

# TORTICOLLIS

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Torticollis (Wryneck): Psychological and Clinical Dimensions

## The Core Definition and Mechanism

Torticollis, often referred to as **wryneck**, is a complex clinical condition defined by the abnormal, sustained, or intermittent contraction of the neck muscles, resulting in the head being tilted, twisted, or rotated to one side. This misalignment is usually painful and involuntary, significantly restricting the normal range of motion. The primary muscle involved in most forms of torticollis is the sternocleidomastoid muscle (SCM), which extends from the mastoid process of the skull to the sternum and clavicle. While the SCM is central to the presentation, other deep cervical muscles, such as the trapezius or scalenes, may also be involved, contributing to the severity and complexity of the head posture.

The fundamental mechanism underlying torticollis involves an imbalance in muscle tone and control. In essence, the condition represents a failure of the nervous system to maintain balanced contraction and relaxation cycles across the cervical musculature. This imbalance can stem from structural issues, such as fibrosis or shortening of the muscle tissue (as seen in congenital forms), or from central nervous system dysfunction (as seen in spasmodic or dystonic forms). The resulting persistent spasm or shortening leads to the characteristic fixed head position, causing secondary issues like chronic pain, ocular disturbances, and adaptive changes in the spine and shoulders.

It is crucial to understand that torticollis is not a single disease but rather a symptom or a clinical presentation with highly varied etiologies. The simple definition belies the extensive array of potential underlying causes, which range from mild, self-limiting muscular strain to severe, progressive neurological disorders. Therefore, the psychological impact and subsequent treatment approach depend heavily on whether the condition is fixed, intermittent, or dynamic, and whether its origin is primarily musculoskeletal, traumatic, or neurological.

## Classification and Etiology

Torticollis is broadly classified into several categories based on its onset and underlying cause. Understanding these classifications is essential, as the etiology dictates the treatment path, prognosis, and the degree of psychological adjustment required by the patient. The three most commonly recognized categories are congenital, traumatic, and neurological, each presenting unique clinical challenges and requiring specialized therapeutic intervention.

**Congenital Torticollis** is present at or shortly after birth. This form, often referred to as Congenital Muscular Torticollis (CMT), is typically attributed to intrauterine positioning or birth trauma leading to a shortened or fibrotic sternocleidomastoid muscle. While primarily physical, the psychological dimension arises from the necessity of early and intensive physical therapy, which requires

significant parental involvement, dedication, and management of developmental milestones. If untreated, CMT can lead to facial asymmetry and plagiocephaly, which may necessitate psychological support later in childhood due to body image concerns.

**Traumatic Torticollis** results from an injury to the neck muscles, ligaments, or cervical spine, such as whiplash or sudden forceful movements. In these cases, the condition is often acute, though it can become chronic if the underlying soft tissue damage is severe or if the patient develops chronic pain sensitization. The psychological factor here is often linked to the trauma itself, involving symptoms of anxiety, fear avoidance behavior (kinesiophobia), and potential post-concussion syndrome, which complicates physical recovery and requires integrated pain psychology approaches to ensure therapeutic adherence.

**Neurological and Spasmodic Torticollis**, often referred to as cervical dystonia, is typically the most psychologically impactful form, as it is a chronic movement disorder. This type is caused by abnormal signaling in the basal ganglia of the brain, leading to involuntary and often painful muscle spasms. Conditions such as stroke, tumors, or nerve damage can induce this type. The spasms are frequently exacerbated by stress, anxiety, or specific movements, leading to a vicious cycle where psychological distress worsens physical symptoms, and the physical deformity causes profound social anxiety and reduced Quality of Life.

## Historical Perspective and Early Understanding

The recognition of the characteristic twisted neck associated with wryneck dates back to antiquity, though detailed etiological understanding only emerged with advancements in anatomical knowledge and neurology. Early physicians often struggled to differentiate between structural deformities (like those caused by congenital issues or infections like tuberculosis) and functional or neurological spasms. For centuries, treatments were rudimentary, often involving forceful stretching, traction, or, in some cases, speculative surgical interventions based on limited knowledge of the muscle and nerve pathways.

The modern understanding of torticollis began to solidify in the 19th and early 20th centuries, particularly with the careful differentiation between congenital muscular shortening and later-onset spasmodic forms. Key psychological and clinical shifts occurred when researchers began to link involuntary head movements to central nervous system disorders, rather than purely local muscle pathology. This distinction led to the eventual classification of cervical dystonia as a movement disorder, recognizing that the root cause was not a simple muscle knot but a complex issue of motor control originating in the brain.

Historically, the spasmodic forms were sometimes misdiagnosed as purely hysterical or psychosomatic disorders, especially when the symptoms waxed and waned with emotional stress. This early, often stigmatizing, classification highlighted the confusion inherent in conditions where

physical presentation is strongly modulated by psychological factors. The evolution of diagnosis underscores the critical need for a biopsychosocial model, acknowledging that while the etiology may be physical, the presentation, severity, and response to treatment are inextricably linked to the patient's emotional state, coping mechanisms, and environmental stressors.

## Clinical Manifestations and Quality of Life Impact

The most obvious manifestation of torticollis is the visibly poor posture and restricted range of motion, but the condition often brings a cascade of secondary physical and psychological symptoms that profoundly affect the patient's life. Physical symptoms commonly include chronic neck and shoulder pain, often radiating into the head, leading to tension headaches or migraines. Furthermore, the persistent tilt can strain the eyes, causing visual disturbances or compensatory head movements known as sensory tricks, where touching the face or chin temporarily alleviates the spasm.

