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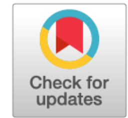

Clinical mixed dissociative and post-traumatic stress disorders in a 10-year-old boy after a traffic accident

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ABSTRACT

The article presents the clinical case of 10-year-old Karim, whose behavior and mental status changed after a traffic accident in which the boy was hit by a car (without loss of consciousness and without traumatic brain injury). In addition to various motor paroxysms (convulsions) that did not meet the criteria for epileptic symptoms, the clinical picture included wave-like psychopathological symptoms and inappropriate behavior. The clinical picture could not be clearly attributed to the manifestation of dissociative disorders or post-traumatic stress disorder. Within two months after the accident, the clinical picture worsened — the "light intervals" during which Karim was completely adequate and critical became less frequent. Neurologists rejected the organic (epileptic) basis of the paroxysmal states. Examination and treatment by psychiatrists did not lead to stabilization of the mental state. In the opinion of the authors, the clinical case belongs to a rare polysyndromic variant of the dissociative subtype of PTSD, not described in the scientific literature, in which a mixture of various psychopathological symptoms was found - dissociative motor paroxysms, Ganser's syndrome, astasia-abasia, onirism, and flashbacks.

Keywords: dissociative disorders; dissociative seizures; Ganser syndrome; puerilism; passing speech; astasia-abasia; onirism; post-traumatic stress disorder; dissociative subtype of post-traumatic stress disorder; differential diagnosis of mental disorders.

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Клинический микст диссоциативных и посттравматических стрессовых расстройств у 10-летнего мальчика после дорожно-транспортного происшествия

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АННОТАЦИЯ

В статье приведён клинический случай 10-летнего Карима, у которого после дорожно-транспортного происшествия (ДТП), когда мальчика сбил автомобиль (без потери сознания и черепно-мозговой травмы), изменились поведение и психическое состояние. В клинической картине, помимо разнообразных двигательных пароксизмов (конвульсий), не отвечавших критериям эпилептических, появились ундулирующая психопатологическая симптоматика и неадекватности поведения. Клиническая картина заболевания не могла быть однозначно отнесена ни к проявлениям диссоциативных расстройств, ни к посттравматическому стрессовому расстройству. В течение 2 мес после ДТП клиническая картина усугубилась — «светлые промежутки», во время которых Карим был полностью адекватен и критичен, становились всё короче. Неврологами была отвергнута органическая (эпилептическая) основа пароксизмальных состояний. Обследование и лечение у психиатров не привело к стабилизации психического состояния. Клинический случай, с позиции авторов, следует отнести к крайне редкому и не описанному в научной литературе полисиндромному варианту диссоциативного подтипа посттравматического стрессового расстройства (ПТСР), в рамках которого был обнаружен микст различных психопатологических симптомов — диссоциативных двигательных пароксизмов, синдрома Ганзера, астазии-абазии, ониризма и флэшбэков.

Ключевые слова: диссоциативные расстройства; диссоциативные конвульсии; синдром Ганзера; пуэрилизм; мимоговорение; астазия-абазия; ониризм; посттравматическое стрессовое расстройство; диссоциативный подтип посттравматического стрессового расстройства; дифференциальная диагностика психических расстройств.

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10 яшьлек малайда юл-транспорт һәлакәтеннән соң килеп чыккан диссоциатив һәм травамадан соңгы стресс тайпылышларының клиник миксты

