PSYCHOLOGICAL ASSESSMENT SERVICES
CLINICAL & FORENSIC PSYCHOLOGY

2107 N. Broadway
Suite 207
Santa Ana, CA 92706

Mailing & Billing Address:
P.O. Box 6299
Laguna Niguel, CA 92607
(714)972-0040
Fax (714)972-0477

10/8/2021

Attn. Robert Bull
S.C.I.F.
P.O. Box 65005
Fresno, CA 93650

RE: **George Soohoo** vs. California Institute for Men
SSN: 562-78-4407
CL#: 06626694

To Whom It May Concern:

Please be advised that our office has an outstanding bill and/or lien for medical services rendered in connection with the above-captioned workers' compensation case. Kindly place our office on the official mailing list for service of process.

Pursuant to California Code of Regulations (CCR) Section(s) 10608, 10615, 10622, 10500, 10510, 10886, and Beverly Hills Multi Specialty Group v. WCAB (1994) 26 CA4th 789, demand for service upon this office is made of the defendant(s), insurance carrier(s), and employer(s) in this case for any and all unprivileged documentary evidence relating to this case, including, but not limited to, the entire medical file, medical reports (including evaluating physicians), pleadings, deposition transcripts of any person including the applicant, witness statements, claims file, compromise and release, stipulation with request for award, findings and award, findings and order, and WCAB order, determination and order, personnel documents demonstrating compliance with Labor Code Sections 3550 and 3551, employers' report of occupational injury and illness, transmittal letter(s) to Agreed/Panel Medical Examiner(s), transmittal letter to defendant doctors, benefit printouts, denial letters, notice of termination of benefits, delay letters, and any other documents upon which defendants base their objections to our lien interest, demand is also made for any and all supporting wage records relating to the injured worker in this case.

Please be advised that we only accept hard copies no cd's or email.

Thank you for your prompt attention to this matter.

Sincerely,
Elizabeth Flores

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. **INSURER NAME AND ADDRESS**: S.C.I.F. P.O. Box 65005 Fresno, CA 93650 — PLEASE DO NOT USE THIS COLUMN

2. **EMPLOYER NAME**: California Institute for Men — Case No.

3. Address: No. and Street: 14901 Central Ave. City: Chino, CA 91710 Zip — Industry

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.) — County

5. **PATIENT NAME** (first name, middle initial, last name): George Soohoo

6. Sex: X Male ___ Female

7. Date of Birth: Mo. Day Yr: 11/28/1953 — Age

8. Address: No. and Street: 2506 Lighthouse Lane City: Corona Del Mar, CA 92625 Zip

9. Telephone number: (949)892-8277 — Hazard

10. Occupation (Specific job title)

11. Social Security Number — Disease

12. Injured at: No. and Street City County — Hospitalization

13. Date and hour of injury or onset of illness: Mo. Day Yr. Hour: **1/1/2015-6/10/2021;8/1/2015-7/6/2018;6/11/2020-6/11/2021** _____ a.m. _____ p.m.

14. Date last worked: Mo. Day Yr — Occupation

15. Date and hour of first examination or treatment: Mo. Day Yr. Hour: **10/01/2021** _____ a.m. _____ p.m.

16. Have you (or your office) previously treated patient? ___ Yes ___ No — Return Date/Code

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.) The patient reports that, while working for the California Institution for Men/State of California Institution for Med, he was exposed to work overload, work pressure, work stress, incidents of harassment, and an incident of physical assault by one of his supervisors. Overtime, he developed pain in his neck, shoulders, hands, and back which he attributed to the heavy and repetitive nature of his work. As a result of his pain and work exposure, he developed symptoms of anxiety and depression. His pre-existing Posttraumatic Stress Disorder further worsened.

