

Traumatic Neuroses*

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INTRODUCTION

Before proceeding to the subject at hand, it seems wise to introduce the general subject of psychoneurosis or as it is more commonly called, neurosis.

Psychoneurosis or neurosis is one of the four types or varieties of mental illnesses, the other three being Psychosis, Mental Deficiency, and Psychopathic Personality.

Definition of Neurosis. Neurosis is a form of maladjustment in which a patient, despite the fact that he is well oriented to the external world, uses complaints or symptoms of a physical nature to express psychological needs which arise from conflicts that are hidden from the conscious aspect of his mind.¹ He may use complaints or symptoms either to satisfy the self-protective needs arising from his unconscious conflicts, or as a defense against them. For example, in the first situation a headache may serve as an excuse for avoiding a situation in which the patient would feel insecure, while in the second case a paralysis of a hand may act as a defense against an unconscious need to use that hand in some forbidden, aggressive or guilt-laden act. It should always be emphasized that, by definition, the dynamics of this process are unconscious in nature, and therefore not known by the patient.

Other Types of Mental Illness. In contrast, the individual who suffers from Psychosis has lost some or all of his ability to orient himself to the real world about him; that is, he shows some loss of contact with reality. The third classification of mental illness, Mental Deficiency, comprises those individuals who are commonly described as feeble-minded. The fourth group of mental illnesses includes those individuals who are called Psychopathic (Sociopathic) Personalities because of their behavior difficulties which occur on the basis of their inability to accept authority figures and social codes.

Kinds or Varieties of Neurosis. The most useful classification of the neuroses is a four part one, consisting of the groupings of hysteria, anxiety neurosis, psychasthenia, and mixed types.

Hysteria, or conversion hysteria, is a variety of neurosis in which the patient complains of loss of function of some part of the body on the basis of unconscious needs. Hysterical complaints include sensory losses, such as numbness of the skin, inability to see,

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etc.; motor losses such as inability to move a part of the body or to speak; sexual losses, such as impotence; and mental decrements, such as loss of memory for a given situation or a given segment of time. Physical examination of the hysterical person reveals nothing of an objective nature to supplement the complaint, and the typical patient shows a remarkable unconcern about his condition.

Anxiety neurosis is the most common form of neurosis and is a more serious condition than hysteria. It is characterized by a continuing state of apprehension with symptoms and signs of internal tension. The patient has a feeling of impending danger which he cannot identify consciously or assign to a reasonable cause in his present environment. Such persons are unusually alerted in terms of mobilizing their body resources. They appear as if they were about to engage in what is called a fight or flight reaction.

Psychasthenia is the most severe form of neurosis. In these cases the expression of the unconscious needs of the patient become so deeply channelled that they cause stereotyped complaints in the form of obsessions and compulsions. Obsessions are recurring thoughts which persist and which are often painful and distressing. Compulsions are recurring acts which are also stereotyped and which are without logical meaning in the conscious experience of the patient.

There are also patients with mixed types of Neuroses who show combinations of these sub-types, the most common being a state of anxiety-hysteria.

STATEMENT OF THE PROBLEM

The term, traumatic neurosis, is reserved for a state of neurosis or psychoneurosis that is probably the direct result of a stated, antecedent injury. However, it should be very clear that there is no constant, direct relationship between trauma and neurosis; that is, injury is not always followed by neurosis, and neurosis is not always due to injury.

More than that, in those cases in which there is a cause and effect connection, there is no uniform relationship. Injury may be the major cause in one case, the chief precipitating factor in another instance, only an aggravating factor in a third case, and no more than a minor factor in a fourth case. It requires both training and diligence to determine the exact role played by the particular trauma in the individual case of neurosis occurring after an injury.

There is fairly general agreement that the majority of traumatic neuroses occur in situations in which there is a possibility of obtaining some form of compensation. There seems to be ample evidence (Noyes) that Workmen's Compensation Acts and the

widespread use of accident insurance have greatly increased the incidence of claims for traumatic neuroses.

The whole idea of neurosis as a result of injury is relatively new and more or less parallels the elaboration of new dynamic conceptions in Psychiatry during the last seventy-five years. Modern psychiatric thinking stresses the importance of the unconscious aspect of the mind, and this knowledge is basic to the theory of neurosis.

In general, the central theme of the neuroses is to use symptoms and complaints to gain some stability in the face of difficult adjustment. This phenomenon of gain through illness, albeit at an unconscious level, makes the traumatic neuroses a difficult problem to evaluate. In this connection it is to be remembered that there is more to be gained from illness than money alone. However, one would be foolish to underestimate the lure of money, and here it is to be noted that the amounts concerned in tort cases are usually far greater than the settlements which are involved in Workmen's Compensation cases.