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Аннотация

Мәкаләдә юл-транспорт һәлакәтеннән соң (аң югалту, баш мие җәрәхәте күзәтелмәгән) тәртибе һәм психик халәте үзгәргән 10 яшьлек Кәрим белән булган клиник очрак тәкъдим ителә. Авыруның клиник картинасында, эпилепсия симптомнары критерийларына туры килмәгән төрле хәрәкәт пароксизмнарыннан (конвульсияләрдән) тыш, төрле психопатологик симптомнар һәм адекват булмаган тәртип барлыкка килә. Авыруның клиник картинасын диссоциатив тайпылыш билгеләренә дә, травмадан соңгы стресс тайпылышларына да кертеп карап булмый. Авариялән соңгы ике ай эчендә авыруның клиник картинасы тагын да кискенләшә, Кәрим тулысынча адекват булган “якты аралар” сирәгәя бара. Неврологлар пароксизмаль халәтләрнең органик (эпилептик) нигезен кире кагалар. Психиатрларда тикшеренү һәм дәвалау авыруның психик халәтен тотрыкландырмый. Авторлар фикеренчә, әлеге клиник очракны фәнни әдәбиятта сирәк очрый торган, аз тасвирланган, диссоциатив мотор пароксизмнары, Ганзер синдромы, астазия — абазия, ониризм һәм флешбэклар кебек төрле психопатологик симптомнар күзәтелгән посттравматик стресс тайпылышының диссоциатив подтибына караган полисиндром вариантына кертеп өйрәнү кирәк.

Төп сүзләр: диссоциатив тайпылышлар, диссоциатив конвульсияләр, Ганзер синдромы, пуэрилизм, мимикрия, астазия-абазия, ониризм, травмадан соңгы стресс тайпылышы, травмадан соңгы стресс тайпылышының диссоциатив подтибы, психик тайпылышларның дифференциаль диагностикасы.

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In recent years, patients with paroxysmal conditions have increasingly begun to consult psychiatrists, and organic mental disorders had to be differentiated from functional ones.

This study presents the case of 10-year-old Karim whose behavior became inappropriate after he was hit by a car (without loss of consciousness or traumatic brain injury) in a road traffic accident (RTA). In the clinical presentation, in addition to various motor paroxysms (convulsions) that did not meet the criteria for epileptic symptoms, undulating psychopathological symptoms appeared. These symptoms could not be attributed to either dissociative disorders or post-traumatic stress disorder (PTSD).

Within 2 months after the accident, the clinical presentation worsened; the lucid intervals during which Karim was completely adequate and critical became shorter. Neurologists rejected the organic (epileptic) basis of paroxysmal states. Examination and treatment by psychiatrists did not lead to mental state stabilization.

Karim, 10 years old.

Anamnesis vitae. The patient's mother was carrying fraternal twins (Karim and Ramil) who were born premature by cesarean section. The children were raised in a couple family. Their father died when they were 2 years old. Currently, Karim lives with his mother, grandmother, brother, and younger sister.

Karim's development was early and unremarkable; he started attending kindergarten at age 3, participated in matinees, was not shy, and easily made friends with peers. He went to school at age 6, studied successfully, and obtained mostly good and excellent marks. He always had good relationships with his classmates; they constantly called and corresponded with each other, and there were no complaints from teachers about his behavior or studies. In elementary school, he became interested in chess, participated in academic contests, and won prizes. Owing to the busy work schedule of his mother, their family was forced to move to another city for a year and a half. As a result, Karim's studies at the new school began to worsen. After returning to his hometown, he returned to his previous class and was extremely happy about it.

His mother notes his strong attachment to her; he was very upset and still gets upset when she leaves home for work. In his free time, Karim helps around the house with cleaning and cooking. He is very interested in household items, especially construction and repair tools; he can easily initiate conversations with a technician who has come to them for repairs and asks to see their toolbox. In addition, he shows interest in cooking and culinary art. According to his mother, Karim is kind, sociable, cheerful, and always ready to lend a helping hand to those in need. The atmosphere in the family is positive and pleasant.

Medical case history. In the evening of October 27, 2023, Karim left the house to go to the store. Ten minutes later, his grandmother received a call about an RTA in which her grandson was involved (his mother was on a business trip at that time). According to eyewitnesses, the boy was crossing the road when the traffic light was green, but was hit by a passing car. Karim's leg got under the wheel; however, the blow to his body was not strong, and he did not lose consciousness. By this time, his grandmother managed to run to the RTA scene.

