Disorder is a biological phenomenon, passed through the generations genetically. It involves imbalances in the relative concentrations of neurotransmitters of the brain, and it is responsive to biochemical (medical) interventions. Individual episodes may be triggered by stressful environmental events, or they may occur spontaneously, without noticeable external provocation. Approximately 50 to 60 percent of individuals with Major Depressive Disorder, Single Episode can be expected to have a recurrent episode at some later point in their lives. The probability of further episodes increases with each successive bout endured.

In the context of employment litigation and other nonmedical circumstances, it becomes particularly critical to differentiate emotional upset—reactive feelings of sadness, despondency, anger, or irritability that arise in response to environmental provocation but that fade shortly following the removal of the environmental stressor—from the biological psychopathology of Major Depressive Disorder. Overlap of vocabulary and experience lends itself to misunderstanding and even frank exploitation and abuse in a contentious legal arena. Simple feelings of sadness or indignation—even though described in the vernacular as "depression"—are normal human responses to stress and should not be misconstrued as rising to the level of diagnosable psychiatric disorder.

DSM-IV-TR diagnostic criteria are designed to establish the minimal constellation of symptoms necessary to warrant the hypothesis that an episode of Major Depressive Disorder underlies presenting complaints of altered mood. Symptom criteria required for diagnosis of a Major Depressive Episode are set forth in Table 5-6. Those necessary to diagnose Major Depressive Disorder, Single Episode are outlined in Table 5-7, and those involved in a diagnosis of Major Depressive Disorder, Recurrent are listed in Table 5-8.

Table 5-6 *DSM-IV-TR* Diagnostic Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). *Note:* In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

continued

Table 5-6 *Continued.*
***DSM-IV-TR* Diagnostic Criteria for Major Depressive Episode**

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. *Note:* In children, consider failure to make expected weight gains.
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

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Table 5-7 *DSM-IV-TR* Diagnostic Criteria for Major Depressive Disorder, Single Episode

A. Presence of a single Major Depressive Episode.
B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

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Table 5-8 *DSM-IV-TR* Diagnostic Criteria for Major Depressive Disorder, Recurrent

A. Presence of two or more Major Depressive Episodes. *Note:* To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.
B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. *Note:* This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

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Notable in the *DSM-IV-TR* diagnostic system is the attempt to differentiate Major Depressive Disorder from phenomenological "masqueraders"—i.e., transient and minimally pathologically significant changes in affective status. Symptoms of Criterion A define the biologic character of Major Depression, and they must be present for at least two continuous weeks to rule out reactive, fleeting mood fluctuation. Criteria B, C, and D attempt to distinguish other conditions whose symptoms overlap those of Major Depressive Disorder, such as Bipolar Affective Disorder (Manic Depressive Illness); mood dysregulation induced artificially through toxin administration (e.g., barbiturates, alcohol); mood disorder produced as a side effect of a general medical (nonpsychiatric) condition (e.g., hypothyroidism, cancer); or disturbance in mood resulting from the universal, nonpathological circumstance of bereavement. Criterion C operationalizes the concept of clinical significance—symptoms present must provoke notable, meaningful impairment in social, occupational, or other important areas of functioning.

Treatment success rates are extremely high for Major Depressive Disorder. Antidepressant medications are abundant and exist in several chemical classes, such that a patient who reacts badly to one is more than likely to respond to another, or to some combination. Specific forms of psychotherapy (e.g., cognitive or behavioral therapy) have been developed that are highly effective, in and of themselves. Ideally, treatment of an episode should include both appropriate medication management and psychotherapy of the appropriate type, administered by a practitioner trained and experienced in the use of these techniques.

Correctly managed, most Major Depressive Episodes will resolve in less than six months. Occasionally, residual symptoms will remain longer, fading more slowly over time. Rarely will such residual symptoms be of sufficient magnitude to significantly impede effective day-to-day social or vocational functioning, however.

Rare individuals will prove resistant even to skillful psychopharmacologic and psychotherapeutic management. For these patients, Electroconvulsive Therapy (E.C.T.) becomes the treatment of choice. Contemporary E.C.T. is actually the safest, most effective treatment there is for the treatment of serious bouts of Major Depression, a far cry from stereotypic images of "shock treatment" popularized in movies and in television tabloids. Typically, with a short (two- to three-week) course of E.C.T., a patient can safely and painlessly be relieved of symptoms of Major Depression, entering a period of remission at least as resistant to relapse as that induced through medication or psychotherapeutic management, with fewer concurrent side effects and with virtually no clinically meaningful side effects.

