

more flagrant behaviors are often most pronounced in early adulthood. Numerous impulsive, aggressive, and antisocial behaviors of diagnostic significance are presented in DSM-III-R.

The behaviors exhibited in this disorder—diffuse aggression, impulsiveness, and disregard for norms and laws—contribute to unsafe driving. (See references 62 through 64 and 67 through 72.) The antisocial person's often inappropriate quest for excitement and risk-taking behavior adds to the danger. The following diagnostic criteria are of special concern: (1) failure to conform to social norms with respect to lawful behavior (traffic laws and safe driving practices); (2) irritable, aggressive, pugnacious, assaultive behavior (overly aggressive driving); (3) recklessness regarding safety, e.g., driving while intoxicated or recurrent speeding. (6) Additionally, an associated concern is the increased risk of psychoactive substance abuse disorder (addressed separately in this report).

For an individual who has been diagnosed with APD using established DSM-III-R criteria, the task force members recommend that the risk assessment for personality disorder be performed to further assess the possible risks' validity. Individuals with APD are often unreliable informants, and mendacity is a common feature of the disorder. Hence, collateral interviews are most important and should aim to further assess the individual's history of aggressive and impulsive behaviors, violation of social norms and laws, history of seeking excitement in a manner that entails unnecessary risk, driving practices, and evidence of substance abuse. Psychological testing by a clinical psychologist should assess, in particular, hostility, aggressive tendencies, impulsiveness, social judgment, and hunger for excitement. The psychiatrist should evaluate the following records: school records, with special attention given to discipline and behaviors that are aggressive and impulsive; military and employment records, noting any and all signs of aggressive, impulsive, norm-violative, and unsafe behaviors; and records pertaining to prior treatment/rehabilitation for substance abuse.

In determining if an applicant with APD should be recommended as psychiatrically qualified for commercial driving, the psychiatrist should emphasize the following features of the disorder, if present: (1) reckless disregard for safety, including driving while intoxicated or recurrent speeding; (2) dual diagnoses, e.g., APD and a substance abuse disorder, (3) failure to conform to social norms including traffic laws and principles of safe driving; and (4) irritability and pugnaciousness, including overly aggressive driving.

Borderline Personality Disorder

The essential feature of borderline personality disorder (BPD) is a pervasive pattern of unstable self-image, relationships, and mood. (6) Characteristic symptoms are abruptly changing dysphoric moods associated with impulsive behaviors and low frustration tolerance. The BPD patient typically lacks a consistent and well-integrated sense of self.

No scientific data relate BPD to driving performance. Nonetheless, abnormal impulsivity, low frustration and stress tolerance, angry outbursts, and recklessness can reasonably be expected to compromise driving safety. (See references 63, 67, 68, 70, and 71.) Among the diagnostic criteria, the following should raise concern for driving safety: (1) impulsive behavior such as reckless driving and substance use; (2) inappropriate, intense anger or lack of control of anger; and (3) recurrent suicidal threats or behavior (vehicular

crashes are sometimes caused by drivers who intend to commit suicide). An associated concern is that some individuals with BPD will, under extreme stress, experience transient psychotic symptoms.”

For an individual who has been diagnosed with BPD using established DMS-III-R criteria, the task force members recommend that the risk assessment for personality disorders be performed to further assess the possible risks' validity. Collateral interviews should aim to further clarify the history of aggressive behavior, impulsive behavior, low frustration and stress tolerance, reckless behavior, temper outbursts, substance use, suicidal threats and behavior, psychotic speech and behavior, and unsafe driving practices. (Any inquiry pertaining to suicidality should include not only frequency and lethality of threats and attempts, but also the relationship of thoughts of suicide to vehicular crashes.) Psychological testing by a clinical psychologist should assess hostility, aggressive tendencies, impulsiveness, low frustration tolerance, suicidal and morbid thought content, and reality adherence. The psychiatrist should evaluate the following records: school records, with special attention given to discipline and behaviors that are aggressive and impulsive; military and employment records, noting any and all signs of aggressive, impulsive, and unsafe behaviors; records pertaining to prior treatment/rehabilitation for substance abuse.

In determining a patient's psychiatric qualification for commercial driving, the psychiatrist should emphasize the following features of the disorder, if present: (1) impulsive behavior involving reckless driving or substance abuse; (2) suicidal thoughts, preparation, or attempt via vehicular crash; and (3) angry outbursts or recklessness shown to compromise safe driving.

Histrionic Personality Disorder

The essential feature of histrionic personality disorder (HPD) is a compelling quest for affection and reassurance that others like and care for the individual. Those with HPD are excessively emotional and attention seeking.

No known scientific data relate HPD, as defined in DSM-III-R, to driving performance; however, one study showed the "hysterical personality" to be disproportionately represented among drivers in automotive accidents. (75) The only symptom of special concern for driving is exaggerated emotional expression that may include "temper tantrums. During extreme stress, the individual may experience psychotic symptoms.

Many individuals with HPD do not have temper tantrums, excessive aggression, or psychotic symptoms. HPD, per se, should not disqualify an applicant for a commercial driver's license. However, the examiner should look for abnormal aggression and psychotic symptoms that may warrant an alternative diagnosis (e.g., BPD) and that would therefore be disqualifying.

For an individual who has been diagnosed with HPD using established DSM-III-R criteria and who shows evidence of suicidality, the task force members recommend that a risk assessment for personality disorders be performed to further assess if the possible risks are valid. Collateral interviews should aim to further clarify the history of aggression,

impulsiveness, low frustration and stress tolerance, recklessness, temper outbursts, substance use, psychotic speech and behavior, unsafe driving practices, and suicidal threats and behavior. (Inquiry pertaining to suicidality should include not only the frequency and lethality of threats and attempts, but also the relationship of suicide thoughts to vehicular crashes.) Psychological testing by a clinical psychologist should further assess hostility, aggressive tendencies, impulsiveness, low frustration tolerance, suicidal and morbid thought content, and reality adherence. The psychiatrist should evaluate records pertaining to prior treatment/rehabilitation for substance abuse and prior psychiatric hospitalization.

HPD with a history of suicidal behavior, recent suicidal thoughts, or recent psychiatric hospitalization (i.e., within the previous 6 months) should be weighed heavily in deciding whether to make an affirmative recommendation. (See references 62, 65, 67, 71, 74, 76, and 79.)

