Common whiplash: psychosomatic or somatopsychic?

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Abstract
One hundred and seventeen randomly selected patients were assessed for different psychological variables (personality traits, wellbeing, and cognitive ability) in relation to somatic symptoms after common whiplash. Patients were investigated at an average of 7-4 (SD 4-2) days after trauma and again at three and six months. The course of recovery could not be explained by the patients’ disposition. The results indicated that improvement in wellbeing was associated with recovery from somatic symptoms. There was, however, cognitive impairment in patients who suffered from symptoms. These findings support the view that the psychological and cognitive problems of patients with common whiplash are mainly related to somatic symptoms.

In accordance with previous reports, common whiplash is defined as a musculoligamental sprain or strain of the cervical region due to hyperflexion or hyperextension without fractures or dislocations of the cervical spine. Common whiplash in this study excludes any head trauma or alteration of consciousness.

Patients with common whiplash are most often injured in automobile accidents where frontal or rear end collisions occurred. A high percentage of patients recover from this type of injury within three months. Beyond six months the diagnostic outcome is referred to as late whiplash syndrome, which is increasingly likely to become a chronic condition.

Patients and methods

Different psychological and cognitive problems have been reported during the course of common whiplash syndrome. Recently it has been documented that psychosocial factors have little power in explaining the course of recovery from common whiplash during the first six months. There is, however, a lack of prospective work using a random sample of recently injured patients with common whiplash to evaluate how psychological and cognitive problems develop in such patients. The issues to be considered here include: do the psychological problems of patients with common whiplash primarily influence recovery from somatic symptoms or is the change in psychological and cognitive state of patients with common whiplash related to somatic symptoms? In the first case somatic symptoms after common whiplash should depend particularly on the patients’ disposition (personality traits). Also, negative affectivity and neuroticism, as factors influencing symptom reports, should significantly influence the course of recovery. If somatic symptoms related to injury initiated the change in wellbeing and cognitive ability of patients with common whiplash then psychological and cognitive state should improve in parallel with recovery from somatic symptoms.

The primary aim of this study was to evaluate the relation between somatic symptoms and psychological and cognitive problems during a six-month follow up of a random sample of recently injured patients with common whiplash.

In the present study a mean age of 30-8 (SD 9-6) years (median 26-0 (Q1/Q3 = 23-0–33-0)) and a mean educational attainment of 12-7 (SD 3-0) years (median 12-0 (11-0–14-0)). The interval between trauma and baseline examination was 7-4 (SD 4-2) days (median 7-0 (4-0–10-0)). They encountered the whiplash injury exclusively in automobile accidents (rear end collisions 73 (62%); 91 (78%) patients were not at fault) and all 117 were fully covered by accident insurance.
EVALUATION STRATEGY
At three and six months, patients who had fully recovered and those who were still symptomatic were compared with respect to scores on formal testing. Additionally, the scores of patients who were fully recovered at the six-month examination and those who still suffered from injury related symptoms were compared with the initial scores from the baseline examination.

METHODS
Examinations at baseline, three and six months included: neurological evaluation, cervical spine radiography (only at baseline), a semistructured interview, selfratings of patients' wellbeing and subjective cognitive ability, and personality traits (at baseline). The patients' subjective complaints were assessed at interview.

FORMAL TESTING
Self rated wellbeing
Self rated wellbeing was assessed with the wellbeing scale.14 This is considered to be a valid, reproducible and sensitive test in assessing changes in patients' wellbeing on repeated measures.14 It consists of a list of 28 pairs of adjectives polarising the positive and negative aspects of a particular affective state (for example, fresh v dull, pleased v melancholy, jolly v whiny). Subjects are asked to choose one of the extremes from each pair. An overall score is calculated by totalling the individual points acquired for each item represented on the scale. The higher the total score on the wellbeing scale the greater the impairment of the subjects' wellbeing. Scores greater than 17 (normal range 4–17 points) reflect a significantly impaired wellbeing,14 which is a facet of negative affectivity.10

