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Compensation Psychosis

Kennedy (1946) stated that "A compensation neurosis is a state of mind, born out of fear, kept alive by avarice, stimulated by lawyers and cured by a verdict". This theme, supported by Miller's influential paper in 1961, has ensured that generations of patients have been regarded with suspicion if they dared to present with psychological symptoms following an accident. The view remained unchallenged for over a decade and is still often presented to, and accepted by, our Courts, despite the fact that Miller reached his conclusions after examining patients who presented for legal reports in whose cases it was not surprising that he found a relationship between compensation and psychological sequelae. The psychological effects of proceeding litigation on the victim of an accident remain a matter of current debate. McKinley *et al* (1983), reported differences between those patients suffering a severe blunt head injury claiming compensation and those not claiming compensation. The reports given by relatives of changes in both patients were very similar. However, reports given by patients themselves differed with claimants reporting slightly more symptoms than non-claimants. In a study by White in 1981, the author followed up 163 victims of accidents admitted to the Birmingham Accident Hospital (76 burns and 87 general accidents). One year after their accident, psychological sequelae were found in approximately two-thirds of the group, one-third being moderately-to-severely psychologically affected. There was no statistical difference between those victims in whom the accident had given rise to litigation and in whom the case was still proceeding and those victims where compensation was not an issue.

Miller also reported that symptoms disappeared following compensation, but again recent studies disagree with this finding (Merksey & Woodforde, 1972; Kelly & Smith, 1981). Merksey & Woodforde (1972) report that neuronal loss and axonal damage has been documented even after mild head injury suggesting therefore, that, when a head injury results from the accident, some symptoms might be understood in organic terms allowing further room for misunderstanding and disagreement.

Case history

Mr H.T. was aged 51 at the time of his accident in 1982. Whilst working at a building site a 35 lb thermolite block was thrown from a first floor window down towards a skip on the ground below. On route it struck him a glancing blow on the back of his head, pushing his head forward towards the skip. It is uncertain whether or not he was rendered unconscious, he had a pre-traumatic amnesia of only a few minutes and the length of his post-traumatic amnesia is uncertain. His skull was not fractured and, although he was taken to hospital after the accident, he was not admitted.

The workman who threw the thermolite block accepted full responsibility, explaining that he had not seen Mr H.T. when he threw it. The blame was also accepted by the company. Our patient bore no resentment towards his fellow-worker, though he did feel that his employers had been perhaps less than sympathetic.

In the weeks that followed the accident, he experienced feelings of unreality, during which he would touch various objects to ensure that they really did exist. According to

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his wife he needed constant help and guidance, behaving rather like a child. On occasions, she would even have to do up his shoelaces. He was irritable, argumentative and easily upset. He complained that his memory was impaired, and also of being depressed, saying that he felt a sense of frustration and despair due to his memory impairment. He retained a good appetite and he did not describe sleep disturbance or diurnal variation. Whereas previously he had suffered no disturbance of sexual function, following the accident he was unable to sustain an erection.

Our patient had suffered no previous psychiatric illness and there was no history of any such illness in the family. Prior to his accident he was described as a hardworker, conscientious, and enjoying a good sense of humour.

He is the third of eight children and enjoyed a happy, normal childhood. He attended school until the age of 14 and became an apprentice carpenter and joiner, receiving further education at technical college (day release and evening classes). He later became a foreman carpenter and then a site manager, the latter being his employment for 25 years. At the time of the accident he had been working for that particular building contractor for only a few months.

He married at the age of 24 and has one adult son with whom he gets on well. Both he and his wife stated that they had enjoyed an excellent relationship prior to the accident. The change in his behaviour subsequently did, however, affect it adversely. He has never drunk to excess and was not taking medication at the time of the accident.

Assessment and progress

Mr H.T. was initially referred by his general practitioner for treatment and only later did his solicitor request a legal report. It was felt that many of his symptoms could be understood in terms of a traumatic neurosis but that it was appropriate to investigate further. Both EEG and CT scan proved normal and there was no evidence of intellectual deterioration. His memory quotient, however, was significantly impaired. These tests were carried out on four occasions between 1982 and 1985. His full scale IQ (WAIS) varied between 118 and 121 with the memory quotient varying between 90 and 106. There was no evidence of progressive deterioration. EEG and CT scan repeated in 1985 again proved normal.

Following his accident in February, 1982, he was off work for approximately 5 months. After returning to work for 2 weeks he was unable to continue, becoming markedly upset because he could not recall giving or receiving instructions or whether he had completed various tasks. Following a fortnight at home he again returned to work, then once more found himself unable to cope with his duties, remaining at home for a further 6 weeks. He returned to work again, but in August 1983, became markedly anxious and depressed and was admitted to a psychiatric hospital. He returned to work in November 1983, and remained there until January 1984, at which time he was again admitted to hospital and has not worked since that time. Whilst at home, he was able to exercise some of his skills in the form of carpentry but would require his wife to help him as otherwise he could not remember where he had placed his tools and would constantly mislay them.

