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Functioning Well in a Dysfunctional System: Recommendations for Clinical Psychologists in Workers' Compensation Settings

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Abstract Clinical psychologists working in workers' compensation (WC) settings face unique and complex professional and ethical challenges. The present paper provides recommendations to clinical psychologists for avoiding the largely unintentional harm to clients and unethical practices that can occur within the realm of WC. Although the psychologists working in WC settings more often than not act in ethical ways grounded in years of academic and professional training, the unique tasks required of psychologists in WC settings (e.g., rating injuries; determinations of causality) and the pressures inherent in the system can potentially lead even the most well-intentioned mental health professionals into unsavory ethical and professional scenarios. The authors examine the (un)witting contributions of psychologists to the current dysfunction in the WC system and provide recommendations for traversing the oft-serpentine terrain of mental health evaluations and treatment in WC settings. Specifically, the authors discuss, among the many possible potential pitfalls, (1) bringing personal bias into the evaluative setting, (2) engaging in unsavory advertising practices, (3) cherry-picking and other missteps in record review, (4) engaging in cursory consenting, (5) failure to engage in evidence-based assessment and report writing, and (6) role challenges.

Keywords Workers' compensation · Psychological injury · Ethics · QME

There are multiple players and stakeholders in any workers' compensation (WC) case. And yet, despite their disparate roles in the WC system, perhaps the one point of agreement among the various parties (e.g., injured workers [IWs], defense attorneys, insurance companies, applicant attorneys, lien claimants, and evaluating/treating health professionals) is that the current system is flawed. WC in North America has been identified as "inconsistent" (Schatman, 2012, p. 355), "dysfunctional" (Ladou, 2010, p. 292), and "demeaning" (Strunin & Boden, 2004, p. 344). The degree of dysfunctionality varies, to a considerable extent, from state to state (Schatman, 2012). The contributing role of psychologists to the dysfunction is complex. It is fair to posit that the majority of psychologists functioning within the system are doing so with professionalism and with ethical best practices in mind. Indeed, as Nicholson and Norwood (2000) pointed out, there have been numerous guidelines, training programs, and certification attempts to increase the rigor and quality of psychological assessments in forensic settings. Furthermore, psychologists have arguably been among the most professionally self-critical in the field; much has been published about the ethical and professional challenges that psychologists should anticipate and mitigate when working within the system (e.g., Gholizadeh, Malcarne, & Schatman, 2015; Heilbrun, 1992; Schatman, 2012; Young, 2008).

Schatman (2009) published an important article in this same journal, directed at personal injury attorneys, describing ways that financial and professional pressures could contribute to unintentional harm to their clients and unethical practices. He noted of personal injuries that, "... as with workers in any profession, they are subject to adopting facile or even

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deceptive practice that, either knowingly or unknowingly, violates the ethical behavior and practice expected of them" (p. 149). Schatman (2009) aimed to elucidate the potential for harm because, "Hopefully, doing so will help personal injury attorneys avoid inflicting unintentional collateral emotional harm to the clients that they represent" (p. 149). This article similarly describes unintentional harm and unethical practices but is addressed to clinical psychologists serving evaluative and report-writing functions within the WC system. Although the psychologists working in WC settings more often than not act in ethical ways grounded in years of academic and professional training, the unique tasks required of psychologists in WC settings (e.g., assessing injuries; writing medical-legal reports[1]; determinations of causality; discussions of apportionment) and the pressures inherent in the system can lead even the most well-intentioned mental health professionals into unsavory ethical and professional scenarios. Here, the authors examine the (un)witting contributions of psychologists to the current dysfunction in the WC system and provide recommendations for traversing the oft-serpentine terrain of mental health evaluations and treatment in WC settings.

Although, to the authors' knowledge, a study examining attitudes of attorneys and others involved in WC cases toward clients involved in alleged psychological injury claims has not been undertaken, even a cursory examination of what is written in legal blogs and forums quickly reveals the tainted image of mental health in WC settings. Worse yet, such sentiments exist on both sides of the legal spectrum (i.e., defense and applicant sides). There are concerns about mental health claims as frivolous and meritless add-ons that might be used by applicant attorneys to leverage insurance companies into more favorable settlement terms for their clients (Matsumoto, 1994). However, such prejudice against the veracity of mental health claims can also be observed from the vantage point of the applicant side as well, with such microaggressive acts as encouraging exaggeration of mental health symptoms in the hopes of monetary retribution for, for example, denied claims of physical injuries or aversive work environments (*see* Gonzales, Davidoff, Nadal, & Yanos, 2015 for a discussion on microaggressions around mental illness). The legal environment for the IW who is truly suffering from work-related psychological distress is likely not a pleasant one. Indeed, the stigma in the WC system that injured workers feel in general and specifically around mental health claims can be significant (Lax & Manetti, 2001; Lippel, 2007; MacEachen, Ferrier, & Chambers, 2007; MacEachen, Kosny, Ferrier, & Chambers, 2010; Strunin & Boden, 2004).

Although there are specific acts by clinical psychologists that constitute blatant ethical violations (e.g., sexual misconduct with clients), other acts are more subtle and may not be clear violations of ethics guidelines or laws, but nevertheless tarnish the reputation of the psychologist and the profession and/or cause harm to individuals. The present paper will focus on these less obvious acts. It can be useful to differentiate between the two broad categories in which clinical psychologists most commonly encounter the WC system: (1) as evaluators of alleged psychological injury and (2) as treatment providers for IWs. The focus of the present paper will be on specific behaviors that will be explored in the context of the *evaluation* (i.e., not treatment) of alleged psychological injury. Specifically, we will discuss, among the many possible potential pitfalls, (1) bringing personal bias into the evaluative setting, (2) engaging in unsavory advertising practices, (3) cherry-picking and other missteps in record review, (4) engaging in cursory consenting, (5) failure to engage in evidence-based assessment and report writing, and (6) role challenges.

Ethical codes and guidelines, including the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (subsequently referred to as the Ethics Code; American Psychological Association, 2010) and the Guidelines for Forensic Psychologists (hereafter, Specialty Guidelines; American Psychological Association, 2013)[2] and legal cases will be incorporated as relevant. We present recommendations for issues to consider with a clear understanding that the WC setting is inherently complex and there are multiple vantage points from which to approach any of these issues. The examples provided come largely from the California WC setting and thus there may be state/province-specific challenges not directly addressed; however, the general content should be relevant to clinical psychologists across geographic settings. It is our hope that the present paper will at least stimulate discussion around these issues and raise awareness for the potential for ethical and professional challenges that may arise in the evaluation or treatment of IWs.

[1] Reports authored by clinical psychologists for the purposes of evaluation of alleged psychological injury will be referred to by the broad category of medical-legal reports. Furthermore, although the present paper is targeting clinical psychologists and references ethics codes for that profession, the content may be relevant to evaluators across professions (e.g., psychiatrists).

[2] While information in both the APA Ethics Code and Specialty Guidelines are extremely useful for psychologists, it should be noted that the APA Specialty Guidelines provided by Division 41 are described as "aspirational in intent… not intended to be mandatory…" (APA, 2013, p. 8). The Ethics Code includes five general principles and 10 ethical standards and the general principles are similarly described as aspirational whereas the standards are enforceable (i.e., failure to comply to comply can constitute sanctions).

