PSYCHOLOGICAL EVALUATION of MARITIME STRESS CLAIMS

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Occupational illnesses and injuries are rising dramatically in the United States. In particular, stress-related illness has reached epidemic proportions among both blue collar and white collar workers, costing the United States some $200 billion annually. The unique physical perils and stresses of maritime industries make them especially vulnerable. In 1990, shipbuilding and repairing was in the top three industries for injuries involving lost workdays. In addition, longshoring and other services incidental to water transportation had the highest number of lost workdays per injury. Although physical injuries are the most common type of claim, the rise of stress-related illness, either as an independent mental disorder or in combination with a physical disorder, is a growing concern. Indeed, stress and psychosocial factors have been shown to have a strong relationship to physical conditions such as low back pain and repetitive motion injury which are among the highest causes of industrial disability. Therefore, evaluation of maritime stress claims involves an assessment not only of purely psychological disorders, but also physical disorders which may have associated psychological factors. At times, those psychological factors are the primary source of the condition.

Workers in the maritime industries often face exceptional job stresses. Seamen, for example, may work under difficult physical conditions and have less than ideal personal health habits. Behavioral risk factors such as alcoholism, smoking, and lack of leisure time physical activity are prevalent. Studies have identified a number of other factors which may have an adverse effect on health and well being. These include: constraints due to safety regulations and procedures, unusual shift schedules and work/leave patterns, confined living and working space, lack of privacy, absence of windows and natural light, noise and vibration, and isolation from family and friends. In a group of offshore gas and oil extraction industry workers, who were exposed to a hazardous working environment that is acknowledged to be dangerous, arduous, and socially isolating, levels of job dissatisfaction and anxiety were noted to be high. Comparing onshore and offshore employees in the oil industries, offshore workers consistently showed higher levels of anxiety, even though rates of overt mental illness were not clearly different. Most importantly, socioeconomic trends affecting labor have not spared the maritime industries. For example, in the past thirty years, the United States' fleet of privately owned and operated merchant marine ships has shrunk from around 900 to fewer than 400, and U.S. shipboard jobs have dropped correspondingly to less than one quarter of their original numbers. Cargo carriers complain that it is difficult to compete with foreign vessels. Inevitably, this creates an atmosphere of job uncertainty and insecurity which compounds existing stress.

When a personal injury or illness has occurred, maritime remedies are typically provided under general maritime law and statutory law. In stress-related illness, recovery is more complicated. For example, while seamen have a right to medical care and treatment under the maintenance and cure remedy, there is no clear recognition of a right to recover damages for negligent infliction of emotional distress which is unaccompanied by physical injury. However, in common law a physical impact is not required in all jurisdictions for recovery, and the U. S. Supreme Court has acknowledged, at least in the case of railway workers under the Federal Employers' Liability Act (from which the Jones Act for seamen was an outgrowth), that recovery was possible if the plaintiff was merely in the zone of danger. Therefore, stress claims need to be examined in light of both physical and non-physical precipitants, the distinction between which may often be less useful than intended.

CAUSES OF PSYCHOLOGICAL INJURY

Although physical injury is usually necessary to recover for emotional distress in maritime claims, several categories outlined by the Fifth Circuit Court of Appeals have been offered as a means of

establishing legitimate causation. These are: (1) physical impact followed by emotional distress; (2) no physical impact but plaintiff was in the zone of danger; (3) the bystander rule, where the plaintiff is physically near someone who is injured, personally observes it, and is closely related to the victim; (4) the full recovery rule in which a reasonable person, normally constituted would not be able to cope adequately with the mental distress occasioned by the circumstances. From a psychological standpoint these causal situations can be divided broadly into those in which there is physical impact and those in which there is no physical impact.

