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A Follow-up Study of Accident Neurosis

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Summary: Thirty five claimants with accident neurosis, in which there were gross perplexing somatic symptoms without demonstrable organic pathology were traced and followed-up in their homes, from one to seven years after compensation was received. Few claimants recovered and such recovery as did take place was unrelated to the time of compensation. Family processes leading to over-protection by relatives were examined and appeared to be vitally important in the prolongation of symptoms. The legal process and the delays involved caused great distress.

There can be few medical groups stranger than the knots of up to six senior consultants who, freed at considerable expense from the burdens of the NHS, mingle with lawyers and clients in the corridors of the High Court in compensation cases. They watch with wry amusement the strange mating dance of counsel for the plaintiff's Trade Union and for the defendant's insurance company, as these lawyers explore the chance of a settlement which will avoid a court hearing. Most cases never get to court, but of those that do, most are settled in this way in the corridor, and the system would be unworkable otherwise. For the injured party, this can be the climax of five or six years (occasionally more) of medical treatment after an accident and from two to 15 or more visits over years to different specialists on both sides. There are only two issues in these cases—liability and quantum of damages. It is possible to have the issue of liability separately settled in advance, but more often than not, the injured party does not know until the day of the case whether liability will be accepted. Unless someone else is liable, he will get no money. He may be bewildered by the barrister, who he has usually never even met before (although earlier conferences are possible), when he is told that liability is in doubt, and that he should settle for less than the case would otherwise be worth. It may not be until this stage that negotiation becomes possible. Sometimes the claimant accepts what he is advised is the best that he can get, perhaps on such unsatisfactory ground as the known view of the particular Judge. Sometimes he is too terrified to go into the witness box, and so accepts a settlement which is lower than it otherwise might have been.

Sometimes he fights and often he wins, but it is small wonder that he usually emerges scarred from this strange and chancy experience.

The most difficult cases, with the smallest percentage of agreed medical reports, are those of so-called "accident neurosis", in which one group of usually surgical 'hawks' will be retained by the insurance company and may often be set against a group of medical or psychiatric 'doves', responsible to the Trade Union. The same faces appear frequently on such occasions and their views are often pushed rather further to one side or the other than they would like by the adversarial system. Courts generally hold the view about these litigants that they will get better when they have received some money, and therefore they obtain much less than those with organic injuries. In such cases, opinions are usually given with great force on the basis of very inadequate scientific evidence.

The object of this paper is to present a follow-up study of 35 litigants who represent the most difficult of all, in that they had severe somatic symptoms such as bizarre gait, paralysis of a digit, or incomprehensible pain, where it was agreed that there was no adequate demonstrable basis for these symptoms in physical pathology. Special attention is paid here to social factors which seem to be associated with prolongation of symptoms, and the role of the legal process is critically examined.

Previous studies

None of the previously reported studies are directly comparable with each other, in that they are made up of cases chosen in different ways, and follow-up was often very incomplete. The subjects were sometimes seen again by the doctor who examined them initially, but more often reviewed by letter or from medical records. The first and most influential study is that by Miller, a neurologist, which has held sway in the Courts since its publication in 1961, in spite of subsequent work that refutes it. He advocated the exercise of scepticism in such cases, and pointed out that it was possible for claimants to deceive quite deliberately, or to exaggerate for gain at a conscious level.

Great play was made of a few personal cases in which this happened, and there is no doubt that his view appeals to many lawyers—including in particular Lord Justice Lawton (1979). However, his follow-up study was only concerned with one-quarter of a total group of 200 head injury cases; these impressed him as having "gross neurotic symptoms". With 80% men and 60% of cases arising from industrial accidents, this series is not very different from subsequent ones, but it does differ in having only 50% in the lower social classes and an average interval from accident to settlement of only three years. It was an unrepresentative neurotic group, in that 25% had a moderately severe organic injury as well. There cannot have been great disagreement about them, because only four out of 50 actually came to Court, and two of these lost on liability. The cases in Miller's sample were injured at a time of full employment in Britain, and it is perhaps partly for this reason that they experienced far greater improvement than any group since. Certainly, his figure of 90% of 45 working people who went back to the same or similar jobs has never since been confirmed. The only other study to agree with any of his conclusions was that of Guthkelch (1980), who found a similar inverse relationship between the severity of the head injury and that of any emotional sequelae.