The emergency doctors who arrived at the scene carried the injured Karim to the ambulance and took him to the hospital. According to his grandmother, Karim complained of leg pain and even lost consciousness for a short period of time during the ambulance ride. Then, unexpectedly for his grandmother and doctors, he began to behave inappropriately; in particular, he asked his grandmother to tell him a fairy tale. This behavior seemed strange.

In the hospital emergency room, Karim was diagnosed with a closed fracture of the fibula and tibia of the right lower extremity; a traumatic brain injury was not confirmed. He did not complain of headaches or any other symptoms. On the same day, surgery was performed under general anesthesia, and the Ilizarov apparatus was installed. After recovery from anesthesia and subsequently in the department, Karim behaved normally and showed no psychopathological manifestations; however, twitching occurred in the operated leg at intervals. According to the surgeons, the surgery went "perfectly well" and that the twitching could not be associated with the fracture or surgery. Karim had problems sleeping in the department. He sometimes reflected on the RTA, saying, "It's good that it was only a broken leg, but I could have died… it's good that I remained alive".

The mood after discharge was normal, without sudden fluctuations or signs of anxiety or depression, and sleep was without disturbances. Some time later, his mother noticed behaviors and reactions that were unusual for Karim. Periodically, he began to smile inappropriately and unnaturally ("too broadly").

The patient's condition began to deteriorate 2 weeks following discharge. One day, when his mother went on a business trip again, Karim had an attack, with uncontrollable movements of his arms and legs, and he began to choke and could not speak. This happened 1.5 h after his mother left home. An emergency medical team was then called. The doctors assumed that Karim had been poisoned by something and admitted him to the hospital. After the stomach was washed and no signs of intoxication were found, Karim's condition returned to normal, and by the morning, all signs completely improved.

Computed tomography (CT) of the chest revealed no pathological changes. Electrocardiogram was normal. Electroencephalography (EEG) revealed no epileptic activity. The neurologist concluded on "encephalopathy with behavioral disorders". The psychiatrist did not reveal any pathology. On hospitalization day 1, Karim's mother returned and took care of him. In the department, the attacks of

uncontrolled movements stopped; however, it was noted that Karim became slower when making movements.

The day after discharge and thereafter, the attacks began to recur several times a day. However, lucid intervals made up most of the time. Karim continued to study at home. His mood was even, he was interested in what was happening and asked for the opportunity to meet friends. However, at times, he began to remember the RTA and asked his grandmother to repeat what exactly happened “that day”. From the same time, attacks lasting 10 min began to occur, regardless of the time of day. At this time, Karim made uncontrolled movements of his limbs and fell onto the bed; he was motionless for 2–3 min and muttered something. Sometimes he pronounced the word “car-car” stereotypically.

Karim’s grandmother and mother said that his falls were never traumatic and that he always (even while “unconscious”) controlled where he could fall so as not to damage the injured limb or some other part of his body. During these periods, despite the external signs of “blackouts”, he heard people nearby and remembered what was happening at that moment. When he returned to an adequate state, he said that he was “very tired of these attacks”. He said that he saw a car and was very scared. Moreover, he began to have bouts during which he could not stand or walk straight, he could feel his legs faltering, and he “fell over” on his side. Additionally, his mother noted that periodically during the attacks, he began to twist his mouth and squint his eyes, while his pupils rolled upward and “become numb”, and his arms looked “like those of patients with cerebral palsy”.

Sometimes Karim had episodes of childish behavior that was inappropriate for his age; for example, while sitting on the bed, he waved a pillow, smiled broadly, and made short cries of “Abuuu… abuuu” (similar to the babbling of a baby), after which he returned to normal. Sometimes Karim behaved unusually and spoke out of turn. During one of these “attacks”, he asked his mother to take him to the toilet and pointed in the direction of the crutches. When he received them, he said that he did not need crutches but an ironing board “on which crutches are ironed”.

