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What Price Compensation?

Formulated by the
Committee on Psychiatry in Industry

Group for the Advancement of Psychiatry

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“An accident is not just an isolated occurrence; it is an event which happens in an interactive process.”

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This is the last and ninth in a series of publications comprising Volume IX. For a list of the other GAP publications on current topics of interest, see last page of book herein.
STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 800 psychiatrists, most of whom are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of psychiatry and the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisions a continuing program of work according to the following aims:

1. To collect and appraise significant data in the fields of psychiatry, mental health, and human relations
2. To reevaluate old concepts and to develop and test new ones
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations

GAP is an independent group, and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

WHAT PRICE COMPENSATION? was formulated by the Committee on Psychiatry in Industry, which acknowledges on page 975 the participation of others in the preparation of this report. The members of this committee are listed below. The following pages list the members of the other committees as well as additional membership categories and current and past officers of GAP.

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The preparation of this report took place over a period of several years and during the tenure of three chairmen: Harry H. Wagenheim, Clarence J. Rowe, and Herbert L. Klemme. Current members of the Committee are listed on page 967. Several members who have participated in the preparation of this report have since gone on contributing or inactive status. They are: Spencer Bayles, Thomas L. Brannick, Matthew Brody, Jephtha R. McFarlane, Kenneth Munder, Graham C. Taylor and Harry H. Wagenheim.

The Committee also wishes to acknowledge the assistance of the following consultants during the preparation of this report: Howard Hess, M.D., Alexander Hirschfeld, M.D., Arthur Larson, J. D., Harry Levinson, Ph.D., William D. Longaker, M.D., Virginia McLean, Preston K. Munder, M.D., and Abraham Zaierik, D.B.A.

To all of the above we express our sincere appreciation as well as to our fellow GAP members from other committees who so willingly assisted us in our endeavors. We wish to express special thanks to our colleague, Knight Aldrich, for his valuable assistance and to the following Ginsburg Fellows who also played an active role in our deliberations: Richard A. DeVaul, Anthony Petrilli, and Jack C. Morgan.

Herbert L. Klemme
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PREFACE

For a number of years, members and guest consultants of the Committee on Psychiatry in Industry have studied the subject of the injured employee and the psychological factors concerned with restoring him or her to their previous work role, or as near to its equivalent as possible. This group strongly believes that the psychological factors have received less consideration than is warranted. Although the mental health professions generally are not consulted until all other resources have been utilized, we agree with the statement that “psychological rehabilitation belongs at the beginning, not at the end of the patient’s treatment.”

To give psychological rehabilitation its proper place requires major changes in long-established attitudes and values to allow the application of knowledge that has been accumulating for a number of decades. Failure to use this knowledge is detrimental to the injured employees and their families and results in needless costs to industry. A concerted effort must be made to overcome the resistance to change and to revise the current priorities. This report is designed to:

1. Examine the system as it is;
2. Present a representative case history dealing with compensation problems;
3. Offer a model, primarily as a guideline, to stimulate the groups addressed in this paper and to improve the system.

The report is addressed not only to psychiatrists but also to worker compensation lawyers, compensation insurers, occupational health professionals involved in industry, various members of unions, and national organizations associated with the psychological concerns of workers in industry.
Worker compensation laws are designed to provide satisfactory means of handling occupational disabilities. The advent of the industrial revolution greatly stimulated this phenomenon. The principle, namely, that the employer was responsible for an employee's injury or death which resulted from a negligent act by the employer existed prior to this. Those disabled had to prove that their injury was a result of employer negligence.

The mass movement from the farm to the factory significantly increased the number of industrial accidents and personal injury suits. It soon became evident that the accepted common law defense—contributory negligence, assumption of risk, and negligent acts of fellow workers—operated too severely on claims of disabled workers. Subsequently, to meet this demand, employee liability laws were adopted between 1900–1910. These laws attempted to modify common law defenses; however, employees still had to prove employer responsibility and negligence.

In 1911 the first worker compensation laws were enacted in the United States. Today, each of the 50 states as well as the Dominion of Canada has a worker compensation law. In addition, federal worker compensation laws have been enacted; e.g., the Workmen's Compensation Law of the District of Columbia, Federal Employees Compensation Act, and the U.S. Longshoremen's and Harbor Workers' Compensation Act, the latter providing for private or public employees in nationwide maritime work. Worker compensation laws are designed so that industrial employers assume the
cost of occupational disabilities—without regard to any fault involved. Resulting economic losses are considered costs of production chargeable, to the extent possible, as a price factor. The laws therefore serve to relieve the employers of liability from common law suits involving negligence. What appeared to be a relatively simple situation was subsequently demonstrated to be considerably more complex, so much so that Congress created a National Commission on State Workmen's Compensation Laws. The commission submitted its final report 9 to the President and Congress in July of 1972, and urged the various states to comply with the essential elements by July 1, 1975, by including:

1. Compulsory coverage.
2. No occupational or numerical exemptions to coverage.
3. Full coverage of work-related diseases.
4. Full medical and physical rehabilitation services without arbitrary limits.
5. Employee's choice of jurisdiction for filing interstate claims.
6. Adequate weekly cash benefits for temporary total (disability), permanent total (disability) and death cases.*

It is noteworthy that in the entire 151-page report of the Commission there is only minimal reference to the psychologic and psychiatric dimensions of compensation. This report is an attempt to supplement the commission's recommendations in this area, and except for this deficit, we agree with these essential elements of the recommendations of the National Commission. It is significant that, as reported in the Social Security Bulletin, the U.S. Department of Health, Education, and Welfare estimated that 7.8 billion dollars was spent in 1974 to insure against work injury risks. This is over a billion dollars more than was spent in 1973.

