BEHAVIORAL ASPECTS OF INJURIES

PSYCHOPATHOLOGY FOLLOWING INDUSTRIAL INJURY - IATROGENIC FACTORS

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Industrial injury with its attendant symptoms is never incurred in a vacuum. It is always experienced by a particular person within a gestalt-type milieu including that person's totality of intra-psychic function at the time of the injury, the character of his relationship to his job-peers-supervisors, and the nature of contact with medical personnel in diagnostic and treatment efforts. Frequently interjected into this milieu within a short period of time are insurance companies and lawyers. Whether or not functional psychopathology follows industrial injury invariably is dependent upon the characteristics of these factors in varying combinations.

You will note that I use the term "functional psychopathology" rather than "traumatic neurosis". The latter terminology usually connotes that it has been the accident itself that has had a "traumatizing", overwhelmingly frightening effect. The accident per se is held to be the critical danger factor in promoting psychodynamic change out of which develops the psychopathology.

It has been my experience that this is true in only a very small percentage of physical injury cases.[1] Most clinical psychopathology following physical injury is related psychodynamically to the particular symptoms being experienced and/or the manner in which other important persons relate to the injured person. The psychic trauma need have nothing to do with the accident producing the injury. Symptoms and care-providing people take on a symbolic quality. Diagnostic and treatment procedures are misunderstood or misrepresented.

Psychic trauma is always a complex reaction initiated by what Krystal terms "psychic reality" - that is, the totality of the individual experience, interpreted, as it were, within the particular person, by the mental associations it provokes. Experiential stimuli are traumatic not by virtue of their physical intensity but by their psychological meaning to the person and the emotions they evoke. The intensity of the stimulus is relevant only in the conceptualized frame of reference of what seems, to that person, to be a "danger situation". This bears most directly upon the particular emotions experienced. It matters

little which of the various factors in the gestalt-milieu mentioned above constitutes the emotion-producing stimulus. Most critical is the "affect tolerance" of the person, the ability he has to deal with the feelings aroused. These feelings most usually will include anxiety, shame, anger, depression, guilt. Additionally there may be suspicion, passivity and dependence, seductiveness, and self-destructiveness with a fusion of these multiple reactions being most common.[2] The physician, nurse, employer-representatives, insurance companies and lawyers play vital roles in the constellation of emotions aroused and how the injured worker deals with them. What we say and do, how we perform and relate and what we do not say and do can have grave consequences.

The psychological meaning of physical injury and impairing physical symptoms is particularly significant in the population constituting industrial workers, both male and female. In the main, this population is a physically oriented group in contra-distinction to psychologically or philosophically, or intellectually oriented. The feeling of physical integrity and self-reliance constitutes a major basis for a sense of integrated personality functioning. They deal with themselves and life in a literal and concrete fashion rather than in abstractions and conceptualizations. Their self-imagery, self-representation, self-esteem depends on their physical being. Activity and stamina spell successful function and provide acceptance on the job, by social peers and even family members. They are intolerant of weakness or impairment. They are the "Bread-winner", whether male or female, with all the symbolic representations that go with that term.

Contributing significantly to this self-representation is the frequent reality of inadequate education, academic tools, absence of skilled-work training and self-acknowledgment that financial survival is almost wholly dependent upon physical capability. Many in the industrial population are "under-achievers". They are occupationally static, "stuck" in their jobs, do not even aspire to make foreman. They are inhibited persons. Physical injury may be taken by them as confirmation of their fears regarding themselves and create even further inhibition of occupation and personal function.

Shands and Meltzer[3] may have added another characteristic of the industrial population that has relevance. They recently reported a study of psychiatric evaluation by a Workmen's Compensation Board of 88 out of 120 persons referred. The patients demonstrated an inability to adapt to a new situation, plaintively repeating over and over that they just want to be the way they were before

their injury. They seemed unable to accept that they are the same person who has suffered an accident.

The authors suggest that a cognitive deficit found on psychological testing seemed to make these people particularly vulnerable to disorganization and interpersonal disintegration in situations where they are required to adapt abruptly to a new self-definition, to "conserve" their feeling of self in the face of a significant change of context. They seem unable to "stand back" from themselves sufficiently to say "I have been injured, I have changed to some extent, but I'm still me".

Blinder[4] points to another facet of characterizing the man or woman emotionally pre-disposed to a post-traumatic psychological disorder. He cites the personality characteristics of hyper-conscienciousness, obsessive perfectionism, militant self-reliance, over-achievement, and great emphasis of physical appearance, activity, stamina. He agrees that typically strength and athletic prowess are the principle sources of self-esteem.

