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Workers' Compensation:
Mental Injury Claims

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Foreword

During the l980s and 90s I was challenged by the process of evaluating Workers' Compensation claims, almost always for the defense. This proved to be very thought-provoking, particularly since the law concerning Workers' Compensation had evolved from legal cases, not from consideration of human psychodynamics. Most of my practice has been as a clinician, treating patients both in the office and in the hospital. I was advised early on not to try to do therapy except on a supportive basis with patients who were pursuing a suit. This suggestion had a pragmatic basis. Only later did it become clear that most suits involve use of defense mechanisms which do not allow the patient to be introspective or willing to change.

The types of situations involving mental/emotional aspects of workers disability are usually divided into three categories: Mental-Mental (mental disorder without physical injury); Physical-Mental (physical injury precipitating emotional disorder); and Mental-Physical (mental problems engendering physical illness). This paper treats the first two categories involving workers who are adults and who are not brain injured. A discussion re children would be an entirely different matter.

My goal in this paper is to explicate factors involved in Workers' Mental Health Injury Claims and to clarify the nature and interrelationships of various factors involved from a psychodynamic point of view. These include (1) the origins of mental illness, (2) cause and effect relationships, (3) stress and stressors, (4) mental injury from legal and psychiatric points of view, (5) character pathology, (6) harassment, (7) Workers' Compensation law. I hope that the reader will find this discussion stimulating and a contribution to increased understanding of a complex subject.

Introduction[*]

Workers compensation law has been given the task of dealing with a worker's industrial illness through a legal procedure that previously would have been dealt with in tort law. The area of tort law provides redress or compensation for emotional upset, "pain and suffering," "loss of consortium," and other categories of damages. These constitute normal emotional reactions. When provoked by negligence or malice these emotional

[*] While workers are of both genders, for simplicity the pronoun "he" will be used to refer to workers in this paper.

reactions become the basis for legal action. Psychiatric diagnosis and treatment should not be necessary parts of this process. A diagnosis of mental disorder presumably would not be required for a successful suit. But Workers' Comp law is based on the presence of illness, not merely normal emotional reactions. The psychiatrist is in the awkward position of having to make a diagnosis of illness and after suspending psychodynamic understanding affirm that the illness is caused by factors of employment. In cases which are Physical-Mental it is easier to conclude that there is a connection between the industrial injury and subsequent emotional distress or disorder. While most disabled workers return to work in a reasonable time frame, a certain percentage do not The frustrated physicians and insurance carriers often refer these latter workers for psychiatric consultation. They present puzzling problems. Clinical evaluations of these workers have been complicated by a presumption that the evaluations should conform to a series of legal decisions.

At times the injured party may suffer an illness rather than a normal emotional reaction. Frequently, the legal process plus the injured person's character pathology may combine to prolong the individual's symptoms, so that he appears to have a chronic mental disorder. The question of cause and effect has been difficult to assess in this area of emotional disorder. Since Causation has critical legal ramifications, it deserves thorough examination. While the efforts of administrative processes and the courts to be fair to both workers and employers are commendable, the area of Workers' Compensation needs more rigorous criteria for evaluating and compensating injured workers. It is hoped that a psychodynamic understanding of causation can evolve as distinct from legal formulations.

Background

During the 20th century the understanding of the relationship between emotional disorder and employment evolved bit by bit in a series of legal decisions. In early decisions about "stress injuries", unconscious and characterological forces were not acknowledged. The concept that "industry takes the employee as it finds him" (*Liberty Mut. Ins. Co. vs Ind. Acc. Com*. (1946) 73 Ca. App 2d 555,559) led the courts to apply a subjective test in evaluating injuries related to stress. In his book of 1983 re Workers' Compensation, Judge Herbert Lasky[1] summarized current thinking as of the *Albertson* decision of l982 (*Albertson's Inc. vs WCAB (Bradley)* (1982) 131 Cal. App. Bd . 308,314).

1. Subjective perception of stress can support a finding of industrial injury.

2. In order to prove that an injury arose out of and occurred in the course of employment and was proximately caused by employment, it must be shown that the employment is one of the contributing causes without which the injury would not have occurred.
3. These conditions are not met if the employment was a mere passive element that a non-industrial injury happened to have focussed on, or a mere after-the-fact rationalization.