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

The patient reports feeling sad, helpless, hopeless, lonely, afraid, and irritable. He tends to socially withdraw from others. He has lost confidence in himself. He has a decreased motivation to do things. He feels as though everything requires a great deal of effort. At times, he feels pushed to complete tasks. He experiences crying episodes. He feels much more sensitive and emotional than he once was. He has a decreased appetite. He experiences sleep difficulties. He awakens throughout the night and early in the morning. He maintains a low energy level and feels easily tired and fatigued throughout the day. He experiences nightmares, distressing dreams, flashbacks, and intrusive recollections of the events surrounding his exposure to incidents of stress and harassment at the workplace. He feels nervous, restless, and tense. He has difficulty making decisions, concentrating, and remembering things. He is fearful without cause and worries excessively. He is bothered by episodes of dizziness, muscle tension, and heart palpitations. He feels apprehensive. He reports headaches, diabetes, hypertension, and chronic pain. His headaches are exacerbated and/or triggered when he feels under stress. He also reports lung cancer and a history of kidney cancer with removal of right kidney.

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)

A. Physical examination

The patient presented with an anxious and dysphoric mood, depressed affect, and preoccupation with physical limitations and pain and his cancer condition.

B. X-ray and laboratory results (State if none or pending.)

Psychological testing was performed. Testing report detailing results will be sent under a separate cover.

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ____ Yes X No

AXIS I: Posttraumatic Stress Disorder, Chronic (F43.12).
Major Depressive Disorder, Single Episode, Mild (F32.0).
Anxiety Disorder Not Otherwise Specified (F41.9).
Stress-Related Physiological Response Affecting Headaches (F54).

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? X Yes ____ No If "no", please explain.

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

22. Is there any other current condition that will impede or delay patient's recovery? __x__ Yes _____ No If "yes", please explain.

The patient's persisting pain and worries about his cancer condition.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.) Psychological Evaluation

PLEASE BE ADVISED, a more comprehensive report will be issued with RFAs for the treatment listed below.

24. If further treatment required, specify treatment plan/estimated duration

Cognitive Behavioral Group Psychotherapy (90853) 1X/week for 8 weeks.

Hypnotherapy/ Relaxation Training (90880) 1X/week for 8 weeks.

The patient should continue to participate in mental health services at the VA Hospital with his current mental health providers.

Referral for an evaluation by Oncologist to determine whether the applicant's exposure to Asbestos while working for California Institution for Men/State of California Institution for Med, from 1998 through 2011, may be a contributing factor to the patient's cancer condition.

Referral for an evaluation by Internist to determine whether the patient's exposure to Asbestos for approximately 13 years while working for California Institution for Men/State of California Institution for Med may have contributed to his diabetes and hypertension conditions.

Follow up in 45 days.

The research literature and treatment guidelines listed in the Appendix section of this report provides medical evidence in support of the necessity and appropriateness of the treatment intervention recommended for this patient (Please see Appendix sections I and II).

25. If hospitalized as inpatient, give hospital name and location — Date Admitted Mo. Day Yr. — Estimated stay

N/A

26. WORK STATUS -- From the psychological standpoint, is patient able to perform usual work? ____ Yes __x__ No

If "no", date when patient can return to:

Regular work ___/___/___

Modified work ___/___/___ Specify restrictions :**To be determined when patient reaches MMI status**

Doctor's Signature _____ CA License Number PSY12317

Doctor Name and Degree (please type) Nelson J. Flores, Ph.D., QME — IRS Number 33-0889238

Address 2107 N. Broadway #207, Santa Ana, CA 92706 — Telephone Number (714) 972-0040

FORM 5021 (Rev. 4)
1992

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

I reviewed the medical and collateral records. __x__ 15 mins. ___30 mins _____ mins.

REQUEST FOR UTILIZATION REVIEW

The patient verbally consented to telehealth.

APPENDIX

I. The following research literature provides medical evidence that the treatment modalities that I have recommended for this patient, including cognitive-behavioral and individual/group supportive psychotherapy, relaxation training, hypnosis and a combination of psychotherapy and psychotropic medications prescribed by a psychiatrist are reasonable and necessary for the treatment of patient's emotional symptomatology and persistent chronic pain.