Narcissistic Personality Disorder

The essential feature of narcissistic personality disorder (NPD) is a sustained, insatiable quest for self-aggrandizement, respect, and admiration from others. The narcissistic individual holds grandiose aspirations, an inflated view of her/himself, hypersensitivity to evaluations by others, and lack of empathy for others. Many individuals with NPD are capable of a high level of job performance. However, many experience depression when self-esteem is attacked or aspirations are frustrated.

No scientific data relate NPD to driving performance. The quest for self-improvement could conceivably serve to foster safe driving, although evidence also suggests egocentricity or self-centeredness is related to accident proneness. This disorder should not be considered medically unqualifying by itself. If depression or psychosis develops, other exclusionary diagnoses will then need to be addressed.

No special assessment procedures are required for NPD per se. For clinical and risk assessment in an individual with a history of psychosis or depression, the evaluator must refer to the corresponding section of this report.

Avoidant Personality Disorder

The essential feature of avoidant personality disorder (APD) is a pervasive avoidance of social involvements despite normal desire for human contact. The individual is timid and shy, fears negative evaluations by others, and easily experiences unbearable discomfort in social situations.“”

No scientific data relate APD to driving performance. One could ask whether social timidity results in driving timidity of such extreme as to present a hazard. This possibility is far too speculative to be a useful concern. No sound reason exists for considering a commercial vehicle driver with APD alone as medically unqualified. Therefore, no special assessment procedures are required for APD per se.

Dependent Personality Disorder

The essential feature of dependent personality disorder (DPD) is a pattern of dependent and submissive behaviors. The individual with DPD relies heavily on others to make most decisions affecting his/her life.

No scientific data relate DPD to driving performance. Conceivably, lack of self-assuredness can affect driving style, but this observation is too speculative to be a useful consideration. DPD alone should not be criteria for medical unqualification. Therefore, no special assessment procedures are required for DPD per se.

Obsessive-Compulsive Personality Disorder

The essential feature of obsessive-compulsive personality disorder (OCPD) is a pervasive pattern of perfectionism and inflexibility. (61) Overconcern with control over time, money, emotions, etc., is pronounced. Individuals with OCPD may be highly orderly and organized in most areas of their lives.

Diagnostic criteria for this disorder do not present sufficient reason for concern over driving safety. The tendency toward perfectionism, **the valuation** of order and rules, and the desire to conscientiously maintain control in activities may actually enhance safe driving practices. However, a nondiagnostic associated syndrome that sometimes occurs with OCPD warrants mention. Some OCPD personality traits overlap with "Type A" personality traits such as hostility and aggressiveness, sense of time urgency, and risk of myocardial infarction.

To assess the presence of untoward aggression and its relationship to safe driving in an OCPD patient, the task force members recommend that the risk assessment for personality disorder be performed. Collateral interviews should aim to further clarify the history of aggressive behavior, low stress tolerance, temper outbursts, and unsafe driving practices. Psychological testing by a clinical psychologist should aim to further assess the patient's level of hostility, aggressive tendencies, and vulnerability to stress.

OCPD alone should not be reason for a commercial driver to be considered medically unqualified. However, if the disorder is diagnosed, the clinician should also look for "Type A" personality traits. Traits that have led to present or past dysfunction on the job or excessive hostility and aggressiveness known to compromise job performance should lead to further risk assessment.

Passive-Aggressive Personality Disorder

The essential feature of passive-aggressive personality disorder (PAPD) is "pervasive resistance to demands for adequate social and occupational performance. The individual has difficulty dealing with anger directly and adaptively. Instead, resentment leads to passive neglect and poor performance. Earlier conceptualizations of PAPD included an aggressive subtype with angry outbursts. Today an individual with temper outbursts and violent behaviors may carry the diagnosis of APD, BPD, or intermittent explosive disorder (IED).

Although presently accepted diagnostic criteria for PAPD do not suggest unsafe driving practices, this type of individual will not be an ideal employee because of unreliability.

No scientific data relate PAPD, as defined in DSM-III-R, to driving performance. However, a few studies show PAPD to be over-represented among drivers who attempt suicide or homicide by automobile.^(75,78) Therefore, although PAPD alone does not indicate further risk assessment, when combined with recent suicide or homicide thoughts, recent hospitalization (within the past 6 months), or prior arrest for violent offense, PAPD warrants further inquiry.

Personality Disorder Not Otherwise Specified

This category includes other personality disorders not fully recognized by DSM-III-R and mixed personality disorder. (d) Any personality disorder characterized by excessive, aggressive, or impulsive behaviors warrants further inquiry for risk assessment. These conditions include impulsive personality disorder, explosive personality disorder, and sadistic personality disorder. Every effort should be made to apply currently recognized nosologicdiagnostic terms. For an individual with a personality disorder characterized by aggressive or impulsive behaviors, the task force members recommend that the risk assessment for personality disorders be performed to further assess if possible risks are valid.

Mixed personality disorder consists of disorders with some criteria of more than one personality disorder, but not enough of any one disorder to establish its diagnosis. Mixed personality disorder should not render a candidate medically unqualified if the symptoms are those of disorders that are not medically unqualifying. If the symptoms derive from disorders that require further inquiry, attention should be given to the nature of the diagnostic criteria themselves. For example, under APD, the diagnostic criterion of failing to sustain a totally monogamous relationship for more than 1 year would not be medically unqualifying for a commercial driver's license, because this symptom has no relevance to driving. On the other hand, reckless behavior, including recurrent speeding, would warrant a complete risk assessment as is otherwise done for ADP.

IMPULSE CONTROL DISORDERS NOT ELSEWHERE CLASSIFIED

intermittent Explosive Disorder

IED has the following two essential features: (1) several discrete episodes of loss of control of aggressive impulses, resulting in serious assaultive acts or destruction of property, and (2) a degree of aggressiveness expressed during these episodes that is grossly out of proportion to any precipitating psychosocial stressor.

Concern that the patient may exhibit abnormally aggressive behavior while driving is valid. Although symptom control may appear to be achieved with medication (carbamazepine, phenytoin, lithium, beta blockers, etc.), effective treatment is experimental at this time.

Although unsafe driving practices are not mentioned in the DSM-III-R description of IED, some investigators have asserted that this disorder is a diagnostic feature of a related phenomenon, the dyscontrol syndrome, if not a correlate of recurrent violence in general. One of four symptoms designated the dyscontrol syndrome is "[a] history (in those who drove cars) of many traffic violations and serious automobile accidents." However, the other symptoms of dyscontrol syndrome (i.e. physical assault, pathological intoxication, and impulsive sexual behavior) do not conform to the DSM-III-R criteria for IED, and the dyscontrol syndrome has not been recognized as a mental disorder. The other symptoms overlap more with those of BPD or APD. The important point is the suggestion that unsafe driving may be associated with other aggressive behaviors, such as those of IED.

