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The Bio vs. Psycho vs. Social Model of Psychopathology, and the Neglected Issues of the "Passive and Convenient Focus" and the Use of Psychological Defense Mechanisms

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For several decades, it has been the formally accepted premise of psychiatric theory that a comprehensive psychiatric evaluation involves consideration of all relevant "bio-psycho-social" factors. This involves fully taking into account and considering "biological" factors, which include biochemical substrates of affect and behavior; innate neurologically-determined temperament, neurophysiological phenomena, hormonal effects, and the impact upon psychological functioning and symptomatology of medical conditions, symptoms, and illnesses. At the same time, there must be the careful evaluation of "psychological" factors, which include underlying emotional conflicts (which are ubiquitous to the human condition), basic personality traits, personal psychodynamics, the intrapsychic use of defense mechanisms, and the subjective experiences and perceptions of the patient. Finally, there must be a full appreciation of objective external (i.e., "social") issues such as "stress", trauma, the quality of interpersonal relationships and interactions, family dynamics and socio-cultural influences. Theoretically, only through an integrated analysis of all of these factors, can an accurate psychiatric evaluation be completed – and only at that point, can there be a comprehensive case formulation, which addresses the nature and etiology of any psychopathology present, as well as indicated psychotherapeutic, psychopharmacological and/or behavioral/psycho-social interventions.

However, in current clinical practice, and particularly within the medical-legal arena (*especially in my experience working within the California Workers Compensation system*), it seems that such comprehensive evaluations are rare, and more often than not, the biological, psychological and psychosocial contributions to a person's problems, even if individually appreciated, are implicitly seen as independent variables rather than being recognized as *interdependent* aspects of psychopathology which need to be integrated. Often, each area is evaluated or clinically addressed by different "specialists" or "sub-specialists"; and quite often, depending upon the circumstances of

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the evaluation and/or the bias of the evaluator, at least one of the three areas are completely ignored, not infrequently in the service of arriving at a simple medical-legal conclusion, or “plugging” a patient into a rather simplistic protocol of counseling and/or psychopharmacological intervention.

Often within the medical-legal system (and within the “managed care”-based system as a whole), clinically, psychiatric symptoms are addressed primarily through psychopharmacological intervention, without attention to any intrapsychic or psychosocial issues. When there is psychotherapeutic intervention, it often takes the form of very basic supportive counseling, or what is often labeled as “cognitive/behavioral therapy” – but what in actuality, is little beyond basic supportive counseling, with perhaps some therapeutic “advice” regarding changing some simple behavioral patterns. At the same time, within written medical-legal evaluation reports, an opinion regarding what is known in medical legal terms as “Causation” – which realistically, is not at all different from the clinical term “etiology” – may be offered based totally upon the situational (workplace) issues which are driving the litigation, without reference to any evaluation of underlying psychodynamics, and without consideration of other (personal) psycho-social issues. This focus on “stress”, that is, specific situational events, often occurs even while the treatment being provided to the patient is primarily or exclusively psychopharmacological intervention. This creates the implications that addressing situational problems is primarily an issue of pharmacologically containing secondary symptomatology. Obviously, this is both illogical, and untrue. All too often, the patient is further confused, reinforced in their sense of entitlement, or even “victimized” by this paradoxical medical-legal approach.

Similarly, not infrequently there is a narrow focus upon the situation at the heart of the litigated alleged injury – be it a “stress claim” secondary to an industrially-related physical injury, or a claim of injury due to workplace administrative actions, or interpersonal disputes between a person and their co-workers or supervisors. Even concurrent unrelated medical issues, which may be impacting the patient’s affective functioning – but which are not the focus of the litigated medical-legal issues at hand – are neglected and left poorly if at all considered, in the determination of a diagnosis, the etiology/Causation of that diagnosis, and an appropriate treatment plan.

