A VIEW OF TRAUMATIC NEUROSIS

by

Herbert A. Raskin, M.D.*

I would like to paint a picture for you. At 8:35 a.m., Mrs. Automobile Driver and Miss Passenger were en route home from work where they had served on the midnight shift. Mrs. Driver was twenty-six years of age and Miss Passenger was twenty-one years old. They were both nurse's aides at a convalescent home, and had just spent a rather difficult night working with many "disturbed oldsters" and a supervisor that "had a crank on." But it was after quitting time; the day was bright and clear; and they were chatting, trying to relax, just ambling along at 30 miles per hour on a four-lane divided highway. Mrs. Driver was way over in the right lane. She was being especially careful because this was the very first brand new car which she and her husband ever owned. They had worked and scrimped and finally made the down-payment four months previously. Miss Passenger suddenly screamed, "Look out!" Mrs. Driver then noted, for the first time, another car coming into her path from the left at a right angle to her. She had just started to swerve to the right when the other car struck the left front of her car and they ground to a stop on the side of the road.

Mrs. Driver struck her head on the mirror, the top of the car, and she struck Miss Passenger. She also bruised her left

---

*Adjunct Associate Professor of Psychiatry, Wayne State University

shoulder, arm and thigh; but she was able to get out of the car easily. Miss Passenger also struck her head -- right and left temples and occiput. Neither was knocked unconscious; but Miss Passenger somehow injured her left ankle and neck so that she had to remain in the car until the police came and could extricate her. They were both sent to a local hospital and cleared by X-ray. Miss Passenger was provided with crutches. They were discharged home with instructions to consult with their family doctors.

Mrs. Driver immediately encountered severe headaches, dizziness and visual blurring. Her doctor began treatment for "cerebral concussion including a left vestibular disturbance demonstrated by caloric testing." In addition, she stated that she was a "nervous wreck; all shook up." She described almost constant agitation and great waves of feelings of depression. She was unable to eat, unable to sleep and was beset with ruminations of death - although not particularly related to the accident. There were likewise strong feelings of guilt. "I coundn't stop crying; it would start all of a sudden for no reason at all." The guilt attached itself to the injuries she had inflicted upon her "close girl friend and coworker" but more especially on the smashing of her car. "Wrecking it was like losing a loved one; we had put everything we had into it, and I smashed it." Action patterns, moving about and doing things were the only means of relieving the depression. This was the main reason she returned to work after the dizziness subsided in four days; but at work and at home, sudden, spontaneous waves of depression and

uncontrollable sobbing made her miserable. There were likewise daily ruminations that took the form of self-recrimination. She was aware that she had been cautious, had a new car in which there was great pride of acquisition. She had been thinking anticipatedly of possible accident, was ready to ward off any danger and, in spite of it, the accident still happened. This only emphasized to her her sense of inadequacy and helplessness as a person. Her self-imagery of being self-sufficient had failed. At the same time, however, there was the feeling that fate had dealt her a dirty trick. There was no justice.

She experienced only a single dream of death; otherwise there was no change in her dream patterns. There were no anxiety dreams and no dreams of the accident. She was able to drive a car alone shortly after the accident but was unable to take a passenger with her for a week, and it was even longer before she would trust herself to take her children with her. The depressive episodes had remained relatively unchanged to the time of psychiatric examination six weeks after the accident and they constituted the major clinical findings at that time.

Miss Passenger hobbled around on crutches for a week before she could bear full weight on her ankle. She had been beset with a constant state of restlessness, uneasiness, irritability, lack of patience, and very easy loss of temper. She stated that she had been constantly tense, all muscles tight, and she described episodes of acute exacerbations of anxiety. Constant fatigue and "no energy" had been prominent. There had been a

loss in body weight from 106 pounds to 98 pounds, which she had not been able to regain. She had not been able to ride in a car without severe tension and apprehension. She even had to move out of her parent's house and in with a girl friend in order to escape her father's very critical and strict attitudes plus the noise and activity of the young children in the home. There had been a comparable intolerance on the job, to which she returned after seven days, and irritability with the demands of the patients and the directions of the supervisors.

