Issues with Chapter 14, GEPI, 6th Edition – Mental & Behavioral Disorders (M&BD)
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Major changes from 5th Edition
- provides a numerical Impairment Rating (IR)
- changes how secondary M&BD (those apparently stemming from a physical impairment) are considered
- divides MB&D into ratable and unratable diagnoses

A. Principles of Assessment
 1. Psychiatrist or Psychologist (thanks, even if ambivalent)
 2. Diagnosis "forms the basis … of the IR (really, or is it just a gate keeper?)
 3. Diagnostic Categories
  a. Ratable (why? as reliability and validity established for De, Mania & Po?)
   i. Mood Disorder: INCLUDING Major Depressive and Bipolar Disorders (others too?)
   ii. Anxiety Disorders
   iii. Psychotic Disorders (these are caused by an event? same with bipolar. IR definition, Chap 1)
  b. Not ratable
   i. Emotional reaction to pain (part of the IR for the physical injury; my impression of pain causing MI is there is usually an identifiable third factor)
   ii. Somatoform Disorders (no reason given; perhaps because they are considered pre-existing or not reasonable to see them arise from a work injury?; includes Pain Disorder)
   iii. Dissociative Disorders (no reason given; all past causes?)
   iv. Personality Disorders (no reason given; pre-existing, not causable?)
   v. Psychosexual, Factitious, MR & LD, Substance Use
   vi. Sleep Disorders, Dementia & Delirium and TBI covered in Chap 13

B. The IR Evaluation
 1. "Foundation" is Hx, Record Review and MSE
 2. may add (neuro)psychological testing, lab workup, neuro-radiological testing. (and collateral interviews)
 3. Malingering better identified with the interview and records than with psych. testing (really?)

C. Features of M&BD IME
 1. Neutrality of E is important
 2. Best source of information is Pt's description of symptoms and their impact (really?)
 3. If suspicious of poor information, augment with "additional objective data" (additional? And, what do you do with this information or suspicion – somehow dock the IR?)
 4. Assess motivation to
  a. improve, and

b. report symptoms (granted this is important to have an accurate IR, but where does this "figure in" in computing the IR?)

D. MMI

1. Pt's condition (level of impairment) will be stable regardless of medical or surgical intervention

2. Consider adequacy of treatment, vocational issues, structural settings

E. IR Concepts (i.e., rating scales – all ordinal)

1. Brief Psychiatric Rating Scale - BPRS
   a. Symptom focused, 24 items, 7 pt rating - not present to extremely severe
   b. Items 1-14 are what the Pt says they are, with items 7, 12 and 13 also E ratable
   c. Items 15-24 are E's observations
   d. What does "excellent reliability" mean?
   e. How valid is this, given its total subjectivity (Pt and E) and vulnerability to over reporting
   f. Further, how does anyone NOT get an IR with this scale and its conversion table
2. Global Assessment of Functioning - GAF
   a. Symptom or functioning focused
   b. Rating is essentially 1 to 10
   c. "Satisfactory" inter-rater reliability (to whom? personal experience with GAFs. How can the ratings be reliable with so much slop in the categories?)
   d. Validity – does this really accurately measure impairment – GEPI admits that there could be problem with rating either symptoms or functions, and may seriously miss the mark e.g., high rating for Anorexic who could die, low rating because of one serious symptom, but says that by also using the BPRS and the PIRS "these issues are remedied" (good to know that)
   e. Further reliability and validity problems with the GAF
      i. what is the meaning of "or" - which one do you pick?
      ii. murkiness of the various descriptions – some, moderate, slight, serious
      iii. the examples are no better – e.g., "Serious symptoms – suicidal ideation, severe obsessional rituals, frequent shoplifting" - results in 15% IR
   f. So, why even use this? Perhaps APA and AMA connection
3. Psychiatric Impairment Rating Scale – PIRS
   a. Function focused, 6 areas, 1 to 5 – STICES
   b. No comments on reliability or validity.
4. Does using three scales somehow improve the validity of the IR?
   a. Confirmation bias
   b. 3 thermometer example – if unreliable and even if reliable

"Clearly, interview, review of records, mental status exam, along with assessment of these three scales will provide an excellent basis for arriving at a strongly supportable IR" (really?)

F. Further Considerations

1. Weed out symptoms and functional limitations due to
   a, Axis II – PD & MR are pre-existing and not caused by the injury

b. Poverty

c. Physical impairment

d. All those other unratable diagnoses

2. Be aware the degree of impairment, not just the number of impairments

3. Ability to concentrate can be difficult to rate in one interview, so may have to use corroborating data (how about resilience and employability?) – a person may be able to concentrate on a MSE or a psychological test but not when they are watching a movie (huh?)

4. Add to the IR a judgment of degree of WORK IMPAIRMENT (really?)

G. Method

E. Examples

1. Four of the examples have no causative event. – why are thery even presented?

2. Ratings on Adjustment Disorders in Case 4 and 5, so it is ratable?

3. Case 5 indicates that suspicion or evidence of symptom exaggeration does not get factored in, you just used what the patient says, I guess? I am not sure how the diagnosis of Adjustment Disorder was made, so perhaps that is the area where symptom exaggeration etc. comes into play.