

## BOOK REVIEW

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### A Review of *Post-Traumatic Neurosis*

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**REFERENCE:** Trimble, M. R., *Post-Traumatic Neurosis*, John Wiley & Sons, 605 Third Ave., New York, NY 10158, 1981, 156 pp., \$33.75.

Post-traumatic neurosis became an important concept in legal medicine over a century ago when bodily injuries and severe emotional stress were experienced in connection with railroad accidents. The disorder has especially flourished since the advent of the automobile and whip-lash injuries. While nowhere specifically defined in this volume, the title alludes to the emotional and perhaps to the neurological consequences of acute physical injury.

*DSM-III [1]*, the official diagnostic nomenclature of the American Psychiatric Association and other organizations established Post-Traumatic Stress Disorder as a new formal diagnostic label. In essence, PTSD is a psychological response to a catastrophic external stress that would evoke significant symptoms of distress in almost everyone, that is reexperienced psychologically by the individual, that leads to numbing of responsiveness to or reduced involvement with the external world beginning some time after the trauma, and that often has other associated psychological symptoms. Some clinicians have argued that almost any upsetting daily event can qualify as a sufficient stressor, even losing a job. However, this does not have quite the enormity of rape, assault, flood, earthquake, torture, death camps, "car accidents with serious physical injury," and so forth as cited in *DSM III*.

Your reviewer hoped to find in this volume definitions to distinguish PTSD from the also newly accepted diagnoses of Factitious Disorder and Malingering. While these distinctions are touched upon here, unfortunately they are ill-defined.

Dr. Trimble includes the historically important issue of possible organic damage of the central nervous system as a nonpsychological stressor. This possibility is casually dismissed in *DSM III*, which indicates that "the trauma . . . may even involve direct damage to the central nervous system"; neurological damage is not a necessary aspect of PTSD. Dr. Trimble cites earlier writers who demanded positive neurological findings to diagnose Post-Traumatic Neurosis. He shows that subtle cortical brain tissue changes may be demonstrable by neuropsychological testing while grosser, deeper brain changes may not be demonstrable at all. He emphasizes that the distinction of structural versus functional changes based upon postmortem findings is fallacious, "as clearly it depended on the power of the methods used to detect changes." He alludes to electron microscopy and to study of neurotransmitters for submicroscopic tissue changes.

Dr. Trimble appropriately devotes considerable attention to "functional" disorders. This buzzword has become synonymous with "psychological" or "lacking an organic basis" known to the doctor! He emphasizes that despite some contention to the contrary, "functional" is not

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synonymous with malingering, a title easy to name but hard to prove. He writes: "A main difficulty is that clear, clinical differences have not been demonstrated between patients regarded as malingering, and patients regarded as having a neurosis." This necessary distinction has not been achieved, and herein lies your reviewer's disappointment.

However, Dr. Trimble does write:

Malingering must of course remain a possible diagnosis in some patients but how is it recognized? The most persuasive arguments for malingering . . . hardly give clear guidelines for its detection. Malingering is, after all, a diagnosis in the same way that depression and multiple sclerosis are diagnoses, and criteria must be specified for its recognition. . . . To make a diagnosis on purely negative grounds may do a great injustice to patients, and is not good medical practice.

This reviewer suggests that *DSM III's* criteria often are not much clearer. One clinician's perception that symptom production results from pursuit of a goal "obviously recognizable and understandable" may contrast with another clinician's sense that subtle psychological forces are at work. The diagnosis of Malingering may as much be a result of the social and psychological set and goals of the clinician as of the psychology of the patient.

Dr. Trimble values psychological testing to demonstrate impaired brain function. He writes that

living is a sustained task, and it is perhaps no coincidence that many post-traumatic neurotic symptoms occur when patients attempt to return to work. If their performance is impaired, as some psychological results suggest, it is not surprising that they fail to cope with a job that previously they had coped with quite well.

Dr. Trimble discusses his topic in a literate, articulate little volume with a good historical perspective. He dissects the history of the malady at some length, considers opposing viewpoints, and attempts to synthesize a perspective that encompasses the narrow limits of our knowledge. This is a book worth reading, especially by forensic psychiatrists and others whose patients/clients are involved in litigation.

## Reference

- [1] *DSM-III: Diagnostic and Statistical Manual of Mental Disorders*, third ed., American Psychiatric Association, Washington, DC, 1980.