Problematic Behaviors That Might Occur Among Clinical Psychologists

Bringing Personal Bias into the Evaluative Setting

There are different names for evaluators in WC settings. For example, a psychologist may be conducting the evaluation as a qualified medical examiner (QME), agreed medical evaluator (AME), and independent medical evaluator (IME) depending on how the individual is selected. For the purposes of the present paper, psychologists conducting evaluations in the WC setting will be referred to as medical-legal evaluators (MLE). Regardless of the specific designation, MLEs are called upon to provide unbiased evaluations. Whereas lawyers may have strong feelings about the policy underpinning the WC system and proudly proclaim that they are tireless advocates for IWs or that they are dogged defendants of small businesses and business interests, an MLE who has very strong feelings about the system may, consciously or not, allow these biases to inappropriately influence the evaluative process. Given the lack of standardization in the evaluation of alleged psychological injury, the room for subjectivity in issues such as assessment of impairment, causation of injury, and apportionment (Gholizadeh & Malcarne, 2015) is immense. Furthermore, efforts should be undertaken to maintain a constant awareness of the potential for implicit biases to unwittingly color one's evaluations. For example, a clinical psychologist may be consistently rounding down global function of assessment (GAF) ratings (i.e., to show greater disability) for IWs in certain professions without even being aware of this pattern.

The research on implicit bias is rich. Since Greenwald and Banaji's (1995) seminal review of implicit social cognition, there has been greater attention paid to attitudes and stereotypes and the importance of indirect measures to ascertain the presence of biases. For example, a study of emergency medicine residents identified that, while the physicians reported no explicit racial preference, they demonstrated evidence of implicit racial bias favoring White Americans compared to Black Americans; the authors cautioned that the results suggested a role of implicit physician racial bias in disparities observed in medical treatment decisions (Green et al., 2007). Clinical judgments are considered biased when accuracy is skewed by group membership (e.g., if diagnoses of a personality disorder are more accurate in men than women; Garb, 2013). Previous research has identified negative attitudes and stereotypes in clinical psychologists toward physically unhealthy individuals (James & Haley, 1995) and overweight individuals (Davis-Coelho, Waltz, & Davis-Coelho, 2000). The insidious role of such biases in the evaluative setting is interesting to consider; for example, in an experimental design using identical vignettes with only the weight of the hypothetical client manipulated, overweight clients were assigned lower GAF scores than were normal-weight clients (Davis-Coelho et al., 2000). There are also issues such as diagnostic overshadowing bias, wherein psychological symptoms in certain groups may be overlooked. Mason and Scior (2004) empirically demonstrated the presence of such a bias in psychiatrists and clinical psychologists in diagnosing mental health disorders among adults with intellectual disabilities.

In the realm of WC evaluations, the opportunity for such biases is prodigious and can include any number of cultural contexts (e.g., race, gender, sexual orientation), but can also include characteristics such as occupation, and, even more broadly, IW status. In many instances, the MLE has knowledge of whether a claim has been accepted or denied by the defendant, and this may also lead to biases regarding the veracity of the applicant's claims. Furthermore, such biases can exist even when there is an explicit belief that they do not (Green et al., 2007). Such biases can contribute to an evaluator being labeled as applicant- or defense-oriented, calling into question one's professional integrity.

Recommendations

Because room for subjectivity is vast in evaluations of psychological injury (*see* Gholizadeh et al., 2015; Gholizadeh & Malcarne, 2015), an MLE's personal bias has the potential to dangerously enter into the evaluative process. It is incumbent upon the evaluator to provide an impartial evaluation, especially in the realm of determinations of causality, a construct without justifiable diagnostic criteria on which to base an assessment. This is true regardless of how the MLE has been selected and who is providing payment for the services (Kane, 2007). It is not the evaluator's task to help build or destroy a case, but rather to provide an objective comprehensive evaluation with all the facts clearly presented. One way to try to alleviate the role of one's own bias in entering the evaluation is to standardize one's own procedures for conducting WC evaluations. For example, having a standardized approach to the record review (e.g., efforts to procure missing records; diligence with which one reviews records), the interview (e.g., amount of time spent trying to understand upbringing and childhood history), and formal assessment (e.g., use of malingering or effort scales) can mitigate the unintentional role of biases.

Future research examining both explicit and implicit biases among evaluators can provide useful targets for education and intervention. Research may examine explicit biases which may be more readily accessed, in open-ended, qualitative research with psychologists who serve evaluative functions in WC settings. Although implicit biases might be more difficult to access, they can be explored through well-established paradigms such as an Implicit Association Test. Also, Meehl (1954) has written extensively on the importance of clinicians having a self-critical approach that encourages actively

challenging one's clinical findings (i.e., searching for disconfirming evidence) to combat confirmatory biases that may dull clinical judgment. Such research can open the door to greater insight about the explicit and implicit biases that may be tainting an individual's professional obligation to unbiased evaluations.

Engaging in Unsavory Advertising Practices

In a digital age that offers a plethora of opportunities for advertising one's services, the ideal of the lone psychologist, guided by the adage that the cream always rises and that consistently producing high-quality evaluations will gradually garner her/him a solid reputation and attract a steady flow of business, can be quixotic. With so many previously unimaginable opportunities for advertisement (e.g., from eBooks to digital newsletters to prolific med-legal Twitter accounts), psychologists may be lured by these opportunities for self-promotion. Such venues can provide important educational resources to IWs, attorneys, and the community and are not inherently problematic. Indeed, some of these materials are extremely important in disseminating high-quality information about psychological injury and mental health. However, certain practices (e.g., advertisements pandering heavily to one side) can lend a biased and unprofessional aura to one's work and reputation.

The line between advertising one's work in order to attract business and engaging in inappropriate advertising practices is not clearly demarcated. The ways in which WC institutional pressures and mechanisms may increase unethical practices, although not formally examined in the literature, are not difficult to hypothesize. The current process of selection of QMEs is one example of such a potential catalyst. In California, once a WC claim has been filed, the Division of Workers' Compensation generates a QME Panel, which includes the names of three randomly generated QMEs based on proximity to the injured worker. If the injured worker has an attorney, a Strike Panel QME commences wherein the attorneys from each side are allowed to strike the name of one of the listed clinicians; the remaining clinician then becomes the Panel QME for the case. It is also possible for both sides to agree upon an evaluator without engaging in the striking process, in which case the selected evaluator is designated as the Agreed Panel QME. Of course, it is also possible to forgo the panel process entirely if both sides agree to an evaluator, in which case the evaluator is called an AME. The potential problems with this process should be apparent in that one would wonder on what basis the attorneys are striking the listed QMEs. Anecdotally, it is understood that QMEs who have garnered a reputation for being defense-oriented will likely be stricken by applicant attorneys, and vice versa. This process is meant to ensure access to a fair and impartial legal process. However, for many QME hopefuls, the financial pressures of wanting to be selected as a QME may lead to attempts to garner favor with one or both sides of the WC table.