1. **ACOEM's Occupational Medicine Practice Guidelines at pages 399 to 400,** "The psychology literature contains much information about meditation, relaxation techniques, and biofeedback for stress and anxiety…using these techniques can be preventive or helpful for patients with specific physiologic responses to stress. Relaxation techniques include meditation, relaxation response, and progressive relaxation. These techniques are advantageous because they may modify the manifestations of daily, continuous stress."

2. Experimental subjects suffering from chronic pain and treated in a multi-modality based setting including the provision of psychotherapy reported less pain, better control over pain, more pleasurable activities and feelings, less avoidance and less catastrophizing. In addition, disability was reduced in terms of social roles, physical functions and mental performance. (Basler HD, Jakle C, Kroner-Herwig B. Incorporation of cognitive-behavioral treatment in to the medical care of chronic low back patients: a controlled randomized study in German pain treatment centers. *Patient Educ Couns.* 1997; 31(2): 113-24.)

3. **Farrugia, D. & Fetter, H. (2009). Chronic pain: Biological understanding and treatment suggestions for mental health counselors. *Journal of Mental Health Counseling, 31*, 189-200.** There is abundant research to support the effectiveness of psychological intervention for chronic pain, especially the application of cognitive-behavioral techniques (Turk, D., & Gatchel, R. (Eds.). (2002). *Psychological approaches to pain management: A practitioner's handbook.* New York: Guilford Press). More than any other counseling approach, the effectiveness of cognitive-behavioral therapy (CBT) in management and amelioration of chronic pain has been supported and empirically tested by outcome-based research (Thron, B. (2004). *Cognitive therapy for chronic pain.* New York: Guilford Press. Turk, D., & Gatchel, R. (Eds.). (2002). *Psychological approaches to pain management: A practitioner's handbook.* New York: Guilford Press). The goals of CBT are to moderate the demoralizing and potentially depressive experiences of the person in chronic pain and to encourage self-efficacy through psychological and physical behaviors that help enhance treatment outcomes (Turk, D. (2002). biopsychosocial perspective on chronic pain. In D. Turk & R. Gatchel (Eds.), *Psychological approaches to pain management: A practitioner's handbook* (pp. 138-158). New York: Guilford Press).

4. **Pavlek, M. (2008). Paining out: An integrative pain therapy model. *Clinical Social Work Journal, 36,* 385-393.** In recent years, leading pain-management centers, Centers for Mind-Body Medicine and Centers for Complementary and Alternative Medicine (CAM) have been addressing the complexity of chronic pain by focusing on holistic, integrative approaches based on biopsychosocial modalities, mind-body healing and alternative medicine (Caudill 1995; Osborne et al. 2006; Roelofs et al. 2002; Sandmaier 2000; Secor et al. 2004; Wallis 2005). The following modalities are effective in pain management: cognitive-behavioral therapeutic models for chronic pain (Caudill 1995; Grant and Havercamp 1995; Osborne et al. 2006), progressive relaxation (Hammond 1990; Shaw and Erlich 1987), and clinical hypnosis for chronic pain (Barber 1996; Hammond 1990; Erickson 1994; Erickson et al. 1990; Erickson et al. 1976; Rossi and Cheek 1988). Recently, leading pain-management centers for Mind-Body Medicine and Centers for Complementary and Alternative Medicine (CAM) have been treating chronic pain through integrative approaches. Such integrative approaches are based on bipsychosocial modalities, mind-body healing and alternative medicine (Caudill 1995; Osborne et al. 2006; Roelofs et al. 2002; Sandmaier 2000; Secor et al. 2004; Wallis 2005). These approaches support that pain has to be understood and dealt with as a complex mind-body phenomenon that impacts a person's physical, mental social and emotional functioning (Barber 1996; Bloch 2000; Caudill 1995; Erickson 1994; Hammond 1990; Harma et al. 2002; Ohayon and Schatzberg 2003; Rossi and Cheek 1988). Previous research reveals that cognitive-behavioral therapy (CBT), clinical hypnosis and progressive relaxation have been effective modalities of treatment for chronic pain (Caudill 1995; Grant and Havercamp 1995; Osborne et al. 2006; Hammond 1990; Shaw and Erlich 1987; Barber 1996; Hammond 1990; Erickson 1994; Erickson et al. 1990; Erickson et al. 1976; Rossi and Cheek 1988).