2. *Dysthymic Disorder*

CASE EXAMPLE

Dr. E was an anesthesiologist working as an employee in a large HMO. For years, Dr. E complained to friends and associates about chronic feelings of fatigue, low self-esteem, and being "down in the dumps."

Financial circumstances forced the HMO to downsize, and remaining staff physicians including Dr. E were required to assume extra duties and extra on-call hours, and also to accept a 20 percent pay cut. Dr. E loudly and publicly protested these changes and led an unsuccessful campaign to have them reversed. Nonetheless, Dr. E continued working; he neither complained of, nor was he noted by anyone to display, any increase in or exacerbation of his perpetual low-level symptoms of disgruntlement.

Three months after the downsizing and Dr. E's failed attempt at insurrection, Dr. E presented to the HMO administration a note from his psychiatrist diagnosing Dr. E with "Severe Major Depression" and requesting, on this basis, an Americans with Disabilities Act "reasonable accommodation."

The accommodation proposed to the HMO (no on-call time, only daytime work hours, no more operating room time than had been required prior to downsizing) was deemed administratively unacceptable (and impossible), and Dr. E was terminated when he refused to honor the HMO's performance requirements. A lawsuit soon was filed on Dr. E's behalf, alleging violation of the ADA as well as wrongful termination.

Dysthymic Disorder is best thought of as a chronic, low-level depression. It may be biologically determined like Major Depressive Disorder (with a clear family history and responsive to medication), or it may be characterologic,

with its origins in chronic discontent engendered by the perpetual dissatisfactions, failed expectations, and unreasonable interpersonal demands of a personality disorder. (The latter phenomenon is reflected in older nomenclatures for Dysthymic Disorder—terms such as "depressive neurosis" or "characterologic depression.")

Fundamental to Dysthymic Disorder is the chronic, unwavering nature of the depressive experience; while there may be mild ups and downs, depressed mood is prominent for most of the day, more days than not, for most of the individual's life (technically, for two or more years continuously). Equally fundamental is the relatively moderate to mild degree of the disturbance. Those with Dysthymic Disorder may not be fun or luminous, but they are seldom totally disabled from their occupation or unable to engage in ordinary social interaction.

Table 5-9 sets forth the *DSM-IV-TR* diagnostic criteria for Dysthymic Disorder. Most evident in these criteria is the chronicity component. While symptoms must, as always, cause clinically significant distress or impairment in social, occupational, or other functioning to rise to diagnosable significance, they must do so continuously for a minimum of two years. Dysthymic Disorder is not a reactive condition, as is sometimes erroneously alleged in litigation; it cannot be caused or triggered by isolated, commonly litigated workplace events such as harassment, discrimination, or termination (wrongful or legitimate); and it is, in fact, one of the preexisting conditions most likely misattributed to alleged adverse workplace events by hasty and superficial forensic evaluators.

Table 5-9 *DSM-IV-TR* Diagnostic Criteria for Dysthymic Disorder

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. *Note:* In children and adolescents, mood can be irritable and duration must be at least 1 year.
B. Presence, while depressed, of two (or more) of the following:
   1) poor appetite or overeating
   2) insomnia or hypersomnia
   3) low energy or fatigue
   4) low self-esteem
   5) poor concentration or difficulty making decisions
   6) feelings of hopelessness
C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.
D. No Major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.

continued

Table 5-9 *Continued.*
***DSM-IV-TR* Diagnostic Criteria for Dysthymic Disorder**

Note: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial 2 years (1 year in children or adolescents) of Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.
F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.
G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Early Onset: if onset is before age 21 years
Late Onset: if onset is age 21 years or older

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Clinical management of Dysthymic Disorder is similar to that of Major Depressive Disorder, particularly when a biological component is prominent. The same antidepressant medications with the same approaches to psychopharmacology (single agents or rationally derived combinations) are employed. The same (Cognitive-Behavioral) psychotherapy is also effective.

Where characterological etiology looms large, treatment may prove more difficult and is definitely a longer-term undertaking. Medications may still be helpful, but their efficacy is less predictable. Significantly, psychotherapy must switch from the didactic, "here and now" orientation of Cognitive-Behavioral treatment to a longer-term, more exploratory psychodynamic focus. In order to alleviate misery born of the self-fulfilling prophecies, passive-aggressive self-sabotages, and irrational demands and expectations of personality pathology, that pathology itself must be uncovered, identified, confronted, and ultimately rejected by the patient. Such process, successfully undertaken, will invariably alleviate dysthymic byproduct along the way.

