

Psychological Rehabilitation after Trauma (or Mr Dickens' Neurosis)

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 [Keywords to Follow]

Abstract

Angus Lyon considers the literature produced over the last 15 years concerning the treatment of psychological trauma in the NHS and under The Rehabilitation Code, identifies a number of reasons why such injuries are left untreated and encourages more effective co-ordination in provision of treatment between the legal and medical professions and insurers.

Introduction

On June 9, 1865, Charles Dickens was returning from France with his mistress and her mother, travelling by rail to London when the train and most of the carriages left the track as a result of an engineering error. Renovation works were taking place on the track at Staplehurst in Kent at a point where the line ran over a river bridge. Ten people died in and after the accident and 49 were seriously injured. Dickens was 53-years-old at the time. He survived the incident uninjured physically and, by all accounts, acted with considerable presence of mind in rescuing and comforting victims, some with appalling injuries.

Although he remained physically unscarred by the accident, it is clear he was deeply shocked by what he witnessed of its aftermath. Four days after the accident, he wrote to an old school friend Thomas Mitton, apologising for not writing earlier, stating:

“I am a little shaken, not by the beating and dragging of the carriage in which I was, but in the hard work afterwards in getting out the dying and dead, which was most horrible”.

Concluding the letter, he wrote, “In writing these scanty words of recollection, I feel the shake and am obliged to stop”. Had he been assessed for psychological symptoms today, it is

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probable that a provisional diagnosis of acute stress disorder would be made. It seems very likely, in view of the progression of his psychological symptoms, that a formal diagnosis of post traumatic stress disorder (PTSD) would have been made in due course. No doubt he would also have been invited to join class litigation for compensation.

Claimant personal injury lawyers are confronted regularly with clients who have experienced psychological trauma, whether or not they have also been physically injured. Usually, the physical symptoms are identified and treated. It is, however, common for psychological problems to emerge and, in a large number of cases, for these ultimately to become a significant, if not the most significant, aspect of the client's ongoing problems, in many cases unnecessarily so.

For the five years between his accident and his death, it seems clear that Dickens was preoccupied with the horrors that he witnessed at Staplehurst. It is evident that he became an exceptionally anxious rail passenger. In his writings during these years he returned on a number of occasions to describe and allude to scenes of disaster, possibly by doing so to try to achieve some mastery over the grip of his post traumatic recollections.

Had Dickens sustained his psychological trauma today, not only would he be entitled to financial compensation, but also to appropriate psychological rehabilitation.

This article is written with the relatively narrow focus of provision of psychological rehabilitation following assault or accident. From personal experience over recent years as a claimants' solicitor, it seems that notwithstanding publication of various rehabilitation guides, many clients slip through the net where this area is concerned. I detail some of these reasons below. I will generally refer in this article to trauma caused by an accident. It is understood that this type of psychological injury may be caused by a wide range of insults, including both physical and sexual abuse, and by witnessing horrific events. The terms "client" and "patient" are used interchangeably.

Writing in JPIL in 2005, Colin Ettinger stated his opinion that "on the basis of anecdotal evidence, it seems that in the vast majority of personal injury cases, the question of how a claimant can be assisted to a better recovery is not on the agenda".² From my experience, this is particularly true when psychological rehabilitation is considered.

Research studies

Since the Rehabilitation Code was first introduced in 1999, two studies in particular have informed the treatment of psychological injuries in relation to road traffic accidents.

The first of these studies in 1993³ concluded that acute, moderately severe emotional distress following road traffic accidents was common. It was noted that almost one fifth of subjects had suffered from an acute stress syndrome, characterised by mood disturbance and horrific memories of the accident. Anxiety and depression usually improved over the 12-month period of the study, although one tenth of patients had mood disorders at one year. In addition, specific post traumatic symptoms were common. PTSD occurred during follow-up in one tenth of patients and phobic travel anxiety as a driver or passenger was found to be more common and frequently disabling. Emotional disorder was associated with having pre-accident psychological or social problems and, in patients with multiple injuries, continuing medical complications. Post traumatic symptoms were not associated with a

²[2005] J.P.I.L. 5, 45–50.

³R. Mayou, B. Bryant, R. Duthie, "Psychiatric Consequences of Road Traffic Accidents" [1993] BMJ 307, 647–651.

neurotic predisposition but were strongly associated with horrific memories of the accident. They did not occur in subjects who had been briefly unconscious and were amnesic for the accident. Mental state at three months was highly predictive of mental state at one year.