For one week after the accident there were daily anxiety dreams, awakening her in a startled reaction state; the dreams recapitulated the sequence of events preceding, during and immediately following the accident. Invariably, she awakened at the point of her sitting in the car, unable to move herself, and a crowd of people gathering and staring at her. Each dream was a duplicate of the reality experience, even to the subject being discussed immediately prior to being struck. These dreams had not recurred since the end of the first week. By the time of examination, six weeks after the accident, nearly all the symptoms had disappeared. She still had her ankle bound, and she was a little "leery" regarding returning home but expected that she would shortly. The clinical examination revealed practically no psychological abnormalities.

Here then are two people sharing the same experience and manifesting two different postaccident mental disturbances. It illustrates the commonly observed phenomenon that if a number of people are exposed to presumably the same stress experience, only

certain ones will develop a psychological illness. Whether or not such occurs and, if so, the type and extent of psychopathology that develops will be specific for that particular person at that particular moment in his living continuum. What evolves will depend on the combined effect of the totality of the particular experience, or some particular part of it, the very specific meaning of the event, both conscious and especially unconscious, coupled with the person's own particular experiential history, psychological growth and development, previous psychological trauma and particular characteristics of personality structure, organization, level and type of functioning. This particular coupling, the combination of prior history and status with the immediate stress-experience, becomes most pertinent, actually essential, in the subsequent development of psychoneurotic or psychophysiologic phenomena.

Even trauma cannot be assessed in terms of the external situation alone, but in every case the internal situation of the person must be considered and the external situation only as experienced by him. Thus a radical environmental upset may be in no way traumatic, and at the opposite extreme, a trauma may be experienced in an external situation that appears to the observer to be perfectly ordinary. The experience indeed may even be one that the person has mastered in a satisfactory manner on previous occasions. The same situation, for example, may become traumatic when the person is physically ill.

Krystal in discussing psychic trauma indicates that it is always a complex reaction initiated by what he terms "psychic

reality" -- that is, the individual experience, interpreted, as it were, by the mental associations it provokes. As a result, stimuli are traumatic not by virtue of their physical intensity, but by their meaning and emotions they evoke. The intensity of the stimulus is relevant only in the conceptualized frame of reference of a "danger situation."

Psychological symptoms are something that happen which the patient experiences as strange and unintelligible. This something may be involuntary movements, other changes of bodily functions and various sensations. There may be an overwhelming or unjustified or inappropriate degree of emotion or mood as spells of anxiety or depression. There may be experienced unusual impulses or thoughts, compulsions and obsessions. All symptoms give the impression of something that seems to break in upon the personality from an unknown source, a something that disturbs the continuity of the personality and that is outside the realm of the conscious will. The normal and rational way of handling the demands of the external world as well as the impulses from within is substituted by some irrational phenomenon which seems strange and cannot be voluntarily controlled.

One factor of marked significance in the personality functioning of the person contributing to predisposition to psychopathological response and extent of symptom formation is that of "affect tolerance," the ability to deal with feelings around by the incident. These feelings most frequently will include anxiety, shame, anger, depression, guilt. The patient's reaction to these emotional experiences may be most difficult because for

many people it is unacceptable to experience feelings of anxiety or depression. They become angry and ashamed of themselves. There is also the well-known fear of being afraid which may start a circular reaction. Thus, a frequent problem encountered is a tendency for these feelings to snowball and perpetuate themselves.

When an individual's affect tolerance is exceeded he may have to ward off the feelings, isolate them from conscious experience. This involves suspension of a significant number of ego functions. He seems to be experiencing the event as an observer. The peculiar feeling may be frightening in itself and the patient may panic, fearing he is losing his mind.

A very frequent request voiced by patients is "Doctor, I suffer from this depression (anxiety, anger). I cannot stand it. I am afraid I am going to lose my mind. Please stop it!"

It is to be noted that the common denominator of all functional psychopathological phenomena is an insufficiency of the normal control apparatus; i.e., ego function. The Ego represents that group of mental functions or operations that serves as the executant-director of all mental functioning. It is that part of mental functioning that tries to maintain a harmonious balance between the needs, wishes, urges, impulses and biological drives of the individual, his own internal ideals and prohibitions, and the external demands, regulations, rules and requirements of Society which exist external to himself. One way in which this insufficiency of ego functioning can be manifest is by what has been termed "traumatic neurosis."