3. "Double Depression"

Individuals who are chronically discontent and unhappy as a function of Dysthymic Disorder will sometimes—perhaps in response to identifiable environmental stressors or perhaps not—develop an acute Major Depressive Episode superimposed upon chronic, baseline symptoms. Such an episode is circumscribed,

time-limited, and governed by all the laws of Major Depressive Episodes not experienced in conjunction with Dysthymic Disorder. Though not a formal *DSM-IV-TR* diagnostic entity, this state of psychological affairs is often termed "Double Depression."

The superimposed Major Depressive Episode, treated in the same way as is any Major Depressive Episode, subsequently clears, and the individual returns to his or her chronic state of mild to moderate discontent. Typically, the post-episode symptom picture is, upon careful scrutiny, indistinguishable from the pre-episode picture.

In litigation-related evaluation, a bout of Double Depression obviously must be carefully distinguished from a case of a new Major Depressive Disorder with refractory, treatment-resistant post-episode symptoms. Meticulous discovery of pre-episode functioning—via review of medical and mental health records, as well as employment, school, and military records—generally provides the basis for such differentiation.

4. Bipolar Affective Disorder

CASE EXAMPLE

A lawsuit was filed against the U.S. government when Ms. F, a custodian at a U.S. Air Force base, slipped on wet, slippery tundra at the base, allegedly because she had been "supremely upset" by an ethnically tainted joke she had just been told by one of the base's senior officers. Although there was no documented loss of consciousness or visible physical lesion, orientation and memory were intact in the emergency room, and brain scan, E.E.G. and neurologic workup were all within normal limits, Ms. F was noted by E.R. personnel to be excessively talkative and pressured of speech, giddy, and "hyper." A mild closed head injury was diagnosed, and Ms. F went on within the week to file a lawsuit claiming severe cognitive deficits as damages.

A few months after the alleged head injury, Ms. F was psychiatrically hospitalized when police found her naked in a park, on her knees, praying to an unspecified deity. At the hospital Ms. F was noted to be giddy, hypersexual, uninhibited, speaking unintelligibly, and somewhat delusional, claiming to be "the Earth Mother" and "the Mother of Us All." Ms. F was treated with antipsychotic medications as well as the mood stabilizer lithium and released as stable. Within the month, Ms. F stopped taking her medications and was similarly rehospitalized. She expanded her legal claim against the United States, adding damages described as "Traumatically Induced Manic Depression" to her earlier alleged "severe cognitive deficits." Forensic psychiatric evaluation revealed a recurrent religious delusional theme permeating Ms. F's post-incident psychotic episodes, as well as a propensity to flop down on the ground in religious ecstasy at such times. This led to discovery of documentation showing that pre-event, Ms. F was divorced by her first husband as a result of episodes of disinhibition, indiscreet hypersexuality and spending, and hyperreligiosity that included "physically inappropriate behavioral displays of public praying."

In light of the objectively minimal nature of any head injury sustained at the U.S. Air Force Base, embedded as it was in this striking psychiatric history, the court

he became increasingly morose. His sleep was fitful and interrupted. He lost his appetite, and he lost weight.

About two months after his initial episode, Mr. G was noted by colleagues to be confused and rambling. He came to work unshaven, wearing inappropriate, rumpled clothing. He seemed hostile and irritable.

On the eleventh week after his first panic attack, Mr. G filed a complaint of discrimination with the Equal Employment Opportunity Commission (EEOC), copied to his company's Director of Human Resources. In a loose, convoluted, illogical logic, Mr. G explained that he was the victim of religious harassment and discrimination at the hands of the company founder. Being of Jewish descent, Mr. G reasoned that this stemmed from his parents' survival through a terrifying internment in one of the Nazi concentration camps during World War II. He complained that the company founder, a German American, "has taken it upon himself to avenge my parents' fortitude, and redeem the honor of his forefathers by maligning, persecuting, and torturing me."

Panic Disorder, with or without comorbid Agoraphobia or Major Depression, is a frequently encountered complaint in employment litigation settings, particularly where an alleged inability to work is asserted. For example, a lawyer may become unable to litigate, for fear of experiencing a panic attack upon entering the courtroom. A surgeon may become unable to operate, for fear of jerking the scalpel, or a gynecologist may become unable to deliver for fear of dropping the baby. With Agoraphobia, the employee is too afraid of potential panic attack even to venture forth from his or her home.