Any general statement of the problem of traumatic neuroses should include and emphasize the conception that this condition, *per se*, cannot be regarded as a permanent disability. Traumatic neuroses must be considered as dynamic states in patients from which a return to normal status may occur, and also as kinds of reactive conditions which may recur if the causative factors again come into being.

INCIDENCE OF THE TRAUMATIC NEUROSES

There is no general agreement as to the incidence of neuroses which arises as a direct result of injury. It is believed, as stated above, that these conditions are increasing because of the growing tendency to give the injured person opportunities for compensation. There is also the general, if somewhat philosophical, background factor that in this country (and also elsewhere, as in Great Britain) more and more emphasis is being placed upon security, and that there are reasons to speculate, if not to believe, that our people are becoming more dependent and less self-reliant.

The opinions as to the present incidence of traumatic neurosis range from that of Davidson, who states that psychoneurosis following injury is exceedingly common, to that of Walshe, who believes that the term, traumatic neurosis, is a misnomer since he believes that trauma alone cannot be the cause of a neurosis. It is impossible to state which, if either, of these two widely differing viewpoints is correct. It is probable that the truth lies somewhere between these two extreme views. In the last analysis, psychiatrists as well as attorneys, judges, and juries will render decisions as to the existence of traumatic neuroses partly on the basis of their own

personal feelings, and particularly on the basis of their personal reactions to human suffering and weaknesses.

CAUSATIVE FACTORS

There are two possible sets of causative factors, namely, a predisposition to neurosis in the patient before he was injured, and second, the injury itself either as a precipitating or aggravating factor.

The question of predisposition. It appears reasonable to believe that everyone has the capacity for mental breakdown or illness. In the present connection, it may be said that each person has a definite potential for becoming neurotic. This neurotic potential begins in childhood and varies in degree from person to person. It is the difficult task of the psychiatrist to evaluate the relative importance of this individual potential for neurosis and the relative importance of the injury in question. There is nearly always some neurotic potential in the injured person and thus an error will be committed in almost every instance if all of the causation of traumatic neurosis is assigned to the injury, and if the background is held to be without importance.

There are very wide differences in the amount of potential for neurosis in different individuals. Some persons are very highly predisposed to a neurotic breakdown and their life experiences do not need to be very traumatic or frustrating to cause neuroses to appear. It is also true that certain persons have been conditioned or predisposed on a specific basis, as is the case of a person who has lost one eye and who then feels threatened with the loss of the remaining eye.

The predisposition to traumatic neurosis is closely related to immaturity, selfishness and a need to be dependent on others, but this predisposition is not entirely on the basis of greed for money. In immature individuals the primary motivation may be that of an unusual need for passive security, a need to attract attention and to be in the limelight, and a need to retaliate and punish others who have caused the patient to suffer pain. Such a person may have a strong need to escape from duties, and occupational responsibilities and dissatisfactions, and to receive unusual personal attention and care. It is to be stressed that these needs or motivations can operate at unconscious levels as well as at conscious ones. In the area of the traumatic neuroses, we are dealing with needs that are, by definition, unconscious in nature.

Injury as a precipitating factor. Traumatic neuroses may be brought about by the mental stresses attendant upon certain physical injuries, (and especially by some specific kinds of injuries), and also by psychological or sociological stresses (so-called psychic stimuli) in the absence of actual physical injury.

It should be clearly understood that it is not the physical nature of the injury that is important in causing traumatic neurosis but rather the emotional and symbolic meaning of the injury. In fact, some of the most severe cases of traumatic neurosis occur when the physical injury is minimal.

The injuries that are most likely to precipitate neurosis are those which carry an actual or implied threat to one of the two basic human drives, namely the self-preservation drive or the race-preservation drive. The individual who is threatened with death or deformity in the terms of being crushed or torn, or being burned or buried may react with neurotic thinking and behavior. The same is true when the injury threatens a vital part of the body such as the heart or the head. The security of the individual is also threatened when the preferred hand or the eyes are threatened or damaged. However, there may be a background of predisposition in these cases, either in the form of an unusual preoccupation with health and well-being, or unusual guilt feelings which exert a need for punishment to which the injury in question may be related.

Injuries to the sexual organs are commonly followed by neurotic reactions. There is a greater than average chance that this will occur in individuals who have previously suffered from sexual frustration or from feelings of sexual inferiority.

It should be noted that the threat of certain injuries may precipitate neurosis although there is no actual physical injury. In many cases the psychological stress comes from elements that exist in the injury situation or in the initial medical care. If fright is postulated as a precipitating factor, it must have been unusual in its nature and intensity and of such a quality that it would panic the "average" person.

