Is There an Assault Syndrome?

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The clinical syndromes now designated posttraumatic stress disorder (PTSD)[1] have been discussed in the psychiatric literature for 100 years, beginning with Erichson's description of "railway spine" in 1882[2] and Page's "nervous shock" in 1883.[3] In the 1880s Oppenheim coined a phrase "traumatic neurosis" which became generally accepted[4,5] and even today is frequently found in medical and legal writings. "Compensation neurosis" appeared at the turn of the century with a proliferation of workmen's compensation laws.

The two World Wars spawned a variety of appellations such as shell shock, war neurosis, combat exhaustion, flight fatigue, three-day schizophrenia, and prisoner of war syndrome. The post-World War II period contributed concentration camp syndrome and reparation neurosis. In recent years articles have appeared on accident neurosis, disaster syndrome, survivors' syndrome, delayed Vietnam syndrome, and rape trauma syndrome.[6]

At The Menninger Clinic, we have seen a number of victims of assault and battery presenting disabling psychiatric symptoms. Each had retained an attorney and was involved in a legal suit. Our clinical observations stimulated thoughts about the heuristic value of defining an assault syndrome, following the historic precedent of identifying the traumatic agent. Prefacing the remainder of this discussion, I wish to state that I am opposed to burdening the literature with additional jargon that does not deepen medicolegal understanding and facilitate interprofessional communication.

A.B., an unmarried 28-year-old Caucasian male, lives with his girl friend and has worked for a company for four years. He drives a city truck route, delivering and picking up packages and occasionally collecting and carrying money. His attorney referred him for medical evaluation of possible untoward psychologic consequences from an assault.

A.B., having made a store delivery, was walking through an alley to his truck when he was accosted by two black males, one armed with a revolver. The frightened victim put up his hands and submitted to a search. While bending down, as ordered, to take off his pants over his boots, he was struck twice in the face with the handgun and fell flat; whereupon the assailants fled. He staggered back to the store and the police were called.

In a hospital emergency room, X-rays disclosed facial and orbital fractures which were surgically repaired one week later. During the week's wait he

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experienced considerable facial pain, was unable to chew, and lost weight. He felt tense and exhausted, could not sleep, and had nightly anxiety dreams of being paralyzed, unable to move even though in some vague frightening situation. After surgical reconstruction he convalesced at home for two months, during which time he was apprehensive about going back to the job. He became quite irritable, snapped at his girl friend over trivial matters, and even slapped the dog when it barked. He was too restless to watch a television program, smoked excessively, and was up in the middle of the night pacing the floor. Sexual activity was sharply reduced because he could not achieve or sustain an erection. He walked warily along the street and would cross to the other side to avoid passing a black man. His companion reported that he was withdrawn, talked less, and their social life was nil because he would not go out at night. She was considering leaving him.

Upon returning to work, he found his memory and concentration impaired and forgot assignments. He was nervous about driving in traffic and refused to enter an alley. After six months he quit and obtained employment in a warehouse at reduced income.

When examined seven months after the assault some symptoms were improved. His primary concerns were his phobic reaction to any situation in which he felt caught, his sexual inadequacy, and nightmares which still occurred three or four times a month. His irritability had lessened somewhat and he no longer noticed concentration and memory difficulties. During the examination he related well, was pleasant and cooperative, and even cheerful. He talked in a chatty manner and was interested in the doctor's explanation of his symptoms and their probable course.

The patient's clinical picture was of a classical PTSD with anxiety, tension, restlessness, fatigability, irritability, difficulty with memory and concentration, repetitive nightmares reproducing the assault, social and sexual withdrawal, and a phobic-avoidance reaction to circumstances reminiscent of the assault situation. The legal question posed: was there permanent disability? Postoperatively his father insisted that he consult an attorney, who obtained workmen's compensation payments for the two-month period. The attorney was medically informed that A.B. currently had a 25 percent occupational disability but that permanent effects could not reliably be estimated for another year, since the natural course of the disorder is continued gradual improvement over time, and that the phobic reaction would probably continue for some years.

C.D. is a 30-year-old man of short stature. He is married, childless, and has two years of college credits. He worked as a counselor in the maximum security cottage of a state boys' industrial school. In April, while the only staff person on duty, he was cornered by three boys all larger than he,

pushed to the floor, and under threat of having his eyes gouged out, surrendered his keys. The three escaped but later were captured. He did not receive criticism or censure for the incident. He was aware of being more watchful and generally uncomfortable at work, but developed no specific symptoms of a PTSD.

A month later, C.D. submitted a statement and request to the administrator concerning one of the three boys who he thought was a hazard to others because of the escape and the fact that this boy threw tables and chairs when angry. Also, C.D. protested the fact that there was only one staff member assigned to that particular cottage. His letter was ignored.