A. Physical Impact

The requirement of a physical impact for emotional distress claims springs from public policy concerns which support limiting emotional distress recovery generally. Among those concerns are: (1) the difficulty of identifying false claims; (2) the potential for unlimited defendant liability to multiple plaintiffs; and (3) the potential for a flood of superfluous litigation. Emotional or stress-related illness claims have always been looked at skeptically because of their subjective nature. A physical connection is thought to help establish objectivity, whether the trauma that is the precipitant of an emotional injury is a physical one or, as in mental-physical claims in workers' compensation actions, the consequence of the injury is a physical one. The premise is that there is something observable and the claim does not rely on unverifiable descriptions of the plaintiff. But a physical connection may not be as objective as presumed, since in many cases the illness that follows a physical injury is psychologically generated, and, where physical symptoms are claimed, they are often merely the subjective experience of the sufferer. The popularly dubbed chronic pain syndrome is a good example of this phenomenon. While physical trauma can at times have such a profound effect on the psyche that the individual deteriorates emotionally and physically as a consequence of the trauma, in other instances the traumatic event may have merely served as an opportunity for pre-existing psychological processes to become operative and manifest themselves as physical illness. Here, the traumatic event is only incidental. Pre-existing personality predisposition, psychiatric illness, or psychosocial and environmental factors may be the actual cause of pain, i.e. the force producing its effect.

In addition, trivial physical impact can at times be followed by dramatic out-of-proportion illness consisting of both physical and emotional symptoms. In these cases, a physical connection to the degree of distress cannot be established just because a physical impact preceded it. Psychological factors no different than in pure emotional or non-physical impact claims are the primary, if not sole, cause of the illness. Again, if an opportunity was needed for the expression of psychological and social conflict, the physical impact provided it. Therefore, even in physical impact cases where a physically traumatic event can be identified, the subjective account of pain, suffering, and distress can dominate the clinical presentation.

B. No Physical Impact

Subjectivity is highest in non-physical impact claims. Yet, where they are allowed, some attempt is often made to try to objectify the experience by requiring a recognizable traumatic event that has an understandable consequence. So, if someone was in the zone of danger, at least the danger was known to exist in close proximity to the plaintiff and some psychic effect is understandable. Historically, in workers' compensation claims where mental stress was allowable, there was often a requirement that it be in the form of a nervous shock. This implied that a circumscribed incident of an intense nature had occurred whose effects were not ambiguous. In more recent years, as mental stress claims have moved to allow cumulative emotional trauma, this attempt at objectivity has become eroded.

Even if a distinct event which produces nervous shock or fright can be identified and understandable, this does not mean that it necessarily leads to lasting effects or illness. The popular and growing diagnosis of Post-Traumatic Stress Disorder (PTSD) is a good example of that. In spite of its frequent use in litigation today, researchers have observed that the disorder is relatively rare following

exposure to trauma, and risk factors other than the trauma are a greater predictor of who will have symptoms. Certainly, it is known that stress can lead to maladaptive response patterns, deterioration of coping mechanisms, mental and physical exhaustion, and possibly a mental or physical disorder.

Studies have shown that a marked excess of certain stressors, particularly involving loss and disappointment, can precede depression, and some researchers have shown that individuals who undergo a great many life changes, positive or negative within a short period of time, are more prone to develop physical and mental disorders. But, stress, distress, and disease are not easily distinguished. Stress by itself is a difficult concept to define, since it is so tied up with normal human experience. It is commonly assumed that stress means strain or some disruption of harmony or peace within the individual. However, in fact, stress is not really pathological but an inevitable consequence of interacting with one's environment.

Even the stress response, which includes central nervous system and hormonal arousal, is not pathological but serves both a defensive and a growth purpose for the organism. Where stresses are perceived as undesirable or threatening, they have the capacity to elicit distress, but even where a psychiatric disorder such as depression may be preceded by stress, the correlation between the two will always be small because stress is so much more common than depression. Furthermore, the relationship between stress and mental disorder is strongest in mild cases which may not seek psychiatric help at all, compared to the more severe ones which do. This latter group of more severe and disabling cases are very likely to fall into categories of endogenous disorders (springing from within) or biological illness. So, the presence of stress and distress does not define disease and should not necessarily imply emotional damage.