Kelly (1975), another neurologist, also followed-up cases of head injury. Of his group of 100 post-traumatic syndrome patients, he was only able to trace 50 and only obtained information about 43, receiving questionnaires from 31 people—less than a third of his sample. He was impressed by the adverse effect on his group of legal delay and of the resentment that these claimants showed. His group was of similar age to Miller's and showed quite a wide social class range; it contained eight immigrants, and he did not think that they showed greater problems than native-born Britons. In the more difficult industrial times of the 1970s, most of these patients did not get back to work within his average 2½-year follow-up period. Kelly concluded that accident neurosis was a respectable entity of poor prognosis; he felt that doctors did not try to treat it early enough or with adequate energy. He believed that the swing in fashion towards closed head injury as probably not 'organic' was wrong in terms of physical pathology. Kelly later (1981) put forward the forthright view that "it is no longer justifiable for a neurologist or lawyer to stand up in Court and affirm that it is well known that patients with such symptoms immediately return to work after their claim has been settled."

In Australia, Balla a neurologist, and Moraitis, a general practitioner, reviewed (1970) the experience of 82 patients in a single general practice population. The patients were all of Greek origin, at a time when the Greeks in Melbourne were similar to the West Indians in Britain before these were rendered jobless by the present recession, in that they took on the unskilled poorly-paid work which had mainly been rejected by native-born Australians. The group was not specifically selected as neurotic; in fact, 90% had back injuries, so that the series was not strictly comparable to the others mentioned here. Of 80 patients, 40 returned to work before settlement, but only another ten afterwards, and it was only for this latter minority that the time of compensation appeared to influence subsequent events. It was considered particularly important that these people came from a different culture from the native Australian-born majority, and were therefore unable to accept and verbalise emotional distress, except in somatic terms. Neither Cole (1970) nor Parker (1970), both of whom studied groups of patients with accident neurosis, produced adequate follow-up studies. Mendelson (1982) briefly reviewed follow-up studies; he emphasised the generally poor prognosis and the fact that these claimants are "not cured by a verdict". He followed-up 101 patients seen by himself after industrial or motorcar accidents: 33 returned to work before settlement, and of the other 66, he was only able to find nine who had returned to work within the first 16 months after settlement. The work of Ellard (1974) has been influential in focusing interest upon the prolongation of illness by abnormal needs for attention from within the family, but again contains no specific follow-up study.

The most recent studies come from Woodyard (1980, 1982), an orthopaedic surgeon, who found similar characteristics of the syndrome to those recorded by other authors. In his sample, there were more men, more unskilled workers, and more industrial accidents—as well as a rather older group of claimants. The main mode of follow-up involved visiting general practitioners' surgeries to get access to patients' records; 40% were found to have residual symptoms, and those with back injuries had the worst prognosis. Settlement did not in any way guarantee relief of symptoms or return to work, but the consultation rate with their doctors then dropped substantially. Finally, Weighill (1982) has recently reviewed the literature fully and comments upon the absence of adequate follow-up studies, concluding that a prime need is for more systematic investigation of personality and family factors.

Method

We followed-up 35 cases, derived from a group of 50, seen by MJT for psychiatric reports with a view to compensation; all reports were requested by solicitors on behalf of the claimant

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plaintiffs. The cases were selected on the basis that their symptoms showed gross somatisation and that their cases had given rise to medical perplexity and argument. In all cases, orthopaedic surgeons and/or neurologists had said that the patients' symptoms had no adequate organic cause to explain them. These people represent an extreme group in the spectrum of post-accident cases and were much more seriously and inexplicably disabled than any previously reported group of accident victims who have been systematically followed-up. Five of this group had died and ten could not be traced; the untraced group included a high proportion of socially transient West Indians. Tracing was often difficult and involved circularising referring solicitors for permission to visit and for details of any new abode. it also sometimes involved phoning general practitioners and abstracting all relevant hospital records. Index relatives were visited and neighbours were sometimes questioned so that, altogether, 35 out of the 50 whose cases had been settled were traced and interviewed. This tracing often needed substantial detective work.