In California, being designated as an AME, a medical-legal evaluator who has been agreed upon by both applicant and defense sides to evaluate the IW (as contrasted with a QME, who has been chosen from a panel of three names via the Division of Workers' Compensation Medical Unit) has certain advantages, including being compensated at a higher rate than the QME for doing the exact same work. Although one would hope that promoting oneself as a fair evaluator (or simply hoping that the quality of the evaluative work garners such a reputation) would be sufficient to attract a steady flow of business, some MLEs, anecdotally, describe a more competitive field wherein they can feel compelled to build a reputation as being "applicant-sided" or "defense-sided" with the respective parties. Clearly, to be perceived as both applicant and defense-sided is a difficult (if not impossible) endeavor which can lead to an ethically sticky ground wherein the MLE develops materials skewed to play upon the desires of each party. In essence, one is playing both sides in the hopes of being agreed upon by both parties. For example, consider a psychologist eager to get her name into the local WC community who hires a marketing firm, an increasingly common practice, who procures presentation slots at leading applicant and defense firms presenting on a topic such as, "Determinations of Apportionment in Psychology Injury Claims." She may deliver different versions of her PowerPoint depending on to which audience she is presenting. Although this educational activity is not in and of itself unethical, the pandering to different parties can contribute to an unsavory reputation for not only the MLE, but also for the profession. Such practices may be incredibly savvy from a purely marketing perspective. However, advertising and marketing experts may not be aware of the very specific guidelines around advertising in the Ethics Code to which clinical psychologists are expected to adhere, which include avoidance of deceptive statements (Standard 5.01) and media presentations (Standard 5.04), opening the participating clinical psychologist to ethical missteps.

Clinical psychologists should also pay attention to how they are labeling themselves. Standard 5.01.b of the ethics code stipulates that "psychologist do not make false, deceptive or fraudulent statements concerning (1) their training, experience, or competence…". Of note, while Standard 5.01.a states, "psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice…," Standard 5.01.b does not include the word "knowingly," because psychologists are expected to have sufficient knowledge about their training and competencies (Fisher, 2003). There may also be state/province-specific WC regulations about advertising one's services. For example, in California regulations, addressing fraudulent or misleading advertising is quite specific and includes such

prohibitions as, "Any advertising copy which advises or recommends the securing of any medical-legal examination, or which suggests that a tactical advantage may be secured by obtaining any medical-legal evaluation," and "Any advertising copy which contains a firm name, trade name, or fictitious business name which contains the phrases 'Qualified Medical Evaluator,' 'Qualified Medical Examiner', 'Agreed Medical Evaluator', 'Agreed Medical Examiner', 'Independent Medical Examiner', 'Independent Medical Evaluator' or the designations 'QME', 'AME' or 'IME.'" (Cal. Code Regs. tit. 8, § 153).

Recommendations

The institutional zeitgeist in current WC is one that is unfortunately ripe for systemic abuse in the realm of advertising one's services. Suggestions for changes in policy (e.g., the panel QME process) are beyond the scope of the present paper; however, there are efforts that clinical psychologists can take to try to avoid the most blatant violations. While presenting materials heavily skewed to one side may not be in direct violation of ethical standards or laws, it is professionally unsavory and problematic in light of the Ethics Code principles of Fidelity and Responsibility (Principle B) and Integrity (Principle C). Furthermore, most states and providences have specific regulations for advertising in WC settings.

A text on risk management for clinical psychologists has a chapter titled "The Reluctant Business Person," to underscore that aspects such as advertising may be out of the realm of expertise for many in the profession (Bennett et al., 2006). Clinical psychologists should be aware that advertising and marketing are specialized endeavors that may be out of their comfort zones. Attempts to bring on marketing experts should be undertaken very carefully, however, as such experts may not be aware of the advertising standards and regulations specific to clinical psychologists working in WC settings. Prior to engaging in any type of advertising, whether traditional or nontraditional (e.g., a Twitter account), one should (1) review the Ethics Code Standard 5 on advertising and other public statements, (2) be familiar with state/province-specific rules impacting how clinical psychologists advertise in WC contexts, and (3) consult with others in the field. Bennett et al. (2006) also suggest avoiding "vanity credentials" (p. 202). For example, "J. Doe, Ph.D., licensed psychologist in workers' compensation issues" would be inappropriate. Presumably, the psychologist would add such a descriptor in attempt to showcase experience in a given subfield. However, the attempt would imply a degree of specialization which does not exist and for which there is no specific licensure or board certification.

Cherry-Picking and Other Missteps in Record Review

Prior to ever setting eyes on the IW, MLEs should ideally engage in a thorough record review. Depending on the system in which most commonly work, psychologists may have differing experiences with access to records. For example, psychologists working at Veterans Administration hospitals or other integrated care settings will often have access to an open-note system and readily be able to view the evaluee's prior mental and physical health records and clinician notes. In WC settings, there are specific rules regarding the exchange of information and ex parte communications. For example, in California, the claims administrator (or employer) or IW may provide records to MLEs; however, there are rules concerning the timeliness of how the records and documents are delivered. For example, the applicant and defense sides should provide copies of the information that they hope to deliver to the evaluator to the opposing party at least 20 days prior. The opposing party then has 10 days to object to any nonmedical records or other information. Furthermore, there are rules regarding barred materials and communications with evaluators (e.g., all substantive communications with an evaluator should be done in writing; Cal. Code Regs. tit. 8, § 35).

Focusing on requests for independent medical examinations at the behest of insurance companies in cases in which treatment or diagnosis may be disputed, Schatman and Thoman (2014) echoed a 2005 statement by The American Medical Association (AMA) (American Medical Association, 2005) that explicitly cautioned against the cherry-picking of records such that the evaluator selectively chooses which aspects of an individual's record to highlight or disregard to fit with a particular conscious aim. Schatman and Thoman argued that despite current rules in most jurisdictions calling for the inclusion of all relevant medical records, the problematic practice of record "cherry-picking" continues to flourish in forensic contexts. Although their focus was on insurance claims managers, the authors also advocated that psychologists be vigilant to potential selective record-editing (e.g., by claims managers) given the pervasiveness of the practice. Schatman and Thoman (2014) acknowledged that some have argued against such role expansion (e.g., Sullivan & Main, 2007). However, they argued that the vulnerable role of injured workers justifies such advocacy on the grounds of the Ethics Code's calls via Principle A to "safeguard the welfare and rights with whom [psychologists] interact professionally" and Principle D to "recognize that fairness and justice entitle all persons to access to and benefit from the contributions of psychology and to equal quality in the processes, procedures, and services being conducted by psychologists." Beyond the "bad-faith" selective record review described by Schatman and Thoman (2014), there is also the perhaps more subtle

possibility of unconscious bias leading to cherry-picking of records, underscoring the many ways that record review can be mishandled.

Because the evaluator may only see an IW on a single occasion, the review of general medical records is an important source of data that will impact not only the report but also the clinical interview and assessments. It is highly unlikely that an evaluator who has not engaged in a thorough review of records will be adequately prepared to engage in the type of evaluation that is necessary to provide substantial evidence in terms of diagnosis, causality, and apportionment of alleged psychological injury. The records are generally comprehensive and include medical records (psychological and nonpsychological) and legal records (e.g., deposition transcripts, sub rosa investigation recordings). In certain cases, the clinical psychologist may feel overwhelmed by the sheer volume of records (although, more files usually also indicate more time reviewing records, corresponding to higher fees as MLEs tend to charge by the hour for record review) or feel that he or she lacks the specialty knowledge required to interpret a given document. Although it is generally inappropriate for a psychologist to critique medical records outside of mental health/psychology contexts (e.g., finding fault with an orthopedist's report describing injury to the spine), the psychologist should include sufficient detail in the report to acknowledge receipt and review of all pertinent records.