It was concluded in the 1993 study that psychiatric symptoms and disorder were frequent after both major and less severe road accident injuries. Post traumatic symptoms were described as common and disabling. Early information and advice might reduce psychological distress and travel anxiety and contribute to road safety and assessing “nervous shock”.

A follow-up study, published in 2001,⁴ looked into the identification of predictors of one year outcomes for patients in a hospital emergency department following motor vehicle accidents and to describe the prevalence and course of four types of psychiatric outcome. The study concluded that different frequencies and courses of PTSD, phobic travel anxiety, general anxiety and depression were reported by a third of the subjects of the study both at three months and one year following the accident. Many of the subjects reported improvement between three and 12 months, but others described late onset of psychiatric outcomes after the accident.

It was concluded that these four types of psychiatric outcome overlapped, were persistent and had different early predictors. The opinion was expressed that the findings had implications for the early recognition of psychiatric consequences of motor vehicle accidents that would enable early intervention.

To avoid confusion, this article focuses only on these four types of psychiatric outcomes after accidents (PTSD, phobic travel anxiety, general anxiety and depression). It is recognised that co-morbidity of a large number of psychological conditions may occur after an accident. It is also recognised that accident trauma can lead to a wide variety of psychiatric disorders and a patient’s psychiatric condition prior to the accident can sometimes be identified as a predictor for certain disorders. PTSD as a single diagnosis is rare.⁵

The Rehabilitation Code

The Rehabilitation Code was first published in 1999. It was a collaborative venture on the part of a number of organisations involved in the injury compensation process, involving input from both claimant and defendant lawyers, insurers and rehabilitation organisations. The stated aim of the Code, last updated in 2007,⁶ is to promote the use of rehabilitation and early intervention in the compensation process so that the injured person makes the best and quickest possible medical, social and psychological recovery. The objective applies whatever the severity of the injuries sustained by the claimant. The Code is designed to ensure that the claimant’s need for rehabilitation is assessed and addressed as a priority and that the process in so doing is pursued on a collaborative basis by the claimant’s lawyer and the compensator.

The purpose of the Code is to provide a framework within which the claimant’s health, quality of life and ability to work are restored as far as possible before, or simultaneously with the process of assessing compensation. The Code sets out responsibilities for different parties involved in the compensation process. The duty is ongoing throughout the life of the case, but is of most importance in the early stages. The Code emphasises that rehabilitation

⁴R. Mayou, B. Bryant, A. Ehlers, “Prediction of Psychological Outcomes One Year After a Motor Vehicle Accident” [2001] *Am J Psychiatry* 158 8, 1231–1238.

⁵M. Wrenger, C. Lange, M. Langer *et al.*, “Psychiatric disorders after an accident: Predictors and the influence of the psychiatric condition prior to an accident” [2008] *European Psychiatry*.

⁶The Rehabilitation Code 2007.

considerations should be a collaborative process and sets out model timetables for notification, assessment and implementation of rehabilitation. It assumes full disclosure of information revealed on assessment and that this information will be exempt from disclosure in the claims process itself.

International Underwriting Association of London/Association of British Insurers Report

In 2004, the International Underwriting Association of London (IUA) and the Association of British Insurers (ABI) Rehabilitation Working Party published “Psychology, Personal Injury and Rehabilitation”,⁷ a very detailed appraisal of the implications of the Rehabilitation Code of Practice, with specific reference to psychological injuries. The research group included representatives from medicine, insurance, the law and rehabilitation organisations. The purpose of the report was to provide information and guidance on understanding the diversity of outcomes that are found in practice, identifying obstacles to recovery in systems and in individuals and in identifying opportunities for improvement. Recommendations were made as to changes in current practices and as to future research. The Report identified an ongoing dichotomy between medical and legal approaches, indicating that whilst psycho-social factors seemed to be major determinants of ultimate outcomes in many cases, rehabilitative interventions continued to be constrained by the established traditions of the compensation systems (the law) and purely biomedical models (medicine). It seemed to the group that both professions were working to do the best for their client or patient but that lack of co-ordination in these efforts was failing to prevent unnecessary severity and chronicity of psychological harm.

