FOIL NI

FORUM OF INSURANCE LAWYERS

Informing Progress - Shaping the Future

Making a Drama out of a Crisis

This learning event was held on 26th October and was hosted by FOIL NI.

The speaker was **Dr Neta Chada** FRCPsych, a consultant psychiatrist. These notes incorporate the speaker's slides.

Psychiatric reactions to trauma depend on a number of factors:

- Some are due to the nature or severity of the incident itself. The speaker is not concerned with whose fault the accident may have been, but she is always interested in what happened. The person's perception of what happened is important to their psychiatric reaction to it.
- Some are due to the consequences – e.g., whether they have experienced pain; are still in pain; or have a disability.
- There are then the losses suffered, which may include loss of job, loss of function, loss of role, and financial impact.
- Often there is anger about circumstances of accident (why did the other party not see me?); or perception of the penalty handed out to the other party (it was not sufficiently severe}; the other party's reaction (their anger/hostility). Even comments from ambulance staff, police and others can affect the victim's psychiatric response (e.g., 'You were lucky you weren't killed}.

How the person presents on psychiatric examination is also important.

- What personal factors may influence their reaction to what has happened? There may be vulnerability factors, such as a long history of mental health issues; low self-esteem; or mental health issues within the family. Adverse experiences in the past and how the individual dealt with them are very important.
- Factors relating to the event.
- Perpetuating factors: what is keeping this condition going? Are there other reasons why there are still problems a long time after the incident? An example was given of

an examination several years after an incident but where the individual had suffered bereavement and that was the cause of their continuing depression.

- Gain relates to other factors that may be influencing the individual's reaction such as financial problems/debt or not liking the job they were in.
- Misattribution relates to other drivers which may be knowingly or unknowingly brought into account. For example, the individual may blame the incident for physical symptoms that were pre-existing and not caused by it.

All of this leads to psychiatric diagnoses following the trauma.

The psychiatric examination seeks to capture the following information:

- Details of incident.
- Background history.
- Previous experiences of trauma and how they reacted to that, including any breakdown in relationships or bereavement.
- Family history.
- History of mental ill-health.
- Hobbies/activities/habits/benefits.
- Coping skills – bereavements/ break-ups.
- Mental state examination: their mental state now, including a basic cognitive test, including concentration.
- Psychological consequences of incident – what's the difference between a flashback and a memory?
- What treatment has the person had and what difference did that make?

All of this will inform the diagnosis and prognosis.

Personal factors/vulnerability

- Family history of mental illness.
- Personal history of mental illness.
- Premorbid functioning. If the person was not performing well pre-incident, has the incident caused an exacerbation or deterioration of a pre-existing problem? If there was nothing much before the incident, is their condition something new?
- Coping styles/ personality.
- Maladaptive coping, e.g., alcohol, which is a depressant, or drug use.
- Previous traumatic experience
- Type of job: were they enjoying it, or were they stressed? Were they valued?

- Past medical history: specifically had they complained of IBS, headaches, fibromyalgia, which may be psychologically-mediated?
- Had they had previous compensation claims?
- Were they on any medication at time of incident and if so, has that changed?

There are then **factors related to the trauma**.

- Was the incident life threatening? This could be relevant to there being PTSD.
- Was there a fatality? The speaker felt that the phrase 'life changing' had lost its value; is too widely used; and means different things to different people.
- The patient's perception: what ifs… (what if they had been killed; prevented from working; etc)?
- Relevance: it might be very relevant if the individual had a brother fatally injured in a road traffic incident 20 years before.
- How did accident happen? Does the individual have survivor's guilt or do they feel guilty, for example because they wanted to go out that day?
- Other people's comments – 'lucky to be alive'
- People sometimes believe there was smoke in the car and panicked, when it was only airbag dust. Or, they may not know that spinal boards are used routinely as a precaution and not necessarily because it was thought there was a serious injury.

There may be **perpetuating factors**.

- Ongoing physical symptoms – chronicity.
- Use of alcohol/drugs.
- Non-compliance with medication, whether for psychiatric or other reasons.
- Pre-existing symptoms/other stressors – whole and sole cause
- Primary/Secondary gain
- Misattribution

ICD 11 is the coding system for psychiatric injuries.

- This International Classification of Diseases by WHO has recently been updated but is not yet widely used (see below).
- There are sections for each illness, of which mental health is one section.
- DSM 5 is the American equivalent, which is often used for research. It has wider definitions for illnesses, possibly because in the USA there is payment for treatment.