A critical question regarding IED **is** to what extent the temper outbursts are compartmentalized and restricted to nondriving situations. Or, conversely put, to what extent are temper outbursts more likely under the pressures of heavy traffic, slow traffic, or when driving amidst other drivers who are aggressive and provocative?

To further assess if recurrent aggressive outbursts as a serious driving risk are a valid concern, the risk assessment for personality disorder would apply here as well. Collateral interviews should aim to further clarify the history of aggressive, impulsive, and reckless behaviors; temper outbursts including situational-cultural aspects; and unsafe driving practices. Psychological testing by a clinical psychologist should assess hostility, aggressive tendencies, impulse control, stress tolerance, and violent thought content. The psychiatrist should evaluate school records, with special attention given to discipline and behaviors that are abnormally aggressive, and military and employment records, noting signs of aggressive, impulsive, and reckless behaviors.

Kleptomania, Pathological Gambling, and Pyromania

No known scientific data relate any of these disorders to driving performance, and none of these conditions pertain directly to it. However, kleptomania (pathological stealing) can affect an individual's desirability as an employee. The critical question regarding kleptomania is whether the behavior is truly and absolutely encapsulated in a single behavior or whether the most pronounced symptom is a sign of more generalized impulsiveness and disregard for social norms. What may first appear to be stealing alone may, under closer scrutiny, prove to be only one of several impulsive, aggressive behaviors of another disorder that warrants special risk assessment (e.g., APD). In contrast, if pathological gambling occurs alone, no further risk assessment is needed.

On the other hand, recurrent pathological fire setting should result in risk assessment in any event. Fire setting is itself very dangerous and destructive, and it is commonly associated with other aggressive, impulsive violent behaviors. (See references 81 through 86.) The danger of misdiagnosing pyromania without other impulsive behaviors is too risky when the safety of many people must be considered. Therefore, pyromania is an indication for further risk assessment.

The task force members recommend that the risk assessment for personality disorders be performed to further assess if these impulsive or aggressive behaviors, not restricted to fire

setting alone, present a serious, valid driving risk. Psychological testing by a clinical psychologist should further assess aggressive tendencies, diffuse poor-impulse control, and violent thought content not restricted to fire setting. The psychiatrist should evaluate school records, with special attention given to discipline and behaviors that are abnormally aggressive, and military and employment records, noting signs of aggressive, impulsive, and reckless behaviors.

Trichotillomania

Trichotillomania is often associated with some degree of attentional problem. Further psychiatric interview alone should suffice to assess this disturbance and its possible relationship to safe driving.

Factitious Disorder

Individuals with factitious disorders (FD) consciously and deliberately feign symptoms of physical (factitious disorder with physical symptoms) or mental illness (factitious disorder with psychological symptoms).⁽⁶⁾ In contrast to a malingerer, whose motive is avoiding work, this individual is driven by a psychological need to assume the sick role and is unable to refrain from such behavior though he/she has no other obvious self-serving objective.

No known scientific data relate FD to driving performance, and the diagnostic criteria do not pertain directly to driving, except where hospitalization necessarily removes the individual from the highway. Nonetheless, the presence of FD implies severe psychopathology as well. This diagnosis is an indication for further assessment to rule out a severe personality disorder that itself requires a detailed risk assessment (e.g., BPD).

Furthermore, depending on the nature of the disorder simulated, some very specific and serious risks can affect driving. For example, an individual who injects him/herself with insulin can suffer from hypoglycemia and become comatose; these conditions would cause an extreme hazard if they occurred while the individual was driving. Drug abuse is an associated feature with corollary risks (see section on drug use).

Because this disorder implies serious, associated psychopathology and presents secondary risks to the individual's physical and mental well-being, it warrants risk assessment if it is presently active or recurrent. If the FD was once active and symptomatic years ago, but not since, and the individual appears to be in fine mental and physical health now, no specific procedures for risk assessment may be needed.

If a physical disorder has been self-induced (e.g., insulin-induced hypoglycemia), the individual should be referred to the appropriate medical specialist and other guidelines may apply. Other aspects of the psychiatric evaluation should carefully establish the presence of other personality disorders and substance abuse disorders.

SELECTED DIAGNOSTIC CONDITIONS

Psychological Factors Affecting Physical Conditions

The scientific literature does not indicate whether or not psychological factors that affect physical conditions cause driving impairment. The variety of physical conditions that may be affected, their severity, and the nature of the psychological factors make it impossible to speak **appecifically**. In evaluating the condition, the disability associated with the psychological factor would best be considered; e.g., a migraine headache that comes on precipitously and blindingly may well impair the driver on the road significantly. The fact that it may also be brought on or associated with psychological factors does not alter this basic situation. Therefore, the task force that addresses the physical conditions should speak to these issues. However, psychiatric evaluation may be helpful in determiniing if a specific predictable psychological risk factor would preclude interstate commercial driving or if treatment of the condition would enable the individual to perform such work safely.

Interaction Between Personality Disorders And Substance Abuse

Alcohol abuse and personality disorder (especially APD) are the two psychiatric conditions most associated with a higher incidence of traffic accidents, including traffic fatalities. (See references 87 through 91.) Thus, those people who suffer from both conditions are at the greatest risk. However, much of the scientific literature supports the idea that alcohol use, not necessarily alcohol dependence, is the disabling factor for drivers. Therefore, reviewing the problem of the overlap of substance abuse and personality disorders, or simply alcohol abuse, addresses only part of the problem. Although the following discussion separates alcohol and other drug problems, in reality much substance abuse is polysubstance abuse, especially among persons with antisocial and certain other personality disorders.

Active alcohol abuse and ~~dependence disorders~~ **are disabling conditions** with respect to driving safety whether or not the patient has APD. However, when in remission, alcoholism is not disabling unless transient or permanent neurological changes have occurred. Because many primary alcoholics express and manifest antisocial behaviors as a symptom of their illness, when it is effectively treated and in remission, alcoholism is less disabling for drivers than concurrent alcoholism and APD. If the recovering individual has coexisting APD, the remission will reduce the degree of disability only to that level of disability caused by APD. Some alcoholics who actively engage in Alcoholics Anonymous may possibly improve their APD as well and thereby further reduce the disability. However, alcohol abuse may also be an expression of the impulse control difficulties of APD, an expression that further diminishes impulse control. This condition is disabling and quite unpredictable. Furthermore, engaging such a person in treatment for APD may be difficult.