In October 1985, he became increasingly agitated and refused to leave his home as he felt convinced that neighbours were spying upon him and that the police were about to raid his house in order to look for evidence to use against him. He was admitted to hospital as an emergency. He freely and spontaneously stated that he felt people would spy upon him in order to interfere with his claim for compensation. He described how, during a previous hospital admission, he came to realise that a fellow patient, a solicitor by profession, had been planted by his former company's solicitors in order to spy upon him and obtain evidence to use against him in court. He believed that a neighbour, a director of a security firm had tricked him into helping him mend a car in order to prove that he was not ill. He suspected that his neighbours were reporting his actions back to the insurance company and was convinced that hidden cameras and microphones were recording his every move and utterance.

He was commenced on Trifluoperazine and within 7 days his paranoid symptomatology was much less evident and a few weeks later he was able to admit that all his previous beliefs must have been erroneous and were "more like a nightmare than reality". During his admission he ate and slept well, mixed with other patients and at no time appeared depressed or tearful. His compensation psychosis has not recurred but his memory deficit and symptoms of anxiety and depression remain some months following receipt of a £50 000 settlement.

Discussion

Following a head injury, this patient initially presented with three problems; (1) a post-traumatic neurosis, (2) a post-traumatic personality change as described by Brooks & McKinlay (1983) and (3) a stable impairment of memory with preservation of global intellectual function. Nearly 4 years after the injury he developed features of a paranoid psychosis, describing delusions whose content reflected his preoccupation with the current compensation claim and legal proceedings. His memory impairment could be explained as follows:

(a) that his memory loss was in essence a deliberate disability produced either to gain compensation in monetary terms or to achieve psychological advantage;
(b) the memory impairment was due to an hysterical amnesia i.e. was produced by unconscious dynamic mechanisms which served to protect the victim of this accident from certain fears which had been caused or resurrected by the accident;
(c) memory impairment resulted from cerebral damage.

The first possibility would seem to the authors to

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be unlikely. Individuals who deliberately produce poor results from psychometric testing tend either to do badly on all the tests or to produce erratic results. In this case tests of intellectual function were similar on each occasion. Initially, verbal scales were slightly higher than performance scales (initial two tests) later becoming virtually identical. Memory quotient remained abnormal when tested on four occasions over 5 years. An organic explanation is most likely and it is supported by the direction of the discrepancy between verbal and performance scales at the initial assessments. It would be hard to accept that a lay person could fake his responses across a wide battery of subtests in order to produce an organic looking pattern. The above tests cannot unequivocally distinguish between organic and hysterical amensia, but again the pattern of results would make the former most likely.

Hysterical amnesia is usually of short duration. The hallmark of hysteria is said to be the absence of psychological distress i.e. 'belle indifference' with the hysterical symptoms protecting the patient against the cause of his distress. In this case the memory loss lasted for 4 years. It remains despite the settlement of his compensation case: the memory difficulties have themselves been the greatest cause of distress to him.

The aetiology of his compensation psychosis occurring as described some 4 years after the accident might also be open to debate.

As a result of differing medical opinions and the failure of the insurance company to agree to early settlement of the case, our patient eventually saw six consultants and two psychologists. He became increasingly preoccupied and anxious over the legal proceedings and particularly upset when he felt there was any implication (by those acting for the insurance company) that he was choosing not to work. It could therefore be argued that the development of his psychosis was due to a natural progression of dynamic processes.

The second possibility is that he coincidentally suffered a psychotic illness and, because of his preoccupation, his delusions naturally took the form described.

A third explanation, the most controversial but perhaps the most interesting, postulates that the organic process which causes memory impairment has eventually led to the development of his psychosis. This accepts the effects of dynamic stresses but suggests an underlying organic abnormality. In this case the process would have caused functional abnormality (both memory impairment and psychosis) without evidence of structural damage as demonstrable by an EEG or CT scan. Such a process is described in the model hypothesised by Wexler (1986) who suggests processes which are intermediary constructs between anatomy and cellular physiology on the one hand, and subjective experience and behaviour on the other.

Whatever the explanation, this patient, like many who have the misfortune to suffer an accident, has experienced great distress. Perhaps in 1986 Kennedy's aphorism could be amended so that psychiatric illness following accidents could be said "to be born out of trauma, kept alive by lack of understanding, complicated by litigation, but requiring appropriate treatment".

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