He brings to our attention, however, that frequently these traits have developed to conceal or defend against the expression of great feelings of insecurity, repressed anger, and unmet dependency needs. These persons often through compulsive work - "they live to work" - successfully unconsciously deny an intense craving for dependency and nurturance. They also often harbor a secret disappointment at being obliged to labor arduously at tasks they unconsciously feel to be beneath the level of their hopes and aspirations. Their over-achieving is artificial, and rather precarious protection from their own ill-perceived inherent weakness. I would add the frequently observed defensive shield of invulnerability which the injury may break down.

When the industrial worker is suddenly, often quite precipitously, deprived of these defensive mechanisms, he becomes particularly sensitive to the way we care-providers relate to him. This is but one way in which we can be instrumental in the evocation of emotional responses beyond his own affect tolerance level, beyond his own ability to deal with feelings. 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 and makes his psychological balance and integrity even more tenuous. Feelings of fear and helplessness especially predispose the patient to the phenomenon of regression.

In studying the psychological complications of convalescence, Krystal and Petty[5] direct special attention to the phenomenon of regression and narcissistic withdrawal, a turning backward from prior attained levels of psychological growth and maturation. This is especially true in a person who has experienced an illness or physical injury which results in a loss of a significant part of function. The clinical state itself may present a situation that is not acceptable to the patient. Often the enforced dependency and an inability, psychologically or realistically, to indulge it arouses great conflicts that have to be dealt with. Fear which may be provoked through any mechanism exerts pressure toward such regression. This process further favors the resomatization of anxiety, the retranslation of emotion into physiological, physical elements produced and there result additional symptoms or a heightening of those produced by the injury.

Successful convalescence requires a restructuring of self-representation, self-imagery. The sequelae of injury are added to the former self-image, especially body-image. Beyond the basic feeling of " and in spite of all, I survive", there is the question of acceptance, to one's self and to the world. Frequently, the patient will use the all-powerful doctor and other significant persons to test his acceptability.

This is complicated, however, by part of the regression involving the tendency toward projection (it's not me, it is you) which arises from the patient's failure to integrate the total experience. Instead of being able to acknowledge his loss, or even his clumsiness or preoccupation which may have been involved in the accident, he has to attribute it all to the company, the doctor, to somebody. This becomes manifest in a demanding attitude or belligerence.

Another aspect of regression may include the patient dealing with the question of "Why did this happen to me?". The problem of guilt feelings may cause the patient to look for, even seek, evidence of being punished and/or rejected. This can contribute toward the development of depression or even paranoid trends.

These factors add considerably to the problem of how the care-providers perceive and react to the injured patient. We must be ready to understand the psychological malfunction represented. We must deal with it objectively, not take it as a personal assault and then counterattack.

Bartemeier[6] also stresses the importance of regression. Every patient-doctor relationship is to some extent in all of us a

re-experiencing of the child-parent relationship. Sick and injured people are often frightened and feel helpless, often dependent like children. For them the physician is the substitute parent-person possessed of medical knowledge and skill.

He notes additionally that physicians have varying degrees of awareness of their own feelings about patients. The patients, however, usually sense whether the physician likes them, respects them or dislikes them, and all else the physician may feel about them. The condition of illness often makes them more sensitive, more appreciative of being understood, more easily offended and less tolerant than would be their wont were they in good health.

The doctor's personal influence can be considerable in relation to the clinical course of the patient. Regardless of his attempts to hide his feelings from the patient, which too often might not even be the case, they sense his distrust, disrespect, suspiciousness, indecisiveness, uneasiness and uncertainty through the tone of his voice, his choice of words, his hesitancy of speech, bodily tensions, the suddenness of brusqueness of his movements and in numerous subtle ways. While the doctor studies his patient, the patient is observing many facts about him which he may never disclose but which may have an important influence on clinical developments. Direct correlation must be made to Krystal's observation of emotions aroused in the patient and his level of affect tolerance as major factors in the genesis of psychopathology following injury.

The first contact with the accident victim is of utmost importance[7]. After the accident, the patient usually views his environment as hostile, for the incident symbolizes being attacked. He frequently responds with counter aggression. At this time he needs more than anything the steadying influence of a friendly, sympathetic doctor as an aid toward restoring his psychic equilibrium. He needs to feel that he is being cared for. This is true whether the accident was a near miss, a minor one, or a major one.

Too often, however, the patient is immediately greeted with suspicion, implied if not direct accusations that he is faking or deliberately exaggerating symptoms in the pursuit of getting something for nothing. The patient then has to prove that he has been injured and is having genuine pain. There should be no tacit assumption that the patient is solely interested in compensation, a "free ride", until a thorough diagnostic study has been made. This must also include psychological factors; a casual observation of a "functional overlay" is totally inadequate in evaluating anything. Malingering must constitute a definitive

diagnosis derived from definitive clinical evndence, not merely the absence of well-defined organic pathology.