* Words in parentheses added by the committee.

THE COMPENSATION PROCESS AS IT IS

OBJECTIVES OF THE COMPENSATION PROCESS

Six basic objectives underlie worker compensation laws:10
1. Provide sure, prompt and reasonable income and medical benefits to victims of work accidents, or income benefits to their beneficiaries, regardless of fault.
2. Provide a single remedy and reduce court delays, cases, and workloads arising out of personal injury litigation.
3. Relieve public and private charities of financial drain incident to uncompensated industrial accidents.
4. Eliminate payment of fees to lawyers and witnesses as well as time-consuming trials and appeals.
5. Encourage maximum employee interest in safety and rehabilitation through appropriate experience rating mechanisms.
6. Promote frank study of accidents (rather than concealment of fault) reducing preventable accidents and human suffering.

The extent to which the present worker compensation laws have met the desired objectives is less than hoped for. They fragment and fail to integrate all parties involved in the compensation process.

CURRENT ELEMENTS OF THE COMPENSATION PROCESS

Safety function

The safety department in large organizations has responsibility for the prevention and investigation of accidents.
Nearly all large organizations delegate specific responsibilities for safety. They may range from a casual assignment of duties to one person to the development of an extensive department employing highly developed professionals. Such a safety department is accountable for continuous surveillance of the physical aspects of the workplace, the identification, monitoring and control of hazardous materials, the installation of protective devices, the establishment of better safety methods and procedures, the utilization of protective equipment, and training programs for the employees. The staff of the safety department investigates all accidents and, based on their findings, recommends needed modifications for the prevention of future accidents. Often the safety department provides first aid care for the injured employee. However, it is unusual for any safety department to conduct investigations regarding the psychological facts involved in an accident.

**First aid**

The first aid department (provided there is one) is the first unit called to assist the injured person. Variations among organizations are great. First aid availability ranges from nearly ideal arrangements to the absence of any trained personnel or equipment. The most common arrangement consists of a small unit in which there may or may not be a specifically trained professional. Some industries have highly visible, readily available first aid equipment in every hazardous area, and a designated employee on all shifts who is knowledgeable, and who has been provided with approved and current training. Such training rarely includes an opportunity to become aware of the psychological factors affecting the injured person and the concurrent reactions of those in his environment.

**Medical department**

If an injury requires more than simple first aid, the accident victim enters the medical department. Here, too, the facilities provided by the medical system vary widely. Small businesses may rely upon the employee's personal physician to arrange for medical care. The Occupational Safety and Health Administration (OSHA)* requires others to use the emergency unit of the local hospital. In many cases, the work organization designates a local practicing physician as a part-time physician in occupational medicine to oversee the care of the injured employee.

Small medical departments generally consist of a nurse employed part or full time under the supervision of a part-time physician. Large corporate medical departments will generally have central, regional, and local medical directors accountable for the competent care of all employees, consistent with the employers' policies. Many workers in larger organizations also have access to a comprehensive range of services supported by insurance programs.

The medical department usually provides emergency evaluation and, subsequently, definitive care. Such care may be adequate from the physical point of view, but at times has been noted to be impersonal and unsophisticated with regard to psychic distress. The injured person may be identified as "an industrial case" and handled quite differently from patients whose illnesses are not directly related to the work environment. As in other aspects of medical practice, the patient moves from the emergency service to an area of definitive or continuing care. Unfortunately, there are times when emotional factors complicating the physical impairment may be omitted in the evaluation. When recovery is

*Occupational Safety and Health Administration (OSHA) recommends in any work setting where 50 or more people are employed, at least two persons who are graduates of training programs conducted by the American Red Cross. At the present time there is little or no training of a psychological nature in the program.
subsequently hampered by these emotional factors the patient may become the target of unexpressed or unrecognized angry feelings on the part of the treatment team. In addition the physician may be concerned about his own vulnerability to malpractice proceedings should he not eliminate all the possibilities associated with a delayed recovery. Inevitably, many utilize a number of unnecessary laboratory and radiological investigations, as well as frequent consultations, to rule out physical problems. When physical factors are eliminated and the patient still continues to have problems, the treatment team may become increasingly impatient. The patient may be told, "There is nothing wrong with you," or "it's all in your head." In private discussion, members of the team may begin treating the patient as a "malingering"* and a new series of consultations may be requested, further compounding the situation.

In this long, complicated, and contradictory process, the patient may be under the care of a number of physicians, each in his turn responsible for his treatment. Each physician usually focuses upon physical malfunction and reinforces the need of the patient to prove and support his physical disability, thereby avoiding acceptance of a psychological cause for the problem.† Hence, a number of parties including physicians, the patient, the insurance company, worker compensation systems, etc., may request consultation for second opinions to rule out a number of physical disorders. These all, in turn, contribute to reinforcing the pathology of the patient. All too often the psychiatrist is the last consultant to be approached. It is not unusual for two or three years to elapse before the psychiatrist is called upon. By this time, a

* Malingering—Deliberate simulation or exaggeration of an illness or disability that, in fact, is nonexistent or minor, in order to avoid an unpleasant situation or to obtain some type of personal gain.
† Thus there can be an unconscious collusion between the doctor and his patient to avoid acceptance of the psychological cause of the illness. The physician should be made aware that, unwittingly, he may support disability rather than healing.

