Mental Illness: Causation Considerations Specifically for Legal Claims

by Robert J. Barth
Parkridge Hospital Plaza Two
2339 McCallie Ave, Suite 202
Chattanooga, TN 37404
423/624-2000

With contributions from:
Allen J. Frances
Les Kertay
Joel S. Steinberg

NOTE: Less complete versions of this discussion have been published in each edition of the AMA Guides to the Evaluation of Disease and Injury Causation

NOTE: The chapter is a more elaborate discussion of the project that was undertaken for the mental illness chapter of the AMA Guides to Disease and Injury Causation, Second Edition. The deadline for this project was many months prior to the recent publication of the new edition of the American Psychiatric Association’s diagnostic manual (commonly referred to as DSM-5). Further, the American Psychiatric Association has formally designated a companion text for the DSM-5 as “essential”, but that essential companion text will reportedly not be published until this AAOS course has been completed. The unavailability of that essential companion text prevents an updating of this chapter for purposes of compensating for the recent publication of the DSM-5 (essential information is simply not available). Therefore, readers are asked to tolerate some potential confusion that could be caused by the disconnect between the deadline for this project, the late publication of DSM-5, and the non-availability of the essential companion text for DSM-5.
A. Introduction

Legal claims focused on mental illness almost always involve a claim that some experience has caused the illness. There are many obstacles to finding credible scientific support for such claims. Many of the obstacles are highlighted by the causation analysis protocol that serves as the foundation of the *AMA Guides to the Evaluation of Disease and Injury Causation* (Barth 2012a; Melhorn and Ackerman; Melhorn, Talmage, Ackerman, and Hyman). This chapter uses that protocol as a framework for purposes of explaining the obstacles.

Most of the protocol steps are discussed in this chapter, because each of them introduces unique obstacles. Such obstacles are actually produced by the first step. Therefore, readers are reminded that the six steps must be performed in sequence (Hegmann & Oostema; Barth 2012a). If any one step fails to produce credible support for a claimed causative relationship, that one step alone ends the process (thereby revealing a lack of credibility for the claimed causative relationship). The discussion of multiple steps in this chapter should not be misconstrued as an indication that it is credible to move on with subsequent steps, after an early step reveals obstacles to confirming that a claimed cause has led to a claimed clinical presentation.

The first edition of the Causation *Guides* (Melhorn & Ackerman) explained that the legal standards from most judicial and administrative systems place the burden of proof on the claimant’s/plaintiff’s side of the argument. That legal standard has consequently become a guiding principle for forensic work (see Table C; Simon). Given this burden of proof issue, and given the causation considerations that are discussed in this text, it will be an uphill battle, in any individual case, to credibly justify claims of work-relatedness, injury-relatedness, accident-relatedness, or any relationship which involves civilian adult life events as a cause of mental illness. This chapter illuminates the steep nature of that hill, and offers examples of the obstacles that must be overcome if such a claim of causation is to be credibly endorsed.

B. The necessity of independent evaluation

The starting point of causation analysis for any individual legal claim of mental illness is an independent evaluation, and/or an independent review of records. Professional standards, including ethics codes and licensure laws, prevent treating mental health clinicians from becoming involved in forensic issues, such as causation. This creates a need for independent evaluation or review, whenever causation must be addressed. Reasons for the restriction against treating clinicians becoming involved in forensic issues have been published by the American Psychological Association (Greenburg and Shuman, 1997 and 2007), the American Psychiatric Association (Hales et al.), and the American Medical Association (Barth & Brigham).

A detailed discussion of this issue has been provided in the listed references. For the purposes of this chapter, the following summary is being provided. Treating mental
health clinicians should refrain from addressing forensic issues, including causation, because becoming involved in such issues:

- creates extreme financial and social conflicts of interest for the treating clinician (the extreme nature of the conflicts is unique to treating clinicians)
- compromises the quality of the treatment that the clinician is attempting to provide
- deprives administrative and legal systems of the objectivity that they need in order to work properly.

Additional literature has explained that it would be a violation of the ethics guidelines of the American Psychological Association and the American Psychiatric Association for a treating clinician to offer conclusions regarding causation (or any other forensic issue) (Reid).

**Table A: The Nature of the Diagnostic System for Mental Disorders, as Explained by that System’s Historical Chairperson**

*Based on previously published content from Allen J. Frances and Thomas Widiger (Frances & Widiger)*

*Summarized for the purposes of this text by Robert J. Barth, in consultation with, and with review by, Allen J. Frances*

*Until late May 2013, the current edition of the American Psychiatric Association’s diagnostic manual was a Text revision of the Fourth Edition. That edition is typically referred to by a set of initials (and one Roman numeral) – DSM-IV-TR.*

*In the DSM-IV-TR’s listing of the people who created it, the name at the top is Allen Frances. Dr. Frances chaired the process of creating the DSM-IV-TR. Consequently, clarifications from Dr. Frances regarding the nature of the diagnostic system for mental illness are especially noteworthy.*
Dr. Frances has worked diligently over the past few years to warn of the apparently misdirected approach that a new revision of the diagnostic manual was taking. Readers are strongly urged to read his many writings on that subject, in order to develop an understanding of the frightening nature of that revision process, and the resulting product.

In the process of offering those warnings, Dr. Frances has also provided valuable clarifications regarding the nature of the diagnostic system for mental disorders. In this regard, his writings have a great deal of relevance for the causation analysis protocol that serves as the foundation of the AMA’s Guides to the Evaluation of Disease and Injury Causation, because the first step in that protocol is the credible establishment of an explanatory diagnosis (preferably, based on objective findings).

Examples of such clarifications are provided below. Some of these examples address causation generically and directly, while others address the primary step in the causation analysis protocol (diagnosis), and others address the issue for which the AMA Causation Guides were created (forensic causation analysis).

All of the following issues have been addressed in a paper which Dr. Frances provided for the 2012 Annual Review of Clinical Psychology, with co-author Thomas Widiger (who served as the Research Coordinator for the DSM-IV-TR) (Frances and Widiger, 2012). Readers are referred to the original article in order to gain a more thorough understanding.

In order to minimize the risk that this discussion will be taken out of context, this review begins with a discussion of the necessity and usefulness of the DSM-IV-TR. The review then concludes with a discussion of the limitations of the diagnostic system for mental illness (limitations which applied to the DSM-IV-TR, and which apparently apply to an even more
substantial extent for the new edition, which is commonly referred to as DSM-5).

Necessity and Usefulness

• The DSM-IV-TR is “indispensable”, because it “provides a common language for clinicians, a tool for researchers, and a bridge across the clinical/research interface.”

• It also provides a standardized coding system.

• It “is our best current way of communicating about mental disorders”.

• It “does its job reasonably well if it is applied properly and its limitations are understood.”

• It “is necessary to carry forth the current, everyday, practical clinical and administrative work that is its first priority”.

• The process for creating the DSM-IV-TR was designed in a fashion that “maximized the potential for informative critical review”.

Limitations

• “There is no scientifically proven, single right way to diagnose any mental disorder”.

• “There are no objective tests in psychiatry; no X-ray, laboratory, or exam finding that says definitively that someone does or does not have a mental disorder.”

• Scientific findings of relevance to diagnosis “are not only thin but also mostly derived from highly specialized research settings that have questionable generalizability to the real world.”
• “A problem is that available information on the validators for most diagnoses is usually equivocal and inconsistent.”

• The diagnostic system is “not quite detailed enough for the tastes of researchers”.

• “Mental disorders are no more than useful constructs – they are not real and independent psychiatric illnesses with clear boundaries.”

• The formal recognized mental disorders have arisen “without a sufficient underlying system or scientific necessity”; “The rules for entry have varied over time and have rarely been very rigorous”.

• “Each of these (formally recognized mental disorders) is just description – not an independent disease.”

• Instead of the diagnostic system identifying “well defined psychiatric illnesses”, the system only provides “descriptive prototypes that are inherently heterogeneous”. Schizophrenia is offered as an example of such heterogeneity, as the text explains that the concept of schizophrenia may eventually be found to include “20 or 50 or 200” different disorders.

• In its current state, the system does not provide a listing of “etiologically defined diseases”.

• “A gaping disconnect exists between the brilliant discoveries informing genetics and neuroscience and their almost complete failure to elucidate the causes of mental disorders.”

• “Classification in psychiatry has so far been singularly unsuccessful in promoting a breakthrough discovery of the causes of mental disorders.”
The flaws of this diagnostic system, and its vulnerability to misuse, have contributed to “a basic background of overdiagnosis”. The overdiagnosis phenomenon also produces “false epidemics”, including at least four that we are in the midst of currently.

The diagnostic system is “not nearly precise enough for lawyers”.

Recent worsening the Inadequacies of the Mental Illness Diagnostic System

The project which produced the chapter that you are reading right now had a deadline that was months prior to the publication of the new edition of the American Psychiatric Association’s diagnostic manual (DSM-5).

Based on pre-publication reports from the American Psychiatric Association, Frances and Widiger published concerns that the new edition of the manual actually represents a deterioration of the diagnostic system for mental illness. For example, they reported:

"The DSM-5 is being prepared with little or no attention to the methods of evidence-based medicine and risk analysis; to its public health and public policy impact; to how its suggestions will play in average mental health settings and in primary care; to the effects on health economics; and to its misuses in forensic settings."

One manifestation of the inadequately defined nature of mental disorders has been termed “diagnostic inflation”. This phenomenon is perhaps best illustrated by the report that only six disorders were listed in the original census of mental patients in the mid-nineteenth century, but DSM-IV-TR involved close to 300 (including those that are “just slight accentuations of the everyday” functioning of
“normal” humans). “Society also has a seemingly insatiable capacity (even hunger) to accept and endorse newly minted metal disorders”. The preliminary information regarding the new edition of the diagnostic manual indicates that changes will include new diagnoses, and lowered thresholds for existing diagnoses (specifically including the construct that Simon has reported as a “growth industry” for claimant/plaintiff attorneys, Posttraumatic Stress Disorder-PTSD). These changes will increase the rate of diagnosed mental illness, thereby increasing the already established pattern of over-diagnosis, and increasing the number of false epidemics.

- Frances and Widiger have also reported that preliminary information indicated that diagnostic protocols will once again be changing. This means that the minimally useful scientific knowledge base will completely lose all value for any mental illness construct which undergoes such re-definition. This phenomenon will have specific consequences for the types of legal claims for which this Guides was created. For example, the re-definition phenomenon is reportedly going to include PTSD (Frances and Widiger).

- In a separate publication (Frances), Frances reported that the results of the field trials for the new edition of the diagnostic manual were “abysmal”. Those results indicated that the limited set of revised diagnostic protocols which were subjected to field trials had insufficient reliability for administrative coding, treatment selection, and clinical research. This is a dramatic departure from previous editions of the DSM, which could at least claim to be reliable from one clinician who attempted to follow the system precisely to another. Frances also conveyed the news that additional field testing had been canceled, which indicates that the unreliability problems of the revised
protocols will not be corrected.

Other reports (Spence) have characterized the diagnostic inflation that is inherent to the new edition of the diagnostic manual as the medicalization of normality, and have characterized the reported expansion of diagnostic inflation as a byproduct of 75% of the creators of that new edition having financial conflicts of interest which involve drug companies: “It is yet more industrial mass production psychiatry to serve the drug industry, for which mental ill health is the profit nirvana of lifelong multiple medications.”

There are already indications that the new edition of the diagnostic manual might not have the widespread acceptance that was attained by its predecessors. For example, the British Psychological Society has posted its concerns regarding the proposed revisions. A division of the American Psychological Association (Society for Humanistic Psychology) posted a petition expressing its reservations about proposed revisions, and that petition has now been endorsed by a very long list of professional associations.

C. Step 1: Definitively establishing a diagnosis

The requirements of the first step of the causation analysis protocol include (Hegmann & Oostema; Barth 2012a; Melhorn, Talmage, Ackerman, and Hyman):

- the establishment of a definitive diagnosis
- that diagnosis should actually be of an explanatory nature (i.e., it should provide an explanation, or at least a partial explanation, for the clinical presentation)
- that diagnosis should be based on objective findings
- the method by which this diagnosis is established should be scientifically validated.
None of these requirements can be satisfied through utilization of the diagnostic system that has been established for mental illness (details discussed below). That diagnostic system is documented in a publication from the American Psychiatric Association which is titled *Diagnostic and Statistical Manual of Mental Disorders*. The version of this manual which was current at the time of the deadline for the AMA project on which this chapter is based was a “text revision” of the 4th Edition. It is commonly referred to as DSM-IV-TR (the “IV” in the center is the Roman numeral for four). A Fifth Edition was published in May 2013 (it is commonly referred to as DSM-5). Table A (above) provides an introductory discussion of the historically non-scientific nature of that diagnostic system, and the deterioration of that system which has been associated with the new DSM-5.

Many obstacles to justifying legal claims of mental illness are created by the abnormal and inadequate nature of the diagnostic system for mental illness (details are discussed below). Consequently, in order for a legal claim of causation for mental illness to be justifiable, the claim would have to involve the presentation of scientifically credible information that somehow eliminates the credibility problems that are created for the claim by the diagnostic system for mental illness. Health science does not currently provide any such scientifically credible information. Instead, as is explained in later sections of this chapter, the relevant scientific knowledge base actually creates additional obstacles to justifying legal claims of causation for mental illness.

C. 1. The mental illness diagnostic system is fundamentally inadequate for purposes of causation analysis

For mental illness, the nature of the diagnostic system creates a pervasive obstacle to credibly claiming that a person’s experiences are the cause of the clinical presentation. The state of the relevant scientific knowledge base, and other aspects of the diagnostic system, is simply not adequate for purposes of satisfying the requirements of the first step of the causation analysis. For example:

- In regard to step #1’s call for the establishment of a definitive diagnosis:
  - There is no credible method for definitively determining whether someone is mentally ill. (Table A; Frances and Widiger)
  - The diagnoses that emerge from this diagnostic system are not well-defined illnesses, but simply descriptive prototypes. They are inherently heterogeneous. The system does not provide clear boundaries between one diagnosis and another. (Table A; Frances and Widiger)
  - The DSM-IV-TR (American Psychiatric Association) itself explains, “there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other
mental disorders or no mental disorder…individuals sharing a diagnosis are likely to be heterogeneous even in regard to the defining features of the diagnosis”.

- Consequently, the diagnostic system simply does not provide a mechanism for the establishment of a definitive diagnosis.

- In regard to step #1’s call for the diagnosis to be of an explanatory nature:
  - In all health specialty areas other than mental illness, diagnosis is at least partially explanatory because it is based on some aspect of the etiology of the clinical presentation (Hyman) (e.g., a diagnosis of AIDS specifically means that HIV infection has played a causative role for the clinical presentation). In contrast, the diagnostic system for mental illness is not based on the etiology of the disorders (Hyman), and consequently does not carry any explanatory value. In fact, the DSM tradition has involved a concerted effort to be “neutral with respect to theories of etiology” (American Psychiatric Association 2000), and the new edition of the American Psychiatric Association’s diagnostic manual (American Psychiatric Association 2013) specifies “a diagnosis does not carry any necessary implications regarding the etiology are causes of the individuals mental disorder” (page 25).
  - The American Psychiatric Association’s literature regarding its diagnostic system has specified that this abnormal approach to diagnosis has been made necessary by the lack of identifiable causes for most mental illnesses (Caine).
  - Consequently, each of the formally recognized mental disorders is just a description of a clinical presentation. None of them are a real illness. The system does not provide a listing of etiologically defined diseases. The system is an almost complete failure for purposes of causation analysis. (Table A; Frances and Widiger)
  - Consistent with all of the above, the DSM-IV-TR (American Psychiatric Association) offers this direct warning in regard to attempts to impose the diagnostic system onto the legal system: “Nonclinical decision-makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the causes of the individual’s mental disorder or its associated impairments.” Similarly, the new edition of the American
Psychiatric Association’s diagnostic manual (DSM-5) (American Psychiatric Association 2013) specifies “a diagnosis does not carry any necessary implications regarding the etiology or causes of the individual’s mental disorder”. Similarly, DSM five specifies that incompatibilities between the diagnostic system for mental illness and the expectations of the court system create “a risk the diagnostic information will be misused or misunderstood” in forensic settings. The DSM-5 explains further that the diagnostic system for mental illness is not consistent with the “questions of ultimate concern to the law”. For example, a DSM-5 based diagnosis “does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder”.

- Consequently, the diagnostic system for mental illness does not provide explanatory diagnoses, and cannot satisfy the expectations or requirements of a forensic causation analysis.

