

Clinical Insights from a Pain Psychologist in the Workers Compensation System

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The International Association for the Study of Pain (IASP) defines pain as "**An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage**". This 2020 revision highlights that pain is personal, subjective, and influenced by biological, psychological, and social factors.

Key Notes on the Revised Definition:

- **Subjectivity:** Pain is always a personal experience influenced by biological, psychological, and social factors.
- **Not Limited to Tissue Damage:** Pain can be present in the absence of actual tissue damage, covering cases where it only "resembles" that associated with damage.
- **Expression:** Inability to communicate verbally does not negate the possibility that an individual is experiencing pain.
- **Learning:** Individuals learn the concept of pain through life experiences.
- **Non-Verbal Indicators:** The definition acknowledges that pain can be expressed in many ways beyond verbal reports.

This definition replaced the 1979 version to be more inclusive of non-verbal patients and modern understandings of pain as a multi-dimensional, rather than solely physical, experience.

MG30 Chronic pain



Pain is an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage. Often, pain serves as a symptom warning of a medical condition or injury. In these cases, treatment of the underlying medical condition is crucial and may resolve the pain. However, pain may persist despite successful management of the condition that initially caused it, or because the underlying medical condition cannot be treated successfully.

Chronic pain is pain that persists or recurs for longer than 3 months. Such pain often becomes the sole or predominant clinical problem in some patients. As such it may warrant specific diagnostic evaluation, therapy and rehabilitation. Chronic pain is a frequent condition, affecting an estimated 20% of people worldwide. It is multifactorial: biological, psychological and social factors contribute to the pain syndrome.

To learn more about chronic pain and the ICD-11 chronic pain classification in general, see [Treede et al., 2019](#).

DEFINITIONS OF Chronic Pain Syndromes

The definitions listed here can be accessed in the ICD-11. ICD-11 is licensed under the CC BY-ND 3.0 IGO, or the “ICD-11 License”, available [here](#).

Reference: International Classification of Diseases, Eleventh Revision (ICD-11), World Health Organization (WHO) 2019/2021 <https://icd.who.int/browse11>. Licensed under Creative Commons Attribution-NoDerivatives 3.0 IGO licence (CC BY-ND 3.0 IGO).

[MG30 Chronic pain](#)

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[MG30.0 Chronic primary Pain](#)

Chronic primary pain is chronic pain in one or more anatomical regions that is characterized by significant emotional distress (anxiety, anger/frustration or depressed mood) or functional disability (interference in daily life activities and reduced participation in social roles). Chronic primary pain is multifactorial: biological psychological and social factors contribute to the pain syndrome. The diagnosis is appropriate independently of identified biological or psychological contributors unless another diagnosis would better account for the presenting symptoms. Other chronic pain diagnoses to be considered are chronic cancer-related pain, chronic postsurgical or posttraumatic pain, chronic neuropathic pain, chronic secondary headache or orofacial pain, chronic secondary visceral pain and chronic secondary musculoskeletal pain. Patients with chronic primary pain often report increased depressed and anxious mood, as well as anger and frustration. In addition, the pain significantly interferes with daily life activities and participation in social roles.

Chronic primary pain is a frequent condition, and treatment should be geared towards the reduction of pain-related distress and disability.

Diagnostic Criteria

Conditions A to C are fulfilled:

1. Chronic pain (persistent or recurrent for longer than 3 months) is present
2. The pain is associated with at least one of the following:

B.1 Emotional distress due to pain is present.

B.2 The pain interferes with daily life activities and social participation.

1. The pain is not better accounted for by another chronic pain condition.

Comments

The presence of pain and emotional distress or interference in daily activities due to pain should be established based on a thorough assessment procedure using standardized measures.

To learn more about chronic primary pain, see [Nicholas et al., 2019](#). Find chronic primary pain and its sublevels in the ICD-11 [here](#).

