

**CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**

**How Should Clinicians Determine a Traumatized Patient's Readiness to Return to Work?**

Tabitha E. H. Moses, MS and Arash Javanbakht, MD

**Abstract**

A clinician's standard primary role is to treat and monitor their patients' health and to be their ally. Clinicians with obligations to patients and to organizations, however, must also assess patients for nontherapeutic purposes (eg, readiness to resume work). These 2 obligations can conflict, and, when they do, clinicians must balance their duties to patients and to society. We propose criteria clinicians should consider when determining a patient's readiness to return to work and offer recommendations for interpreting factors that influence this decision.

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**Case**

In the United States, police brutality is a leading cause of death among young men,<sup>1</sup> a fact well-known to Dr Z, a mental health clinician with many years' experience working with law enforcement officers in clinic- and field-based settings. Dr Z has been caring for TW since TW was shot while pursuing an alleged perpetrator last year in a city neighborhood of predominantly Black American residents.

TW has healed physically and has recovered preinjury levels of mobility and agility. But TW still experiences intense, prolonged distress when discussing details of the shooting, recurrent "night terrors" (replaying the incident), and inability to fall back asleep due to feeling hypervigilant. TW tries to avoid anyone who talks about Black Lives Matter (BLM) and is triggered to anger quickly by BLM banners in public spaces or on social media posts. Dr Z is concerned that TW's ability to regulate intense stress remains compromised by chronically heightened fight-or-flight responses<sup>2,3</sup> and is not at all convinced that TW is psychologically ready to return to community policing duties, particularly in the neighborhood that TW patrolled before the shooting.

In recent prior sessions, Dr Z has suggested that TW consider returning to the department but not to community policing just yet. TW has not expressed openness to an ease-in transition back to work and becomes increasingly irritated when Dr Z mentions this possibility again. TW responds, "I know you think I'm not ready because I

have the night terrors. Maybe I need to stop telling you about those. They're not real. They're just dreams! I don't want to push papers around or do a desk job. I feel good and I'm ready to get back out there now." Dr Z considers how to respond.

### Commentary

Mental health clinicians are commonly asked to complete fitness-for-duty evaluations by police departments when there is a question about whether officers can safely carry out their job requirements and duties. Although these types of evaluations also give rise to concerns about employment discrimination due to real or perceived disability<sup>4,5,6,7,8</sup>—which is especially pertinent to professions such as law enforcement and medicine wherein the lives of others are affected<sup>9,10,11</sup>—the issues of fitness for duty and employment discrimination are separate. It is important to highlight that the purpose of this evaluation is not simply to identify whether a person has a psychiatric disorder; it is about **determining risks** associated with a person's behaviors, how to identify behaviors that could be dangerous in a line of work, and whether there are ways to mitigate harms so that a person can return to work safely. The goals of this commentary are to examine potential conflicts and clinicians' roles in performing fitness-for-duty evaluations and to offer criteria to inform clinicians' decisions about a traumatized officer's readiness to return to community policing.

### Potential Conflicts

A central question concerns clinicians' roles in balancing patients' needs against those of the community. At first glance, one might assume this task to be simple: needs of one (officer) vs needs of many (community members). However, these needs are not actually in conflict. The major risk arising from officers prematurely returning to their extremely demanding and often high-risk work is to the mental and physical safety of the officers themselves, not only those they aim to protect. The needs of officers and communities are actually aligned.

Another possible conflict arises from clinicians serving 2 roles: primary mental health caregiver and judge of readiness to return to work. This case demonstrates the risks of this dual role, as conflict between these roles can **undermine a therapeutic relationship** and create communication pitfalls. TW appears to believe that Dr Z's concern about their readiness to return to work is solely based on night terror symptoms and expresses distrust, which is made evident by TW saying "maybe I need to stop telling you about those." If Dr Z's concerns are grounded in other symptoms, there has been a communication failure as well as erosion of the therapeutic relationship. Finally, we cannot ignore context. This case arises in 2020, when there is **increased awareness** of unjust violence against people of color, distrust of police, and very high levels of general civil unrest.<sup>12,13,14</sup> Increasingly, negative views of law enforcement have resulted in significant officer demoralization,<sup>15,16</sup> which might affect TW's reaction to Dr Z and hence undermine the therapeutic relationship.