- In regard to step #1’s call for the diagnosis to be based on objective findings:
  - There is nothing objective about the diagnostic system for mental illness. (Table A; Frances and Widiger)
  - Almost every diagnostic protocol within the system is subjective. They are primarily based upon the subjective complaints of the examinee, and the subjective impressions of the diagnostician. The details of the diagnostic system can be reviewed directly (see the American Psychiatric Association 2000 and 2013 references) to confirm that this is the essential nature of the system.
  - Psychological testing has been scientifically validated for purposes of introducing some objectivity into this completely subjective process. However:
    - Such testing is not comprehensive. For example, the Millon Clinical MultiAxial Inventory (Millon) has been validated for the purposes of determining which diagnoses a clinical presentation is most consistent with, but it directly addresses less than 20 of the nearly 300 mental illnesses listed in the DSM-IV-TR. All other relevant tests are similarly far from being comprehensive.
    - Such objective testing is dependent on cooperation from the examinee. For the most well-designed and validated tests, results
from a non-cooperative examinee will probably reveal the lack of cooperation (if the analysis of the results is thorough). However, that lack of cooperation will thwart diagnostic efforts. Such a lack of cooperation from examinees is extremely common in the forensic cases for which this chapter is being written (Larrabee).

- Individual diagnostic protocols have not incorporated any such testing (with minimal exceptions, such as intelligence testing for the new construct of “intellectual disability”). The details of the diagnostic system can be reviewed directly (see the American Psychiatric Association 2000 and 2013 references) to confirm that the vast majority of diagnostic protocols fail to consider objective test results (even when directly relevant tests are available). The diagnostic system only makes an indirect call for such testing, in that the malingering protocol which is built into that system calls for a comparison of the examinee’s subjectively claimed stress or disability to objective findings (American Psychiatric Association 2013), and the only reliable source of such objective findings is relevant scientifically validated psychological testing (Patterson et al.). This indirect call for introducing objective testing into the process fails to take advantage of such testing’s ability to add objectivity to differential diagnostic considerations other than malingering.

- Consequently the mental illness diagnostic system does not provide a comprehensive mechanism, or even a nearly comprehensive mechanism, for objectively establishing a diagnosis. This creates another obstacle to satisfying the requirements of the protocol from the *AMA Guides to the Evaluation of Disease and Injury Causation*.

- In regard to step #1’s call for the diagnosis to be based on a scientifically validated method:
  - There is no scientifically validated method for diagnosing mental illness. (Table A; Frances & Widiger)
  - The system has been created in a manner that lacks scientific rigor (and which has even lacked a reliable system for the creation/recognition of the mental illnesses). (Table A; Frances & Widiger)
  - The diagnostic standards for most of the mental illnesses are equivocal
and inconsistent. (Table A; Frances & Widiger)

- The minimal scientific support that is available has mostly emerged from highly specialized research settings, which causes any potential generalizability to normal practice (or forensic practice) to be questionable. (Table A; Frances & Widiger)

- The inadequacies of this diagnostic system actually create obstacles to scientific advancement. (Table A; Frances & Widiger; Hales et. al.; Insel)

- The initial field trials for DSM-5 were reportedly a dramatic failure, and such attempts to establish reliability for the system were consequently abandoned (Frances).

- Consequently, the mental illness diagnostic system does not provide a scientifically validated diagnostic method, thereby creating yet another obstacle to satisfying the requirements of the *AMA Guides to the Evaluation of Disease and Injury Causation*. 

Given these fundamental inadequacies of the mental illness diagnostic system, this system cannot be credibly utilized for purposes satisfying the requirements of the first step in the causation analysis protocol. The state of the relevant scientific knowledge base is simply inadequate for purposes of justifying the causation claims that are typically inherent to legal claims of mental illness. 

Specifically in regard to the new edition of this diagnostic system (DSM-5), there is no credible basis for hoping that it will overcome the shortcomings of its predecessors. For example, the Director of the National Institute of Mental Health has reported that DSM-5 involves “only modest alterations,” that those alterations are themselves “contentious” (rather than involving clear improvements), that DSM-5 will be an impediment to scientific progress (rather than being a part of scientific progress) and that, consequently, the NIMH efforts to create a credible diagnostic system will be oriented away from DSM-5 (Insel). Additionally, the chairperson of the DSM-IV-TR has reported that DSM-5 will actually be inferior to its predecessor, because the process for creation of the DSM-5 has been far inferior to the process that was used for the creation of DSM-IV-TR (see Box A; Frances and Whitaker; Frances).

**C. 2. Over-diagnosis is the norm**
The flaws of the mental illness system, and its vulnerability to misuse, have contributed to “a basic background of overdiagnosis” (Table A; Frances & Widiger). The overdiagnosis phenomenon also produces “false epidemics” of mental illness (Table A; Frances & Widiger). This tendency toward excessive diagnosis will reportedly worsen due to the content of the new edition of the diagnostic manual (Frances and Whitaker).

This widespread over-diagnosis creates another obstacle to the credible endorsement of mental illness claims. Specifically, clinical/forensic evaluators, and judicial/administrative decision-makers, need to be aware that there is an elevated risk of false diagnosis in cases that involve claims of mental illness. Consequently, those evaluators and decision-makers must be prepared to apply unusually intensive scrutiny to the diagnoses that are presented in such claims.

C. 3. Inadequacy for forensic purposes, even beyond causation analysis

This chapter focuses on the inadequacy of the mental illness diagnostic system for one forensic issue – causation analysis. Other literature has explained that the inadequacy of this system extends into other aspects of forensic work. For example, Frances and Widiger (Table A) explained that the system is severely lacking in terms of the level of precision that is needed by legal professionals. Similarly, the Guidelines for Forensic Assessment of Posttraumatic Stress Disorder claims (Simon) report the near irrelevance of the diagnostic system for legal claims, by explaining: "When DSM criteria are approached legalistically, they rarely fit real-life patients."

The DSM-IV-TR itself addresses its inadequacies for forensic purposes, directly and repeatedly. Very specifically, the DSM-IV-TR states: “In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a mental disorder, mental disability, mental disease, or mental defect”. The DSM-IV-TR consequently warns that attempts to impose the mental illness diagnostic system onto the legal system will create significant risks of misunderstanding and misuse. This warning is echoed in the text of the new edition of the diagnostic manual (DSM-5) in the form of statements such as “the clinical diagnosis of a DSM-5 mental disorder…. Does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder”

D. Step 2: Applying relevant findings from epidemiologic science to the individual case

As was explained in various American Medical Association publications regarding the protocol from the AMA Guides to the Evaluation of Disease and Injury Causation (Melhorn and Ackerman; Barth 2012a; Melhorn, Talmage, Ackerman, & Hyman), if a definitive and explanatory diagnosis can be objectively established in the first step of the causation analysis, then the process continues with consideration of whether there is a
scientifically established link between that diagnosis and the claimed cause. Given the information that was discussed above in regard to the first step of the causation analysis protocol, it is unlikely that the analysis of any legal claim of mental illness will be able to credibly move on to the second step. However, the second step is being discussed because it introduces additional obstacles to credibly claiming that mental illness is caused by adult life experiences.

The key issues for this step include (Melhorn and Ackerman; Barth 2012a; Melhorn, Talmage, Ackerman, & Hyman): In order for a causative relationship between a definitively established diagnosis and a suspected cause to be claimed in a credible fashion, the claim must be based on credible and reliable scientific findings that have convincingly established that such a specific causative link actually exists. In other words, such claims are only credible if they are grounded in credible and reliable scientific findings that indicate that the specific claimed cause is a significant risk factor for the definitively and objectively established explanatory diagnosis.

This section (D) provides only a generic discussion of the scientific literature that is potentially relevant to legal causation claims of mental illness. Scientific findings of more direct relevance to several specific mental illness constructs are discussed in a later section.

D. 1. Scientific findings have predominantly been contradictory of claims that adult life experiences cause psychopathology

Perhaps the strongest generic contradiction of the premise that adult life experience causes psychopathology is the history of scientific findings which address the normal human response to challenging experiences. Specifically, findings have reliably revealed that the normal response is a phenomenon that has been labeled “posttraumatic growth”. This term has been defined as “positive psychological change experienced as a result of the struggle with highly challenging life circumstances” (Tedeschi and Calhoun). Research findings have consistently indicated that this phenomenon is reported by 75% to 90% of the survivors of traumatic experiences (Janoff-Bulman).

Primary examples of this dominant tendency for humans to respond to traumatic and challenging experiences by demonstrating psychological improvement include (Calhoun and Tedeschi):

- Developing “psychological preparedness” – an increased ability to face future challenges with less distress
- Experiencing greater satisfaction with life
- Finding more meaning in life
- Developing a greater sense of purpose
- Developing a greater appreciation of life
- Enhanced realization of psychological strength
- Developing new interests, new activities, and significant new paths in life
- Developing a stronger sense of connection, intimacy, or closeness to other people
- Developing increased compassion for other people
- Developing an increased sense of freedom to be oneself

Reviews of relevant research projects (Calhoun & Tedeschi) have noted that this posttraumatic growth phenomenon has been empirically verified in samples of military combat veterans, bereaved individuals, cancer patients, HIV/AIDS patients, patients with other chronic health problems, heart attack survivors, vehicle accident survivors, rape victims, victims of other forms of sexual abuse, survivors of hostage situations, life-threatening attack survivors, and survivors of disasters.

More detailed information regarding the nature and course of human responses to traumatic stress is available from research by Frazier et al. Their research revealed that the majority of the participants reported experiencing beneficial psychological effects even as of only two weeks after having been assaulted, and that the awareness of beneficial psychological effects increased over time (while aversive psychological effects decreased over time).

As an example of the robustness of the scientific findings regarding this normal human response to stress, it can be noted that relevant well-designed research has specifically studied people who experienced stress that was both chronic and life-threatening (cancer), and compared those participants to controls who had not experienced any unusual life stress (Cardova et al.). The stressed participants demonstrated psychological growth that was not demonstrated by the controls. This beneficial effect of chronic life-threatening stress was demonstrated even though the measurement strategy was not capable of detecting all of the potential stress-related psychological growth (Stanton et al.).

Similarly, using military combat for purposes of studying extreme stress, longitudinal research (Elder & Clipp) indicated a response involving posttraumatic growth, and a dose-response gradient. Specifically, more positive psychological effects were found for military combat veterans who had “high combat experience”, compared to veterans with “light combat experience” or no combat experience. Examples of the benefits that were more strongly associated with “high combat experience” than “light” or no combat experience included:
Better ability to cope with adversity
More self-discipline
Obtaining greater value from life
Having a clearer sense of direction
Greater assertiveness
Greater resilience

Consistent with all of the above, study of the psychological effects of disaster (Joseph et al.) has revealed that:

- the majority of survivors reported that their psychological functioning had changed for the better following the disaster
- the survivors endorsed more positive changes than negative changes in their personal psychology
- the positive changes in the victims’ lives were reported to be of a strong nature
- over 90% reported improvement in their relationships.

The scientists who work on the issue of human responses to stress and trauma are usually very careful to emphasize that their findings regarding the normal posttraumatic growth response does not negate the significance of the distress that trauma and stress can precipitate. Researchers demonstrate a fear of being perceived as insensitive, or even offensive (Lev-Wiesel & Amir). In an apparent attempt to ward off accusations of insensitivity or offensiveness, researchers frequently emphasize that the research participants who acknowledge their experience of posttraumatic growth will simultaneously report that, in spite of the benefits, they wish they had never experienced the trauma or stress, and they do not wish similar experiences onto anyone else (Calhoun & Tedeschi). But it is important to note that such distress and wishes are not synonymous with mental illness. Additionally, well-designed research focused on stress that is both chronic and life-threatening (e.g. cancer) has produced results which indicate that:

- severe psychological disturbance in response to the chronic life-threatening stress is rare (Anderson et al.)
- psychological disturbance attributable to the stress is generally not enduring when it occurs (Anderson et al.)
- most of the relevant research participants resumed normal psychological functioning (Anderson et al.)
- a majority reported experiencing psychological benefits from the experience (O'Connor et al.)
- overall, such research participants report significantly more positive psychological effects, than negative psychological effects (Collins et al.).
Likewise, psychological disturbance in response to catastrophic injury (spinal cord injury) has been found to have a similarly temporary course (Richards).

Similarly, other research on the chronic life-threatening stress (i.e. HIV/AIDS) (Milam) has produced reports that the positive effects of such stress actually “buffer against” mental illness, and the overwhelming majority of relevant research participants report beneficial psychological effects.

The nature of the scientific knowledge base regarding the normal human response to stress and traumatic experience creates the following obstacle for relevant legal claims of mental illness: In order to be credible, any claim that adult experience has caused psychopathology must involve a credible explanation, supported by relevant scientific findings, of why and how:

- the claimed cause somehow overwhelmed the natural human tendency toward posttraumatic growth, and caused mental illness instead

- the claimed aversive psychological effects are being characterized as mental illness, instead of normal transient distress.

D. 2. The inadequacies of the mental illness diagnostic system actually prevents credible etiology research from being conducted

A previously published prominent review of the etiology science for mental illness (Hales et al.) specified that the nature of the diagnostic system for mental illness impedes scientific advances. Relevant aspects of that diagnostic system were discussed above, and include the unreliability of the diagnostic system, the heterogeneous nature of mental illness constructs (e.g., a single diagnosis applies to a wide variety of different clinical presentations), the lack of clear boundaries between different mental illness constructs, the high rate of comorbidity for the mental illness constructs, the inability of the diagnostic system to clarify the nature of ambiguous cases, and the lack of scientific validation for the diagnostic system.

The director of the National Institute of Mental Health has similarly reported that the diagnostic system for mental illness, specifically including the new edition of that system (DSM-5), creates obstacles to scientific advancement in all areas, and that NIMH has consequently concluded that it must move away from the DSM tradition (including DSM-5) in order to make scientific progress (Insel).
As an example of the obstacles to credible etiology research that is created by the inadequacies of the diagnostic system, the following predicament is offered:

- In order for etiology research to credibly focus on a specific mental illness construct, there must be a method for definitively determining which potential research participants have the mental illness (and only that one mental illness), and which ones do not have that mental illness.

- As was discussed above, there is no credible, objective, or scientifically validated method for making such determination.

D. 3. Potentially relevant scientific investigations have been pervasively inadequate for purposes of justifying legal causation claims involving mental illness

Publications prior to the Second Edition of the Causation Guides had already documented the lack of support that is available from the scientific knowledge base for legal claims of causation for mental illness. For example:

- An American Psychiatric Association publication (Caine), focused specifically on determining causation, explained that most mental illnesses do not have an identifiable cause.

- The chairperson of the mental illness diagnostic system, and that system’s research coordinator, explained that scientific efforts had produced a “complete failure to elucidate the causes of mental disorders” (Frances and Widiger).

In spite of such high-level reports indicating that the scientific knowledge base is incapable of providing credible support for legal causation claims involving mental illness, the contributors to the Second Edition of the Causation Guides undertook a new literature review in keeping with the plan from Chapter 4 of that Guides. Consistent with the previous reports referenced above, that process left the three reviewers (RJB, LK, JSS) with the impression that the available published research findings are not capable of providing credible scientific support for a legal claim of causation for mental illness. The potentially relevant published projects that were reviewed in this effort appear to be universally afflicted by severely inadequate research designs. In other words, the previously published reports of a lack of scientific credibility for mental illness causation claims (Caine; Frances & Widiger) were supported by our findings.

The literature search strategy that was delineated in Chapter 4 of the Second Edition of the Causation Guides, when applied to mental illness, involved the following steps:
• A list of 41 diagnoses was created, based on the mental illnesses that the lead author (RJB) had seen as focuses of actual legal claims. The complete list is provided in Table B (below).

• Over 1000 citations emerged from the resulting literature search.

• Preliminary information (e.g., title, abstract) was reviewed for each citation.

• Any that were found to have the slightest chance of credibly addressing the etiology of at least one of the listed mental illness constructs were ordered through the library services that had been made available for Guides contributors. Publications that were limited to military or pediatric cases were excluded from the review process, for reasons such as the extreme non-generalizability of any findings. Publications that were not available in English were also excluded, due to a lack of translation resources.

• The publications for which the library services were able to provide full text copies prior to the deadline were reviewed in detail by three contributors (RJB, LK, JSS).

• The reviewers were instructed to only create evidence tables for articles which actually complied with modern diagnostic standards for mental illnesses. In order to qualify, an article had to specify all of the following:
  
  o A through mental health evaluation had been conducted on each participant by a licensed mental health specialist (the DSM-IV-TR specifies that the diagnostic system is only to be utilized by such clinicians).

  o Those evaluations had to be conducted in accordance with the DSM-IV-TR, as specifically explained in relevant companion texts (Othmer & Othmer, Volumes 1 and 2).

  ▪ This criterion is of critical importance because many projects have used diagnostic systems which differ from the DSM-IV-TR. This includes protocols from previous editions of the DSM (which differ from the DSM-IV-TR protocols), and protocols which have emerged from esoteric sources that are completely separate from the DSM tradition (and which also differ from DSM-IV-TR protocols). Such projects were excluded because they were
studying something other than mental illness constructs as currently defined. Applying research data that is based on such obsolete and esoteric protocols to DSM-IV-TR mental illness constructs is analogous to claiming that a credible understanding of apples can be obtained through the study of oranges.

This process was dramatically non-productive. By the time of the AMA’s deadline, none of the obtained articles met our criteria for inclusion. We did not find a single article which adhered to modern diagnostic standards (as detailed in the above criteria).