Of these three only the third introduces elements which can be considered psychodynamic. The second rule mentions "injury" but does not define what a mental injury is. This rule first introduces the matter of Proximate Cause and then speaks of "contributing causes". The latter is a much looser concept then Proximate Cause. In early years the train of causation was vague, as in the nursery story about "but for the nail the shoe was lost, but for the shoe the horse was lost, etc". This line of reasoning was tightened up by the concept of Proximate Cause wherein an event had to be of critical importance, not merely "contributing".

Causation

Human beings in their formative years (up to the early twenties) develop personality structures of varying degrees of strength and learn to handle the kinds of situations that come up in the normal expectable course of human existence. Thus when the worker arrives in the job arena, he has in place to a variable degree the mechanisms for handling the vicissitudes of adult life. Mental illness represents a breakdown of the effectiveness of the individual's mechanisms and the development of pathological symptoms and mechanisms.

The sine qua non of the development of most mental illnesses in adults is the vulnerability, both constitutional and acquired, which the individual brings with him from his formative years. Constitutional factors include natural endowment regarding IQ and energy level, intrauterine or birth injuries, and biologically based illnesses, including schizophrenia, bipolar disorder and panic disorder. The great majority of events associated with the development of mental illnesses in adult life are not events which in and of themselves mandate the development of mental illness. Confusion about this point contributes to the mystery which seems to surround the causation of mental illness. The

causation of functional mental illness is surprisingly very simple. It depends on the individual's propensity and vulnerability, not on the intercurrent events of adult life. This includes the great majority of events that occur in the workplace. The stressors of the workplace usually lead to normal emotional reactions, not to mental illness per se.

There is a significant difficulty in determining cause and effect in the approach of the Armed Forces towards illness. For many years the Armed Forces have considered an illness developed during the course of a person's military service as being a service connected disability so long as it was considered to be In Line of Duty (i.e., not due to misconduct on the part of the individual), and had not Existed Prior to Enlistment (EPTS). Character Disorders were not considered to be "illnesses." The question of cause and effect was bypassed. Presumably the social policy was determined because a person gives up a large measure of his freedom in joining the military and potentially risks the possibility of dying in the service of his country. Thus there was an impetus for psychiatrists to distinguish between character disorder difficulties and medical illness, but there was little impetus to define accurately the connection between external events and internal emotional reactions, aside from combat experiences.

Stress

Stress relates to the condition of the organism.[2] A condition of "stress" is a normal variation of human functioning, often related to external events or circumstances which act as stressors. Stress is not a state of illness. It may accompany pleasurable activities as well as distressing ones. Negative stressors can be categorized as Extreme, Severe, Moderate, and Mild. The Mental Illnesses which are "caused" by a stressor are Post Traumatic Stress Disorder (PTSD) and Acute Stress Disorder. These require an Extreme Traumatic Stressor. To quote from DSM-IV-TR[3] (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision): "The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate." The diagnosis of Acute Stress Disorder is made if the disturbance lasts less than one month. (One can argue that stressors

that do not involve direct personal experience constitute Severe Stressors rather than Extreme ones. In any case the deciding factor is the development of the characteristic symptoms of PTSD after the stressor). The fact that a Severe Stressor (e.g., death of a spouse) leads to a severe reaction does not mean that the reaction qualifies as Acute Stress Disorder or PTSD. Maladaptive Reactions are caused by the vulnerability of the individual and the failure of his or her particular coping mechanisms, not by the nature of the stressor (except those noted above).

While Extreme Traumatic Stressors can occur in the workplace, the great majority of stressors in the workplace are normal, more or less expectable variants and do not warrant being classified as Extreme or even Severe ones. Attempts to categorize stressors usually put loss of a spouse as the most severe stressor one can experience in the course of adult life (*see* Dr R Rahe). By using this approach to stress and stressors, one ensures that any occupational mental injury which causes illness would indeed be the result of a stressor which satisfied the above quoted criteria.The construct of mental "injury" in the law is a far different matter than the construct of "Psychological Trauma" (Extreme Traumatic Stressor) as defined in DSM-IV. Thus in tort law the injuries such as distress from harassment, pain and suffering, loss of consortium, and so forth, all represent a kind of "injury." These are normal emotional reactions. If an illness ensues, it is based on the individual's vulnerability and is not based on the nature of the stressor itself. The psychological construct of "injury" only results in mental or emotional illness in those rare cases which would satisfy the definition of Extreme Traumatic Stressor