"traumatic neurosis" is apt to be well established and most resistant to successful intervention.

Depending on the sophistication and size of the city, the patient may subsequently be referred to the rehabilitative or restorative treatment program. The better programs, classically, deal with both psychological and physical disorders of the individual. The rehabilitative program was developed to fully utilize the remaining strength of the injured worker and reduce the encumbrance of his weaknesses.

Compensation

Notification of injury is sent to the compensation insurer immediately following an accident. Every state including the District of Columbia requires employers to provide worker compensation benefits to their employees. Most employers obtain worker compensation insurance to pay these benefits. Many states administer worker compensation programs directly without utilizing private insurance carriers. The statutes were originally enacted to provide benefits for disabilities due to accidental injuries occurring during the course of, and arising directly out of, employment. By repeated extension and amplification of the laws in the legislatures, industrial commissions, and the courts, such benefits are now generally provided for illnesses of whatever nature, whether organic or functional, which are considered to be caused, precipitated, or even aggravated by a condition of employment or any aspect of the work environment.

The injured person may become immediately aware of his involvement in the compensation process. This subsequently may modify his attitude towards himself, his environment, and his treatment program. Soon after any injury, a representative of his employer is required to inform the injured person of his benefits. A report is made to the industrial commission. Most insurance carriers handle this matter in a
routine, impersonal way, using form letters, file numbers, and questionnaires. In the eyes of the injured worker the entire process may seem mechanical, indifferent and confusing. In larger companies, that have their own insurance departments, the procedure can be more individualized and special efforts are made to personally inform the injured person of his benefits. More by act and attitude than by words, it may indicate to the injured person that by having had an industrial accident and subsequent involvement in the compensation system the person is now perceived to be a different kind of worker than he or she was prior to the injury.

When emotional problems are identified and are considered contributory to the injury, the attitude of the insurance company or of the industrial commission may be altered. This might be manifested by intensification of the questioning by these agencies and more detailed probing of the past life of the individual. We are concerned that this leads to unnecessary and increased stress on the individual.

Legal resources

Often disability may become more serious or prolonged. Emotional factors often seem to complicate recovery. Disputes arise between the individual and the administrator responsible for worker compensation decisions. When such disputes and disagreements occur, the individual may wish to obtain legal counsel and transfer the case to the legal system. Courts are available for the ultimate resolution of differences which people are unable to resolve for themselves. Questionable cases and those not covered by precedent must be resolved by the law courts. There are often legitimate delays before the case can be heard, and numerous petitions for postponement by either of the parties. This further increases the nature of the problem leading to reinforcement of certain coping mechanisms, primarily those of regression,* primary † and secondary ‡ gain.

Family

The incapacitation of a family member, particularly one who is the primary wage earner, significantly alters the dynamic equilibrium within the family structure. How the illness is perceived is determined by a number of variables such as personal reaction of the injured person, and the impact of the injury on specific members of the family. The phenomenon of loss, with its associative ambivalent reactions of fear, anxiety and hostility are oftentimes not recognized within the family group. Depending on the previous adaptation of the family to crises situations a number of consequences can develop: (a) the injured member may be isolated, (b) a new leader may emerge leading to further isolation and feelings of rejection by the injured party, and (c) a new dynamic equilibrium is established within the family structure. It is particularly difficult to outline any specific form of family reaction since "injury" may, in fact, exacerbate covert power conflicts already established within the family group. Each family member is significantly affected and the reaction of the members might subsequently facilitate or impede the recovery process of the injured member. Note the parallels between the five stages of dying, as outlined by Elisabeth

* Regression—the partial or symbolic return to more infantile patterns of reacting. Manifested in a wide variety of circumstances such as normal sleep, play, severe physical illness, and in many mental disorders.
† Primary Gain—the relief from emotional conflict and the freedom from anxiety achieved by a defense mechanism. The concept is that mental states, both normal and pathological, develop defensively in largely unconscious attempts to cope with or to resolve unconscious conflicts. All mental mechanisms operate in the service of the primary gain, and the need for such gain may be thought of as responsible for the initiation of an emotional illness.
‡ Secondary Gain—the external gain that is derived from any illness, such as personal attention and service, monetary gains, disability benefits, and release from unpleasant responsibility.
Kubler-Ross, and some of the dynamic reactions within the family group, such as denial, anger, bargaining, depression and acceptance.

Community

A number of authors have stressed the competitive achievement orientation of industrial society. Among them are McClellan's achievement orientation, and Fromm's concept of power. It is within the organization that individuals establish their primary identification; that is, most people are known "by what they do. To work and to achieve is not only experienced positively by the individual, but is also reinforced by a community which rewards this behavior. It would be reasonable to assume therefore that the removal of an individual from this system for a significant period of time would result in negative consequences experienced by the individual as well as shared by his society.

Unions

Traditionally unions have represented workers in a number of areas including: fair pay, reasonable working conditions, vacation and sick leave, health insurance programs (which in recent years have included full or partial reimbursement for the cost of psychiatric treatment), safe working conditions and fair and equitable treatment at work. The union is particularly sensitive to the need for just and equitable treatment of the injured worker. In some instances, however, union policies retard the rehabilitative process; thus, one patient could not return to work on a limited basis because union rules prohibited it, although a gradual assumption of full activity was medically indicated.