The individual who is forced into a situation against his own desires and wishes, and who is injured while in that situation, is more likely to develop neurosis than if he were operating as a free person. If onlookers, fellow-workers, police, physicians, medical technicians, nurses or hospital aides attach the impression of great seriousness to the injury at the time of its occurrence or soon thereafter, it may constitute an additional psychic trauma. Similarly, if those in medical attendance infer that the patient was injured through his own neglect, or that he is a coward, or if they openly neglect his medical care, it is possible that such events may facilitate the development of a neurosis. In traffic accidents, the conduct of the other driver following the accident may help to lay the groundwork for a neurotic reaction. All of the actions just described contribute to the development of resentment in the injured person and he then uses self-justification and continued dependent needs to satisfy and cover his resentment.

VARIETIES OF TRAUMATIC NEUROSES

TRAUMATIC HYSTERIA

A hysterical reaction following trauma represents a fairly direct and superficial way of dealing with unconscious conflict and frustration engendered by the injury. In traumatic hysteria, function is withdrawn from a part of the body, either the part that was injured or threatened by injury or a part whose functional loss symbolizes the emotional reaction to injury. For example, a hand that was threatened with being cut or burned off may become numb or paralyzed in one patient, while in another patient a hand may become numb and paralyzed in order to protect the patient from making a physical assault upon a boss, a fellow worker or the driver of another vehicle, against whom the patient feels a terrific resentment. In the latter instances, the paralyzed hand allows him to make a social adjustment to his unconscious need to strike or to kill.

The hysterical patient characteristically shows a phenomena that has been called "la belle indifference," a state in which he shows a striking loss of concern for his physical complaints, and a pronounced lack of anxiety. The reason for this indifference is that the complaint represents a compromise "cure" of the strife or conflict between his unconscious needs and his conscious insights.

TRAUMATIC ANXIETY NEUROSES

In these neuroses there are marked feelings of insecurity and inadequacy with a secondary shift (called a regression)² to more dependent relationships with other persons. In other words the patient with anxiety neurosis becomes more child-like and more helpless. This form of neurotic illness involves the entire personality and the patient constantly feels that he is called upon to meet situations whose demands far exceed his abilities. Nonetheless, he continues to exist in a state of being keyed-up and over-alerted for impending emergencies. He feels tense and apprehensive; his pulse may be rapid; his systolic blood pressure may be somewhat elevated and his hands are usually cold, sweaty and tremulous. He feels that he cannot face the responsibilities of adult adjustment such as being a mate or parent, and a wage-earner. He feels that he must get away from it all and have someone take care of him. There is a particular need to escape from the present situation. Insomnia is very common in the anxiety state. The symptoms often appear or get much worse when the patient is expected to return to his usual activities.

TRAUMATIC PSYCHASTHENIA

This is a very severe form of neurosis and one which is probably never entirely due to trauma. The psychasthenic personality

pattern is usually established in childhood, or at least by early adult life and it is not probable that trauma can do more than bring out symptoms of the basic personality distortion.

In assessing the clinical picture it is important to learn if the obsessions and compulsions have a symbolic meaning in terms of the injury in question, or if they are merely a part of non-industrial, personal maladjustments which arise out of the patient's daily existence apart from the injury in question.

PSYCHIATRIC EXAMINATION

The diagnosis of any neurosis by the psychiatrist rests upon an evaluation which includes the taking of the history, not only of the present illness, but of the entire past life of the individual, the recording of the patient's complaints, and the psychiatric examination proper. The latter includes not only the psychiatric interview but also the evaluation and measurement of the patient's behavior during the interview.

The main purpose of the psychiatric history is to obtain two types of information. First, the examiner needs to know the nature of the structuralized experience in the patient's mind. This involves going far back into the early life of the patient and obtaining history not only about the patient himself but also about his family. The second goal in the history taking is to obtain as much information as possible about the injury in question, and especially the emotional reactions of the patient to that injury experience.

The patient should be asked to give all of his complaints and it is highly desirable that they be written down in his own words without any editing on the part of the doctor. The patient should be encouraged to complain freely so that he will express not only his bodily complaints but also his mental attitudes.

The examination in these cases should seek to bring out definite psychological patterns to indicate not only that a state of neurosis exists, but also that it is probably due to a certain, specific injury. Without such findings, an accurate diagnosis cannot be made.

There is absolutely no justification in making a diagnosis of neurosis solely on the absence of physical defect or disease. When this is done, there is always the possibility that physical illness has been overlooked, but more than that, it certainly does not follow that because a person complains without having a demonstrable, physical basis for his complaints, he is therefore necessarily neurotic. In every case it is essential to identify the definite psychological mechanisms which are characteristic of neurosis in the patient. If the examiner merely records the conscious content of the patient, he will have little or no basis for a diagnosis of neurosis, since the neuroses are unconscious in motivation.