Additionally, it is not unusual for there to be medical-legal reports which seem to give some credence to the issues of underlying intrapsychic issues and inner emotional states, but only in a very superficial manner, demonstrating a significant lack of insight into the understanding of the interactions between intrapsychic identity, “self-esteem”, unresolved emotional conflicts, and the use of psychological defenses. A report may attribute all of a patient’s problems to a specific situational “stress” or “trauma”, and claim that this has resulted in what is essentially an intrapsychic problem related to narcissistic injury, but with the report only describing essentially in lay terms a “loss of self-esteem”, with no exploration or elaboration. The concomitant case discussion,

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treatment plan, and clinical treatment notes often indicate that the patient is being “treated” with a primary focus of chemically manipulating neurotransmitters to reduce manifest affective symptomatology (which may be significant, or which may actually be rather minor emotional discomfort and anger related to a sense of narcissistic injury), without any attention to the complexity of the sources of “stress” or trauma; with psychopharmacological intervention perhaps accompanied by some simple “stress-reduction” and “cognitive-behavioral” interventions, but without any attention to, or understanding of, the underlying emotional conflicts and intrapsychic phenomena (psychodynamics) – which are actually the deeper determinants of the reaction to the perceived narcissistic threat which has led to the emergence of disruptive symptomatology.

Evaluations often neglect to address the fact that the patient who is being evaluated is an individual who not only has a unique constitutional/biological makeup relevant to determining the prescription of psychotropic medications; but who also has a unique psychosocial history, with related underlying emotional conflicts and ambivalent feelings; and who brings to the situation at hand a pre-existing personality structure, based upon the use of an array of psychological defenses, some being mature and effective – some being immature, and at least intermittently, dysfunctional. Within most reports, there is no evaluation or discussion of the use of even basic defenses such as denial, repression, suppression, displacement or projection – let alone more complex and problematic defenses such as splitting, projective identification, dissociation, or self-defeating, “masochistic” acting out.

Within the medical-legal milieu, when examining a patient who has claimed to have suffered a psychiatric injury which is in effect being “blamed” upon some specific course of external events or interpersonal interactions, while it is necessary to objectively evaluate the reported situation in question, it is also necessary to understand the context in which the situation has arisen, vis-à-vis the person’s personal life history and circumstances, and the personality structure and use of psychological defenses the patient brings to the situation. It is usually deferred to a “Trier of Fact” to determine the objective reality of the actual events in question, but there should be consideration by mental health experts regarding *how and why* those events have created the *particular* emotional impact and symptomatology in question. At times, this requires laying out different scenarios, based upon what the objective reality of the external events may be found to have been (based upon objective investigation) – as opposed to merely accepting at face value the *perception* of events described by the patient. While the patient’s *perception* may be key to understanding *some* aspects of their emotional reaction – evaluating and understanding the psychological defenses which may have had a significant impact upon *creating* that perception is at least equally as important in arriving at an objective evaluation of the etiology of the symptomatology, and the indicated course of mental health treatment. Often, when the issue revolves around a physical injury, rather consistently, non-mental health medical practitioners attribute any

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emotional difficulties only to the specific physical condition they are treating, without any consideration of other issues – and not infrequently, treating mental health professionals simply (naïvely or disingenuously) accept these assumptions as the basis for the intervention they are to provide. Similarly, when the issues revolve around interpersonal events, the discussion focuses only on the most proximately identified events, and chiefly the behaviors of others, rather than investigating the totality of the nature and quality of patient’s personal relationships and interpersonal attributes and skills, which they bring to interactions with others – whether the other party happens to be more or less “mature” or “dysfunctional”.

It is rather simple to take a narrow approach, and draw a superficial formulation between a specific “stress” and current symptomatology. But this is often misleading, or overtly inaccurate. The more difficult aspect of an appropriate evaluation is to determine the extent to which the attempt to attribute all current emotional distress and/or disability and impairment to those specific circumstances which are the focus of litigation, may actually be impacted by the patient’s use of unconscious psychological defenses. In fact, it is quite common that after an objective and comprehensive evaluation, those intrapsychic issues turn out to become central, and more relevant to the development of symptomatology, than the manifest external “causes” which form the basis of the legal claim.

