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By

Thelma V. Owen, M. D.
Huntington, W. Va.

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A.CUTE TRAUMATI.C NEUROSIS

By THELMA V. OWEN, M. D.
Owen Clinic Institute, 1319 Sixth Avenue
Huntington, West Virginia

IT is sometimes difficult to find a specific diagnostic label for the psychiatric patient. Kraepelin served psychiatry well when he differentiated the psychoses from the psychoneuroses. The general divisions and many of his descriptions of diagnostic syndromes have stood the test of time. As our knowledge of psychiatry grows through practice and research, the standing Committee on Nomenclature of the American Psychiatric Association is ever on the alert to redefine diagnostic categories so that we may have better communication among ourselves and other professional groups with whom we work.

At the initial interview the doctor is at times uncertain as to which psychoneurotic reaction, described in the Diagnostic Manual[1] of the American Psychia,tric Association, best fits his particular case. Regardless of the presenting symptomatology, the psychotherapist knows his patient is suffering from "anxiety." It is easy in all oases to attribute anxiety to the social milieu or nuclear age in which we live but, from the time when Jesus said, "Martha, Martha,

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you are anxious and troubled about many things," (Luke 10:41) writings in every age disclose anxious people.

The cause of the anxiety iil the "Marthas" of any age is found to be feelings of resen,.qnent plus feelings of guilt. .The R plus-G-equals-A usually-can be discovered at the initial interview in psychoneurotic reactions. It was the inability to find the R-plus-G in many trauma cases which prompted this study.

Trauma may trigger a psychosis, but this paper concerns itself only with the differentiation of "Acute Traumatic Neurosis" (T.N.) from the Psychoneurotic Reactions (P.N.).

The Study

Several years ago we began working actively with the courts. The physician is expected to clarify what is meant by Traumatic Neurosis, Conversion Reaction, Malingering and Psychoneurose. of various categories. He is expected to give his opinion whether this particular trauma caused the patient's illness or merely aggr,avated an already existing personality characteristic. He is expected also to give an opinion as to whether the patient is cherishing hi symptoms with the hope of monetary reward. This preliminary study was made to determine: (1) Is "Acute Traumatic Neurosis" a symptom complex of its own, distinct from the Psychoneurotic Reactions? (2) Do these patients have a neurotic predisposing personality? (3) Are monetary rewards a secondary gain?

Method

The first 28 cases diagnosed "Acute Traumatic Neurosis" (T.N.) were chosen so that there would be sufficient time for longitudinal

observation. Some patients had had hospitalization for physical injuries but were treated for the emotional disorder on an outpatient basis. The T.N. group was compared with 28 outpatient cases diagnosed psychoneurotic reactions (P.N.). The P.N. were taken from the files at random, the only specification being that they must have had at least three psychotherapeutic interviews.

Results

The fact that the T.N. comprised 19 males, 9 females and the P.N., 11 males, 17 females indicates that males engage in more hazardous oocupations. The slight increase of females over males in the **P.N.** may indicate that the psychiatrist is a female.

The lower education level of the **T.N.** (more than half had less than ninth grade) is due to locale of the study. Until recent years West Virginia farmers and miners did not sufficiently value higher education. The higher education level of the P.N. (15 attended beyond the ninth and seven reached college) is due to type of referral. All T.N. were referred either by physicians or attorneys; most P.N. were self-referred because of unhappiness.

Twenty-six P.N. gave as a precipitating cause divorce, marriage, birth, death or some other emotional scapegoat. In only two cases was physical trauma blamed. Twenty-six T.N. suffered some physical injury, ranging from mild to severe. In one instance physical injury was most minor; in another trauma was false arrest.

The **P.N.** were vague in dating the onset of difficulties. When the precipitating factor was given, in all but four oases the interval between

the event and the first visit was more than a year. The emotional difficulties were dated either as "for yoors" or "all my life." The T.N. definitely dated the onset of difficulties to the traumatic experience.

Leopold and Dillon[2] have stated, "Familiarity apparently breeds in the organism a loss of the capacity to defend itself." In all T.N. cases the trauma occurred suddenly when the individual was in what he considered a most secure situation. It was a "blow" to his feeling of self-security.

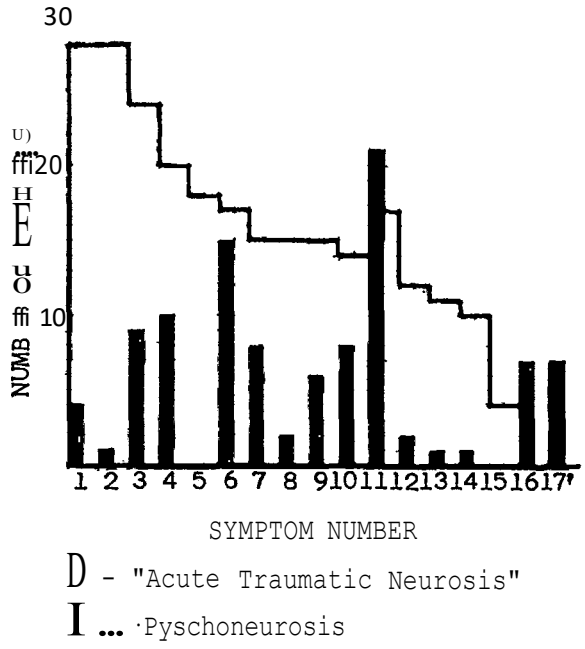

Figure 1. (1) Insomnia; (2) Nightmares; (3) Irritability; (4) Fatigue; (5) Sex disturbance; (6) Depression; (7) Weakness; (8) Headache; (9) Inefficiency; (10) Pain; (11) Fear; (12) Dizziness; (13) Memory defects; (14) Impaired judgment; (15) Tinnitus; (16) Smothering; (17) Nausea.