Two-thirds of the interviews were conducted by CR and the rest by MJT; all interviews took over an hour, except in two cases where the subjects were uncooperative. They were conducted in the subjects' homes, which were visited within a 50-mile radius of Manchester. In all but six cases, full supplementary information was obtained from a close relative, usually the spouse. Subjects were sometimes seen with relatives, but often relatives indicated that they had further comments to make, and were seen separately as well. No specific psychometric instruments or questionnaires were used and no complex family assessment scales were given. The whole study was intended to be exploratory, and we did not have the resources of a full research team; in any case, a substantial minority of subjects would not have tolerated even more lengthy assessments.

In all these family interviews, we were particularly interested to try to establish whether the family had played a role in either establishing or perpetuating symptoms. The clinical observation of MJT before settlement was that severely disabled claimants almost always appeared to have with them relatives who believed in their symptoms and helped them with those life tasks that their injuries made impossible. Because of this, we thought it should be possible to test out whether this pattern of intra-familial dependence would continue. Our hypothesis was that such a pattern would be associated with continuation of symptoms. In forming this hypothesis, we were impressed by the work of Rickarby (1979), who worked in a Hospital Rehabilitation Unit and thought the role of the family was very important. He postulated various mechanisms within the family that might be important as producing a threat to the integrity of the family, when the main provider became ill. Our object therefore was to try clinically to build up a view of the family psychodynamics, particularly those associated with the workplace.

The interview was structured in order to try to answer the following questions:

1. Has compensation been received, and if so how much and how was it used? Did the compensation seem to the subject to be fair, and had it made any major difference to his life?
2. What was the current level of physical and mental symptoms, and what demands were being made on general practitioners and local hospitals?
3. If symptoms were prolonged, was this because of resentment about the former employers or the doctors or the lawyers?
4. Most importantly, it seemed at the original interviews that those most severely disabled were supported in their posture by spouses who believed absolutely in the truth and physical cause of their symptoms. We tried to find out whether or not a major degree of protection by the immediate family continued, and whether such protection appeared to be correlated with the prolongation of symptoms. The quality of the marriage, both sexual and otherwise, was assessed by interview. Specific questions were also asked to find out who took responsibility for domestic tasks and decisions.

Subjects

The group was different from all previous studies in having equal numbers of men and women—in line with national changes in the composition of the employed population in the last 15 years. Two-thirds were married. The average age of 42 (range 28—58), was similar to other reported groups. Of those injured, 75% has suffered accidents at work and the others mainly on the road; there was also one criminal injury for which compensation was being sought. Only seven were non English-speaking (four European and three Asian). All but two of the series fell into social classes IV and V. One-half of the injuries were to the back: another eight were to the hands and arms, and the others miscellaneous, involving disorders of gait, of potency, or of the cervical spine. Thus, the group was broadly similar in age and social class to others that have been reported, but more even in relation to sex and site of injury.

Results

(a) Return to work

An important aspect of this series is that the average length of time elapsing between accident and compensation was higher than in any other, averaging over five years. There was thus a great deal of time for patterns of illness to become fixated and part of the everyday attitude to life.

One Indian lady had never worked, and two subjects (a man with psychogenic impotence and a woman with a hysterical paralysis of a finger) did not leave work. Excluding these, only two men returned to work before settlement, but after settlement, a further four returned to the same work, and four more to easier and less well paid work. Of the eight people who did return to work after settlement, one returned after one year, five after two years, a further man in three years, and another after five. No simple pattern of return associated with payment could be discerned. In the whole series, therefore, return to work was the exception rather than the rule, and did not occur in two-thirds of those involved (or more, if those who died had been included).

(b) Settlements

The actual settlements varied from £24,000 to nil, and only six were over £5,000. The largest was annexed by the lady's husband, and she was merely given pocket money, thus

making her marriage even worse than before. The next largest was mainly squandered in indiscriminate gifts by a lady of extreme religious persuasion. Another two invested £10,000 sensibly, although, as one was in permanent local authority residential care, the money did not greatly help her. Another substantial settlement was lost in an injudicious business venture. All the other settlements just went into the family kitty, sometimes paying off debts, sometimes buying new cars or furniture, sometimes helping with dowries for children. One lady was able to buy her own house, but in nearly all cases, the generally poor level of settlement did not make a major difference to the way in which lives were carried on, and did not appear a fair reward, often for large financial loss and years of continuing invalidism. For what it is worth, two recipients considered their compensation 'generous' and nine considered it 'fair'. The other 22 who received money considered the sums mean. Whether or not the subjects' view of the generosity or otherwise of their settlements is correct, it is certain that far more money would have been given if the court had taken the view that the symptoms were organically based. The fact that there is no structural lesion means, both to the lawyer and to the insurance company doctor, that recovery is always possible.