Self rating of cognitive ability
Cognitive ability was assessed from the cognitive failures questionnaire.15 This assessment scale comprises 25 questions, each identifying real life circumstances in which subjects can rate the change in their cognitive abilities as a result of injury. Five possible response choices, ranging from never (0) to very often (4), are available. An overall score over 30 indicates significant cognitive impairment.15

Personality traits
Personality traits were examined with the Freiburg personality inventory,16 which is a well validated and widely used assessment scale in clinical routine in German speaking areas. The answer analysis of the Freiburg personality inventory reveals scores of different personality traits that are transformed into standardised values.16 Standardised values between 4 and 6 are comparable with 54% of a random sample, and values above 6 are pathological. For the present analysis the following dimensions (scales) of the Freiburg personality inventory were relevant: (1) neuroticism, which in particular is thought to be a sensitive indicator of the manner and seriousness with which symptoms are reported and hence may have an important influence on reports of wellbeing and cognitive ability; (2) irritability and nervousness, which identify subjects prone to develop psychosomatic conditions but may be raised during the course of somatic illness; (3) spontaneous aggressiveness, excitability and reactive aggressiveness, which identify neurotic subjects; (4) passivity scale, which indicates a tendency to passive or resignation behaviour; (5) depression scale, reflecting aspects of negative affectivity.10

Statistical analyses
Group differences were assessed with the Mann-Whitney U test or t test (where distribution was normal); group comparisons on dichotomous variables by χ² test; and correlations with Pearson's correlation coefficient (r).

Results
At the three-month examination 66 patients (56%) had completely recovered, and at the six-month examination 81 patients (69%) had no symptoms. No major neurological or radiological findings were recorded in the entire sample. In patients who had recovered from somatic symptoms at follow up no psychological complaints (for example, irritability, forgetfulness) were identified during the interview. No patient had symptoms fulfilling the criteria of post-traumatic stress disorder according to the Diagnostic and Statistical Manual of Mental Disorders (DSM)-III-R.17 No patient was involved in litigation during follow up.

WELLBEING SCALE (FIG 1)
At baseline the entire sample (n = 117) scored a median of 15·0 points (interquartile range 5·0–25·5). At baseline in the entire sample statistically significant correlations were found between the Freiburg personality inventory scales for nervousness, depression and neuroticism and the score on the wellbeing scale (r = 0·32, p < 0·01, r = 0·45, p < 0·01, and r = 0·33, p < 0·01, respectively).

At the three month examination patients who had fully recovered (n = 66) scored a median of 6·0 (2·0–9·0) points. On the other hand those patients who were still symptomatic at three months (n = 51) scored a median of 10·0 (4·0–22·0) points. There was a significant difference between the symptomatic and asymptomatic groups at three months for scores on the wellbeing scale (U = 1049·9; p < 0·001).

The asymptomatic patients (n = 81) at the six month examination scored a median of 4·0 (2·0–8·0) points on the wellbeing scale whereas symptomatic patients at six months (n = 36) obtained a median of 9·5 (4·5–17·0) points (U = 797·5; p < 0·001).

COGNITIVE FAILURES QUESTIONNAIRE (FIG 2)
The entire sample (n = 117) at baseline
At baseline the entire sample on the wellbeing scale showed average scores in the pathological range (normal range 4-17 points). Both patient groups who at three and six months comprised the symptomatic and asymptomatic groups on average showed decreased scores. These data show that there was a certain degree of adaptation even in patients who remained symptomatic at follow up.

Figure 2  Scores on the cognitive failures questionnaire. Boxes refer to Q1/Q3 values, horizontal bar is median, and symbols are the group average scores. Patients who still had symptoms at three and six months consistently showed higher impairment. Patients who comprised the symptomatic group at six months showed almost pathological results on this assessment scale even at baseline. This indicated a lack of improved cognitive ability in this group during follow up.