One of the reviewers (LK) has voiced the experience of all of the reviewers, by stating that this review process was “stunning”. All of reviewers are experienced mental health clinicians who have diligently attempted to keep up with relevant health science, and who have all been invited by the American Medical Association and other health science associations to contribute to professional Guides and continuing education programs. As such, we were all aware of previous reports of the lack of credible causation science for mental illness, the manner in which the diagnostic system prevents the development of credible scientific projects focused on the causation of mental illness, and the manner in which many scientific projects that claim to address causation do so in a manner that actually adds additional credibility problems. What stunned us was our complete inability to find a single relevant research project which actually adhered to modern diagnostic standards.

As an example of the inadequate research designs that were found in the reviewed literature, it can be noted that the most common design involved an extremely limited survey of diagnostic criteria for a single mental illness. Such designs were typically flawed in numerous ways, including:

- There was no actual evaluation. There was no mention of, and definitely no compliance with, the method that is specified in the American Psychiatric Association texts (American Psychiatric Association 2000; Othmer & Othmer, Volumes 1 and 2), which explain how the diagnostic system is to be used.

- Such surveys were applied to every participant regardless of whether the participant presented in a fashion which warranted the application of the diagnostic criteria. Often, there was no clinical presentation whatsoever – projects specified that the surveys were being applied to people who had never sought mental health care, and who were not seeking any form of health care. All of this is a violation of standards for the utilization of DSM-IV-TR protocols, in that the relevant companion texts call for the application of the diagnostic protocols only to clinical presentations which involve certain essential components (Othmer &
Typically, the narrowly focused survey data was gathered by non-clinicians, rather than by licensed mental health clinicians (which violates the requirement of the DSM-IV-TR).

In spite of the lack of clear boundaries between mental illness and lack of mental illness, the lack of clear boundaries between the various mental illnesses, and the extensive overlap between various mental illnesses (Table A; Frances & Widiger), the designs were of a nature that implied that it was somehow credible to study a single diagnostic protocol in isolation.

There was no differential diagnostic process, as is called for by the DSM-IV-TR system for almost every mental illness.

There was no utilization of objective assessment methods.

Often, the survey data did not even correspond to the diagnostic criteria for the mental illnesses that the projects claimed to be studying (e.g. some form of generic, diagnostically non-specific, depression questionnaire was used as a surrogate for the depressive mental illness constructs that the project claimed to be studying).

Consequently, by the time of the AMA’s deadline for this text, we did not find a single published project which actually involved a design that credibly addressed the etiology of any mental illness (there was unanimous agreement on this point from the three reviewers – RJB, LK, JSS). Many articles claimed that their projects had done so, but instead of actually addressing mental illness, they only addressed questionnaire data. The questionnaire data was of extremely minimal, and extremely insufficient, relevance to the mental illness diagnostic system.

No articles were found that could be credibly subjected to the evidence table approach that was described in chapter 4. In order to apply the evidence table approach, the reviewers would have to pretend that the articles actually addressed mental illness. That pretense would contribute to a tradition of misleading literature by creating evidence tables for projects which addressed some inadequate surrogate of mental illness, instead of actually addressing mental illness.

For the sake of emphasis and clarity the following redundant summary is offered: The search strategy that had been established for the Second Edition of the AMA’s Causation
Guides produced more than 1000 articles. Many of these claimed to address the etiology of some mental illness, but we could not find any that actually did so. Overwhelmingly, the studies addressed etiology for some extremely inadequate surrogate data, rather than actually addressing the mental illness constructs that they claimed to measure. The library resources were not able to obtain every potentially relevant article by the time of the deadline for this review, but the large set of articles that we were able to review, in conjunction with the preliminary information for the articles that were not obtained prior to the deadline, did not provide us with any reason to suspect that a credible relevant research project has been overlooked.

One of the reviewers (JS) called our attention to another pervasive shortcoming of the obtained literature: “None of these studies seem to include any sort of consideration about what the person reporting the symptoms might have to gain by either falsely reporting symptoms or falsely reporting the degree of severity of the symptoms, etc. Without looking at those issues, I find it very difficult to know how much credibility can be placed on the information”. Consistent with this observation, none of the studies involved an objective or diagnostic assessment of the validity of the participants’ presentations. Such validity assessment is critically important, given scientific findings which have indicated that approximately 50% of clinical presentations within a legal claim produce objective evidence of malingering (when objective assessment is actually applied to such cases) (Larrabee). Several standardized assessments have been scientifically validated for this specific purpose (Larrabee; Patterson et al.; Rogers). The diagnostic system for mental illness additionally includes a standardized protocol for the assessment of malingering (American Psychiatric Association 2000; Patterson et al.). Given the scientifically established high rate of malingering, and given the almost completely subjective nature of the diagnostic system for mental illness, relatively thorough utilization of the objective and diagnostic assessments for malingering is necessary in order for any causation research to be credible. In the absence of such objective assessment, there is no mechanism for identifying, or controlling for, error that is caused by participants who falsely endorse diagnostic criteria (because of secondary gain considerations or any other desire to artificially manipulate their clinical presentation). Our review process failed to discover any project which controlled for the risk of such error. This result highlights yet another way in which the etiology research for mental illness appears to be comprehensively inadequate for purposes of supporting a legal causation claim.

The literature that was reviewed for this chapter also demonstrated another pervasive shortcoming. The first edition of the causation Guides explained that it is necessary to know the population prevalence of a disease, and the false positive rate of any questionnaire that is used as part of the research strategy, in order to evaluate the
credibility and value of any epidemiologic study. None of the reviewed articles sufficiently provided such data.

In an effort to insure that nothing had been overlooked, two prominent texts which imply that adult life events might play an etiological role for some mental illness constructs were scrutinized (First & Tasman; Hales et al.). This process revealed that scientific projects which were cited in support of such claims would not have been accepted for our review because of issues such as:

- They were actually published prior to DSM-IV-TR (and even prior to its predecessor, DSM-IV), and were therefore studying something other than modern mental illness constructs. As an example of the extent of this problem, it can be noted that this exclusion criterion applied to every relevant publication that was referenced by the Frist & Tasman text in the context of implying that life events might play a role in the development of Posttraumatic Stress Disorder. As another example, it can be noted that the Hales et al. text actually referenced a study which was published approximately five years after the publication of DSM-IV, but which was based (insufficiently) on the criteria from DSM-IV’s predecessor.

- The references included projects that were focused on survey data collected by non-clinicians, rather than on actual mental health evaluations conducted by a licensed mental health clinician in accordance with DSM-IV-TR and its companion texts.

- None of the referenced publications mentioned utilization of scientifically validated objective assessment, or diagnostic assessment, of the validity of the clinical presentations that were studied.

- None of the referenced studies sufficiently addressed the issues of population prevalence and false positive rates, as required by the Causation Guides.

It can be noted that in spite of the flawed manner in which these texts implied that adult life experience might contribute to the development of some mental illnesses, they also clearly indicated that adult life experience is not a sufficient risk factor for the development of mental illness. The majority of the discussion that they dedicate to the etiology of mental illnesses does not involve discussion of civilian adult life events.

At the recommendation of one of the contributors (LK), all three reviewers (RJB, LK, JSS) are offering endorsement the following statement in an effort to leave no ambiguity: All of the issues discussed above have left us with a very strong impression that the
scientific knowledge base is so flawed that it cannot be credibly used to justify any legal claim of causation for any mental illness.

D. 4. The Repeatedly Changing Nature of the Mental Illness Diagnostic System Repeatedly Causes the Relevant Scientific Knowledge Base to Become Obsolete

The protocols for many to most mental illness constructs have repeatedly changed with each new edition of the DSM. As a result, clinical presentations that warrant a given diagnosis under one edition will not warrant that same diagnosis under another edition. Some editions actually list mental illness constructs that are completely absent from other editions. The DSM-IV-TR (American Medical Association) predicted that this tradition of unreliability “will undoubtedly” continue with future editions of the diagnostic system. That prediction was justified with the publication of the latest edition of the diagnostic system (DSM-5), as entire categories of mental illnesses abruptly went out of existence (e.g. Mood Disorders, Somatoform Disorders).

Consequently, each new edition of the DSM invalidates the pre-existing scientific knowledge base for each mental illness that has a new protocol (Hales et al.). The scientific findings that were obtained through utilization of a previous version of the diagnostic protocol for a given mental illness construct cannot credibly be applied to the modern construct, because the research will have been based on different clinical presentations than those to which the modern construct applies.

A prominent review of causation science for mental illness (Hales et al.) has emphasized the pervasiveness of this problem. For example, that text has specified that the problem is especially relevant to the most common category of mental illness constructs, anxiety disorders (NOTE: DSM-5 divided this category into at least three separate categories, but the Hales text, which you are reading about at this moment, predated DSM-5). The anxiety disorder category was also of greatest relevance to legal claims, in that it included Posttraumatic Stress Disorder, which has reportedly become a “growth industry” for claimant/plaintiff attorneys (Simon). In summary, Hales et al. emphasized that the forced obsolescence of the scientific knowledge base by each new edition of the American Psychiatric Association’s diagnostic manual is especially pronounced for the most common mental illnesses, including the mental illness that has been a “growth industry” for legal claims.

Because the relevant scientific knowledge base already borders on uselessness (as was discussed above), the manner in which each new edition of the DSM invalidates that knowledge base might be insignificant (the loss of a nearly useless scientific knowledge base is not a significant loss). None-the-less, this repeating history of the relevant scientific knowledge base becoming obsolete overnight should be noted because of the
way that it puts a time limitation on even potentially useful scientific findings. Indeed, the National Institute of Mental Health has noticed this problem, and has announced its decision to avoid utilization of the DSM-5 in order to avoid this problem (and the other problems created by DSM-5) (Insel).

D. 5. Another obstacle to legal causation claims of mental illness is created by scientific findings which indicate a causative relationship that is the opposite of what is typically legally claimed

Legal claims of causation for mental illness face an additional obstacle caused by scientific findings which indicate a causative relationship of the extreme opposite nature: mental illness is actually a risk factor for stressful experiences, including traumatic experiences. The mental illness construct which has reportedly become a “growth industry” for claimant/plaintiff attorneys (Simon), Posttraumatic Stress Disorder (PTSD), provides a prominent example of such scientific findings, in that PTSD-like presentations have repeatedly been found to be a predictive risk-factor for traumatic experiences (i.e. the PTSD-like presentation precedes the traumatic experience, and increases the risk of future traumatic experience) (Cougle et al.; Krause et al.; Messman-Moore et al.; Perez & Johnson). Such findings have general relevance for mental illness (beyond the construct of PTSD) given the variety of scientific findings which indicate that PTSD symptoms are a generic manifestation of mental illness, rather than being a manifestation of a unique or specific entity (details discussed later in this chapter). Similarly, more generic conceptualizations of “mental health problems” and “behavior problems” have also been scientifically established as predictive risk factors for traumatic experience (Banyard et al.; Helzer et al.; Koenen et al. 2005; Messman-Moore et al.).

In order to overcome the obstacles to a legal claim of causation for mental illness that is created by such findings, the claim must involve presentation of credible, relevant, and reliable scientific findings which explain why unidirectional causation (experience caused the mental illness) is being claimed, instead of acknowledgement being presented that presentations of mental illness have been scientifically established as preceding, and elevating the risk of, stressful and traumatic experiences.

D. 6. Workers compensation claims of mental illness face yet another scientific obstacle

Workers compensation claims of mental illness inherently involve a premise that work has somehow caused the claimed illness. In addition to facing the obstacles that have been discussed above, such claims face an additional obstacle: Work has actually been scientifically established as being beneficial to mental health (Talmage et al; Barth &
Roth; Waddell and Burton). Because of such findings, it can be credibly asserted that an individual claimant would have been more likely to demonstrate mental illness if she or he had never obtained employment. In order to credibly address this obstacle, a workers compensation claim of mental illness must involve presentation of credible, reliable, and relevant scientific findings which clearly indicate that the general scientific knowledge base does not apply to the case at hand.

**Table B: Summary of the Findings From the Literature Review that Was Conducted for This Chapter**

The “potential risk factor” that was studied for each of the following diagnostic constructs was simply adult life experience. The literature that was reviewed was inadequate for establishing a credible basis for even such a wide-ranging risk factor (as has been explained in the text of this chapter). Therefore, the review process did not afford any opportunity to consider more narrowly defined risk factors.

For each of the mental illness constructs that are listed below, an additional step was taken. Specifically, references were scrutinized from prominent previously published reviews of the etiology science for mental illness (First & Tasman; Hales et al.). This extra step was undertaken in an effort to determine if the literature search process used for the Second Edition of the AMA’s Causation Guides had missed literature which would have changed the results. That extra step failed to reveal any such missed literature.

It should be noted that the one exception to this literature review’s focus on adult life experience was military combat experience. This issue was excluded from the current analysis because of multiple reasons, including the extreme lack of generalizability of any findings, and the reports that mental illness diagnoses in the US military and Veterans Administration are being established in an especially non-credible fashion, and that associated claims are similarly
being scrutinized in an especially non-credible fashion.

<table>
<thead>
<tr>
<th><strong>Diagnostic Construct</strong></th>
<th><strong>Result</strong></th>
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<tr>
<td>Acute Stress Disorder evidence</td>
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<tr>
<td>Adjustment disorder evidence</td>
<td>INSUFFICIENT</td>
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<tr>
<td>Alcohol Abuse evidence</td>
<td>INSUFFICIENT</td>
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<tr>
<td>Alcohol Dependence evidence</td>
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<tr>
<td>Anxiolytic Abuse evidence</td>
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<tr>
<td>Bipolar I Disorder evidence</td>
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<td>Bipolar II Disorder evidence</td>
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<tr>
<td>Brief Psychotic Disorder evidence</td>
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<tr>
<td>Cannabis Abuse evidence</td>
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<td>Cannabis Dependence evidence</td>
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<td>Cocaine Dependence evidence</td>
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<td>Conversion Disorder evidence</td>
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<td>Cyclothymic Disorder evidence</td>
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<tr>
<td>Disorder</td>
<td>Evidence</td>
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<tr>
<td>Delusional Disorder</td>
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<td>Depersonalization Disorder</td>
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<td>Disorder</td>
<td>Evidence</td>
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<td>Polysubstance Dependence</td>
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<td>Stuttering</td>
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<tr>
<td>Undifferentiated Somatoform Disorder</td>
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</table>

E. **Step 3: Obtain and Assess the Evidence of Exposure**

As has been explained in several AMA Guides Library publications (Melhorn and Ackerman; Barth 2012a; Melhorn, Talmage, Ackerman, and Hyman), if credible and reliable scientific support for a claimed causative relationship is actually found in step 2, then the causation analysis continues with consideration of whether the case at hand involved sufficient exposure to the claimed cause. Given the information that was discussed above in regard to steps 1 and 2 of the causation analysis protocol, it is unlikely that any legal claim of causation for mental illness can credibly reach step 3. However,
this step is being discussed because it introduces yet another obstacle to credibly claiming that civilian adult life experience has caused mental illness.

If the causation analysis for any individual mental illness claim somehow makes its way to this step, then this step will usually bring attempts to justify a legal causation claim to a halt. For example, one of the key issues for this step is: What evidence, predominantly objective, is available that clearly verifies that the exposure to the claimed cause was of sufficient magnitude to account for the development of the claimed clinical presentation? (Melhorn and Ackerman; Barth 2012a; Melhorn, Talmage, Ackerman, & Hyman). The relevant Guides publications additionally explain that actual measurements of exposure are the most reliable information for this step, while the claimant’s/plaintiff’s report of exposure is among the least reliable types of information.

For mental illness claims:

- There is no scientifically validated method for measuring the magnitude of exposure to the claimed cause.
- Given the subjective nature of mental illness, there is little chance that an objective measure of the magnitude of exposure to the claimed cause can be developed.
- The examinee’s unreliable and subjective report will almost always be the sole indicator of the magnitude of the claimed exposure (see Barth September/October, 2009 regarding the unreliability of such reports; details discussed in a later section of this chapter).
- The literature review that was conducted specifically for mental illness chapter of the Second Edition of the AMA Causation Guides did not reveal any scientific findings that are of relevance to this step (even if the fact that the reviewed studies did not actually address mental illness is ignored, there still was not any information from those articles which would allow for this “exposure” step to be sufficiently addressed).
- The previously published etiology reviews that were scrutinized for the development of the mental illness chapter of the Second Edition of the Causation Guides (First and Tasman; Hales et al.), failed to mention any mechanism for addressing this “exposure” step.

In order to credibly overcome the obstacles created by this step, a legal claim of causation for mental illness must present and utilize some scientifically validated and relevant
measurement of exposure, and must reference credible scientific findings which clearly indicate that the measured level of exposure for the case at hand has been established as sufficient for causing the definitively established diagnosis.

F. Step 4: Consideration of other relevant factors

F. 1. Generic Considerations

As was explained in several AMA Guides Library publications (Melhorn and Ackerman; Barth 2012a; Melhorn, Talmage, Ackerman, & Hyman), if preliminary support for a legal causation claim is found in each of the first three steps, then the causation analysis continues with consideration of alternative risk factors (risk factors other than the claimed cause) for the diagnosis that was established in the first step. Given the information that was discussed above in regard to the first three steps of the causation analysis protocol, it is unlikely that any legal claim of causation for mental illness can credibly reach the fourth step. However, this step is being discussed because it introduces additional obstacles to credibly claiming that civilian adult life events have caused mental illness.