C. Other Factors

Mental disorders by their very nature interfere with an individual's social and occupational functioning. Of course, mental disorders can have many possible sources, including biological defects, psychological conflict, or environmental stresses totally unrelated to a work situation. When the disorder becomes full blown, it may invade all aspects of the individual's life, including family, friendships, recreation, and work. When coping mechanisms deteriorate, the individual is no longer able to have an adaptive stress response and every demand that life brings becomes an overwhelming burden. Often, the work becomes too much. The more that work performance is affected by illness, the more desperate an individual may become, seeking to blame what is convenient for the distress. This typically and erroneously can include family, friends, or workplace. With time, poor work performance actually creates new burdens since there can be a threatening employer response, fear of reprimand or demotion, or even termination. Of course, this leads to low self-esteem, financial hardship, and further aggravation of the mental disorder.

Again, in workers' compensation cases, some jurisdictions have described the doctrine of active vs. passive role of employment, which attempts to shift analysis from a subjective to a more objective test. The determination here is whether the employment itself was a positive factor influencing the course of disease, as distinguished from a mere stage for the event, an after-the-fact rationalization, or a mere passive element on which a non-industrial condition happened to have focused. When employees who are suffering from mental disorders have difficulty in performing their job or relating to others at work, this can be a source of stress. But the work is only a convenient focus or a retrospective rationalization which is later blamed for all the problems.

Among the most difficult issues in industrial stress claims is that of warranted administrative or personnel actions by the employer. For example, it is understandable that if an employee is given a warning or reprimand for poor performance, that this would be stressful, but that stress is not a personal injury arising out of employment conditions nor is it rightfully due to the employer's actions. Instead, if the employer has acted in good faith, the employee's own behavior has led to the employer's response with its stressful consequences. In addition, stress of a potential layoff or termination can greatly affect employees. Even when employees are engaged in deliberate misconduct

or criminal activity for which they are sanctioned or terminated, this too is stressful but may not be a proper basis for an industrial claim. These organizational dynamics often form the framework in which an unrelated incidental injury or stress claim is made.

The subjective nature of industrial stress claims allows many of these anomalous assertions to flourish. The stress of any event is usually validated by self report alone. With a sudden, single event such as nervous shock, there may be independent observers to provide corroboration. But with chronic stressful events, there may be no corroboration, and adverse circumstances routinely fluctuate in severity making quantification difficult. Also, there is inevitably a reciprocal relationship between the nature of the claimed stress and the ineffectual coping mechanisms of the individual. In addition, an individual's account may not fit the true sequence of events, and must be scrutinized as to the timing of those claimed events in relationship to the distress. It is clear that people have a need to attribute causation to things that provide meaning to their perspective. Therefore, the individual's own assessment of the impact of an event may distort the history. Many of these assessments are culture bound or tied to a particular context, not the least of which is the presence of litigation. Finally, individuals forget events and, later, either supplement their memory with necessary information or extinguish information from memory which is not compatible with their perspective. None of this should imply that the individual is necessarily fabricating an account, but only that the account may not be reliable.

One of the fundamental misconceptions in pure emotional stress claims is that the process of damage is always analogous to that seen in physical injuries. While it is true that in many instances a stressful situation can create a weakening of an individual's coping mechanisms and thereby make that person vulnerable to the development of a mental or nervous disorder, the nature of the disorder in light of all the circumstances must be examined more closely. Prior to the turn of the century, common law both in Great Britain and America routinely denied recovery for damages based on fright or nervous shock on the theory that such damages were too remote. If damages flowed from such a shock, they were not considered the probable or natural consequences of a person of ordinary physical and mental vigor.

In essence, the fright was considered an independent intervening cause and any further consequences were unforeseeable. Subsequently, courts have taken the position that if the defendant could have foreseen that the wrongful act was likely to frighten the plaintiff, liability should rest for all the consequences resulting in a regular chain of causation from the fright, regardless of whether the particular consequences should have been foreseen or not. However, unlike physical injury to a bodily organ where the degree of damage and the natural healing process follow a measurable course, mental injuries can often stimulate the person to consciously or unconsciously use the incidents to promote personal and psychological needs.