Recommendations

Utilizing the same rigorous behaviors (e.g., efforts to procure records, time spent reviewing records relative to the amount of records) for all clients can circumvent one's own biases that may be inadvertently influencing the evaluation. Selective record review can influence and can be problematic in that the records paint a picture of the IW and injury scenario that can influence what questions are asked or what assessments are offered in the evaluative interview and be instrumental in determinations of causality and apportionment. Used appropriately, records are a critical source of information for evaluators that serve as a form of reliability assessment. Thus, efforts should be made to include (and ensure the inclusion of) all relevant records in order to have a complete assessment for each case, rather than only using those records consistent with an MLE's diagnosis and descriptions of causality and apportionment.

Additionally, efforts to mitigate cherry-picking of records are challenging because of specific guidelines around communication between evaluators and the applicant and defense sides. The role of clinical psychologists in preventing unscrupulous practices, such as cherry-picking of records, is controversial. Schatman and Thoman (2014) described, "At times, psychologists serving as advocates, and functioning within the parameters of all appropriate professional guidelines and ethical codes, can also take preemptive measures to ensure that an IME provider is able to have access to all of the relevant records prior to conducting an examination. Although this type of advocacy may be considered controversial, it is not provided that it comports with extant professional guidelines and codes in a system that is not necessarily always just." (p. 294). The rules regarding the exchange of information relating to records can be quite specific in a given state/province. Thus, clinical psychologists should be aware of the rules and ensure that they are not acting outside the bounds of regulations, for example by reaching out to one side via phone call asking for a summary of the records or accepting materials from one side that have not been sent in accordance to the regulations. That said, consultation when necessary to produce a complete and accurate report is often encouraged in regulations as long as new information garnered is explicitly detailed within the body of the report. Psychologists should generally avoid critiquing records unless they are within their realm of expertise and relevant to their diagnosis and report.

Engaging in Cursory Consenting

For the MLE, a given evaluation may be one of thousands conducted over the course of their professional career and may even be the second or third one of that day. For the IW, this may be his/her first contact with the mental health system. The purpose of informed consent is to allow the IW the opportunity to make an informed decision about participating in the evaluation and to demonstrate respect for the autonomy of the IW (Fisher & Oransky, 2008). In addition to the elements that should be present in every consent form, there are also special considerations in the WC evaluative context, including understandability, limits to confidentiality, and fees.

The protection of confidentiality is a paramount responsibility for clinical psychologists (APA, 2010). However, the topic of confidentiality is a highly contentious one in that it is simultaneously one of the greatest responsibilities of the psychologist and a source for numerous ethical complexities and dilemmas (Fisher, 2008). Fisher (2008) described that as disclosure demands increased in legal settings in the 1970s, so too did ethical quandaries associated with confidentiality. As the profession has moved into the ambiguous grounds of conditional confidentiality, ethical dilemmas in forensic settings abound. Fisher (2008) wrote,

> Many of the conditions now placed on confidentiality allow psychologists to avoid risks to themselves. For example, when psychologists obey reporting laws, they thereby avoid the legal and financial risks of civil disobedience; but this simply transfers the risk to the clients whose confidences are betrayed. Similarly, when psychologists disclose information against a client's wishes in a court case, they avoid a contempt citation, a

> financial penalty, and incarceration; the risk is borne instead by the client whose confidential information becomes public information. (p. 3)

Thus, Fisher (2008) advocated for an ethics-based confidentiality practice that can be a useful outline for all psychologists. Fisher (2008) emphasized that it is incumbent upon psychologists to first develop and maintain education addressing limits to confidentiality such that they can be disseminated in a transparent and timely fashion. Furthermore, psychologists should be aware of their state-specific exceptions to therapist-patient privilege given discrepancies across states (Hudgins, Rose, Fifield, & Arnault, 2013) while having the professional confidence, "not to treat an attorney's discovery subpoena as if it had the legal authority of a court order" (Fisher, 2008, p. 10).

The APA Ethics Code addresses informed consent directly in Standard 3.10 Informed Consent, among other sections, and calls for psychologists to obtain consent "using language that is reasonably understandable to that person" (p. 6). With the possibility of head injury, trauma, or cognitive difficulties, ensuring understandability of the consent form is paramount in WC settings. With estimates of nearly one quarter of American adults living with low literacy skills (Kirsch, Jungeblut, Jenkins, & Kolstat, 1993), ensuring that the forms are understandable is especially important. Readability can be easily assessed via the Flesch-Kincaid readability statistic that is readily available via Microsoft Word and proves a grade level ranging from 0 to 12 (Paasche-Orlow, Taylor, & Brancati, 2003). Although there are no formal cut-offs for grade level in forensic consent forms, Paasche-Orlow et al. (2003) have recommended writing consent forms at a 4th–6th grade level to balance delivery of information needs with average reader comprehension. Capacity to provide consent should also be considered; rather than viewing capacity to consent in a binary manner, taking a continuum approach that tailors the consenting process to the specific needs and challenges of the given IW can help ensure that the individual is making an informed decision (Fisher & Oransky, 2008).

A key ethical question prevalent in many psychological settings that may also influence consent form language is, "Who is the client?" Such questions can exist in many scenarios, for example in cases involving minors in which the parent is paying for the therapy, but are especially serpentine in WC settings where there can be multiple third party payers or even payment by lien. Furthermore, the IW being evaluated may never be seen by the psychologist again, whereas the IME may have frequent contact with the attorneys and insurance parties involved in the case because of involvement in other cases.

The American Academy of Psychiatry and The Law (AAPL) has created guidelines specific to disability evaluations and in describing the consenting process cautioned that "despite the lack of confidentiality inherent in disability evaluations," evaluators should still take care to discuss limits of confidentiality and that, "information that is not relevant to the disability evaluation should be considered confidential" (Gold et al., 2008, p. S10). The AAPL further recommended that informed consent include language specifying that (1) the evaluation is not for the purpose of treatment, (2) the evaluee is not/will not be the MLE's patient, (3) the purpose of the evaluation is to gather information in order to present an opinion regarding the mental state and disability of the evaluee, and (4) the information and results from the evaluation will be shared with the referral source and possibly other sources involved in the disability determination. Each of these recommendations carries additional questions and points for possible clarification. For example, clarifying to which parties the evaluee can reasonably expect the report to be disseminated can be important.

Recommendations

If MLEs are using the same consent forms that they would use in other (e.g., private practice treatment) settings for their WC evaluations, they are very likely failing to include important information. There has not been a study to assess existing informed consent forms used by MLEs in WC settings in order to understand the percentage of forms that include certain information (e.g., limits to confidentiality specific to WC) and to compare wording differences; the field would certainly benefit from such a study, and from greater standardization or suggestions for informed consent forms. Referencing ethical standards and guidelines to ensure basic compliance with best practices is an important first. Consulting with other providers of similar services and looking at several versions of informed consents from other MLEs can also provide useful information. Ultimately, the development of a consent form that an MLE uses in his or her practice should be an iterative process involving asking various lay (i.e., not involved in legal or health professions, where exposure to such forms may be standard) persons to repeat back the information described to ensure that it is understandable.