Youth has not yet developed a sense of self-security. This would account for 14 T.N. being over 40 years as contrasted with seven P.N.

This is exemplified in the history of four T.N. patients, members of one family. When a gas line blew up near their home, the parents were blown out of their bed and found themselves on the floor. The three children were in a state of confusion, fire was all about and stones rained on the roof. The parents, in their early fifties, the 19- and 14-year-old sons all developed T.N. The 11-year-old daughter did not develop the illness in spite of the fact that she had sufficient damage to her labyrinth apparently to produce tinnitus. The 19- and 14-year-olds responded to treatment and were again effective people after four interviews. After a year of treatment, the parents have not yet regained complete emotional stability although improvement is marked and they are functioning at near their previous level emotionally.

Symptomatology

Figure 1 contrasts the characteristic symptoms of the T.N. with the inconsistent P.N. Table 1 depicts the difference in quality of symptoms held in common by both groups. Unless the patient's symptomatology conforms closely to the profile in Figure 1, his illness probably is not "Acute Traumatic Neurosis,"

The paucity of symptoms distinctive of the P.N. is due to the limited number of cases; a symptom was recorded only when at least four complained of it. T.N. was superimposed upon physical injuries of various degrees in 22 cases, eight of which were head injuries. Further studies are being made to determine whether

the dizziness, memory defects, impaired judgment and tinnitus are due to the emotional illness, the physical injury, or both.

Personality

This study did not confirm the statement of many writers that "post traumatic neurosis" occurs in individuals with a predisposing neurotic personality. The individual was considered "stable" if he had a steady and consistent work record and satisfactory interpersonnel relations. He was considered "unstable" if he complained of chronically poor physical health and difficulties in interpersonnel relations. Usually his work record was inconsistent and unsatisfactory.

In the T.N. 24 were in the "stable" group. Of the other four, two had efficient work records but were tense worriers; only two had had previous emotional disorders sufficient to interfere with efficiency.

Since this study included only outpatient P.N., all were working, but only four felt they were doing an adequate job. All P.N. except these four and one other 22-year--old had a long history of previous treatment either for physical or emotional disorders. All complained of difficulty in some type of interpersonnel relations.

Medicolegal

Table 2 would indicate that litigation is of little importance in "Acute Traumatic Neurosis." A typical statement in these cases is, "I wouldn't go through this again for all the money in the world," and they mean it. Four were Workmen's Compensation oases, two were receiving Social Security disability but considered this a mere pittance in comparison with their previous earning capacity. Two were being retrained

by the State Rehabilitation for jobs more suited to their limited physical capacity.

Juries in West Virginia are not prone to award large monetary judgments. In only one case was the monetary judgment more than sufficient to recompense for doctors' bills and loss of wages. In all but this one case the financial condition of the patient was much worse at the time of discharge than it was at the time of the accident.

Discussion

This syndrome has been called variously Traumatic Neurosis, Post Traumatic Neurosis, Post Concussive Syndrome, Psychoneurotic Reactions, Conversion Hysteria, Compensation Neurosis and The Accident Process. "Acute Traumatic Neurosis" is appropriate because of the acute onset, although in severe physical injuries the syndrome may not appear for as long as six months following the trauma. Three of these patients, seen within one month of the trauma, originally were diagnosed "normal" anxiety concerning their physical injuries, only to return within one to six months with the illness full blown. Both patient and family, however, will insist, "He has not been the same since the accident."

Chadoff[3] has said, "The traumatic neurosis has always been something of a misfit in Freudian theory . . ," Leopold and Dillon[2] stated, "It is suggested that post traumatic psychological states be considered diagnostic categories in themselves."

Thompson,[4] in his study, warns that a diagnosis of Post Traumatic Psychoneurosis must have a clear-cut diagnostic syndrome present. He was able to fit Post Traumatic Psychoneurosis in seven of the ten well-defined sub-

types of Psychoneurotic Reactions. His study was based on the reoords of 500 psychoneurotics, with their many and various complaints recorded by different psychiatrists. In the present study, patients occasionally had psychoneurotic complaints. These were investigated and when found not to be contributory to the present illness were h·eated as a separate entity. Two patients had had minor psychoneurotic reactions previously with ulcer symptoms, but the old symptoms did not recur with the acute traumatic illness.

