THE WETC PSYCHOLOGY NEWSLETTER

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The Nietzsche Factor in Apportionment

When it comes to apportionment, recent research indicates that people with a history of a modicum of life time adversity are less negatively affected by recent adverse events than people with low or high levels of life time adversity. In short, in some cases, that which doesn't kill us makes us stronger.

In almost 30 years of doing workers' compensation evaluations and treatment, I've had my share of dealing with issues of apportionment. My general impression is that most professionals involved in workers' compensation agree with the position that virtually every aversive event in an individual's psychological background is at least a possible source of apportionment. Thus, in psychological and psychiatric reports it is common to see a doctor stating that there has been some permanent psychiatric disability as a result of the applicant's work but that disability can be apportioned to one or more of a variety of past events.

For example, it is common to see doctors apportion permanent psychiatric disability to an abusive childhood, childhood illnesses, the loss of a parent, alcoholic parents, drug addiction in the nuclear family, major medical illnesses, natural disasters, broken marriages, war, deaths in the family, prior aversive experiences in the job market, financial difficulties, legal difficulties, siblings and spouses with one or more of the above difficulties, prior litigations, cheating spouses, broken hearts, unemployment and just about everything else short of hangnails.

The underlying theory in apportioning psychiatric disability to prior aversive experiences is the notion of vulnerability. According to this theory most if not all of life's aversive experiences weaken the individual so that when a serious orthopedic injury comes along, or when a particularly grievous interpersonal problem occurs in the workplace, the applicant is more likely to develop a psychological disorder and a subsequent permanent psychiatric disability. Logically, it makes a lot of sense. Essentially, this school of thought states, "That which does not kill us makes us weaker." However, and there always seems to be a "however," there is a growing body of research literature that says that this concept, if not wrong, is only one way of looking at aversive experiences. In fact, this research seems to be agreeing with the German philosopher, Nietzsche, who said the opposite, or, "That which does not kill us makes us stronger."

Support for this conclusion is found in a recent groundbreaking article published by Drs. Serry, Holman and Silver in the Journal of Personality and Social Psychology. After first acknowledging that a variety of adverse events can have negative outcomes on a person's psychological status, they go on to state that adversity does not always have negative effects on an individual's mental health and psychological well-being and that when such negative effects occur, they are not necessarily long lasting. In discussing their conclusions, they formulated the concept of resilience, which they refer to as the successful adaptation to a potentially traumatic life event or what can be thought of as the individual's ability to rebound from adverse circumstances. Essentially, they believe that people have a psychological immune system that works to minimize the effects of adverse events. In this regard, they talk about stress inoculation or immunization as a result of exposure to stressful events or the "toughening effect" of adversity. Basically, they believe that when bad things happen to good people, those people can learn to master the adversity and gain control over the bad events and become stronger in the process, not weaker.

The basic finding of the Serry, Holman and Silver research is that there is a curvilinear relationship between adverse events and vulnerability such that too much or too little adversity causes a lack of resilience. No one needs to be told how too much adversity can cause a problem but it may be counter-intuitive to see how too little adversity can have a negative effect. However, a good example to keep in mind concerns child rearing. One doesn't have to stretch one's imagination very far to think about how vulnerable an over-protected child might be who has been shielded from all of life's bad experiences. While sheltering a child from stressors may temporarily protect them from distress, in the long run it weakens their ability to cope with adversity. Citing research up and down the phylogenetic scale, they point out that a modicum of adversity, neither too much nor too little, may be the best of all worlds. Too much adversity is crushing and too little prevents the individual from developing mechanisms to deal with tough times.

Now Drs. Serry, Holman and Silver were not just talking through their hats. They collected data from over 2,000 people from all walks of life and found that some lifetime adversity, relative to both no adversity as well as a high level of adversity, has more positive psychological effects. In particular, they found that people with a history of a modicum of lifetime adversity are less negatively affected by recent adverse events than people with low or high levels of lifetime adversity. Of course the trick here is to define what one means by a modicum, which is where apportionment comes into the picture.

In applying the Serry, Holman and Silver data in workers' compensation or personal injury cases, the bottom line is that one cannot simply look at the events that have occurred in a person's life and draw inferences about apportionment from a simple telling of their history. One needs to know what their reaction to those events has been and how they have coped with those adverse circumstances in order to intelligently discuss apportionment. Simply noting the occurrence of adverse events and pulling an apportionment percentage out of one's head is not enough. What is needed in discussing apportionment is sound reasoning for concluding that any event or set of events has resulted in permanent psychiatric disability. Thus, if the doctor wants to apportion an individual's permanent disability to a childhood in which they were exposed to an alcoholic father, one needs to know what their reaction to that experience was and their overall toughness in dealing with life's traumas before one can realistically discuss apportionment.

In short, whether an experience that doesn't kill us makes us stronger or weaker depends on the individual, and simply knowing that they have had a particular experience doesn't tell us much about whether they have been more or less vulnerable to their industrial injury.

Given the above, what the doctor really has to be prepared to do if he or she wants to apportion some permanent psychiatric disability to prior occurrences is to demonstrate that those prior occurrences created vulnerability, not resilience. He or she should not simply be allowed to say "in my professional opinion," since it is possible to collect data that make a summarily provided conclusionary opinion into "bad medicine." For example, if a woman has been widowed the doctor can and should ask her to discuss her grieving process. If grieving is still an issue then it is reasonable to assess how much of an issue and apportion any permanent psychiatric disability appropriately. Similarly, if a man lost a finger in an accident not having to do with the current claim, one can assess the vulnerability associated with that loss by simply asking for a narrative about the loss and listening to how strong the negative feelings are about the loss. Once again, the patient's narrative gives you a basis for apportionment. In the simplest terms, the interviewer can simply ask, "How much does that still bother you?" and then listen carefully to the answer. "Hardly a day goes by that I don't think about it" leads to one set of conclusions; "I put that behind me a long time ago" leads to another.

In short, not all adverse events in a person's life create vulnerability and require apportionment of permanent psychiatric disability. Additionally, apportionment does not have to be a guessing game since the doctor can obtain and use narrative data from the patient indicating what effect a past adverse event has on their current behavior.

This is the forty-second 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

February, 2010 - Common flaws in psych reports #2

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

August, 2010 - Mental Status Examination

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)

March, 2012 – Apportionment of Orthopedically Produced Permanent Psychiatric Disability: Food For Thought

April, 2012 – Depositions are War! How to Win!

May, 2012 –Biofeedback

June, 2012 – The Epworth Sleepiness Scale