That same day in the bathroom, he carefully examined the bottle of hair conditioner, saying that he wanted to read the annotation and find out the composition. Then, he began to study the instructions for detergents. Further, he asked to be taken to the window. Walking around the room, he noticed a bottle of water on the floor and said casually, “This is the floor, and this is water”. Seeing a cup with an apple on the table, he asked, “Why is the cup in the apple?” He took an apple core, went to the window, opened it, and put the core in the ice with the words “now the ice will grow”. Half a minute later, he asked in surprise, “Why doesn’t ice grow? It must grow up”. Looking through the window at the parking lot, he said in dismay, “All these cars will hit all the people”. In response to his mother’s words that “cars move carefully”, he asked, “Why did it hit me then?” He then immediately drew attention to the fact that his “leg is ugly”, and unexpectedly said, “No, not a leg, but an arm… I walk on my hands”. Moreover, he claimed that it was night, although it was day.

Once, at the moment of falling asleep, he experienced a state of psychomotor agitation, during which he sat down on the bed, began to fight off someone with a pillow, screamed, and cursed, with his eyes expressing horror. His mother believed that, at that moment, Karim saw and heard something that was not there in reality and was not available for productive contact.

Subsequently, the patient’s condition worsened progressively; his attacks of uncontrolled fanciful movements of the arms and legs with rolling of the eyes and “switching off” for 3–4 s became more frequent. Then, apathy began to dominate the clinical presentation. He spent most of his time in bed and could only walk or stand for 20–30 min/day. Sometimes he said, “Mom, it’s so hard for me”.

Mental status. The patient was examined twice over a 2-week period. During visit 1, together with Karim’s grandmother and mother accompanied him; they helped him climb to the second floor to the doctor’s office and checked whether he was placing the crutches correctly so that he would not fall. His movements were calm, and he answered questions. His facial expressions were lively, corresponding to the topic of the conversation. He did not look away, and his speech was grammatically correct and well-modulated.

During the conversation, Karim periodically experienced shuddering of the whole body, sometimes with his head lag and spastic contraction of the neck muscles. At this moment, he closed his eyes, groaned, and did not lose consciousness. Some paroxysms were manifested by contraction of the muscles of the upper and lower extremities and torso rotation. This lasted for 5–10 s and was not provoked by external influences. Karim refused to talk about RTA and seizures. During the initial conversation, no active psychopathological production was identified.

During conversation 2 (2 weeks after conversation 1), which was organized in the form of a consultation with the participation of more than 60 doctors and residents, productive contact was not possible throughout the conversation. Upon entering the clinic building, Karim began to shouted, “Abuu-abuuu”, which he repeated for an hour and a half. During this time, he never returned to an adequate mental state. Throughout the conversation, he waved his arms from side to side, nodded his head up and down, clutched his head, and slid out of his chair, and most of the time, his eyes were tightly closed. At times, motor paroxysms occurred in the form of pendulum-like movements of the head and spastic contractions of the upper extremities. During this, he never hit his head against the wall. For a short period of time, these phenomena completely disappeared, and he did not experience hyperkinesis when he drank water from a bottle. At the same time he said the word “water”.

According to his mother, after leaving the audience, he periodically returned to his normal state, declared his desire to go to the toilet, and asked his mother to take him

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home because he was tired. In the taxi, on their way home, Karim was in a similar detached state; however, when his grandmother was unable to pay for the fare by phone, he took her phone without explanation and paid for it. Having arrived home, he suggested going to the store for a cane, which was ordered in advance. After the cane was taken away, he became extremely talkative and discussed the weather. When his mother and grandmother recalled what happened at the consultation, Karim periodically corrected them saying, “No, there were psychiatrists, neurologists, and those who have worked there for a long time, and not just students”. Then, his mother suggested going for a walk, and she went out with her two sons to view the New Year’s performance. During this time, only one short “attack of convulsions” occurred.

After the consultation and the start of therapy (alimemazine, fluvoxamine), Karim’s condition was characterized by sharp fluctuations. On some days, he was in an adequate state 60% of the time during the day, played with his brother and sister, and spoke normally. On other days, he could utter only two words, and the rest of the time, he made uncontrolled movements with the arms and legs and was unable to stand up and move steadily. Occasional attacks of excitement appeared when he, sitting on a chair or lying in bed, began to grimace, laugh inappropriately, and was inaccessible to productive contact.