For example, while we may classically think of “projection” as being related to clinical paranoia, and “dissociation and “splitting” as being related to persons who harbor overt, “full-blown” borderline personality disorders – a less intense (essentially “neurotic”, if I may use the term) use of those defenses is ubiquitous, and may well be reinforced in a patient by his or her legal representatives and treating practitioners, in the course of medical-legal litigation, either unintentionally (or unconsciously), or intentionally (and disingenuously).

Simply put, just because “stressful” or even “traumatic” events have objectively occurred, does not rule out the simultaneous use of less-than-optimally mature defense mechanisms, which can exacerbate symptomatology and stymie mental health treatment, and which must be appropriately taken into account in developing a formulation regarding etiology, medical-legal responsibility, and the development of an effective mental health treatment strategy.

Thus, the external scenario in question must be explored as to whether objective events 1) of themselves were of such a traumatic or disruptive nature, as to induce a breakdown of previously generally effective psychological defenses, resulting in the emergence of symptomatology; 2) whether the actual events in some combination with pre-existing underlying emotional conflicts, and vulnerabilities borne out of partially or significantly dysfunctional psychological defenses, have led to the manifest pathology; or, 3) if the external events were objective rather typical life “stresses”, i.e., reasonably

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benign frustrations, which have served as a “passive and convenient focus” for the acting out and elaboration of unresolved intrapsychic conflict, with symptom formation being either the direct result of the use of those dysfunctional defenses, and/or the presence of internal (often unconscious) ambivalence regarding the use of those defenses. That is, it must be determined if the external events in question were actually causative, or merely a stage upon which pre-existing unresolved intrapsychic pain and conflicts are able to be acted out for primary and secondary gain. Using a chemical analogy – were the situational events in question essentially an inactive catalyst; or an active participation in the development *de novo* of a pathological process and related symptomatology, where none was present previously, and none would have been present but for the circumstances in question.

To reiterate, this issue is not only crucial to the medical-legal question of the compensability/Causation, but this issue is clinically crucial to provision of effective treatment. To ignore the presence of projections, displacements, rationalizations or splitting, is to reinforce pathology, rather than to treat the underlying dysfunction. The validation of distortions caused by psychological defenses may, in the short term, provide a sense of “support”, and thus decrease acute affective symptomatology. That is, a person may feel “comforted” and less overtly anxious or depressed, when perceiving that their doctor/therapist and/or attorney support and “believe in” their complaints and allegations. Yet concurrently, the underlying pathology may actually be intensified by that process, leaving the person less likely to resolve their conflicts, less likely to develop more effective coping mechanism, and more likely to have similar problems in the future.

This is a problem not only related to the medical-legal evaluation process, but also, often the patient has been steered into the medical-legal arena by a well-meaning doctor or therapist who is naïve to the underlying psychological/intrapsychic issues; or by a managed care/HMO setting which can reduce their own treatment costs by suggesting patients file Workers Compensation claims, when a prompt referral for a comprehensive psychiatric evaluation and provision of informed mental health treatment might have provided a relatively prompt reduction in symptomatology and impairment, and an improvement in the patient’s long-term state of emotional health – while avoiding the need for involvement in a protracted (and often dysfunctional) medical-legal process. At the same time, “defense” evaluators may neglect and underestimate the actual impact of objective events and may fail to fully address the intrapsychic conflicts present, relying on an “easier” defense of focusing on the presence of pre-existing “affective disorders” – for which it is then suggested that appropriate psychopharmacological intervention (on a non-industrial basis) would solve the problem – which only gives the patient false hope. Additionally, there is the unfortunate situation when non-psychiatric physicians embark on a course of treatment for somatic complaints, not infrequently including the prescription of psychoactive drugs (which themselves may be depressogenic or disinhibiting) along with psychotropic medications,

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and although recognizing that there is “psychological overlay”, they still fail to refer the patient for comprehensive psychiatric evaluation and treatment, which might offer real hope of leading to lasting clinical improvement.

Thus, whether or not the person “wins the case” in a court of law, ironically, the patient has become even more of a “victim”, and has effectively “lost the case” vis-à-vis receiving effective mental health treatment.