THE WETC PSYCHOLOGY NEWSLETTER

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Apportionment of Orthopedically Produced Permanent Psychiatric Disability: Food For Thought

Whether it's in personal injury or workers' compensation, a large proportion of psychiatric injury claims are a result of orthopedic injuries. Typically, what has occurred is that an individual has suffered a physical injury that falls into the domain of orthopedics and, for one reason or another, there are residuals of that orthopedic injury that have not gone away and may never dissipate. Those residuals may be pain, limited mobility or other functional losses, or changes in the injured person's appearance. At times, those residuals may cause psychological problems, most frequently a clinical depression. However, other psychological disorders may occur both as a result of the orthopedic problem or perhaps other aspects of the event that produced the injury.

When an individual gets clinically depressed as a result of an injury, they typically find their way into some form of psychological and/or psychiatric treatment. If their injury has led to some form of a legal claim or a lawsuit, whether it is work related, due to an injury in a non-industrial auto accident, a non-insured slip and fall involving a social security claim, or a non-industrial injury resulting in a personal disability policy claim, they typically are referred to a mental health practitioner for their treatment. That treatment usually continues until the patient's disorder remits or they are no longer getting any better. Sometimes the treatment is needed for the foreseeable future. Regardless, when there is a claim or lawsuit, reports are written for the insuring agency and/or the attorneys involved in the case. In workers' compensation, when an individual's condition has plateaued they are said to have reached Maximum Medical Improvement or their condition is permanent and stationary.

"*apportionment of permanent psychiatric disability cannot be expected to follow the apportionment of permanent orthopedic disability because different factors or variables are involved in the cause and measurement of those disabilities.*"

In workers' compensation, as well as in other types of claims, in settling the case and providing compensation and benefits, the individual's pre-existing condition is taken into consideration. For example, if a psychiatric injury has been determined to be the result of a work related orthopedic injury, the doctor reporting on the individual's residual permanent psychiatric disability is charged with the responsibility of determining if anything else but the work related injury is responsible for any of the individual's permanent psychiatric disability. In this regard, the doctor's responsibility is to apportion the permanent psychiatric disability, coming up with conclusions as to how much of that disability was a result of the injury in question and how much of it was the result of other factors having nothing to do with the work injury in question.

In some cases, individuals will have had pre-existing psychiatric problems, or have developed subsequent non-industrially produced psychiatric issues, that have contributed to their permanent psychiatric disability and the doctor will apportion or attribute the amount of permanent disability due to those pre-existing or subsequent problems and the amount due to the injury in question. However, sometimes the psychologist or psychiatrist is faced with a situation in which the patient's permanent psychiatric disability is clearly due to their orthopedic problems but the permanent psychiatric disability may not be entirely

due to the industrial injury. For example, it is not unusual for a psychologist or a psychiatrist to deal with a patient who has suffered a traumatic back injury in 2010 that comes on the heels of a prior back injury occurring in 2004. How should the psychologist or psychiatrist deal with that problem when it comes time to apportion their psychiatric disability?

In patients who have had multiple orthopedic injuries, and perhaps multiple claims and lawsuits, the psychologist or psychiatrist must consider what specific aspects of the injury have produced the patient's psychological disorder and hence their permanent psychiatric disability. In approaching this issue, let's stick with clinical depression since that is the most frequent psychopathology likely to be encountered.

People who have developed a clinical depression as a result of orthopedic injuries are likely to get depressed for a number of reasons, such as: persistent and unremitting physical pain, an inability to perform at one's profession or occupation, an inability to engage in previously enjoyed non-industrial behaviors, disruptions in one's social life, unwanted and forced changes in their lifestyle, and changes in one's perception of themselves in a negative direction.

In the hypothetical case alluded to above, where there has been a traumatic back injury in 2010 that comes on the heels of a prior back injury occurring in 2004, all of these changes may have occurred following the 2010 back injury. However, what effect has the prior back injury had on the 2010 back injury and therefore on the patient's psychiatric disorders and disabilities?

In reading the orthopedist's reports about our hypothetical patient, it is not unusual to find something akin to the following statement: "Mr. Jones has a Whole Person Impairment (WPI) rating of 28%, but considering his 2004 injury I am apportioning 25% of his current permanent disability to his 2004 injury."

Well, is this helpful to the psychologist or the psychiatrist apportioning the patient's permanent psychiatric disability? The answer is, "yes" and "no." It is helpful in that it allows the psychologist or psychiatrist to understand that the patient's clinical depression **may** in some part be due to his 2004 injury that led to pain, physical disability, social disruption and changes in self-perception. However, the extent to which the 2004 injury led to the psychiatric injury is not necessarily the same proportion or percentage that resulted in the orthopedist's apportionment.