(c) Psychiatric status

Only two of the whole group had been involved as psychiatric patients after their injuries. One was a man in his forties who suffered from severe pains affecting his chest, arms, and head who was also very depressed and had made several suicide attempts. He had been in a psychiatric hospital on three occasions and was regarded as suffering from a severe depressive hypochondriasis; no physical treatment made more than marginal difference in his case. The other had a paranoid psychotic episode which lasted for a few weeks; it seemed to be related to a schizoid personality and to later marital stress, and not specifically caused by her post-accident psychogenic backache. Ten others could have been regarded as suffering from illness of hysterical or hypochondriacal type, and could have been legitimately referred to psychiatrists. Of these, five had hysterical disuse of the upper limb, two involving fingers only and three involving either a hand or a hand and arm. They were just as handicapped as if the paralysis had an organic cause. Two others had severe bizarre hysterical gait disorder, and three more had profound, totally disabling hypochondriasis. One of these was so badly disabled that she needed care in an old peoples' home. These ten would all reach the level where they could have been rightly classified as mentally ill. Otherwise, many of the subjects were unhappy and worried about their pain or discomfort or empty lives, but not to the level where they would have been generally regarded as needing either formal psychotherapeutic support or as likely to benefit from antidepressant drugs.

(d) Physical status

Only one of those with injury to the upper limb improved. The two who had head injuries improved. The two who suffered from psychogenic impotence had a return of their potency after three years, but with other partners. Of the three with leg injury, one was severely disabled at follow-up and the other two had only minor symptoms.

The most important group were those who had suffered back injury. At follow-up, three were severely disabled, four moderately disabled, and another 11 were still complaining volubly of backache. The single most common complaint was of pain leading to limitation of activity. Men did not work or help in the home, and housewives could not make beds or carry shopping. Those with hand injuries could not sew, cook, or do anything in their gardens.

One lady with a hysterical paralysis of her hand was sitting happily when visited, while her brother was peeling the potatoes for lunch. Another lady of 54 had fallen against her outstretched hand when a works bus stopped too quickly, and had wrenched her wrists. She could not dress, wash, or cook because of pain in her wrists and talked like an amputee of the accident "in which I lost my hands".

The presence of continual pain, which did not respond to very large amounts of simple analgesics, prescribed for years, was offered as an explanation for general unhappiness and bad temper. Insomnia and reduced frequency and enjoyment of sexual relations were usual. Most of the group saw their general practitioners frequently for medication with simple anxiolytics and/or analgesics, and for support.

(e) Role of other groups

It seemed likely that illness might be prolonged by a pattern of resentment against employers, those who precipitated accidents, lawyers, and Trade Unions.

In fact, work-mates came off lightly and were seldom resented. Employers too were seldom criticised, perhaps because this group is so disabled that the question of finding lighter jobs in the same firm usually didn't arise.

Trade Union officials tended to visit soon after the accident and advise that a claim was possible. On the whole, our group thought that the Unions had been helpful and had not pressured them into taking proceedings which they might otherwise not have intended. Where a claimant's course through legal minefields had been disastrous, the initiating Union was seldom blamed. There was only one man (really quite paranoid), who believed that Union officials had arranged for him to lose his job after an earlier accident and had discredited him for years, including during the present proceedings.

Claimants reserved their wrath for the whole medical and legal merry-go-round, even though they would start by saying they knew the professional men had a job to do. They resented the number of different medical examinations for both sides, and complained of distress associated with reliving their accidents and rehearsing their story on many occasions. They found it difficult to have examinations for the benefit of lawyers, when no effort was made to treat them, or indeed to tell them what might be wrong. One unfortunate lady found the orthopaedic establishment in one city entirely against her, and had to make many visits to orthopaedic surgeons 40 miles away to recruit supporters of her position. Some claimants complained in particular of lengthy and frightening interrogation from insurance company doctors.