The key question which needs to be addressed in this step is (Melhorn and Ackerman; Barth 2012a; Melhorn, Talmage, Ackerman, & Hyman): Are there risk factors, other than the cause that is being claimed in this specific case, which could contribute to the development of the claimed clinical presentation?

As was discussed above, the relevant scientific knowledge base is inadequate for justifying legal causation claims for mental illness. That inadequacy is primarily attributable to research designs while fail to adhere to diagnostic standards, and consequently fail to actually study modern mental illness constructs.

An additional obstacle is created by results that have emerged from that limited science, in that findings have actually been contradictory of the premise that civilian adult life events cause psychopathology. A previous section of this chapter reviewed the science regarding human responses to challenging life experience, and the findings which indicate that the normal human tendency is to respond to such experience by demonstrating psychological improvement.

An additional obstacle to legal claims of causation for mental illness is summarized in a prominent previously published review of scientific findings regarding the etiology of mental illness (First & Tasman). That review produced the conclusions that “the largest proportion of risk for mental illness is genetic”, and other relatively well-established risk factors for mental illness include pre-birth maternal stress, nutrition, and infection. All of these relevant scientific findings reportedly indicate that the time frame for prevention of mental illness is the second trimester of a person’s pre-birth development (First & Tasman).
Conclusions from another prominent review (Hales et al.) of the development of psychopathology adds an emphasis on the childhood family experience of the individual: e.g., “a conscious or unconscious attempt to gratify wishes that were appropriate in childhood but that may not be appropriate in a well-functioning adult”; “No adult can go back to childhood and receive from his or her parents and others what was not received from them as a child. Unfortunately, however, many adults continue to try”.

Obstacles to attributing mental illness to civilian adult life events have also emerged from attempts to scientifically study specific mental illness constructs. Examples are provided below.

F. 2. Considerations of specific relevance to individual diagnostic constructs

The following discussion of specific diagnostic constructs contains information that is of relevance to step #2 as well as step #4. Information of relevance to both steps is being presented in this unified fashion in order to provide a single coherent discussion of each construct.

F. 2 a. Posttraumatic Stress Disorder (PTSD)

In the information that was collected for the first edition of the AMA Causation Guides, PTSD appeared on the lists of mental illness constructs that are most commonly reported in legal claims. In several ways, this is not a surprising finding:

- In the American Psychiatric Association’s forensic literature (Simon), PTSD has been specified as a “growth industry” for claimant/plaintiff attorneys.

- The definition and diagnostic protocol for this construct are of a nature which readily lends itself to a misdirected assumption that traumatic experiences are the cause. However, such assumptions are contradicted by the DSM-IV-TR and the DSM-5, and have been a failure when subjected to scientific scrutiny (details are discussed below).

The prevalent attempts to claim that this disorder is caused by traumatic events stem from the text of the various editions of the American Psychiatric Association’s diagnostic manual, such as the following passage from the DSM-IV-TR (American Psychiatric Association 2000): "The essential feature of Posttraumatic Stress Disorder 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 threat to the physical integrity of another person; are learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate."
Apparently, the word "following" in the above quotation is regularly misinterpreted, in legal claims, as meaning "caused by". This misinterpretation is contradicted by:

- scientific findings (discussed generically previously in this chapter, and discussed specifically for PTSD below)

- the DSM-IV-TR’s text (American Psychiatric Association 2000), which explains that the DSM tradition has involved a concerted effort to be “neutral with respect to theories of etiology”, and which offers this explanation specifically for legal decision-makers: “Nonclinical decision-makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the causes of the individual’s mental disorder or its associated impairments”

- and by similar text from the new DSM-5 (American Psychiatric Association 2013).

The inadequacies of the published etiology science for mental illness in general (discussed previously in this chapter) are especially prominent for PTSD. For example, the literature search produced more articles claiming to study PTSD than any other diagnostic construct, but the reviewers for this chapter did not discover a single PTSD article that specified that the project involved a credible mental health evaluation being provided for the participants (details in regard to the criteria for a credible mental health evaluation were specified previously in this chapter, and a more elaborate discussion is provided below). Almost all of the reviewed articles violated diagnostic standards in multiple ways, and substituted a narrowly focused questionnaire for a mental health evaluation.

Additionally, most of that PTSD causation research is afflicted by a technicality which renders the findings useless for the purpose of the AMA’s Causation Guides. Specifically, the diagnostic protocol for PTSD requires the person to have experienced a trauma that fits the description quoted above. In other words, this technicality means that a person cannot be given this diagnosis unless they have experienced such trauma, even if they have every symptom of PTSD, and their presentation satisfies all of the other diagnostic requirements. This is a very unfortunate set of circumstances for causation analysis, because it creates a definitional confounding of the claimed exposure with the claimed clinical presentation. Therefore, if a research design does not somehow overcome this definitional confounding, then the only possible research outcome is a misleading finding that the syndrome of PTSD is always associated with trauma. This is analogous to concluding that all cars are blue, as a result of a research project which excluded, from the beginning, any cars that were not blue.

It is only recently that research designs have emerged which allow for a consideration of the symptomatic nature of PTSD apart from this definitional confounding with trauma. That research has reliably produced results which indicate that there is no actual correlation between a protocol-type trauma and the clinical presentation of PTSD. If a traumatic experience is actually the cause of PTSD, then the symptoms of PTSD should
be more common among individuals who report that they have experienced such trauma. Research findings have indicated that this is not the case.

For example, scientific findings have actually included a lower rate of PTSD symptoms among individuals who reported that they had experienced a protocol-type trauma, and, correspondingly, a higher rate of PTSD symptoms among those who had not experienced such a trauma (Gold et al.; Mol et al.; Jurbergs et al.). Additionally, significantly fewer people who had experienced a protocol-type trauma satisfied symptom requirements for a PTSD diagnosis, and, correspondingly, those who did not experience a protocol-type trauma were actually more likely to satisfy symptom requirements for PTSD (Gold et al.). In other words, scientific investigation has repeatedly produced findings which are the exact opposite of what would be expected if traumatic experience was the cause of PTSD symptoms.

The recurrent scientific finding that PTSD symptoms are actually less common among people who have been significantly traumatized than among people who have not been significantly traumatized is consistent with the research findings that were reviewed earlier in this chapter, which indicated that the normal human response to traumatic stress involves psychological improvement.

The results from these research projects also indicated that normal life stress is more strongly associated with PTSD symptoms, than is the experience of traumatic stress (even chronic, life-threatening stress). Such findings are consistent with previously published reports from different designs (Burstein; Helzer et al.; Long et al.; Olff et al.; Scott & Stradling).

These projects are population based studies, rather than being based on mental healthcare patients. Research on patients has produced similar results. Research that was limited to people who sought mental health care revealed that rates of PTSD symptoms were the same for those who had not experienced a protocol-type trauma, as for those who had (Bodkin et al.). In other words, the results indicated that the complex of symptoms that have been included in the diagnostic protocol for PTSD is not actually correlated with traumatic experience. The symptoms of PTSD appear to be a generic manifestation of mental illness, which does not manifest any more often among patients who have experienced trauma, compared to those who have not.

Other research findings indicating that the constellation of symptoms which has been written into the construct of PTSD is actually just a generic manifestation of pre-existing mental illness include:

- There is extreme overlap of PTSD-like presentations with other mental illness constructs. It is very unlikely for a PTSD-like presentation to be manifested in a case which does not simultaneously satisfy the diagnostic requirements of other mental illness constructs (Koenen et al. 2008; Wrenger et al.).

- Scientific findings have established pre-existing mental illness as a dominant risk factor for PTSD-like presentations. For example, research findings have indicated
that PTSD-like presentations “almost always develop in the context of other (pre-existing) mental disorders” (Koenen et al. 2008). Pre-existing “mental health problems” have actually been scientifically established as being a better predictor of PTSD-like presentations than the individual’s acute response to the traumatic experience (van der Velden & Wittmann), even though the individual’s acute response is actually written into the DSM-IV-TR protocol for PTSD (and pre-existing mental illness is not). Published reports of relevant findings have consequently warned: “Without taking into account pre-existing disorders, the incidence (of PTSD) may be overestimated” (Wrenger et al.).

- Scientific findings have indicated that pre-existing psychopathology is the only risk factor for prolonged PTSD-like presentations – exposure to traumatic experience had no predictive role (McFarlane 1988) (Note: the relevant research was not capable of considering the role of another dominant factor that is discussed below, eligibility for compensation).

In addition to the relatively recent findings which indicate that trauma is not a necessary cause of PTSD symptoms, attempts to comprehensively review the relevant literature had previously indicated that a traumatic experience is also not a sufficient cause of PTSD. For example, research has consistently revealed that a PTSD-like presentation is not likely to follow trauma (First & Tasman; Hales et al.; Simon; Yehuda 1998 & 1999). Scientific analysis has also indicated that exposure to any specifically claimed trauma is not even the most important risk factor for PTSD (Yehuda 1999). Therefore, when considered in its entirety, the history of relevant scientific findings indicates that trauma is neither a necessary nor a sufficient cause of PTSD symptoms.

Consistent with all of the above, scientific investigation has demonstrated that there is not a reliable dose-response gradient for a supposed relationship between severity of a trauma and the development of PTSD (McFarlane 1988; Richter et al.; Tucker et al.). The absence of such a reliable dose-response gradient provides additional evidence against a causative role for traumatic experience.

Scientific research has further indicated a lack of a causative role for experience in regard to PTSD-like presentations when an issue of great significance to workers compensation (and some vehicle accident systems) is considered - permanent impairment. Specifically, scientific investigations have indicated that experience does not play any predictive role in the manifestation of long-term PTSD symptoms (this finding actually emerged from a research design that did not even attempt to overcome the definitional confounding of trauma with symptoms) (McFarlane 1988). The findings indicated that the only predictor of such long-term symptoms is pre-existing psychopathology. Such findings create yet another obstacle to credibly claiming that adult life events can play a causative role in the development of permanent impairment from PTSD-like presentations. Such findings also provide an additional indication that the symptoms that have been written into the
construct of PTSD are actually nothing other than a generic manifestation of mental illness.

Scientific studies of PTSD-like presentations also provide an illustration of the fundamental role of genetics in the causation of mental illness. Relevant research findings include genetic factors accounting for up to 34% of the variance for the development of PTSD symptoms, and specifically accounting for more symptoms than did trauma exposure (even without controlling for the definitional confounding of trauma and symptoms) (True et al.).

An important example of an alternative risk factor for PTSD-like presentations is eligibility for compensation. Research has revealed that eligibility for compensation has a much more profound role in determining whether a diagnosis of PTSD will be made, than does traumatic experience. While PTSD is diagnosed in only 7-12% of general population individuals who are exposed to accidents (Breslau 2001), rates of 85% have been documented when the accident created an opportunity to seek compensation (Rosen). In other words, the indication from such science is that at least 73% of the claims of PTSD would be more likely attributable to eligibility for compensation, than to traumatic experience. Consequently, in an artificial exercise when the only causes being considered for an individual claim of PTSD are traumatic experience and eligibility for benefits, eligibility for benefits would overwhelmingly be the more probable cause.

This dominant causative role of eligibility for compensation has also been directly demonstrated for workers compensation (Mason et al.). Specifically, compensation claimants were more likely to report PTSD symptoms, even though their injuries were less severe than a non-compensation group.

All of the above scientific findings in regard to the construct of PTSD, and all of the findings that were previously discussed in this chapter regarding the normal human response to extreme stress, are consistent with published reports that “the concept of PTSD has moved the mental health field away from, rather than towards a better understanding of the natural psychological responses to trauma” (McHugh & Treisman). Such observations take the discussion beyond causation, and the PTSD construct is indeed flawed in ways that go far beyond causation considerations. A full discussion of the fundamentally misdirected nature of the construct is beyond the scope of this text, but interested readers can find more information in Rosen & Lilienfeld’s review of the literature, which revealed that “virtually all core assumptions and hypothesized mechanisms (of PTSD) lack compelling or consistent empirical support”.

F. 2. b. Major Depressive Disorder (MDD)

MDD was prominent on the recruited lists of mental illness constructs that frequently appear in workers compensation claims. From a scientific perspective, the appearance of MDD on these lists is shocking. For MDD to appear on those lists, there must be some
assumption within workers compensation that work is a cause of this construct. Research has repeatedly indicated that such an assumption would be false, and in fact, would be the extreme opposite of relevant scientific findings.

Specifically, research findings have reliably indicated that work is a protective agent in regard to MDD (Gabbard; Sadock & Sadock). It is not a risk factor, and therefore not a cause. This is not even a matter of there being a lack of relationship between work and MDD. Instead, work has repeatedly been demonstrated to have an inverse relationship to manifestations of MDD. MDD is approximately three times less common among people who are working, as opposed to people who are not working.

Scientific findings have also indicated actual risk factors for MDD-like presentations, thereby providing some understanding of what it is that work is protecting vulnerable individuals from. For example, as is the case with most mental illness constructs, genetics reportedly play a dominant etiological role (Hales et al.), and childhood experience also appears to play a "compelling" role (Sadock & Sadock).

Research findings have also provided some clues in regard to how work protects people from MDD-like vulnerabilities. Important factors appear to include the manner in which work improves an individual's financial state, self-esteem, social connectedness, motivation, and sense of purpose. Additionally, work provides a "mental respite" from both internal and external correlates of mood disturbance (Rothman et al.).

Of more general relevance to a premise that traumatically stressful experience causes symptoms of depression, scientific investigation of body handlers after the Oklahoma City bombing demonstrated that there was not a reliable dose-response gradient for any such relationship (Tucker et al.). The absence of such a reliable dose-response gradient provides additional evidence against a causative role for stressful experiences.

Another obstacle to establishing occupational or tort-relevant causation for MDD is the chronic nature of this construct. The MDD construct is made up of major depressive episodes. The DSM-IV-TR (American Psychiatric Association 2000) specifies that the MDD construct only applies to individuals who report having experienced discrete “major depressive episodes”. The specific requirements for the identification of what constitutes a major depressive episode are also defined in the DSM-IV-TR. The chronic nature of MDD is indicated by scientific findings which indicated that any individual who has had one major depressive episode at any point in his or her life is probably going to experience, or has already experienced, other major depressive episodes (American Psychiatric Association 2000). In most cases, an MDD-like presentation is going to be a chronic recurring pattern, rather than a focused response to some specific experience. Subsequently, it becomes extremely difficult to justify a claim of recent causation for any one demonstration of a major depressive episode. If a history of a previous episode is acknowledged, then any new episode would be a normal and expected manifestation of the pre-existing pattern, rather than being some unexpected event that might require an explanation (an explanation such as occupational or tort-relevant causation). It would actually be unusual, and more worthy of explanation, if the new episode had not
occurred. The situation does not benefit from the examinee denying any previous episodes, given the repeated scientific findings which indicate that such denials are extremely unreliable, and consequently cannot serve as a credible basis for clinical, forensic, or administrative decision-making (Barth September/October, 2009).

The data which was collected and reviewed specifically for the creation of the first edition of the AMA’s Causation Guides indicated that there is a trend for legal claims to involve MDD, because the MDD is being attributed to chronic pain complaints, and claim-relatedness is also being asserted for those chronic pain complaints. Attempts to justify such legal causation claims face numerous obstacles. For example:

- There is a general lack of scientific support for legal causation claims focused on chronic pain. Scientific findings have actually been contradictory of such claims (Barth 2012b; also discussed in other sections of both editions of the AMA’s Causation Guides).

- There is a general lack of scientific support for legal causation claims focused on MDD. Scientific findings have actually been contradictory of such claims (details discussed herein). Additionally, many attempts to comprehensively review the scientific literature on the etiology of MDD-like presentations are available, and those reviews reliably fail to index pain as a cause of this construct (First & Tasman; Hales et al.).

- Scientific findings have indicated that any combination of chronic pain and a MDD-like presentation (or any other mood disorder-like presentation) raises the probability that there will be no objective general medical explanation for the pain complaints, thereby moving the entire case further away from justifying a legal causation claim (Magni).

- Reports from a claimant/plaintiff that the MDD-like problems were not manifested prior to the development of the pain complaints (or even that the pain complaints were not present prior to the claimed cause) are extremely unreliable and consequently cannot be credibly used for purposes of clinical, forensic, or administrative decision-making (Barth September/October, 2009).

- Additionally, research findings have indicated that MDD-like presentations (and other presentations from the historical category of mood disorders) tend to precede chronic pain complaints, rather than follow them (Polatin et al.). Even a family history of mood disorder (the historical category of mental illness constructs which included MDD) tends to predispose individuals to the development of chronic pain complaints (Raphael et al.). Therefore, scientific findings more easily support a conclusion that MDD is a risk factor for chronic
pain complaints, rather than a claim that the chronic pain complaints caused the MDD, or claims that such combined presentations are work-related or injury-related.