5. **Farrugia, D. & Fetter, H. (2009). Chronic pain: Biological understanding and treatment suggestions for mental health counselors. *Journal of Mental Health Counseling, 31,* 189-200.** Numerous counseling strategies have been used successfully with persons who experience acute as well as chronic pain. A recent meta study found that cognitive behavioral therapy, behavioral techniques, self-regulatory techniques such as hypnosis and relaxation training, and general supportive counseling all proved not only helpful for clients coping with chronic pain but also reduced pain intensity. (Hoffman, B., Papas, R., Chatkoff, D. and Kerns, R. (2007). Meta-analysis of psychological interventions for chronic low back pain. *Health Psychology, 26*, 1-9).

6. Treatment with psychotherapy has also shown to cause a decrease in the degree to which pain interferes with activity, increasing the ability to cope with pain, and allowing a decreased use of some medications and other physical treatments (Puder RS. Age analysis of cognitive-behavioral group therapy for chronic pain outpatients. *Psychol Aging*. 1988; 3 (2): 204-7.)

7. Patients with mental disorders due to injuries involving pain and stress require the fellowship and spiritual elevation of group encounters with like members just as substance abuse and other medical condition patients require AA meetings or medical condition support groups with human contact to help offset isolation, depression and medical and emotional regression.

8. The following evidence in the literature documents the effectiveness of individual and group psychotherapy in chronic pain patients:

   a) Gamsa A, Braha RE, Catchlove RF, The use of structured group therapy sessions in the treatment of chronic pain patients. *Pain.* 1985; 22(1), 91-6.; Spence SH.

   b) Cognitive-behaviour therapy in the treatment of chronic, occupational pain of the upper limbs; a 2 year follow-up. *Behav Res Ther.* 1991; 29(5): 503-9.; Basler HD.

   c) Group treatment for pain and discomfort. *Patient Educ Couns.*1993; 20(2-3): 167-75.; Li EJ, Li-Tsang CW, Lam CS, Hui KY, Chan CC.

   d) The effect of a "training on work readiness" program for workers with musculoskeletal injuries: a randomized control trial (RCT) study. *J Occup Rehabil.* 2006; 16(4): 529-41.; Thorn BE, Kuhajda MC.

   e) Group cognitive therapy for chronic pain. *J Clin Psychol.* 2006; 62(11): 1355-66.)

9. **Pavlek,M. (2008), Paining Out: An Integrative Pain Therapy Model. *Clinical Social Work J, 36*, 385-393.** The hypnotic phenomenon has been applied for many eras and by various cultures as a healing mechanism. The use of hypnosis first started with Franz Mesmer (1734-1815) (Battino and Thomas 1999; Erikson et al. 1990). One of the first times hypnosis was used to treat pain was in 1845 by Esdaile (1957). He was working as a surgeon in India and used hypnosis for surgical anesthesia and analgesia. The past decade, clinical hypnosis has gained more recognitions as a beneficial pain therapy tool. In 1995, A National Institute of Health (NIH) census found that clinical hypnosis is a reliable and effective modality for treating chronic and acute pain symptoms.