So, for example, in a condition such as Conversion Disorder, the mind literally creates physical symptoms which serve a psychological purpose totally unrelated to the injury. Although this may be on an unconscious level, the person is still actively generating the condition. In other conditions, there is dramatic exaggeration of symptoms and magnification of impairment for personal gain. The distinction between the conscious and unconscious activity of the mind in these situations is easily blurred. In either case, this active generation of symptoms should be considered an independent intervening cause, and the mental injury which stimulated it is merely a passive and incidental circumstance.

DEFINING MENTAL DISORDERS

Nowhere is the medicalization of our society more apparent than in the area of mental disorders. Some estimate that 20% of Americans now claim to suffer from some form of diagnosable psychiatric disorder. Dysfunction has become a growth industry, and in the 1990's young people are ten times as likely to be depressed as their parents and grandparents were at their age. The Diagnostic and Statistical Manual of

Mental Disorders (DSM) of the American Psychiatric Association (now in Volume IV) has expanded over the last thirty years and doubled the number of diagnoses available. It has been affected by changing social norms and attitudes, and political and economic trends. While it still may be a valuable tool for research and clinical use, it may not be as helpful in understanding stress claims. Its authors have recognized this limitation and specifically include a cautionary statement which in part says, *the clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgements ...*

Some of the problems with using the DSM in any litigation setting are: (1) many diagnoses are overlapping, including some mild disorders with more severe disorders; (2) the criteria for a disorder are often based on subjective complaints alone, which are easily influenced by the context in which they are presented, (3) ordinary human distress can easily find a diagnosis if needed; (4) identification of a disorder does not by itself establish specific impairment or disability. Advances in medicine in psychiatry over the last hundred years have helped to identify the biological and psychological origins of mental disorders and their specific characteristics. Modern psychiatric and psychological treatment has also been of significant benefit to countless numbers of sufferers. Where the DSM has provided a common language among professionals and guidelines for assessment of patients, it has served a valuable role. Clearly there are illnesses such as Schizophrenia and Bipolar disorder (formerly manic depressive illness) which have such unique and dramatic symptoms that are not easily confused with ordinary human suffering. But the subjective nature of many stress-related illnesses and the ease in which a disease label can be attached, offer the litigant a range of possibilities from the least severe to the most severe types of disorders which are often distinguished only by the intensity of suffering that the individual conveys.

Although hypothetically any of the diagnoses in DSM could be claimed to be caused or at least aggravated by industrial stress, the more common types are: *Mood Disorders, Anxiety Disorders, Adjustment Disorders and Somatoform Disorders* (physical symptoms that suggest a medical condition but are greatly affected if not caused by emotional factors). The most frequently seen symptoms are those that relate to depression or anxiety. Depression can be as simple as a state of sadness and discouragement, or as complicated as a marked disinterest in life with accompanying weight loss, insomnia, difficulty in concentration, lack of energy, suicidal ideation, and even psychotic thinking. Anxiety symptoms can range from nervousness to an intense state of fear, panic, and physiological arousal. Depending on the constellation of these symptoms and their professed intensity, they are categorized into specific diagnostic mental disorders. Some of the disorders have strong biological or physical cause and may be recurrent or chronic regardless of any environmental influence. Not only can they constitute a preexisting condition, but the symptoms of the disorder may actually lead to work performance problems and the stress complications which the disorder has then caused. In other cases, environmental or stress factors can trigger or aggravate the disorder.