F. 2 c. Dysthymic Disorder (Note: This disorder was essentially wiped out of existence by the publication of DSM-5 in May 2013)

This section exists because there had historically been a mental illness called Dysthymic Disorder, and that diagnosis was prominent in the tabulations which were recruited for the first edition of AMA Causation Guides (tabulations of mental illness diagnoses that frequently appeared in legal claims). According to DSM-5 (American Psychiatric Association 2013), Dysthymic Disorder no longer exists. A new mental illness construct has been created which, according to DSM-5, is a consolidation of Dysthymic Disorder and one variant of Major Depressive Disorder. This new mental illness construct (labeled “persistent depressive disorder”) never existed before the publication of DSM-5 in May 2013; consequently, it has no basis in science.

Readers can probably expect to see the historical diagnosis of Dysthymic Disorder continuing to appear in claims for years to come. This has been the historical trend, when other diagnostic constructs were discontinued in the past. For example, the diagnostic construct “Somatoform Pain Disorder” was discontinued when DSM-4 was published in 1994, but that diagnosis still appears within claims with such frequency that participants at the annual American Academy of Orthopaedic Surgeons Occupational Orthopaedics course were compelled to specifically request formal continuing medical education programming focused on that diagnosis in 2012 (18 years after the diagnosis was discontinued).

When readers see the Dysthymic Disorder construct being used within a claim, they can apply the scientific knowledge base to the claim (that knowledge base is summarized in the remainder of this section). Because of the discontinuation of this construct by DSM-5, it can also be pointed out that any such claim is based on an obsolete diagnostic concept.

The previously discussed generic obstacles to justifying legal claims of mental illness apply to this construct. Dysthymic Disorder claims face additional obstacles that are relatively unique to this construct.

For any case that actually complies with the historical diagnostic requirements for Dysthymic Disorder, the probability is that the clinical presentation is of a pre-existing nature, rather than a work-related or tort-relevant nature. This is due to the scientific findings that the presentation usually begins in childhood or adolescence, rather than manifesting as a consequence of adult life experience (U.S. Department of Health and Human Services).

Similarly, previously published discussions of scientific findings regarding the etiology
of such presentations have emphasized risk factors that do not involve occupational or tort-relevant issues (First & Tasman; Sadock & Sadock). Examples of reported risk factors include certain types of sleep disorders, thyroid abnormalities, faulty personality development, social disappointment early in life, and dysfunctional fantasies.

Similarly, scientific study of adult traumatic experience revealed that such trauma was not associated with any increased rates of Dysthymic Disorder-like presentations (Winfield et al.), and that there was no dose-response gradient for symptoms of depression (Tucker et al.).

F. 2 d. Pain Disorder

This section exists because there had historically been a mental illness called Pain Disorder, and that diagnosis was prominent in the tabulations which were recruited for the first edition of AMA Causation Guides (tabulations of mental illness diagnoses that frequently appeared in legal claims). According to DSM-5 (American Psychiatric Association 2013), Pain Disorder no longer exists. DSM-5 offers a variety of other diagnostic possibilities which might apply to people who would have historically had a diagnosis of Pain Disorder.

Readers can probably expect to see the historical diagnosis of Pain Disorder continuing to appear in claims for years to come. As was discussed above, this has been the historical trend, when other diagnostic constructs were discontinued in the past.

When readers see the Pain Disorder construct being used within a claim, they can apply the scientific knowledge base to the claim (that knowledge base is summarized later in this section). Because of the discontinuation of this construct by DSM-5, it can also be pointed out that any such claim is based on an obsolete diagnostic concept.

The following detailed discussion of Pain Disorder was prepared at the direction of the organizers of the 2012 American Academy of Orthopaedic Surgeons Occupational Orthopaedics course, due to requests from course participants for such educational material. Participants had explained that the requested such educational material because they frequently see the Pain Disorder diagnosis being used in legal claims.

F. 2 d. 1. Basic definitional considerations for Pain Disorder

Pain Disorder was in the category of mental illnesses that is was called somatoform disorders (NOTE: DSM-5 discontinued this entire category, as well as discontinuing Pain Disorder). This category of mental illnesses was defined as involving “physical symptoms that suggest a general medical condition and are not fully explained by a
general medical condition, by the direct effects of a substance, or by another mental disorder” (American Psychiatric Association 2000).

The ramifications of this category definition include: A diagnosis of Pain Disorder (or any other diagnosis from this category) means that physical injury and other general medical considerations are not capable of providing an explanation for the pain (NOTE: the phrase “general medical considerations” means considerations that are not primarily the focus of psychology, and which are instead primarily the focus of other fields of science; an example would be diabetes) (American Psychiatric Association 2000). The pain is instead a manifestation of mental illness.

This definitional consideration is apparently often ignored, given the reports from databases and AAOS course attendees that this diagnosis frequently appears within legal claims. Those reports indicate that it is very common for injury to be claimed as a cause of Pain Disorder. Detailed discussion with AAOS course attendees indicated that this is indeed a common claim. Therefore, there is apparently a strong need for the following fact to be emphasized: Any attempt to attribute Pain Disorder to injury actually violates the definitional nature of Pain Disorder.

Within the category of somatoform disorders, Pain Disorder was more specifically defined as a mental illness for which “the essential feature…is pain that is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention” (American Psychiatric Association 2000).

There is also an apparent need for one aspect of the history of this construct to be emphasized. Through a review of much documentation from other clinicians (for example, a review of almost 700 workers compensation files that involved mental health specialists, which was conducted for the creation of the first edition of the American Medical Association’s Guides to the Evaluation of Disease and Injury Causation [Melhorn and Ackerman]), and through teaching for several years at the American Academy Of Orthopedic Surgeons’ annual worker’s compensation course, the author of this chapter has learned that there is widespread use (especially within legal/administrative claims) of an antiquated concept entitled “somatoform pain disorder”. Therefore, it appears to be important to emphasize that the concept of “somatoform pain disorder” was formally discontinued as of 1994. In explanation, “somatoform pain disorder” was a construct that was incorporated into obsolete versions of the American Psychiatric Association’s diagnostic manual (for example, American Psychiatric Association 1987). It has been excluded from more recent versions of the diagnostic manual, starting in 1994 (American Psychiatric Association 1994), and continuing through the current version (American Psychiatric Association 2013). Because the 1994-2013 construct of Pain Disorder was within the category of “somatoform disorders”, it might seem to be appropriate to use the phrase “somatoform
pain disorder” to refer to the 1994-2013 construct. However, it would actually not be appropriate to do so, because the construct that was entitled “somatoform pain disorder” was quite different from the construct of Pain Disorder (for example, different in terms of essential features, diagnostic protocol, sub-constructs, differential diagnostic considerations, associated features, age features, course information, associated disability, associated complications, predisposing factors, gender features, and familial pattern). The differences between “somatoform pain disorder” and Pain Disorder are sufficient to justify a conclusion that the constructs are not even close to being synonymous. Consequently, any clinician who has claimed a diagnosis of “somatoform pain disorder” is automatically indicating that he or she is practicing in a fashion that has been obsolete since 1994.

F. 2 d. 2. Pain Disorder involved two sub-constructs that were mental illnesses

The two sub-constructs for the mental illness Pain Disorder were (American Psychiatric Association 2000):

- Pain Disorder Associated with Psychological Factors
- Pain Disorder Associated with Both Psychological Factors and a General Medical Condition

In the first sub-construct, Pain Disorder Associated with Psychological Factors, psychological factors have a major role in the presentation of pain, and general medical conditions play either no role or a minimal role. The following bullet points are discussed in detail later in this chapter, but it is important to note them immediately:

- The first characteristic of this sub-construct (psychological factors have a major role in the presentation of pain) automatically applies to every presentation of pain (given relevant definitional and scientific considerations, which are discussed later in this chapter).

- The following considerations can be noted in regard to the second characteristic of this sub-construct (general medical conditions play either no role or a minimal role). The Editor of DSM-IV-TR (American Psychiatric Association 2000) has provided an elaborated discussion of DSM-IV-TR constructs (First & Tasman). In regard to the types of clinical presentations for which the various “pain disorder” constructs might be relevant, that elaborated discussion explains:
There is a large statistical probability that any relevant clinical presentation will not involve a general medical explanation for the pain.

For the large majority of cases in which the complaint of pain is not “fully explained by a general medical condition”, “it may be assumed that psychological factors play a major role.”

In the second sub-construct, Pain Disorder Associated with Both Psychological Factors and a General Medical Condition, both psychological factors and a general medical condition have a major role in the manifestation of the pain.

- Again, the role of psychological factors automatically applies to every presentation of pain (a detailed discussion of relevant definitional and scientific considerations is provided later in this chapter).

- In regard to a general medical condition having a major role:
  
  - The DSM-IV-TR (American Psychiatric Association 2000) offers an example, involving a patient with pain that is caused by diabetic polyneuropathy, also demonstrating a somatoform presentation of pain.
  
  - Otherwise, the diagnostic protocol does not provide a method for determining whether a general medical condition is contributing to the presentation of pain. Therefore, if a diagnostician is considering using this sub-construct as a diagnosis, he or she should use some scientifically credible method for establishing the role of a general medical condition in the creation of the pain, should document the utilization and results of that method, and should be prepared to identify and explain the scientific support for that method.
  
  - As is discussed in greater detail later in this chapter, scientific findings have indicated that it is very unlikely that a relevant presentation of pain will involve a general medical condition playing a major role in the manifestation of that pain (First and Tasman). Consequently, it is highly unlikely that Pain Disorder Associated with Both Psychological Factors and a General Medical Condition would be a credible diagnosis in any given case.
F. 2 d. 3. DSM-IV-TR’s discussion of Pain Disorder lists a third sub-construct, which appears to be a useless distraction

The discussion of Pain Disorder that is provided in DSM-IV-TR (American Psychiatric Association 2000) lists a third construct, which is entitled “pain disorder associated with a general medical condition”. As is explained by the discussion that is provided in the remainder of this section, this third construct appears to be a confusing and useless distraction, rather than being a helpful diagnostic construct.

F. 2 d. 3. a. This third “Pain Disorder” sub-construct is not a mental illness

DSM-IV-TR specifies that this third construct is not a manifestation of the mental illness Pain Disorder, or any other mental illness. This inclusion of such a non-mental illness in the diagnostic manual for mental illness is just one of several confusing aspects of this construct (other confusing aspects are discussed below).

The confusion that has been caused by this construct has been demonstrated by psychiatrists who have documented in forensic cases, and who have testified under oath, that the construct is a mental illness (a scenario that has been witnessed by this author multiple times). Such claims and testimony are clearly false, given the fact that DSM-IV-TR specifies that this concept is not a mental illness (American Psychiatric Association 2000). The psychiatrists who offered such reports and testimony had apparently not actually read, or understood, the diagnostic system that they were claiming to use.

F. 2 d. 3. b. This third sub-construct of Pain Disorder does not appear to be any type of diagnosis

The confusing nature of this construct is compounded by its non-diagnostic nature: in addition to not being a mental illness, it does not actually appear to be a formal diagnosis of any type. For example, DSM-IV-TR (American Psychiatric Association 2000) does not assign a diagnostic code to this construct. Consequently, it cannot be found in the American Medical Association’s published comprehensive list of diagnostic codes (Buck). Similarly, a review of the AMA’s alphabetical listing of all recognized diagnoses also fails to reveal any formal recognition for a diagnostic entity entitled “pain disorder associated with a general medical condition” (Buck).

Additionally, the directives from the DSM-IV-TR (American Psychiatric Association 2000) indicate that this construct is not actually a “disorder”, in spite of the word “disorder” having been written into its title. Instead, DSM-IV-TR specifies that the diagnostic “code for this subtype is selected based on the location of the pain or the
associated general medical condition if this has been established”. This means that the specific diagnosis in any case of “pain disorder associated with a general medical condition” will not actually be “pain disorder associated with a general medical condition”, but will instead be either some other (some actual) disorder, or it will not be any “disorder” – it will simply a symptom instead. This direction from DSM-IV-TR (American Psychiatric Association 2000) relegates “pain disorder associated with a general medical condition” to the status of a non-disorder, and a non-diagnosis.

F. 2 d. 3. c. This third Pain Disorder sub-construct is based on a fundamentally misdirected premise

The construct of “pain disorder associated with a general medical condition” is additionally problematic due to an inherent contradiction between a misdirected premise on which it is based, and both the definitional nature of pain and the scientific knowledge base in regard to pain.

In order to understand this inherent contradiction, consideration should first be given to the following specification from DSM-IV-TR (American Psychiatric Association 2000):

A “diagnosis” of “pain disorder associated with a general medical condition” means “psychological factors” “play either no role or a minimal role in the onset or maintenance of the pain”.

The definitional and scientific considerations that are reviewed in the remainder of this section indicate:

- Any presentation of pain is inherently and even primarily of a psychological nature (by definition).

- Given the definitional nature of pain as an inherently psychological phenomenon, it is not credible to conceptualize a presentation of pain in which “psychological factors” might “play either no role or a minimal role in the onset or maintenance of the pain”. The pain itself is a “psychological factor”. In the absence of the psychological functioning of the individual, there is no pain.

- The scientific knowledge base is strongly supportive of the above definitional considerations, as psychological (and social) factors have consistently been found to play a dominant role in relevant clinical presentations.

- Scientific findings have also indicated that relevant clinical presentations are very unlikely to lead to credibly explanatory general medical findings. Therefore, in
addition to being definitionally untenable, it is also statistically improbable that a “diagnostic” claim of “pain disorder associated with a general medical condition” will be justifiable.

- Consequently, the construct of “pain disorder associated with a general medical condition”:
  - is untenable, because it is incompatible with the definitional nature of pain
  - is highly unlikely to be relevant to any individual case (even if it was a definitionally sound concept)

F. 2 d. 3. c. 1. This premise that “psychological factors” might “play either no role or a minimal role in the onset or maintenance of the pain” is actually inconsistent with the definitional nature of pain.

Relevant considerations include the following issues from the International Association for the Study of Pain’s definition of pain (Mersky & Bogduk):

- Pain “is always a psychological state”
- Pain is “always” “an emotional experience”
- “Activity induced in the nociceptor and nociceptive pathways by a noxious stimulus is not pain…”
- “Many people report pain in the absence of tissue damage or any likely pathophysiological cause; usually this happens for psychological reasons. There is usually no way to distinguish their experience from that due to tissue damage if we take the subjective report.”

Similarly, each of the two most recent editions of the American Medical Association’s Guides to the Evaluation of Permanent Impairment (Rondinelli; Cocchiarella and Andersson) has specified that pain is definitionally an “emotional experience”.

The AMA has also published additional definitional considerations, which have been specifically built on the IASP definition (Evans):

- Those AMA materials (Evans) specify that “pain is a perception and not a sensation”:
- Sensation is defined as “the process or experience of perceiving through the senses” (VandenBos)

- Perception is defined as “the process or result of becoming aware of objects, relationships, and events by means of the senses, which includes such activities as recognizing, observing, and discriminating. These activities enable organisms to organize and interpret the stimuli received into meaningful knowledge.” (VandenBos)

- Consequently, this distinction that is made in the AMA materials (Evans) regarding the nature of pain emphasizes that pain is not an automatic sensory phenomenon, but is instead a process of the individual recognizing, observing, discriminating, organizing, and interpreting the sensation, and is also the result of all of that psychological activity. In other words, pain is inherently psychological.

- These AMA materials (Evans) summarize the significance of the above distinction in the following fashion: “In all cases, the reality that pain is a perception indicates the potential for profound influence of psychological and emotional factors…”

- These AMA materials (Evans) additionally emphasize a hierarchical model which also highlights the primarily psychological nature of pain. The primarily psychological nature of pain is indicated by the strictly psychological nature of two of the three components of that hierarchy [“a motivational–affective component (e.g., depression, anxiety), and a cognitive-evaluative component (e.g., thoughts concerning the cause and significance of the pain)"]. The third component involves sensation, but indicates that the sensation aspects of pain are inextricably linked to the psychological/perceptual aspects [“a sensory-discriminative component (e.g., location, intensity, quality)"].

- These AMA materials (Evans) additionally specify that there is not an inherent relationship between pain and general medical phenomena. Relevant passages include:

  - “There is an important implication of both the IASP definition and the hierarchical model of pain: As a perception, pain may or may not correlate with an identifiable source of injury.”
“...pain can develop and be unrelated to any identifiable physical process...”

F. 2 d. 3. c. 2. This premise that “psychological factors” might “play either no role or a minimal role in the onset or maintenance of the pain” is additionally inconsistent with the scientific knowledge base.