Events of the workplace involving interpersonal conflicts, employment termination, discipline, demotion, evaluation or transfer should all be viewed as normal, expectable, variants of the workplace. These stressors are managed by the usual coping abilities of the individual. If an individual develops adjustment disorder or mental illness subsequent to any of these events, these conditions should not be viewed as "caused" by the external event, but should be viewed as a product of the person's own vulnerability. In other words, the concept of "Post Hoc Ergo Propter Hoc" does not apply. If employers permit work conditions which can be harmful to the employees, these conditions should be addressed by OSHA or the Labor Code, not through Workers Compensation.

Physical and Mental Stressors

A closely related source of confusion lies in the failure to distinguish between Extreme Traumatic Stressors and physical trauma or injury. A physical injury (leaving aside brain injury) can involve a variety of mental-emotional reactions. Most of these reactions will fall under the category of normal reactions which bring into play the coping abilities of the individual.

The next most common reactions would be what are called in DSM-IV, Adjustment Disorders. "The essential feature of this disorder is a maladaptive reaction persistent for no more than six months." DSM-III (1987)[4] described types of stressors, most of which could be considered to be the unfortunate vicissitudes of life. Some of these stressors are Severe but not Extreme, i.e., they do not qualify as Extreme Traumatic Stressors for adults (though they may very well do so for children). DSM-IV has wisely omitted the attempt to categorize stressors.

Persons suffering PTSD will be subject to varying degrees of disability. Many will continue to work or return to work fairly soon, albeit at a reduced level of efficiency and personal comfort. Some individuals will have prolonged disability with failure to return to work. Here one must consider the possibility that the prolongation is due to character pathology rather than a product of the PTSD per se.

Some physical injuries can occur concurrently with Extreme Traumatic Stress. The PTSD is "caused" by a work injury. The majority of physical injuries involve various degrees of psychic stress in dealing with the injuries and the mental/emotional adjustment that becomes necessary during the healing process. Technically the "cause" of a pathological reaction lies in individual's personal vulnerability. However since the primary physical disorder is work related, then ancillary Mental-health treatment will certainly be justified. Many workers will need mental health care to recover from their physical illnesses and return to work in a timely fashion. Mental health care will need to be provided to treat the whole picture of physical injury, whether the worker's response is quasi-normal, an Adjustment Disorder, or other. However many workers with physical illness continue to be symptomatic and disabled long beyond the period for recovery which their physicians normally expect. Many workers continue to pursue disability indefinitely. In these cases the initial pathology is replaced or prolonged by factors in the workers personality structure. Attempts to treat such workers are to little avail. Such individuals are

frequently referred to Mental Health resources for diagnosis and treatment by the worker's treating physician who is usually quite exasperated by the failure of the patient to respond. However the worker's resistance to mental health care is usually quite pronounced. The only possibility of change might occur after the legal matters are settled.

Character Pathology

A major source of confusion in the area of occupational mental health and illness (and perhaps more importantly in the area of physical disability) involves character pathology which strongly determines the individual's wish to blame his difficulties on sources outside himself and which strongly determines the motivation he might have to return to the work force after being disabled.

DSM-IV enumerates eleven types of specific personality disorders. These are traditional categories. The related area to which the study of character pathology must devote attention involves the area of personality weakness or deficit.[5] These terms refer to a developmental failure. No moral judgment is intended by the use of the words. Most people will have fairly firm personality development in adult life. Unfortunately there will be a sizable proportion of people who have a personality weakness. Most of the time this "weakness" will not have led them to come in contact with legal or mental health systems. Thus a superficial look at a person's past functioning may not present the usual kinds of episodes or behavior which one ordinarily associates with various personality disorders.

