Psychological wounds of trauma are a diagnosis that is not very often understood or considered when an individual has experienced physical trauma or been involved in a motor vehicle accident. When a patient is not responding to the usual types of physical, medical, or chiropractic treatment interventions, it is important to consider the co-morbid issues and needs involved in the case. Such patients struggle to improve their pain and functioning, but continue to be blocked and overwhelmed by the psychological experience leaving providers frustrated and confused. Pain medications may be increased as the patient’s pain seems to only get worse and seems uncontrollable. In reality, trauma patients may well, unknowingly and ineffectively, utilize pain medications as a means to modulate their moods. Traumatic psychological variables are most predictive of injury case outcomes.

Traumatic Responding Patterns
Trauma occurs when the person has had an actual event or experience that has threatened their life, physical wholeness, or sanity and overwhelsms the individual’s ability to psychologically cope. The actual injuries can be minor yet it is estimated that up to 32 percent of such cases have had resulting traumatic symptoms. Though such traumas are usually associated with abuse, wars, natural disasters, and domestic violence, the incidence of reported traumatic responding patterns noted in car accidents is underreported.

Traumatic responding patterns occur as a result of feeling out of control of one’s physical and/or emotional experience. Since a sense of having control over one’s life is central to feeling stable and comfortable in one’s life experience, a loss of this sense can be quite overwhelming, exhausting and confusing. When an extraordinary event or experience occurs that alters one’s existential experience, it is unexpected and threatens our sense of security and certainty in the world. It is especially difficult to handle when children, adolescents and young adults are involved in such experiences where their sense of security is threatened and changes their developmental realities. Further, the psychological trauma becomes multi-dimensional when an individual is struggling with other life stressors and/or changes that are now even more complicated by the injury/accident. In such a case, post-injury pain can lead to disability, depression, post-traumatic stress disorder and frequently last longer than a year resulting in long-term, moderately severe pain and other significant problems in functioning.

Comorbid Psychological Symptoms
When physical or mental traumas occur, it is normal to be anxious, depressed, agitated, or to experience nightmares. Eighty percent of those experiencing trauma will find themselves struggling with such symptoms. However, up to 15 to 40 percent of those injured will struggle with more involved traumatic responding patterns that seem to continue and exacerbate their pain and injury. Figure 1 presents comorbidity statistics associated with post-traumatic stress disorders.

According to the diagnostic manual, post-traumatic stress disorders are usually not fully diagnosable until the symptoms have continued for more than three months. Prior to that, the diagnosis is an Acute Stress Syndrome—a condition noted in the first three months following a trauma.
The typical symptoms are usually not acknowledged to providers unless more pointed questions are asked to gain additional information from the patient. Many patients are embarrassed about discussing such symptoms, for multiple reasons. Frequently patients feel guilty and weak for having such reactions and for not being able to be in control of their emotional and physical lives. Catastrophic negative thinking is common and adds to a sense of feeling overwhelmed, lost and confused. Sleep problems and nightmares disrupt sleep-wake cycles causing more confusion, problems concentrating, and an increased sensitivity to pain.

### Symptom Clusters

The typical symptoms noted with a traumatic experience are feeling out of control and helplessness related to the injury incident. Three or more of the following trauma symptoms is usually sufficient for concern about the presence of trauma responding patterns:

- Recurrent and intrusive distressing recollections of the event.
- Recurrent distressing dreams of the event.
- Acting or feeling as if the traumatic event were occurring.
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- Feeling "wound-up" and startling easily.
- Physiological reactivation upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- Suddenly feeling or acting as if the accident/injury/trauma were recurring due to some incident or thought reminiscent of the original event causing the trauma.
- Efforts to avoid thoughts, activities, places, people, or conversations associated with the trauma.
- Persistent symptoms of increased arousal causing sleep problems.
- Irritability, concentration problems, hyper-vigilance, and exaggerated startle response.

The traumatic responses should not be seen as permanent in nature as long as the patient is involved in treatment directed at resolving, or reducing, these traumatic responding pattern issues. PTSD trauma responses are more likely when comorbid issues are present as the person is more susceptible to traumatic responses. Crises activate and aggravate previous unresolved crises/traumas—many of which the person has been trying to deny or avoid thinking about or seeking resolution.