Regarding the overlap of personality disorder and other drug abuse, less can be said. While CNS depressants, amphetamines, antihistamines, marijuana, and opiates have all been implicated as a cause of increased accidents, ~~(29)~~ few of these studies are convincing or extensive. Most of these substances have been shown to impair performance Of a variety of cognitive and motor tasks, but the most relevant question concerning the actual

effect on driving performance at a given dose in an addicted person has not been studied well. Common sense dictates that addiction to drugs other than alcohol can be disabling to the driver. Driving impairment due to marijuana use is well substantiated ⁹⁸⁾ and is of special concern because of its prevalence among adolescents and young adults. ¹⁰⁰⁾ Also, a person who has APD and is addicted to any drug would seem to be significantly more disabled than someone with APD alone. When the substance abuse or dependence is in remission, the disability would fall to the level of that associated with APD. Other personality disorders associated with impulse control difficulties may fall under the conclusions reached here, especially BPD.

Alcohol and other drugs cause impairment through both intoxication and withdrawal. Episodic abuse of substances by commercial drivers that occurs outside of driving periods may still cause impairment during withdrawal, even a hangover is associated with cognitive, motor, affective, and behavioral impairment.

The interaction of alcohol and other drug dependencies and abuse with personality disorders might best be conceptualized by stating that each is a profound risk factor in the presence of the other.

The central question in the evaluation is whether or not a person with an addiction is capable of commercial driving when psychoactive substances have been recently used. The answer is best determined by urine screening, not by clinical examination or driving examination. Clinical examination is most relevant to determine the diagnosis and the presence or absence of neurological complications. Collateral interviews are usually essential in the diagnostic process. Driving tests are most useful for assessing whether neurological changes are sufficient to impair driving. An evaluation of driving records would also greatly help assess risk. Frequent urine screening would be recommended for those in whom substance abuse or dependence has been diagnosed.

DISRUPTIVE DISORDERS OF CHILDHOOD OR ADOLESCENCE

Conduct Disorder

The essential feature of this disorder is a persistent pattern of conduct in which the basic rights of others and major age-appropriate norms or rules are violated. Diagnostic criteria such as lying, stealing, absence from work, aggressiveness, and other antisocial acts would impair work performance and attendance. Associated features such as poor frustration tolerance, irritability, temper outbursts, and recklessness are frequent characteristics. Substance use is common. Complications include substance abuse or dependence, high rates of injury due to all types of accidents, and suicidal behavior. Impairment is mild to severe.

The outcome and course of the disorder are variable. Mild forms frequently show improvement while severe forms tend to be chronic. Over 50 percent of conduct-disordered children do not become antisocial as adults.⁽¹⁰²⁾ The group type is particularly associated with reasonable social and occupational adjustment as adults. However, early onset (e.g., before

age 10 to 12) is associated with a higher risk of continuation into adult life as APD. Also, among children referred for antisocial behavior, 84 percent then had a diagnosis of a psychiatric disorder as an adult.⁽¹⁰³⁾ Other characteristics predict continued antisocial behavior in adulthood: (1) a greater number of different types of antisocial behavior; (2) a higher frequency of antisocial episodes; and (3) serious antisocial behavior in childhood, especially if the behavior could be grounds for adjudication. The severely conduct-disordered individual has a markedly increased chance of a violent death in adolescence or young adulthood, the death may involve a driving accident.

Individuals who have been diagnosed with either moderate or severe conduct disorders in the past are more likely to display continuing or coexisting symptoms. Therefore, an individual who has a past history of conduct disorder should undergo a mental examination so that recent symptoms that may adversely affect driving are documented. The functional assessment of such individuals as related to driving competence should include a personal history and collateral data to document any ongoing degree of impulsiveness, antisocial behavior, aggressiveness, and substance use/abuse. The individual's complete legal history and driving record for all offenses should be evaluated. Particular attention should be paid to aggressive or undifferentiated conduct disorder. Aggressive behavior is likely to be a stable characteristic and is an indication for risk assessment relative to driving. Objective testing may also document the degree of continuing sociopathy.

Oppositional Defiant Disorder

The essential feature of this disorder is a pattern of negativistic, hostile, and defiant behavior without serious violation of the basic rights of others. Impairment is greatest within the home, although in some cases symptoms are displayed outside the home. Associated features include mood lability, low frustration tolerance, and temper outbursts. Substance abuse or ADHD may also be present. Although the course of this disturbance is unknown, it may evolve into a conduct disorder or a mood disorder.

Functional assessment should include the following components: (1) interview of family members and past employers to document the absence or presence of oppositional behaviors; (2) collateral interviews to document antisocial, hyperactive, and mood disorders; (3) review of legal records and past traffic offenses; and (4) consideration of a detailed substance history with collateral verification.

Attention Deficit Hyperactivity Disorder

The essential features of this disease are age-inappropriate levels of inattention, impulsiveness, and hyperactivity. Symptoms worsen in situations that require sustained attention. The patient has difficulty sitting still. Work may be careless and impulsively performed. The patient may display impulsiveness by changing activity on the spur of the moment from a previous obligation. Associated features include mood lability, low frustration tolerance, and temper outbursts. ADHD often coexists with oppositional defiant disorder, conduct disorder, and specific developmental disorders. In the majority of cases, the disorder persists throughout childhood. One prospective study indicates that approximately two-thirds of children with ADHD show continued signs of the disorder into adulthood, with

complaints of restlessness, poor concentration, impulsiveness, and explosiveness. Numerous studies have strongly supported the link between the presence of ADHD in childhood and significant antisocial behavior in adolescence and adulthood.””””

The effectiveness of stimulant medication in the treatment of ADHD children is well known. However, medication alone does not prevent antisocial acting out. For example, in one study group of hyperactive children treated with drugs alone, these children had a 10 to 20 times higher juvenile arrest rate and rate of institutionalization compared to a normal control group. (10) Multimodal interventions (including both medication and intensive cognitive-behavioral-interpretive treatment based upon an individual treatment plan for each child) have been demonstrated to prevent antisocial behavior in ADHD children. Therefore, the preferred intervention of hyperactive children is multimodal. **Such** treatment should be ongoing for 2 to 3 years.

Current data indicates that an individual with a past diagnosis or behavior consistent with ADHD will probably continue to display related symptoms. In addition, ADHD has considerable comorbidity in adulthood with APD and BPD. However, the percentage of patients with ADHD who sustain a moderate to marked degree of improvement on stimulant medication is between 50 to 70 percent.