In June, while inspecting a restroom, he was hit on the head from behind and fell. The "bad" boy and one other attacked him and he tried to fight back but lost consciousness. The boys took his keys and escaped. A third boy got help. C.D., amnesiac regarding the next several hours, regained reality contact in a hospital bed. Findings from a neurologic examination, EEG, X-rays, and laboratory tests were all normal, and he was released in a few days.

He promptly began to experience frequent headaches and periods of dizziness without loss of consciousness, depression, tension, and repetitive nightmares. He felt mentally slowed and had difficulty with memory and concentration. He was cautious and suspicious and when walking along a street found himself automatically turning to see who might be following him. He became somewhat irritable, lost interest in sexual relations, and was socially withdrawn.

Neurophysiologic test results were equivocal and the patient was referred by his neurosurgeon for psychiatric evaluation and possible treatment. When seen three months after the second attack he was pleasant, cooperative, and articulately expressed himself in a logical sequential fashion. He was a subdued and private person, reluctant to describe his preaccident life and family history. His headache and dizziness had disappeared and he was forcing himself to initiate a few social contacts. His wife did not complain that he was irritable, but was concerned about his sexual impotence and social withdrawal. His chief persisting symptom was a strong reluctance to return to work. He planned to seek other employment, preferably in another city.

After several therapeutic sessions he decided to try working part time and the school administrator agreed to his returning two days a week. The work environment proved to be too unsettling: even though assigned to a less disturbed cottage he was wary, uncomfortable, concentrated poorly, and his relationships with the inmates were strained. Aware that he was not doing a good job, he applied for and was given a clerical job with another

state agency. After a month his condition was much improved. C.D. is still considering the rationale of instituting a personal injury suit in order to expose unsatisfactory conditions at the school.

In his case, as with A.B., the label of PTSD seems appropriate. He displayed the whole syndrome and he too was impelled to leave the job because of his great discomfort in that setting.

In both of these men no symptoms or behaviors could be identified as unique to a possible "assault syndrome." When compared with the PTSD patients whose traumatic experiences occur on a highway or at work and always involve something inanimate (car, train, machine, fire, scaffold, slippery surface), the only difference was the fear of specific people or a particular class or group characterizing the attackers.

E.F., a 38-year-old married female with a 15-year-old son, works as a bank teller. At 8 pm, she was in the kitchen, her husband in the basement, and her son upstairs. The front door burst open, shattering the lock, and several men dressed in black and brandishing guns entered. She began screaming and her husband rushed up from the basement only to be grabbed and frisked. The son was brought downstairs at gunpoint. The three were held in the kitchen while the intruders ransacked the house, pulling down books and pictures, emptying drawers and shelves, and searching the car and garage. Eventually a warrant was produced and the men declared themselves law enforcement officers. They left with no explanation or apology.

E.F. stayed up all night, feeling tense, anxious, and fearful that the incident might recur. For three days she continued to be distraught and tense, could not sleep, and vomited everything she ate. An attorney friend suggested that the family seek legal advice. A lawyer was engaged: he learned that the raid, based on an informer's tip, was a search for drugs.

E.F. consulted her priest and also an internist who stopped the vomiting with medication, but not her nausea and diarrhea. He referred her to us for psychiatric evaluation and management one week after the traumatic event. She reported sleeping only three or four hours a night and having upsetting nightmares of shadowy figures bursting into her home. She started screaming in her dreams and awoke with severe chest pain. Her husband confirmed that her talking and yelling in her sleep wakened him. She complained of exhaustion and wanted to leave town to find a place where she could rest.

The patient had several specific fears or phobias. She ruminated that the men would return since they were obviously connected with some criminal element. The family had not had one word of explanation, inquiry, or apology from the police; they could return surreptitiously, plant something in the house, then raid again. Whenever the dog barked or the doorbell rang, she jumped. She was distracted, her concentration was poor, and she

made errors at work. She returned to work five days after the raid and felt safer there. She would not stay in the house alone; if her husband had to go out in the evening she spent that time at a neighbor's.

Over the next month the patient was consistently depressed and weepy, had no appetite, and slept fitfully. I was gradually able to persuade that proper Christian lady to express her anger at the trespassers, the chief of police, the Attorney General, etc., and her depression lessened. Her husband said that she talked about the raid to anyone who would listen and injected increasing anger into her narrations. She was encouraged not to follow her impulse to stop work and leave town. There was no change in sexual interest and behavior; "I need to be close to my husband."

