AMNESIA AND RELATED DISORDERS

INTRODUCTION

Amnesia and similar disorders are categorized by psychiatrists as dissociative disorders. They include dissociative amnesia, dissociative fugue, dissociative identity disorder, and depersonalization disorder. Dissociative disorders are usually triggered (precipitated) by overwhelming stress. The stress may be caused by experiencing or witnessing a traumatic event, accident, or disaster. Frequently, a person may experience inner conflict so intolerable that his mind is forced to separate incompatible or unacceptable information and feelings from conscious thought.

DEPERSONALISATION DISORDER

Depersonalization disorder is characterized by a persistent or recurring feeling of being detached from one's body or mental processes (depersonalization) and by a feeling of being an outside observer of one's mental processes, body and life. It causes significant distress or impairment in social, occupational and other areas of one's life.

The symptom of depersonalization is the third most common psychological symptom (after feelings of anxiety and feelings of depression) and often occurs after a person experiences life-threatening danger, such as an accident, assault, or serious illness or injury. Depersonalization disorder has not been studied widely, and its cause and occurrence in the population are unknown.

Symptoms and Diagnosis

People with depersonalization disorder have a distorted perception of their identity, body, and life that makes them uncomfortable. Symptoms may be temporary or persist or recur for many years. People with the disorder often have a great deal of difficulty describing their symptoms and may fear or believe that they are going crazy.

Depersonalization disorder can be a minor, passing disturbance with little noticeable effect on behaviour. Some people can adjust to it or even block its impact. Others are continually plagued with anxiety over their state of mind, worrying that they are going crazy or ruminating over the distorted perceptions of their body and their sense of estrangement from themselves and others. Mental anguish may disable them.

The diagnosis of depersonalization disorder is made on the basis of symptoms. A doctor evaluates the person to rule out physical disorders (such as a seizure disorder), drug abuse, and other mental health disorders. Psychological tests and clinical interview procedures may help the doctor recognize the problem.

Treatment and Prognosis

Depersonalization disorder often disappears without treatment. Treatment is warranted only if the disorder persists, recurs, or causes distress. Psychodynamic psychotherapy, behaviour therapy, and hypnosis have been effective for some people. Sedatives and antidepressants help some people with the disorder. Depersonalization disorder is often associated with or triggered (precipitated) by other mental health disorders, which require treatment. However, it should be noted that depersonalisation disorders do not necessarily occur in the presence of other psychiatric disorders. Any stresses associated with the beginning (onset) of the depersonalization disorder must also be addressed.

Some degree of relief is usually achieved with treatment. Complete recovery is possible for many people, especially those whose symptoms occur in connection with stresses that can be addressed during treatment. Other people with depersonalization disorder do not respond well to treatment, although they may gradually improve on their own. A few remain unresponsive to all treatments.

DISSOCIATIVE AMNESIA

Dissociative amnesia is a type of amnesia caused by trauma or stress resulting in an inability to recall important personal information. It is too extensive to be explained by plain forgetfulness.

Dissociative amnesia is one type of amnesia. Amnesia is the total or partial inability to recall recent or remote experiences. When amnesia is caused by a psychological rather than a physical disturbance, it is called dissociative amnesia. Amnesia may also be a symptom of other disorders, such as acute stress disorder, dissociative identity disorder, dissociative fugue, posttraumatic stress disorder, or somatization disorder.

In dissociative amnesia, the lost memory usually involves information that is normally part of routine conscious awareness or "autobiographical" memory—who one is; what one did; where one went; to whom one spoke; what was said, thought, and felt; and so on. Sometimes the information, though forgotten, continues to influence the person's behaviour.

People with dissociative amnesia usually have one or more memory gaps spanning a few minutes to a few hours or days. However, memory gaps spanning years or even a person's entire life may occur. Most people with dissociative amnesia are aware that they have "lost some time," but some become aware of time loss only when they realize or are confronted with evidence that they have done things that they do not recall. Some people with dissociative amnesia forget some but not all events over a period of time; others cannot recall their entire previous life or forget things as they occur.

