

**EVALUATION OF PSYCHIATRIC DISABILITY  
In the Context of Negative Administrative/Personnel Actions**

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*"It is much more important to know what sort of patient has a disease than what sort of disease the patient has."* Sir William Osler, M.D. (also attributed to various others)

Within the current statistically-focused environment of "Evidence Based Medicine" and "Managed Care," the central issues of understanding, diagnosing and providing appropriate individualized intervention and treatment for clients have given way to simply describing details of subjective complaints of emotional discomfort and then prescribing superficial palliative interventions: prescription of psychotropic medications, granting of disability status, and/or certification of the need for "accommodations."

The diagnosis of "stress" has become common. However, "stress" is a generic and nonspecific term referring to a *situational experience* and does not necessarily imply illness, psychopathology, the presence of a diagnosable disorder, or justification for certification of disability. The use of the term "stress reaction" as a psychiatric diagnosis is no more meaningful in describing the actual nature or seriousness of potential psychopathology than it would be to use the diagnosis of a "heat reaction" for a patient with a burn injury – which clinically may range from a minor discomfort to a life-threatening third-degree burn.

Emotional and behavioral responses to various life circumstances and/or occupational events are difficult to manage appropriately unless there is an understanding of the complexities of the psychology of the particular individual patient. In any case, there can be a *complex and unique interplay* of acute subjective complaints, clinical symptomatology and underlying characterological structure.

Regarding certification of disability status and/or implementation of "accommodations," as well as determining the propriety of psychopharmacological and/or psychotherapeutic treatment, a comprehensive understanding of the person presenting with complaints is necessary in order to predict whether intervention will serve to:

- ❖ Resolve discomfort, improve adaptive functioning and decrease the probability of a recurrence of the problematic symptomatology/behavior;
- ❖ Have no effect upon the response to the environmental stress beyond encouraging situational avoidance, denial and/or projection; or,

- ❖ Reinforce and actually increase the probability of recurrence of dysfunctional reactions to “stresses” the person may later encounter.

Taking a comprehensive history must address a hierarchy of issues in order to provide appropriate intervention for complaints of a “stress-related injury”:

- ❖ Evaluation of any immediate danger and institution of appropriate supportive measures:
  - Is there symptomatology which causes impairment of function to the extent that presents a danger to self or others, risk of irreparable damage to the person’s life situation, or the potential for a severe or catastrophic emotional decompensation?
    - If so, obviously immediate comprehensive mental health treatment is required, and the patient probably should be considered totally disabled.
- ❖ Evaluation of pathological processes present and institution of treatment to reverse and relieve symptomatology:
  - Is there *bona fide* symptomatology (as opposed to non-pathological discomfort) which causes significant impairment of functioning?
    - If so, therapeutic attention (psychotherapeutic and/or psychopharmacological intervention) is probably required, and total or partial disability status or appropriate accommodations may be justified, depending upon the objective level of impairment.
- ❖ Evaluation of impairment of functioning and institution of palliative measures;
  - Determination of the presence of emotional discomfort or malaise which may represent a reasonable, appropriate and *non-pathological* response to a life event and which may justify provision of appropriate psycho-social support, but is not of itself an illness or a medically/psychiatrically disabling condition.
  - Is the current presentation simply an aspect of the patient’s baseline level of functioning in reaction to uncomfortable circumstances, perhaps a perfectly “normal” experience of discomfort, or perhaps indicating the presence of immature or histrionic characterological traits?
    - The person may benefit from basic psycho-social support
    - The person may be in need of a long-term, multi-disciplinary plan for treating underlying characterological dysfunction

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- One must be very careful in certifying as “disabling” or requiring “accommodation” a report of “symptomatology” that may simply represent a baseline level of discomfort in response to an unpleasant situation.
- Non-pathological discomfort should not be reinforced in becoming a passive and convenient focus by which to seek medical or mental health attention and to “medicalize” a practical issue, so as to avoid addressing the specific circumstances at hand.
- It is essential that opinions regarding disability status be based upon evidence of practical impairment, and not just upon subjective symptomatology.
  - For example, any reasonable person is likely to become upset in dealing with a negative performance evaluation. However, that reaction is not of itself pathological, and even if temporarily somewhat distracting, does not necessarily justify certification of disability status, and certainly should not be used as a subterfuge for avoiding appropriately confronting and addressing the practical situation at hand.

### In summary:

- ❖ If a patient is deemed psychiatrically Temporarily Totally Disabled, there should be documentation explaining the presence of such severe disruption of affect, cognition or behavior that verifies a complete inability to perform any productive activities in any reasonable workplace.
- ❖ If a person is deemed to require “accommodations” on a psychiatric basis, there should be documentation explaining the presence of such severe disruption of affect, cognition or behavior as to justify avoidance of facing normal adult responsibilities.
- ❖ Discomfort may take the form of mild emotional lability, and very typically, at least transient interference with of sleep, appetite and concentration. However, unless those issues are significant and practically disruptive, they represent normal, non-pathological responses, which do not justify a psychiatric diagnosis, certification of disability, or institution of “accommodations.”
- ❖ Provision of therapeutic psycho-social support may well be appropriate to guide the person towards a more mature and effective response to the situation, but the fact that some form of therapeutic intervention may be warranted does not necessarily imply that there has been an injury or illness requiring practical accommodation (or prescription of psychotropic medications).

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- ❖ Issues of aptitude must be objectively differentiated from issues of disability (i.e., impairment due to primary psychiatric symptomatology vs. anxiety that arises secondary to a poor career choice).