

## CASE

# Dissociative amnesia: a case with management challenges

Priti Singh, Rajeev Dogra, Krishan Kumar, Rajiv Gupta

## Abstract

A case of dissociative amnesia with regressed behaviour was diagnosed applying the existing criteria for dissociative disorder in the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Though there are number of cases of such condition, but when coupled with regressed behaviour it adds to new dimension in the management. An applied strategy in lines with both pharmacological and non pharmacological was used, and we found that it helped our patient to gradually improve her behaviour. This is one of the few cases reported and we hope more such cases should be reported in understanding the psychopathology.

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**Correspondence:** keshusony@rediffmail.com

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Dissociation is a neurotic defense reaction which temporarily but drastically modifies a person's character or sense of personal identity to avoid emotional distress. In 1970s, the interest in dissociation revived as a result of various studies relating the effects of psychological trauma, especially among Vietnam War veterans presenting with dissociation as a natural protective defense against trauma.[1] Dissociation can impair functioning and increase susceptibility to psychopathology. Increased dissociative phenomenon in psychiatric conditions might be expected and signify more severe dysfunction. Dissociative experiences can be found in a plethora of psychiatric conditions including dissociative disorders, borderline personality disorders, eating disorders, anxiety disorders, posttraumatic stress disorder (PTSD), and psychotic disorders including schizophrenia.[2]

Dissociative amnesia is characterised by inability to recall important autobiographical information, usually of traumatic or stressful nature, that is inconsistent with ordinary forgetting. There is significant distress or socio-occupational dysfunction.[3] Localised amnesia consists of failure to recall events during a circumscribed period of time whereas generalised amnesia is characterised by complete loss of memory for one's life history. Janet was the first to articulate the clinical principles of dissociative disorder and to systematically treat the traumatic memories underlying dissociative behaviour.[2] Functional amnesic states confine patient's biography triggered by environmentally induced stress and trauma

leading to lasting inability to retrieve autobiographical events.[4] Twenty nine per cent of convicted prisoners with life sentence showed amnesia for offence that was of psychological origin. Cases of dissociative amnesia with regression are reported in literature.[5-8] We are discussing here an interesting case of dissociative amnesia with regression following conflicts with family members and husband, and the difficulties in her management.

## Case

Mrs X, a 27-year-old matriculate married Hindu housewife belonging to middle socioeconomic status from urban background presented with acute onset illness characterised by inability to recognise her husband, inability to do household work, neglecting self and her children, and exhibiting childish behaviour for the last two months precipitated by conflict with her sister-in-law. Patient was blamed by her sister-in-law for beating her stepson (ten years old). She was physically assaulted by her husband and was forced to leave the house with a threat of leaving her permanently. Due to marriage in the family, she was again brought back home the same evening. Patient started behaving abnormally by not recognising her husband and other family members. She started behaving like a child by running around the house, playing with sand, and demanding for sweets and toys. She would cry if her demands were not met and would throw temper tantrums. She would talk to her family members as if they were strangers. She completely denied of her marital status and having a child, though she could remember everything about her schooling, parental family,

and relationship with friends and siblings. There was no family history of any psychiatric illness. She was married to a widowed Army man seven years back who had a son from his previous marriage. The relationship between husband and wife was not cordial. There were frequent fights and physical abuse by her husband. The husband usually used to leave her either at his home or to her parental home on such occasions. There were frequent interferences by the husband's family members especially her sister-in-law who blames her for neglecting the son. She used to scold the patient in front of the children on many occasions.

Mental status examination revealed increased psychomotor activity, childish behaviour, soft speech with decreased rate, tone and volume, la belle indifference. Except for a circumscribed period covering her marriage to the incidence, her memory was intact. She was oriented to time, place, and person, but refused to recognise the husband. Her judgement was intact and she lacked insight. She was taken up for psychological intervention and regular sessions along with low dosage of anti-anxiety drugs were given. During sessions, various issues related to her interpersonal conflicts were exposed and dealt with. She gradually started talking about the harsh and insulting behaviour of her husband and sister-in-law as well as uncertainties in her life. During this phase, her behaviour became very irritable and low dosage of antipsychotics was added for short period. Her lost memories were gradually recovered and her behaviour became more mature.

