

# Compensation Neurosis

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The concept of compensation neurosis developed in the wake of the nineteenth century Industrial Revolution and subsequent enactment of workmen's compensation laws. The nosologic designation of traumatic neurosis was not consensually accepted until after World War II; the compensation label was epithetically applied as a simplistic explanation of puzzling postaccident disability. In diagnostic evaluation of postaccident symptoms not attributable to tissue damage, these factors are relevant: secondary gain and loss; alteration in family dynamics; iatrogenic influences, particularly from industrial medical departments; liberalization of workmen's compensation laws; the symbolic significance of money in our culture; the climate of creeping socialism. One consequence stemming from the conceptualization of a compensation neurosis is implicit adherence to the anachronistic mind-body dichotomy.

Twenty-five years ago I wrote, "Some of our medical colleagues and even our legal colleagues use the term compensation neurosis as an epithet. Such use is a slap at the patient, and a slap at psychiatry, saying in a sense that we are fools: we have diagnosed someone as neurotic whereas all that is wrong with him is that he is after money."<sup>1</sup> I might now modify the rhetoric but not the meaning of that statement.

There was a significant number of papers on compensation neurosis in the literature from the 1930s to the 1960s, but current interest appears to be waning, with a few exceptions. A search by the National Medical Library, Washington, DC, for the years 1966 to 1984 revealed 23 articles on compensation neurosis: Germany, 7; Great Britain, 6;

Australia, 5; Spain, 1, Switzerland, 1; France, 1; Israel, 1; United States, 1. The subject seems to be of continuing concern in the United Kingdom and, as in the prior 50 years, primarily by neurologists and neurosurgeons who see patients with head injuries.

A consequence of the Industrial Revolution in the late nineteenth century was a great variety of injuries from new inventions—sewing machines to railroad trains. Complaints, claims, and eventually lawsuits arose as the injured felt themselves victims of machines, unsafe working conditions and exploitive employers. Workmen's compensation laws were enacted in Germany in the 1880s in Great Britain in 1896, and in the United States in 1911. Those laws placed the cost of occupationally induced disability on the employer without regard to fault or negligence on either side and thus removed workers' claims from litigation. The worker had

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no need to retain a solicitor and sue, the employer was not subject to charges of exploitation and negligence, and the courts' workloads were reduced.

### Traumatic Neurosis

The concept of traumatic neurosis was well established by the 1890s, particularly through the clinical observations of Erichsen and Page in England. Erichsen<sup>2</sup> described syndromes he labeled hysteria, neurasthenia, hypochondriasis, and melancholia. He thought them all due to molecular disarrangements in the central nervous system from jolts and blows, thus the historic designation "railroad spine." Page<sup>3</sup> introduced the concepts of nervous shock and functional disorders precipitated by alarm, as well as the idea of physiological rather than anatomical disturbance. The medical experiences in World War I elucidated the psychologic factors in stressful, life-threatening experiences and the multiple maladaptive reactions thereto. In 1921 Ferenczi, Abraham, Simmel, and Jones published a monograph on the war neurosis,<sup>4</sup> delineating a symptom picture that is still considered valid today and clarifying the psychogenic etiology. In the foreword Freud lucidly separated the classical traumatic neurosis from those psychoneuroses upon which his early theories were based.

### The Compensation Label

However, the organic and physiologic orientations of most medical professionals persisted and accident victims were informally categorized as those with legitimate injuries and claims and those with disability out of proportion to the

tissue damage they had sustained. The latter were suspect and regularly labeled some kind of "neurosis": injury, industrial, occupational, indemnity, compensation, litigation, accident. This attitude was simply an extension of a not uncommon medical view of all neurotics, particularly by certain neurologists. "Neurotic" was a disparaging term; adding one of the pejorative designations was doubly demeaning. Strauss and Savitsky<sup>5</sup> complained of "the unwarranted hostility and antagonism toward the neurotic," which led to medical neglect of many injured persons. They quoted Hoch, who reported comments from colleagues calling victims of traumatic neurosis dirty pigs, refusing to have anything to do with such birds and declaring that the application of money, the "greenback poultice," will obliterate symptoms. The virulence of such remarks is surprising and some authors have suggested they are evidences of medical frustration from poor therapeutic results when standard organic treatments are misapplied to nonorganic syndromes.