Types of psychological reaction

Obviously, at the bottom of the scale is no psychological reaction to an incident. Next is:

Acute stress reaction, which is relatively rare:

- A transient disorder.
- In response to stress.
- Usually subsides within hours or days.
- Individual vulnerability and coping capacity play a role.
- May be agitated and over activity.
- Symptoms of anxiety.
- Symptoms appear within minutes of event.
- Usually disappear within hours or days.

More common are **anxiety disorders**.

- These are mental and physical manifestations of anxiety not attributed to real danger and occurring either in attacks (panic disorder) or persisting as a state (generalised anxiety disorder).
- An emotional state with the subjectively experienced quality of **fear**.
- Unpleasant which may be accompanied by a feeling of impending doom/death.

Everyone suffers from a level of anxiety, ranging from helpful to unhelpful but when it passes a certain point on the scale, it becomes a disorder.

Next are **phobic (i.e., avoidance) disorders**.

1. Fear is out of proportion to the demands of the situation.
2. It cannot be explained or reasoned away.
3. It is beyond voluntary control.
4. The fear leads to an **avoidance** of the feared situation.

Examples are agoraphobia, social phobia, animal phobias and specific phobic travel anxiety. The clinician wants to know how disabling the phobia is.

There is then **generalised anxiety disorder**.

This is a more generalised, persistent feeling of anxiety without the specific symptoms of phobia or panic.

- Subjective apprehension, fear or worry.
- Motor tension
- Feeling edgy, unable to settle, raised heart rate and short of breath.
- Vigilance and scanning with difficulty sleeping and tiredness.

Next is **panic disorder**.
These can occur unpredictably, though certain situations may become associated with them, such as travelling in a car; or seeing a ladder. This can produce an intense emotion, with acute symptoms.

- *Clinical Symptoms*

- Sudden onset of intense apprehension, anxiety, fear.

- *Somatic Symptoms*

- Shortness of breath, palpitations, chest pains, choking, flushing, sweating, etc.

The symptoms tend to be short-lived but may lead to the development of "anticipatory fear".

A commonly seen diagnosis is **adjustment disorder**.

- Subjective distress and emotional disturbance which usually interferes with social function and performance.
- Arises in the period of adaptation to significant life change or to consequences of a stressful life event.
- Individual predisposition or vulnerability plays a role**.**
- A variety of symptoms may include depressed mood, anxiety, worry, feelings of being unable to cope.
- Onset usually **within one month** of the event.
- The duration is usually less than six months. However, it can extend to 24 months if it is a prolonged depressive adjustment disorder. Beyond two years, it can no longer be classified as an adjustment disorder.

Post-traumatic stress disorder

- Arises as a delayed or protracted response to a stressful event or situation of an **exceptionally threatening or catastrophic nature** (war, rape, a fatality).
- It is likely to cause **pervasive** distress in almost anyone.
- **Pre-disposing factors** such as personality traits or previous history of neurotic illness are often present.

Typical symptoms include:

- Reliving of trauma/flashbacks/nightmares.
- Numbness and social withdrawal.
- Detachment from other people.
- Anhedonia (loss of enjoyment).
- Avoidance of activities and situations reminiscent of the trauma (avoiding the site of the incident; or not watching certain programmes on tv).

- Individuals often present with hyperarousal with hypervigilance and enhanced startle.
- Anxiety and depression common.
- The individual may turn to the use of alcohol or drugs, which may complicate the situation (a form of self-medication).
- Latency period may range from a few weeks to months (**rarely exceeds 6 months**).
- **The majority will recover** although the speaker sees individuals who have not recovered after a prolonged period.

The next category is **depressive disorders**,

- These may be mild, moderate, or severe but the individual must satisfy a number of criteria.

Common Symptoms include (starred items are particularly significant):

- Depressed mood
- Loss of interest / *loss of enjoyment*.
- Reduced energy * (especially psychomotor retardation).
- Feeling tired.
- Decreased activity.
- Reduced concentration and attention.
- Reduced self-esteem and self-confidence.
- Ideas of guilt and unworthiness.
- Bleak and pessimistic views of the future.
- Ideas or acts of self-harm or suicide ('life not worth living').
- Disturbed sleep especially EMW * (early morning waking).
- Diminished appetite *.
- Weight loss *.
- Loss of libido *.

Mood often unresponsive to circumstances.

- Diurnal mood variation * (often worse first thing in the morning, at having to face another day).

Other symptoms – anxiety, distress, agitation, irritability, alcohol misuse, exacerbation of pre-existing phobic or obsessional symptoms.

For diagnosis, there needs to be a duration of at least two weeks (but this may be shorter if there are severe symptoms)

<u>For mild depression:</u>

- There should be two out of first three and at least two others on the list (none severe or intense).