10. **Alladin, A. and Alibhai, A (2007). Cognitive hypnotherapy for depression: an empirical investigation. *Intl. Journal of Clinical and Experimental Hypnosis, 55*(2), 147-166.** There are six clinical reasons for utilizing hypnosis with depression: (a) hypnosis amplifies subjective experience, (b) hypnosis serves as a powerful method for interrupting symptomatic pattern, © hypnosis facilitates experimental learning, (d) hypnosis helps to bridge and to conceptualize responses, hypnosis provides different models of inner reality, and (f) hypnosis helps to establish focus

of attention. Yapko, M.D. (1992). Hypnosis and the treatment of depressions: Strategies for change. New York: Brunner/Mazel. The rationale for inducing hypnotic trance is to produce relaxation, somatosensory changes, and a sense of control. In a research study, the participants who attended the cognitive hypnotherapy group became intrigued that for the first time in their lives they were able to relax completely, replace their depressive feeling with good feeling, and felt empowered to realize that their "mind is so powerful." Hypnotherapists routinely observe such changes in their patients. This study reveals that the addition of hypnotherapy-an extra component to CBT, which largely focuses on changing behaviors and automatic thoughts-enhances treatment outcome.

11. The following research literature have found that cognitive therapy significantly improves symptoms compared with no treatment:

a) Gloaguen V, Cottraux J, Cucherat M, et al., A meta-analysis of the effects of cognitive therapy in depressed people 1998. J Affect Disord 1998; 49:59-72. Search date not stated; primary sources Medline, embase, references in books and Pappers, previous reviews and meta-analyses, abstracts from congress presentations and preprints sent by authors).

b) Elkin I, Shea MT, Watkins JT, et al. National Institute of Mental health treatment of depression and collaborative research program: general effectiveness of treatments. *Arch Gen Psychiatry* 1989; 46:971-982.

c) Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, et al. Randomized controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. *BMJ* 1995; 310:441-445.

d) Dowrick C, Dunn G, Ayuso-Mateos JL, et al. Problem solving treatment and group psychoeducation for depression: multicentre randomized controlled trial. *BMJ* 2000; 321: 1450-1454.

e) Bower P, Rowland N, Mellor Clark J, et al. Effectiveness and cost effectiveness of counseling in primary care. In: The Cochrane Library, Issue 2, 2002. Oxford: Update Software. Search date 2001; primary sources medline, Embase, psychlit, Cinahl, Cochrane Controlled Trials Register; CCDAN trials register, personal contact with experts and CCDAN members, search of unpublished sources (clinical trials, books, dissertations, agency reports, etc.), and hand searches of one journal and reference lists.

12. The following research literature substantiate that in patients with mild to severe depression, psychotherapy in addition to antidepressant medication is more useful/effective than either treatment alone:

a) Thase ME, Greenhouse JB, Frank E, et al. Treatment of major depression with psychotherapy or psychotherapy - pharmacology combinations. *Arch Gen Psychiatry* 1997; 54:1009-1015. Pooled results of six research protocols conducted 1982-1992 at the Mental Health Clinical Research Center, University fo Pittsburgh School of Medicine.

b) Keller MB, McCullough JP, Klein DN, et al. A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy and their combination for the treatment of chronic depression. *N. Engl J Med* 2000; 342:1462-1470.

c) DeJonghe F, Kool S, Van Aaist G, Dekker J, Peen J. Combining psychotherapy and antidepressants in the treatment of depression. *J Affect Discord* 2001; 64:217-299.

13. **Gould RA, Otto MW, Pollack MH, et al.** Cognitive behavioral and pharmacological treatment of generalized anxiety disorder: a preliminary meta-analysis. *Behav Res Ther* 1997; 28:285-305. Search date1996; primary sources Psychlit, Medline, examination of reference lists and unpublished articles presented at national conferences.

II. The following ODG, APA, ACOEM Guidelines, and research literature provide medical evidence that the treatment modalities and the length of treatment recommended for this patient is reasonable and necessary.

14. **ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Pain (Chronic) (updates 12/08/09)** Behavioral interventions: Recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. Several recent reviews support the assertion of efficacy of cognitive-behavioral therapy (CBT) in the treatment of pain, especially chronic back pain (CBP).