After six interviews she departed for a previously scheduled summer holiday with her husband. I heard no more from her until she came six months later for additional counseling sessions because her attorney had filed a lawsuit against city and state law enforcement agencies and she was facing having to testify in court. She reported that her symptoms became less severe during the summer except for her refusal to stay in the house alone; "There is no rest there." Now, however, an acute exacerbation had occurred. She was tense, very irritable, could not sleep, had frightening dreams again, and could not eat because of nausea and vomiting. "I finally broke yesterday and have cried for two days." The patient was depressed and also angry, a sullen depression. Encouraged by the psychiatrist's empathy she loosed a tirade against "those people—the officers, media, Attorney General, etc. She hoped the publicity from the trial would deter their attacking another family. In subsequent interviews she was much improved: spirited but more relaxed, she moved and stretched and talked spontaneously.

Here again E.F. presents the familiar posttraumatic symptoms: anxiety, tension, restlessness, fatigability, insomnia, repetitive nightmares, and concentration difficulties. However, phobic apprehension of repetition of the attack, retaliation by the intruders, and being home alone are reminiscent of the rape trauma syndrome. In fact, the patient did recall that at the time the men burst through the door, among her confused thoughts was the possibility of rape. Peters presents the best statistical description of the post-rape syndrome from his study of 369 patients at the Philadelphia Rape Center.[7] More than 70 percent suffered specific fears of being attacked again, of offender retaliation, of being at the scene of attack (or similar setting). They also suffered eating disturbances and insomnia with nightmares. E.F. displayed most of the symptoms of the postaccident syndrome and the rape trauma syndrome. The current literature on rape victims has emphasized the comparable importance of the assault to the actual act of intercourse. The case of E.F. contributes another piece of evidence that

assault alone, without battery or sexual penetration, can precipitate most of the rape trauma symptoms. Bard and Sangrey[8] report several subjects' returning home to find the house had been invaded, disarranged, and burglarized. Their reactions to such invasion of their sanctuary were often as severe as those of robbery and battery victims.

Discussion

Although the PTSD is a regular accompaniment of war experiences and of natural disaster, the most frequent occurrence bringing a patient to the psychiatrist is a single unexpected accident on the highway, on the job, or at home. Assault and battery, including rape, are types of "accidents" producing the syndrome. In nearly all of those cases, the basic psychologic mechanism that precipitates the symptoms is the same: the victim is engaged in familiar routine work or activity, with no reason to expect danger or catastrophe. His/her psychologic guard is down and the fight-flight physiologic set is not preparatorily activated. In such situations the attack, whether by man or circumstance, is completely unexpected and produces in the victim an overwhelming sense of vulnerability.

A.B.'s assailants placed him deliberately in a state of helplessness with his trousers around his knees, then battered him. Although C.D. was, in a general sense, alerted by the first tussle with the three boys, the second attack from the rear (our most psychologically vulnerable area) and the immediately disabling concussion rendered him helpless. E.F. experienced an invasion of her life space, her castle, by a weaponed army giving her no hope of escape or a glimmer of explanation or rationality to cling to. Bard and Sangrey, in *The Crime Victim's Book*,[8] entitle the first chapter, I Never Thought It Could Happen to Me, an apt definition of the dismay experienced by all three victims.

On clinical grounds there seems little justification for promoting a discrete assault syndrome. E.F. may be a possible exception because of the mixture of symptoms resulting from her experience. In contrast to the two men, she experienced assault but not battery. Legally, assault is defined as essentially a mental rather than a physical invasion, and possible recovery of legal damages is for mental disturbance including fright, shame, and humiliation.[9]

In discussions with attorneys and compensation boards and the elucidation of juries, there may be useful communicative value in using assault syndrome to explain a victim's disability. The law is concerned with proximate cause and, as I have already noted, the historical use of trauma, disaster,survivor, and rape as adjectival modifers has solid medical and legal precedent. Also, medical authority is respectfully recognized in legal evaluation of such cases and a clear cut diagnostic label exerts definite impact.

In the last few years, the plight of victims of crime is achieving some attention in the literature, in legislatures, in courts, and by the press. *The Invisible Victim*[10] and *The Crime Victim's Book*[8] are two examples. Reiff[10] reports on the work of the Crime Victims' Service Center in New York City and observes that of 259 clients interviewed approximately one month after a victimizing crime, 9.3 percent evinced definite emotional distress requiring professional help. It is estimated that about one-half of the states now have legislation providing restitution and compensation for crime victims through special review boards or the state workmen's compensation commission. The final report of the President's Task Force on Victims of Crime urged changes in the federal law and even the Constitution including a system of payments to victims.[11]

Such developments suggest that psychiatrists may expect an increasing number of assault victims referred to them for evaluation and determination of disability and need for treatment.

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