MG30.3 Chronic secondary musculoskeletal pain

Chronic secondary musculoskeletal pain is chronic pain arising from bone(s), joint(s), muscle(s), vertebral column, tendon(s) or related soft tissue(s). It is a heterogeneous group of chronic pain conditions originating in persistent nociception in joint, bone, muscle, vertebral column, tendon and related soft tissues, with local and systemic etiologies, but also related to deep somatic lesions. If the pain is related to visceral lesions, it should be considered whether a diagnosis of chronic visceral pain is appropriate; if it is related to neuropathic mechanisms, it should be coded under chronic neuropathic pain; and if the pain mechanisms are non-specific, chronic musculoskeletal pain should be coded under chronic primary pain.

Chronic secondary musculoskeletal pain can be characterised either by persistent local or systemic inflammatory illness, which may be due to infectious diseases, crystal deposition or auto-immune processes, or attributable to structural changes.

Other biomedical causes responsible for musculoskeletal pain may also apply (such as neurologically caused muscle spasms and referred pain from deep tissues).

The musculoskeletal origin of the pain (that is, nociception in musculoskeletal tissues) should be highly probable.

If the musculoskeletal origin does not appear highly plausible and no neuropathic origin is ascertainable; consider using codes in the section of chronic primary pain.

Diagnostic Criteria:

Conditions A to C are fulfilled:

1. A) Chronic pain (persistent or recurrent for longer than 3 months) in joint(s), bone(s), muscle(s), vertebral column, tendon(s) or related soft tissue is present. The pain may be spontaneous or movement induced.
2. B) At least one of B1 to B3 is fulfilled:

B1) A musculoskeletal disease with inflammation due to infection, auto-immunity, auto-inflammation or metabolic disorders (crystals) is present (demonstrated by appropriate clinical examination or appropriate tests) and causes the local activation of nociceptors.

B2) A musculoskeletal disease with structural / biomechanical factors (demonstrated by appropriate clinical examination or appropriate tests) is present and causes the local activation of nociceptors.

B3) A neurological disease (classified elsewhere) is present and causes altered biomechanical function (demonstrated by appropriate clinical examination or appropriate tests) that is responsible for the activation of nociceptors.

1. C) The pain is not better accounted for by another diagnosis of chronic pain.

Disorder (which includes *Pseudocyesis*, a false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy).

SOMATIC SYMPTOM DISORDER

The diagnostic criteria for Somatic Symptom Disorder noted in DSM 5 are:

- A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
- B. Excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
 - 1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
 - 2. Persistently high level of anxiety about health or symptoms.
 - 3. Excessive time and energy devoted to these symptoms or health concerns.
- C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Specify if:

With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

Specify if:

Persistent: a persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

Specify if:

Mild: Only one of the symptoms specified in Criterion B is fulfilled.

Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

DSM 5 Somatic Symptom and Related Disorders

The latest edition of DSM 5 has moved away from the need to have no medical explanation in order to make the diagnosis of 'medically unexplained symptoms' and gain access to appropriate treatment. The emphasis now is on symptoms that are substantially more severe than expected in association with distress and impairment. The diagnosis includes conditions with no medical explanation and conditions where there is some underlying pathology but an exaggerated response.

'The major diagnosis in this diagnostic class, *Somatic Symptom Disorder*, emphasises diagnosis made on the basis of positive symptoms and signs (distressing somatic symptoms plus abnormal thoughts, feelings, and behaviours in response to these symptoms) rather than the absence of a medical explanation for somatic symptoms. A distinctive characteristic of many individuals with somatic symptom disorders is not the somatic symptoms per se, but instead the way they present and interpret them.'(APA, 2013)

A new category has therefore been created under the heading '*Somatic Symptom and Related Disorders*'. This includes diagnoses of *Somatic Symptom Disorder*, *Illness Anxiety Disorder*, *Conversion Disorder*, *Factitious Disorder*, and a variety of other related conditions. The term '*Hypochondriasis*' is no longer included. In two of the conditions the absence of any medical pathophysiology is a criteria for diagnosis; these are *Conversion Disorder* and *Other Specified Somatic Symptom and Related*

Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

The expected prevalence of *Somatic Symptom Disorder* stated in DSM 5 is higher than that for *Somatization Disorder* (<1%) but lower than that of *Undifferentiated Somatoform Disorder* (19%). Both are more common in women. Nevertheless, the term *Somatic Symptom Disorder* is considered by DSM 5 to be broadly equivalent to ICD10 F45.1 and ICD9 300.82 *Undifferentiated Somatoform Disorder*, and includes most patients with *Hypochondriasis* ICD 10 F45.21 and ICD 9 300.7.

ILLNESS ANXIETY DISORDER

The diagnostic criteria for *Illness Anxiety Disorder* noted in DSM 5 are:

- A. Preoccupation with having or acquiring a serious illness.
- B. Somatic symptoms are not present or if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
- C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
- D. The individual performs excessive health-related behaviours (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g, avoids doctor appointments and hospitals).
- E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
- F. The illness-related preoccupation is not better explained by another mental disorder, such as *somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type*.

Specify whether:

Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.

Care-avoidant type: Medical care is rarely used.

The important distinction between *Illness Anxiety Disorder* and *Somatic Symptom Disorder* is that with the former, the individual's distress emanates not primarily from the physical complaint itself but rather from his or her anxiety about the meaning, significance, or cause of the complaint. DSM 5 considers the prevalence over 1-2 years to be between 1.3 and 10% of populations, and 6-month to 1 year prevalence to be between 3 and 8%. *Illness Anxiety Disorder* encompasses those patients with *Hypochondriasis*, ICD 10 F45.21, ICD 9 300.7 who do not have somatic symptoms.

CONVERSION DISORDER (FUNCTIONAL NEUROLOGICAL SYMPTOM DISORDER)

The diagnostic criteria for *Conversion Disorder* noted in DSM 5 are:

- A. One or more symptoms of altered voluntary motor or sensory function.
- B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.
- C. The symptom or deficit is not better explained by another medical or mental disorder.
- D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Specify symptom type:

With weakness or paralysis

With abnormal movement

With swallowing symptoms

With speech symptom

With attacks or seizures

With anesthesia or sensory loss

With special sensory symptom

With mixed symptoms

Specify if:

Acute episode: Symptoms present for less than 6 months.

: Symptoms occurring for 6 months or more.

Specify if:

With psychological stressor: (specify stressor).

Without psychological stressor.

Terminology can get confusing when clinicians are describing **Conversion Disorder**. The concept is often considered so difficult to address with the patient, and much terminology inherently pejorative, that physicians may choose obscure terminology to avoid any appearance of directly challenging the patient. Some will choose 'psychogenic', while others chose the more neutral 'functional' (as in abnormal central nervous system function). The term 'functional disorder' is not the same as 'functional overlay' which applies to exaggeration of symptoms as seen in **Somatic Symptom Disorder** and **Factitious Disorder**.

The diagnosis only includes symptoms of a central neurological disorder when clinical findings demonstrate clear incompatibility with neurological disease. There are many classical examples where an individual shows and describes obvious disorders, but when observed at other times or when tested in other ways, they are clearly normal (such as weakness or absence of plantar flexion when lying down, but the ability to walk on tip-toes when standing, or an apparent Grand Mal seizure while responding to commands). The diagnosis does not include disorders such as chronic pain, but **Conversion Disorder** may co-exist with **Somatic Symptom Disorder**. Co-morbidity with anxiety disorders and depressive disorders is common.

Conversion disorder is often associated with dissociative symptoms, and it is often associated with stressful life events and maladaptive personality traits. It is important to distinguish it from **Factitious Disorder** and Malingering. DSM 5 considers the prevalence to be around 5% of referrals to neurology clinics, with an annual incidence in the general population of 2-5/100,000.

Conversion Disorder is classified as ICD 10 F44.4-7 (depending on symptom type), ICD 9 300.11.

