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Dangerous Misidentification of People Due to Flashback Phenomena in Posttraumatic Stress Disorder

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ABSTRACT: Misidentification of people may occur in a number of psychiatric disorders associated with delusional thinking. Misidentification of people may also occur in the context of visual flashback phenomena associated with post-traumatic stress disorder. People who misidentify someone during a flashback associated with previous war combat experience may perceive and conceptualize the misidentified object as an enemy who may be both feared and disliked. This might make the misidentified objects become the targets of violent attacks by the affected person. In this article we present five cases of flashback-induced misidentification of people who were subsequently attacked within the context of the flashback experience. The nature of the misidentification of persons due to flashback experiences is discussed. The association between the type of misidentification and aggression is also discussed.

KEYWORDS: forensic science, misidentification of persons, misrecognition, aggression, violence, post-traumatic stress disorder, visual perception, forensic psychiatry

Misidentification phenomena occur in a number of psychological contexts that span both normal psychology and psychopathology. Loftus, for example, has studied how normal people may fail to visually recognize others, leading to cognitive misidentifications. Loftus has conducted systematic research designed to identify the multiple cognitive, perceptual, psychosocial, and environmental factors involved in identifying people as a part of eyewitness testimony. She has found that the above-mentioned factors can affect the accuracy of both visual and cognitive identification of others by normal subjects who serve as potential eyewitnesses (1).

In the psychiatric area misidentification phenomena have been associated with psychotic disorders, especially in the context of delusional misidentification. In delusional misidentification the affected individual has delusions of misidentification involving the physical and/or psychological makeup of the self and/or others (2). Misidentification phenomena that occur in the context of delusions can lead to dangerous ideas and violent behaviors directed at others (3–7).

Hostility and aggressive actions toward others are generally mediated by two psychologic mechanisms. The first occurs when delusional persons believe that the misidentified object is malevolent and intends to harm them. The second occurs when they delusionally misidentify themselves and as a result become hostile toward others because others fail to acknowledge their usually grandiose delusional self-concepts (4–6).

Posttraumatic stress disorder (PTSD) is a mental disorder that can also be associated with hostility and physical aggression (8–10). The factors responsible for aggression in PTSD are multiple and their interactions very complex. It is likely that factors associated with cognition, perceptual disturbances, dissociative phenomena, mood disturbances and personality abnormalities are involved in the genesis of aggressive behavior in PTSD.

In the first part of the present article we present five cases of men who suffered from PTSD and misidentification phenomena not caused by a psychotic condition. We provide support for the idea that such misidentification is in large part secondary to visual flashback phenomena and that PTSD-induced misidentification may also contribute significantly to aggression.

Case 1

Mr. A, a 44-year-old male, was hospitalized on a psychiatric unit because of recurrent flashbacks and fears that he would lose control of his aggressive impulses. Mr. A had been involved in numerous acts of violence associated with flashbacks of his Vietnam combat experiences. Mr. A described his flashbacks as lasting from a few minutes to an hour during which he would experience visual images of Vietnam. During these episodes he would lose contact with reality by varying degrees and at times would believe that he was actually in Vietnam confronting the enemy. During some flashbacks he would only perceive people as enemy Vietnamese without perceiving the Vietnam landscape. Although his flashbacks could spontaneously occur without any apparent precipitant, they frequently followed an anxiety- or anger-provoking situation.

At times his flashbacks developed slowly and during those times he noted that the faces of others would ''slowly become disfigured'' and transform into the faces of the ''Viet Cong.'' At other times he quickly experienced the visual images and concurrently noted that other people displayed faces of the Viet Cong along

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with being attired in black-colored clothing. Once he had pulled a pistol on his mother while he perceived and believed her to be a Vietnamese woman who intended to harm him. It took about 20 minutes before he was able to recognize his mother and give her the gun. He did not perceive his environment as being Vietnam during this occasion. On another occasion, a stranger reportedly had threatened him. During the ensuing flashback, Mr. A attacked the man and cut his face with a knife. During the episode Mr. A had perceived that he was ''slicing up the face of a Viet Cong soldier.'' Mr. A was briefly jailed as a result of this incident. On yet another occasion Mr. A had met two strangers who were playing billiards. He then experienced a flashback in which he perceived the two strangers as enemy Vietnamese soldiers holding rifles instead of billiard sticks. He reacted to this misperception by threatening the two billiard players with a knife. Fortunately, a friend eventually persuaded him to surrender the knife without injuring anyone. During both of these later occasions he did not perceive his environment as that of Vietnam.