The disorder is most common among young adults, more commonly among people who have been involved in wars, accidents, or natural disasters. It may also block memories of childhood sexual abuse, later recalled in adulthood. Dissociative amnesia can occur for some time after a traumatic event. Whether such recovered memories reflect real events in the person's past remains unknown, unless confirmed by another person.

<u>Symptoms and Diagnosis</u>

The most common symptom of dissociative amnesia is memory loss. Shortly after becoming amnesic, a person may seem confused. Many people with dissociative amnesia are somewhat depressed or very distressed by their amnesia.

To make the diagnosis, the doctor carefully reviews the person's symptoms and performs a physical examination to exclude physical causes of amnesia. Tests, including electroencephalography and blood testing for toxins and drugs, are sometimes needed to exclude physical causes. A psychological examination is also performed. Special psychological tests often help the doctor better characterize and understand the person's dissociative experiences to develop a treatment plan.

Treatment and Prognosis

A doctor begins treatment by helping the person to feel safe and secure. If the missing memories are not spontaneously recalled, or if the need to recall the memories is urgent, memory retrieval techniques are often successful. Using hypnosis or drug-facilitated interviews (interviews conducted after the person is calmed and sedated with an intravenous drug such as amobarbital or midazolam) the doctor questions the amnesic person about the past.

A doctor uses hypnosis and drug-facilitated interviews to reduce anxiety associated with the period for which there is amnesia, and to penetrate or bypass the defences the amnesic person has created for protection from recalling painful experiences or conflicts. The doctor must be careful not to suggest what should be recalled or stimulate extreme anxiety. Memories recalled through such techniques may not be accurate and may require external corroboration. Therefore, before hypnosis or a drug-facilitated interview is performed, the doctor informs the amnesic person that memories retrieved with these techniques may or may not be accurate and obtains the person's consent to proceed.

Filling in the memory gap to the greatest extent possible helps restore continuity to the person's identity and sense of self. Once the amnesia has disappeared, continued psychotherapy helps the person understand the trauma or conflicts that caused the disorder and find ways to resolve them.

Most people recover what appears to be their missing memories and resolve the conflicts that caused the amnesia. However, some people never break through the barriers that prevent them from reconstructing their missing past.

DISSOCIATIVE FUGUE

Dissociative fugue is a disorder in which one or more episodes of sudden, unexpected, and purposeful travel from home (fugue) occur, during which a person cannot remember some or all of his past life.

Dissociative fugue affects about 3 of 1,000 people in the world. It is much more common in people who have been in wars, accidents, or natural disasters.

Causes

The causes of dissociative fugue are similar to those of dissociative amnesia. Dissociative fugue is often mistaken for malingering, because both conditions may occur under circumstances that a person might understandably wish to evade. However, dissociative fugue occurs spontaneously and is not faked. Malingering is a state in which a person feigns illness because it removes him from accountability for his actions, gives him an excuse to avoid responsibilities, or reduces his exposure to a known hazard, such as a dangerous job assignment. Many fugues seem to represent a disguised wish fulfilment (for example, an escape from overwhelming stresses, such as divorce or financial ruin). Other fugues are related to feelings of rejection or separation, or they may protect the person from suicidal or homicidal impulses.

When dissociative fugue recurs more than a few times, the person usually has an underlying dissociative identity disorder.

Symptoms and Diagnosis

A fugue may last from hours to weeks or months, or occasionally even longer. A person in a fugue state, having lost his customary identity, usually disappears from his usual haunts, leaving his family and job. If the fugue is brief, the person may appear simply to have missed some work or come home late or, if confused, may come to the attention of medical or legal authorities. If the fugue lasts several days or longer, the person may travel far from home and begin a new job with a new identity, unaware of any change in his life. During the fugue, the person may appear normal and attract no attention. However, at some point, the person may become aware of the memory loss (amnesia) or confused about his identity.

Often the person has no symptoms or is only mildly confused during the fugue. However, when the fugue ends, the person may experience depression, discomfort, grief, shame, intense conflict, and suicidal or aggressive impulses.

A doctor may suspect dissociative fugue when a person seems confused about his identity or is puzzled about his past, or when confrontations challenge the person's new identity or absence of one. The doctor makes the diagnosis by carefully reviewing the person's symptoms and performing a physical examination to exclude physical disorders that might be contributing to or causing memory loss. A psychological examination is also performed.