The Report indicated that there was very clear evidence that psychological and social factors were among the most significant predictors of the scale of disability and compensatable outcomes following injury and illness. It was clear that many of the systems used in case handling created psycho-social conditions that actually made outcomes worse than they needed to be or, more often, delayed recovery. The Report concluded that it was not widely accepted that even apparently minor accidents can have significant psychological impact on the victim, contributing to greater physical deterioration, disability and/or slower recovery. Rehabilitation programmes and other interventions were more likely to succeed if they took into proper account the psychological factors. It was thought that this aspect of rehabilitation has received considerably less attention in the United Kingdom than it had in countries such as Finland and Australia. The Report concluded that the physical, psychological and social effects of injury influenced each other and should be considered together, not in isolation.

The Report highlighted shortcomings in the current system of compensation and rehabilitation and recommended changes in medical, legal and insurance practice.

Recommendations were made as to providing a “stepped approach” to medical care. This approach recognises that it is not practical to investigate each accident victim’s psychological state or circumstances at the outset. However, this may change if the condition fails to respond to good routine care. In a minority of cases, individual extra psychological and social care programmes would be required and had been shown to be effective. The paucity of specialists was highlighted.

⁷International Underwriting Association of London (IUA)/Association of British Insurers (ABI) Rehabilitation Working Party, “Psychology, Personal Injury and Rehabilitation” (2004).

The Report found that doctors and therapists are inadequately trained in the recognition and management of psychological and social factors. Both legal and insurance professions should provide education for all levels of case handling and encourage all concerned to look out for high risk cases or cases that do not respond to care. Signs of difficulty can usually be detected within three months of injury, although catastrophic injuries can take longer to become clear.

The Report proposed that both lawyers and insurers should make arrangements for obtaining more detailed assessment in high risk cases and for providing additional services if required. This would require co-operation between lawyers and insurers. Most significantly, it was recommended that appropriate care should not be delayed by medico-legal procedures.

The Report set out recommended treatments and aspirational timetables for ongoing assessment of psychological problems. The therapies of choice for the four conditions with which this article deals are Cognitive Behavioural Treatment (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR). In brief, CBT involves the patient learning skills that help to change negative thought processes, including the use of mental imagery of the traumatic event to help to work through the trauma and to gain control of the fear and distress. EMDR involves making sets of side-to-side eye movements while recalling a traumatic incident. This appears to help reduce distress and to develop more positive emotions, behaviour and thoughts.

Further stress was laid on the inadequacies in training, knowledge and information on the part of medics, lawyers and insurers. From the medical point of view, "knowledge is often patchy and follow-up services are not readily identified". It was emphasised that lawyers and insurers also needed to be aware of the importance of psychological factors. Communication with claimants and psychological experts "are both areas where there is much room for improvement".

Recommendations as to treatment highlighted the fact that in the compensation claim process, reports are often prepared a considerable time after the event and are frequently vague about recommended treatment and how it might be obtained. It is difficult for experts to suggest treatment where resources are scarce, particularly within the NHS. The suggestion is made that there are almost certainly much greater opportunities to use good quality private treatment and that interim awards may be necessary to achieve this.

The Report runs to some 100 pages, is thorough and represents a very detailed analysis of a particularly complex area. A concern must be that, because of the complexity of the subject matter and the day-to-day exigencies of medical and legal practice, the suggestions and recommendations will take a considerable time to become commonplace in the enormous number of cases each year where the client is suffering from trauma related psychological injury (whichever label or DSM diagnosis one applies), and this goes unaddressed.

National Institute of Clinical Excellence Clinical Guideline 26

In 2005, the National Institute of Clinical Excellence (NICE) published its guidelines for the treatment of PTSD by GPs and specialists.⁸ The Guidelines set out timed interventions for those suffering from, or suspected of suffering from PTSD and recommended appropriate drug treatments and psychological therapies. Drug treatments are the exclusive preserve of

⁸Post traumatic stress disorder (PTSD). The management of PTSD in adults and children in primary and secondary care. National Institute for Clinical Excellence, March 2005.

the medical profession and I will deal in this article only with psychological treatments. The application of psychological treatments provided under the NHS, private medical care (if the patient has the benefit of medical insurance) or organised by lawyers under the Rehabilitation Code or interim payment may overlap.

The Guidelines recommend a period of watchful waiting where the symptoms of PTSD are mild or have been present for less than four weeks after the trauma, with a recommendation of a follow-up contact within one month of trauma. Single session interventions (de-briefing) that focus on the traumatic incident are not recommended as a routine step.

Where symptoms have been present between one and three months of the trauma, the patient should be offered trauma-focused CBT. If the symptoms are deemed to be severe, then early CBT is recommended. The patient should be offered between eight and 12 sessions of trauma-focused CBT, or fewer sessions if the treatment starts in the first month after the event. The psychological treatment should be regular and continuous, usually once a week and delivered by the same person.