When physical symptoms spring from emotional factors, there may or may not be subjective emotional symptoms. In other words, some patients claim that they are under no emotional distress even while dramatic physical symptoms without explanation have taken over their lives. Others patients, such as those with chronic pain, may have a great deal of depression or anxiety, but will invariably say it is due to the pain. Distinguishing whether the emotional reaction is secondary to the physical symptoms and only a complication, versus one in which the emotional symptoms have a primary role, is not easy and requires a very thorough psychological assessment. Many psychosocial variables have been implicated

in these chronic physical conditions, and they represent a major industrial health problem. One of the best predictors for disability is pre-existing job dissatisfaction.

One of the most common anxiety disorders seen in litigation today is *Post-Traumatic Stress Disorder.* This is most likely due to the fact that it is one of the few diagnoses which actually implies trauma or causation within its very name. The original diagnosis evolved from more narrow concepts of shell shock or battle fatigue in which an out of the ordinary stress or stunned the individual into an altered state of awareness and reactivity, and caused intrusive and involuntary reliving of the traumatic event. This diagnosis has now been expanded to include just about any stressful situation and the claim often rests on no more than remembering the event with distress. The actual and detailed criteria required by the diagnosis are frequently twisted and have practically become almost meaningless. The diagnosis of *Post-Traumatic Stress Disorder* has been a controversial one and remains vulnerable to severe criticism even today. There is no question that distressing symptoms following severe trauma occur, but how many people actually suffer lingering effects and what degree of impairment remains are debatable.

Frequently there is the stress that results from job dissatisfaction, uncertainty about employment, reaction to a reprimand or warning, and threatened or actual termination. This is sometimes diagnosed as *Occupational Problem.* While there may be a great deal of subjective distress, and vague symptoms of anxiety and depression, there may not be an otherwise properly diagnosable disorder. These personnel, administrative, and occupational problems often precede or are the backdrop of industrial stress claims. Psychological evaluations need to focus on personality characteristics of the employee as obtained from complete assessment of the individual through interviews and psychological testing, as well as from reports of behavior in and out of the workplace. Many *Personality Disorders* create an unusual sensitivity through suspiciousness of others, reading hidden meaning into remarks, unforgiveness of insults, impulsivity, mood instability, inappropriate intense anger, or fluctuating intense patterns of interpersonal relationships. These employees can create chronic problems in a work environment, and when their own behavior leads to untoward consequences, may initiate an industrial stress claim. It is important to note that these personality disorders are not just passive weaknesses on which the stress of employment has a greater effect, but also represent an active process that perpetuates its own difficulties.

CONDUCTING PSYCHOLOGICAL EVALUATIONS

Most often opinions regarding stress-related illness and disability are made by a mental health provider who is currently treating the employee. This can be a doctor of psychiatry or psychology, social worker, or therapist. The employee usually gives a history of symptoms and circumstances surrounding those symptoms to the doctor, who typically makes a diagnosis and may advise the employee to not return to work for the time being. Later, this treating doctor may be called upon to provide a more extensive report regarding the employee's condition or to testify on behalf of the employee's claim. Sometimes attorneys will refer an employee to a particular doctor both for treatment and expert opinion in the stress claim. It is often asserted that the treating doctor is in the best position to give this opinion because he or she has intimate knowledge of the patient and has often been in contact with the patient over a period of time.

A number of serious problems arise in this regard. First, the doctor may not be trained in the evaluation of these often quite complex cases. The initial opinion and recommendations may have been given after a brief interview where the history relied almost exclusively on the subjective reports

of the employee. Rarely has the treating doctor reviewed, in advance, recorded information, other opinions, past medical records, or statements from collateral sources. Second, the treating doctor inherently accepts the patient's account and, in the absence of obvious manipulation, becomes allied to the patient's interest. It would be impossible for a treatment relationship to continue if the doctor did not believe the patient or, even worse, expressed an opinion contrary to the patient's position in the claim. Third, the treating doctor may have adverse financial consequences by not supporting the claim since at times therapy bills can be dependent on such an opinion.