The organization

An organization has a culture which is constantly developing and expressing a set of values which is subsequently reflected in the formation of its structure. The degree of openness encouraged or discouraged, the degree of communication developed among the colleagues and the amount of interpersonal investment that is reinforced within the group depends on the character of the organization. Depending on the position of the individual within the organization, a number of responses occur as a result of an injury. This is particularly significant, for it determines in part the individual's ability to subsequently return to the work situation.

The injured person

It is oftentimes difficult to predict the reaction of the individual to injury. A number of variables need to be included: a) the pre-existing characteristics of the injured party including reactions and previous coping mechanisms to stress, loss, dependency and aggression; b) circumstances at the time of the accident; c) the nature of the injury (the area affected associated with the degree and chronicity of incapacitation); d) reality factors determining whether the individual can return to work full or part time; e) circumstances surrounding the individual's life which facilitate or inhibit the degree of incapacitation (primary and secondary gains involved in the accident). For some individuals (primarily on an unconscious basis) the accident may provide an opportunity for restructuring their life. As Hirschfeld and Behan state, "an accident looking for a place to happen."
Return to work

When the individual returns to work the plan followed is in most instances: examination by the treating physician; certification of the employee's ability to resume work; validation of these facts by the medical department or organization consultant; and, finally, a memorandum to the supervisor that the person is ready to return. After a long absence, returning to work can be a source of considerable anxiety and this fact is usually given little or no consideration. In many instances, unless the person can resume full-time employment, he or she is not allowed to return. Some companies, however, do permit gradual resumption of duties as soon as work ability has been determined. Full pay is maintained or resumed and they are given assignments commensurate with their capabilities. This latter attitude can be very beneficial in the restoration of an injured person's confidence.

ILLUSTRATIVE CASE

CASE REPORT

The following case has been chosen from a number of similar cases. It has been thoroughly disguised to preserve confidentiality. It is a condensation of a number of situations designed to demonstrate the dynamic conflicts involved in compensation problems.

On a cold winter afternoon A.A.W., 53 years old and an air traffic controller with more than 20 years of service, took a five-minute break to go to the restroom. He had to walk down an open, outside iron stairway to the floor below. He failed to notice some ice which had formed on the stairs, and as his heel hit the first step he slipped and fell. He suffered injury to his right shoulder, had a pain in his lower back, and pain in his neck where it had struck the steps. A.A.W. lay down for the next two hours and left only shortly before the end of his shift. He was thankful the next two days were not scheduled work days for him. When the pain persisted the next morning, he consulted a chiropractor who reported "...a strained back, right arm, and right shoulder."

Two days later he returned to duty but was very uncomfortable, tense, had only limited use of his right arm, and felt very unsure of himself. He was assigned to a secondary, supporting position in the control tower. When he had not improved appreciably by the end of the week, his supervisor insisted he consult a physician.

Although laboratory and X-ray examinations revealed no abnormalities, the physician reported marked to moderate
pain in the right shoulder with limitation of motion, probably caused by dislocation; pain in the neck; and both pain and limited flexion of the lumbar spinal region. He was also feeling depressed and complaining of dizziness. His physician recommended he be placed on sick leave and prescribed physiotherapy, analgesics, and tranquilizers. A.A.W. commented during the initial examination, "I had told them those steps were dangerous, but they didn't fix them until after I got hurt!"

**Family and personal history.** A.A.W. was born the second of four children having a sister who was two years older, and a sister who was two years younger, and a brother who was ten years younger than he. His father worked for one organization for 46 years. A.A.W. idealized his father, saw him as forceful, dependable, highly respected in his community and on the job, physically strong, never in debt, a good provider who put all of his children through college (except A.A.W. who quit after two and one-half years to join the Armed Services.) A.A.W.'s mother, now 78, was a farm girl from a town near that of her husband and is described as being very affectionate. She and the husband are reported to have had no marital difficulties. A.A.W. had always been in good health and took great pride in his physical well being. He played football in high school and worked out regularly with weights until the day of his injury. His physical health had always been good with the exception that he now has to wear dentures and recently it was necessary for him to have a hemorrhoidectomy.

At 20 years of age A.A.W. was married after nearly a five-year courtship. The marriage was highly compatible and remained so until the time of the injury. Now he feels there is a great deal of difficulty because of his poor disposition. The couple's only child, a daughter, was born in their sixth year of marriage and she has had no problems.

**Work record.** The patient left college at age 21 to join the Armed Services where he remained for four years. Although he has had 25 years experience in the kind of work he now does he has only been working for this company for the last 20 years. During his career he has had several different duty stations in different parts of the country. He has had no unfavorable entries in his work record. After he had worked 15 years at his current position he was offered a promotion to supervisor which he refused.

He describes his work as requiring a continuous attention to an enormous amount of detail. He must maintain instant access to large amounts of precise information. He must be able to monitor as many as five or six different machines simultaneously without making mistakes in any of them.

"I had adjusted to my job being a business and had done it well. It made me feel worthwhile. I had done something which made a difference. Fellow workers who were dependent upon the quality of my work would often come to me and tell me how thankful they were that I did my job efficiently. I ate it up. They recognized me. I often would run into people from the different duty stations I had been in and sometimes they would tell me how they appreciated my helping them out. Before the accident I had something to live for. After that, I lost out on the job that was my life. Work was my hobby, my social outlet, and my recreational resource. It was all my contacts, all the people I knew."

