

MIXED DISSOCIATIVE STATES IN A COMBAT PTSD PATIENT TRIGGERED BY RE-TRAUMATISATION 15 YEARS AFTER THE TRAUMATIC WAR EXPERIENCE – CASE REPORT

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INTRODUCTION

Although many studies have investigated the link between trauma and dissociative states (Kaufman et al. 2002, O'Toole et al. 1999), there is a lack of data about dissociative disorders in combat-related PTSD. Clear descriptions of such disorders would significantly contribute to a better understanding of the causation, development and treatment of dissociative disorders in this group. The aim of this paper is to present a case of intermittent mixed dissociative states, following re-traumatisation fifteen years after the end of the war in a high functional war combat veteran.

CASE REPORT

NL, is a 40-year old, married man with two children. He served in a combat unit during the Homeland War 1990-1995 and experienced a serious traumatic event. He has witnessed a fellow soldier being burnt alive in a tank, but he immediately continued his combat involvement according to the rules of engagement. After this event he experienced strong feelings of guilt, but he did not ask for professional help. Fifteen years after the war, NL was employed as a fire-fighter in addition to running his own small business. At that time he caused a motor vehicle accident (MVA) in which he hit a pedestrian whilst driving his car. The pedestrian had no serious physical injuries. Immediately after the MVA, he became increasingly anxious, suffered from insomnia and was overwhelmed with feelings of guilt. A few days later, he started to have intrusive thoughts about his war traumatic event. These symptoms worsened, which initiated a referral to psychiatric services. Following the first psychiatric assessment, NL was diagnosed with PTSD. The PTSD assessment tool used to support clinical diagnosis was the Mississippi scale for combat-related posttraumatic stress disorder M-PTSD (Keane et al. 1988). This is a 35-item self-report measure that assesses combat-related PTSD in veteran populations. It is designed to assess re-experiencing, avoidance and

numbing, and hyper arousal symptoms associated with PTSD. Respondents are asked to rate how they feel about each item using a 5-point, Likert-style response categories. Cut off score for a probable PTSD diagnosis for a sample of Croatian veterans is 106. This measure has demonstrated good test-retest reliability ($r=0.97$, 1-week interval), internal consistency ($\alpha=0.94$), and diagnostic accuracy (90% diagnostic efficiency) in a sample of Vietnam combat veterans (Keane et al. 1988, Kulka et al. 1991). Nevertheless our patient did not seek psychiatric help till that time because of fear of being stigmatised and even losing his job. Also, the reason for not seeking help may be his possible coping skills such as choosing a fire-fighter job to maintain some symptoms, such as hyper arousal in a socially accepted way. He was prescribed antidepressant medication (escitalopram). His wife reported episodes when he behaved in a markedly different way from his usual behaviour, which she even video recorded. He went to a village and on his return; he could not remember where he had been and how he had spent this time. The next dissociative episode occurred several months later as they passed near the place of the RTA. The subsequent attacks became more frequent, occurring every few weeks initially, followed by attacks a few times a week and finally several times a day. The dissociative states would last from 5 minutes up to 4 hours. The patient had complete amnesia for these episodes.

On the assessment of the video recordings, he looked lost, without respond to his wife's questions, smoking cigarettes and throwing the end of cigarettes in a ritualistic manner and saying "poof" as it falls on the ground, looking at the palm of his hand indicating that there was something on it. He appeared to search his home according to military rules and giving some signals to others. On one occasion, he saw in his own daughter a "devil's head".

The patient scored 39 on the Dissociative Experiences Scale-II (Carlson et al. 1993), a brief, self report measure of the frequency of dissociative experiences. The scale was developed to provide a reliable, valid and

convenient way to quantify dissociative experiences. It consists of three main factors of dissociation: the amnesia factor, the depersonalization/derealization factor and the absorption factor. The cut-off score is 36. The patients' factor scores were: amnesia 3, depersonalization/derealization 11 and absorption 25. The total score of 39 was mainly due high results on the absorption subscale.

The patient subsequently underwent neurological assessment to exclude temporal lobe epilepsy (TLE) as a diagnostic differential. The MRI scan was normal. Two EEG recordings showed primary cerebral activity of mixed alpha and beta waves and some slower waves (5-6Hz), on the first EEG in the left lateral region and on the second EEG in the right lateral region. These did not change with provocation (hyperventilation, sleep deprivation, photo stimulation). The final neurological assessment did not support diagnosis of TLE, thus indicating psychogenic nature.

Amisulpiride was introduced (200 mg, increased to 400), but with no improvement in the dissociative symptoms. Then he was started on olanzapine 5mg OD which soon led to the disappearance of the dissociative episodes.

DISCUSSION

The concept of dissociation represents the repression of traumatic memory and may account for the formation of the intrusions of dissociated experiences such as flashbacks, somatosensory experiences or even dissociative states into consciousness (De Prince & Freyd 2004, van der Kolk & Fisler 1995). The question is why the appearance of dissociative states occurred at this particular time (after the MVA)? We therefore, suggest intense feelings of guilt as a trigger. In this particular case it is interesting that NL was employed as a firefighter, the job in which he had a high chance of being exposed to visual and audio reminders of his war trauma. We even propose this job choice as his way of dealing with trauma and exculpation. We are faced with different features of dissociation. The first one, when he drove to the countryside, and had no memory of this, would clinically be best explained by a dissociative fugue. During subsequent shorter dissociative episodes, he appeared confused and performing some activities he was later able to link war experiences; although he had amnesia for the dissociative period. A similar experience was described by Kardiner in a patient with episodes of dissociative fugues with some fragmented "dissociative memories" (van der Kolk et al. 1996). Also, some authors have described acute dissociative disorder with brief psychotic features, often with visual hallucinations (Sar & Öztürk 2008). In the case of our patient, he clearly experienced visual hallucinations and one could potentially consider a case of a dissociative psychosis. This unusual clinical scenario involving

intermittent dissociative episodes with brief psychotic symptoms, presents a challenging case that does not meet diagnostic criteria for dissociative disorders according to the current ICD-10 classification (WHO 2010). According to ICD 10, dissociative "amnesia" is usually centred on traumatic events, such as accidents or unexpected bereavements and is usually partial and selective" (WHO 2010). However, our patient had intermittent complete amnesia for everyday life events, not traumatic ones.

The change in EEG lateralization leaves open the issue of links between dissociative states of consciousness and changes of cerebral activity which do not correspond to epileptic states. This could be in line with recent findings of differences in functional connectivity and greater activation of neural networks in dissociated PTSD subjects (Lanius et al. 2005)

CONCLUSIONS

This case presents different dissociative states (fugue, dissociative psychosis and dissociative conscious disorder) in the same combat PTSD patient with amnesia for everyday events but not traumatic ones. These may suggest the introduction of "dissociative syndrome" into the dissociative states diagnostic group. Also, it illustrates the need to view PTSD from various perspectives within the multidimensional transdisciplinary approach (Jakovljević et al. 2012), including neurological perspective in the case of this patient. Further, this case seems in line with findings that personality traits have an important role in timing and clinical expressions of PTSD (Jakšić et al. 2012).

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