PSYCHOLOGICAL FACTORS AFFECTING OTHER MEDICAL CONDITIONS

The diagnostic criteria for *Psychological Factors Affecting Other Medical Conditions* noted in DSM 5 are:

- A. A medical symptom or condition (other than a mental disorder) is present.
- B. Psychological or behavioural factors adversely affect the medical condition in one of the following ways:
 - 1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
 - 2. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
 - 3. The factors constitute additional well-established health risks for the individual.
 - 4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.
- C. The psychological and behavioural factors in Criterion B are not better explained by another mental disorder (e.g., *panic disorder*, *major depressive disorder*, *posttraumatic stress disorder*).

Specify current severity:

: Increases medical risk (e.g., inconsistent adherence with antihypertension treatment).

Aggravates underlying medical condition (e.g., anxiety aggravating asthma).

: Results in medical hospitalization or emergency room visit.

: Results in severe, life-threatening risk (e.g., ignoring heart attack symptoms)

This diagnosis should be reserved for situations in which the effect of the psychological factor on the medical condition is evident, and the psychological factor has clinically significant effects on the course or outcome of the medical condition. Individuals who develop anxiety as a consequence of a condition should be diagnosed with ***Adjustment Disorder***. While the prevalence is not clear, DSM 5 notes that it is more common than ***Somatic Symptom Disorder***. The most frequently seen examples are likely to be avoidance of or poor adherence to treatment because of anxiety, and avoiding investigations when a serious condition is suspected.

Psychological Factors Affecting Other Medical Conditions is classified as ICD 10 F54, ICD 9 316.

FACTITIOUS DISORDER

The diagnostic criteria for Factitious Disorder noted in DSM 5 are:

Factitious Disorder Imposed on Self

- A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
- B. The individual presents himself or herself to others as ill, impaired, or injured.
- C. The deceptive behavior is evident even in the absence of obvious external rewards.
- D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Specify:

Single episode

Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

Factitious Disorder Imposed on Another (Previously Factitious Disorder by Proxy)

- A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
- B. The individual presents another individual (victim) to others as ill, impaired, or injured.
- C. The deceptive behavior is evident even in the absence of obvious external rewards.
- D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Note: The perpetrator, not the victim, receives this diagnosis.

Specify:

Single episode

Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

The essential feature is falsification of medical or psychological signs and symptoms. The diagnosis requires demonstrating that the individual is taking surreptitious actions to misrepresent, simulate, or cause signs or symptoms of illness or injury in the absence of obvious external rewards. It includes false reporting of facts such as symptoms, events, and investigation results. Individuals are at great risk of harm through inappropriate diagnoses and treatments, as well as from induced injury and disease. The condition is usually one of intermittent episodes. Persistent unremitting episodes, and single episodes, are less common. DSM 5 estimates the prevalence of 1% in hospital settings although it is very difficult to achieve an objective measure in a condition where deception is a key criterion. An important differential diagnosis is malingering, where there is personal gain such as financial gain or time off work. There needs to be an absence of obvious rewards in order to meet the diagnostic criteria.

Factitious Disorder is classified as ICD 10 F68.10, ICD 9 300.19.

OTHER SPECIFIED SOMATIC SYMPTOM AND RELATED DISORDER

DSM 5 notes that this category applies to presentations in which symptoms characteristic of a **somatic symptom and related disorder** that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the **somatic symptom and related disorders** diagnostic class. Examples include:

1. **Brief somatic symptom disorder:** Duration of symptoms is less than 6 months.
2. **Brief illness anxiety disorder:** Duration of symptoms is less than 6 months.
3. **Illness anxiety disorder without excessive health-related behaviours:** Criterion D for illness anxiety disorder is not met.
4. **Pseudocyesis:** A false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy.

These are classified as **Other Somatoform Disorders** ICD 10 F45.8, ICD 9 300.89.