As he worked at his job, A.A.W. was becoming increasingly aware of his aging process and was concerned about how this would affect his capacity to do his job. He was in the second "high five-year period" that would be used in the calculation of his retirement benefits, if he were to retire at the end of 25 years of service. He was also beginning to be aware that the pressures were greater; that the machines were becoming more complicated, and they seemed ever to be increasing their speed. His department was under increasing pressure.
in regard to its mission to prevent breakdowns; and an attitude, partly substantiated by past experience, prevailed that if he should make one mistake, he was likely to be terminated immediately and would lose all of his retirement benefits, without hope of any alternative reemployment.

**Subsequent course.** Within one week of the accident, A.A.W. was placed on sick leave and began to progressively deteriorate. His previous equilibrium was shattered and he apparently could find no gratifications which even approximated those of his job. He began to manifest symptoms of disorganization; he developed a tremor when attempting to use the right hand, he began to tire more easily, he began to become more depressed and irritable around the house and to fly into temper tantrums on minimal provocation; sometimes he would even get so angry he would ram his fist through door panels.

He was referred to a neurosurgeon who found no physical explanation for his symptoms. The neurosurgeon described the symptoms as "conversionary" and noted a considerable degree of "compensationitis." These terms are often used in a pejorative sense and indicated that the physician harbored some hostility toward A.A.W. whether he had been aware of it or not.

Five months after the accident, A.A.W. was hospitalized briefly under the care of a psychiatrist. He was treated for depression and anxiety with antidepressant medication and he improved considerably. He did not accept the recommendation of the psychiatrist that he continue to be seen for outpatient treatment of his problem.

Eight months after the accident, A.A.W. attempted to resume his duties and was able to work for one month. He continued to feel anxious, unsure of himself, and incapable of making decisions. He resented intensely working on a provisional status and being supervised by a man who was many years his junior. He wanted to continue on his job but was persuaded by his friends and supervisors that he should accept medical retirement.*

Ten months after the accident, A.A.W. reluctantly capitulated and accepted medical discharge, but only after reexamination by a number of consultants. They were in agreement stating: "... the patient is unable psychologically to maintain stability enough to be left alone. He also has some limitation of motion in the right shoulder joint and has an intention tremor of the right arm and hand."

Two years after the accident, psychiatric reevaluation was requested by his attending physician. This time the patient accepted psychotherapy on an outpatient basis. He began to admit to intense resentments toward the organization to which he gave the best years of his life, his devotion, and his unquestioning loyalty; an organization which he felt had rejected him with no indication of personal interest. He resented the delays in the making of decisions. Above all, he resented the fact that he could not, at any time, reveal his hostilities since he felt totally dependent upon the administrative whims of the faceless officials with whom he dealt.

He had marked periods of depression associated with suicidal ruminations—his "caring" family role was compromised because he was concerned that his family had not been adequately protected by the disability insurance.

He progressively withdrew from his previous social contacts. He no longer continued his busy correspondence with former associates. He desperately wanted to be back on the job and to take part in the social activities of the work system, but his occasional visits there so intensified his feelings of isolation and noninvolvement that he was distressed for a

* An alliance was established between A.A.W.'s fellow workers and supervisor. The decision to suggest retirement was based on their concern that A.A.W.'s retirement benefits might be lost if he committed an error of judgment as a result of his disability.
number of days after each visit, and thereafter rarely visited his workplace. He would accept invitations from a few close friends to go fishing or hunting, plan to go with some anticipation, but when the time for the trip arrived he would make excuses in order to stay home. His wife had made a number of attempts to get him interested in any kind of activity but without much success.

The changed family constellation. The role of A.A.W. in the family has radically changed. He is no longer the leader. He depends upon his wife for emotional support, direction and guidance. His wife has assumed the responsibility for all of his correspondence because he is "too upset to do it himself." The family acts to protect him against all upsets, which he says he appreciates. At the same time, he experiences a growing resentment at being left out and of having things kept from him.

Summary. Compared to his functioning before the accident, A.A.W. remained virtually an invalid. When the study was concluded, he was 61 years of age and did not work. He puttered a bit in his yard, but no more than thirty or forty minutes each day. He abandoned his physical fitness program because of the aggravation of pain in the sites of the injury. Aside from his family he lived in relative social isolation in respect to his friends and colleagues. Despite eight years of extensive physical treatment along with supportive psychotherapy, belatedly prescribed, he has made minimal improvement.

Interpretive comment

Prior to the accident A.A.W. performed his complex work assignment quite well. Considering the number of variables requiring split-second decisions the job realistically created a considerable number of stresses. The case history indicates A.A.W.'s high commitment to his work, and his personal responsibility for caring for himself physically. The injury had profound effects on his life: it reinforced his sense of vulnerability both in the physical and psychological sense—it indicated to him that he was capable of making a serious mistake. It resulted in a physical impairment which significantly affected his work process and reinforced his concern regarding the aging process. On an unconscious level, however, it removed him from the stress of his job, and the ever-present concern of making a mistake. In fact, the physical impairment justified his retirement and at the same time preserved his sense of self-esteem, as though he were saying, "I would like to work, I just physically can't." His fears were subsequently reinforced by a number of outside influences including his supervisor, physician, friends and family. They, in fact, allowed him "to justify" removing himself from the stressful situation. This did not, however, resolve the problem primarily because of the ambivalent nature of his feelings regarding physical injury and the subsequent retirement from his job. It has allowed him to project strong, hostile, aggressive feelings onto an environment which "forced him" to retire from his position. The coping mechanism of projection thereby allows him to maintain his own sense of self-worth primarily because he can "justify his incapacitation" by holding society responsible for its unfeelingness and lack of support.