The significant feature of such personality weakness involves the use of primitive emotional defense mechanisms of denial, splitting and projection. These constitute the essential features of Borderline Personality Organization[6] BPO, (not *Disorder*). The typical worker using these defense mechanisms comes to the psychiatrist or other resource denying that he has any emotional conflicts in his life other than in the workplace; he splits his personal view of the world into the "bad" workplace and the "good" area of his personal virtue and his personal life; and he projects blame for his emotional difficulties onto external forces while at the same time taking no responsibility for his own emotional reactions, his motivation to work or conquer pain, etc. The individual then "acts out" his hostile feelings toward the "bad parental image" projected on the workplace by staying away from work and claiming "disability" under Workers' Compensation. While he may indeed be disabled by his character pathology, the fact of blaming it on stressors in the workplace does not establish a cause and effect relationship. The fact that he "honestly

believes" his allegations does not substantiate a cause and effect relationship. It merely means that his conscious thinking is in the grip of unconscious forces. This area of personality pathology, i.e., Borderline Personality Organization, has not been well identified in psychiatric work. Psychiatrists have been reluctant to identify personality pathology unless it fits one of the traditional categories. One rarely sees a picture of obvious Borderline Personality Disorder. An expert on Personality Disorders, John M. Oldham M.D. M.S.,[7] notes that DSM-IV includes a diagnostic category, Personality Disorder N.O.S. (Not Otherwise Specified) which has been reported to be the single most frequently used diagnosis in clinical practice.[8] This usage may be indicative of an awareness by the clinician of personality factors for which a diagnosis of BPO would be appropriate.

This area of pathology, BPO, is the most significant determinant of whether a worker with a physical injury or a "stress" claim returns to the work force. An individual with this type of character pathology does not have a firm sense of identity as a worker. Thus at times of conflict this individual may forego a previous identity of worker and self reliant person, and assume a new identity of injured, disabled individual. This new identity is a kind of solution for the individual's internal conflicts and he does not readily relinquish it, particularly in older age. Such a change of identity is an attempt to solve internal conflicts as well as an attempt to ensure financial support.

One expects that when a person and the stressor are separated, the symptoms of the worker will ameliorate or end. But people using borderline defenses may remain symptomatic indefinitely or until compensated monetarily, though perhaps not even then if retirement is their goal. This prolongation of symptoms falls in the category of Passive Aggressive/Passive Dependent behavior. It is no longer classified as separate character pathology in the DSM-IV, but is now best identified as a behavior problem, an elaboration of the splitting defense: refusal to return to work or to seek help to overcome the worker's Passive Aggressive attitudes and behavior. The diagnosis of 309.4 Adjustment Disorder, Mixed Disturbance of Emotions and Conduct comes closest to describing the condition.

A word about Neurosis is appropriate here. Neurosis should be distinguished from Character Problems. Neurosis may be a fixed part of a person's usual functioning. However it is potentially ego-alien and usually does not involve a need for borderline defenses and goals: long term avoidance, dependency and compensation. A person wishes

to rid himself of the neurosis and only uses it for long term functioning when it constitutes a "lesser evil" i.e., to maintain homeostasis.

The terms "neurosis" and "trauma" have been used by various authors to reflect different parts of the picture. W. Donald Ross, M.D.[9] used the term "Traumatic Neurosis" as an equivalent to PTSD. The prolongation of symptoms and disability he classified as "Compensation Neurosis". On the other hand Lester Keiser, M.D[10] used these terms to describe the "Traumatic Neurosis", which he identified as a condition usually not part of a primary illness and generally beginning three to six months after an accident. This seems to be another way of describing the prolongation of symptoms which can be attributed to BPO. The following clinical cases illustrate contrasting character functioning.

Don was a Protestant caucasian policeman, about 40 years old, in good physical health, married with teenage children. He and his partner were called to check out a situation wherein a woman had called who said her husband was drunk and brandishing his rifle in the garage. As Don approached the garage the man shot several bullets through Don's abdomen. They were steel jacketed and did not explode within him but passed straight through. The man threw down his rifle before Don's partner could shoot him. (This triggered illness in the partner which eventually led to his medical retirement).

Don was treated successfully in the hospital and was left with a significant back disorder which was helped by rehab. He refused medical retirement and insisted on returning to work. Each day he spent a prolonged period exercising to get his pain under control before going to work. However in the next two years he became increasingly depressed as his marriage fell apart and his partner did not return. When he became suicidal he was referred for psychiatric evaluation and treatment. Diagnostically he suffered from Major Depression and covert PTSD. He did not stop working. His conditions remitted gradually with therapy and he continued to work for many years.