The Fifth Edition of the Guides to the Evaluation of Permanent Impairment (Cocchiarella and Andersson) provided a review of relevant scientific findings which emphasized that “a variety of nonbiological factors strongly influence” presentations of pain. The “nonbiological” factors that are specified in the associated text include:

- “beliefs, expectations, rewards, attention, and training”
- “social and environmental factors”
- “spouse solicitousness”
- “job dissatisfaction, lack of support at work, stress and perceived inadequacy of income”
- “financial compensation, receipt of work-related sickness benefits, and compensation-related litigation”
- “poor education, language problems, and low income”
- “tendencies to be preoccupied with one’s body and symptoms”
- “depression and daily hassles at work”

Discussions of psychological and social factors that have been scientifically indicated as being the dominant driving forces behind legal/administrative claims involving a focus on pain are also provided in other publications from the American Medical Association and the American Academy of Orthopaedic Surgeons (examples include: Barth 2006; Barth 2007a; Barth May/June 2009; Barth November/December 2009; Barth 2011; Barth 2013a; Barth 2013b; Barth 2013c; Melhorn and Ackerman; Melhorn, Ackerman, Talmage, and Hyman).

F. 2 d. 3. c. 3. Even if this third Pain Disorder sub-construct was definitionally sound, it would be highly unlikely to be relevant to any individual case.

Scientific findings have indicated that relevant clinical presentations are very unlikely to lead to credibly explanatory general medical findings. Therefore, in addition to being definitionally untenable, it is also statistically improbable that a “diagnostic” claim of “pain disorder associated with a general medical condition” will be justifiable in an individual case.
Discussions of the relevant science include:

- Various American Medical Association publications have reviewed scientific findings of a lack of explanatory general medical findings in a large majority of relevant cases (e.g., 85% of such cases) (Cocchiarella & Andersson; Barth 2006; Talmage & Melhorn; Barth 2012a).

- The elaborated discussion (First & Tasman) provided by the editor of DSM-IV-TR (American Psychiatric Association 2000) reviews scientific findings which indicate that 75% of the cases involving a presenting complaint of pain will not result in a general medical explanation for the pain.

- Other prominent reviews of relevant science have reported that up to 90% of relevant cases will not involve credibly explanatory general medical findings (Deyo & Weinstein).

F. 2 d. 4. Diagnostic protocol for Pain Disorder

The diagnostic protocol for Pain Disorder involves criteria, differential diagnostic considerations, associated features, associated disorders, culture/age/gender features, prevalence information, course information, familial patterns, and specifiers (American Psychiatric Association 2000). This section addresses those portions of the protocol which might be of primary importance to clinicians and reviewers who are working on relevant claims.

F. 2 d. 4. a. Criterion A for Pain Disorder

The first criterion (of five) is: “Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention” (American Psychiatric Association 2000).

The diagnostic protocol for Pain Disorder (American Psychiatric Association 2000) does not provide any method for determining whether the pain “is of sufficient severity to warrant clinical attention”. Other texts, which have been published by the American Psychiatric Association for the specific purpose of clarifying how the DSM-IV-TR system is to be used, either fail to even mention Pain Disorder (First MB, Spitzer RL, Gibbon M, Williams JBW; Othmer & Othmer Volume 1), or similarly fail to offer any method for addressing this criterion (Othmer & Othmer Volume 2). An elaborated text from the DSM-IV-TR’s editor (First and Tasman) actually refers readers to the second criterion as an explanation for the first criterion, thereby indicating that the two criteria
are synonymous, and consequently creating a mystery into why there are two separate criteria which the system’s editor has implied are synonymous with one another. Quite unfortunately, that elaborated text from the editor (First & Tasman) offers no method for addressing the first criterion (other than mysteriously equating it with the second criterion), and also fails to offer a method for addressing the second criterion (the second criterion is specifically discussed below).

Therefore, any diagnostician who is entertaining the possibility of making a Pain Disorder diagnosis will have to address this criterion in an idiosyncratic fashion (because there is no standardized method specified in the diagnostic system or its associated texts). Given the lack of standardization, any such diagnostician should be prepared to provide scientifically credible justification for the method that they used to address this criterion. In the absence of such justification, a diagnostic claim of Pain Disorder will not be credible (it will be based on a method that lacks both standardization and scientific credibility).

Any reviewer who is scrutinizing a claim of Pain Disorder (one which has been made by some other diagnostician), should be specifically looking for the diagnostician to have clearly identified some scientifically credible justification for the method that the diagnostician utilized to address this first criterion (such scientific justification is necessary, given the lack of any standardized method for addressing this criterion, as has been discussed above). If such scientifically credible justification for the utilized method is not specified in the diagnostician’s documentation, then the diagnostic claim of Pain Disorder is baseless and should not be accepted.

F. 2 d. 4. b. Criterion B for Pain Disorder

The second criterion is: “The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (American Psychiatric Association 2000).

Readers should first note the use of “impairment” within this criterion is inconsistent with the American Medical Association standard, as documented in the *Guides to the Evaluation of Permanent Impairment Sixth Edition* (Rondinelli). Readers who are unfamiliar with the relevant professional standards are referred to the glossary of the *Guides to the Evaluation of Permanent Impairment Sixth Edition* (Rondinelli), in order to see that the standard definition of “impairment” is limited to considerations of body structure and body function (rather than being applicable to “social, occupational, or other important areas of functioning”). Limitations or restrictions in regard to “social,
occupational, or other important areas of functioning” would fall within professional standards for the definition of “disability”, but not “impairment” (Rondinelli).

This unconventional use of the word “impairment” creates a quandary for the diagnostician. Specifically, the diagnostician is left to speculate in regard to what is meant by the use of the word “impairment” in this criterion, given all the following considerations:

- The obvious inconsistency with the standard definition of “impairment” from the American Medical Association’s *Guides to the Evaluation of Permanent Impairment Sixth Edition* (Rondinelli)

- The failure of DSM-IV-TR (American Psychiatric Association 2000) to provide any alternative definition for “impairment”

- The failure of DSM-IV-TR (American Psychiatric Association 2000) to provide an explanation for the unconventional nature of its use of the word “impairment”

- The failure of DSM-IV-TR (American Psychiatric Association 2000) to provide any indexing for its unconventional use of the word “impairment”

- The failure of other texts, which have been published by the American Psychiatric Association for the specific purpose of clarifying how DSM-IV-TR is to be used, to even mention Pain Disorder (as was discussed and referenced above), and the resulting lack of clarification from those texts for DSM-IV-TR’s unconventional use of the word “impairment”.

Given all of the above considerations, it cannot be credibly claimed that a diagnostician has addressed this criterion in a standardized fashion. The criterion itself is incompatible with professional standards, given the unconventional use of the word “impairment”. Consequently, any attempt to utilize this diagnostic criterion is inherently incompatible with professional standards regarding impairment (as documented in the American Medical Association’s *Guides to the Evaluation of Permanent Impairment Sixth Edition*) (Rondinelli).

The obstacles to credibly claiming that the diagnostician has utilized this criterion in a manner that is consistent with professional standards are compounded by additional text from DSM-IV-TR (American Psychiatric Association 2000). DSM-IV-TR explains that the core of this criterion (“clinically significant distress or impairment”) is a feature of almost all mental illness constructs, and that it has actually been written into the generic definition of “mental disorder”. Unfortunately, DSM-IV-TR also explains that the
utilization of this criterion is a matter of “inherently difficult clinical judgment”. In other words, there is no standard method for addressing this diagnostic requirement, and it will always be dependent upon the idiosyncratic and subjective judgment of a clinician.

As was explained and referenced above, other texts which have been published by the American Psychiatric Association for the specific purpose of clarifying how DSM-IV-TR is to be used, fail to even mention Pain Disorder. Consequently, those supplemental American Psychiatric Association texts also fail to provide a method which would allow the diagnostic process to move beyond the idiosyncratic and subjective judgment of a clinician.

In regard to the issue of “clinically significant distress” that is mentioned within this criterion, the elaborated discussion that has been provided by DSM-IV-TR’s editor (First & Tasman) makes an unexplained claim that “a number of instruments have been developed to assess the degree of distress associated with the pain”. Unfortunately, that text then names “instruments” that actually fail to add anything other than additional subjectivity from the examinee (e.g. visual analog scale). Consequently, the mention of such instruments accomplishes almost nothing in terms of scientific credibility, objectivity, or professional expertise, and intensifies the diagnostic system’s crippling reliance on subjectivity (as was discussed previously in this chapter).

Consequently, even beyond this criterion’s unexplained reliance on an unconventional utilization of the word “impairment”, the considerations discussed in the preceding three paragraphs clarify that there is not a standard method for addressing this criterion. Therefore, the need for scientifically credible justification of any utilized method, and the ramifications of any lack of such justification (all of which was discussed above), also apply to this second criterion (although the unconventional use of the word “impairment” will compromise the credibility of diagnostic claims of Pain Disorder even if such justification is provided).

**F. 2 d. 4. c. Criterion C for Pain Disorder automatically applies to every presentation of pain**

The third criterion is: “Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.” (American Psychiatric Association 2000)

As was discussed above, this criterion applies to every presentation of pain. For example, given the definitional and scientific considerations that were reviewed above, “psychological factors” will “have an important role in the onset, severity, exacerbation,
or maintenance of the pain” in every presentation of pain. At the very least, this is true because:

- Pain is always a psychological phenomenon (pain itself is always a “psychological factor”).

- In the absence of the psychological functioning of the individual, there is no pain.

F. 2 d. 4. d. Criterion D for Pain Disorder automatically excludes this diagnostic possibility within any legal/administrative claim.

The fourth criterion is: “The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or malingering).”

For any legal/administrative claim, this criterion removes Pain Disorder from diagnostic consideration. This automatic removal of Pain Disorder from diagnostic consideration is caused by the malingering protocol that is built into DSM-IV-TR (and which was actually created for purposes of utilization within any case, even those that do not involve claims of mental illness [American Psychiatric Association 2000; Patterson CS, Barth RJ, Brigham CR, Talmage JB, Leclair S, and Coupland M]). That component of the diagnostic system specifies that “malingering should be strongly suspected” for any case that involves the following two issues:

- “Medicolegal context of presentation (e.g., the person is referred by an attorney to the clinician for examination)”

- “Marked discrepancy between the person’s claimed stress or disability and the objective findings”

These two components from the malingering protocol will always apply to every legal/administrative claim which might otherwise warrant consideration of a diagnosis of the mental illness Pain Disorder, because:

- Every such legal/administrative claim will have a “medicolegal context of presentation” (by virtue of the fact that there is a legal/administrative claim).

- Every such case will involve a “marked discrepancy… (from)…objective findings” due to the completely subjective nature of pain (and any “stress or disability” associated with the pain).
Consequently, DSM-IV-TR actually excludes Pain Disorder from diagnostic consideration for any case that involves a legal/administrative claim.

If, in cases where there is no legal/administrative claim, a diagnostician is considering making a diagnosis of the mental illness Pain Disorder, then this criterion requires, at a minimum:

- Full utilization of the malingering protocol from DSM-IV-TR (American Psychiatric Association 2000), and documentation of that utilization and the results. A discussion of how that protocol is to be fully utilized has been provided by the American Medical Association (Patterson CS, Barth RJ, Brigham CR, Talmage JB, Leclair S, and Coupland M).

  - That American Medical Association discussion of how the malingering protocol is to be fully utilized emphasizes the need for objective assessment, in order to act on the malingering criterion which calls for consideration of a discrepancy between the clinical presentation and objective findings. For presentations of pain, this would mean utilization of standardized assessments that have been scientifically validated for purposes of objectively discriminating between valid and non-valid presentations of pain.

  - That American Medical Association discussion also explains the need for an extensive effort to obtain and review a complete set of the examinee’s healthcare records, in order to comply with the additional criterion from the malingering protocol which directs the diagnostician to consider whether there has been any “lack of cooperation during the diagnostic evaluation and in complying with prescribed treatment regimen”.

  - That American Medical Association discussion also explains the need for utilization of the diagnostic protocol for Antisocial Personality Disorder (American psychiatric Association 2000 and 2013), in order to comply with the additional criterion from the malingering protocol which directs the diagnostician to consider whether that diagnosis is applicable to the examinee. It should additionally be noted that an examinee who is actually diagnosable as having Antisocial Personality Disorder is highly likely to hide antisocial characteristics from a diagnostician, due to the socially unacceptable nature of those characteristics. Consequently, a diagnosis of Antisocial Personality Disorder cannot be credibly ruled out unless the diagnostician has introduced utilization of relevant scientifically validated objective testing, and has engaged in a diligent process of attempting to
obtain and review all records that might reveal antisocial characteristics (criminal records, vocational records, military records, school records, healthcare records, etc.).

- Full utilization, and documentation of that utilization, of the diagnostic protocol for Factitious Disorder (American Psychiatric Association 2000). The diagnostician must be extremely thorough in this regard, given the inherent nature of Factitious Disorder, which is that the examinee is attempting to hide the disorder from all clinicians. Steps that should be taken in an effort to achieve the necessary level of thoroughness include:
  
  o A diligent effort to obtain and review records (e.g. medical, vocational, school, legal, etc.) from the examinee’s entire life

  o Utilization of not only the criteria from the diagnostic protocol (American Psychiatric Association 2000), but also all of the other information from the diagnostic manual’s discussion (e.g. associated features and disorders) (American Psychiatric Association 2000 and 2013), and similar information from additional publications (for example: Hales, Yudofsky, & Gabbard; Othmer & Othmer Volume 2). The diagnostician should apply all such information to the findings from any evaluation, and (probably more importantly) the findings from a review of the examinee’s records.

  o Objective assessment of the health complaints (as was described above in regard to malingering)

Unless the diagnostician has taken all the steps listed in this section, and documented the results, a claimed diagnosis of Pain Disorder will not be credible, because the diagnosis will not have been based on diagnostic requirements.

F. 2 d. 4. e. Criterion E for Pain Disorder and other differential diagnostic considerations

The fifth criterion is: “The pain is not better accounted for by a mood, anxiety, or psychotic disorder and does not meet criteria for Dyspareunia.” (American Psychiatric Association 2000)

The American Psychiatric Association’s primary textbook (Hales, Yudofsky, & Gabbard) has highlighted this criterion as an example of the manner in which the diagnostic
The protocol for Pain Disorder is “quite indecipherable” and “insufficiently operationalized”. An attempt to overcome such shortcomings is presented later in this section.

Additionally, the differential diagnosis section of DSM-IV-TR’s discussion of Pain Disorder (American Psychiatric Association 2000) calls for the differential diagnostic process to also include Somatization Disorder, Conversion Disorder, all other mental disorders that are commonly associated with pain, as well as the previously discussed issues of Factitious Disorder and malingering.

Consequently, if a diagnostician is considering making a diagnosis of the mental illness Pain Disorder, then this criterion and the associated differential diagnostic section requires, at a minimum, that the diagnostician must utilize, document utilization of, and document the results from such utilization for, all of the following diagnostic protocols:

- Mood disorders: There are at least 10 such protocols that the diagnostician will need to apply (American Psychiatric Association 2000).

- Anxiety disorders: at least 12 such protocols (American Psychiatric Association 2000)

- Psychotic disorders: at least nine such protocols (American Psychiatric Association 2000)

- Dyspareunia

- Somatoform Disorders: The American Psychiatric Association’s primary textbook (Hales, Yudofsky, & Gabbard) specifies “the characteristics of patients with pain disorder can overlap considerably with those of patients with other somatoform disorders, obscuring distinction”. There are at least six relevant somatoform protocols (American Psychiatric Association 2000).

- Personality disorders: As has been explained in other American Medical Association and American Academy of Orthopaedic Surgeons publications (Barth 2006; Barth 2012b; Barth 2013a; Barth 2013c), scientific findings have repeatedly indicated that personality disorders are an extremely strong risk factor for the development of pain complaints. There are at least 11 such protocols (American Psychiatric Association 2000).

- Substance related disorders: There are at least 22 such protocols of relevance to substance abuse or dependence (American Psychiatric Association 2000). As has been explained in other American Medical Association and American Academy
of Orthopaedic Surgeons publications (Barth 2006; Barth 2012b; Barth 2013a; Barth 2013c), scientific findings have repeatedly indicated that substance related disorders are a risk factor for the development of pain complaints.

- Sleep disorders: Scientific findings have indicated that sleep disorders are a risk factor for the development of pain complaints, with potential linking mechanisms including deconditioning and other mental illnesses (Hales, Yudofsky, & Gabbard). There are at least 14 potentially relevant sleep disorder protocols (American Psychiatric Association 2000).

- Factitious Disorder (as was discussed above in regard to criterion D)

- Malingering (as was discussed above in regard to criterion D)

The considerations listed thus far indicate that the diagnostician who is considering making a diagnosis of the mental illness Pain Disorder will need to utilize, and document the results of the utilization of, at least 87 protocols from DSM-IV-TR (American Psychiatric Association 2000). The phrase “at least” is used in the preceding sentence because there are additional mental illnesses for which complaints of pain can be a manifestation (but which were not included on the above list because the association with pain is less prominent). In the absence of such utilization and documentation of at least the protocols listed in this section, a diagnosis of Pain Disorder will not be credible, because the diagnostician will have failed to comply with the diagnostic standards that are specified by criterion E, and the differential diagnosis section of DSM-IV-TR’s discussion of Pain Disorder (American Psychiatric Association 2000).