If the patient has symptoms more than three months after trauma, trauma-focused CBT or EMDR should be offered, again involving between eight and 12 sessions.

Trauma-focused psychological treatment should be offered, regardless of the time that has elapsed since the trauma.

The medical practitioner should consider extending the trauma-focused psychological treatment beyond 12 sessions and integrating it into an overall care plan if several problems need to be addressed, for example, after multiple traumatic events, traumatic bereavement, where chronic disability originates in the trauma or where significant co-morbid disorders or social problems are present.

PTSD sufferers who have no or only limited improvement after specific treatment has been provided, should be offered an alternative form of trauma-focused psychological treatment in addition to pharmacological treatment.

From direct practical, albeit anecdotal, experience involving clients over the last few years, I believe these Guidelines offer an admirable but normally unattainable counsel of perfection for busy medical practitioners. I strongly suspect that this is because of limited NHS resources, but also equally significantly because of the very nature of the conditions themselves, which largely involve a wide degree of psychological avoidance.

Interface Guide 2006

A year and a half after publication of the NICE Guidelines, the British Society of Rehabilitation Medicine (BSRM) produced a study in conjunction with the Royal College of Physicians and the Association of Personal Injury Lawyers (APIL), identifying the need for a strong working collaboration between members of the medical and legal professions when working for people with highly complex disabilities, specifically those with neurological and spinal injury, limb loss, multiple trauma and complex pain issues.⁹

The Guide identified historical communication difficulties between the medical and legal professions and the need for closer co-operation between the two, with recommendations for funding to be set up and provided as soon as possible after a catastrophic injury.

⁹British Society of Rehabilitation Medicine, "Guide to Best Practice at the Interface Between Rehabilitation and the Medico-Legal Process" (London, 2006).

Although not specifically targeted at psychological injuries, the significant thrust of the Guide is to highlight the different models of working of the medical and legal professions to ensure more open communication, provision of funding and collaboration. The same principle applies directly to patients suffering psychological injury.

APIL Best Practice Guide

In 2008, APIL updated its Best Practice Guide on Rehabilitation.¹⁰ Claimant personal injury lawyers will be familiar with the contents of the Guide. Building on the considerable literature that has developed in rehabilitation medicine over the last decade, lawyers are encouraged to consider whether rehabilitation is appropriate in every case. It is emphasised that the Pre-Action Protocol for personal injury claims in the Civil Procedure Rules and the Rehabilitation Code place obligations on lawyers to do just this. The Guide emphasises a holistic approach to personal injury litigation and that lawyers should always consider rehabilitation as well as compensation. Lawyers should think in each and every case, “What can I do to make my client better?”

Different funding options are identified, including NHS medical rehabilitation, private health insurance and defendant liability insurance (whether organised through the services of rehabilitation organisations paid by the defendant’s insurers or by interim payments in the litigation).

Guidance is provided in obtaining an early independent needs assessment and a structured approach is underlined in relation to the assessment of the severity of injuries. Psychological and psychiatric injury are classified under the “Major Injuries” category where there is a definite need for some rehabilitative attention, and also where there is an element of waiting to see how the injury develops with the possibility of future rehabilitative treatment. The object of rehabilitation is to help the injured person back into a normal routine as quickly as possible and to obtain the necessary funds to do so. Case management may be necessary for psychiatric or psychological injury. Recommendations are provided as to procedures for and immediate needs assessment so that appropriate treatment can be provided at the earliest opportunity.

Allowing for the necessary procedural steps of writing the letter of claim to the proposed defendant, response from the defendant’s insurers, early assessment and reporting, it is envisaged that in an ideal claim, agreement may be reached on appropriate treatment within nine weeks or so of injury.

In practice, this will generally mean that if treatment under the NHS (recommended by the NICE Guidelines) cannot be provided within this time scale for whatever reason, it should be available within the medico-legal process. Clearly, if liability for an accident is in dispute, then early proceedings and an application for interim payment will be necessary to fund the rehabilitation.

Rehabilitation—A Practitioner’s Guide

In June 2008, the Bodily Injury Claims Management Association (BICMA) updated its Practitioner’s Guide to Rehabilitation.¹¹ BICMA includes members from the legal profession,

¹⁰ Association of Personal Injury Lawyers, (*APIL Best Practice Guide on Rehabilitation*, 2nd edn (2008)).