Essentially, the psychologist or psychiatrist must form an independent judgment of how much the 2004 injury affected the patient's psychological status. For example, for the sake of argument, let's simplify the case. Let's say that the injured worker is an attorney. Let's also say that the attorney may have some physical disability according to the orthopedist's ratings in terms of the DRE or ROM but is still able to do their job without any of those physical disabilities interfering with their performance. Let's also say that the attorney has not suffered any changes in their social life and that their perception of themselves as a worthwhile and functional person has been unaffected. Clearly, from a psychological perspective this attorney's clinical depression is due entirely to the pain. Now, How can the psychologist apportion the permanent psychiatric disability due to this pain in terms of the 2004 and the 2010 injuries? Well, they cannot do so unless the orthopedist has or can make the following statement: "I have examined Mr. Jones and find that in all reasonable medical probability he is in pain and that approximately 25% of the cause of that pain is due to the 2004 injury and approximately 75% of the cause of that pain is due to the 2010 injury." The next orthopedist's report that apportions pain, an inability to engage in specific work and non-work activities, social functioning and/or self-perception will be the first report of that nature that I have seen!

In short, when an individual has had multiple physical injuries in a given medical discipline such as neurology, orthopedics, and internal medicine, to name just three, the apportionment percentages used by those practitioners in addressing the individual's disability in those medical disciplines is of virtually no use in

apportioning the individual's permanent psychiatric disability that has occurred as a result of a psychiatric injury due to a physical injury in those areas. Simply put, apportionment of permanent psychiatric disability cannot be expected to follow the apportionment of permanent orthopedic disability because different factors or variables are involved in the cause and measurement of those disabilities.

The best the psychologist or psychiatrist can do is to identify the disorder, describe the associated permanent psychiatric disability, and connect that disability to specific physical signs, symptoms and other life changing factors found in the patient's history and their medical records and discussed at length in the doctor's report. Considering that practitioners in related medical disciplines, such as orthopedics, do not provide or "apportion" specific signs and symptoms, but permanent disability using methods of measurement not applicable to psychological variables, their reports are not helpful in apportioning permanent psychiatric disability due to apportionable injuries in their disciplines.

This is the thirty-eighth of a series of monthly newsletters aimed at providing information about psychological evaluations and treatment that may be of interest to attorneys and insurance adjusters working in the areas of workers' compensation and personal injury. If you have not received some or all of our past newsletters listed on the next page, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.

February, 2009 – Litigation Problems With The GAF

March, 2009 – Common Flaws In Psych Reports

April, 2009 – The Minnesota Multiphasic Personality Inventory (MMPI)

May, 2009 – Apportioning Psychiatric Disability In Workers' Compensation cases And Assessing Aggravation In Personal Injury Cases

June, 2009 - Subjectively Interpreted Projective Psychological Tests

July, 2009 - Sleep Disorders And Psychiatric Injuries

August, 2009 - Posttraumatic Stress Disorder

September, 2009 - Compulsive Computer Use Disorder

October, 2009 - Major Depressive Disorder

November, 2009 - The Millon Tests

December, 2009 - Psychological Factors Affecting Medical Condition

January, 2010 - Pain Disorders

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March, 2010 - Drugs: Use, Abuse and Dependence

April, 2010 - Common Flaws In Psych Reports #3

May, 2010 - "Impossible" MMPI-2 scores and their consequences for litigation

June, 2010 - Adjustment Disorders

July, 2010 - Bipolar Disorders

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September, 2010 - Symptoms, Signs and the GAF: A Potential Litigation Problem

October, 2010 - What vs. Why: Determining Causality in Psych Cases

November, 2010 - Tightrope Walking and the GAF

December, 2010 - Apportioning Psychiatric Injuries: A More Complete View

January, 2011 - Personality Disorders

February, 2011 - Apportioning Psychiatric Disability With Multiple Orthopedic Injuries

March, 2011 - How To Cx a Shrink

April, 2011 - The Mental Status Examination - Revisited

May, 2011 - Dysthymic Disorder

June, 2011 - The Credibility of Psychological Diagnoses

July, 2011 – Physical and Psychiatric Injuries: A Tale of Three Patients

August, 2011 – Panic Attacks and Panic Disorders

September, 2011 – Psychological Treatment Records

October, 2011 – Anger: An Overlooked Injury

November, 2011 – Neuropsychology and Psychiatric Injuries

December, 2011 – GAF: What Every Litigator Needs to Know

January, 2012 – Violence in the Workplace

February, 2012 – Malingering (V65.2)