Particularly in the legal literature, however, the term "traumatic neurosis" seems to have acquired a diagnostic concept and Law has accorded it the status of an officially recognized illness. This terminology, however, has been used so loosely and so broadly that it has practically lost meaningful value in cases of personal injury litigation. This is quite unfortunate and hopefully cooperative efforts between the Law and Medicine can rectify the situation. Too frequently the field of Law will utilize this terminology to represent practically any form of psychopathology that is related to an accident. To many psychiatrists, it represents a very specific and well-defined clinical syndrome even though it will not appear as a specific entity in the official APA Diagnostic and Statistical Manual of Mental Disorders (DSM II).

Freud in 1933 stated "The essence of a traumatic situation is an experience of helplessness on the part of the ego in the fact of accumulation of excitation, whether of external or internal origin." The insufficiency in the functioning of the ego mental mechanism involves an increase in the influx of stimuli. Too much stimulus excitation entering the mental apparatus within a given unit of time, which cannot be mastered, which cannot be successfully dealt with, constitutes a state of emergency and such experiences are called "psychically traumatic." The experience lies beyond the ego's adaptative capacities, beyond the sufficiency of the normal control apparatus. It connotes the inability of the particular person's ego organization and level of function to effectively cope with, to master, a particular

event at a particular moment. To that person, it has the connotation of helplessness.

But do not forget that "too much excitation, too high an influx of stimuli," is a relative, individually determined concept and will vary from person to person and also within the same person at different times.

Additional observations pertinent to the etiology of the traumatic neurosis need be made. These include factors of mental economy and conditions existing before and during the potentially traumatic experience. These are directly relevant in discussing ego capacity and its relation to trauma and relative insufficiency of ego function.

The individual's physiological constitution, the quantity and rate of drive energy, and the state of the physiological apparatus used by the ego in discharging its functions are important factors of mental economy. In this aspect of etiological programming are so-called "ego-exhausting" factors: the effect of being tired, exhausted or sick. These are factors of energy depletion. Fatigue, hunger, pain, chronic sensory over-stimulation, chronic strain or stress must also be mentioned.

As already alluded to, the individual's living experiences from birth on and their relation to his psychological organization and level of function at the time of the accident play a role. The most important factor here is the degree to which the mental defense mechanism of "repression" has been established and utilized. Maintaining repression, or most other defense

mechanisms, requires energy, are energy-depleting operations, and so deprive the ego of the mental energy necessary to deal with incoming stimuli.

Another factor is that of the previous creation of points of particular psychological vulnerability, areas of emotional conflict which are hit by the specific experience either directly, or through some mental association pathway, or through some symbolic representation to the individual that involves some form of threat or harm.

Conditions existing before and during the experience also include the role of ego function of anticipation, the ability of the individual to think ahead, prepare for the future by making ready amounts of energy to bind excitations. An incident is likely to have a traumatic effect in direct proportion to the unexpected, unanticipated, unprepared-for aspect of the stimulus situation with which he has to deal.

Another ego function, in this same sense, involves the use of motility, the ability to take voluntary muscular action. This effectuates the discharge of tension energy through movement, through doing something. A decisive factor may be whether or not, at the time of the stressful situation, motor actions are possible. The blocking of such activity increases the probability of breakdown of ego functions and the development of a traumatic reaction pattern.

The symptoms of a traumatic neurosis can be quite varied but certain groups of malfunctioning are rather typical.

Blocking of ego functions results from a concentration of all mental energy available on the task of mastering the intruding overwhelming excitation. The urgency of this task makes all the other ego functions relatively unimportant. The blocking, especially the function of perception and the process of analyzing, synthesizing, integrating, evaluating and absorbing experience, serves to prohibit the influx of further excitation. Different ways are developed of protecting one's self against too great a quantity of stimulation. New stimulations are refused to be met with. A common example is that the sexual interests of the person are diminished and in male patients temporary impotence is quite frequent. It will also be reflected in noise intolerance, people intolerance, ease of frustration and irritability, intolerance of things not going the way desired, social withdrawal and comparable avoidance patterns.