Table 1  Comparison between patients who comprised the asymptomatic and symptomatic groups at six months with regard to data from baseline examination

<table>
<thead>
<tr>
<th></th>
<th>Age (y) *</th>
<th>Educational attainment(y) *</th>
<th>Sex†</th>
<th>Rear end collisions†</th>
<th>Blame for accident (patients)†</th>
<th>Interval from accident to baseline*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic patients at six months (n = 81)</td>
<td>26-0 (22-0-33-5)</td>
<td>13-0 (11-5-14-0)</td>
<td>Female 49</td>
<td>Male 32</td>
<td>49 (60)</td>
<td>17 (21)</td>
</tr>
<tr>
<td>Symptomatic patients at six months (n = 36)</td>
<td>34-5 (25-0-43-75)</td>
<td>12-0 (11-0-13-0)</td>
<td>Female 25</td>
<td>Male 11</td>
<td>24 (66)</td>
<td>9 (25)</td>
</tr>
<tr>
<td>p value</td>
<td>U = 1065-5, &lt; 0.05</td>
<td>&gt; 0.05</td>
<td>&gt; 0.05</td>
<td>&gt; 0.05</td>
<td>&gt; 0.05</td>
<td>&gt; 0.05</td>
</tr>
</tbody>
</table>

*Median and interquartile range (Q1/Q3) are given. For these variables (because of skewed distribution) the difference between groups was calculated with the Mann-Whitney U test. †Calculated by χ² test.
cognitive failures questionnaire were $r = 0.33$ ($p < 0.01$), $r = 0.40$ ($p < 0.01$), and $r = 0.30$ ($p < 0.01$). The respective correlations for the symptomatic patients at six months were $r = 0.23$ ($p > 0.05$), $r = 0.32$ ($p > 0.05$), and $r = 0.20$ ($p > 0.05$).

**Discussion**

The aim of this study was to evaluate the relation between psychological problems and somatic symptoms during the course of recovery from common whiplash. We believe that this is the first prospective study to empirically investigate the development of the psychological and cognitive problems of patients with common whiplash. We used clearly defined injury criteria for screening, together with random sampling procedures. By including only patients with the same native language, sample homogeneity was increased and potential cross cultural differences in illness behaviour were excluded. The investigated sample was similarly homogenous with regard to the fact that all patients were injured in automobile accidents and were all fully covered by accident insurance for immediate economic loss as well as potential long term disability. This rules out the possibility that the course of recovery from symptoms and results from the formal testing could primarily be related to the ability to claim compensation.

At the baseline examination considerably impaired wellbeing assessed by the wellbeing scale and slight impairment on the cognitive failures questionnaire were found in the entire sample. These results indicate a certain degree of injury related psychological problems and change in cognitive equilibrium.

Analysis of baseline examination results revealed higher average scores on both the wellbeing scale and the cognitive failures questionnaire in patients who were symptomatic after six months. Both groups (symptomatic and asymptomatic at six months), however, had initial baseline values within the normal range on all scales from the Freiburg personality inventory. In particular there was no significant difference on this test between the groups for neuroticism.

Furthermore, baseline results from the wellbeing scale and cognitive failures questionnaire for the entire sample showed significant correlation scores with the scales of nervousness, depression, and neuroticism from the Freiburg personality inventory. These data suggest a good internal validity of findings. Also, the present results indicate that although neuroticism may be relevant for symptom reports, similar average scores on the neuroticism scale for both groups show that baseline assessment of wellbeing and cognitive ability cannot be explained by neuroticism and the relevance of neuroticism has little power in predicting the extent of recovery in the investigated sample.