At this stage of the traumatic neurosis, there is little likelihood of a successful resolution. The victim of the accident is locked into a situation that is painful to him and to those of his immediate environment. The system is subsequently locked into paying off large benefits for as long as the man lives. There was a period of time when successful intervention and rehabilitation might have been achieved. Should this intervention be delayed significantly, however, the process is set and rather rigid, and resolution of such a complex
psychophysiological problem becomes highly improbable. There were significant clues during the first several weeks of the illness which if properly acknowledged could have possibly led to a more successful resolution. These included: a) disparity between physical evidence of damage and the amount of disability exhibited, b) high levels of anxiety associated with early depressive symptoms, c) failure to improve with treatment. It was at this point that psychological data should have been utilized with the hope that the life course of the individual could have been assessed and possibly altered in order to prevent long-term incapacitation.

THE COMPENSATION PROCESS AS IT COULD BE

INTRODUCTION
The case presented represents a major dilemma confronting our culture. Each of the various groups exposed to A.A.W. consciously and unconsciously exacerbated the conflict and reinforced A.A.W.'s impairment. To find solutions we must transcend limited goals and recognize the need for a unifying approach which deals with the individual as part of a total culture. The following represents a possible model for handling compensation problems in the future.

AN APPROACH TO THE PROBLEM
An accident is not just an isolated occurrence; it is an event that occurs to a given individual at a specific moment of time. It may be consciously or unconsciously determined by that individual or by those in the individual's environment (co-worker, friends, family, etc.). Each accident has a special set of circumstances developed over a period of time influencing the nature and quality of the accident. In the case presented, the conflict of being an air traffic controller was directly proportional to a number of stress variables including, a) the increased congestion of air traffic, b) maintenance of an adequate physical state, and c) dealing with simultaneous communication. Hence a future model regarding the treatment of compensation problems should include the anticipation of factors (age, reaction, stress, etc.) complicating work assignments. The situation is further complicated by the
popular belief that an “accident” implies external responsibility as contrasted with a physical problem (diabetes, hypertension, cancer), in which the disability is viewed as happening to a person exclusive of organizational factors. In summary, the interplay of forces affecting the individual in his struggle to be healthy and avoid sickness are:

1. The psychological determinants within his own personality.
2. The external environmental, psychosocial, and physical events.
3. The individual’s abilities to cope with the external environmental events.
4. The restitutive efforts of both the individual and his environment.

OBJECTIVES OF THE SYSTEM

Earlier, we listed the six objectives which are currently the basis for the worker compensation laws. Although these objectives are satisfactory as far as they go, they are nevertheless inadequate for three major reasons. First, they fail to pay significant attention to the human and psychological side of accidents, and, secondly, they do not adequately recognize any of the three crucial aspects of prevention: primary, secondary, and tertiary. Finally, they lack a perspective of the accident victim and his milieu as an interacting system that recognizes the critical significance of all parties’ contributions to the accident, to its sequelae, and to rehabilitation. All parties must be accountable for the acceptance of the responsibility for utilizing prescribed restorative resources.

Safety function

A number of large organizations (e.g., Polaroid, DuPont, Eastman-Kodak, Exxon) have developed sophisticated safety programs. In smaller organizations two possibilities could exist: 1) the safety department might consist of a first aid designee or team supervised by a rehabilitation team* or 2) the organization could make use of a number of community rehabilitation teams as their safety department, e.g., American Red Cross, hospital emergency rooms, Police and Fire Departments. A safety department should perform a number of essential tasks including the education of employees regarding specific hazards, the investigation of these hazards and accidents, and the coordination of all groups involved to fulfill these functions.

First aid

Once more, we stress the importance of this department as the first step in the rehabilitation process. We propose that in addition to the traditional medical procedures, the members of this department be fully versed regarding the psychological factors during and after an accident process. This can be successfully achieved by continuing education programs which stress the development of psychological and physical skills so as to totally evaluate the injured person.

Medical department

Injury considered sufficiently severe activates the medical department. In a majority of cases the individual is handled with dispatch and in a routine manner. For more complicated situations we propose a task force to serve as a rehabilitation team with the primary physician as the coordinator and director. This team should address itself to the needs of all

*Rehabilitation team is described subsequently under the medical department.
those involved; the injured worker, the family, his fellow workers, his supervisor, management, the union and all the physicians involved or those to become involved including the individuals responsible for worker compensation. This team would have the primary task of integrating and coordinating the efforts of all those involved so as to aid in restorative efforts of the injured worker. Of primary importance is an attempt by this team to anticipate conflicts arising between various groups within the organization. A number of organizations have begun the task of developing a system of evolving, defining and refining their modes of operation. We propose that this team should be in constant operation. The team would have four basic functions: 1) prevention, 2) training, 3) supervision, and 4) treatment.