The various emotional spells represent archaic and involuntary emergency discharges. There may be restlessness, hypermotility, a tendency to cry and shout. Anxiety or rage is easily produced. The anxiety may range from mild apprehension to panic. Chronic muscular tension with inability to relax, the presence of tremors and restlessness are also common. Startle reactions occur. There may be poor concentration, memory deficits and especially intolerance of discussing one's symptoms or the traumatic event itself.

Unmastered amounts of excitation makes sleeplessness one of the main symptoms. There is an inability to relax, and sleep

presupposes a state of relaxation. Active repetition of the trauma appears as manifest content in dreams and is considered to be almost pathognomonic. These repetitive dreams are frightening, laden with anxiety and produce startle awakenings in a state of fear. The dreaming represents the hope that by experiencing again and again what once had to be gone through in the trauma, control may slowly be gained and mastery instituted.

Repetitions will also occur in the waking state in the form of ruminations, at time almost obsessional in character. These also represent a continuing working-through in order to regain control of the intruding excitation.

It is only this type of clinical reaction, this particular clinical syndrome, that should be termed a "traumatic neurosis." It actually represents a minority of cases that are so commonly termed. Our Miss Passenger demonstrated most of the symptoms that are found in such a clinical situation.

It has been my experience that most instances of clinical psychopathology in personal injury claims are represented by some type of psychoneurotic reaction or psychophysiologic reaction following the subject experience, either precipitated by the experience or aggravating already existing psychopathology with an acute exacerbation of symptoms. I offer Mrs. Driver in illustration. These represent another means by which insufficiency of ego functions can be made manifest.

The genesis of these types of psychopathological states relates not to a sudden excessive influx of stimuli but

directly to the anxiety-producing unconscious meaning of the total incident or some particular part of it. This will include the symbolic and uncounscious meaning of the actual physical injuries incurred or the fantasied and anticipated events which spell to this person some kind of threat to his personal integrity. There is the existence of a previous blocking or decrease of drive energy discharge, for some reason or other, within the person's psychological growth which has produced a state of damming-up of tension within the person. This constitutes the "personality predisposition," the psychological matrix out of which the psychoneurosis will develop in response to a particular precipitating event. At a given later moment what would be usual and ordinarily normal excitations, generally expected to be well-handled experiences, will operate relatively like traumatic ones and precipitate the psychodynamic changes out of which evolves the psychoneurotic or psychophysiologic phenomenon.

The diagnostic differentiation between traumatic neurosis and other types of psychopathological reactions in an accident situation is quite important to the process of litigation. Even though during the immediate postaccident period it may present more intense symptomatology and a greater degree of incapacity and impairment, the prognosis of the traumatic neurosis is generally much better. It can usually be anticipated that a shorter period of time will be required to gain resolution and reestablishment of pre-accident level of ego organization and function.

This is, of course, assuming that a psychoneurotic reaction or other psychopathology does not ensue as the traumatic state is resolved.

We would be remiss if we were not to comment briefly on an additional type of mental illness, psychopathology that can develop in direct relation to such traumatizing experiences. I refer to the mental disturbance known as a psychosis or psychotic reaction. There will be times when the psychopathology and the clinical findings that develop will show ego changes of a different nature. They have taken on a different form of presentation, the individual has leveled functionally at an entirely different kind of mental organization and there will be presented an entirely different kind of clinical picture. These will represent a much more serious type of ego disorganization and ego dysfunction, a much more severe type of psychopathology. The factors involved in the genesis of the psychosis, however, will follow exactly the same principles elucidated before.

There can also be the case of head injury and brain injury with acute and chronic organic brain changes, the development of organic structural change underlying the psychopathological picture of the psychoneurosis or psychosis. The entity of post-concussive syndrome with concomitant cognitive and emotional changes must also be mentioned.

We would be especially remiss if we failed to recognize that there will be instances of valid psychiatric personal injury

claims in the absence of any type of physical accident or injury. These will be cases where in contrast to "acute shock trauma" there can be the factor of "chronic stress trauma." The psychologically stressful experiential circumstances may persist over a varying period of time, being cumulative, and finally reaching a critical point which may be an incident of comparatively relative slight degree of intensity or actually nothing particularly observable at all. Perhaps the most striking example of this, occurring over a twelve-day period and precipitating an overt psychotic state, was the classic workmen's compensation case of Carter vs. General Motors.