Panic attacks are appropriate physiologic arousal functions occurring at inappropriate times. The organism's normal, biologically adaptive adrenergic nervous system response—the "fight or flight" set of physiologic adaptations that energizes animals to deal instantaneously with threat by either fighting it off or fleeing—is being activated spontaneously and inappropriately, when in fact there is no environmental menace present. The individual suffering a panic attack is, in essence, being prepared for an attack by a wild animal when in fact no such animal is in sight.

Panic attacks may be spontaneous—occurring with no identifiable stimulus—or they may be predictably triggered by specific situations or stimuli such as driving in rain or being in a large, crowded mall. The attacks are classically characterized by an abrupt onset of characteristic symptoms such as heart palpitations, shortness of breath and hyperventilation, dizziness, or tremor. Onset to peak episode intensity is usually within 10 to 15 minutes, followed by gradual waning of symptoms. Table 5-15 exhibits the specific *DSM-IV-TR* definition of a Panic Attack.

Table 5-15 *DSM-IV-TR* Diagnostic Criteria for a Panic Attack

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

(1) palpitations, pounding heart, or accelerated heart rate
(2) sweating
(3) trembling and shaking

continued

Table 5-15 *Continued.*
***DSM-IV-TR* Diagnostic Criteria for a Panic Attack**

(4) sensations of shortness of breath or smothering
(5) feeling of choking
(6) chest pain or discomfort
(7) nausea or abdominal distress
(8) feeling dizzy, unsteady, lightheaded, or faint
(9) derealization (feelings of unreality) or depersonalization
(10) fear of losing control or going crazy
(11) fear of dying
(12) paresthesias (numbness or tingling sensations)
(13) chills or hot flashes

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"Agoraphobia" is a term often used inappropriately in lay contexts, including those surrounding employment litigation. Common misinterpretations include "fear of leaving the home," "fear of social situations," "fear of crowds," and "fear of public places."

Correctly, Agoraphobia denotes a single, very specific condition. It is a state of profound anxiety that arises when one finds oneself in places or situations from which escape might be difficult or humiliating (or in which help might not be readily available) in the event of having a panic attack or significant panic-like symptoms (e.g., chest pain, sudden diarrhea). Such anxiety typically gives rise to avoidance of a variety of situations. At its most extreme, it may result in a refusal to leave one's home or to be alone in one's house. Less crippling are situation-specific agoraphobic avoidances, such as being in a crowded movie theater or in a car, traveling by plane or train, being in an elevator, going through a tunnel. Sometimes, the avoidance is total. Other times, the individual is willing to confront feared stimuli, but only in the presence of a trusted friend or relative who can effect a rescue if necessary.

Panic Disorder is diagnosed when the presence of recurrent, unexpected panic attacks is followed by at least one month of worrying about or acting in response to worry about further attacks. As Tables 5-16 and 5-17 display, Panic Disorder may be diagnosed with or without Agoraphobia.

Table 5-16 *DSM-IV-TR* Diagnostic Criteria for Panic Disorder With Agoraphobia

A. Both (1) and (2):
(1) recurrent unexpected Panic Attacks
(2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
(a) persistent concern about having additional attacks
(b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
(c) a significant change in behavior related to the attacks

B. The presence of Agoraphobia.
C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

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Table 5-17 *DSM-IV-TR* Diagnostic Criteria for Panic Disorder Without Agoraphobia

A. Both (1) and (2):
   (1) Recurrent unexpected Panic Attacks
   (2) At least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
      (a) persistent concern about having additional attacks
      (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
      (c) a significant change in behavior related to the attacks
B. Absence of Agoraphobia.
C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

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Prevalence of Panic Disorder is estimated at between 1 percent and 3 percent of the general population. About one-third to one-half of those in the community with Panic Disorder also suffer from Agoraphobia. As mentioned earlier, comorbidity of symptoms of Panic Disorder and symptoms of Major Depressive Disorder is notably high.

The same medications most often employed in the treatment of Major Depressive Disorder—so-called Selective Serotonin Reuptake Inhibitors (SSRIs) and Tricyclic Antidepressant Agents (TCAs)—prove to be remarkably

Following the mold for Panic Disorder, specific and innovative cognitive-behavioral protocols for the treatment of Obsessive-Compulsive Disorder have been developed and continue to be refined. Advocates report marked improvement of symptoms in 60 to 70 percent of patients who regularly employ such techniques. Combination of psychopharmacology and psychotherapy proves multiplicatively more effective than treatment via either approach alone.