No less than one claimant in three resented their lawyers. Several had tried to change solicitors, and one had complained about her lawyer to her MP. Foreign claimants were most dissatisfied. The universal complaint was that there appeared to be unreasonable delay. The next most

common was that claimants felt that they were never told what was happening or why. A few thought that their lawyers were not even interested. Those who got to Court were often terrified, and had no idea what to make of their barristers, whom they had usually never even met before. Several regretted the way in which they were told to settle with very little explanation. Those few who 'had their day', and were able to go into the witness box and tell their story were on the whole satisfied that they had been fairly treated.

Family processes

These processes seemed to us at follow-up to be extremely significant. We identified the following four patterns as appearing to be important in family behaviour, although they often overlapped and may appear artificial. We scored each family unit for each pattern, and correlated this with the severity of physical symptoms.

1. Family over-protectiveness

By this, we mean the families' excessive reaction to the initial acute episode, leading to the assuming of responsibility for the patient in both a mental and physical sense. This led in most severe cases to an almost child-like dependence by the patients, many of whom had previously carried out demand-

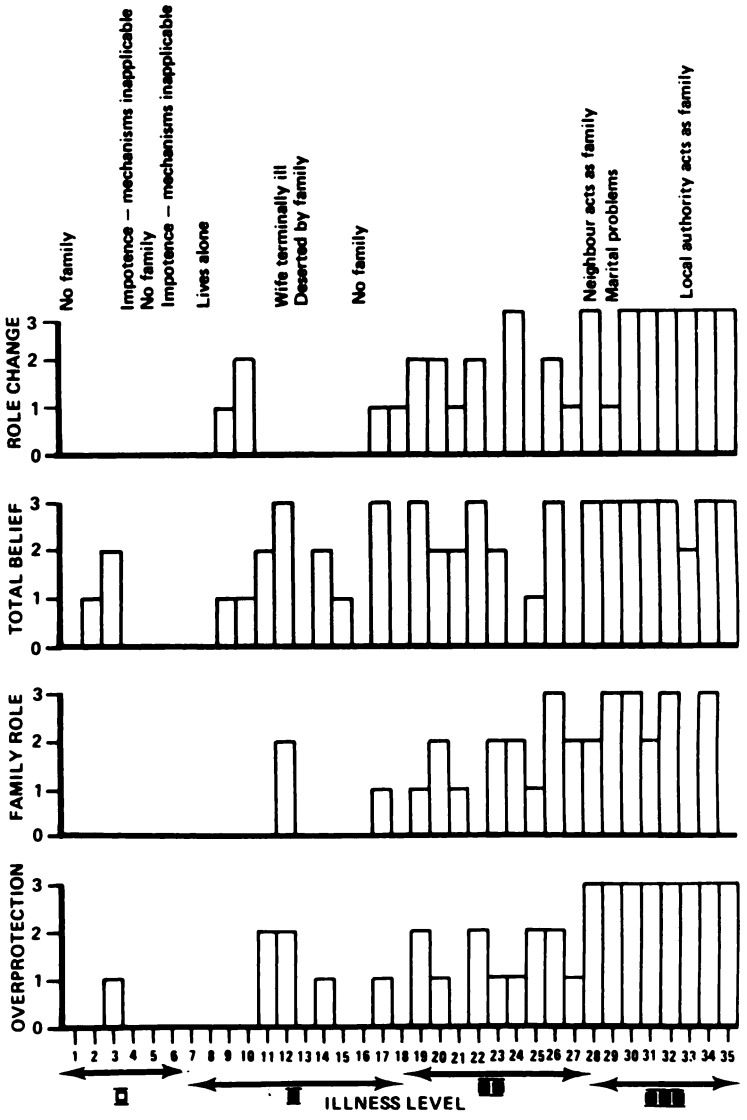

FIG 1. Abnormal family attitudes compared separately with degree of illness

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ing jobs in addition to their domestic commitments. Illustrating this point is the case of Mrs. A, a 32 year-old English lady, who injured her back whilst working as a process-line supervisor. At interview, she was living a life of total dependence, being both literally and metaphorically carried by her husband, and contributing nothing to her physical care, the running of the household or the upbringing of her son. Similar dependent behaviour was shown by Mr. W, described by Teusch (1982) who had a psychogenic paraparesis after a ladder fell on his head and "extracted total attention from his resolute wife who acts as therapist".