T.N. patients described in this paper and by Kamman[5] are different from those described by Hirschfeld and Behan[6,7] in The Aocident Process as 'Compensation Neurosis.' Apparently attorneys and physicians who work largely with accident oases are conversant with the latter syndromes as they are rarely referred to our Clinic. Since the writer is not an examining physician but is known as a treating psychiatrist, it is those who show a real desire to get well who are referred.

The Diagnostic Manual1 states that "Gross Stress Reaction" should be used only when a group of people have experienced a common disaster. The acute traumatic patient with his individual trauma develops much the same symptomatology as described by Eitinger[8] and Chadoff3 in "Concentration Camp Syndrome," and by Archibald,[9] et al in "Gross Stress Reaction in Combat-A 15-Year Follow-up."

The present study agrees with the findings of the above mentioned authors, as well as Leopold and Dillon,[2] that the "post traumatic syndrome" occurs most commonly in persons considered "stable personalities." It also resembles closely

Table 1

DIFFERENCE IN QUALITY OF THE SAME SYMPTOM

Symptom	Psychoneurosis	Acute Traumatic Neurosis
1. Insomnia	Prompt sleep, early wakening, vague as to time.	Delayed sleep, sudden waken ing, checking time.
2. Dreams	Varied.	Nightmares of Impending death, crying out.
3. Irritabi ity	"I've always been nervous."	"I never was nervous, now I'm cross and can't stand noise."
4. Fatigue	"I've always been tired," or spasmodic.	"1 've always enjoyed work; now I'm tired a l the time."
5. Sex	Non contributo ry.	Sudden disinterest.
6. Depression	Vague, varied and spasmodic.	Sudden, continuous. "I'm finished."
7. Weakness	Periodic.	Con tin uous.
8. Headache	Infrequent in O.P.D.	Frequent. Many associated with head, neck and back injuries.
9. Inefficiency	"I've never been too good a worker."	.. I always was a good worker until this happened."
10. Pain	Bizarre, frequent, vague, intestinal complaints.	Definitely related to site of Injury.
11. Fear	Irrational, no basis in fact.	Fear of permanent injury. Based on fact.
12. Dizzi n ess	When "worried."	Following sudden movement or exercise.
13. Memory Defects	Inattention, self-engrossed.	Tries hard to remember.
14. Impaired Judgment	A permanent characteristic.	Sudden onset.
15. Tinnitus	Spasmodic.	Continuous.
16. Smothering	Common.	Not present.
17. Nausea	Common.	Not present.

Table 2

MEDICOLEGAL

Present Status	Disposition by trial	
Discharged as recovered 12	Continued* Set	7
	Discharged prior to termination	5
Continued treatment until discharged . • ..... • .. • . 2	Terminatedt ..... • ..... •	2
Improving, still under treatment .. .. • .. • . • 5	Continued ..... ••	4
	Terminated ..... • ..... • . • . •	1
Died ..... • ..... • 2	Continued	1
	Terminated • ..... • .. •	1
Refused treatment .. • .. • .. •• . 7	Terminated • ..... • .. •	3
	No follow-up	4

*Continued- Still in litiaation.
tTerminated-Litigation ended.

those studies by Moldin[10] in symptomatology, background and personality. These patients have taken pride in their emotional stability and their ability to carry responsibilities. Rather than "secondary gain," it is a sad blow to the ego suddenly to become a cantankerous person, uncertain, unsure and dependent.

It is not the purpose of this paper to discuss treatment, but a few statements on this subject help to clarify personality. It is confusing to the doctor who has spent many years of his life guiding the maladjusted while he uncovers his repressions, resentments, and guilt feelings to meet in his office individuals whose mental mechanisms have apparently operated constructively to help him adjust to his environment. He must be accepted as an open, simple individual who is accustomed to dealing with life's problems realistically. Improvement begins after the first interview when he is told what is wrong with him both physically and emotionally and a direct program of treatment outlined whereby he can help himself. In retrospect it might well be proven that many cases diagnosed P.N. who surprised the doctor by rather prompt recovery were really T.N. who got well in spite of the doctor's blundering efforts to help.

This study also indicates that litigation is of minor importance although apprehension over an impending trial interferes slightly with treatment. In being passed from doctor to doctor, especially in Workmen's Compensation investigations, the patient develops the feeling described by Meerloo[11] in his examination of German extermination camp survivors, "... they encountered a cold, defensive wall of silence on the part of the interviewer, which only aroused

in toom the old bitter feeling that there was no justice to be found in this world."

Kelly,[12] in his review of the book, "Trauma and Disease," stresses the• fact that the defense attorney will belabo): 'the points of predisposing personality and '1malingering or compensationitis" and belittle the role of trauma. It thus behooves the psychiatrist to study his "Acute Traumatic Neurosis" case thoroughly so he may present its distinguishing features to the jury clearly and distinctly.

Summary

Twenty-eight cases of "Acute Traumatic Neurosis" are compared with 28 cases diagnosed Psychoneurosis from :the standpoint of symptomology, background and personality.

"Acute Traumatic Neurosis" is presented as: 01) a distinctive symptom complex different from the Psychoneurotic Reactions, (2) this illness occurs most frequently in stable, secure individuals and (3) monetary gain is of little importance.

Acknowledgment

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