It has been stated that the organs of the body speak the

language of the unconscious. Therefore, it is often true that the behavior of the body organs gives the psychiatrist better insight into the unconscious aspect of the patient's mind than does the psychiatric interview, unless the content of that interview is interpreted on the basis of its hidden symbolism. Therefore, the observation and measurement of the patient's pulse, respirations, blood pressure, deep reflexes and hands (the latter in terms of temperature, wetness, and movements) are most important aids in diagnosis.

Following the examination, the diagnosis should first be stated in terms of the existence of a neurosis apart from any consideration of trauma. Second, a formulation should be made with relation to the extent of traumatic causation in the development of the neurosis. This latter evaluation is to be made, first with respect to the probable effect of this particular injury on the hypothetical "average" person, and second with regard to the probable effect upon the individualized personality structure of the particular patient in question.

The differential diagnosis includes the states of nervousness and malingering. Nervousness is a variation in the range of healthy adjustment, while neurosis is a form of illness. This distinction should always be borne in mind. It is a rare person who is never nervous, and nervousness is not a disease, but a variation in the range of normality. The neurotic individual has an actual disorder within his personality, which manifests itself as difficulty in adjustment; the nervous person is not subject to personality pattern distortion and is temporarily disturbed by transient stresses from without.

The problem of the traumatic neuroses will probably always be contaminated by some persons whose motivations are entirely conscious, who are knowingly seeking monetary gains, and who are willing to fake illness and manufacture complaints to gain their ends. These persons are malingerers and they should never be classed with the true sufferers of traumatic neuroses.

OTHER CONSIDERATIONS

When a diagnosis of neurosis is established, it should be clearly understood that the condition cannot be regarded as an inevitable permanent disability. The fact that a neurosis has gone on for two or three years does not deny this proposition, especially if opportunities to gain by being ill continue to exist. On the other hand, the strength of the predisposing factor largely determines the length and severity of the neurotic process, and on that basis many patients live out lives which are fairly replete with neurotic thinking and behavior.

There is general agreement among psychiatrists that treatment of traumatic neuroses is exceptionally difficult as long as the pa-

tient is gaining or expecting to gain from his illness. There are occasional cases who really want psychiatric help and who profit from it. The treatment of these traumatic neuroses is not different from the treatment of neuroses that are not related to injury.

No single generalization can be made as to the effect of settlement in cases of traumatic neuroses. Recognizing that money is not the only need to be satisfied in these cases it is not remarkable that cash settlements do not always cure these persons, despite a common belief to the contrary.

In any event, it is agreed that settlements should be final and that they should be made as early as is feasible.

SUMMARY

The difficult problem of the traumatic neuroses has been reviewed.

This is an area of Medicine in which precise scientific formulations are almost certain to be modified by the philosophical reflections and even the emotional attitudes of the doctor, the attorney, the judge and the jury. It cannot be forgotten that the patient is gaining some satisfaction from this sort of illness, and it is often difficult to determine how much of his motivation and satisfaction is unconscious and how much is conscious. Thus, there is always the possibility that the patient may exploit the situation.

The best medical approach to the problem is to first determine whether a state of neurosis actually exists without regard to any question of causation. Then the examiner can evaluate the injury in terms of its probable effect on an "average" individual, and finally in terms of its probable effect on a person with the peculiar personality structure of the individual patient.

¹ The main difficulty encountered by the untrained person who attempts to understand the human mind and such problems as Neurosis is that of grasping the idea of the unconscious and conscious aspects of mental activity, and especially of appreciating the dynamic nature of the unconscious. The unconscious is not a place or a part as such, but an accumulation of experience that is *in use* outside the field of conscious awareness. This identical accumulated experience may also operate within the field of conscious experience, at either the same or at other times. Therefore, it is too simple to think of mental material as being either entirely conscious or wholly unconscious.

Adjustments that are worked out at an unconscious level operate on a pain-pleasure formula (that is, to avoid pain; and seek, gain or have pleasure), and it is on the basis of over-developed needs of this type that the neuroses exist. Frustration in the process of adjustment brings pain to the patient or deprives him of pleasure.

Finally, the conscious level deals with the unconscious needs on a symbolic basis, and it requires special training to learn to interpret the symbolic meaning of thinking and behavior which arises from unconscious needs.

² Regression is the return to earlier, more dependent levels of adjustment on the basis of unconscious needs. The latter include the wishes to have

unusual amounts of love, care and support, as well as needs to escape from more mature responsibilities. Regression is, therefore, a retreat or escape to a more selfish status.

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