The psychological distress associated with torticollis, particularly the chronic neurological forms, is immense. Patients frequently report significant social anxiety, embarrassment, and fear of public scrutiny due to the visible deformity and involuntary movements. This often leads to social withdrawal, avoidance of professional situations, and depression. The unpredictable nature of spasmodic torticollis means patients constantly anticipate the next painful spasm, resulting in hypervigilance and generalized anxiety disorder. This cycle of pain, anxiety, and avoidance severely degrades the patient's overall Quality of Life, often rendering simple daily tasks challenging.

In clinical settings, addressing these psychological sequelae is as important as managing the physical symptoms. The chronic nature of the pain and the visible disability require sustained psychological resilience. Patients often struggle with feelings of helplessness and loss of control over their own bodies, which demands therapeutic interventions focused on acceptance, cognitive restructuring, and developing effective pain coping strategies. Without this integrated approach, adherence to challenging physical treatments, such as repeated stretching protocols or injections, often falters.

## Psychological Significance and Interdisciplinary Management

In modern clinical psychology, torticollis serves as an important model for studying the interplay between movement disorders, chronic pain, and mental health. Its significance lies in demonstrating how a physically based condition requires comprehensive psychological support for successful long-term management. The psychological interventions focus primarily on improving coping mechanisms, managing the distress linked to visible disability, and enhancing adherence to demanding physical rehabilitation protocols.

Interdisciplinary management typically involves neurologists, physical therapists, and psychologists. The role of the psychologist is multifaceted. They may utilize Cognitive Behavioral Therapy (CBT) techniques to challenge maladaptive thought patterns surrounding pain and disability, reduce kinesiophobia (fear of movement leading to increased stiffness), and manage the anxiety that triggers or exacerbates spasms. Furthermore, biofeedback training can be particularly useful in teaching patients to consciously relax the hypertonic muscles, offering a sense of control over involuntary movements.

For patients receiving medical treatments such as botulinum toxin injections--the current standard for cervical dystonia--psychological support is vital for maximizing the therapeutic window. The injections provide temporary relief, but patients must utilize that pain-free period to aggressively pursue physical therapy and behavioral habituation. Psychology helps ensure motivation and consistency during this crucial phase, preventing the patient from returning to old, painful postural habits once the medication wears off.

### Practical Example: Navigating Chronic Torticollis

Consider Sarah, a 45-year-old marketing executive who develops spasmodic torticollis following a period of intense professional stress and poor sleep. Initially, she dismisses the mild neck stiffness, but soon, her head begins to involuntarily pull strongly to the right, especially during presentations or meetings. This visible, unpredictable movement causes her intense embarrassment and fear, leading her to cancel client meetings and eventually work remotely, illustrating a classic pattern of avoidance behavior common in chronic movement disorders.

Sarah's journey illustrates the practical application of psychological principles in managing torticollis. Her interdisciplinary team identifies that her stress and anxiety are potent triggers for the intensity of her spasms. The psychological intervention focuses not just on managing the emotional fallout, but actively integrating behavioral strategies into her daily life.

The "How-To" of applying this psychological principle involves the following steps:

**Trigger Identification and Monitoring:** Sarah is instructed to keep a detailed journal noting the time, severity, and emotional context of each major spasm episode. She quickly identifies that the spasms peak 15 minutes before a demanding work deadline or after consuming excessive caffeine.

**Cognitive Restructuring:** Using CBT, Sarah challenges the catastrophic thought that "everyone is staring at my neck," replacing it with the realistic assessment that her colleagues are focused on her work. This reduces the anticipatory anxiety that fuels the muscle tension.

**Relaxation and Biofeedback Integration:** During her relatively pain-free period following botox

injections, Sarah works with a therapist using surface electromyography (sEMG) biofeedback to learn how to consciously decrease the electrical activity in her hyperactive sternocleidomastoid muscle.

**Graded Exposure and Social Reintegration:** Sarah gradually reintroduces herself to public settings, starting with small, low-stress meetings, and slowly building back up to full presentations. This behavioral exposure systematically reduces her social avoidance and associated anxiety, stabilizing the neurological feedback loop that exacerbates her condition.

## Connections to Related Psychological Concepts

Torticollis, particularly its chronic and idiopathic forms, shares significant conceptual overlap with several key areas of psychology, primarily within health psychology, pain psychology, and the study of somatic symptom presentation. Because the condition is often characterized by chronic, disabling pain and highly visible symptoms, it is closely linked to theories surrounding body image, perceived control, and the functional consequences of illness.

One crucial connection is to the field of **Pain Psychology**. Torticollis frequently transitions from an acute muscular injury to a chronic pain state, where central sensitization--the nervous system becoming hyper-responsive to pain signals--plays a dominant role. Psychologists involved in pain management help patients understand that pain signals are not always proportional to tissue damage, allowing them to engage in movement and activity without fear, thereby preventing the cycle of disuse and increased stiffness.

Furthermore, in cases where no clear organic cause (neurological, congenital, or traumatic) can be identified, or where symptoms are disproportionately severe compared to physical findings, the condition may intersect with concepts related to Somatic Symptom Disorder (SSD). While most torticollis has a verifiable organic basis, the intense focus on physical symptoms, distress, and excessive health-related anxiety seen in some patients aligns with the broader category of functional neurological symptoms, where psychological factors significantly influence the presentation and persistence of physical disability. Torticollis is thus studied under the broader category of **Behavioral Medicine**, a subfield of psychology that applies behavioral science to the prevention, diagnosis, and treatment of medical conditions.