Mr. A said that he had been arrested and jailed five times for becoming violent toward others whom he misperceived and misidentified as enemy soldiers during his flashback episodes. He had never been convicted of any felonies. Mr. A also experienced nightmares associated with Vietnam, irritable effects associated with hostility, feelings of guilt, marked paranoia, early, middle and late insomnia, diminished attention span, and avoided events that would remind him of his combat experience in Vietnam.

Mr. A also had chronic feelings of depression, generalized anxiety, feelings of helplessness and hopelessness. He has never had serious head injuries and does not suffer from nonpsychiatric medical illnesses.

His physical and neurological examination, complete blood count, urinalysis, and serum chemistries were normal. He met DSM-IV criteria for PTSD and dysthymic disorder (11). He was prescribed carbamazepine and a very low dose of neuroleptic medication. This pharmacotherapeutic combination substantially diminished his PTSD symptoms, including his flashbacks. He also reported having less depressive symptoms and paranoid ideation with the present medication regime.

Case 2

Mr. B, a 49-year-old man, was admitted to a psychiatric hospital because he began to have increased fear that people in his neighborhood intended to rob him. He had loaded his gun and had been sleeping hiding in the bushes instead of inside his home. One week prior to hospitalization his home had been vandalized.

Mr. B was a combat veteran with involvement in multiple fire fights while serving in Vietnam. Mr. B had witnessed many of his army comrades sustaining serious injuries. He began to experience symptoms related to his combat experiences shortly after returning from Vietnam. He began to have visual phenomena during which he would see Vietnamese landscapes and enemy Vietnamese soldiers. These flashback experiences have progressively subsided, but have not disappeared completely. Stressful situations that increase his anger have tended to precipitate the flashbacks. His flashbacks generally last for several minutes. Mr. B intermittently abuses alcohol. However, his flashbacks occur whether or not he is intoxicated with alcohol.

Mr. B has been involved in numerous physical fights with both acquaintances and strangers. During some of these altercations he had visual flashbacks during which he attacked complete strangers who appeared to him to have acquired the physical, including facial appearances, of the Viet Cong for several minutes. During these flashbacks he would perceive the environment as Vietnam. He recounted that most often when he attacked these people he would believe that they were the Viet Cong. He would attack them with his fists. Although he has sometimes in the past carried a gun to protect himself from others, he has no history of initiating an attack while armed. He has never been convicted of any felonies.

Mr. B experienced lack of concentration, insomnia, nightmares containing combat themes, marked irritability and an exaggerated startle response. He avoided situations that would remind him of his Vietnam combat experience and often isolated himself from others, including his family. He had lost many jobs due to excessive mood lability, fear of others and frequent hostility. He has heard at times voices related only to the Vietnam experience. There is no evidence of mood congruent hallucinations, thought disorder or delusions. His family psychiatric history was negative.

His physical examination, complete blood count, urinalysis, and serum chemistries were normal. He has a history of hypothyroidism that is well controlled with thyroid replacement. He met DSM-IV criteria for PTSD (11). He was treated with carbamazepine which worked well by decreasing his PTSD symptoms, including his flashbacks. The misidentification phenomena associated with his flashbacks also subsided when he took both his carbamazepine as prescribed and remains relatively free of psychosocial stressors.

Case 3

Mr. C, a 48-year-old male, was admitted to a psychiatric hospital because he was suffering increasing anger and flashbacks related to his combat experiences during the Vietnam War. He came to the hospital because he believed that he was going to lose control of his hostile impulses. In the past he had engaged in many violent confrontations with civilians because of his mood lability, but usually did not become violent in direct association to his flashbacks. However, he would frequently have flashbacks during which he would see himself in a Vietnam panorama. He would also perceive people as acquiring the facial features of the Viet Cong but usually knew that such facial changes were a product of his PTSD and that those people who appeared to be Viet Cong were actually civilians. On one occasion, however, he became angry toward a Caucasian police officer and visually perceived the police officer to be a member of the Viet Cong. Mr. C then became extremely angry and physically attacked the officer with his fists as well as by kicking the officer. He recalled that during much of the duration of the flashback, which lasted approximately five minutes, he also believed that the officer was indeed a member of the Viet Cong.