An American monograph by Huddleston<sup>6</sup> is illustrative of a common neurologic attitude of the time. Although more moderate in word choice than some of his colleagues, Huddleston joined what he termed "the weight of medical authority" is defining compensation neurosis in derogatory terms. He explored many etiologic factors such as age, sex, intelligence, intercurrent disease, and alcoholism but emphasized the importance of a preexisting neurosis or a constitutional psychopathic state. He

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listed some 15 classifications of postinjury neurotic reactions in the literature, attesting to the confused conceptualizations of the time, but stood firmly on his "medical authority." As society condones revenge, the payment of compensation satisfies the worker's revenge motive and the "neurosis" is cured. The basis of compensation neurosis is covetous wishes, which can be appeased by compensation. It is impossible to cure a traumatic neurosis with a lawsuit pending. Huddleston's extensive book is essentially devoid of references to psychiatric writings or concepts. His only quotation from Freud concerned the differentiation of apprehension and fright, indicating that he did have some awareness of Freud's work.

In the 1940s and 1950s a number of papers and books by psychiatrists and psychoanalysts offered alternative explanations to those of the organicists, but the attitude expressed by Huddleston persisted, particularly among British neurologists and neurosurgeons who treated patients with head injuries. An important paper by Miller,<sup>7</sup> based on a study of 200 cases of head injury, perpetuated the familiar viewpoint.

In Miller's series 104 head injuries resulted from industrial accidents and 94 from traffic mishaps. He noted an inverse relationship between the physical severity of the injury and the occurrence of a neurosis; and the pertinence of accident neurosis to low socioeconomic status, employment by a large industry, and below-average intelligence. He summarily rejected all possible psychologic or psychiatric ex-

planations, particularly the concept of unconscious determinants, and defined accident neurosis as a concomitant of the compensation eventuality and hope of financial gain. "The condition is not encountered where this hope does not exist." To "prove" his point he followed up 50 neurotic victims and found 45 had recovered two years after settlement of litigation. He was apparently not aware that the majority of such patients, whether in litigation or not, recover in a two-year period. Several later writers cogently criticized Miller's methodology and conclusions.<sup>8-10</sup>

Such was the interest in the presumed peculiarities of industrially injured or afflicted persons that a new journal, *Compensation Medicine*, was published in 1946, although discontinued several years later. With the rapid ascendancy and acceptance of psychiatry in the 1950s and 1960s, relatively objective accounts of responses to accidents and injuries appeared. Concerning 55 patients after cervical spine fusion, White *et al.*<sup>11</sup> reported good to excellent results in 69 percent of those not involved in compensation and 62 percent of those in litigation. Behan and Hirschfeld<sup>12</sup> studied 300 industrial compensation cases of injured patients refractory to treatment or rehabilitation, comparing them with 30 similar cases involving no lawsuit or litigation to complicate the clinical picture. They found no differences in symptom formation or duration of disability in the two groups.

A study of merchant seamen patients by Leopold and Dillon<sup>13</sup> is instructive: because they were federal employees,

compensation other than medical care was not available to them. After a harrowing experience when their ship sank, 76 percent had distressing and disabling psychiatric symptoms. When re-examined four years later 90 percent were found to have sought psychiatric help and only 35 percent had been able to return to regular sea duty. Kelly and Smith<sup>14</sup> evaluated 42 patients two years after compensation settlement. Twenty-two were still disabled and unable to work but 16 had returned to work before settlement. Of the other four, one had returned to full-time and three to part-time work after settlement. The authors state that the data discredit the myth that money cures a traumatic neurosis.