UNSPECIFIED SOMATIC SYMPTOM AND RELATED DISORDER

DSM 5 reserves this category for rare occasions where there are predominantly somatic symptoms but there is insufficient information to make a more specific diagnosis. These are classified as ICD 10 F45.9 and ICD 9 300.82.

APA 2013. *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders*, Arlington, VA, American Psychiatric Association.

WAC 296-14-300

Mental Condition/Mental Disabilities.

(1) Claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of an occupational disease.

Examples of mental conditions or mental disabilities caused by stress that do not fall within occupational disease shall include, but are not limited to, those conditions and disabilities resulting from:

- (a) Change of employment duties;
- (b) Conflicts with a supervisor;
- (c) Actual or perceived threat of loss of a Job, demotion, or disciplinary action;
- (d) Relationships with supervisors, coworkers, or the public;
- (e) Specific or general job dissatisfaction;
- (f) Work load pressures;
- (g) Subjective perceptions of employment conditions or environment;
- (h) Loss of job or demotion for whatever reason;
- (i) Fear of exposure to chemicals, radiation biohazards, or other perceived hazards;
- (j) Objective or subjective stresses of employment;
- (k) Personnel decisions;
- (l) Actual, perceived, or anticipated financial reversals or difficulties occurring to the businesses of self-employed individuals or corporate officers.

(2)(a) Stress resulting from exposure to a single traumatic event will be adjudicated as an industrial injury. See RCW 51.08.100.

(b) Examples of single traumatic events include: Actual or threatened death, actual or threatened physical assault, actual or threatened sexual assault, and life-threatening traumatic injury.

(c) These exposures must occur in one of the following ways:

(i) Directly experiencing the traumatic event;

(ii) Witnessing, in person, the event as it occurred to others; or

(iii) Extreme exposure to aversive details of the traumatic event.

(d) Repeated exposure to traumatic events, none of which are a single traumatic event as defined in subsection (2)(b) and (c) of this section, is not an industrial injury (see RCW 51.08.100) or an occupational disease (see RCW 51.08.142). A single traumatic event as defined in subsection (2)(b) and (c) of this section that occurs within a series of exposures will be adjudicated as an industrial injury (see RCW 51.08.100).

(3) For certain firefighters, law enforcement officers, and direct care registered nurses there is a presumption that posttraumatic stress disorder (PTSD) is an occupational disease as provided by RCW 51.08.142, 51.32.185, and 51.32.395.

(4) For public safety telecommunicators, PTSD may be considered an occupational disease as provided by RCW 51.08.142.

(5) Mental conditions or mental disabilities that specify pain primarily as a psychiatric symptom (e.g., somatic symptom disorder, with predominant pain), or that are characterized by excessive or abnormal thoughts, feelings, behaviors or neurological symptoms (e.g., conversion disorder, factitious disorder) are not clinically related to occupational exposure.

Impairments of mental health.

Rules for evaluation of permanent impairment of mental health:

(1) Mental illness means malfunction of the psychic apparatus that significantly interferes with ordinary living.

(2) Each person has a pattern of adjustment to life. The pattern of adjustment before the industrial injury or occupational disease serves as a base line for all assessments of whether there has been a permanent impairment due to the industrial injury or occupational disease.

(3) To determine the preinjury pattern of adjustment, all evaluations of mental health shall contain a complete preinjury history including, but not necessarily limited to: Family background and the relationships with parents or other nurturing figures; extent of education and reaction to it; military experience, if any; problems with civil authorities; any history of prolonged illness, and difficulty with recovery; any history of drug abuse or alcoholism; employment history, the extent of and reaction to responsibility, and relationships with others at work; capacity to make and retain friends; relationships with spouses and children; nature of daily activities, including recreation and hobbies; and lastly, some summary statement about the sources of the patient's self-esteem and sense of identity. Both strengths and vulnerabilities of the person shall be included.