Functional assessment should include the following components: (1) a practical driving test conducted by an occupational therapist, (2) collateral contact with employers or others who have observed individuals in group settings and doing tasks requiring sustained attention, (3) an evaluation of the applicant's full legal and driving records, and (4) a review of the individual's detailed work history documenting the length of service and mode of termination for each employer.

ANXIETY DISORDERS OF CHILDHOOD OR ADOLESCENCE

Separation Anxiety Disorder

The essential feature of this disorder is excessive anxiety concerning separation from major attachment figures. At the time of separation, the child may experience panic level anxiety. Children with this disorder are uncomfortable when they travel independently to unfamiliar places, including school. Symptoms may include difficulty staying alone, clinging behaviors, and somatic symptoms when separation is anticipated or occurs. These children may be preoccupied by fears or perceived dangers, depressed mood, or demanding and in need of constant attention. The impairment may be very incapacitating when the child is unable to attend school or otherwise function independently. As adults, the dysfunctional individuals may have diagnoses of phobic states, often anxiety disorders, or depression.

The clinical course of this disorder is varied. Individuals with an early history (5 to 7 years old) with acute school refusal often have a good prognosis. However, if school refusal occurs slowly in the adolescent years, the prognosis is much more guarded. Longitudinal outcome studies indicate that one-third of children who refuse to attend school continue to manifest significant psychiatric symptoms. A positive **outcome** is associated with intelligence,

treatment before the patient reaches age 14, and substantial improvement after treatment (inpatient in this study).

Functional assessment should include the following components: (1) a detailed mental status examination detailing the degree of active symptoms of anxiety or depression and any resulting activity restrictions, (2) collateral interviews with family members to verify activity restrictions, (3) a detailed work history indicating the impact of anxiety symptoms upon occupational performance, and (4) consideration of a practical driving test conducted by an occupational therapist.

Avoidant Disorder

The essential feature of this disorder is a shying away from contact with unfamiliar people to such a degree that it interferes with social functioning in peer relationships. A child with this diagnosis often appears socially withdrawn, embarrassed, or timid in the company of unfamiliar people. This disorder rarely occurs alone: children with this disorder usually have another anxiety disorder such as overanxious disorder. The impairment in social functioning is often severe.

The course of this disorder is variable. Some children recover while others fail to form friendships and social bonds outside the family with resultant feelings of isolation and depression. How often their disorder becomes chronic and persists into adulthood is unknown. Related disorders of adulthood are APD and social phobia.

Functional assessment should include the following components: (1) description of the impact of current symptoms upon social functioning relevant to work, (2) contact with previous employers to document work-related behavior, and (3) a mental status examination to assess presence and impairment of overt anxiety disorders.

Overanxious Disorder

The essential feature of this disorder is excessive or unrealistic anxiety or worry for a period of 6 months or longer. Such a child worries about past behavior and future events. The child may spend an inordinate amount of time inquiring about the discomforts or dangers of a variety of situations and need much reassurance. Somatic complaints may be evident.

The onset of overanxious disorder may be sudden or gradual. Its clinical course is characterized by exacerbations associated with stress. Overanxious disorder may persist into adult life as an anxiety disorder such as generalized anxiety disorder or a social phobia. Complications in childhood include unnecessary medical workups, poor school performance, and a failure to engage in age-appropriate activities.

Functional assessment should include the following components: (1) a mental status examination and collateral sources describing any work-related restrictions posed by active or fluctuating symptoms and (2) consideration of a practical driving test conducted by an occupational therapist.

ANXIETY DISORDERS

Generalized Anxiety Disorder

No specific scientific data refer to drivers with this condition. The individual with generalized anxiety disorder (**GAD**) **may have the following characteristics: preoccupied and ruminative**, leading to inattention to a given task; hypervigilant, leading to indiscriminate responses to unimportant stimuli and distraction from the task at hand; inwardly focused on somatic symptoms; easily startled and distracted; and restless, nervous, and impatient. Daily functioning is significantly compromised in severe cases. If very anxious, an individual would probably have difficulty maintaining attention, being aware of the surrounding circumstances, and dealing with stress. Individuals with GAD may also be depressed. Some suffer major depression, others dysthymia. Comorbid depression probably lessens the ability to function. Some excessively anxious individuals use alcohol for symptom relief. Caffeine and other stimulants often increase anxiety symptoms.

Effective treatment for GAD includes behavioral and cognitive therapy and medications. When treated adequately, the patient's functioning improves. The most common pharmacologic agents used to treat GAD, benzodiazepines, may impair driving performance.

GAD may interfere with safe driving when it is severe and untreated or is coexistent with depression, other anxiety disorders, or alcohol or stimulant use.

When an individual referred for psychiatric evaluation has GAD, the evaluating psychiatrist should interview collateral sources regarding the individual's condition and review the individual's record of traffic offenses. A practical driving test conducted by an occupational therapist should be considered.

Obsessive-Compulsive Disorder

No specific data refer to drivers with this condition. The individual with obsessive-compulsive disorder (OCD) suffers from intrusive and unpleasant thoughts that interfere with concentration and responsiveness to external events and that result in compulsive acts requiring an intense focus on completion of the ritual. Daily functioning is significantly compromised in severe cases. Such an individual would probably have difficulty maintaining attention, keeping track of the surrounding circumstances, and dealing with stress. Severely affected individuals usually lead very limited lives. Individuals with OCD may also suffer from depression, Tourette's syndrome, and other anxiety disorders such as panic disorder. Comorbid conditions probably lessen the patient's functional capacity.

Effective treatment for OCD includes medication and cognitive-behavioral therapy. Functioning may improve markedly with adequate treatment. OCD may interfere with safe **driving** when it is severe and untreated, unresponsive to treatment, and/or coexistent with other conditions. These individuals would not be able to function effectively as commercial drivers.

When an individual referred for psychiatric evaluation has OCD, the evaluating psychiatrist should interview collateral sources regarding the individual's condition and review the individual's record of traffic offenses. A practical driving test conducted by an occupational therapist should be considered.

Posttraumatic Stress Disorder

Specific data regarding individuals with posttraumatic stress disorder (PTSD) secondary to a motor vehicle accident indicate that these individuals may have driving phobias of a partial or complete nature. Preoccupation with traffic, weather and road conditions is reported to be common. Some individuals with PTSD have difficulty discerning the proximity of other vehicles in traffic. Some individuals reexperience or revisualize the past traumatic situation while driving. (112) Such revisualizations prove to be distracting and, in 45 percent of cases, lead to hazardous driving circumstances, as judged by the drivers. Individuals with PTSD may also suffer from depression or high levels of anxiety. Severe symptoms of depression or anxiety would probably reduce functional capacity.