It is surprising how few authors attempt a definition of compensation neurosis. Many seem to assume that their readers understand the condition without explication. The clearest statements are from writers who accept the usefulness of the label but reject the legitimacy of the condition. Kennedy<sup>15</sup> states that compensation neurosis "is a state of mind, born out of fear, kept alive by avarice, stimulated by lawyers, and cured by verdict." Rickarby's statement<sup>16</sup> is in a similar vein: compensation neurosis "is that behavior-complex associated specifically with the prospect of recompense and is in contradistinction to traumatic neurosis and psychiatric illness, or other illnesses, precipitated by the stress of illness, accident and injury" (p. 333). What seems a global or imprecise conceptualization marks papers by Lloyd<sup>17</sup> and Weighill,<sup>10</sup> who still consider posttraumatic neu-

rosis, accident neurosis, and compensation neurosis synonymous.

### Current Perceptions

That war clouds regularly have medical silver linings was confirmed in World War II. After floundering with the terms combat neurosis, flight fatigue, combat exhaustion, and three-day schizophrenia, most military psychiatrists settled on "traumatic neurosis" and a psychogenic explanation of symptom formation.<sup>18</sup> Additional experience with victims of prisoners of war internment, concentration camps, brainwashing experiments, and civilian disasters further solidified the concept of a gross stress reaction to noxious circumstances. The accumulated clinical evidence was the construct of the officially designated diagnostic category, posttraumatic stress disorder, applicable to many syndromes previously labeled traumatic neuroses.<sup>19</sup>

The current climate in understanding the role of compensation in illness, disability, treatment, and rehabilitation conduces the viewing of a human indivisible biopsychosocial organism<sup>20</sup> and medical endeavor as holistic.<sup>21</sup> Attack on the mind-body dichotomy continues, with attempts to examine that ancient concept in relevant social and cultural contexts. As Engel<sup>20</sup> states:

To provide a basis for understanding the determinants of disease and arriving at a rational treatment and pattern of health care, a medical model must take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effect of illness, that is, the physician's role in the health care system. (p. 132)

As this enlightened view of medical practice has received attention, published papers are describing many symptoms of patients that were formerly labeled compensation neurosis, in a variety of medical conditions not involving injury from accidents or compensation: laryngectomy,<sup>22</sup> blindness,<sup>23</sup> whiplash injury,<sup>24</sup> brucellosis,<sup>25</sup> myocardial infarction,<sup>26</sup> abdominal surgery,<sup>27</sup> poliomyelitis.<sup>28</sup> The common denominator seems to be development of psychologic regression, onset of secondary gain, and incorporation of the sick role into the patient's self-concept.

In applying these broad concepts to the injured patient, it can be said that injury may damage tissues, but accidents happen to persons who are embedded in family, work, and community. Keiser, in his 1968 book, *The Traumatic Neurosis*,<sup>29</sup> devotes separate chapters to the roles of the physician, attorney, employer, insurance company, family, society, and psychiatrist. Another monograph, *The Compensation System*,<sup>30</sup> lists 10 factors influencing the outcome of industrial accidents: the injured person, the safety department of the industry, first aid, the medical department, unions, the industrial organization, family, community, the compensation process, and legal resources.

Certain negative assumptions pertaining to "compensation neurosis" have been cogently questioned by Trimble<sup>9</sup> from a neurophysiologic perspective. Following his thorough review of the literature regarding research findings in brain concussion, he describes the subtle, microscopic changes found in brain

tissue from the mechanisms of concussion and torsion even when unconsciousness was not a clinical factor. Replicated findings of impaired intellectual functioning have been revealed by sophisticated psychologic testing many months postconcussion. He concludes that some neurotic-like symptoms in head-injured patients have a neuropathologic explanation that can be substantiated by careful investigation.

