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Andrew C. Briggs, MA, MB, ChB, MRCPsych, *ConsultantPsychiatrist, Rauceby Hospital, Sleaford, Lincolnshire*

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Automatism and Post-traumatic Stress Disorder

JONATHAN I. BISSON

A soldier with post-traumatic stress disorder (PTSD) who committed a criminal act during a dissociative episode is described. This report and other published cases indicate that criminal acts can occur during dissociative episodes among people who suffer from PTSD. However, the evidence suggests that such incidents are rare and may be overemphasised. There often seems to be little relationship between the crimes committed by war veterans and their war experiences.
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Post-traumatic stress disorder (PTSD), as described by DSM–III–R (American Psychiatric Association, 1987), includes among its diagnostic criteria "sudden acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative [flashback] episodes, even those that occur upon awakening or when intoxicated)".

There is clearly potential for criminal acts during dissociative states. The frequently portrayed caricature of the war veteran engaging in some bizarre crime seems to add credence to this, especially in the eyes of the general public. However, surprisingly few descriptions of criminal acts committed by people with PTSD during a flashback exist, particularly in the UK, and the true incidence may be small.

McDougle & Southwick (1990) describe an American patient with PTSD admitted after being arrested for recklessly shooting a gun during what was felt to be a dissociative state. Sparr *et al* (1987) refer to several pleas of "not guilty by reason of insanity" having been accepted in the USA where the defendant was said to have committed a crime in a dissociative state secondary to PTSD.

The relationship between PTSD and criminal acts appears open to debate. Wilson & Zigelbaum (1983) found that severity of PTSD significantly correlates with driving under the influence of alcohol, disorderly conduct, assault and weapons charges in a group of 114 Vietnam veterans. Shaw *et al* (1987), comparing a sample of Vietnam veterans being held in jail with a group in the community, showed a similar incidence of PTSD in both groups. In no instance was a direct relationship between PTSD and the crime leading to imprisonment observed. However, if such a relationship exists imprisonment might be less likely.

One of the few documented cases in the UK is that of an ex-soldier, a veteran of Northern Ireland. He repeatedly fired a firearm in Nayland, a village in Suffolk. He was apparently acting as if back in Northern Ireland, before he was apprehended by the police and subsequently diagnosed as suffering from PTSD (R v. King, Ipswich Crown Court (1989), T890683).

The case below describes a soldier who recently presented to the Queen Elizabeth Military Hospital.

Case report

B, a 23-year-old soldier, was brought up in northern England. His father was a strict yet supportive man, in whom B never felt wholly able to confide. B enjoyed school until the last year or so, when he lost interest. He was never in any serious trouble and did not play truant. He was an accomplished footballer who played at county level in his youth. He was popular among his peers and, although he was concerned that he was unable to maintain relationships with women, he is now married. According to his own description and that of his parents he was premorbidly a calm man who occasionally lost his temper, shy until he got to know people but quite extrovert in his own social group. He displayed no marked antisocial personality traits or other traits associated with dissociation.

He was never in any trouble with the police, nor did he have any psychiatric or significant medical history. On leaving school he worked as a trainee coachbuilder which he enjoyed. Eventually, however, he became bored with working standard hours and continuing to live in the same place. He therefore joined the army at the age of 19. He adjusted well to army life and was well respected by his peers and superiors as a reliable, capable soldier who had promotion potential.

He first served in Northern Ireland at the age of 21. Retrospectively he feels he was not prepared for what he experienced. His normal duties included patrolling the streets armed with a gun and stopping and searching cars. He had difficulty in contending with the local population

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and was especially disturbed by children under the age of ten who would spit at him and his colleagues. He found the whole situation tense, confusing, and difficult to comprehend. He also described several more traumatic incidents. During one patrol his duties enforced him to guard a shop which was suspected of containing a bomb. He described his increasing feelings of fear and anxiety which were ultimately proved groundless when investigations showed it to be a false alarm.

After this six-month tour, B had mild symptoms of PTSD, including distressing nightmares, avoidance of reminders and hyperarousal, but no flashback phenomena. These settled over several months and he described himself as feeling ready for his second tour. Significantly, his parents had noticed a change in their son, feeling he was more irritable than before his tour of Northern Ireland, and at times tearful.

Approximately a year after his first tour he commenced training, which involved simulating patrols, for a second tour in Northern Ireland. During this training he spent a weekend at his parents' home in northern England. One evening his father found B in the house acting strangely, talking about Northern Ireland, yet apparently unable to communicate with him. He was taken to the local hospital where no abnormalities were found, in particular no evidence of substance abuse, and within an hour he was fully recovered with no memory of the event. The only precipitant identified was the fact that he was preparing for another tour of Northern Ireland.