A wide variety of scientific findings have indicated that it is highly unlikely that the process of applying criterion E to a clinical presentation will produce results that are supportive of a diagnosis of the mental illness Pain Disorder. The relevant scientific findings indicate that the application of criterion E will reveal another mental illness, for which pain is a common manifestation, in a large majority of presentations of pain (thereby excluding Pain Disorder from diagnostic consideration). For example:

- Scientific findings have repeatedly indicated that personality disorders will be discovered in a large majority of chronic pain patients, if the possibility of a personality disorder is actually investigated (Barth 2012b; Barth 2013a; Barth 2013b; Barth 2013c).

- In a scientific investigation focused only on mood disorders and anxiety disorders (a small minority of mental illnesses), 53% of the cases that would have otherwise
been diagnosed as Pain Disorder were accounted for (Fröhlich, Jacobi, & Wittchen).

- In addition to the majority of such patients who are accounted for by personality disorders, mood disorders, and anxiety disorders, DSM-IV-TR (American Psychiatric Association 2000) also notes scientific findings which indicate that substance dependence or abuse disorders account for up to 25% of patients who might otherwise be diagnosed with Pain Disorder.

Readers should note that these scientific findings indicate that a small fraction of the formally recognized mental illnesses have accounted for a large majority of studied presentations for which Pain Disorder would otherwise have been considered a diagnostic possibility. The size of that majority would probably increase if the hundreds of mental illnesses not included in the above referenced scientific projects were studied in the same fashion. Consequently, scientific findings have indicated that the possibility of the clinical presentation satisfying the requirements of criterion E, and the differential diagnostic section of the protocol for Pain Disorder, in a manner which would actually support a diagnosis of Pain Disorder, is extremely small.

When differential diagnostic considerations for the entire category of somatoform disorders (the category of mental illness that Pain Disorder resided within) are considered, the possibility of justifying a Pain Disorder diagnosis becomes even smaller. Specifically, DSM-IV-TR (American Psychiatric Association 2000) specifies that a somatoform diagnosis (such as Pain Disorder) means that the clinical presentation is “not fully explained by…the direct effects of a substance”. The significance of this differential diagnostic consideration has been elevated by the prescription narcotics epidemic that is currently causing extensive and extreme harm throughout the United States (Barth 2011). Because of that epidemic, many presentations which might preliminarily warrant consideration of Pain Disorder as a diagnostic possibility will come from examinees who are consuming prescription narcotics. Scientific findings have indicated (repeatedly, reliably, and strongly) that narcotic consumption is a risk factor for the development of, and progressive worsening of, abnormal presentations of pain (such as the presentations which might otherwise warrant consideration of a diagnosis of Pain Disorder) (Barth 2011). Consequently, the differential diagnostic consideration discussed in this paragraph indicates that a diagnosis of Pain Disorder is not going to be credible for any individual who is consuming narcotic medication (which is, currently, a great many individuals), because the abnormal presentation of pain is probably a consequence of the narcotic consumption.
In order for a diagnostic claim of the mental illness Pain Disorder to be justifiable, the diagnostician must document having credibly addressed all of the issues discussed in this section, and must document explanations for how the diagnosis has been justified in spite of such issues.

F. 2 d. 4. f. DSM-IV-TR requires, after all of the diagnostic considerations discussed thus far have been established as being supportive of a diagnosis of the mental illness Pain Disorder, that the diagnostician must choose between the two sub-constructs.

Those two sub-constructs were discussed above. Readers are reminded of the indication from much of the above discussion that a diagnostician is not likely to reach this point in the process (the attempt to apply the Pain Disorder diagnosis to any individual examinee will probably have failed before this point is reached).

F. 2 d. 4. g. DSM-IV-TR requires, after all of the diagnostic considerations discussed thus far have been established as being supportive of a diagnosis of the mental illness Pain Disorder, that the diagnostician must specify duration in a dichotomous fashion.

A diagnosis of the mental illness Pain Disorder is to include a specification of “acute” if the duration of the disorder has been less than six months, and “chronic” if the duration of the disorder has been six months or longer. Significance for this distinction has been claimed by the editor of DSM-IV-TR (American Psychiatric Association 2000), in an elaborative text (First & Tasman). That elaborative text references scientific findings which indicate that the likelihood of general medical factors playing a role in a presentation of pain is limited to cases that would be classified as “acute”, and that psychological issues dominate cases which would be classified as “chronic”.

F. 2 d. 5. Causation analysis for Pain Disorder

This section reviews numerous obstacles to credibly claiming that a presentation of Pain Disorder can be attributed to adult life events (such as injury, accidents, workplace events or circumstances, etc.). These obstacles create the impression that it is generically non-credible to attempt to claim that a presentation of Pain Disorder is attributable to adult life events. Consequently, in order for any such claim to have credibility, the parties making such a claim must present scientifically credible justification for concluding that all the following obstacles do not apply to the individual case.

The previously discussed generic obstacles to justifying legal/administrative claims which attempt to attribute mental illness to adult life events apply to the construct of Pain Disorder.
As was also discussed previously in this chapter, Pain Disorder was in the category of somatoform disorders, which means that it was a mental illness which is characterized by physical complaints. As such, it is definitionally impossible to attribute Pain Disorder to injury. The definition of all somatoform disorders specifies that they cannot be accounted for by any general medical condition (such as an injury) (American Psychiatric Association 2000).

Additionally, a literature review that was conducted for the Second Edition of the *Guides to the Evaluation of Disease and Injury Causation* (Melhorn, Ackerman, Talmage, and Hyman) was especially non-productive for Pain Disorder. The librarian’s efforts to search for published projects which addressed the etiology of Pain Disorder did not lead to the discovery of any articles which specifically addressed Pain Disorder (or any research publications documenting even the use of a measure that was specifically intended to be a surrogate for Pain Disorder). Similarly, the elaborate text (First & Tasman) from the editor of the DSM-IV-TR (American Psychiatric Association 2000) provides a review of scientific findings of relevance to the etiology of Pain Disorder, and that review also fails to identify any research projects that were actually focused on Pain Disorder.

In addition to all of the above obstacles, attempts to establish occupational or tort-relevant causation also face the obstacle of the non-occupational and non-tort-relevant nature of the risk factors that have been previously published for Pain Disorder. Potential causative factors that have been listed in previous attempts to comprehensively review the relevant literature include: the pain is an expression of some internal conflict, the examinee has an inability to use words to describe his or her feelings, the examinee is creating the pain complaints so that he or she will have a legitimate claim to the fulfillment of his or her dependency needs, the examinee is creating the physical complaints in order to atone for perceived sins, the examinee is creating the pain complaints as an expression of guilt, the examinee is creating the pain complaints as an expression of aggression, the pain is created by the examinee because he or she believes that he or she deserves to suffer, the pain is created by the examinee as a means of obtaining love, the pain is created as a way of identifying with a loved one who also has pain complaints, the pain complaints are being rewarded in some way (such as the solicitous and attentive behavior of others, monetary gain, or avoidance of distasteful activities), the pain is created by the examinee as a means of manipulation and gaining advantage in personal relationships, and/or the pain is caused by pre-existing anatomical or biochemical abnormalities that produce otherwise unexplainable experiences of pain (Sadock & Sadock).

**F. 2 d. 6. Presentations diagnosed as Pain Disorder are not eligible for impairment ratings**

As was explained previously, Pain Disorder was in the category of mental illnesses which is entitled “somatoform disorders”. The *Guides to the Evaluation of Permanent*
Impairment Sixth Edition (Rondinelli) explains that disorders within that category are not ratable (section 14.1c Diagnostic Categories; page 349).

This is another issue whose importance has been highlighted by public demonstrations of psychiatrists violating the relevant professional standards (similar to the issue that was discussed above, regarding “pain disorder associated with a general medical condition” being repeatedly misrepresented by psychiatrists). Specifically, psychiatrists have documented in forensic matters, and have testified under oath, that they have created an impairment rating in compliance with the Guides to the Evaluation of Permanent Impairment Sixth Edition (Rondinelli) for a claim of Pain Disorder (the author of this paper has personally witnessed this scenario multiple times). Such public violations of professional standards create a clear need to emphasize that a diagnosis of Pain Disorder actually means that the clinical presentation is not eligible for an impairment rating.

F. 2 d. 7. Another indication of the lack of benefit to be gained from utilization of the Pain Disorder construct is its irrelevance for treatment planning

The American Psychiatric Association’s primary textbook (Hales, Yudofsky, & Gabbard) states: “The current diagnostic criteria for Pain Disorder are not useful with regard to assisting in the planning and coordination of treatment.”

Consistent with that summary statement, DSM-IV-TR (American Psychiatric Association 2000) explains that “important factors that appear to influence recovery” include “recognition and treatment of comorbid mental disorders”.

In other words, recovery from the pain complaints can be positively influenced by the identification of mental illnesses, other than the problematic construct of Pain Disorder, which are driving the presentation of pain. Treatment planning can then focus on those other mental illnesses, and such a focus will be more fruitful than a focus on Pain Disorder would have been.

F. 2. e. Substance-related disorders

Prior to the publication of DSM-5, there was a category of mental illness that was labeled “Substance-Related Disorders”. That category was dominated by concepts of “Substance Dependence” and “Substance Abuse”. All of this was eliminated by DSM-5, thereby once again separating modern clinical practice from the scientific knowledge base which had developed around the category of “Substance-Related Disorders”, and the constructs of “Substance Dependence” and “Substance Abuse”.

Therefore, it should be noted that the reason for the existence of this section is the historical category of “Substance-Related Disorders”, and the finding that the tabulations
that were collected for the first edition of the AMA’s Causation *Guides* revealed substance-related disorders to be among the most common mental illnesses that appear in legal claims.

The review of a large set of relevant files indicated a trend for substance abuse or dependence to become a focus of legal claims because narcotic medication was reportedly being abused or had led to dependence, and the medication had been prescribed within the context of a legal claim. However, such simplistic legal claims are contradicted by scientific findings. Findings have repeatedly indicated that neither chronic pain complaints nor the prescription of narcotic medications leads to a significant elevation in the rate of substance abuse. Instead, the findings indicate that when substance abuse occurs within the context of chronic pain and/or prescription narcotics, the history of substance abuse is more likely to have preceded that context, rather than to be a consequence of it (Brown et al.; Martell et al.; Breckenridge & Clark; Von Korff et al.; Dersh et al.). In other words, if there is a causative relationship, it is more likely that substance abuse tendencies are the cause of the chronic pain complaints (and consequent prescription of narcotic medications), rather than vice versa.

Similarly, large scale study of alcohol-related disorders following disasters revealed that over 97% of participants who reported problematic alcohol use after exposure to a disaster admitted that the problematic use started prior to the disaster (North et al.).

**G. Step 5: Scrutinizing the Validity of the Evidence**

As is explained in several AMA Guides Library publications (Melhorn and Ackerman; Barth 2012a; Melhorn, Talmage, Ackerman, & Hyman), if preliminary support for a legal causation claim is found in each of the first four steps, then the causation analysis continues by scrutinizing the validity of the case presentation. Given the information that was discussed above in regard to the first four steps of the causation analysis protocol, it is unlikely that any legal claim of causation for mental illness can credibly reach the fifth step. However, this step is being discussed because there are several substantial obstacles to a causation claim which often will not become apparent until this step is reached. The almost completely subjective nature of the mental illness diagnostic system, when considered along with the scientific findings discussed below, indicates that the fifth step would reveal additional obstacles to justifying any legal causation claim involving mental illness.

**G. 1. The prominence of malingering, and the pervasive avoidance of credibly evaluating for this possibility**

Scientific findings have indicated that approximately 50% of clinical presentations within a legal claim produce objective evidence of malingering (when objective assessment is
actually applied to such cases) (Larrabee). Mental illness claims are especially vulnerable, due to their almost completely subjective nature.

Consequently, in order to even minimally comply with the requirements of step #5 from the causation protocol, the analysis needs to include the following:

- **Objective assessment of the validity of the clinical presentation:** Several standardized assessments have been scientifically validated for this specific purpose (Larrabee; Patterson et al.; Rogers). In the absence of thorough and credible utilization of such assessments, and in the absence of the results of such assessments revealing that the clinical presentation is objectively consistent with legitimate presentations of mental illness, there is no credibility for claims that a clinical presentation is valid.

- **Compliance with the diagnostic system’s malingering protocol:** The diagnostic system for mental illness includes a standardized protocol for the assessment of malingering (American Psychiatric Association 2000 and 2013; Patterson et al.). There is no credibility for a legal claim of mental illness unless this portion of the diagnostic system has been thoroughly considered, and found to have no relevance to the case.

Empirical investigation undertaken for the first edition of the AMA’s Causation Guides revealed that there is a pervasive avoidance of these evaluation components in legal claims of mental illness. Specifically, 632 cases were reviewed which involved legal claims of mental illness that were specifically supported by a mental health specialist. None of the documentation from any of those files made any reference to the diagnostic system’s malingering protocol, even when the documented details of the case were clearly of a nature for which the diagnostic system mandates that a strong suspicion of malingering should be adopted. Additionally, while the diagnostic system’s malingering protocol requires consideration of Antisocial Personality Disorder, utilization of the diagnostic protocol for this diagnostic possibility was not documented in any of the reviewed cases. Similarly, while the malingering protocol requires consideration of objective data which can only be reliably obtained through thorough utilization of scientifically validated psychological testing, the vast majority of claims failed to involve documentation of any utilization of such testing, and those which documented utilization of testing provided insufficient information regarding the results to allow for completing the requirements of the malingering protocol. None of these files included any documentation of a justification for such violations of diagnostic standards, or for such avoidance of objectivity.

G. 2. The pervasive violation of diagnostic standards within legal claims

Previous portions of this chapter explained the fundamental inadequacy of the mental illness diagnostic system for purposes of causation analysis, even when diagnostic
standards are followed precisely. An additional obstacle to credibly endorsing legal claims for mental illness is created by a pervasive trend for diagnostic standards to be violated within such claims.

Scientific findings have indicated that even the inadequate diagnostic system is routinely ignored within legal claims. Relevant scientific investigation was conducted specifically for the first edition of the AMA’s Causation Guides. Several agencies that gather relevant data nationally were asked to tabulate and report the mental illness constructs that most frequently appear within legal claims. The reports from each of these agencies included “diagnoses” which were not actually mental illnesses. Examples included “depression”, “neurotic depression”, “situational depression”, “postconcussional disorder”, “chronic pain”, “mood disorder due to chronic pain”, “chronic pain syndrome”, and “mood disorder due to work related injury”. None of these commonly claimed diagnoses was actually recognized as a mental illness in the DSM-IV-TR (American Psychiatric Association 2000), which was the diagnostic standard at the time. This discovery indicates that clinicians who promote legal claims routinely invent idiosyncratic mental illnesses that actually violate diagnostic standards.

In order to illustrate this finding and its significance, several examples can be discussed in greater detail:

- "Depression” can be a perfectly normal part of human existence, and as such it would not represent a mental illness (Gabbard). Depression can also be a symptom of many different mental illness constructs, but it is not a mental illness construct on its own. When it is a part of a mental illness construct, a diagnostic claim of “depression” does not actually provide significant diagnostic clarification. That lack of clarification is demonstrated by reports that depression is a symptom of at least 41 different mental illness constructs (Sadock & Sadock). Consequently, a “diagnostic” claim of depression is meaningless.

- “Postconcussional disorder” is documented in the DSM-IV-TR (American Psychiatric Association) as having been considered for recognition as a mental illness construct, but it was rejected. The protocol that was rejected is specified in an appendix of the DSM-IV-TR. Given the data that was reported above, it appears as if many clinicians are relying on that appendix without actually reading it, and have subsequently failed to realize that this diagnostic construct was rejected.

- Similarly, “chronic pain syndrome” is not on the list of recognized mental illness constructs. The AMA’s Guides to the Evaluation of Permanent Impairment (Rondinelli) explains that such presentations can be a manifestation of several different mental illness constructs, but “chronic pain syndrome” is not recognized as a mental illness itself.
These reports from the various data collecting agencies were not surprising to the primary author of this chapter (RJB). Decades of exposure to legal claims had created the impression that there was a prominent tendency for the involved clinicians to invent idiosyncratic “diagnoses” that actually violate diagnostic standards. The data from the agencies actually appears to understate the extent of this problem. Specifically, the agency data was often shaped by a reliance of ICD diagnostic codes which came from the clinicians’ billing, rather than the actual diagnostic claims that were listed in the clinical documentation. The use of ICD codes camouflages some of the invented diagnoses, because computerized analysis of such codes would create the misleading conclusion that the claim involved whatever mental illness is associated with that code (rather than the invented diagnoses that the clinicians had actually claimed).

Because of the apparent understatement of the extent of the problem, a review of files from workers compensation claims that were in the primary author’s (RJB) possession at the time of the creation of the first edition of the causation Guides was undertaken, in order to investigate the actual nature of diagnostic assertions that occur within legal claims. The review included 632 claims of occupational mental illness which involved the diagnostic evaluation having been conducted by a mental health specialist. Analysis of the clinical documentation from those files revealed that approximately 43% involved a diagnostic claim that did not involve a DSM-IV-TR mental illness construct. Frequent examples included diagnostic claims that were similar to the invented labels that were discussed above, as well as “anxiety”, “occupational stress”, “anxiety disorder due to work-related injury”, “depression due to work related injury”, “personality change due to occupational trauma”, “alcohol abuse due to occupational stress”, “work-related drug abuse”, “chronic pain due to work-related injury”, and “substance abuse due to work-related pain”.