3. Generalized Anxiety Disorder

Generalized Anxiety Disorder is something of a catchall diagnosis, encompassing people who are excessively worried and emotionally aroused most of the time, but whose symptoms do not fit the patterns of any of the more specifically delineated psychiatric entities. There are some who question the existence of a unique, "Generalized Anxiety Disorder" condition altogether, hypothesizing that those so diagnosed are actually more correctly manifesting symptoms of Mood Disorder, another Anxiety Disorder, Personality Disorder, or most likely, some combination of character pathology and Axis I symptomatology.

Phenomenologically, individuals said to have Generalized Anxiety Disorder spend most of their time worrying about things. They worry about health. They worry about finances. They worry about acceptance. And their worry exceeds pathological threshold in its pervasiveness, its intensity, and its invasion into other domains including cognitive efficiency, physical sense of well-being, and ability to sleep or interact socially.

Population prevalence rate for Generalized Anxiety Disorder is estimated at between 2 percent and 3 percent. Table 5-19 outlines formal *DSM-IV-TR* criteria for the diagnosis.

Table 5-19 *DSM-IV-TR* Diagnostic Criteria for Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The person finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). *Note:* Only one item is required in children.
   (1) restlessness or feeling keyed up or on edge
   (2) being easily fatigued
   (3) difficulty concentrating or mind going blank
   (4) irritability
   (5) muscle tension
   (6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

continued

Table 5-19 *Continued.*
***DSM-IV-TR* Diagnostic Criteria for Generalized Anxiety Disorder**

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

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Because it is so often a camouflage for underlying, more specific and fundamental psychopathology, suspicion of a Generalized Anxiety Disorder, particularly in a forensic psychiatric context, should trigger even more fastidious than average documentary and historical search for a Mood Disorder, Personality Disorder, other Anxiety Disorder, or even psychosis. Even more scrupulously than usual, an underlying general medical illness must be ruled out through examination and appropriate diagnostic testing. Even more painstakingly than per routine, drug, alcohol, or other toxin exposure must be considered. Only when such alternatives have been either completely treated or thoroughly ruled out should a clinician be content to diagnose, and proceed to treat, amorphous Generalized Anxiety Disorder.

Psychopharmacologic management of Generalized Anxiety Disorder tends to reflect the diffusion of the diagnosis itself. Tricyclic antidepressants have been tried and said to be effective, most probably due to their sedating side effects. Antipsychotics have been employed and reported helpful, most likely because they have even greater sedating side effects than tricyclics. Benzodiazepines have been useful, but must be strictly time- and dosage-limited because of patients' potential to build up physical tolerance to, and psychological dependence upon, these agents. The nonbenzodiazepine buspirone avoids such dangerous complications, but opinion is sharply divided between practitioners who insist buspirone has no positive effects and those who almost literally sing its praises.

Psychotherapy for Generalized Anxiety Disorder tends to be pragmatic. Relaxation techniques and strategies are taught, exercise and meditative regimens are prescribed, psychoeducation and stress avoidance and reduction counseling are offered. Often, involvement of the family is helpful in identifying

entrenched habits and patterns of interpersonal/intrafamilial interaction that are as obviously certain to outside observers to nourish a chronic crisis climate in the home as they are undetectably second nature to the participants.

4. Posttraumatic Stress Disorder

CASE EXAMPLE

Ms. I, a computer programmer at the corporate headquarters of a large publishing concern, was dating a software engineer at the same company. Ms. I broke up with the coworker when she discovered she was pregnant with another man's baby. The coworker took the breakup hard, becoming increasingly irritable, depressed, and morbid over the next few months.

On the three-month anniversary of the breakup, the coworker followed Ms. I home and confronted her on her lawn. Verbal attacks escalated to pushing and shoving and the two tumbled to the ground. Ms. I managed to knee her coworker in the groin, which served to inflame him further.

The coworker grabbed a large stone from the property's landscaping and began beating Ms. I wildly. He broke her rib and crushed her hand. He thrashed her face, and then he finally regained control and fled the scene.