In addition to standard informed consent details, including details about the nature of the WC evaluation may also be important in promoting greater transparency. For example, details describing what is being evaluated and what will be included in the report (i.e., diagnosis, causality, apportionment), how the MLE was retained, fee structure, and limits of confidentiality may be appropriate. The lack of guidance around standard consent language may present an opportunity for psychologists to get more involved in WC by creating a task force to develop standard language that should be included across consent forms, or even developing a standardized consent form template to use across evaluations.

Failure to Engage in Evidence-Based Assessment and Report Writing

More than two decades ago, Heilbrun (1992) brought attention to the lack of "critical but balanced examination of the appropriate parameters for the forensic use" (p. 257) of psychological tests and called for "an independent set of standards for the selection, administration, and interpretation of psychological testing in forensic contexts" (p. 269). At present, these calls have largely gone unheard; the use of psychological assessments in WC settings is left to the discretion of the MLE and thus may be influenced by such factors as an individual's experience and familiarity with certain assessments rather than an empirically grounded determination of what assessment would best capture a given construct, or answer a particular question. Assessments, including the clinical interview, are the foundation for the medical-legal report. A poorly written report (i.e., one that is not considered substantial evidence) can be frustrating for all the stakeholders in a given case involving alleged psychological injury. The many pages of the report may be glossed over by others interested in the results, at least initially, to get to the financial crux of the report(s): the Global Assessment of Functioning (GAF) score, from which permanent disability is calculated, and apportionment. The psychometric weakness of the GAF in WC settings (Gholizadeh et al., 2015) and issues with determinations of causality/apportionment (Gholizadeh & Malcarne, 2015) have been previously discussed in detail.

The expectation is that a psychologist, as expert, can impart information beyond that which can be garnered by the applicant and other lay individuals (e.g., colleagues or family members asserting a change in the individual's functioning; Goodman-Delahunty & Foote, 1995). Because the signs and symptoms of psychological injury are often less obvious than those of physical injury, applicants may not recognize the presence or extent of injury. The stigma associated with expressing psychological concerns may also preclude individuals from voicing their concerns. Goodman-Delahunty and Foote (1995) provided the example of an individual who was awarded compensatory damages for psychological injuries on the basis of expert testimony despite superficial signs that he was functioning well (e.g., not missing work, not seeking counseling) because he wanted to maintain his good standing at work (*see* Stallworth v. Schuler, 1985). On the other side of the spectrum, psychological assessment in such settings can capture instances of malingering or symptom exaggeration (e.g., DuAlba & Scott, 1993; Lees-Haley, English, & Glenn, 1991; Sumanti, Boone, Savodnik, & Gorsuch, 2006).

Two types of assessments are of key interest. First, there is the psychological interview (i.e., intake) and second, there are standardized assessments. Together, these pieces are used to inform diagnosis; determine severity of the problems; provide evidence of key constructs, such as malingering or functioning; and make determinations of causality (i.e., industrial versus nonindustrial). Unlike psychological measures, such as the Beck Depression Inventory-II (Beck, Steer, & Brown, 1996), which are standardized even to the point of the exact order in which questions should be presented, response options anchored, and scoring interpreted, the psychological interview is a relatively amorphous beast that can range from the highly structured (e.g., Structured Clinical Interview for the DSM (SCID-IV-TR); First, Spitzer, Gibbon, & Williams, 2002) to a psychologist's own loosely assembled series of questions that can vary depending on a variety of factors (e.g., the client's clinical presentation, or even, the amount of time the MLE has before her/his next appointment).

The psychological interview has been called "the single most important means of data collection during psychological evaluation," in that "without interview data, most psychological test results are meaningless" (Groth-Marnat, 2009, p. 65). However, the lack of required structure of the psychological interview is arguably problematic, especially for determinations of causality, because the MLEs' theoretical orientation or other biases can influence what types of questions are being asked, how much information is gathered in a particular domain (e.g., childhood history), and lead to low interrater reliability (Gholizadeh & Malcarne, 2015). *Standard 9.01 Bases for Assessments* requires that evaluative statements be based on "information and techniques sufficient to substantiate their findings." The standard also requires that psychologists only opine about the psychological characteristics of an individual *after* an examination "adequate" to support their findings. This underscores the importance of the standardized assessments and other supporting information (e.g., medical records) to corroborate information gathered in the psychological interview. *Standard 9.02 Use of Assessments* requires that psychologists "administer, adapt, score, interpret, or use assessment techniques, interviews, tests, or instruments" for purposes appropriate given the existing research and knowledge base; culturally appropriate assessment is also referenced in this standard, which calls for reliability and validity of the instrument in the population being assessed. *Standard 9.05 Test Construction* requires that psychologists who develop tests and "other assessment techniques" utilize appropriate psychometric rigor and current scientific knowledge to ensure adequate test design and elimination or limitation of test bias. Thus, while psychologists may be tempted to create and administer their own assessments for constructs such as pain or disability, without appropriate psychometric evaluations of the measures, such assessments would be unethical if used for diagnostic or other evaluative reasons.

There may also be specific requirements in the law. For example, for psychologists working in California workers' compensation settings, there exists a "more suggestive than prescriptive" guideline to writing an evaluative report per the

INDUSTRIAL MEDICAL COUNCIL, PSYCHIATRIC PROTOCOLS (1992; amended 1993; hereafter *Protocols*). The Protocols describe psychological testing as an "additional source of information" and provide no guidance regarding specific tests; evaluators are paid according to the hours spent on the evaluation and thus largely based on the types of testing they employ, which can be used to justify billing for more complex cases. The categories begin with "Routine Screening," for which two to five hours of billing are allowed, and that is appropriate for a "routine workers' compensation case;" the types of tests provided as examples for "Routing Screening" include the MMPI and MCMI. The next tier of testing is "Complex Psychological Testing," for which six to 10 hours of billing are allotted. Examples where complex testing may be appropriate are provided as, "…cases where elaboration; reading, language and intellectual barriers; or confusional states exist…[or]… to explore more thoroughly issues of personality, cognition, and malingering and/or exaggeration." The types of tests suggested here include projective measures such as the Rorschach test. That projective tests, which hold relatively little empirical support in the context of evidencing the types of referral questions guiding the evaluations (e.g., extent and severity of psychiatric disability), are included speaks to the need for more empirically informed guides and protocols. Piechowski (2011) cited the lack of evidence for the use of projective tests in the assessment of disability, the potential for challenges in admissibility, and the time-constraints involved in a disability evaluation as reasons why IMEs should avoid the use of these tests. Finally, there are also allowances for "Neuropsychological Testing," for which eight to 15 hours of billing are permissible.

Schwarz (1999) described a series of experiments spanning decades demonstrating that the ways in which questions are asked of respondents can influence the answers being given. For example, Schwarz and Scheuring (1992) found that 62 % of respondents asked about physical symptoms reported a frequency of more than twice per month when provided a response scale that ranged from "twice a month or less" to "several times a day;" however, when the response scale ranged from "never" to "more than twice per month," only 39 % of respondents endorsed symptoms more than twice per month. In other words, participants were wary to endorse a seemingly high-frequency category of disturbance, which is how they understood the latter question. It is useful to consider the assessment not as a sterile tool in a vacuum but as a socially and culturally constituted attempt to quantify a given construct. It should not be taken for granted that respondents simply understand the questions being asked. Beyond the literal meaning (i.e., semantic understanding) of the questions being asked, there are also issues of pragmatic meaning that participants take into consideration (Schwarz, 1999). The Gricean maxims are of relevance in determinations of pragmatic meaning. For example, the maxim of quantity, "…enjoins speakers to make their contribution as informative as is required, but not more informative than is required…to provide information the questioner seems interested in…discourages the reiteration of information…provided earlier, or that 'goes without saying'" (Schwarz, 1999, p. 94). Thus, it can be very important for the MLE to track both the literal and pragmatic understanding of the IW throughout the interview and assessment process.