Marie was a caucasian Catholic office worker, married with no children and in apparantly good physical health (but with a history of back injury from which she had recovered). One day she was working at a lower drawer of a filing cabinet. When she stood up her head struck a drawer that had been opened above her. She suffered a neck injury. She felt this disabled her and she started a long process of treatment under Worker Compensation. At one point she seemed suicidal and was referred for psychiatric evaluation and treatment .She was diagnosed as having Depression and later as having a

Psycho-Physiological Disorder which perpetuated her complaints and disability. These were so persistant that at one time surgery was contemplated.

Her previous history of back disorder was significant. At a previous job she had slipped on a newly waxed floor incurring low back injury. She was off work under Worker's Compensation which eventually settled financially. She also had a successful third-party suit against the company that made the wax. She never returned to that job.

In therapy her improvement was slow and she showed no inclination to resume her job. However she became well enough physically to participate as a dancer in a community theater production! It became apparent that she clung to her therapy due to a combination of BPO plus a positive transference to the therapy process. Her therapy and Worker's Compensation suit were discontinued. However her conflicted mental state required further therapy by a second therapist. She never returned to the job.

This case illustrates the contrast between the behavior of a worker of good ego strength versus that of a worker whose character is impaired . Don's case illustrates how a person with a firm sense of identity overcomes obstacles to maintain his usual identity as a worker. In contrast, the worker with a character deficit, i.e., Marie, behaves as described above: passive-aggressive behavior (avoids work), splits the world into good and bad ("with" her or "against" her), takes a victim role, sets aside the identity of being a worker on a job, and claims persistent disabling physical symptoms.

Insurance

The expectation that a person with an emotional disorder will seek appropriate help brings up the dilemma of insurance coverage. When an illness is not caused by employment, the worker optimally can seek help using his personal health insurance coverage. Unfortunately many plans do not provide mental health coverage or the benefits are very limited. In such cases, an evaluator may be disposed to find the worker's illness to be job related so that the worker can have access to mental health care. While the desire to see the worker get help is understandable and important, the solution lies in having insurance policies that provide good mental health coverage. Many examiners seem to assume that only Worker's Compensation is appropriate and available for disabled workers.

Harassment

Some years ago the concept of Cumulative Trauma was accepted in relationship to certain physical disorders affecting work capacity. Persons doing physical labor were concluded to have had many small injuries which eventually led to a major illness which precluded their usual work, e.g., spine disorders, carpal tunnel syndrome, etc. Subsequently, psychiatrists began to try to apply similar reasoning to mental disorders. There emerged the concept of Harassment on the job as being the mental health equivalent of Cumulative Trauma.[11]

This equation does not stand up under close inspection. Harassment is a normal human phenomenon with which one learns to deal with varying degrees of success from childhood. Harassment may be handled by the individual via a normal emotional reaction or by adjustment disorder. While it might be the basis for legal action in tort, it is not a cause of mental illness. If a mental illness develops, it is the product of the worker's vulnerability, not of the harassment per se. Paradoxically it appears that at times persons with a deficient sense of self will provoke and thrive on what they view as harassment. They thus feel enlivened and can project blame outwards rather than face their own sense of emptiness.

The concept of cumulative injury is seldom applicable in psychiatric work. Certainly if a person were robbed at gunpoint with the threat of violence on repeated occasions, the person might be able to shake off the first couple of episodes but then be increasingly traumatized by subsequent episodes. Each event would qualify as the kind of event which would potentially induce a PTSD. This is a rare occurrence however. The fact that one is criticized by one's boss, that one is moved from job to job, and the other sorts of complaints that people tend to add up as a cumulative trauma, are merely normal expectable variants of the workplace and do not add up to Extreme Traumatic Stressors. A recent case illustrates a healthier way of dealing with harassment.

A black probation officer, Morris, had been subjected to harassment by his supervisor for many years.[12] Morris sought psychiatric help. His therapist endorsed the pursuit of a suit and encouraged him to stay on the job. Management did nothing about the harassment. In fact at one point his supervisor concocted a story that three female employees had complained that Morris had sexually harassed them. At trial they all denied making such an allegation. Morris continued to work and ultimately prevailed in his suit

with monetary damages awarded including punitive damages against his supervisor. This case illustrates a healthy way to deal with harassment. The pursuit of a suit uses current law appropriately and does not imply the use of the defense of "splitting".