In explaining the continuance or termination of symptoms and disability in the injured patient, most psychologically oriented authorities find value in the concept of secondary gain, derived from the unconscious-preconscious-conscious levels of thinking advanced by psychoanalysis. Having become legitimately ill, injured, impaired, or disabled, certain psychological advantages of the sick role may secondarily accrue to the patient. Disability may legitimize latent dependent needs and longing to be cared for, allow punitive retaliation against an employer or a spouse, provide escape from an intolerable situation, accomplish temporary resolution of preexistent life conflicts (including sexual), allay anxiety and insecurity, or indulge a masochistic need to experience pain.<sup>31</sup> Although those implied advantages are unconscious, that is, not consciously goal-directed, they tend to perpetuate symptoms and vindicate the sick role if they serve relatively well to satisfy the patient's unexpressed needs.

The term secondary gain is a misnomer, in that the gains are illusory.<sup>32</sup> Actually the loser, the patient can "gain" only by remaining ill and disabled in all

roles: worker, spouse, parent, community participant. To obtain a full perspective of secondary gain one should also evaluate secondary loss. As workmen's compensation laws uniformly allow only partial wage payment during time off work, in some cases just 50 percent, the worker is a financial loser<sup>28,33</sup> This point seems to escape those who perceive compensation as curative.

We are said to be the only animals capable of symbolic thinking. Money is a symbol common to most cultures; in the western world it is of paramount significance. As a universal medium of exchange, its symbolic applicability is limited only by our imagination. Thus the promise of monetary compensation can easily represent most of the secondary gains listed above.<sup>29</sup> Although the injured party may seem stubborn by striving wholly for compensation, it is seldom the real issue, but instead a displacement from other important personal struggles.<sup>34</sup>

### **Family Dynamics**

In the recent literature two aspects of the disability-litigation process receive considerable attention: family dynamics and medical practice. Noy<sup>34</sup> states that the primary problem is always within the family and the "secondary gain" is something relevant to the family: status, love, dependency, domination. If the wage earner is disabled, family dynamics are necessarily disturbed; hierarchy, roles, and functions must be realigned and reassigned. Many families are inept in such matters and disorganization results. A change in sexual patterns is com-

mon, is seldom discussed, and produces tension, dissatisfaction, and accusations.<sup>33</sup> An inversion of customary male and female roles may occur, particularly if housewife becomes breadwinner. She may enjoy her new role and status, tacitly encourage her husband's continued disability, and resist returning to her previous domestic position.

Another pattern is manifested in the family's solicitous, overprotective attitude, which, in some cases, represents a "secondary gain" for the patient's wife; a certain subtle satisfaction she realizes from her dominating husband's lessened power. Conversely the family may react angrily to its injured member's seeming withdrawal from proper duties and neglect of responsibilities.<sup>16</sup> The result may be the patient's continuation of symptoms to prove entitlement to the sick role. In other instances illness of one of its members may relieve a stressful ongoing family situation and thus serve a family need.<sup>35</sup> The family may unite positively to meet the crisis<sup>36</sup> in group anger toward the indifferent employer, resistive insurance company, or ineffective doctors, abetted by unrealistic fantasies of a financial bonanza.

### **Iatrogenesis**

Both the medical and the legal professions have been criticized for mismanagement of injured victims. The individual and combined activities of lawyers, courts, insurance company adjusters, and workmen's compensation lawmakers deserve fuller discussion than can be addressed here. The medical profession has been accused of overdiagnosis, overtreatment, and maltreatment of some

patients. Hirschfeld and Behan,<sup>37</sup> in reporting a study of 300 injured, chronically disabled Detroit workers whose treatment had failed, emphasized that the attitude of the plant medical department was crucial. "In accidental injuries the physician is not just the therapist; he is the therapy." Unfortunately many physicians do not understand or accept their role in that light. Thus the emotional or psychiatric factors in the illness are recognized eventually, if at all, by exclusion after many other possibilities have been explored. Particularly in cases proceeding to litigation, overdiagnosis is common<sup>33</sup> and the patient regularly is evaluated by six or eight specialists before someone suggests psychiatric referral. By then symptoms, pain, and incapacity have been repetitively displayed as a signal of psychic distress and an indirect cry for help never yet forthcoming, and the injured person is driven further into psychiatric illness.