Two days later, the coworker turned himself into the police. Ms. I, who had remained conscious throughout the ordeal, survived her physical injuries. However, for months following the assault, she was terrified to leave her mother's home. She could not approach her own house. She became nauseous when she approached company buildings. The sight of a computer made her panicky. The ringing of a telephone made her jump. She wanted to see no one, do nothing, say nothing. Again and again, memories of the attack flooded her consciousness, unbidden, unwanted, and irrepressible.

Posttraumatic Stress Disorder (PTSD) is of sufficient importance in the arena of employment litigation to warrant expanded treatment in this volume; it is the subject of Chapter 13, and therefore will not be discussed extensively here. The latest diagnostic refinement of a phenomenon variously termed Shell Shock, Battle Fatigue, or Traumatic Neurosis, PTSD is the only major psychiatric diagnosis formulated in such a way as to embed a specific external attribution of causality within the diagnosis itself. As such, PTSD has become a phenomenon ripe for lay misunderstanding, popular misconception, and professional overuse and exploitation by both medical and the legal practitioners.

Posttraumatic Stress Disorder is the diagnostic embodiment of the intuitive belief that an external, traumatizing event can give rise to an identifiable, lasting set of symptoms. Fundamental to a realistic understanding of the disorder, however, are two psychiatric facts: (1) not all traumatic events will cause PTSD, and (2) relatively few individuals, even if exposed to an event of the magnitude necessary to provoke PTSD, will actually develop the disorder. *DSM-IV-TR* criteria for Posttraumatic Stress Disorder are outlined in Table 5-20.

Table 5-20 *DSM-IV-TR* Diagnostic Criteria for Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) 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
   (2) the person's response involved intense fear, helplessness, or horror. *Note:* In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
   Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   (2) recurrent distressing dreams of the event
   Note: In children, there may be frightening dreams without recognizable content.
   (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
   Note: In young children, trauma-specific reenactment may occur.
   (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. 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:
   (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
   (3) inability to recall an important aspect of the trauma
   (4) markedly diminished interest or participation in significant activities
   (5) feeling of detachment or estrangement from others
   (6) restricted range of affect (e.g., unable to have loving feelings)
   (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   (1) difficulty falling or staying asleep
   (2) irritability or outbursts of anger
   (3) difficulty concentrating
   (4) hypervigilance
   (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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Several points bear brief emphasis here. First is that the threshold stressor criterion, Criterion A, is an extreme one. In order to be capable of shocking the human organism's naturally buffering adrenergic nervous system sufficiently to cause lasting symptoms, the stressful event must be sudden, of enormous intensity, startling, and overwhelming. It must be like a lightning bolt from the sky; a threat to life or limb shattering normal equilibrium and displacing it with fear, helplessness, or horror. Accordingly:

- Lesser, repetitive stressors of minor to moderate intensity, such as sexual harassment with no threat of violence, or interpersonal or physical irritations in the workplace, cannot add up to produce PTSD.
- Events experienced as pleasurable at the time of occurrence but later regretted, such as an inappropriate but voluntary sexual liaison, cannot retrospectively cause PTSD.
- Objectively minor stressors which because of distorted perceptions are experienced as severe, such as a verbal slight or performance admonishment from a supervisor perceived as a narcissistic wound by a personality prone to entitlement and intolerance of criticism, cannot be magnified so as to give rise to PTSD.

In addition, fundamental to the production of PTSD is a conscious, cognizant awareness of the traumatic event as it transpires. Without this, the requisite overwhelming emotional reaction cannot occur. Thus, certain common events claimed to cause PTSD in the context of litigation obviously cannot do so:

- Being blindsided by a blow to the head, such that consciousness is lost.
- Being rear-ended or otherwise struck by a motor vehicle in such a manner as to preclude knowledge of the event's imminence (with no frightening sequelae immediately following impact).
- Suffering a sudden fall or other accident with immediate loss of consciousness.

As is seen in *DSM-IV-TR* Criteria B, C and D, PTSD symptoms overlap with many of the symptoms of other psychiatric disorders, directly mimicking symptoms of Major Depressive Disorder (and other mood disorders), as well as those of Panic Disorder (and other anxiety disorders). Such overlap results in the erroneous diagnosis of PTSD in many persons who coincidentally undergo an unpleasant event during the course of a preexisting depressive or anxiety disorder. Thorough investigation usually permits a clear and orderly differentiation among cases in which a novel stressor caused PTSD, aggravated (or triggered an episode of) a preexisting depressive or anxiety disorder, caused PTSD symptoms to be superimposed upon a preexisting depressive or anxiety disorder, or had no significant effect upon the natural history of a preexisting depressive or anxiety disorder.