2. Providing the family with a role

Here, the secondary gain features of the situation are acting in the family's interest rather than the individual's. The accident and subsequent care of the patient provide the family with a central focus for functioning—"we all had to rally round after the accident".

One family, extending to include a large number of elderly aunts and uncles, had a complex rota system in operation, providing an ever-present attendant for the subject, in addition to running the household and taking over routine domestic work.

Frequently, a whole family had been intimately involved with the compensation claim and its progress through the many visits to specialists. An extreme case of this was Mr. B, the husband of a lady who injured her back at work; he made a 'crusade' of the original compensation claim, pursuing it right through the Court of Appeal after the first settlement. At interview, he and his wife were intricately involved with appeals to the DHSS over its refusal to register his wife as disabled.

3. Family 'total belief'

The total belief of the family in the complaints of the patient appeared strongly to reinforce the patients' acceptance of their post-accident state. This is illustrated by Mrs. C, an Indian lady of 37, who, as the result of a minor head injury, changed from being an active dominant matriarch into an "old and used up woman" (in her own words). She spent most of her day lying down, complaining of head pain, an attitude condoned by her large family as entirely fitting, and they were content to wait on her hand and foot, expecting little in return.

By contrast, one of the few patients judged to have returned to near his pre-accident state was Mr. D, a Jewish man of 43 years who improved within three years from a frightening but not physically serious head injury. The demands of his very large ultra-orthodox family were such that his wife had no time to take other than a robust attitude and insist that she didn't want to accept charity from her religious community any longer than necessary.

4. Role change and entrenchment

This has been alluded to in previous sections, but merits separate consideration. Many examples were noted in which the accident resulted in an upheaval of the family structure with respect to the dominant partner and the parent-child relationship, the previous dominant partner becoming submissive and the children adopting a more care-giving role instead of being care-receivers. Once this rearrangement had occurred, it became entrenched and very unlikely in the absence of a massive stimulus to revert to the position before injury; one spouse said "it would take a miracle for us to be like we used to be".

A further illustrative case was Mr. E, a 42 year-old Indian bus conductor who injured his back at work and became almost totally bed-fast, doing very little for himself. Moving completely away from the traditional Indian male-dominated arrangement, his wife took over completely, and when Mr. E was asked questions, he would look to his wife who could answer for him, confidently referring to *her* home, *her* money and *her* family.

The figures give a quantitative account of the correlation observed between degree of illness and the degree to which we judged a particular family process was important. Both are scored on a three-point scale. Illness varied from (i) mild discomfort to (ii) moderately severe symptoms where outside help is needed, to (iii) very severe symptoms where we judged the sufferer would have needed institutional care if the equivalent had not been provided within the family. The scoring of the role of family processes varies from (i) a minor degree of support to (ii) total identification or (iii) the acceptance of total nursing responsibility. The numbers of sufferers in each illness group from (0) to (iii) are almost the same, and the numbers in the two lower and the two higher groups taken together are equal. The correlations in Figure 1 for each separate mechanism show a nearly exact pattern. The summary chart (Figure 2), combining all mechanisms, shows the same pattern more closely. However, there appears to be a less exact correlation between total family belief and illness level than that operating for our three other factors. It appears, therefore, that even if relatives are convinced of the truth and organic nature of the symptoms in their family member, they do not always automatically move to lavish attention upon him.

It is significant that only two patients were separated from their family (one by divorce and one due to death of spouse), and these were the only two people judged by us to have attained complete and total recovery to their pre-accident status.

Discussion

Non-recovery

It is overwhelmingly clear that, for this group of perplexingly disabled people, Miller's (1961) conclusions do not hold up; return to work was unusual and complete recovery positively rare. Most cases still had continuing and often severe symptoms at follow-up, and about one-third of the group seem certain to be always going to lead lives of invalidism, totally dependent on other family members. This study does not confirm the view of Woodyard (1980) that those with back injuries did any worse than others, nor does it confirm the view of Balla (1970) that loss of libido was particularly malign; so far as libido is concerned, there is usually some diminution, but both of our impotent men did eventually recover. The general view of Kelly (1975) and of Mendelson (1982) and other Australian workers, that the overall prognosis is bad, is confirmed.