Individuals with PTSD may lose regard for personal safety, whether the trauma was related to a motor vehicle accident or other trauma, and therefore may be reckless or act dangerously. A common problem associated with PTSD is substance abuse or dependence. Impairment secondary to alcohol or drugs could compromise driving capacity.

PTSD may interfere with safe driving when the individual has symptoms related to driving or has lost regard for personal safety. This interference is probably most common in individuals who were traumatized by a motor vehicle accident. However, treatment ameliorates symptoms and probably improves the person's ability to drive safely.

Effective treatment for PTSD includes psychotherapy and medication. Functioning may improve markedly with treatment. However, some individuals with PTSD receive benzodiazepines as pharmacologic treatment which may impair driving ability.

When an individual referred for psychiatric evaluation has PTSD, the evaluating psychiatrist should interview collateral sources regarding the individual's condition and review the individual's record of traffic offenses. A practical driving test conducted by an occupational therapist should be considered.

Panic Disorder Without Agoraphobia

No specific data refer to drivers with this condition; however, panic attacks can preoccupy or distract the driver from the task at hand. During a panic attack, the individual may become impatient and wish to escape the circumstances quickly. Health concerns created by the panic attacks may be distracting for the individual. Nevertheless, daily functioning is not usually significantly compromised in panic disorder without agoraphobia. Individuals who are most affected are those who develop major health concerns and therefore need to seek health care frequently. Panic disorder without agoraphobia is unlikely to interfere with safe driving.

Effective treatment for panic disorder without agoraphobia includes cognitive behavioral therapy and medication. Symptoms are usually significantly reduced by treatment.

Individuals with panic disorder may also suffer from depression or other anxiety disorders. Comorbid conditions probably lessen functional capacity.

Panic Disorder With Agoraphobia

Individuals who have panic disorder with agoraphobia often have driving phobias. They avoid driving or drive only with great reluctance or hesitation. No data that refer specifically to drivers with this condition are reported in the scientific literature.

Patients who have panic disorder with agoraphobia are prone to feeling caught in unsafe situations; this feeling may lead to rash and incautious actions. When distracted by a panic attack, the patient has difficulty remaining focused on the task at hand. Daily functioning is significantly compromised in severe cases. Such an individual would probably have difficulty maintaining attention, keeping track of surrounding circumstances, and dealing with stresses in a commercial driving situation. Severely affected individuals usually lead very limited lives.

Individuals with panic disorder with agoraphobia may also suffer from depression, anxiety disorders, or substance dependence disorders. Comorbid conditions lessen functional capacity.

Effective treatment for panic disorder with agoraphobia includes cognitive behavioral therapy and medication. Functioning usually is markedly unproved with adequate treatment. However, treatment often includes the use of benzodiazepines, which may compromise driving ability.

Panic disorder with agoraphobia may interfere with safe driving when it is severe and untreated, unresponsive to treatment, and/or coexistent with other conditions. Moreover, individuals with severe cases of panic disorder with agoraphobia are very unlikely to seek work as commercial drivers. If an individual were already working as a commercial driver at the time that this condition started, it is unlikely that the individual would be able to continue working until treatment was provided.

When an individual referred for psychiatric evaluation has panic disorder with agoraphobia, the evaluating psychiatrist should interview collateral sources regarding the individual's condition and review the individual's record of traffic offenses. A practical driving test conducted by an occupational therapist should be considered.

Social Phobia

No specific data refer to drivers with this condition. Individuals with social phobia experience intense anxiety when they feel they are being scrutinized by others. Common circumstances that provoke this anxiety include speaking with or to others, eating in a public place (restaurant), or performing some other activity such as writing in front of others. They

are not symptomatic at other times except when anticipating an anxiety-provoking situation. Driving performance is not affected.

Simple Phobia

While driving, individuals with driving phobias may become intensely anxious, fearful, and feel out of control of the situation. (114) They tend to feel helpless and angry. A previous collision may be one of the causes of driving phobias. The relationship of such episodes to driving safety is not known. However, an individual who is keyed up by intense anxiety has difficulty remaining focused on the task at hand. Thus, a person who is fearful about driving may be worried or preoccupied and therefore not attentive. Nevertheless, no evidence of deteriorating driving skills or loss of judgment in these individuals while driving has been presented.

Effective treatment for simple phobia is cognitive behavioral therapy. Functioning usually improves markedly with adequate treatment.

Simple phobia, that is, driving phobias, may interfere with safe driving when the phobias are severe and untreated. However, individuals with preexisting phobias are unlikely to seek work as commercial drivers. Individuals who have had collisions may be at risk for developing some phobic driving behavior.

When an individual referred for psychiatric evaluation has a driving phobia, the evaluating psychiatrist should interview collateral sources regarding the individual's record of traffic offenses. A practical driving test conducted by an occupational therapist should be considered.

Agoraphobia Without a History of Panic Disorder

No specific data refer to drivers with this condition because these individuals are avoidant and often avoid driving. The individual may experience intense anxiety while driving, leading to a lack of attention to the driving task and possibly poor judgment. Daily functioning may be significantly compromised in severe cases. These individuals lead restricted and limited lives. Individuals with agoraphobia without a previous history of panic disorder may also suffer from depression or other anxiety disorders. These comorbid conditions probably lessen functional capacity.

Agoraphobia without a previous history of panic disorder may interfere with safe driving when it is severe and untreated. However, individuals with this condition are unlikely to seek jobs as commercial drivers.

Effective treatment for agoraphobia without a history of panic disorder is cognitive behavioral therapy. Functioning may improve markedly with adequate treatment.

When an individual referred for psychiatric evaluation has agoraphobia without a previous history of panic disorders the evaluating psychiatrist should interview collateral sources regarding the individual's condition and review the individual's record of traffic

offenses. A practical driving test conducted by an occupational therapist should be considered.

Anxiety Disorder Not Otherwise Specified

This diagnostic entity comprises all anxiety syndromes that do not fall into a clear-cut diagnostic category. Although studies from the 1960's and 1970's refer to psychoneurotic individuals, separating individuals with anxiety disorders from other kinds of neurotic conditions as defined by DSM I is, unfortunately, not possible. Therefore, the report of increased accidents, violations, and serious violations by neurotics in the research cannot be related to current diagnostic criteria.(15) An increased accident rate and an increased violation rate have also been found in male neurotics before hospitalization versus a control group. However, because the study used DSM-I diagnostic criteria, applying contemporary diagnostic standards is difficult.