As an example, the MLE seeking to obtain trauma history may ask about this a number of ways: "Have you had anything traumatic happen in your life?"; "Please tell me about the traumatic events that have happened in your life?"; "Most people experience traumas in their lives; these can be childhood abuse, accidents, health problems, losing a loved one… what traumas have you experienced?" The QME may also administer a standardized questionnaire, such as the Traumatic Life Events Questionnaire (Kubany et al., 2000); or, the QME may have a list of traumatic events that she has created herself (which, as previously described, would be psychometrically problematic), which is far more or less extensive, that she lists off or has the applicant complete in private before the intake. It is presumable that all these methods would render the exact same list, but it is also possible that individual would generate more, fewer, or different events depending on whether and how trauma is defined or normalized; in other words, as Schwarz (1999) cautioned, the questions may shape the response.

The medical-legal report is akin to expert testimony. Psychologists are an important source of expert information in many types of forensic settings (Woody, 2016); they are *the* main source in cases involving psychological injury. However, the aforementioned problems with the reliability and validity of the assessments are not simply a matter of psychometric best practices but could hypothetically constitute a barrier to admission of the expert findings. The role of a psychologist as forensic expert is best understood within the context of a series of cases commonly referred to as the Daubert trilogy. The landmark US Supreme Court case *Daubert v. Merrell Dow Pharmaceuticals* (*Daubert*, 1993) handed the task of determining the admissibility of expert witness' testimony to judges via four standards that are considered to differentiate valid from invalid science. Young (2008) summarized the four standards as (1) the science should be falsifiable (i.e., testable), (2) the science should acknowledge false positives and false negatives, (3) the science should be peer reviewed and vetted, and (4) the science should meet the *Frye* standard (i.e., should be informed by general acceptability among the scientific community). While *Daubert* is often considered to have added more rigor to the standards prior to 1993, which involved simply taking the *Frye* standard into consideration, arguably judges often lack the field-specific training or resources to question the

validity of a methodology or assessment that an expert is purporting to be valid.

A discussion of the history and current interpretation of the Daubert trilogy cases is provided in Woody (2016), tracing the progression from Frye v. United States, 54 App. D.C., 293 F. 1013 (1923), in which the courts decided that admissibility of expert testimony should be determined on a standard of "general acceptance" in the scientific community, to Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993), which stated that, "trial court judges should be the gatekeepers of the admissibility of expert testimony that had to meet the standards of reliability and relevance. Reliability, was to be determined by such tests as error rates, peer-reviewed publication, widely accepted methodology, and the like" (Gutheil & Bursztajn, 2003; p. 206). It is important to note that there is substantial disparity in what standard is used across states, with some states relying on the Frye standard (e.g., California, Washington) and others using the Daubert standard (e.g., Texas, Arizona). The majority of states, however, have adopted Daubert. There has been an interesting discussion in Florida, where there was a call to revert back to the Frye standard in 2015 by Florida courts, rather than the Daubert standard, which had been adopted in 2013. Jordan (2016) however, noted that because WC courts in Florida are considered an executive department of the state, decisions by the Florida Supreme Court would not have authority (i.e., WC in Florida would still utilize the Daubert standard). Jordan (2016) noted that this was ironic because, "Daubert has proven particularly problematic in workers' compensation cases because a treating physician's pure opinion is frequently needed to establish apportionment or major contributing cause . . . Because there is no precise scientific measurement for amount of disability associated with an injury . . . physician opinion is sometimes all we have to establish apportionment in a workers' compensation award. If all opinion testimony is prohibited, then apportionment permitted under Florida workers' comp law doesn't exist." The lack of a gold-standard, psychometrically supported measure for issues such as causality and apportionment and what this means for MLEs acting in various jurisdictions with specific rules for standards of evidence and expert testimony may be an area that requires further legal clarification.

Recommendations

The role of psychologists as experts is a somewhat contentious one at present. However, until further legal and policy clarity is achieved, there exist excellent recommendations for measure selection and use in forensic contexts in Heilbrun (1992) and Marlowe (1995). Combining recommendations from Heilbrun (1992) and Marlowe (1995), we have summarized some of their key recommendations for selections of an instrument in Table 1.

Furthermore, Tracey, Wampold, Lichtenberg, and Goodyear (2014) offered the following recommendations for improving accuracy in clinical psychological settings:

> (a) adopting a Bayesian approach by looking at base rates and the predictability of behavior, (b) obtaining quality information (e.g., relying on valid measures rather than impressions), (c) relying less on memory, (d) recognizing personal biases and their effects, (e) being aware of regression to the mean where less extreme behavior follows extreme behavior, and (f) adopting a disconfirming, scientific approach to practice. (p. 225).

Taking care to standardize the clinical interview and assessment approach as much as appropriate and possible may protect the clinical psychologist from claims of bias in the assessment or report writing. In the same vein, documenting justification for selection of certain measures is recommended. Engaging in informal audits of one's own work can be useful in identifying insidious trends, for example only administering malingering/effort testing scales to IWs in specific cultural contexts (e.g., race/ethnicity; occupation). Furthermore, a review of the literature to ensure that malingering and effort testing is being used appropriately is highly encouraged. Also, psychologists who have conducted evaluations in other contexts may find disparate policies. For example, while utilizing instruments designed to assess effort and malingering is considered good practice in standard forensic disability evaluations, the use of such instruments in assessments for service-connected disabilities for veterans is frowned upon, given the *ex parte* nature of service connection evaluations and a different standard of proof for injuries than in WC settings (*see* Worthen & Moering, 2011 for a discussion). This has engendered a contentious environment in which the desires of psychologists to conduct ethically sound, empirically based assessments can be at odds with the framework of a system that strives to provide a nonadversarial environment for the veterans involved in the process (Worthen & Moering, 2011).