(4) Differences in adjustment patterns before and after the industrial injury or occupational disease shall be described, and the report shall contain the examining physician's opinion as to whether any differences:

(a) Are the result of the industrial injury or occupational disease and its sequelae, in the sense they would not have occurred had there not been the industrial injury or occupational disease;

(b) Are permanent or temporary;

(c) Are more than the normal, self-correcting and expectable response to the stress of the industrial injury or occupational disease;

(d) Constitute an impairment psychosocially or physiologically; and

(e) Are susceptible to treatment, and, if so, what kind. The presence of any unrelated or coincidental mental impairment shall always be mentioned.

(5) All reports of mental health evaluations shall use the diagnostic terminology listed in the edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* designated by the department.

(6) No classification of impairment shall be made for complaints where the quality of daily life does not differ substantially from the preinjury pattern. A patient not currently employed may not engage in the same activities as when working, but the level and variety of his activities and zest for them shall distinguish the purely situational difference from cases of regression and withdrawal. In cases where some loss of use of body member is claimed, no category or impairment shall be assigned unless there are objective findings of physiologic regression or consistent evidence of altered adaptability.

(7) The physician shall identify the personality disorders as defined in the edition of the DSM designated by the department. Patients with these longstanding character disorders may show problem behavior that seems more related to current stress than it is, sometimes unconsciously insinuating themselves into difficult situations of which they then complain.

Emotional reactions to an injury and subsequent events must be carefully evaluated in these patients. It must be medically probable that such reactions are permanent before a category of impairment can be attributed to the injury; temporary reactions or preexisting psychopathology must be differentiated.

[Statutory Authority: RCW **51.04.020**, **51.04.030**, and **51.08.142**. WSR 15-19-139, § 296-20-330, filed 9/22/15, effective 10/23/15; Order 74-32, § 296-20-330, filed 6/21/74, effective 10/1/74.]

Categories for evaluation of permanent impairments of mental health.

(1) Nervousness, irritability, worry or lack of motivation following an injury and commensurate with it and/or other situational responses to injury that do not alter significantly the life adjustment of the patient may be present.

(2) Any and all permanent worsenings of preexisting personality traits or character disorders where aggravation of preexisting personality trait or character disorder is the major diagnosis; mild loss of insight, mildly deficient judgment, or rare difficulty in controlling behavior, anxiety with feelings of tension that occasionally limit activity; lack of energy or mild apathy with malaise; brief phobic reactions under usually avoidable conditions; mildly unusual and overly rigid responses that cause mild disturbance in personal or social adjustment; rare and usually self-limiting psycho-physiological reactions; episodic hysterical or conversion reactions with occasional self-limiting losses of physical functions; a history of misinterpreted conversations or events, which is not a preoccupation; is aware of being absentminded, forgetful, thinking slowly occasionally or recognizes some unusual thoughts; mild behavior deviations not particularly disturbing to others; shows mild over-activity or depression; personal appearance is mildly unkempt. Despite such features, productive activity is possible most of the time. If organicity is present, some difficulty may exist with orientation; language skills, comprehension, memory; judgment; capacity to make decisions; insight; or unusual social behavior; but the patient is able to carry out usual work day activities unassisted.

(3) Episodic loss of self-control with risk of causing damage to the community or self; moments of morbid apprehension; periodic depression that disturbs sleep and eating habits or causes loss of interest in usual daily activities but self-care is not a problem; fear-motivated behavior causing mild interference with daily life, frequent emotogenic organ dysfunctions requiring treatment; obsessive-compulsive reactions which limit usual activity; periodic losses of physical function from hysterical or conversion reactions; disturbed perception in that patient does not always distinguish daydreams from reality; recognizes his fantasies about power and money are unusual and tends to keep them secret; thought disturbances cause patient to fear the presence of serious mental trouble; deviant social behavior can be controlled on request; exhibits periodic lack of appropriate emotional control; mild disturbance from organic brain disease such that a few work day activities require supervision.