SOMATOFORM DISORDERS

Body Dysmorphic Disorder

Although no specific data refer to drivers with this condition, no indications of driving difficulties exist.

Conversion Disorder

No specific data refer to drivers with conversion disorder. However, the presence of fluctuating neurological symptoms such as blindness or paralysis, which may come on at unpredictable times, does raise a concern about driving in these individuals. Therefore, careful evaluation of obvious symptoms is indicated. Some speculate that conversion symptoms occur more frequently in individuals who have been in motor vehicle accidents.

When an individual referred for psychiatric evaluation has a conversion disorder, the evaluating psychiatrist should interview collateral sources regarding the individual's condition and review the individual's record of traffic offenses. A practical driving test conducted by an occupational therapist should be considered.

Hypochondria&

No specific data refer to individuals with this condition. Because these individuals are fixated on being ill, they may be preoccupied, less focused on work, and inefficient. However, they have no obvious problem with driving capacity.

Somatization Disorder

No specific data refer to drivers with this condition. Because they are focused on symptoms and illness, they may have numerous tests and treatments. Therefore, the pharmacologic treatment that they receive (such as an anxiolytic agent like a benzodiazepine,

which might lead to functional impairment) would be an area of concern. Driving performance should not be altered significantly.

Somatoform Pain Disorder

No specific data refer to drivers with this condition. These individuals often do not work because they are disabled by pain and do not hide it. The routine examination and interview for a commercial driving job would probably reveal the fact that they experience chronic pain.

When an individual referred for psychiatric evaluation has somatoform pain disorder, the evaluating psychiatrist should interview collateral sources regarding the individual's condition and review the individual's record of traffic offenses. A practical driving test conducted by an occupational therapist should be considered.

Undifferentiated Somatization Disorder

No specific data refer to drivers with this condition. In general, they tend to be less ill and symptomatic than individuals with somatization disorder. Also, they are very unlikely to have difficulty driving as a result of the disorder.

Somatoform Disorder Not Otherwise Specified

No specific data refer to drivers with this condition because their ability to drive is not compromised.

DISSOCIATIVE DISORDERS

Multiple Personality Disorder

Although specific data refer to drivers with this condition, reports of differences between personalities do raise concerns. For example, an unrecognized personality may have reckless or dangerous characteristics that are not identifiable in the present personality. Different personalities may also have differential knowledge levels; for example, if one of the personalities is a child, driving may be compromised. Belligerent and antisocial characteristics in personalities may make driving hazardous. Individuals with multiple personality disorder may suffer functioning impairment that lasts from minutes to hours to days depending on the nature of the disturbance. Functioning may be severely compromised during periods of dysfunction. This condition may interfere with safe driving when personality shifts occur. Effective treatment for multiple personality disorder is usually psychotherapeutic. Functioning may improve with adequate treatment.

When an individual referred for psychiatric evaluation has a multiple personality disorder, the evaluating psychiatrist should interview collateral sources regarding the individual's condition and review the individual's record of traffic offenses. A practical driving test conducted by an occupational therapist should be considered.

Psychogenic Fugue

No specific data refer to drivers with this condition, and the risk for unsafe behavior in this disorder is unknown. Symptoms arise following stress.

If the patient reports memory lapses, further evaluation is needed and should include the following components: (1) interviews with collateral sources regarding the individual's condition and (2) an evaluation of all traffic offenses.

Psychogenic Amnesia

No specific data refer to drivers with this condition. The individual usually experiences loss of memory after a traumatic event. Although functioning may be impaired when the condition is severe, this condition usually is not ongoing.

When an individual referred for psychiatric evaluation reports memory lapses, the evaluating psychiatrist should interview collateral sources regarding the individual's condition and review the individual's record of traffic offenses.

Depersonalization

No specific data refer to drivers with this condition. These individuals suffer either persistent or recurrent depersonalization. Although they may be disconnected from their surroundings, they are not usually out of touch with reality. Their feelings of detachment and automaton-like functioning may lead to insufficient awareness of their surroundings when driving. In severe cases this condition may cause concern for driving.

Further evaluation of individuals with depersonalization disorder should include the following components: (1) a practical driving test conducted by an occupational therapist, (2) interviews with collateral sources regarding the individual's condition, and (3) an evaluation of all traffic offenses.

ADJUSTMENT DISORDERS

Adjustment disorders are characterized by the development of acute symptoms following significant stress. Symptoms may be behavioral, emotional, or physiological, with variable severity. A wide range of symptoms is possible: minor symptoms cause subjective distress and discomfort, while major symptoms cause functional impairment. When more severe symptoms endure, another Axis I diagnosis is appropriately made. Individuals with adjustment disorders may be affected significantly by symptoms of depression, anxiety, or problematic behavior, but no specific data refer to drivers with these disorders.

Many investigators have studied the role of stress and life events to accidents. (See references 117 through 120.) Some have concluded that stress and life events play a role in traffic accidents. A higher incidence of stressful life events has been found in accident

victims designated at fault as opposed to accident victims designated not at fault (for periods of 12 months, 2 months, and 24 to 48 hours before the accident).“““ Reports also show that drivers have an increased number of accidents 6 months before and 6 months after a divorce.“““ However, one study did not find an increased number of life events for controls or drivers in accidents when compared to a cohort of individuals who had attempted suicide.

Because the findings in these studies are conflicting and no diagnosis of adjustment disorder was made in any of these reports, no conclusions can be drawn from these studies.

Functional impairment due to an adjustment disorder should-lead to further evaluation of a potential commercial drivers. Another Axis I disorder may explain the symptoms or the individual may require additional information from other sources to determine his/her capacity for driving safety. A practical driving test should provide additional information.