Brown<sup>38</sup> and Duncan<sup>39</sup> discuss excessive medical treatment in accident cases. They infer iatrogenic effects from physicians ignoring the psychogenic component, pursuing multiple physical treatments, and losing objectivity in dealing with the unresponsive patients. Physicians may imperceptibly think, "just another industrial case." Duncan suggests that, in those cases of prompt recovery after a financial settlement, improvement "was not due to the money received, but due to the fact that medical treatment was discontinued."

The industrial physician's lot is not always a happy one, and this observation extends to medical specialists to whom industrial physicians may refer patients.

The doctor-patient relationship may be contaminated by an incessant union-employer war.<sup>37</sup> Workers have ready access to the union shop steward whose attitude is frequently (in my experience), "you can't trust the company." The medical department is part of the company structure; its primary function, not unlike that of the military medical service, is to keep as many persons on duty as many days as possible. Consequently, doctor and patient may be thrust into a predetermined adversarial relationship, which often can be managed successfully if the doctor is alert to its potentially negative aspects.

The compensation process does not cause traumatic neurosis, or some vague entity labeled compensation neurosis, nor is it curative; but it cannot be summarily dismissed. It is one factor to be considered in a broad clinical evaluation. Workmen's compensation laws have gradually penetrated every work-related activity, have made compensation for injury freely available if not automatic, and have been liberally interpreted by courts. This trend is part of an ongoing state welfare philosophy, features of which are social security, industrial pensions, health insurance plans, automatic cost of living increases, and general disability compensation (40).

Workers may not fully understand this new social matrix, but they live in it and partake of it. As the law now stands, financial compensation for lost work time is the worker's right, and the burden is on the employer-insurance carrier to disprove entitlement. A workman appearing at the medical office with a badly mangled finger, asked, "How

much is it worth, Doc?" Some workers are amused by, even contemptuous of, the compensation payment system. However, because it is there for the asking, many willingly accept their right to it.

Abuses surely occur. Avarice may consciously influence some claimants. Malingering and other types of fraudulent exaggeration and prolongation of symptoms are possible. Psychiatrists probably see less of those types than other physicians. Simulation of mental illness, including neurotic syndromes, is difficult to maintain over a period of time. Still the psychiatric diagnostician must be alert and capable both of appropriate suspicion and diagnostic techniques that expose malingering.<sup>41</sup>

### Conclusions

The concept of compensation neurosis as a clinical entity, an attitude, or an epithet is based on inadequate and conflicting data, clinical anecdotes, and biased observation. Weighill<sup>10</sup> and Naf-tulin,<sup>42</sup> among others, point to the lack of clear, reliably documented evidence and respectable research studies.

Among the points this review is intended to emphasize are the following:

1. The mind-body dichotomy, which perpetuates either-or conclusions, requires continued attention and refutation. Some parts of current literature still ask, "Is it concussion *or* traumatic neurosis, tissue damage *or* malingering, legitimate injury *or* compensation neurosis?"

2. General systems theory has clinical utility. A given patient is an operating system embedded in a larger system con-

taining smaller systems or subsystems which influence idiosyncratic beliefs and actions. The institutions of family, workplace, medicine, and law have relevance in the individual's particular reaction to a stressful event, including the degree of disability experienced.

3. Because of money's protean symbolic value in our culture, a simplistic assumption that it refers only to cash in hand can lead to clinical misjudgments.

4. Iatrogenesis is an ubiquitous hazard in medical practice, likely to become operative when a given patient does not fit the physician's procrustean test. Self-scrutiny is difficult and too often successfully avoided; it is nevertheless implicit in the Hippocratic oath!

5. The compensation process is established in our social, industrial, and legal systems. Approximately two million industrial and four million highway accidents occur annually. Medicine and the law are essentially involved in the operation of the process. Historic controversies may well continue and it is unlikely that this will be the last paper published on "compensation neurosis."

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