We must recognize the role of social context and understand that, regardless of clinicians' efforts to remain impartial, their personal experiences and interpretations of world events can color their judgment. Neither a decision regarding readiness to return to work nor a conversation about which criteria should be used to make this decision exist in isolation. We must look outside therapeutic sessions to fully consider this case in social context and identify criteria that should inform clinicians' decisions. For the case provided, we do not have sufficient information to make concrete determinations about the therapeutic relationship (or lack thereof), TW's risk to self or others, or TW's

ability to return to active duty. Nonetheless, the case lays a foundation for a conversation about criteria to use in return-to-work determinations and for developing practice recommendations.

### **Clinicians' Roles**

A first consideration is how clinicians should manage their apparent dual role as a mental health caregiver and a judge of readiness to return to work. In standard therapeutic relationships, the clinician's role is to diagnose and treat, so clinicians must create open, trusting therapeutic relationships in order for patients to perceive them as allies. When a clinician must also assess patients for nontreatment purposes, trust can be jeopardized. This confusion of roles and perceived loyalties might affect the way patients interact with clinicians: they might see a clinician as a judge rather than an ally, which could result in their withholding key information. Thus, whenever possible, clinicians should aim to serve in only one capacity: either as a psychiatric caregiver or as an evaluator for an external entity (eg, an employer or an insurance company). However, when clinicians do undertake both roles simultaneously (eg, due to lack of community resources), they must communicate clearly and share decisions to promote the best interests of all involved.

A next step is to consider the purpose of an evaluation. Typically, clinicians are asked by employers to evaluate an employee's fitness to return to work because premature return to work could result in harm, either to an employee or to those with whom they work. For physical injuries (eg, a broken limb), it is relatively simple to follow treatment guidelines and identify when an injury is healed.<sup>17</sup> It is not so simple for psychological injuries. Diagnosis of a psychiatric disorder or prediction of psychiatric symptom development depends on a patient's subjective report and a clinician's subjective observations, both of which can be affected by cognitive and emotional context. By developing a therapeutic alliance and joint understanding of risks and benefits of returning to work, clinician and patient can usually collaborate on a solution without pitting the needs of the community against those of the patient. These 2 considerations—the risks and benefits of returning to work and the cognitive and emotional context of the evaluation—are discussed in more detail below.

### **Balancing Risks**

In this case, one risk to avoid is to community members; it is easy to recall recent articles about police brutality, accidental shootings, and harms to communities of color.<sup>15,16,17</sup> Risk evaluation should be intentionally divorced from the clinician's own beliefs.<sup>18</sup> Although consideration of community- and social-level harms is crucial, we cannot overlook the potential harm to the officer in returning to work. After a traumatic experience, if the officer is not ready to face trauma reminders, returning to work may worsen symptoms.<sup>9,19</sup> Furthermore, if the officer's symptoms result in a harmful or fatal mistake, the officer is likely to suffer long-lasting negative sequela. Officers who kill in the line of duty—even to protect their own life or the lives of others—often experience long-term guilt and negative consequences.<sup>20,21,22</sup> Finally, when officers interact with violent individuals, any distraction could have deadly consequences. In every case, risks to the individual, that individual's colleagues, and the community will differ, but the potential for harm to all involved must be considered. It must be underscored that adopting a paternalistic attitude during the evaluation is inappropriate, as the clinician should not make return-to-work decisions alone. Rather, the clinician should discuss concerns with the patient to ensure that the patient understands the evidence behind any reservations the clinician might have about the patient's return to work. The

clinician's ability to help the patient understand the potential risks of premature return to work is a vital component of developing the patient-clinician alliance. The goal is to support patient autonomy and for both parties to be in agreement about the plan for the patient's return to work.