There are certain physicians who would prefer to delegate the psychiatric aspects of treatment to the rehabilitation team or another specialist. Others prefer to be responsible directly for the total treatment and only request supervision by the team when necessary. Thus, there will be team members qualified to supervise the physicians as they deal with the often vague and disquieting task of giving psychological support. When the demand is large enough, supervision could be carried out with physicians who meet in groups specifically to discuss the psychological components of disability cases. These groups would be led by a psychiatric consultant or team leader who would be skilled in such supervision and knowledgeable about the psychological issues involved in compensation problems. In addition to those on the team with specific medical knowledge others would include: ambulance drivers, first aid workers, safety experts, union stewards, hospital receptionist, and many others who come in contact with the accident victim. Supervisors should be made increasingly aware of signs of fatigue or distraction which would make an individual more vulnerable to injury or accident. Further, they can be taught to be aware of the more subtle signals ordinarily escaping attention by an organization (covert hostility, depression, etc.). Large industrial plants would more likely elect to develop their own team to serve their employees under the auspices of the medical and/or personnel departments. In small industrial organizations and in smaller communities, such teams could be provided by private medical groups, including the emergency care specialty programs in the local hospitals.

Within this team a new medical paraprofessional could emerge. These persons would develop skills necessary for the rehabilitation team, and together with a nurse could perform many of the functions now considered to be within the exclusive role of the physician.

Compensation
The compensation system should require early assessment of both physical and psychological function. Early in the process of treatment and restoration a psychological assessment is crucial. We do not necessarily speak of detailed psychiatric interviews or psychological test batteries. Rather, the designated leader of the rehabilitation team should assume the responsibility for integrating relevant information from all members of the team. The assessment will vary considerably from case to case. In relatively uncomplicated situations with minimal disability, it may be only the nurse or physician who sees the patient and who incorporates a psychosocial evaluation in his or her workup. In the more complicated case, every member of the team as well as outside consultants may be responsible for identifying factors impeding recovery. This includes integrating the mechanics of the compensation process into the treatment and rehabilitation program in a constructive manner. This is both to the economic advantage of the employer and to the psychological advantage of the patient.

The injured person should be encouraged to seek all
necessary help. The therapies prescribed for both physical and psychological disorders should be equally available to the patient, without discriminatory or arbitrary limitations, now often a part of the worker compensation process (e.g., no more than 10 hours of psychotherapy or a maximum of $250 for psychiatric care).

It has often been suggested that a lump sum financial award be made to the injured person as a way to erase the continuing need for psychological dependency upon disability. This is in opposition to the customary practice of partial extended payments for an indefinite period. We do recognize the value of such early administrative resolution and endorse the concept in principle. However, we understand both the legal and medical rationale for the present practice stimulated by the lack of easy determination of ultimate degree of disability. More important, we believe, is the early assessment and appropriate referral for treatment—a process which we feel would be accomplished by the system proposed.

Legal resources

Communication with a legal expert* in the field of compensation suggests several areas of common understanding between legal and psychiatric professionals concerning emotionally disabling reactions to injuries. Traumatic neurosis is universally compensable. The notion of compensation for emotional disability has a long tradition. Both legal and medical authorities agree that rehabilitation is a central aspect of the compensation process, and there is an important role to be fulfilled by psychiatrists in regard to that issue.

The system as it could be needs to evolve further certain concepts as follows:

1. The “victim” of injuries should truly be considered in a broader sense. The work group, the family of the “hurt” person, the organization for which he works, etc., are also injured.

2. More effective incentives for rehabilitation must be found which will act upon employee and employer at the same time. Perhaps legal authority could appropriately find a balanced method to more nearly approximate this need.

3. Because compensation awards, when appropriate, are generally made upon a medical record, it is clear that psychological facts need to be observed and recorded from the earliest stages of evaluation and treatment of an injury, and this needs to be accomplished in a much more systematic fashion than is generally the present case.

4. While legal and psychiatric authorities may consider “protracted delays” from somewhat different perspectives, it appears to the advantage of all concerned to have legal matters resolved as expeditiously as possible. Since the legal system considers that any factor which triggers or precipitates or aggravates—or even renders symptomatic an underlying condition and makes it disabling—is regarded as a cause by the law, then it might be considered that sometimes the legal system itself, compensation, the administrative system, and delays in getting the case to court may constitute just such factors.

5. While it seems a firm belief in the legal tradition that the facts of a compensation case are frozen at the time the injury becomes stabilized, physicians understand the human organism to remain in a constant dynamic state reacting to present and past events, and that the dynamic aspect of this state is as real and important as any other fact.

More dialogue is needed between legal and medical authorities to apply these principles in a humane and pragmatic manner to injured people.
Family

We strongly urge that the family receive serious consideration in the rehabilitation process, particularly in situations where the recovery period is anticipated to be a long one. This would involve use of a professional to increase the sensitivity of the family as well as alert them to any potential complications in dealing with loss due to such phenomena and in certain situations preparing them for alternative lifestyles, particularly where full recovery is not anticipated. The ultimate purpose, as with all supporting groups, is to reduce the potential for chronic dependence and subsequently facilitate the patient's successful return to work.

Community

Realistically it is very difficult to change the patient’s subculture. To a large extent each community is defined by social, ethical, and moral values. These value systems (while not universal) remain relatively fixed and are reinforced and perpetuated by the participants of the community. A change in such a system, i.e., an attempt to alter a particular belief, will be perceived as threatening and will subsequently be resisted by the group. Value systems, however, do change when the community can be made aware of the benefits.