Patients who were fully recovered at the three and six months examinations scored consistently lower on the wellbeing scale as

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**Table 2** Comparison between patients who comprised the asymptomatic and symptomatic groups at the six month examination with regard to initial symptoms (as presented at the baseline examination)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Asymptomatic patients at six months ($n = 81$) (%)</th>
<th>Symptomatic patients at six months ($n = 36$) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck pain</td>
<td>90</td>
<td>97</td>
</tr>
<tr>
<td>Headache</td>
<td>90</td>
<td>78</td>
</tr>
<tr>
<td>Shoulder pain</td>
<td>44</td>
<td>58</td>
</tr>
<tr>
<td>Back pain</td>
<td>37</td>
<td>42</td>
</tr>
<tr>
<td>Blurred vision</td>
<td>15</td>
<td>36</td>
</tr>
<tr>
<td>Dizziness</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>Finger paresthesia</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>Difficulty in swallowing</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Fatigue</td>
<td>51</td>
<td>69</td>
</tr>
<tr>
<td>Anxiety</td>
<td>40</td>
<td>55</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>26</td>
<td>69</td>
</tr>
<tr>
<td>Sensitivity to noise</td>
<td>26</td>
<td>36</td>
</tr>
<tr>
<td>Irritability</td>
<td>19</td>
<td>28</td>
</tr>
<tr>
<td>Poor concentration</td>
<td>23</td>
<td>35</td>
</tr>
<tr>
<td>Forgetfulness</td>
<td>6</td>
<td>33</td>
</tr>
</tbody>
</table>

For initial complaints, patients who were symptomatic at the six-month examination had a greater variety of symptoms. At baseline there were significant differences between the groups for: finger paresthesia ($p < 0.05$), headache, blurred vision, sleep disturbances, and forgetfulness ($p < 0.01$). Combination of symptoms should be considered. Increasing levels of fatigue during the day as a result of involvement in different activities. No chronic fatigue was found. *Phobic reaction in congested traffic; difficulty in falling asleep or sleep interruption due to pain. | An inability to follow the information flow. No real memory disturbances were found.

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**Figure 3** Freiburg personality inventory: profiles as assessed at baseline. Boxes refer to Q1/Q3 values, vertical bar is median and symbols are group average scores (median and Q1 value for reactive aggressiveness scale in the six month symptomatic patients are equal). Both patient groups (asymptomatic and symptomatic groups at six months) showed average scores at baseline within the normal range on all scales and there were no statistically significant differences between the groups (for scales from the top to bottom Mann-Whitney U values were 1234-0, 1425-0, 1235-5, 1243-5, 1129-0, 1421-5, 1412-5, and 1282-0; for all $p > 0.05$). Passivity scale was originally entitled masculinity scale. Originally high scores on this scale indicated an ability to overcome problems by positive action (as opposed to passive or depressive behaviour). For consistency in presentation of data scores on this scale have been reversed so that low scores on the masculinity scale become high scores on the passivity scale.
well as the cognitive failures questionnaire compared with baseline values.

Symptomatic patients, at these times, also showed a decreased score on the wellbeing scale. This suggests a certain degree of adaptation even in symptomatic patients. In our view, this further rules out the possibility that group differences in self ratings at follow up could be explained by factors unrelated to injury, such as malingering. On the other hand symptomatic patients at the third and sixth month investigations consistently reported a greater degree of cognitive impairment as assessed by the cognitive failures questionnaire. These patients also showed considerable impairment in this test even at baseline indicating little improvement in cognitive ability in this group during follow up.

These results highlight the relation between cognitive ability and somatic symptoms, of which neck pain and headache were the most frequent. The fact that the symptomatic group at six months displayed a greater impairment of cognitive ability at baseline and suffered from a greater variety of somatic symptoms may indicate a more severe form of injury in these patients.

In summary, the results indicate that: (1) the disposition of patients (personality traits) does not primarily influence the course of recovery from common whiplash; (2) psychological and cognitive problems of patients with common whiplash may rather be seen as correlates of somatic symptoms; and (3) injury related psychological and cognitive difficulties can initiate a vicious circle, which may explain the secondary neurotic reaction as discussed elsewhere.16 In the light of these results, previous reports2 19 obtained exclusively in retrospective studies, indicating a relation between psychological problems unrelated to trauma and the course of recovery from whiplash injury2 19 20 may require re-evaluation. In these cases a positive association may be related to the selection of investigated patients.

From the present findings, it seems that psychological problems of patients with common whiplash should be interpreted as a difficulty to adjust to somatic symptoms such as pain.

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