The Michigan State Supreme Court in 1960 established a precedent in Carter vs. General Motors by compensating an employee for psychiatric illness not associated with any physical injury, accident, specific event or unusual stress or incident. The man involved, Mr. Carter, had worked as a machine operator for General Motors with intermittent layoffs since 1953. He was recalled to work on October 8, 1956 after a five-month layoff, worked for four days on one job and then was transferred on October 12 to a "hub job." This operation required him to take a hub assembly from a nearby fellow employee's table to his own workbench, remove burrs with a file and grind out holes in the assembly with a drill, and place the assembly on a conveyor belt. He was unable to keep up with the pace of the job unless he took two assemblies at a time to his workbench, and he feared another layoff should he prove unable satisfactorily to do the work. He was instructed repeatedly by his foreman not to take

two assemblies at a time because the assembly parts became mixed up on the conveyer belt when he did so. Thus when he took only one hub assembly at a time, he fell behind and would be berated by his foreman. When he fell behind, he took two assemblies, but when he took two assemblies he got the assemblies mixed up and again was berated by his foreman.

Medical testimony in the case stated "...the patient saw himself as in an impossible situation in which he could not win. He could not please the foreman operating the machine in his job the way he was. If he attempted to do it the foreman's way he would fall behind in his work and the men on the line would complain and the foreman would get after him for this. So he really felt himself caught in an impossible situation which had no solution..."

After twelve days of experiencing increasing anxiety, he was hospitalized and diagnosed with paranoid schizophrenia.

There was no history of previous psychiatric illness. Psychiatric history as reported demonstrated "some evidence of instability earlier in his life," referring to relatively frequent AWOLs in service that brought about his discharge. He had an adequate work history both in construction work and prior at General Motors. Psychiatric examination also referred to "inflexibility of personality." It was felt that the combination of working in a new position with which he was not familiar and finding himself in the bind, impossible situation, described above with the increased feelings of threat regarding

retention of his job were described as precipitating a schizophrenic breakdown.

The marked increase in recent years of comparable personal injury claims has caused considerable concern in many areas of medical, legal, industrial, and insurance groups. A number of very complex social, moral and legal questions have been raised. Obviously this question lies beyond the scope of this presentation.

It is quite clear that if the psychiatrist is to serve the lawyer and/or the court in deliberations of personal injury claims, it is extremely important that he be permitted sufficient time to do an adequate investigation and evaluation. Mere temporal coincidence does not connote cause and effect relationship or even a psychodynamic relationship, and it definitely does not delineate the significance of a particular event as an etiologic factor in the production of a particular psychopathological status.

It is also of great value to the psychiatrist to have documentary evidence of all medical contact that the patient has experienced. Medical reports of hospitalizations and treating physicians both pertinent to the accident per se and relative to any significant factors in his medical history can be extremely valuable. This can serve many functions. It can contribute to increased knowledge of the personal history of the patient, the manner in which he reacted to illness previously, and, perhaps even more important, it aids in cross-checking the accuracy and validity of the patient's impression of what happened to him

while he was under a particular doctor's care or in the hospital. There frequently is found to be marked difference between what a physician tells a patient and what the patient heard the physician telling him. It is sometimes quite fascinating to check the patient's recitation against doctors' reports of examination, recommendations, prognostic statements, progress notes and observations reflected in nurses' notes.

Obviously complete social history often is essential. Psychological testing can be quite valuable in view of the usual time limitations in accomplishing clinical evaluation.

In closing, I would offer to the lawyer the idea that in many cases of personal injury litigation, even negative findings regarding active psychopathology can be quite helpful in the development of his case. As an example, I would offer the following type report:

"Mr. Smith appeared in my office on February 12, 1973 for purposes of psychiatric examination and evaluation. In addition to my personal examination, I had available for study various medical reports related to his condition.

"Psychiatric examination demonstrates no evidence of psychopathology and no psychiatric diagnosis is to be established. It is to be noted that mental status examination showed Mr. Smith to be a very sincere person who presented himself in a quite honest and forthright manner. There was no evidence of malingering. It was my impression that his complaints were valid representations of what he was experiencing and were premised on an organic basis."