Thus, the clinical case of 10-year-old Karim appears to be diagnostically ambiguous and therapeutically resistant. All his psychopathological symptoms can be rightfully divided into two groups.

Group 1 includes motor paroxysms of various forms (syncope, convulsions, hyperkinesis, dystonia, astasia–abasia, etc.), which were not of an epileptic or other organic nature and which can be classified as dissociative (functional) movement disorders, and psychopathological forms of dissociative disorders. The clinical presentation of Karim’s disease included episodes of passing speech and puerilism, which are part of the structure of Ganser syndrome, and mutism.

Group 2 of psychopathological symptoms noted in the patient include experiences and conditions associated with his psychotrauma in history (RTA). These are periodically occurring reminiscences in the form of obsessive memories of trauma, accompanied by severe anxiety and fear (“all cars will hit all people”) and nightmares. Particular attention should be paid to the episode that occurred while falling asleep, during which Karim experienced psychomotor agitation, sat down on the bed, began to fight off someone, screamed, and swore, with his eyes expressing horror. This episode should be considered as a manifestation of parasomnia in the form of onirism syndrome.

The patient’s condition was characterized by an undulating nature and alternation of psychopathological and neurological manifestations. The first sign of inappropriate behavior appeared a few minutes after the RTA—when in the ambulance Karim turned to his grandmother with an inappropriate request to read him a fairy tale, during which his grandmother was confused and embarrassed because the doctors accompanying her grandson were surprised by his “childish reaction”. During the first time he was in the hospital, Karim behaved adequately; however, he often recalled the traumatic event and reflected on the RTA causes.

After discharge, his mother noticed the emergence of behavior and reactions unusual for Karim, when periodically he began to smile inappropriately and unnaturally. The patient’s condition sharply worsened 2 weeks after discharge and coincided with the moment his mother left home on a business trip. Karim had an acute attack of uncontrollable movements of his arms and legs; he began to choke and could not speak. Thus, he was hospitalized in a somatic hospital with suspected poisoning. A comprehensive examination (CT, EEG) did not reveal any pathology, and the consultant psychiatrist did not detect any psychopathological symptoms. A neurologist stated the presence of encephalopathy with an emphasis on behavioral disorders (without indicating specific signs).

Since that time, attacks of motor disorders and psychopathological symptoms in the patient became almost constant. However, at times, he was in an adequate state, talked, and was interested in ordinary life. In particular, he discussed the presidential elections and expressed his own position in support of one of the candidates. During one of the periods of deterioration, according to his mother, he behaved strangely (“like a mentally retarded person”) and spoke out of turn, sometimes in a child’s voice. Subsequently, “all the days were not alike”; on some days he could be in an absolutely adequate state for the whole day, and on other days he was almost completely silent or uttered inarticulate sounds, similar to babbling of a baby. Moreover, during the attacks, his eyes were usually closed tightly.

Considering that two groups of psychopathological symptoms were present in the clinical presentation of the patient’s disease, two diagnostic conclusions could be assumed. The first indicates a combination of different mental disorders, namely, dissociative and PTSD, and the other can be called unifying.

The Diagnostic and Statistical Manual of Mental Disorders, 5th edition, contains a section that, we believe, partially reflects the studied clinical presentation of Karim’s disease. The diagnosis is called dissociative subtype of PTSD [1–17]. In its classic form, this disorder has combined signs of PTSD with dissociative depersonalization and derealization. In the present case, dissociative symptoms within PTSD were broad in nature and included almost all clinical forms of dissociative psychopathological disorders. However, the main psychopathological syndrome could not be determined, as each of the dissociative forms was represented equally and did not predominate over the others.

In recent years, such a combination of disorders has been considered typical of dissociative disorders. According to the

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literature, the prevalence of the dissociative subtype of PTSD (D-PTSD) ranges from 10% to 30% of all PTSD cases.

The psychopathological analysis of paroxysmal states in the studied clinical case does not present diagnostic difficulties, as the patient has paroxysmal dissociative (functional) motor disorders described above and longer dissociative psychopathological disorders interspersed with periodically occurring symptoms, particularly Ganser syndrome [18–21].