Hence we recommend sensitizing and educating the community regarding a number of specific issues, i.e., dealing with the effects of psychological and physical loss, competition, reentry into the community following an impairment, and the concept of identity as a total phenomenon rather than identity that depends on “job-related status.”

Unions

Unions have many opportunities to help accident victims. These include:

A. The education of persons regarding the stress of the job and methods to cope with these conditions.
B. Retraining programs for those not able to continue with previous assignments.
C. Part-time employment in order to minimize the stress of the return-to-work phenomenon.
D. Cross conferences with management to bring the psychological perspective to bear on all subsystems in the compensation process.

The organization

An injured worker significantly affects the morale of his colleagues. Some may feel responsible, others may identify with the injured person and express anxiety that similar things might occur to them. It is important to recognize this fact: that when one is severely impaired, all are injured (psychologically speaking). Periodic educational programs associated with sessions allowing workers to express their concerns would be advantageous in minimizing these potential effects.

The injured person

The injured person is highly vulnerable. His relationship to himself and others is significantly affected by a number of variables. This is particularly true in an individual who has attempted to master control and establish his sense of independence. As Nemiah states:

We can understand this seeming paradox of a person who has always been a pillar of strength and is now quite a helpless invalid, if we look upon both forms of behavior as aspects of a psychological conflict: on the one hand there are in each of these patients excessively strong dependency needs and a potential for violent anger if these needs are not gratified; on the other hand, the patient maintains an image of himself as independent and self-controlled, repudiating anger and de-
pendence as signs of weakness. To control the latter tendencies, he works excessively hard and maintains excessive controls over his anger; he leans over backwards, so to speak, to be the opposite of the sort of person whom he considers weak (a form of psychological defense mechanism termed reaction formation).

The psychological equilibrium thus set up is a successful solution to the conflict of opposed inner tendencies—indeed it enables the individual to be, in fact, a hard-working, conscientious, and valuable member of society. But it also makes him vulnerable, when he is injured, to psychological problems that may seriously jeopardize his recovery and rehabilitation. For with an injury, especially one that prevents him from working for a period of time, two things happen: 1) his habitual, defensive patterns of activity are taken away from him, and 2) the underlying drive toward dependency (with the associated potential for anger or frustration) is invited into the open by the solicitous and helping attitudes of doctors, nurses, and others caring for him while he has the symptoms. In fact, the symptoms now become the keystone of a new psychological equilibrium. Since the injury and ensuing incapacity came accidentally from outside himself, he does not have to accept responsibility for his dependency or admit that he has desires to be dependent. It is not his fault, but the accident's (or fate's, or the company's) that he is helpless; if he were to have his way he would be as active as ever; an alien pain prevents him. As one patient said, "I didn't quit my job, my legs did." The symptoms, then, carry the full charge of the dependency and give the patient an excuse for dependent, demanding behavior; and without his being aware of it, these underlying drives prolong the symptoms long past the point where his physical injuries are healed.

Here we must note an important fact: Once such a pattern in invalidism has become established, it is usually extremely difficult, if not impossible, to reverse it; but the development of such a pattern takes time and the behavior of people important to the patient often plays a crucial part in either preventing or promoting his march toward chronic, psychological invalidism.24

In order for the rehabilitation process to be successful, we believe the individual should accept accountability early in the treatment program. A number of programs validate this statement; that is, early evaluation and early treatment prevent long-term disabilities.25

Return to work

Long absences from work make it difficult to return to work, for a number of reasons, i.e., a) the anxiety associated with being reaccepted into the group; b) the unconscious tendency of the group to exclude a fellow member during his absence; c) the concern about being able to perform one's previous duties at excellent levels; d) the effect of injury on one's sense of self-esteem during the period of "doing nothing and not contributing."

Employers must be sensitive to the needs of returning accident victims. To become so, however, they must be supported by the workers, law makers, and concerned professionals. Hence, we propose a number of flexible systems involving: 1) part-time rather than full-time return to work; 2) gradual reentry; 3) retraining if necessary; 4) discussion with group members prior to return; and 5) the expanded utilization of psychiatric consultation to insure a psychologically sound reentry.
The present approach to treatment of the injured person has been greatly affected as a result of lack of coordination and integration of the efforts of those involved. Two major growing needs exist:

1. The need for direction in order to integrate and coordinate the efforts of those involved.
2. The need to utilize fully the knowledge available from the behavioral science field. Those involved in the "compensation process" cannot continue to ignore the importance of the psychosocial environment of the worker.

We have reviewed the system as it came to be; submitted a case history we consider to be typical of the malfunctioning of the system, and have offered a tentative proposal to improve the components of the rehabilitators and compensation system. The most important statement we have made throughout our treatise is: "The significance of the psychological functioning of the injured worker must be acknowledged by all members of the system." We consider it critical that all those involved must be encouraged to learn, and subsequently teach these basic principles in order that all members of the system will be able to use these principles as an integral part of their own contributory efforts to restore, rehabilitate, or compensate the injured worker. The system that we propose would significantly improve the compensation process by preventing chronic states of invalidism and, thus, obviating the need for compensation over a long period. We recognize the difficulty in establishing such a system but we feel the end result would be most profitable for all those concerned.

REFERENCES

10. See citation 9 above.
13. See citation 9 above.
14. See citation 8 above.
18. See citation 2 above.

FOR FURTHER READING


**ACKNOWLEDGMENTS TO CONTRIBUTORS**

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