In terms of categorizing evaluations for billing purposes, the lack of more clear guidance regarding what would justify labeling a case as "complex" versus "routine" could potentially leave the MLE open to billing criticisms or audits. Thus, the MLE should clearly document and have reasons substantiating why a certain case was categorized as it was; furthermore, although not explicitly called for, having an empirical basis to why certain measures or modes of testing were utilized can be sage. Heilbrun (1992) recommended that psychologists go beyond legal policy and rules of evidence

Table 1 Measurement selection recommendations in WC settings

Criterion	Legal considerations	Psychological considerations
Availability of the test	• "Data have tendency to make existence of any fact of consequence more or less probably and not unduly prejudicial" [Federal Rules of Evidence 401–403] (Marlowe, 1995, p. 211) • The test is "'reasonably relied upon' by members of expert's profession" [Federal Rules of Evidence 703] (Marlowe, 1995, p. 211) • Data used to inform bases for conclusions may be called upon for cross-examination purposes	• Commercially available with documentation in at least two, peer-reviewed sources • Scoring instructions with relevant norming (e.g., by age, gender) standards used if available
Psychometric properties of the test	• "Evidence 'sufficient to report a finding,' or a reasonable jury could conclude, that results are 'accurate'" [Federal Rules of Evidence 901 (a) & (b) (9)] Marlowe, 1995, p. 212)	• Reliability indicators should be consistent with the construct being measured (reliability of at least 0.90 is often recommended for interrater reliability). Test-retest reliability should be particularly high for any tests with subjective interpretations such as the GAF, but also depends on construct and time period. Validity (e.g., construct, convergent) should also be considered consistent with the construct being measured.
Relevance of the test to the legal construct (e.g., disability) or the psychological construct of interest (e.g., depression; malingering)	• "Theory has any tendency to make existence of any fact of consequence more or less probable; and is not unduly prejudicial or confusing [Federal Rules of Evidence 401–403]" (Marlowe, 1995, p. 211)	• Relevance should be supported via peer-reviewed, published, validation efforts, when available. • Results of a test should not be extended to a purpose beyond that for which the test was intended.

issues and take a more active role in developing standards for the use of psychological assessments in forensic settings (see Table 1). Marlowe (1995) recommended that considerations such as standardized administration and relevant norming procedures also be undertaken in an effort to justify admissibility of the testing evidence in the post-Daubert landscape.

Regarding future research and policy, there is a need for empirical queries into such issues as how to assess certain injuries that have clear psychological as well as physical implications (i.e., head traumas) for disability purposes. Concerns about subjectivity of the diagnosis of psychological injury have led to a trend of limiting compensation for psychological injuries in many states/providences. For example, in California, the enactment of Senate Bill 863 (SB863) in 2013 included substantial limitations to the compensation of physical-psychological injures (i.e., physical injury is precipitant to and deemed causal of mental injury); specifically, increases in permanent disability impairment rating for sleep dysfunction, sexual dysfunction, or psychiatric disorders arising from physical conditions were prohibited except if resulting from a "violent act" or "catastrophic injury." Then in May 2016, an important case [(Larsen v. Securitas Security Services, 2016 Cal. Wrk. Comp. P.D. LEXIS – (Appeals Board noteworthy panel decision)] expanded the heretofore nebulous "violent act" such that being hit by a car in this specific case was defined as a "violent act." Thus, the IW was awarded a higher impairment rating that included alleged psychological injuries that previously would not have been included. This was deemed an expansion that would allow many other cases to be eligible for an increase in physical-psychological ratings. The case opened a veritable Pandora's box in legal forums in which arguments were made from both sides regarding how this precedent could be used to increase psychological impairment ratings (i.e., by labeling many more scenarios, for example a fall of a ladder, as "violent") or as a cautionary tale to circumvent such issues altogether and instead rate, when possible, psychological symptoms (e.g., memory loss, depressive symptomatology) relating to certain traumas as postconcussive (i.e., physical injuries) rather than psychological, given fewer restrictions on compensation of physical injuries. This scenario is emblematic of how psychological injuries may be treated in the law in that rules affecting the rating and compensability of injuries and pursuant discussions are often not empirically grounded or based on psychometrically appropriate assessments.

Finally, further research exploring the very role of clinical psychologists as experts is warranted. Shuman (1997) wrote, "An individual psychologist's claim of expertise as a psychologist, for example, rests on the assertion that through education, training, and experience, he or she possesses the knowledge and skills that well-informed psychologists generally possess. However, merely because this psychologist possesses the knowledge and skills that well-informed psychologists generally possess on a particular topic tells us nothing about whether the judicial system ought to accept any group member's claims on that topic" (p. 552). Although the biopsychosocial model suggests that any claims of causality should acknowledge the multifaceted construal of psychiatric

injuries that would preclude a simple cause-and-effect model of a precipitating event to an injury (Young, 2008; Gholizadeh & Malcarne, 2015), it can be tempting for psychologists to take more extreme views in their reports. Indeed, empirically it has been demonstrated that there is a confidence heuristic such that individuals give more credence to experts "who make extreme confidence judgments" (Price & Stone, 2004, p. 39) and demonstrate greater confidence in their forensic testimony delivery (Cramer, DeCoster, Harris, Fletcher, & Brodsky, 2011). The question of what is considered expertise in clinical settings is a controversial one. Shanteau (1992) examined expertise (i.e., improved performance in relation to greater experience) across professions; he argued for the presence of expertise in some professions (e.g., chess masters, insurance analysts, test pilots) and the absence of the construct of expertise in other professions (e.g., psychiatrists/clinical psychologists, court judges, college admissions officers). Tracey et al. (2014) corroborated Sheanteau's (1992) assertion, adding that the reliance on cognitive heuristics can thwart expertise in psychology.

Role Challenges

There have been differing arguments as to the roles that psychologists should accept in working with injury clients. Some have argued that as a vulnerable group, injured workers may, at times, require the advocacy of the professionals working with them, such as their treating psychologists. Schatman and Thoman (2014) described a case example of a psychologist intervening when he felt that his records were not being given to the IME. They argued, "…the psychologist felt that he had a fiduciary obligation to his patient to promote his welfare and minimize potential harm" (p. 294). However, not everyone agrees with this type of advocacy on behalf of clients. Some argue against the legal vulnerabilities the psychologist may be broaching by insisting on involvement in a domain that is beyond the designated role. Others argue that such advocacy is paternalistic and may be unintentionally harming the client (Sullivan & Main, 2007). Although, for those psychologists who do embrace an advocacy approach, spaces to intervene may be present in evaluative and treating roles, treating psychologists may have more opportunities to witness unfair behaviors (e.g., cherry-picking of records, lack of communication with the IW) and arguably, more appropriate scenarios in which to get involved as compared to MLEs.

Depending on the theoretical orientation, treatment goals, and personal clinical style of the treating psychologist, specific details about the case subsequent to the injury may be more or less likely to emerge and become a central focus of the assessment. Schatman and Thoman (2014) provided a series of compelling cases describing ways that the case itself was causing or perpetuating psychological distress, and thus had to be addressed in some way. Regardless of one's orientation or stance on advocacy on behalf of IWs, by virtue of involvement with the WC system, psychologists should familiarize themselves with the WC law and rules around treatment and compensation of psychological injury. Ethics Code standard 2.01 states that, "When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles." Familiarity with the basics of the system will arguably increase credibility and prevent the psychologist from writing a report that is stricken as a result of not being deemed substantial medical evidence. There is a discussion of substantial evidence in Gholizadeh and Malcarne (2015) in the context of California WC. Failing to describe "how and why" an alleged psychological injury is contributing to present disability is a common reason for reports to be deemed "not substantial evidence" and not relied upon in legal settings. When one considers the amount of time, effort, and disclosure required by an IW in a given psychological evaluation, to have a report deemed not substantial medical evidence because of technical inadequacies stemming from the negligence or cursory work of the evaluator is truly a shame.

Recommendations

Some might argue that the easiest way to avoid accusations of ethical misdoing is to keep one's head in the veritable sand and focus on the demarcated task at hand (e.g., administer an assessment; opine on the causality of an alleged psychological injury). However, we recommend a flexible approach that respects role boundaries while also acknowledging that IWs can be a vulnerable population. The challenge is to balance various ethical standards that may be at odds with one's own individual conscience, recognizing that what is legally sanctioned may not be ethically sound, and vice versa. Entering into forensic roles as a psychologist can be rewarding and present wonderful professional opportunities and challenges; however, there is an inherent risk that is also present. This is arguably compounded in WC, with the many psychometric problems (e.g., the use of the GAF) and professional ambiguities (e.g., determinations of causality) present in the current system.