### **Symptom Context and Strategies**

Although the exact processes by which psychological injuries heal is murky, it is possible to use neuroscientific research to develop practical criteria for determining readiness to return to work. During stress, the autonomic nervous system activates the fight-or-flight response via the sympathetic nervous system (SNS), resulting in symptoms typically associated with stress (eg, elevated heart rate).<sup>20,21</sup> SNS activation also affects the brain, resulting in altered functionality across multiple cognitive domains.<sup>23,24,25</sup> One pathway commonly affected by stress is executive functioning.<sup>22,26</sup> Executive functioning encompasses a series of cognitive skills that allow individuals to plan and control behavior<sup>27</sup>; exposure to acute stressors can significantly impair executive functioning.<sup>28</sup> Although small amounts of stress can be beneficial, too much uncontrolled stress can impair attention and memory and make a person more likely to respond inappropriately.<sup>23,24,26,29</sup> Moreover, a person who has undergone trauma can experience hyperarousal,<sup>25</sup> which can accentuate the effects of stressful situations<sup>28,30</sup> and increase sensitivity to trauma-related triggers, which in turn can lead to impulsive responses.<sup>31,32,33,34</sup>

Immediate responses to stress can also be dramatically altered by mindset. For example, negative mood increases the likelihood that a person will identify neutral situations as negative.<sup>27,35</sup> Diminished executive functioning combined with low mood can be particularly problematic; in police officers, decreased working memory, combined with negative mood, is associated with an increased likelihood of shooting errors.<sup>36</sup> These are not the only relevant neural factors, but they are key to gauging risk.

Fortunately, emotions do not define behavior. High-risk emotional responses must be evaluated against a wider backdrop of behavior and circumstances. Although a patient might be quick to anger, responding with anger in a given situation does not always mean anger is unwarranted or disproportionate. In fact, it's not anger, but the patient's response to anger—both immediately and upon reflection—that matters. Individuals who have responded with anger after trauma are more likely to respond with violence in the future.<sup>37,38</sup> Patients' emotional awareness lays the foundation for their ability to respond in constructive and healthy ways to negative emotions. Patients who carefully consider symptoms, their causes, and how to mitigate them demonstrate greater emotional awareness. In the case, TW appears to recognize and verbalize triggers (BLM banners and posts) and associated negative responses (anger). A next step would be for Dr Z to identify positive strategies (eg, mindfulness practice, skills learned during cognitive behavioral therapy, channeling negative energy into nonharmful activities like physical exercise) for managing TW's negative responses.

Patient coping mechanisms provide another key consideration for the clinician. Certain methods for managing emotional distress (eg, drugs) might increase the likelihood of impulsive, harmful, and violent behavior.<sup>31,39</sup> Patients who cope with negative feelings with substance use could be at higher risk of harming themselves or others when returning to work than those who have developed positive stress management strategies.<sup>40,41,42</sup> Conversely, seeking social support is a positive coping mechanism. A habit of reaching out to others for support when experiencing a negative response to a

trigger is an example of a potentially positive coping strategy. Patients with strong, positive extrafamilial support systems are at decreased risk of developing negative coping strategies and succumbing to stress.<sup>32</sup> No person lives in isolation, and no experience occurs in a vacuum, so all individual factors—both internal and external—must be considered.

Finally, clinicians might consider recommending gradual return to work if they or the patient are concerned about returning to work. Controlled reintroduction to the potentially stressful and triggering environment provides the patient with an opportunity to practice regulating emotional responses and allows the clinician and the patient to observe how the patient manages job duties and associated stressors. Gradual reintroduction is not necessary for all patients but can help some develop the confidence needed to feel comfortable returning to full duty.