In the continuing care of the patient there is no room for a doctor's concern with monetary problems, insurance claims or legal responsibilities. There is no room for bias for or against the patient, employer or insurance company. Over-identification by the physician with either the patient or the company or its representatives creates possible emotional damage to the patient.

A frightened patient will exaggerate the importance of his symptoms out of all proportion to their realistic significance. It is the anxiety associated with pain that provides its unbearable quality.[8] It is the anxiety mobilized which threatens to overwhelm all other perceptions and functions of the entire self, but especially to overwhelm conscious ego functions. Anxiety and pain are very closely related. Each state is modified and influenced by the other. Exposure to much pain is likely to produce excessive anxiety, and the presence of anxiety almost invariably predisposes to and increases pain responses.

A brief examination and cursory explanation only serve to reinforce the complaints and fears of the patient. Traumatic effects can also accrue because the attending physician did not listen to the patient's description of symptoms and follow through with appropriate reassuring examinations. Careful explanation is especially important and in language understandable to the patient. His questions must be answered and efforts made to make sure that the patient is hearing what is actually being told to him.

It must be remembered, however, that unnecessary, repetitive and prolonged examinations in themselves can often reinforce in patients the conviction that they are seriously ill and arouse needless emotional stress. This is especially true in litigation where a host of consultants usually enter the picture. Each pursues the gamut of diagnostic procedures and no one tells the patient anything. He often derives contradictory information and advice, if not manifold varieties of medications and treatment modalities with no idea of goals involved. Myelograms, electroencephalography, brain scans, electromyography, and arteriograms constitute highly consequential experiences. To the patient, each diagnostic examination has much meaning. He often does not differentiate evaluation modality from treatment modality. Seeing a doctor is supposed to make him feel better. The doctor is supposed to do something to help him. He walks out of each session more confused and still less understanding of what is really wrong with him. Too often no one is acting as his central

primary care physician, correlating, explaining, directing.

The factors of prescription of unnecessary bedrest, time off from work, physiotherapy and other procedures further contribute to hyper-concern, preoccupation, ruminations, all of which are related to the genesis of anxiety and/or depression.

Let us add to this medical melange casual observations and remarks injudiciously made by physicians and nurses especially, somewhat less so by lawyers and insurance claim adjusters. The effect of the doctor's words can be tremendous. Keiser[7] cites two excellent examples:

A veteran having a lead particle imbedded in his brain. His physicians discuss the pros and cons of an operation in front of him. One doctor said, "the particle is dangerously near the vital centers and any movement in its location might cause sudden death". The patient became almost totally disabled with severe anxiety. Several years later, he was cured by other doctors who told him, after examination, that the "particle was still visible but had become encapsulated" and would not move.

Another patient was "bent almost double and groaning with pain localized in the thoracic spine". His symptoms were traced to the remark of an intern speculating on the possibility that a slightly different position of a laceration on the patient's back would have resulted in paralysis.

I wish I could count the number of cases I have seen where an examining consultant casually dropped the remark that surgery might have to be considered "sometime"; or, a doctor answering a patient's question regarding possible surgery as being totally contraindicated because of the risk involved. The physician here was not aware that the patient was already scheduled for admission to the hospital to undergo that same surgical procedure.

By the same token, however, the failure of the physician to make any commentary other than a few grunts as he proceeds frequently implies to the patient that the physician is hiding something horrible. This is most true in the various consultant contacts.

A final observation is that made by Keiser[7] regarding what he terms "uncertainty in the physician". The physician may be fearful to attribute symptoms to psychological causes. He may be reluctant to believe that psychological factors can actually cause physical symptoms. This uncertainty is conveyed to the patient even when the doctor tries to keep it from him. Psycho-

logical factors must be appreciated and investigated along with whatever other evaluative procedures are clinically indicated.

The possible bias of physicians regarding neurosis may also contribute to the patient either getting better or worse. Condemnation or contempt toward the neurotic, who is viewed as weak, adds but another destructive influence. Physicians must be cognizant of the symptoms indicating emotional illness, have knowledge of general treatment of emotional problems and be willing to seek psychiatric consultation where indicated.

To minimize the iatrogenic contributions to the development of psychopathology requires the careful and conscientious attending to these many forces being experienced by the injured person. A general principle of treatment can be stated. We must constantly maintain the "physicianly attitude", empathic identification with the patient and what he is experiencing, providing human assistance within the capacity of one's own personality. Each of these patients is entitled to respectful acknowledgment of his status as a human being. He should be availed of complete medical, psychological and social assessment and evaluation. He should then be provided the best available treatment of his own particular demonstrated medical, psychological and social needs.

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