No psychiatric defense was attempted. As a result, Mr. C was ultimately convicted of assault and spent two years in prison. Mr. C has no other criminal history. He has abused alcohol and cannabis. There is evidence that alcohol worsened his PTSD symptoms including his flashbacks but he claimed that marijuana diminished his anxiety, anger and flashbacks.

Mr. C met DSM-IV criteria for PTSD, alcohol and cannabis abuse (11). He has been treated with fluoxetine for several years with a modest improvement in his PTSD symptoms.

Case 4

Mr. D, a 53-year-old male, was admitted as a psychiatric inpatient because of having homicidal ideation toward some friends who disagreed with his political views, but which were unrelated to his previous military experiences. Mr. D had been in Vietnam

during the Tet Offensive and had been in close proximity to many fire fights with the Viet Cong. He had been wounded once, sustaining a facial injury without loss of consciousness or evidence of brain injury. Mr. D had seen one army comrade blown up and several other friends severely injured during that confrontation. Shortly after this incident, Mr. D left military service and began experiencing insomnia, marked irritability, hostility, feelings of guilt, moderate depression, occasional suicidal ideation, visual flashbacks and avoidance of situations that reminded him of traumatic Vietnam experiences. He continued to experience flashbacks that usually lasted less than one minute. During his flashbacks he experienced complex visual representations of Vietnam, including those of enemy soldiers. His flashbacks were frequently precipitated by anger and occasionally by stimuli that reminded him of combat.

Mr. D often becomes easily angered and has divorced twice, ostensibly because of his irritability and anger which frequently led to repeated fights with his wives. During many of the marital arguments he would experience flashbacks in which he perceived the faces of his wives as enemy Vietnamese women. During some of these episodes he was aware of the illusory nature of his wives' faces; at other times, however, he has believed that they were the enemy. During these situations he would experience homicidal ideation towards them and once he had attacked his first wife with his hands. On other occasions while misrecognizing and misidentifying people as Vietnamese enemy soldiers during his flashbacks, he had physically attacked them. He had never, however, been charged with a crime. Mr. D often has dealt with his anger by isolating himself from others.

Mr. D's physical and neurological examinations were unremarkable. His complete blood count, urinalysis, and serum chemistries were normal. He met DSM-IV criteria for PTSD and dysthymic disorder (11). He was treated with both divalproex sodium and sertraline with substantial diminution of his hostility and flashback phenomena.

Case 5

Mr. E, a 52-year-old male, was admitted to a psychiatric unit suffering from flashbacks and nightmares related to his experiences during the Vietnam War. He also was suffering from feelings of depression, hopelessness and suicidal ideation. Mr. E has been experiencing symptoms related to combat since a year after he had completed his tour in Vietnam. He would usually experience flashbacks related to the war about 4 to 12 times per month. He would at times misidentify people as Viet Cong, but usually he was aware that he was visually misrecognizing them. During such experiences he would isolate himself until the flashback ended, usually after a few minutes. However, once he had visually misrecognized his wife as an enemy Vietnamese woman during which time she could not convince him otherwise. On that occasion he hit her, inflicting facial soft tissue injuries. Mr. E remembered that he had been able to stop hitting his wife only after a few minutes when he began to recognize her voice pleading with him to stop the attack. He recalled having begun to realize that he was hitting his wife even while he was still perceiving her to be an enemy Vietnamese woman. During this episode he did not recall that the rest of the environment appeared like Vietnam.

Mr. E has a history of violent confrontations outside of his home only after returning from Vietnam. His violence was associated with increased irritability, especially following flashbacks or intrusive thoughts related to his Vietnam experiences. He was convicted of felony assault after fighting over money. He denied any associated flashback experiences during this incident, but believed his irritability, hostility, and hyperarousal had predisposed him to engage in this act of violence.

During his initial hospitalization Mr. E had normal physical and neurological examinations. His complete blood count, urinalysis, and serum chemistries were normal. Mr. E has a history of hypertension that is well controlled with antihypertensives.

Mr. E met DSM-IV criteria for PTSD, major depressive episode and alcohol abuse (11). He was treated with an antidepressant and a low-dose neuroleptic. He was also treated with cognitive therapy. Most of his PTSD symptoms, including his flashbacks, decreased significantly. His nightmares with war content diminished, but he has continued to avoid events that remind him of combat. His paranoid ideation resolved. His symptoms of depression diminished substantially.