## Management

### *Therapeutic goals*

We helped the patient to achieve a sense of cohesiveness about her affects, cognitions, and associated behaviour. Her behaviour was enhanced by promoting self-acceptance, self-knowledge about feelings which were viewed as unacceptable. She was helped in resolving conflicting feelings, wishes, loyalties, identifications, or contrasting expectations.

Patient was desensitised from the traumatic memories, and correct learned attitudes towards life resulting from traumatic events were enhanced. Patient was trained to have healthy attachments and relationships through direct expression of feelings with the family members followed by building trust, i.e. every behaviour, whether verbal or nonverbal, was scanned by the patient; the most important task was to gain confidence. Diagnostic exploration, dealing with fear, and resolving internal conflict were targeted psychodynamically.

**Primary gain:** Primary gain is subdivided into two parallel aspects. In the internal part, illness remains the most economic solution in cases of conflict, and this is the "flight into illness". The external part is linked to

profitable arrangements occasioned in the individual's relational life. Primary gain produces positive internal motivations, i.e. its constitutive element of the illness that is present in the very motive of the illness. Primary gain can be a component of any disease; here stressors manifest themselves as physical symptoms without organic causes, such as a person who becomes blindly inactive after seeing a murder. The "gain" may not be particularly evident to an outside observer.

**Secondary gain:** "Helps the ego in its effort to incorporate the symptom." It procures a satisfaction that is narcissistic or linked to self-preservation. The secondary gain is an addition to the primary gain and comes into play at a later stage. It can also be a component of any disease, but is an external motivator. It consolidates the disorder. If a patient's disease allows him/her to miss work, gains him/her sympathy, or avoids a jail sentence, these would be examples of secondary gain. These may, but need not be, recognised by the patient. However, secondary gain may simply be an unconscious psychological component of symptoms and other personalities.

### *Cognitive interventions*

Patient involved reconnecting, uniting, and processing the dissociated life experiences to help her remember and assimilate previously dissociated thoughts and feelings. Adjunctive behavioural techniques supported modulation of intense affects to permit more rapid affective and behavioural change.

## Discussion

Dissociative amnesia is an uncommon phenomenon and its association with regression makes it important to analyse it psychodynamically. Of the 80 'hysterical neurosis' patients studied by Goswami and Dutta,[9] not a single case reported amnesia. Our patient improved on psychological interventions. Mushtaq *et al.*[3] discussed in first reported case of lorazepam assisted interview in a young Indian female presenting with dissociative identity disorder with total loss of her identity and child like behaviour similar to our case. She finally improved with lorazepam assisted interview. No response to pure psychological interventions was seen in their patient; however, it was contrary to our findings.

In the case reported by Roy,[10] mental status examination revealed a childish silly behaviour, speech had a childish tone, and she was easily distractible just like a child. Provisional diagnosis of mixed dissociative [conversion] disorder (dissociative amnesia and dissociative convulsions) was made.[10]

A case series was reported by Chadda *et al.*[11] where the authors described three cases of loss of autobiographical memory and their treatment. Two of the cases were of dissociative disorder unspecified and

dissociative amnesia. They improved with diazepam and pentothal abreaction respectively. One case was of schizophrenia who was treated with antipsychotics. Our case responded to psychological intervention, and drug assisted interview was not required.

The present case is different from previous cases as the pharmacological intervention was minimal. Clear cut stressors and precipitating factors could be identified during the initial sessions, and an effective intervention could be done at the earlier stage. This case throws light to the fact that even in this biological based era where pharmacotherapy takes the upper hand, there are patients who would need empathic listening and effective psychological interventions.

### **Conclusion**

In summary, it has been concluded that psychosocial dynamics play vital role in dissociative disorder and we should not underestimate psychosocial intervention in this age group, provided it should be done at the earliest stage.

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**Priti Singh**, Professor, **Rajeev Dogra**, Professor, **Krishan Kumar**, Assistant Professor, **Rajiv Gupta**, Senior Professor and Head, Department of Psychiatry, PGIMS, Rohtak, Haryana, India