<u>For moderate depressive episode</u>

- Two of the first three plus at least three (and preferably four) of rest.
  Impact on social/work/domestic life.

<u>For severe depressive episode</u>

- +/- psychotic symptoms. Considerable distress/agitation or retardation. Somatic symptoms present. All three of the first three and four out of rest.

Dysthymia

- Chronic low mood which does not meet the criteria for mild depression in terms of either severity or duration of episodes.
- Usually report low mood, tiredness, everything an effort.
- But usually get on with the basic demands of life.
- Akin to general unhappiness/ dissatisfaction

Conversion/dissociative disorders

The speaker is seeing more of these and they are very complex. As the result of the incident, the individual presents with symptoms for which there is no organic explanation. This includes being in a wheel chair or reporting a loss of sight. Symptoms include:

- Loss of ability to control bodily movements/ sensations/memory.
- Often closely associated with a traumatic event, intolerable and or insoluble problems/disturbed relationships. The condition provides an escape from those. Distinguishing between conscious and unconscious behaviour is very difficult.
- 'Belle indifference' (a paradoxical absence of psychological distress despite having a serious medical illness or symptoms related to a health condition): often but not always.
- Usually resolve quickly – those that last over one-two years usually are resistant to therapy.
- E.g., dissociative amnesia, paralysis, convulsions, aphonia – often their view of what it should be.
- NO physical health disorder to explain symptoms.

Somatoform disorders

These are similar but with slightly different symptoms.

- Repeated presentations with physical symptoms/requests for investigations.
- Not reassured by negative results.
- No physical cause identified.
- Can be triggered by an unpleasant event/conflict/psychosocial stressors.
- They are difficult to distinguish from hypochondriacal disorders – preoccupation with having one or more serious disorders.
- Somatisation disorder – multiple symptoms.
- Somatoform pain disorder.
- Functional neurological disorder.

Another issue is **malingering**.

- Not a mental illness.
- Conscious simulation for manipulation purposes.
- This is for gain.
- NB In the others – can be some conscious and some unconscious elements.

ICD 11 started on 1st January 2022 but likely not to be adopted for some years. It is important because is has changed some of the definitions and approaches, e.g., to personality disorder, neurodevelopmental disorders e.g., intellectual disability, autism, etc. There are also changes to the definition of PTSD, bringing it closer to the definition under DSM V.

Why are psychiatric elements to claims increasing?

- There is more awareness of mental health/impact of stressors. Individuals will now suggest the diagnosis, based on what they have seen in the media. This awareness may, however, mean that people are receiving treatment at an earlier stage.
- There is less stigma and it is topical and almost trendy!
- The speaker was concerned that there may now be less resilience: a wider societal issue.
- Big pay-outs in court *may* be talked about and influence people.
- It may be harder to disprove psychiatric complaints. Recent developments have been an increase in complaints of tinnitus, erectile difficulties, etc.

- **Nevertheless, some are very genuine and the psychological element may be worse that the physical impact**.

Q&A

In response to a question from a delegate, the speaker confirmed that experience of previous traumatic incidents was a major factor to be taken into account: the 'egg shell skull' principle. It is more complicated where the symptoms are being perpetuated by the earlier incident and not the incident in issue. There is also the question of whether if the incident in question has triggered a psychological reaction, would some other triggers have done so? Just how vulnerable was the individual?

If there is no medical record of trauma or symptoms, the expert is totally dependent on the history obtained from the individual. Signs of vulnerability may come from evidence of prior physical symptoms such as IBS. Nevertheless, it may sometimes be the case that the reaction to an incident is not in keeping with a person who had had no previous vulnerability. Over time, most people experience *some* psychological problems.

Q: One of the concerns about the periodical payment of damages is that it acts as a reminder of the accident. Is that a genuine concern?

A: Probably not. If someone has had an injury which was sufficiently severe to warrant a PPO, that person has reminders of the accident every day. If anything, the PPO is protective, reducing the risk of an individual with some psychological problems making rash decisions if managing a lump sum award.

Q: Is it possible to diagnose alcoholism as a consequence of an injury, or should it be seen more as a coping mechanism?

A: After trauma, people may drink for a number of reasons: they may be bored; or drink to manage pain, or psychological symptoms. The increase in consumption is for a specific reason. If use becomes harmful or there is dependency the question is 'why did this arise'?

Q: Is there an age below which a psychiatric report would be unhelpful, e.g., a toddler?

A: Although there is now infant psychiatry, it is probably accepted that below a certain age, children do not form long-term memories. Unless it is severe deprivation, e.g., orphans who are not being fed or are being abused, they tend not to have any long-term memory of trauma.