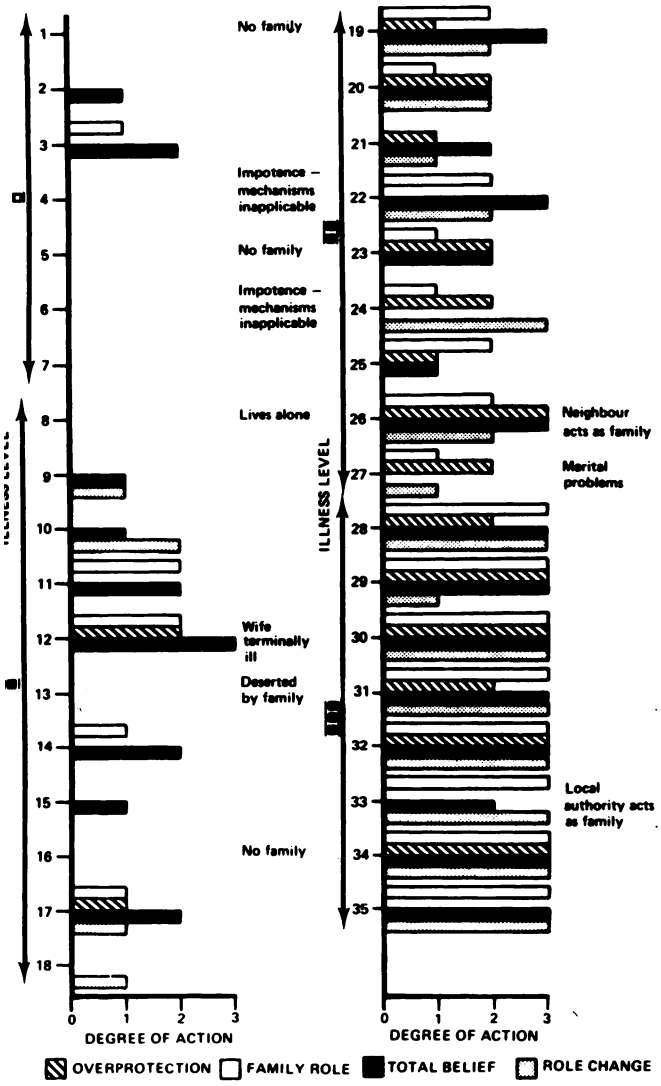

FIG 2. Composite of all family attitudes compared with degree of illness

For immigrants, our results do not confirm Kelly's view that immigrant status is unimportant; they agree with Balla that immigrant status does indeed matter. No less than three of the six of our most seriously disabled group were born in other countries.

This lack of improvement after compensation should of course be appreciated as the main single argument against the insurance company view that many of these people are consciously simulating for financial gain.

Family processes

The influence of families appeared to be paramount; the more that relatives believed totally that a claimant is physically ill and took over helping that person, the more that person relapsed into chronic illness, which becomes a way of life. These collusive family processes have never been exposed and examined systematically by psychiatrists or by social workers, though they might ideally be able to help, once compensation has been settled. No study, including the present one, has been able to demonstrate retrospectively that sufferers had abnormal personalities, poor work records, or abnormal families before their accident took place. Therefore, there appears to be no way of predicting how any particular family might react under these special stresses.

Ellard (1974) and Balla and Moraitis (1970) have both suggested that the structure of immigrant families and their precarious social and financial adjustments in their host countries might contribute to a situation where these families might be less able than others to explore and 'talk out' family problems. We are not in a position to comment upon this view, except to say that we have noted the same immigrant susceptibility in our sample, and feel that such people should be identified, if possible, for help by a professional worker from a similar national background.

Where a family believes in a member's illness and has taken over that member's support, we think it would be extra-ordinarily difficult, if not impossible for that member to recover immediately after money is given out. This may be because the sufferer would, in so doing, tacitly admit that his illness was simulated and would be unable to 'lose face' in front of the believing family. Further research could usefully be directed to exploring with such patients the meaning that they feel their symptoms have in the eyes of their family.

As a practical corollary, we suggest that family members should be routinely seen and assessed as an integral part of a psychiatric examination. Our figures appear to show that, while the neurosis develops within an individual, the support of his spouse and/or total family is needed for that illness to be maintained. It follows, therefore, that any estimate of prognosis will be dependent to a considerable degree on the level of family belief and support that can be demonstrated. The two cases in our series who were severely disabled, but had no families, had both obtained a substitute family—one was looked after by a neighbour and the other by the staff of a local authority home.