(4) Very poor judgment, marked apprehension with startle reactions, foreboding leading to indecision, fear of being alone and/or insomnia; some psychomotor retardation or suicidal preoccupation; fear-motivated behavior causing moderate interference with daily life; frequently recurrent and disruptive organ dysfunction with pathology of organ or tissues; obsessive-compulsive reactions causing inability to work with others or adapt; episodic losses of physical function from hysterical or conversion reactions lasting longer than several weeks; misperceptions including sense of persecution or grandiosity which may cause domineering, irritable or suspicious behavior; thought disturbance causing memory loss that interferes with work or recreation; periods of confusion or vivid daydreams that cause withdrawal or reverie; deviations in social behavior which cause concern to others; lack of emotional control that is a nuisance to family and associates; moderate disturbance from organic brain disease such as to require a moderate amount of supervision and direction of work day activities.

(5) Marked apprehension so as to interfere with memory and concentration and/or to disturb markedly personal relationships; depression causing marked loss of interest in daily activities, loss of weight, unkempt appearance, marked psycho-motor retardation, suicidal preoccupation or attempts, or marked agitation as well as depression; marked phobic reactions with bizarre and disruptive behavior; psychophysiological reactions resulting in lasting organ or tissue damage; obsessive-compulsive reactions that preclude patient's usual activity; frequent or persistent loss of function from conversion or hysterical reactions with regressive tissue or organ change; defects in perception including frank illusions or hallucinations occupying much of the patient's time; behavior deviations so marked as to interfere seriously with the physical or mental well-being or activities of others; lack of emotional control including marked irritability or overactivity.

[Order 74-32, § 296-20-340, filed 6/21/74, effective 10/1/74.]

Mental condition/mental disabilities.

(1) Claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of an occupational disease in RCW **51.08.140**.

Examples of mental conditions or mental disabilities caused by stress that do not fall within occupational disease shall include, but are not limited to, those conditions and disabilities resulting from:

- (a) Change of employment duties;
- (b) Conflicts with a supervisor;
- (c) Actual or perceived threat of loss of a job, demotion, or disciplinary action;
- (d) Relationships with supervisors, coworkers, or the public;
- (e) Specific or general job dissatisfaction;
- (f) Work load pressures;
- (g) Subjective perceptions of employment conditions or environment;
- (h) Loss of job or demotion for whatever reason;
- (i) Fear of exposure to chemicals, radiation biohazards, or other perceived hazards;
- (j) Objective or subjective stresses of employment;
- (k) Personnel decisions;
- (l) Actual, perceived, or anticipated financial reversals or difficulties occurring to the businesses

(2)(a) Stress resulting from exposure to a single traumatic event will be adjudicated as an industrial injury. See RCW **51.08.100**.

(b) Examples of single traumatic events include: Actual or threatened death, actual or threatened physical assault, actual or threatened sexual assault, and life-threatening traumatic injury.

(c) These exposures must occur in one of the following ways:

(i) Directly experiencing the traumatic event;

(ii) Witnessing, in person, the event as it occurred to others; or

(iii) Extreme exposure to aversive details of the traumatic event.

(d) Repeated exposure to traumatic events, none of which are a single traumatic event as defined in subsection (2)(b) and (c) of this section, is not an industrial injury (see RCW **51.08.100**) or an occupational disease (see RCW **51.08.142**). A single traumatic event as defined in subsection (2)(b) and (c) of this section that occurs within a series of exposures will be adjudicated as an industrial injury (see RCW **51.08.100**).

(3) Mental conditions or mental disabilities that specify pain primarily as a psychiatric symptom (e.g., somatic symptom disorder, with predominant pain), or that are characterized by excessive or abnormal thoughts, feelings, behaviors or neurological symptoms (e.g., conversion disorder, factitious disorder) are not clinically related to occupational exposure.

[Statutory Authority: RCW **51.04.020**, **51.04.030**, and **51.08.142**. WSR 15-19-139, § 296-14-300, filed 9/22/15, effective 10/23/15. Statutory Authority: Chapters **51.08** and **51.32** RCW. WSR 88-14-011 (Order 88-13), § 296-14-300, filed 6/24/88.]

Questions?