Specifically excluded from the diagnosis of PTSD are cases in which symptoms occur only during the one-month period following the stressor. Such cases receive the *DSM-IV-TR* diagnosis of Acute Stress Disorder, reflecting growing evidence that brief periods of PTSD-like symptoms commonly occur in the immediate aftermath of severe stressors. These symptoms typically remit within a few weeks of the event.

Impairment among those suffering PTSD is highly variable, apparently contingent more on psychosocial history, personality factors, and current social situation than on anything intrinsic to the disorder itself. Some individuals are limited only with respect to specific circumscribed activities; others are more globally impaired because symptoms interfere with important relationships or capacity to work. Some are affected for little more than the one month required to make the diagnosis; others may still suffer symptoms years after actual occurrence of the traumatic event.

Both spontaneous remission and successful treatment frequently occur. Treatment efficacy has been reported with brief cognitive-behavioral therapy, with medications, and with other methods. Exposure-based psychotherapies have proven especially effective. Research on medication effects is helping to identify which agents are most helpful for which symptoms. Pharmacotherapy, as well as a rational course of psychotherapy, must be tailored to each individual case of PTSD.

D. Somatoform Disorders

Somatoform Disorders are defined by the paradoxical existence of physical symptoms lacking identifiable physiologic etiology or anatomic pathology. Thus, although there can be found no underlying organic lesion to explain the physical complaint being reported, the subjective experience of physical dysfunction driving that complaint remains very real. A limb cannot be mobilized despite intact neuromusculature, or pain is present despite lack of physical injury or tissue damage.

The Somatoform Disorders must be clearly distinguished from Malingering, in which an individual consciously fakes the existence of symptoms to gain an external reward of some tangible kind, and from Factitious Disorder, in which the individual also consciously fakes symptoms, in this case so as to secure the nurturance and sympathy inherent to playing the "sick" role. In the Somatoform Disorders, the conversion of mental need into physical manifestation is unconscious, and it is complete. Symptoms are unambiguously present and nonvolitional, but they cannot be mapped to any corresponding organic pathology.

1. Somatization Disorder

CASE EXAMPLE

Ms. J, a receptionist nearing her three-year employment anniversary, was charming and cordial with visitors, but also notably fragile. In each of her three years she had used up all of her sick days and vacation and personal days treating, and recovering from, multiple diffuse, vague bodily aches, pains, and sundry dysfunctions. At one point, Ms. J went out on a two-week "stress leave." At another, she returned from a doctor declaring she had been diagnosed with Multiple Sclerosis. That diagnosis was

Mr. L with Posttraumatic Stress Disorder: "PTSD is, in this case, the product of the cumulative impact of the many traumatic experiences this man encountered at his former workplace, all this against the backdrop of a fear of failing his family that rendered him particularly vulnerable to those very traumata."

The defense expert disagreed, diagnosing an Adjustment Disorder with Mixed Anxiety and Depressed Mood. He opined, "While Mr. L was certainly hurt by workplace events, and his symptoms were certainly real, neither the stressor involved in giving rise to the symptoms, nor the quality and duration of the symptoms themselves, approach a magnitude consistent with a diagnosis of PTSD. Mr. L's was a transient, reactive phenomenon; once the troublesome circumstances passed, the symptoms passed as well. There are no clinically significant residual effects evident or to be anticipated."

Adjustment Disorders are the psychiatric conditions most likely to be diagnosed to describe symptoms that follow some stressful event. In fact, Adjustment Disorders are the more correct diagnoses for the vast majority of individuals erroneously diagnosed with Posttraumatic Stress Disorder in the context of employment litigation. Adjustment Disorders can be thought of as a formalization of the critical boundary differentiating the "normal" upset reactions human beings experience when they are faced with stressful life events from the experience that must minimally be present to consider an individual's reaction "pathological."

Three elements must exist for one to be diagnosed with an Adjustment Disorder:

- There must be some identifiable environmental event or events to which the individual develops a response, the response manifesting itself within three months of stressor(s)' onset.
- The individual must react to the stressor(s) with marked distress, exceeding that which would be expected in the "average person" exposed to the event; or behaviors or symptoms in response to the stressor(s) must result in significant impairment in social or occupational functioning.
- Symptoms must last no more than six months after termination of the stressful event or of its direct consequences.