Consequently, based on this review of files, and based on the aggregate reports from the various agencies, it is clear that occupational mental illness claims are afflicted by a trend toward invented “diagnoses”. Such non-diagnoses create yet another obstacle to credibly endorsing causation claims.

That review of actual files also provided systematic verification of another trend that had been informally witnessed previously: a pervasive lack of utilization of diagnostic evaluation standards, even when a recognized mental illness was claimed. In explanation:

- The DSM-IV-TR provides a diagnostic protocol for every recognized mental illness. Those protocols were the gold standard for determining whether an individual has a mental illness, and which mental illness is involved.

- In order to justify a diagnosis of mental illness, the diagnostician must (at a minimum) document utilization of the relevant protocol, and a description of how the examinee’s presentation satisfies the requirements of that protocol.

- In the files that were reviewed, when a recognized mental illness construct was
being claimed, documentation of the protocol that would be necessary in order to justify that diagnosis was absent 91% of the time. In other words, even when a recognized mental illness construct is being claimed, the claim is almost never justified at even a minimal level.

The results were even more profound in regard to diagnostic standards for personality disorder constructs. This issue is of primary importance for legal claims, given findings such as a 73% rate of personality disorders among people who claim disabling back pain in a claims context (when the possibility of a personality disorder is actually assessed) (Dersh). Despite the critical importance of assessing for personality disorder constructs, the review process revealed that this standard part of the diagnostic process is reliably avoided when a legal claim is involved. In almost every file that was reviewed (>99%), this portion of the diagnostic process was either "deferred" without explanation and without documented follow-up, concluded with a claim of that there was no personality disorder without any documentation of utilization of the diagnostic protocols that would have been necessary in order to justify this conclusion, or simply not mentioned.

Many of the involved files have been part of utilization review programs that afforded the primary author (RJB) an opportunity to directly speak to the clinicians who created the documentation, and ask why this critical portion of the evaluation process had been avoided. Most responses fell into one of the following four categories:

- The first category involved clinicians who did not understand the question, and offered responses which revealed that they had little to no understanding of diagnostic standards (it is again emphasized that every one of these clinicians claimed to be a licensed mental health specialist). As was the case in regard to the findings for Pain Disorder as discussed above (e.g. psychiatrists claiming that “pain disorder due to a general medical condition” was a mental illness; psychiatrists creating impairment ratings for a diagnosis of Pain Disorder), this finding revealed that widespread incompetence among mental health specialists is one explanation for the manner in which claims of mental illness have inappropriately become commonplace in legal systems.

- The second category involved a report that the clinician realized that any personality disorder would, by definition, not be a claim-related issue, and they subsequently avoided that standard portion of the diagnostic process in order to avoid mixing claim-related issues with non-claim-related issues. The obvious problem with this response is that such an approach could lead to misdirected conclusions of claim-related causation (due to a personality disorder being the dominant causative factor, but being overlooked), and to unnecessary exposure of the claimant to the reliably detrimental health effects of involvement in legal claims (Barth 2012b; Barth 2013a; Barth 2013c; Binder & Rohling; Harris et al.; Rohling et al.).
The third category of responses involved reports that this standard portion of the evaluation process had been avoided because workers compensation payers do not reimburse for mental health evaluations in a manner that would be sufficient to justify the extensive time that is involved in a personality disorder evaluation. These clinicians typically acknowledged that their work had been less than complete, and less than adequate, but claimed that such substandard services were necessary because of the inadequate reimbursement that was available within the workers compensation system. This creates the same jeopardy for the claimant that was discussed in the previous bullet point.

The fourth category of responses involved clinicians specifying that they avoided investigating the possibility of a personality disorder because if they had discovered a personality disorder, that discovery would have caused the clinical presentation to be identified as non-claim-related. The claimant would have consequently lost benefits, and the clinician would not be paid for the evaluation or the treatment that they wanted to provide for the claimant. The clinicians who offered such reports indicated that they believed that the financial benefits for themselves and the claimant somehow justified their violation of diagnostic standards. This set of circumstances creates the same jeopardy for the claimant that was discussed in the previous two bullet points.

The issues that have been discussed in this subsection warrant the establishment of the following warning: Any legal claim focused on mental illness is probably going to be based on an inadequate diagnostic evaluation, and consequently, any such claim should be intensely scrutinized.

G. 3. The logical fallacy that is inherent to legal causation claims involving mental illness

AMA Guides Library publications (Melhorn and Ackerman; Barth 2012a) have explained that it is not credible to conclude that, because a claimed clinical presentation followed the claimed exposure, that the claimed exposure was actually the cause of the clinical presentation. Those publications have explained that such reasoning is a logical fallacy, or faulty logic (akin to concluding that a rooster’s crowing causes the sun to rise).

Given the nature of mental illness, this faulty logic will be inherent to almost every relevant legal claim. Almost all such claims will be dependent on the subjective claim of the claimant/plaintiff that the manifestations of the claimed mental illness did not begin until after the claimed exposure. There will almost never be any other mechanism available for attempts to support a claim that the clinical presentation was caused by the claimed exposure. This set of circumstances leaves almost all legal claims of mental illness without a credible foundation.
G. 4. The pervasive unreliability of claimants’/plaintiffs’ self-reported histories also causes almost all legal claims of mental illness to lack a credible foundation.

A lack of foundation for almost all legal claims of mental illness is also indicated by scientific findings regarding the self-reported histories of claimants/plaintiffs. Scientific findings have indicated that such reports are pervasively unreliable, and consequently cannot serve as a credible basis for causation conclusions (Barth 2009). For mental illness claims, there is no alternative to such self-reported histories (the claimant/plaintiff will always be the only person who knows the state of his or her mind prior to the claimed exposure). Consequently, the subjective nature of mental illness, in combination with the scientifically established pervasive unreliability of histories reported by claimants/plaintiffs, leaves legal claims of mental illness without any credible basis.

H. Components of a Credible Mental Health Evaluation, If Legal Causation Claims for Mental Illness are Going to be Made

If a legal claim of causation for mental illness is going to be made, then the associated mental health evaluation should comply with the modern standards for mental illness diagnosis. Typically, those standards have been published in the most recent version of the American Psychiatric Association’s diagnostic manual (DSM), and its companion texts (such as Othmer and Othmer Volumes 1 and 2 for DSM-IV-TR, and the reportedly forthcoming “Essential Companion” for DSM-5). In spite of the inadequacies of that system, there is simply no generally recognized alternative. Evaluators who stray from that system are violating professional standards, and risk entering into a realm of absolute chaos where there are no standards whatsoever (not even the inadequate and scientifically non-credible standards of the DSM). There is no credible justification for introducing such total chaos into the legal system. It can be hoped that there will eventually be some scientifically credible alternative to the DSM, but none is currently available.

This recommendation is of questionable utility. There is considerable uncertainty regarding whether DSM-5 will attain the same status as a professional standard that its predecessors have attained (for example, the British Psychological Society has posted its review of the proposed revisions, which specifies that the Society has “more concerns than plaudits” to offer).

The guidelines that have been provided in Table C (below) are also recommended, in order to enhance the credibility of any mental health evaluation findings which are offered in support of a legal claim of causation for mental illness. Special emphasis is placed on the following:

- The diagnostic system should be used in its entirety. The empirically established trend for clinicians who are supporting a legal claim to selectively use or ignore various standard parts of the system should be avoided. For example, the
standards for the assessment of personality disorders and malingering should be vigilantly adhered to.

- The extremely unreliable nature of reports from claimants/plaintiffs should be highlighted. Such unreliable reports cannot credibly serve as a primary basis for an evaluator’s conclusions.

- An opportunity to review a comprehensive set of records should be requested, and should be undertaken if authorization is granted.

- An evaluator should enhance the objectivity, thoroughness, and credibility of the evaluation process by utilizing a thorough approach to scientifically validated psychological testing, and providing a thorough and scientifically credible analysis of such testing.

The evaluator should act in accordance with an awareness that mental illness constructs typically overlap in any individual case. Consequently, discussion of any isolated diagnosis is often an especially artificial exercise. In order to develop an adequate understanding of any legal claim of mental illness, the entire clinical history and presentation must be considered. A relatively simple example of this issue involves the reports of co-morbidity between Major Depressive Disorder-like presentations and Generalized Anxiety Disorder-like presentations. If an injured person becomes depressed, meets diagnostic criteria for Major Depressive Disorder, and blames his depression on his injury, then an uninformed evaluator might conclude that the Major Depressive Disorder is caused by the injury. But if that claimant/plaintiff also has a history that is consistent with Generalized Anxiety Disorder, then this uninformed conclusion would be especially lacking in terms of scientific credibility. One element of the lack of credibility stems from scientific findings that 70% of people who satisfied one edition of the construct for Generalized Anxiety Disorder eventually demonstrated consistency with one edition of the construct for Major Depressive Disorder (Breslau 1985). Such findings indicate that the scientific probability is that consistency with the Major Depressive Disorder construct would have manifested for this examinee, regardless of whether he or she had experienced an injury. The consistency with the Major Depressive Disorder construct would be a normal and expected development for this claimant/plaintiff, rather than representing some abnormal development that might require an explanation (an explanation such as claiming it to be a consequence of an injury).

The central role of personality disorder presentations in all types of medical-legal claims is another relatively simple example of the importance of considering the entire clinical presentation. Evaluating for a personality disorder has historically been a standard part of the diagnostic system for mental illness (American Psychiatric Association 2000). The DSM-IV-TR defines personality disorders as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is
pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over
time, and leads to distress or impairment" (American Psychiatric Association 2000). In
other words, personality disorders are conceptualized as a pervasive form of mental
illness which reliably leads to distress/impairment regardless of whether an occupational
or tort-relevant exposure has occurred. Further, consistency with personality disorders
will usually be, by definition, a pre-existing issue when considered within the context of
most claims (because of the definitional onset of such presentations in adolescence or
early adulthood). Given these considerations, a discovery of consistency with any
personality disorder construct creates an obstacle to credibly claiming occupational or
tort-relevant causation for any presentation of distress or impairment (this obstacle is not
limited to claims of mental illness). The critical importance of this standard part of the
diagnostic process is illustrated by the scientific findings that 73% of claimants with
claims of disabling low back pain were found to satisfy diagnostic requirements for a
personality disorder (when the possibility was actually assessed) (Dersh et al.). This
finding is consistent with a long history of research findings which have revealed a high
rate of consistency with personality disorder constructs among chronic pain patients
(Gatchel & Weisberg).

**Table C**

**Beyond the DSM: Guidelines for Forensic
Assessment of Mental Health Claims**

Based on Robert I. Simon’s (editor) *Guidelines for
Forensic Assessment of Posttraumatic Stress Disorder
(PTSD) claims* (Simon)

Summarized and formatted for the purposes of these
Guides by Robert J. Barth

Robert I. Simon has edited two editions of *Guidelines for
Forensic Assessment of PTSD claims* (Simon, 2003). Simon’s efforts were focused on PTSD,
because PTSD has reportedly become a “growth
industry” for claimant/plaintiff attorneys.

Many of those guidelines have relevance for any
claims of mental illness. Those guidelines have been
characterized as an opportunity “to raise the level of
forensic practice” (Shuman), and an “attempt to raise
the bar for forensic practitioners” (Herron).
Therefore, in an effort to raise the level of forensic
practice for all claims involving any mental illness construct, the following discussion involves many of the guidelines being reformatted in a manner that makes them more generic. This reformattting was conducted with Simon’s consultation and review. For the sake of thoroughness, a discussion is also provided of the guidelines which are truly limited to claims of PTSD.

Although the original publication of these guidelines provided additional information which was limited to military claims or to pediatric claims, the creation of the following summary did not include consideration of such narrowly limited content.

Guidelines which are of relevance to all mental illness claims:

In order to be credible, clinical or forensic conclusions or opinions which are offered in support of a legal claim of mental illness must be involve the following characteristics:

- Treating clinicians should not become involved in forensic issues (such as causation) involving their patients. Forensic evaluators should not provide treatment for forensic examinees. Treating and forensic roles should be completely and permanently separated for any individual case.

- The burden of proof is almost always on the claimant/plaintiff. Unless the evaluator is specifically made aware that this standard set of circumstances does not apply to the case at hand, the claims and associated expert testimony should be based on more than generalized assertions. The claimant/plaintiff and his/her representatives and experts need to specifically and convincingly justify the claims.

- For diagnosis, the claims must be guided by
diagnostic standards or scientific findings. Idiosyncratic definitions of a claimed mental illness, and idiosyncratic approaches to diagnosis, must be avoided. If diagnostic standards are not adhered to, the burden of proof is placed on the person who strays from those standards to reference credible scientific support for his or her avoidance of the standards.

- In assessing whether the claimed exposure (to trauma, stress, or any other claimed cause) was sufficient to cause the claimed clinical presentation, the examination should be guided by diagnostic standards and scientific findings. The possible contributions of multiple exposures should be evaluated. A thorough exploration of the psychological, social, and environmental problems listed for axis 4 in the DSM-IV-TR must be conducted to rule in or out superseding or intervening traumatic events that break the claimed chain of causation between the claimed cause and the claimed clinical presentation.

- The evaluation that is associated with such claims must involve thorough consideration of the examinee’s mental health history and general medical history, including a review of prior general medical records, records of mental health care, and other pertinent records (e.g. police reports, witness statements, employment records, military records, criminal records, etc.). The evaluator should recommend that he or she be given an opportunity to review all such records from the examinee's entire life (even though this goal is seldom reached). No such evaluation is credible without a thorough investigation of the examinee’s past. The evaluator should challenge any attempts, by any party, to restrict or constrain the development of a detailed understanding of the examinee's history.

- Such claims/conclusions/opinions will not be sufficient if they rely exclusively on reports from an examinee.
In other words, they will not be sufficient if they fail to consider additional sources of information.

- If there is a request for impairment evaluation for a claim of mental illness, standard assessment methods should be used (e.g. the American Medical Association's Guides to the Evaluation of Permanent Impairment, Sixth Edition). The evaluator should not rely on idiosyncratic criteria, subjective reports and impressions, or exclusively on clinical experience, in assessing psychological impairment.

- An associated evaluation is deficient if it does not include an evaluation for personality disorders.

- Because it is established that passivity reinforces illness and is generally detrimental to the individual, no health science or legal justification exists for the examinee to expect chronic disability, or to resign him or herself to it. This is also relevant to the standard legal expectation that a claimant/plaintiff will minimize damages, by protecting his/her interests. With regard to disability claims associated with mental illness, it is the claimant’s/plaintiff’s responsibility not only to follow medical treatment that might reduce symptoms, but also to attempt to maximize his or her work functioning. This may include returning to the original work as soon as possible, actively seeking alternative work, participating in vocational rehabilitation efforts, or participating in meaningful volunteer work.

- Scientifically validated psychological testing should be utilized to enhance the objectivity, thoroughness, and credibility of the evaluation process.

- An evaluator should request an opportunity to interview at least one family member or close associate of the examinee.
• The evaluator should not interview the examinee or any collateral informant when both are present (each interview should take place in the absence of the other interviewee).

• Third parties (e.g. attorneys, clinicians who are present only for the purpose of observing, family members, court reporters, any individual other than the evaluator or the examinee, and recording devices) should be excluded from the evaluation. (NOTE: The manner in which such observation automatically compromises the credibility of the evaluation is addressed more thoroughly in another Guides library publication, Barth 2007b.)

• The evaluator should take a detailed history of the claimed causative events or other claimed causes, the examinee’s symptoms, treatment efforts, and living patterns.

• The evaluator should inquire about whether the examinee has filed any prior legal claims of any type (e.g., tort claims, workers compensation claims, disability claims, etc.).

• The evaluator should inquire about whether the examinee has any history of arrests or criminal charges.

• When working with the examinee, the evaluator should not give any clues about how legitimate mental illness is manifested.

• When working with the examinee, and when interviewing any collateral informants, the evaluator should insist on detailed reports of the claimed symptoms.

• The evaluator should thoroughly investigate the possibility that a person is malingering. Options in
this regard include special interview techniques, psychological testing, and inpatient evaluation. Suspicion of malingering should be elevated if any of the following criteria are relevant to the case:

- poor work record
- prior "incapacitating" injuries
- discrepant capacity for work and recreation
- unvarying, repetitive dreams
- antisocial personality traits
- over-idealized reports of functioning prior to the claimed cause
- evasiveness
- inconsistency in symptom presentation

Guidelines which may be of clear and direct relevance only for PTSD claims:

- The loss of memory in PTSD primarily involves the circumscribed aspect of a traumatic event, usually the most psychologically painful part.

- In general, most studies indicate that PTSD symptoms and impairment decline in severity over time.

- Even when symptoms persist, the level of functional impairment usually declines significantly.

- No level of disability should be directly or indirectly associated with a diagnosis of PTSD.

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