APPENDIX A-MEDICAL EVALUATION SYSTEM PROCEDURES

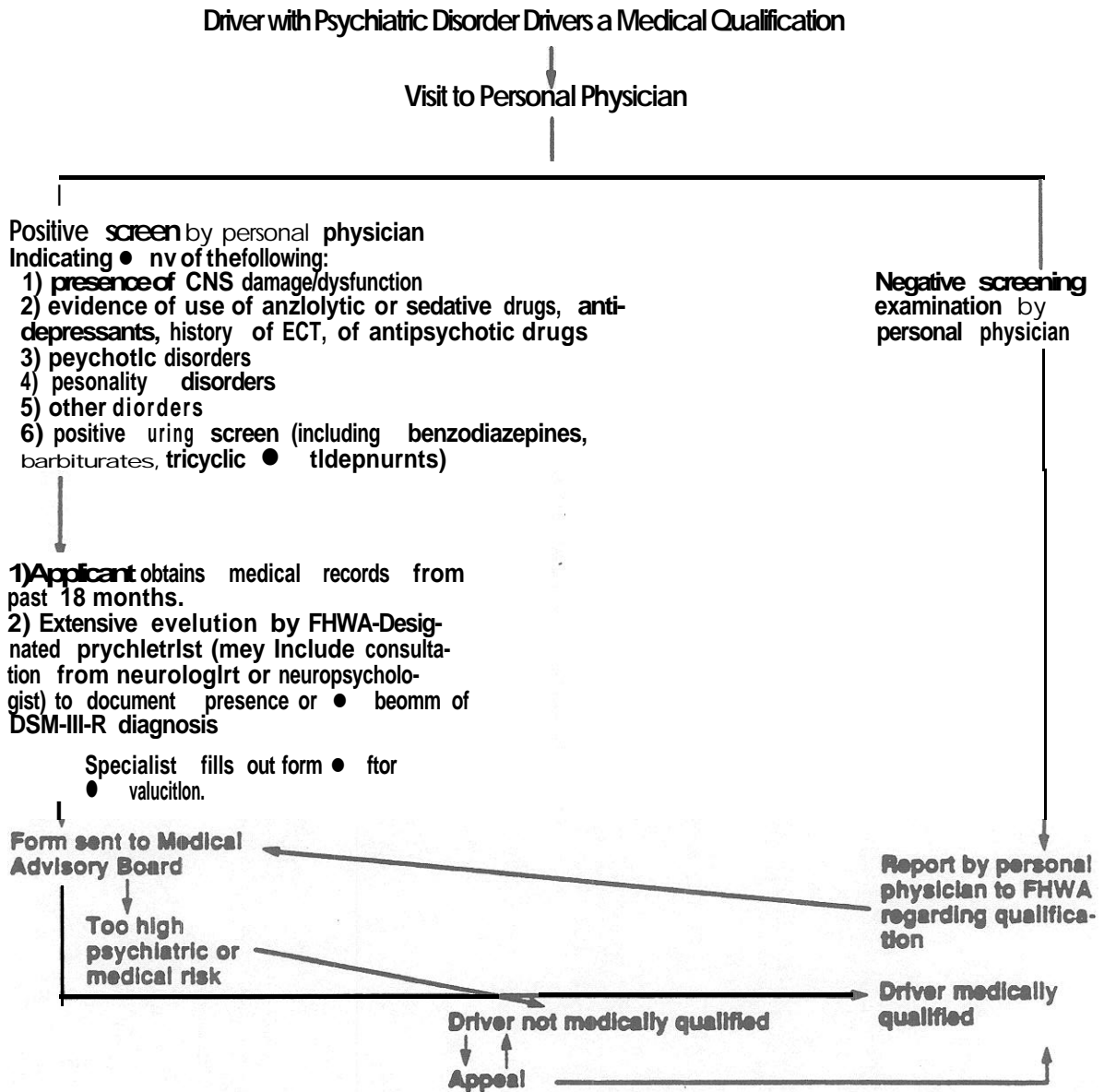


Figure 1. This chart shows the steps recommended by the expert panel for evaluating the psychiatric qualification of applicants for a commercial vehicle driver's license. The left side shows steps to be followed if the examining physician refers the applicant for further psychiatric evaluation.

APPENDIX B-JOB PERFORMANCE CHARACTERISTICS FORM

Few people outside the motor carrier industry fully appreciate the mental and physical demands placed on commercial drivers. Medical examiners should not apply automobile driving experience to evaluate the fitness of commercial driver applicants.

The physical demands of commercial driving and related tasks vary considerably with the type of vehicle and duties involved. To effectively match job demands with an applicant's ability to meet these demands, the examining physician must know the type of vehicle driven, job demands, and the environment involved.

This form is to be completed by a motor carrier official (preferably the applicant's immediate supervisor) and co-signed by the subject driver. The driver or motor carrier will then provide the original copy as part of the driver's waiver application.

On the following page is a universal job task description. Direct your attention to those boxes checked as pertinent to the particular driver.

JOB PERFORMANCE CHARACTERISTICS FORM

A. Vehicle Type

1. Straight *Trucks-are* used mainly for local pickup and delivery and may have up to five axes, utilizing van, flatbed, tank or dump bodies. Drivers may spend hours climbing in and out of the truck and loading and unloading cargo.

a. Gross vehicle weight rating (GVWR) less than 10,000 pounds.

b. GVWR between 10,000 and 26,000 pounds.

c. GVWR greater than 26,000 pounds.

2. *Tractor-Trailers-are used* for both local and long haul operations and are comprised of a power unit (tractor) and one or more trailers. Assume a GVWR of greater than 26,000 pounds.

B. Type of Route

1. ~~short-relay--drives~~ 4-5 hours to a turnaround point, exchanges trucks and drives back to the starting point

2. Long-relay--drives 8-10 hours, sleep for 8 hours and returns to the starting point.

3. Straight-through to destination--includes coast-to-coast operations; typically is away from home for — nights at a time.

4. Sleeper-team--drives constantly for 4 hours followed by 4 hours in the bunk while co-driver drives; typically is away from home for — nights at a time.

APPENDIX C-INITIAL SCREENING

The following guidelines were developed to aid the examining physician in teaching a diagnosis and evaluating the commercial motor vehicle driver.

Observations

Does the applicant have any of the following characteristics:

Suspicious?

Evasive?

Threatening?

Hostile?

Easily distracted?

Flat affect or no emotional expression?

Unusual or bizarre ideas?

Auditory or visual hallucinations?

Dishonest?

Omits important information?

Questions

The examining physician should ask the applicant the following questions:

Have you ever thought of hurting yourself?

Have you ever thought of suicide?

Have you ever attempted suicide?

Have you attempted suicide involving vehicular crash?

Do you ever get into fights?

Have you ever thought of hurting or killing other people?

Do you ever have problems with your concentration or memory?

Have you ever heard voices that other people don't seem to hear or that weren't really there?

Have you ever seen things that weren't really there?

Have you ever been hospitalized for psychiatric problems?

Am you taking any medication for nerves?

Have you ever used medicines inappropriately?

History

In addition to evaluating the driver based on observations and responses to the preceding questions, the examining physician should obtain the following information on the driver:

- Work history.
- Driving history.
- Drug and alcohol history.
- Military history, including type of discharge.
- Legal history.