Discussion

The Phenomenology and Pathology of PTSD Flashbacks

The foregoing five cases all involved PTSD symptomatology, including ''flashbacks'' or visual perceptual abnormalities in which the patients believed that they were visually experiencing situations located in Vietnam during the Vietnam War. In all instances, the affected individual believed that he was perceiving a Vietnamese enemy, while in fact he was perceiving an objective person that bore no physical resemblance to the Vietnamese. It is important to emphasize that another person was present during the flashback experience and it would appear that the other person served as a physical infrastructure upon which a phenomenon consistent with an illusionary component occurred during which a face was perceived to change into that of a Vietnamese face. This stage of the flashback process therefore led to visual misrecognition of an objective facial structure.

A different component of the flashback process involves the conclusion that the affected individual had regarding the identity of another in the context of abnormal perception. It appears that the subjects in our group had experiences that represent a spectrum of cognition regarding whether or not they believe the flashback experience as representations of objective reality. We therefore define a ''flashback-induced personal misidentification'' as a cognition in which the patient believes that the misrecognition of an objective person that occurs during a flashback had become another person. In our subjects the misidentified person became Vietnamese.

The factors that lead to an actual misidentification experience are likely to be strongly associated with the dissociative intensity of the visual flashback. Several investigators have appreciated that PTSD can be conceptualized as a dissociative process. In 1988 Spiegel et al. studied 65 patients who had served in Vietnam and met DSM-III criteria (12) for PTSD (13). They used the protocol for the hypnotic induction profile as a measure of hypnotizability (14) since it is believed that hypnotizability can facilitate and measure dissociative experiences (15). They found that hypnotizability was significantly higher not only when compared with a control group but also when compared with groups suffering from schizophrenia, generalized anxiety disorder, affective disorders and a group with miscellaneous disorders (13). Putnam et al. utilized the dissociative experiences scale (DES), a quantitative measure of dissociation used in PTSD as well as in other diagnostic groups. They found that PTSD along with dissociative disorders scored significantly higher than all other diagnostic groups. Only multiple

personality disorder, a diagnostic entity well known for its intense dissociative pathology, yielded a significantly higher DES score than PTSD (16).

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association introduced acute stress disorder as a short-lived form of post-traumatic stress disorder that is in part defined by the presence of dissociative symptoms such as derealization, depersonalization and a subjective sense of detachment (11). This diagnostic inclusion is consistent with increased awareness by the psychiatric field of the importance of dissociative psychopathology in short-lived stress disorders and complements our awareness of the importance of the role of dissociation in more long-lasting stress disorders, especially post-traumatic stress disorder (17).

In spite of already extensive understanding of the role of dissociative psychopathology in the genesis of PTSD there is little systematic study concerning the relation of dissociative visual phenomena to the structure of visual PTSD flashbacks. However, it does appear that the extent to which a flashback becomes dissociated from the rest of consciousness appears to decrease an individual's reality testing, thereby predisposing the individual to lapses in cognition during which human objects can be misidentified. Therefore, factors that intensify the visual flashback (e.g., derealization in which the environment becomes alien and reduction in awareness of objective aspects of the environment) may predispose affected individuals to perceive and conceptualize the human objects that make up the transformed ''environment'' of the flashbacks as being more alien than the objective human objects.

The Dangerousness of PTSD Flashbacks

PTSD in and of itself has long been thought to be associated with various forms of aggression. As early as 1941 Kardiner suggested that aggression was an important aspect of war neurosis among World War I veterans (18). Grinker and Spiegel also described violent behaviors among men who had been directly involved in military conflict during World War II (19). More recently violence has been noted as a frequent problem among veterans of the Vietnam War (9,20,21). This association suggests the possibility that aggression may be an intrinsic component of PTSD.

Whether aggression represents a fundamental component of the psychopathology of PTSD remains unclear. However, the increased association of aggression with PTSD at least in some cases appears to be better established and this association may have multiple causes. Some relevant factors are personality characteristics associated with a hostile temperament and low impulse control, facilitation brought about by the social environment and a history consistent with reinforcement of hostile behavior (9). It is also possible, as previously mentioned, that the intrinsic nature of PTSD itself may lead to an increased risk for aggression. Such aggression may have its basis in both biological substrates as well as in the psychological organization of PTSD. However, this possibility remains to be systematically studied.