Legal Considerations

The Workers' Compensation area has profited greatly by the development of more specific criteria governing compensability for mental injury. In June 1992 the Workers Compensation Committee of the California Psychiatric Association[13] contributed to modification of the W.C. law. In a Position Statement they discussed the general field. They understood that the levels of responsibility by the employer could be classified as Significant, Substantial and Predominant. They then proposed that the standard of Substantial be adopted and listed 20 examples of job stressors that would in their view satisfy that category. My review of these examples, however, indicates that only four would satisfy the category of Extreme Stressors (Predominant?). Four of them fell under the category of mental problems of the Physical-Mental category. The remainder were situations where the employers business practices were inadequate or unjust but did not require action under Workers Comp but rather by OSHA or the Labor Code. If the employee needed mental-health help, it would be acquired under regular health insurance. In 1993 California law[14] was changed to require that employment be held responsible by "a preponderance of the evidence (i.e., 51%). The bar was raised to exclude minor stresses from the job. However this still left room for severe or even moderate stressors to be held responsible for emotional disorders. As indicated above in the section on Stress only Extreme Stress and PTSD should be sufficient to establish a cause and effect linkage.

In 2003 when further changes in W.C. law were contemplated, a bill[15] was proposed that would raise the bar even higher, to a level of proof by "clear and convincing evidence". This hopefully would have excluded all stressors except Extreme ones. Presumably this would have been a 75-80% or higher level. However opposition to the bill, including from the California Psychiatric Association, defeated it. It may be that the bar should be raised to the highest level and require evidence "beyond a reasonable doubt". Then all stressors except Extreme ones could be eliminated.

The cost of Workers' Compensation Insurance to California employers increased enormously over the years. The legislature made changes to the law in 2004.[16] The previous law generously allowed five years before a claim had to reach final settlement.

This time element allowed the recovery from disability to be quite lethargic. The new law required settlement in 104 weeks, except in certain circumstances.

Conclusion

Workers' Compensation law endeavors to be more than fair to the injured worker. This is commendable but it is very difficult if not impossible to reconcile sound psychodynamic understanding of a case with the various legal precedents with which attorneys and courts must deal. In the instance of a physically injured worker with a concomitant Adjustment Disorder there may come a time for the therapist to make a decision that the worker has recovered from his Adjustment Disorder and that a continuation of his symptoms and disability is the product of underlying Borderline Personality Organization or other mental illness. At this juncture it can be recommended that the worker's connection with Workers' Compensation for mental health care be discontinued and that the worker seek further mental health help through private insurance or government resources. Such a recommendation will help undermine the splitting defense. It is a valid conclusion and may well be helpful to the courts and attorneys. (Of course the patient may complain strenuously!) These factors will very much influence the success or failure of efforts at rehabilitation and/or retraining.

Summary

Mental illness may be precipitated by external stressors but it is caused by internal vulnerabilities. The only exceptions are ASD and PTSD which are *caused* by an Extreme Traumatic Stressor. This way of understanding a Worker's mental situation may seem unsympathetic but it is one that ultimately makes good sense in terms of psychodynamics.

The willingness of the worker to be disabled and adopt a new identity of disabled victim is caused by a developmental deficit of personality structure which produces character pathology with Borderline Personality *Organization*. It would be very helpful if this latter category had a formal designation in the DSM, perhaps as Borderline Personality Organization with Passive-Aggressive/Passive-Dependent Features.

Defense attorneys appreciate comprehensive evaluations. Attorneys for the applicants however prefer that our evaluations remain a bit hazy so that they can bend them to fit the legal precedents they think would be best for the worker. Since the pay for these evaluations can be fairly generous there is an unfortunate tendency for the evaluators to reach conclusions which the referring attorney will find to his/her liking. This is a

seductive process, largely unconscious. If the attorney doesn't like the conclusions, the clinician probably won't hear from him again. To be true to ourselves and the scientific aspects of our profession it is to be hoped that Mental Health Professionals who evaluate these cases can use psychodynamic understanding in dealing with the disabled worker rather than trying to fit their evaluation of the workers' mental state into the Procrustean bed of legal precedent.

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