Writing in the context of family disputes, Greenberg and Gould (2001) wrote, "It is our contention that effective treatment with court-involved families can occur only when the therapist is knowledgeable about the myriad of forensic mental health and legal issues that often are imposed on the therapist, the children, and the treatment itself during custodial disputes" (p. 470). We echo these sentiments in the WC context in that effective treatment of IWs does not occur in a vacuum unaware of the emotional and physical burdens that IWs may be experiencing and the dysfunction inherent in the

system. Of course, the forensically savvy treating psychologist should be aware of the potential for all the ways in which systematic problems may contribute to dysfunction, for example truly vulnerable and high-risk IWs who may benefit from advocacy efforts versus individuals who are malingering or seeking to take advantage of the system.

The potential for boundary violations for psychologists working in forensic settings has been extensively explored in the context of child custody evaluations. The recommendations of Greenberg and Gould (2001) for providing treatment in high-conflict forensic contexts can be adapted to the IW setting as well, however,

> This requires that therapists learn to think forensically about the familial [*WC*] context without exceeding the boundaries of their role or aligning with one side of the family or the other [*defense or applicant side*]. This may require consideration of a variety of issues, including the motivations of both parents [*all parties involved in the case*], the alignment and influence of the extended family [*WC*] system with one parent [*side*] or the other, the child's [*IW's*] vulnerability to external influence, the influence of the sibling [*coworker/family*] …the expectations of the legal system, the impact of changes in the law, the ethical guidelines and standards that guide professional psychological practice, the therapist's need to help, and other relevant variables. (p. 470).

Conclusion

There are numerous ways for psychologists to be involved in the WC system. Whether one is a seasoned QME with a bustling business, a verdant QME hopeful aspiring to learn a new skill while providing a valuable service, a treating psychologist who works frequently with IWs, or a legally savvy clinical psychologist who works as consultant for an insurance company, there is an ethical thread weaving all of these roles together. For many IWs and others involved in a particular case, this may be their first contact with the field of psychology. The few psychologists who engage in unsavory practices may thus not only tarnish their own reputations, but of that of the field overall. By that same vein, psychologists who conduct thorough evaluations, keeping the highest standards of professionalism and ethics in mind, and write unbiased, evidence-based medical-legal reports can positively influence perceptions of mental health among IWs and others involved in any given case.

There are fundamental disparities present in the fields of psychology and law from which sprout philosophical, professional, and ethical impasses. Underwager and Wakefield (1995) describe one such complexity:

> The facts of the science of psychology are those patterns of regularity which can be reliably replicated and predicted across large numbers of people and situations. Law, however, looks at an individual, at individual case-specific circumstances, and at a specific environment to determine the culpability of a specific person . . . If the psychologist succumbs to this temptation and says innocent or guilty, that is beyond both the science of psychology and the competence of any scientist. (p. 1).

By virtue of the cross-disciplinary nature of forensic evaluations, clinical psychologists can find themselves in difficult ethical and professional scenarios. Simply being aware of the potential for such quagmires and openness to critical examination of one's own work and consultation with others in the field are important. Highlighting the multidimensional opportunities for ethical missteps, Bennett et al. (2006) provided the following risk management formula for clinical psychologists:

$$\text{Clinical Risk} = \frac{(P \times C \times D)}{\text{TF}}$$

where P represents patient risk characteristics, C represents context, D represents perceived disciplinary consequences (legal or professional), and TF represents therapist factors. The formula suggests that patient, therapist, and professional/legal standards can act synergistically to determine clinical risk. There are invariably ethical challenges that the most skilled and well-intentioned psychologist may not be able to preempt; however, an awareness of the contextual and therapist factors that may contribute to clinical risk can mitigate such problems and potential disciplinary consequences.

Recent years have seen a trend toward limiting the compensability of psychiatric injuries. Wise (2016), in this issue, summarized coverage of WC psychological injuries by state and identified significant disparities in statutes across states. For example, while all states provide some form of coverage for industrial physical injuries, coverage of psychological injuries is heterogeneous with some states covering physical-mental injuries (e.g., Alabama, Oklahoma), some covering mental-mental claims (e.g., California, New York), and some only covering psychological injuries deemed to have arisen from extraordinary or unusual circumstances (e.g., Vermont, Wisconsin). These limits are often related to perceptions of alleged industrial psychological injuries as frivolous. This is unfortunate, as a recent review written by Schatman and Thoman (2015) strongly supports the position that psychological injuries not only cause emotional suffering but often perpetuate physical suffering as well.

Policy discussions around nuances of compensability are beyond the scope of the present paper. However, to the extent that legal changes may affect quality or access to care, they are

relevant. A major shift in the California Labor Code arrived via California Senate Bill 863 (SB863). Again here, discussions in legal circles have tended to focus on what this means for the financial bottom line and ways to circumvent the system. For example, we came across various online posts discussing the dangers (or merits) of switching to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V; American Psychiatric Association, 2013) given that the potential for the manipulation of codes such as Somatic Symptom Disorder (300.82) to allow clinicians to eke out an existence for physical-mental claims that would have been extinct via SB863. While it is not unheard of for psychologists to assign a diagnosis in cases when the person is on the cusp of meeting diagnostic criteria, to allow the individual to receive services through insurance, such practices are considered fraudulent given that they constitute inaccurate billing and willful misleading of insurance companies (Knapp & Vandecreek, 1993, 2008).

Throughout the present paper, we offer recommendations to increase awareness of and help circumvent inadvertent harm to IWs by clinical psychologists acting as evaluators within the context of the WC system. In our review of relevant (peer-reviewed and professional publications) literature to inform these recommendations, noticeably absent was mention of a specialty group by and for clinical psychologists who work in workers' compensation evaluative settings. Furthermore, such a group or professional society could be instrumental in lobbying and advocating to update current policies that are ethically or professionally precarious. The requirement to have familiarity not only with ethical standards in psychology but also highly specific state regulations and processes for WC settings, coupled with institutional demands and current policies, can open even the most well-intentioned psychologists to missteps. The psychologist interacting with IWs in order to conduct the evaluation is not acting purely within an evaluative bubble; the weight of the evaluation will influence financial compensability to the IW, the decision-making of the WC judge, and the costs to the business and insurance companies. Thus, evaluations are not relevant only via ethical and professional responsibilities of psychologists to IWs, but also to the WC system as a whole (i.e., to applicant and defense attorneys, insurance companies, judges, and the community). Schatman (2009) described that much of what is opined around issues such as "litigation neurosis" (i.e., the iatrogenic psychological symptoms related to the litigation process itself) is based on "theory-rich but evidence poor" data (p. 150). Unfortunately, this is true of many of the well-circulated beliefs about psychological injury. There is a dire need for empirical research to support assertions about psychological injury that often inform policy. Until such research is undertaken, however, psychologists can play an important role in advocacy for the understanding and reputation of psychological injuries in WC.

Compliance with Ethical Standards All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (national and institutional). No animal studies were carried out by the authors for this article.

Conflict of Interest The authors declare that they have no conflict of interest.

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