Legal matters

If the system were to be changed to help the claimant—as well as the employer—the first necessity would be to

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decide liability early. If potential patients knew where they stood early, and in particular, if they knew that no-one was liable for damages, then it seems likely that much neurosis might not arise. For the rest, particularly in cases where the outcome is not clear, there should be more money set aside to avoid hardship by larger interim payments than is the rule today. The idea that once-for-all payment can dispose of the claim is a legal over-simplification which does violence to medical facts. The law awards compensation on the basis that the plaintiff has reached an end-point of disability, but this is usually not the case. In New Zealand, where no-fault compensation is legally enacted, progressive payments are already made.

It would seem better to make payments of compensation over a reasonable length of time, and to have some form of statutory supervision of them. Where the injury is mainly emotional, psychiatric help and specialised employment rehabilitation measures should be provided, and money only given if the claimant takes up and cooperates to the full with all the help offered. The overall system needs to be accelerated and better explained in all medical, legal, and social aspects so that claimant dissatisfaction should not be the obstacle to improvement that it appears to be today.

Even if the 'no fault' system recommended by the Pearson Commission (1978) is too expensive, and even if these views are too unorthodox, money should be found for some localised trial schemes, along the lines suggested above to see whether some avoidable invalidism could be prevented. The Trade Unions should be asked for active help in such endeavours; in particular, the need for residential facilities for rehabilitation should be examined.

The object of compensation is normally taken to be to put the claimant financially in such a position as he might have occupied if he had not been involved in an accident which was the fault of someone else. A most vital aspect of medical reports, therefore, is to assess the prognosis—that is the degree to which recovery might take place and to which the injured person might move on to other work. If the prognosis in these accident neuroses is as bad as our figures suggest, and if further studies confirm our views, then it must follow that the prognosis for these neurotic illnesses is just as bad as if the illness was physically based, and that the sufferers are inadequately compensated. Because the only compensation possible in our system is financial, it also follows that consideration should be given to increasing the general level of settlement in such cases.

References

Balla, J. I. & Moraitis S. L. (1970) Knights in Armour – A follow-up study of injuries after legal settlement. *Medical Journal of Australia*, **2**, 355–361.

Cole, E. S. (1970) Psychiatric aspects of compensable injury. *Medical Journal of Australia*, **i**, 93–100.

Ellard, J. (1974) Being sick and getting better. *Medical Journal of Australia*, **i**, 867–872.

Guthkelch, A. N. (1980) Post-traumatic amnesia, post-concussional symptoms and accident neurosis. *European Neurology*, **19**, 91–102.

Kelly, R. (1975) The post-traumatic syndrome: an iatrogenic disease. *Forensic Science*, **6**, 17–24.

— (1981) The post-traumatic syndrome. *Journal of the Royal Society of Medicine*, **74**, 242–244.

— & Smith, B. N. (1981) Post-traumatic syndrome – another myth discredited. *Journal of the Royal Society of Medicine*, **74**, 275–277.

Lawton, F. (1979) A judicial view of traumatic neurosis. *Medico-Legal Journal*, **47**, 6–17.

Mendelson, G. (1982) Not "cured by a verdict" – effect of legal settlement on compensation claimants. *Medical Journal of Australia*, **ii**, 132–134.

Miller, H. (1961) Accident neurosis. *British Medical Journal*, 919–925, 992–998.

Parker, N. (1970) Accident neurosis. *Medical Journal of Australia*, **ii**, 362–365.

Pearson Commission (1978) Royal commission on civil liability – and compensation for personal injury. HMSO publication no. 7054/123.

Rickarby, G. A. (1979) Compensation neurosis and the psychosocial requirement of the family. *British Journal of Medical Psychology*, **52**, 333–338.

Teusch, L. (1982) What does the facade of a compensation neurosis conceal? *Medijinische Klinik*, **77**, 730–732.

Weighill, V. E. (1983) Compensation neurosis – a review of the literature. *Journal of Psychosomatic Research*, **27**, 97–104.

Woodyard, J. E. (1980) Injury compensation claims and prognosis. *Journal of the Society of Occupational Medicine*, **30**, 2–5.

— (1982) Diagnosis and prognosis in compensation claims. *Annals of the Royal College of Surgeons of England*, **64**, 191–193.

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