14.1 Principles of Assessment

14.1a Initial Considerations

Before using the information in this chapter, the *Guides'* user should become familiar with Chapters 1 and 2 and the Glossary, Chapters 1 and 2 discuss the *Guides'* purpose, applications, and methods for performing and reporting impairment evaluations in general. The Glossary provides definitions of common terms used by many specialties in impairment evaluations. It should be emphasized that the presence of a diagnosis does not necessarily suggest the patient is impaired.

Clinicians who use this chapter will generally be trained in psychiatry or psychology. Other users of this chapter should have:

- Expertise in the utilization of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*.
- Expertise in the psychiatric or psychological evaluation of patients.
- Expertise in the diagnosis and treatment of mental and behavioral disorders.

14.1b Diagnosis

The goal of this chapter is to provide ratings for permanent impairment relating to M&BD. The first critical step is to make a definitive diagnosis, which should be based on the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, commonly known as *DSM-IV*.[1] This manual is the widely accepted classification system for mental disorders. In general, the history, signs, and symptoms of mental disorder should justify and confirm the diagnosis, which should be made according to *DSM-IV*- criteria. The diagnosis (with the associated factors of prognosis and course) will form the basis by which one assesses the severity and predicts the probable duration of the impairment.

The criteria for mental disorders include a wide range of signs, symptoms, and impairments. The *DSM-IV* calls for a multiaxial evaluation, as summarized in Table 14-1. Each of 5 axes refers to a different class of information. The first 3 axes constitute the major diagnostic categories. These include the major clinical syndromes and the conditions that are the focus of treatment (Axis I), the personality and developmental disorders (Axis II), and the physical disorders and conditions that may be relevant to understanding and managing the care of the individual (Axis III). Axis IV refers to psychosocial stressors. Axis V refers to global functional capacity and reflects the effects of the psychiatric impairments.

TABLE 14-1
Multiaxial System of the *DSM-IV-TR*[a]

Axis	Condition
I	Clinical disorders
	Other conditions that may be a focus of clinical attention
II	Personality disorders
	Mental retardation
III	General medical conditions
IV	Psychosocial and environmental problems
V	Global assessment of functioning

[a] *DSM-IV* indicates *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*

14.1c Diagnostic Categories

Although the *DSM-IV* remains the bedrock of diagnosis in mental illness, psychiatrists and psychologists are continuously reconsidering and refining how to classify the conditions they treat. Proponents for reliable diagnostic criteria prompted contributors to the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* ***(DSM-III)*** to include specific criteria for diagnosis.[2] These criteria needed to be observable and clearly defined so they could be readily recognized by different practitioners. The criteria were then subjected to field trials. The result was a standardized diagnostic nomenclature that mental health professionals could apply to the patients they treated.

Over time the *DSM* has swelled to nearly 300 mental and behavioral disorders, and there is significant debate regarding the validity and interrater reliability of many *DSM-IV* disorders, as well as the multiaxial approach in general. One patient may meet criteria for several different disorders, and many dissimilar patients may meet criteria for the same disorder.[3] In contrast, the validity and interrater reliability of the the major mental illnesses/disorders—depression, mania, and schizophrenia—are well established.

The rapid expansion of *DSM* diagnoses has blurred the boundary where mental health ends and illness begins. According to the National Comorbidity Survey Replication, one half of Americans will meet the criteria for a *DSM-IV* disorder sometime in their life.[4] Proponents of expanding the number of *DSM* diagnoses suggest that definitions should be broad enough to include milder conditions that can cause distress or lead to more severe problems later. Others disagree, arguing that criteria should be tightened: (1) to ensure that limited resources go to those with more serious illness and (2) to avoid alienating a skeptical public who is dubious whether such a large proportion of the population truly suffers from a mental illness.[3] A useful analogy might be found in the paradigm of persons experiencing low back pain. Nearly all persons will suffer low back pain over the course of a lifetime. The vast majority of these episodes will be self-limited, will not herald ongoing low back impairment, will improve regardless of treatment, and will adapt to any intermittent or continuing symptoms.[5]

It is not the purpose of this chapter to rate impairment in all persons who may fit a *DSM-IV* diagnosis. It is understood that many conditions are common in the general population, and whether or not they are included in the *DSM-IV*, they do not require an impairment rating (eg, brief adjustment disorder, normal grief reactions).[5] Patients with severe mental illness may have a greater role impairment than a patient with a severe physical ailment.

Because the *Guides* is generally used in medicolegal settings (eg, Worker's Compensation), impairment rating in the Sixth Edition will be limited to 1 of the following diagnoses:

- *Mood* disorders, including major depressive disorder and bipolar affective disorder.
- *Anxiety* disorders, including generalized anxiety disorder, panic disorder, phobias, posttraumatic stress disorder, and obsessive compulsive disorder.
- *Psychotic* disorders, including schizophrenia.

When mental illness is profound, occupational impairment is obvious. It is more difficult to assess occupational impairment when mental illness is more subtle, complicated by the legal setting, and combined with preexisting personality factors.

Disorders that are *not* ratable in this chapter include:

- Psychiatric reaction to pain: It is inherent in the AMA *Guides* that the impairment rating for a physical condition provides for the pain associated with that impairment. *The psychological distress associated with a physical impairment is similarly included within the rating.*
- Somatoform disorders.
- Dissociative disorders.
- Personality disorders.
- Psychosexual disorders.
- Factitious disorders.
- Substance use disorders: Affective or other mental disorders due to substance abuse are *not* rated.
- Sleep disorders: Primary sleep disorders are covered in Chapter 13, the Central and Peripheral Nervous System. Many M&BD are associated with disordered sleep and should be considered as a feature of the M&BD impairment rating in this chapter.
- Dementia and delirium (covered in Chapter 13).
- Mental retardation.
- Psychiatric manifestations of traumatic brain injury (covered in Chapter 13).

The rules for using this chapter would include:

- In the presence of a mental and behavioral disorder without a physical impairment or pain impairment, utilize the methodology outlined in this chapter;
- In the event of a mental and behavioral disorder that is judged *independently compensable by the jurisdiction involved*, the mental and behavioral disorder impairment is combined with the physical impairment;
- Whenever it is specifically required by a compensation system;
- In most cases of a mental and behavioral disorder accompanying a physical impairment, the psychological issues are encompassed within the rating for the physical impairment, and the mental and behavioral disorder chapter should not be used.

14.2 Psychiatric/Psychological Evaluation

The general psychiatric or psychological evaluation involves eliciting a history, review of appropriate records, and a mental status examination. An outline of the mental status examination is summarized in Table 14-2.[6] Readers are referred to standard psychiatric textbooks for details.

There may be adjunctive psychological, neuroradiological, or laboratory testing as well. Neuroradiologic imaging is discussed further in Chapter 13, The Central and Peripheral Nervous System.

TABLE 14-2
Mental Status Examination[a]

- Appearance
- Activity
- Mood and affect; anxiety
- Speech and language
- Thought content and organization
- Perceptual disturbances
- Insight and judgment
- Neuropsychiatric functions

[a] Adapted from Leon et al.[6]