He considered his second tour (again lasting six months) to be more stressful than the first. He worked longer hours and had few days off. He described feeling "More wound up, older and more experienced. The same people were still there walking around the streets antagonising us". The tour again included regular patrols and car searches at gunpoint. He described regularly feeling frightened and overwhelmed. He frequently saw people he suspected to be terrorists walking the streets and, although not directly involved, was in the proximity of several bombings.

On his return to England after the second tour his work became more mundane. He worked in barracks on the outskirts of London doing unfulfilling odd jobs and brushing up leaves. He had aggravated an old back injury and was unable to go to Canada with his friends. Consequently there were few people he knew around the barracks. He felt as if he had no active purpose, and found his existence tedious. He began to feel low in mood, and began to experience distressing recollections of his time in Northern Ireland (although no actual flashbacks). He also described avoidance and numbing of his general responsiveness. More marked were his symptoms of increased arousal with increased irritability, difficulty with concentration, hypervigilance, increased startle reaction, and physiological reactivity on exposure to events that resembled aspects of his Northern Ireland experience.

Four months after his return from the second tour he spent an evening with a friend at a bar inside the barracks. He did not, according to those around him, appear to be under the influence of alcohol. He claimed to have drunk approximately eight units of alcohol over three hours. He remembered returning to his room alone in a sombre frame of mind as he had been supporting his friend who had separated from his girlfriend. He looked through photographs of his family, friends, and Northern Ireland tours and felt frightened, but did not know why: "I think it had something to do with Londonderry. I can't really explain." This is the last thing he remembers until being stopped and arrested by the police some 200 miles away in northern England close to his parents' home. He was driving an unfamiliar car.

In the intervening time he had dressed himself in his combat clothing and driven his own car through the barrier of his base, armed with his own privately licensed rifle. He used this for game shooting but should have stored it in the armoury rather than in his own room. He drove some miles before stopping in a lay-by with a puncture. Some other motorists stopped and asked if he needed help. He acted suspiciously, threatened them with his weapon, and hijacked their car. The police were alerted and he was subsequently arrested. He told the police that he had taken the car as the original occupants were Irish.

He was kept at a police station and interrogated for some 60 hours. He was released to the military before a contemporary mental state examination had been carried out, and kept under close arrest by them for another four weeks. After this he returned to work. He was first seen by a psychiatrist 72 hours after the incident. Then, as now, he remained unable to account for his actions. Full assessment, physical examination, and investigations including electroencephalography and computerised tomography revealed no evidence of any organic disorder. A diagnosis of PTSD with mild depressive features was made.

While awaiting his trial he was seen and treated. He described remorse and confusion at what had happened. He remained disenchanted with army life and continued to display features of depression and PTSD which have not fully resolved with treatment. He has, however, had no further dissociative episodes. On learning what he had done he identified several of his actions as similar to those he would have engaged in if on patrol in Northern Ireland.

Discussion

B fulfils eight out of the nine criteria proposed by Blank (1985) for a diagnosis of "unconscious flashback", including the unpremeditated nature of the event, amnesia, a trigger, lack of current motivation, and the presence of other symptoms of PTSD.

No single major traumatic incident appeared to have precipitated his PTSD; rather the chronic stress of serving as a soldier in Northern Ireland was responsible.

His first dissociative episode appears to have been caused by the fact that he was involved in pre-Northern Ireland training. I suspect that B was sensitised during his first tour and hence rendered vulnerable to further exposure, the pre-tour training being sufficient to trigger a profound psychological reaction. This sensitisation hypothesis may also

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account, in part at least, for his perception of the second tour as more stressful than the first and also the fact that his PTSD symptoms were more severe and have not ameliorated as readily as before.

The second dissociative episode has several features of a fugue state. B suddenly left his place of work, acted in a purposeful manner, and was aparently in this state of mind for several hours. It would appear that B was low in mood on returning to his room on the night of the incident and that this and memories evoked by the photographs precipitated the episode. The episode could be considered as a release from the problems he was experiencing.

Interestingly, both the case of King and one of the cases described by Sparr *et al* (1987) like B, had suffered dissociative episodes before, which unfortunately remained undiagnosed. This emphasises the need for early diagnosis and treatment of PTSD in an attempt to prevent such incidents.

The case of B and the other reported cases suggest that criminal acts as a result of dissociative states in PTSD sufferers do occur and clinicians need to be aware of this possibility. Equally as important is the fact that they seem to occur rarely, and certainly do not account for the majority of criminal acts committed by war veterans with or without PTSD. Indeed, it is likely that there is often little relationship between crimes committed by war veterans and their actual war experiences. It is only by rigorous assessment that those who do commit crimes as a result of their experiences will be identified and receive appropriate treatment.

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Jonathan I. Bisson, BM, MRCPsych, *Senior Specialist in Psychiatry, British Military Hospital, Iserlohn, British Forces Post Office 24*

Correspondence: *Psychiatric Unit, St Tydfil's Hospital, Merthyr Tydfil, Mid Glamorgan CF47 0SJ*

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