### **Recommendations**

There is not enough information provided in the case of TW to come to a decision about how Dr Z should respond in that specific situation. Nevertheless, an understanding of neuroscience and psychology allows for the development of practical recommendations. People who work in high-stress and high-risk occupations (eg, law enforcement) may already have a baseline of heightened arousal, consistent with the risks of the job.<sup>33,34</sup> As such, the return-to-work evaluation and the implementation of any recommendations will require nuanced consideration of the individual case. Every patient differs in terms of the symptom burden with which they can safely return to work. Likewise, the way in which individuals return to work can differ. Clinicians should consider options for gradual reintroduction, which could consist of reduced hours or specified patrol areas to minimize trigger exposure. When care is managed appropriately, patients should recognize that there is no conflict between their needs and those of the community.

To evaluate an individual's risk of harm to self or others, clinicians must conduct a thorough review of the patient's behavior and attitudes beyond the immediate symptoms; this review should include an evaluation of past and recent behavior, along with patient successes and failures in emotional regulation across multiple social, familial, occupational, and clinical contexts. The recommendations provided here focus on communication, risk evaluation, and risk mitigation.

1. *Communication.* The development and maintenance of the therapeutic relationship is paramount. Clinicians entering into the dual role of provider of mental health care and evaluator of readiness to return to work (which we do not recommend) must be careful to ensure that patients have a clear understanding of the implications of their dual roles.
2. *Risk evaluation.* Clinicians should evaluate the risks to all involved and consider symptoms that may indicate higher risk of harm to the patient or others.
3. *Risk mitigation.* Clinicians should evaluate positive factors that could mitigate identified risks. In conjunction with the evaluation of positive and negative factors, clinicians should consider patients' historical and current responses to stressors.

It is vital that clinicians communicate clearly to patients and engage them. Clinicians should outline potential concerns with return to work—including risks both to the patient and to others—and provide a clear explanation of their reasoning and plans for future decision making. Clinicians should work with patients to develop mutual guidelines for a

safe return to work with the understanding that the goal is to ensure the patient's well-being. When possible, bringing to the table others whom the patient confides in (eg, treating mental health clinicians, peer support colleagues, family) might facilitate such discussions. Clinicians should be careful to ensure that this process is collaborative and respects patient autonomy; if a clinician believes a decision is in the best interest of the patient but the patient does not agree, every effort should be made to improve communication and ensure that both parties clearly understand the goals and concerns of the other.

### Conclusion

When evaluating a patient's fitness to return to work, what is best for the patient and what is best for society are usually not in conflict. If officers truly cannot manage their symptoms, then returning to regular duty may worsen their health and put them in a position wherein they overreact to a perceived threat. Although Dr Z's immediate reaction in this case may be to focus on harms to civilians and society, TW's premature return to work would also negatively impact TW and TW's peers. Clinicians must recognize their own assumptions and biases and consider how their decision can be made and communicated in a way that serves the best interests of both the community and their patient. In following the above recommendations, clinicians should not be placed in an adversarial position with patients. Self-awareness and intentionality, as well as nuanced consideration of the individual case, will allow clinicians to follow best practices that maximally protect and support all involved.

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**Tabitha E. H. Moses, MS** is an MD/PhD candidate in the Translational Neuroscience Program at Wayne State University School of Medicine in Detroit, Michigan. Her scholarly and research interests focus on mental health and substance use disorder, including neural mechanisms, harm reduction and treatment, medical education, policy, and ethics.

**Arash Javanbakht, MD** is a psychiatrist and the director of the Stress, Trauma, and Anxiety Research Clinic at Wayne State University School of Medicine in Detroit, Michigan. His clinical work is mainly focused on anxiety and traumatic stress in civilians, first responders, law enforcement personnel, refugees, and victims of torture and trafficking. He researches environmental and neurobiological correlates of risk and resilience among Syrian refugees and their families, the neurobiology of psychotherapy, and uses of augmented reality and telemedicine for therapy.



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