The specificity of the clinical case of Karim was that his psychotrauma history was not classified as catastrophic or a beyond-the-scope-of-life experience [22]. Typically, extreme events, disasters, and violence lead to PTSD. Notably, PTSD is diagnosed in about 36% of children and adolescents exposed to such traumatic events [23, 24].

According to a meta-analysis, the incidence of PTSD among children after exposure to trauma averages 16%. A large epidemiological study in the United States revealed that the lifetime prevalence of PTSD was 4.7% among adolescents, with higher rates noted among girls (7.3%) compared to boys (2.2%) [23]. It is believed that the diagnosis of PTSD can be made starting from the age of 6 years [1].

The most difficult to qualify in the clinical presentation of Karim's disease are episodes of impaired consciousness with psychotic or pseudopsychotic symptoms. One of these episodes occurred while falling asleep and another in waking, when Karim suddenly became detached, was not available for productive contact, grimaced, and smiled inappropriately and his eyes were closed tightly. This phenomenon is referred to as onirism. It belongs to the group of parasomnic disorders and usually occurs in a state of incomplete or partial wakefulness, when falling asleep or waking up [25]. Moreover, dissomnic disorders are considered typical of the clinical presentation of PTSD [25], among which nightmares, sleep disturbances and anxious awakenings, and episodic onirism are commonly noted.

The clinical presentation of Karim's disease included one episode of onirism associated with sleep disturbances and another in a state of wakefulness or partial wakefulness. If the psychopathological qualification of the former does not present any difficulties, then the latter episode is diagnostically difficult. It can be interpreted in different ways, for example, as a rare variant of "onirism in reality" (with eyes closed) [26, 27] in combination with elements of Ganser syndrome against an affectively narrowed (twilight) disorder of consciousness. Outwardly, this was manifested in the patient by absorption in his own experiences, grimacing, and puerilism. The presence of hallucinatory images in the patient could not be assessed during this period.

The literature describes several rare cases of a combination of Ganser syndrome with hallucinations [28–30] and a case of Ganser syndrome with astasia–abasia [31]. It should be noted that for a significant time during the day, Karim is in a state of some aloofness from reality, his eyes are usually closed, and he is immersed in the world of his own experiences; that is, his state cannot be characterized as full awareness of the surrounding reality. Fluctuations in consciousness are associated with any everyday conflicts, such as the behavior of his grandmother, forcing him to change his underwear, his mother leaving home, and a quarrel with his brother.

Theoretical analysis of the problem of the emergence of dissociative disorders after psychological trauma shows that dissociation should be considered as a mechanism of psychological defense [32, 33]. It is known that dissociation is characterized by separation, a severance of connections between individual mental processes, information flow, and personal structures.

Agarkov [32] proposed to distinguish between situational and trans-situational dissociative states. Trans-situational ones are more pronounced in people who have experienced potentially traumatic situations. They play a significant role in generation of a delayed reaction, which can manifest itself as PTSD symptoms. In Karim's case, the psychotrauma was not catastrophic, but could be considered potentially psychologically traumatic. Perhaps the patient considered the disorganization of his entire life as a potential danger because of a broken leg. Karim initially developed puerilism as an element of Ganser syndrome, which was accompanied by both typical signs of PTSD and various dissociative symptoms.

Thus, the clinical case of Karim should be classified as an extremely rare polysyndromic variant of D-PTSD, which has not been described in the scientific literature. Further follow-up of the patient will clarify the course of changes in the identified psychopathological symptoms. According to the literature, D-PTSD is a treatment-resistant disorder, and the patient requires intensive psychotherapy and psychopharmacotherapy [34].

Catamnesis. Two months after the start of psychopharmacotherapy (fluvoxamine, alimemazine), Karim's condition stabilized, his motor paroxysms and sleep disturbances disappeared, no episodes of passing speech or puerilism were recorded, and subwaking psychotic states appeared extremely rarely.

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