¹¹ Bodily Injury Claims Management Association, (*Rehabilitation—A Practitioner’s Guide*, 3rd edn (June 2008)).

insurance industry and rehabilitation organisations and provides definitive guidance in relation to the application of the Rehabilitation Code.

Specifically, in relation to psychological injuries, it recognises that a wide variety of psychological disorders may be triggered by an accident which must be recognised and dealt with. Failure to do so may prevent other treatments from being effective and may hinder a return to work.

The Guide emphasises that support should be offered as soon as possible. This will in part be determined by the willingness of the injured claimant and or their family to accept outside help. This aspect is addressed below. Early assessment can in itself help to identify problems or potential problems in time to prevent prolonged post traumatic stress disorder. Assessment of needed counselling or psychological treatment is best considered soon after the injury and or return home from hospital, in other words normally within the first three months of injury. It is recognised that the need for emotional and psychological support may last much longer than the medical treatment.

NHS . . . the future

The NHS is in the process of implementing the Improved Access to Psychological Therapies (IAPT) Programme,¹² which is designed to support primary care trusts (PCTs) in implementing the NICE Guidelines for patients suffering from depression and anxiety-related disorders. This will include patients with mild to moderate mental health problems. Notionally, this may include patients suffering post traumatic reactions and travel phobias. The intention is that PCTs will be able to provide talking therapies for patients and that they will be able to find sources of treatment closer to home and more quickly than is currently the case. The Programme is being implemented on a phased basis throughout the country and its introduction is planned to continue until 2011.

For the time being, therefore, if patients are left with post traumatic psychological symptoms it seems that treatment of these under the NHS will continue to be inconsistent across different areas of the country, despite the clear indication in the NICE Guidelines that treatment should not be withheld or delayed “because of court proceedings or applications for compensation”. Clients whose post traumatic problems extend beyond three months after accident or assault are likely in any event to be classified as suffering from a “severe” rather than a “mild to moderate” condition. For practical purposes, therefore, it seems that the needs of most patients with significant post traumatic problems will not be met under the IAPT Programme. PCTs’ provision for these patients will inevitably vary. The concern must be that this will create another net for traumatised patients to slip through when providers’ attention and budgets are stretched to the limit at a time of further change in the NHS.

Avoidance and oversight

As referred to earlier, notwithstanding the significant literature in relation to rehabilitation generally and psychological rehabilitation in particular, it will be the experience of many personal injury practitioners that clients’ psychological needs can go unidentified and

¹²See <http://www.iapt.nhs.uk> [Accessed January 7, 2008].

unaddressed in the course of the claims procedure or, where recognised, quite regularly not until considerable time has elapsed during the claim. There may be many reasons for this, including the following:

- The client's distress at reminders of the trauma and reluctance to discuss this with medical or legal practitioners for fear of invoking further painful reminders (e.g. increasing the duration and intensity of distressing flashbacks or nightmares).
- The fear of stigma about the possibility of being branded psychiatrically ill or "mental".
- The hope that memories of the trauma will fade if they are not reactivated.
- Psychological injuries may be masked for some time after trauma by painful physical symptoms.
- Anxieties about undergoing psychotherapy or taking psychiatric medication.
- In many cases the patient will avoid reminders of the accident or injury wherever possible which will include, in road accident cases, travelling by car to see the GP.
- Additionally, on the part of lawyers, an ignorance of the therapeutic help that is available whether under the NHS, privately, or under the Rehabilitation Code, or a failure to appreciate the client's psychological problems.
- Conversely, on the part of the medical profession, an ignorance as to what funding may be available under the Rehabilitation Code or by way of interim payment during the litigation process, as well as failures to appreciate the significance and extent of the client's symptoms or to facilitate early and adequate treatment in over-stretched and under-resourced psychiatric departments.

When writing to his friend, Dickens said, in concluding his letter:

"I don't want to be examined at the inquests and I don't want to write about it. It could do no good either way . . . I am keeping very quiet here."

Dickens recognised that he had what he described as "a constitutional presence of mind". If our clients and patients do not have such presence of mind, then it is likely that their psychological symptoms will be picked up at an early stage. Some who are more self-possessed are likely to be significantly troubled by psychological trauma if ongoing symptoms are suppressed and not adequately identified. Some, like Dickens in his writings, may have the opportunity of expressing these anxieties, maybe to friends or family. Most, however, are not this fortunate and will require considerably more co-ordinated and timely assistance from the medical and legal professions than they currently receive.