15. The APA Practice Guidelines for Major Depression indicate that factors of patient preference and social issues should be considered for the provision of psychotherapy treatment plus medication management treatment. As well, <u>in cases of persistent Major Depression, the Practice Guidelines do not provide for the discontinuation of either modality of treatment, either psychotherapy or medication. In other words, a numerical constriction of the number of psychotherapy or medication visits with the doctor would not be consistent with the standard of care for Major Depression according to the APA Practice Guidelines. "If the patient is symptomatic, the treatment should be continued."</u>

16. In treating depression, continuation treatment has been found to be effective in preventing relapse (Loonen AJ, Peer PG, Zwanikken GJ. Continuation and maintenance therapy with antidepressive agents: meta-analysis of research. Pharm Week Sci 1991; 13:167-175. Search date not stated; primary sources references of textbooks and review articles, Medline, Embase and review of reference lists of primary studies).

17. **ACOEM Guidelines, Page 87,** if personal or psychological factors contribute to delayed recovery, psychological, psychiatric or other behavioral help intervention is appropriate. Continuing medication, physical therapy or surgery without appropriate psychological support in the face of treatment failure creates the expectation of disability.

18. **ACOEM Guidelines, Page 109,** treatment of chronic pain requires specialized knowledge, substantial time and **access to multidisciplinary care.** Judicial involvement of other professionals, such as psychologists, exercise and physical therapists and other health care professionals, who can offer **extra physical or mental therapy** while the physician continues to orchestrate the whole therapeutic process can be helpful.

19. **Chronic Pain Medical Treatment Guidelines, 8 C.C.R. ss9792.20-9792.26, MTUS (effective July 18, 2009), Page 3** "recommended: Psychological evaluations are generally accepted, well established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that re preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. (Main-BMJ, 2002) (Colorado, 2002) (Gatchel, 1995) (Gatchel, 1999) (Gatchel, 2004) (Gatchel, 2005) In a large RCT the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status. (Lin-JAMA, 2003)"

20. **ACOEM Guidelines 2004 Second Edition, Chapter 15,** Stress Related Conditions, Page 388, "Referral for mental health professional assessment may be considered for patients who anticipated absent from work will exceed one week.

21. **ACOEM Guidelines 2004 Second Edition, Chapter 15,** Stress Related Conditions, Page 398, "Serious conditions such as serious depression and schizophrenia be deferred to a specialist, while common psychiatric conditions, such as mild depression are referred to a specialist, after symptoms continue for more than six to eight weeks. The practitioner should use his or her best professional judgment in determining the type of specialist."

22. **Psychological Aspects of Mutilating Hand Injuries. Meyer TM. Department of Psychology, Center for Neuromuscular Sciences, Memorial Medical Center, 701 N. First Street, Springfield, IL 62781, USA.** meyer.therese@mhsil.com The immediate and long-term outcome of a mutilating hand injury can be positively influenced by health care professionals adopting a biopsychosocial perspective toward treatment and management. Such an injury produces a psychological and social impact that should be openly and candidly addressed with the injured individual and with the family. The earlier and more skillfully these issues are addressed, the more likely it is that psychological factors will not impede functional outcome. J Hand Surg [Am]. 1990 May; 15(3):511-5.

23. **Early Psychological Aspects of Severe Hand Injury. Grunert BK, Smith CJ, Devine CA, Fehring BA, Matloub HS, Sanger JR, Yousif NJ. Froedtert Memorial Lutheran Hospital, Milwaukee, Wisconsin 53225.** We investigated the incident and nature of psychological symptoms occurring during the first two months after severe hand injuries. 94% of patients had significant symptoms at some point early in rehabilitation, including nightmares (92%) flashbacks (88%), affective lability (84%), preoccupation with phantom limb sensations (13%), concentration/attention problems (12%), cosmetic concerns (10%), fear of death (5%), and denial of amputation (3%). Two months later, flashbacks (63%) remained pronounced. Nightmares (13%), affective lability (48%), concentration/attention problems (5%), fear of death (0%), and denial of amputation (0%) declined markedly, while cosmetic concerns (17%) and preoccupation with phantom limb sensations (17%) increased. Based on these findings, we believe that psychological treatment should often be given as part of the rehabilitation process. Ann Plast Surg. 1992 Dec; 29(6):532-6.