Independent assessment which includes a thorough understanding of the circumstances of employment, feedback from collateral sources, and a complete history of the employee, both medical and psychological, is necessary. There is no way to adequately determine whether or not a mental disorder is pre-existing or recent without such a thorough assessment. The worker's account alone is unreliable because of the natural tendency to emphasize the factors in the claim itself and minimize other issues. Some emotional disorders occur as isolated episodes in time with no history of symptoms preceding. Others have a chronic or cyclical course which can be traced throughout the life of an individual. Still others are episodic, manifesting themselves only a few times throughout the person's life. A proper diagnosis, therefore, can only be made by a thorough understanding of the entire life history. Specific questions to be answered in assessing an industrial stress claim are:

1. *Is there a diagnosable disorder?*
2. *Are all the symptoms consistent with the disorder, or can they represent some other condition?*
3. *Is the degree of distress measured only by the individual's account, or has it been verified from collateral sources?*
4. *Is the injury, physical or non-physical, likely to have resulted in such a disorder?*
5. *Is the injury verifiable?*
6. *How had this individual adjusted to the job prior to the claimed injury? Other jobs?*
7. *What are the conditions of employment generally and are they undergoing any changes?*
8. *Are there alternative explanations for this disorder, considering the entire life history and personality of the individual?*
9. *Is this a typical course of illness and/or response to treatment? If not, why? Is there motivation to heal?*
10. *What objective measures of impairment and disability are there?*

Psychological evaluations can vary tremendously in depth and in scope, depending on the complexity of the presenting problem. While such evaluations do not determine factual matters, sufficient familiarity with the facts is necessary so that consistency between the claimant's account and other data can be checked. The timing of symptoms in relationship to the injury needs to be validated as do assurances of good medical and mental health prior to the injury. Discovering pre-existing illness or personal conflict does not necessarily mean that the individual could not have been additionally and substantially injured later. Simply lining up pre-existing problems as proof of a weak claim is not conclusive. The proper focus should be on whether or not the disorder flows naturally and consistently from the injury.

The process of the evaluation includes a thorough review of collateral information, possibly collateral interviews, personal interview of the claimant (relying on records alone can lead to only limited impressions), a complete mental status examination and, if necessary, psychological testing. Attention should be paid to primary and secondary gain factors. Primary gain refers to a psychological conflict or need that the symptoms satisfy. It may be avoidance of an unpleasant or threatening personal situation or a means to gain an important response from the environment. The symptom serves a psychological purpose and resolves a conflict with which the individual otherwise cannot deal adequately. This underlying psychological issue is the main initiating and sustaining factor of the symptoms. Secondary gain refers to those perhaps unexpected environmental responses to the symptoms that assist in sustaining them by reinforcement. Examples include financial reimbursement, attention from the family, or avoidance of less than satisfactory work conditions. There is obviously some overlap between primary and secondary gain; both features need to be seen as a process as

opposed to discrete variables. The term compensation neurosis has been used to label some of these phenomena. Finally, the evaluation should be alert to the possibility of malingering but, usually, that is a difficult diagnosis for psychologists to reliably make and may be more likely to be identified through investigative and surveillance techniques.

CONCLUSION

Stress-related illness is an increasing problem in the American workplace, and the maritime industries are no less affected. Unique hazards and difficult conditions may predispose maritime workers to such claims, but the more relevant factors are probably explained by complex social and cultural trends. With stress claims, the subjective nature of the disorders and the overlap between illness and ordinary distress, create a problem in definition that has facilitated the growth of those claims. In addition, medicalization of our society, increased litigiousness, mistrust of corporations, job instability due to layoffs and downsizing, the disappearance of many types of jobs, and greater demands on workers, all contribute to the problem. The requirement of a physical impact for recovery may help narrow claims, but by no means insures objectivity, as the suffering which follows is primarily of a subjective nature anyway. Physical impact and nervous shock frequently serve a convenient focus for a worker to solve personal and psychological conflict or an occupational dilemma totally separate from the injury. Psychological evaluations must widen the scope of inquiry, and carefully scrutinize the claimed distress and disorder to verify that they are consistent and understandable based on the natural course of those conditions.