In the five cases described herein, there are indications that the subjects' violent behaviors were at times at least in part due to the nature of flashback factors, including both visual components (misrecognition) and cognitive components (misidentification). In all five cases the affected person experienced abnormal visual phenomena that would result in misperceiving others as enemy Vietnamese. In many of these visual episodes involving misrecognition, the affected people preserved their ability to realize that they were experiencing a visual phenomenon that was inconsistent with reality. However, in a fraction of episodes of misrecognition due to flashbacks, the affected individual came to believe that the misrecognized figures were actually Vietnamese enemy. In many of these latter episodes the individual responded by fleeing from the situation, likely fearing harm. However, in a small percentage of instances the affected individuals reacted by attacking the misidentified figure, motivated by anger and/or fear that he may be attacked. This sequence of events characterizes the five index cases that engaged in attacking others secondary to PTSD flashback-induced misidentification. In all five cases, violence occurred via hitting with fists. Only case 1 used a knife. Of interest is that two cases (1 and 5) resulted in facial injuries to the victims. It appears that the experience of witnessing illusory facial changes on the misidentified figures may increase the possibility of inflicting injuries to the face. This remains a potential lead for future study. All of these cases also exemplify a rather unplanned attack. In other words, prior to the flashback these individuals were not involved in premeditating the attacks. This lack of premeditation is consistent with the idea that PTSD-induced aggression may be linked to deficits in impulse control. Serious threats of aggression during flashbacks involved four patients, two threatening others with a gun (cases 1 and 2) and two with their fists (cases 3 and 4). Their pattern of hostility is consistent with an unplanned impulse pattern to their threats of violence. Nonetheless, two cases (cases 4 and 5) resulted in a felony conviction with subsequent imprisonment.

Legal Issues

Given the association of PTSD with phenomena such as flashbacks during which the affected person may lose his reality testing for periods during which he can attack others, it is not surprising that PTSD has been used as a way to support psychiatric defenses in which mental capacity has been significantly impaired. Examples include diminished capacity (22,23) and insanity defenses (22–25).

A diagnosis of PTSD in a psychiatric-legal setting is not, however, a trivial undertaking because the diagnosis of PTSD depends in great part on self-report and is therefore readily simulated (26,27). Therefore, the flashback-induced misidentification state will continue to pose a challenge to those who seek to utilize it as a psychiatric defense.

''Successful'' defenses should have some basic phenomenologic requirements. The first requirement is for a well-founded diagnosis of PTSD which must involve objective information gathered from sources independent of the defendant. Second, although DSM-IV has expanded what qualifies as a bonafide stressor that leads to PTSD, in the legal system a severe stressor is likely to be expected. Third, it appears that with increasing degrees of dissociation during the flashback experience would likely make the index flashback more relevant. Operationalizing the assessment of flashback experiences might utilize Blank's criteria for bonafide ''unconscious'' flashback experiences (28). We argue that to qualify for a valid psychiatric-legal defense, flashbacks must not only be experienced by the defendant but must be accompanied by a cognition involving misidentification of the attacked victim. In addition, a history of previous treatment, especially hospitalizations, in which flashback-induced misrecognition and misidentification toward others was well documented will help support the opinion of the forensic expert witness.

It is important to acknowledge that because flashback misidentification represents a spectrum of misidentification rather than an all or none phenomenon, not only in most cases of misidentification

but also in most episodes of PTSD-induced misidentification within a specific individual. With this understanding, the task of the forensic psychiatric expert is to clarify not only the degree of misidentification of the index episode but also, if possible, to identify previous corroborative evidence indicating that the individual in question represents someone who suffers from a recurrent pattern of misidentification states sufficient to warrant mitigation or exculpation from responsibility for an act of violence. Although theoretically a person who rarely experiences flashbacks can experience a severe episode of misidentification, this might not be persuasive to the trier of fact. In this specific situation the highest probability of legal success will likely involve the description of unusual environmental factors such as a rare event in which a PTSD sufferer is aggressively challenged by another with weapons such as guns that clearly represent not only an objective threat but also a clear reminder and a reasonable trigger of a flashback that in turn induces severe misrecognition and misidentification phenomena that lead to the violence occurring in a highly dissociated state.

In conclusion, flashback phenomena may lead to misrecognition and misidentification of others. Such misidentification is usually associated with fear and hostile feelings. This combination of misidentification, fear, and hostility is a more likely one that leads to violence in these cases. But the degree of responsibility is variable, and only severe cases of misidentification in individuals with an objective history of similar episodes are likely to yield a successful psychiatric defense. We estimate that such cases will be few. This is in line with available information indicating that a ''successful'' psychiatric defense in cases involving aggressive individuals who suffer from PTSD is uncommon.

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