The problem is that many patients can still have severe trauma reactions without having all of the qualifying symptoms noted above. For this reason, providers and patients tend to downplay the importance of these symptoms. However, when the pain and injury issues are not resolving it is important to consider that traumatic responding patterns may be playing an important part in the full clinical picture. It is important to note that all three symptom clusters—1) hyper-arousal; 2) re-experiencing; and 3) avoidance and numbing—can aggravate sleep disorders which, in turn, increases a sense of being even more anxious and physically ill.

### Considerations For Treatment

Psychological trauma impacts the level of depression and pain that is noted clinically. The following considerations are helpful in resolving such issues.

1. It is important to consider that a traumatic responding pattern has occurred in those who have been in injury situations such as MVAs. Once acknowledged, it is easy for the provider to note the degree of symptom formation and how these issues are impacting the patient’s response to the usual types of interventions.

2. It helps to inform patients that such responding patterns are natural and normal responses to experiencing a trauma. Putting into words the symptoms that may be experienced—from feeling anxiety, panic, bad dreams, etc.—is important, especially if, at first, the patient denies experiencing any of the symptoms noted. The open discussion helps the underlying issues that the person is trying to suppress rise to consciousness and so can be dealt with.

3. Helping the patient to talk of the event or experience is a way of “getting it out into the open” and allowing the individual to slowly take back control of the traumatic event by...
explaining what happened to them. The patient will frequently have to discuss it multiple times in order to work through the emotional experience that has changed their life experience. Working through the issues is a process that can only happen repetitively over time before the patient can feel back in control of their life.

4. It is important to understand that obsessing over the traumatic experience is an attempt on the part of the person to regain control of their life.

5. Avoidance issues are common and are a part of a desire to not have the fear or anxiety overwhelm their lives. It is a manifestation of the hope that if we don’t go there, or talk about it that, in some ways, the experience can be made to magically go away. Unfortunately, this negative coping technique will only make things considerably worse.

6. It helps for the patient to think about those areas of their lives that they still have control over and also think about past situations where they were able to overcome struggles and move on with their lives. They don’t have to feel guilty that this is not happening for this one particular incident. They have to be reminded that they have gotten through difficult times in the past. This helps to provide a sense of hope and competence that allows them to move forward with their lives.

7. Patients need help in understanding that stress normally affects the weakest identified functions in their body. For example, stress can affect sleep patterns, GI distress, blood pressure, and other physical symptoms. However, when one suffers physical trauma, the stress will easily transfer to the injury/pain areas.

8. It is also helpful to explain to patients that the same place in the brain that processes pain is also the same place that processes and controls our moods. This is not to condemn patients but to help them understand that one factor can affect another. Further, it does not matter what came first but, instead, it is more important to understand what they can control.

9. Learning relaxation techniques will have a positive effect in an individual’s long-term recovery. Patients may state that they know how to relax or that they are not tense and anxious. It helps to explain to patients that from what we know about the brain and the body, it is critical to understand the importance of learning specific relaxation techniques. It further helps if they can work with a professional who can help them to learn relaxation techniques that they can record and take home for daily practice. It will help with their sleep and daily anxiety patterns. While it will not immediately help relieve their pain issues, it will help start the healing process by allowing the body to move from a ‘fight or flight’ high arousal into a more relaxed healing state.

10. A referral for psychological treatment is often critical for those patients who are not able to bring their symptoms under control. It is best to frame this referral under the terms of pain management treatment that is part of the multi-disciplinary approach to care. Trauma responding patterns are complicated issues that require the patient spending time with the psychologist to work through and psychologically process the traumatic experience. Treatment of these comorbid issues then allows the primary treating professional to work on the physiological aspects of care and achieve improved patient outcomes. Figure 2 presents the results of a randomized study on the relief of PTSD symptoms, depression and anxiety using cognitive behavior therapy as compared to supportive and wait list patients.

**Conclusion**

Traumatic responses to even minor motor vehicle accidents injuries are more common than is expected. The traumatic response patterns can directly impact the patient’s pain and injury issues making it difficult for the patient to effectively utilize medical and related treatment approaches. The resulting blocks slow or stop recovery from the pain syndrome causing frustration for both the provider and the patient. Typically, sleep problems develop, pain medications seem to be ineffective, anxiety increases and depression deepens. Understanding the role of acute stress disorders as a result of traumatic responding patterns—caused by a sense of losing control of one’s world and safety—can go a long way in removing these blocks to recovery. Psychological treatment becomes a critical part of the of the pain treatment team when pain recovery seems blocked and is a necessary component in restoring the patient to health and functioning.

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**Additional Resources**


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