In marked contrast to the strictly delineated threshold event of Posttraumatic Stress Disorder, the nature and magnitude of the original Adjustment Disorder stressor are not specified. It may be a single experience (loss of a job), or there may be multiple upsets (repeated incidences of sexual harassment, plus difficulties during a divorce and custody battle). Stressors may be recurrent but periodic (encounters when a traveling manager intermittently comes to town) or continuous (working as a visiting nurse in a dangerous, hostile neighborhood).

Predominant symptoms affecting an individual with Adjustment Disorder may be those of mood (sadness, tearfulness, hopelessness), those of anxiety (nervousness, worry, jitteriness), or both. Disturbance may also take the form of unaccustomed "acting out" (violation of age-appropriate social rules, reckless driving, fighting, truancy).

Table 5-24 contains the *DSM-IV-TR* criteria for Adjustment Disorder. The various subtypes are identified in Table 5-25.

Table 5-24 *DSM-IV-TR* Diagnostic Criteria for Adjustment Disorder

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
B. These symptoms or behaviors are clinically significant as evidenced by either of the following:
   (1) marked distress that is in excess of what would be expected from exposure to the stressor
   (2) significant impairment in social or occupational (academic) functioning
C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.
D. The symptoms do not represent Bereavement.
E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

Specify if:
   Acute: if the disturbance lasts less than 6 months
   Chronic: if the disturbance lasts for 6 months or longer

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Table 5-25 Subtypes of Adjustment Disorders

Subtype	*Typical Symptoms*
With Depressed Mood	Sadness, dysphoria, tearfulness, hopelessness
With Anxiety	Nervousness, worry, jitteriness, irritability
With Mixed Anxiety and Depressed Mood	Symptoms of both depression and anxiety are prominent.
With Disturbance of Conduct	Violations of others' rights or of major age-appropriate societal norms and rules, vandalism, reckless driving, fighting, truancy
With Mixed Disturbance of Emotions and Conduct	Both emotional dysregulation (depression, anxiety) and behavioral dyscontrol (disturbance of conduct) are prominent.
Unspecified	Other types of maladaptive reactions (social withdrawal, anorexia without mood change) are predominant.

Adjustment Disorders are by definition self-limited, but even their mandated six-month maximal course can usually be reduced through supportive

psychotherapy, teaching of coping or relaxation techniques, or sometimes simply via some "ventilation port" such as a sympathetic manager, an Employee Assistance Program, or a diary. If elements (or consequences) of the original stressor(s) continue to affect the individual's environment and to exacerbate symptoms, assistance in removal of the irritants, or in removal of the individual from the irritants, will often prove the most efficacious treatment available.

Generally, psychotropic medications are not indicated in the treatment of Adjustment Disorders. However, if particular symptoms (anxiety, tension headache) are especially acute or bothersome, targeted short-term use of symptom-specific psychopharmocologic agents (anxiolytics, analgesics) may be appropriate for immediate relief.

III. Effective Forensic Mental Health Workup of Axis I Claims in Employment Litigation

Like most medicolegal evaluations involving psychiatric claims, the analysis of those emerging in employment litigation can be organized around three core issues:

- Does there exist a diagnosable psychiatric disorder, and if so, what is the appropriate diagnosis?
- If there does exist a diagnosable psychiatric disorder, how, if at all, does that disorder interact with events at issue in the litigation?
- Has treatment to date been appropriate, what is the prognosis, and are there any suggestions for future case management?

The first of these issues surrounds the medical notion of diagnosis and is critical to the legal concept of damages. The second involves the medical question of differential diagnosis and it relates to the legal concept of causation. The third focuses upon the medical area of treatment and prognosis and addresses legal concerns of extent of injury and possibly of mitigation.

As has been evident in the foregoing review of commonly encountered Axis I disorders, not only is there frequent symptom overlap among these disorders, but many of the disorders are episodic and recurrent. Thus, diagnosis in legal contexts must be exquisitely sensitive not only to symptom pattern but also to symptom history and the correlation of symptoms to timing of events alleged in litigation. Since potential motivational factors (such as financial gain and revenge) are fueled by potential interpersonal factors (such as rage, insult, and envy), those engaging in forensic psychiatric evaluation must include the entire psychosocial, motivational matrix of the employment setting in their analysis. Simply listening to a plaintiff list his or her complaints and describe his or her experiences (as one would do in basic clinical work) is a road certain to lead the forensic examiner to distortion and distorted conclusions, intentionally instilled or not. Extensive data gleaned through review of written materials must be incorporated into any conclusions suggested via psychiatric examination alone.