Sometimes dissociative fugue cannot be diagnosed until the person abruptly returns to his pre-fugue identity and is distressed to find himself in unfamiliar circumstances. The diagnosis is usually made retroactively by a doctor reviewing the person's history and collecting information that documents the circumstances before the person left home, the travel itself, and the establishment of an alternate life.

Treatment and Prognosis

Most fugues last for hours or days and disappear on their own. Dissociative fugue is treated much the same as dissociative amnesia, and treatment may include the use of hypnosis or drug-facilitated interviews. However, efforts to restore memories of the fugue period usually are unsuccessful. A

therapist may help the person to explore his patterns of handling the types of situations, conflicts, and moods that triggered (precipitated) the fugue episode to prevent subsequent fugue behaviour.

DISSOCIATIVE IDENTITY DISORDER

In dissociative identity disorder, formerly called multiple personality disorder, two or more identities or personalities alternate.

Dissociative identity disorder appears to be a rather common mental disorder. It can be found in 3 to 4% of people hospitalized for other mental health disorders and in a sizable minority of people in drug abuse treatment facilities. However, some authorities believe that many cases of this disorder reflect the influence of therapists on suggestible people.

Dissociative identity disorder appears to be caused by the interaction of several factors. These include overwhelming stress; an ability to separate one's memories, perceptions, or identity from conscious awareness; abnormal psychological development, and insufficient protection and nurture during childhood.

Human development requires that children be able to integrate complicated and different types of information and experiences. As children learn to achieve a cohesive, complex identity, they go through phases in which different perceptions and emotions of themselves and others are kept segregated. These different perceptions and emotions become involved in the generation of different selves, but not every child who suffers abuse or a major loss or trauma has the capacity to develop multiple personalities. Those who do have the capacity also have normal ways of coping, and most of these vulnerable children are sufficiently protected and soothed by adults, so dissociative identity disorder does not develop.

<u>Symptoms</u>

People with dissociative identity disorder often describe an array of symptoms that can resemble those of other mental health disorders as well as many physical disorders. Some symptoms are an indication that another disorder is indeed present, but some symptoms may reflect the intrusions of past experiences into the present. For example, sadness may indicate coexisting depression, or it may be that one of the personalities is reliving emotions associated with past misfortunes.

Dissociative identity disorder is chronic and potentially disabling or fatal, although many with the disorder function very well and lead creative and productive lives. People with this disorder are prone to injuring themselves. They may engage in self-mutilation. Many attempt suicide.

In dissociative identity disorder, some of a person's personalities are aware of important personal information, whereas other personalities are unaware. Some personalities appear to know and interact with one another in an elaborate inner world. For example, personality A may be aware of personality B and know what B does, as if observing B's behaviour; personality B may or may not be aware of personality A. Other personalities may or may not be aware of personality B, and personality B may or may not be aware of them.

The switching of personalities and the lack of awareness of one's behaviour in the other personalities often makes life chaotic for people with dissociative identity disorder. Because the personalities often interact with each other, people with dissociative personality disorder report hearing inner conversations and the voices of other personalities commenting on their behaviour or addressing them. They experience distortion of time, with time lapses and amnesia. They have feelings of detachment from one's self (depersonalization) and feelings that one's surroundings are unreal (de-realization). They often have concern with issues of control, both self-control and the control of others. In addition, people with dissociative identity disorder tend to develop severe headaches or other bodily pain and may experience sexual dysfunction. Different clusters of symptoms occur at different times.

People with dissociative identity disorder may not be able to recall things they have done or account for changes in their behaviour. Often they refer to themselves as "we", "he", or "she". While most people cannot recall much about the first 3 to 5 years of life, people with dissociative identity disorder may have considerable amnesia for the period between the ages of 6 and 11 as well.

Diagnosis

To make the diagnosis of dissociative identity disorder, a doctor conducts a thorough psychological interview. A medical examination may be needed to determine if a physical disorder is present that would explain certain symptoms. Special questionnaires have been developed to help doctors identify dissociative identity disorder.

Interviews may need to be prolonged and involve careful use of hypnosis or drug facilitation. Hypnosis or drug-facilitated interviews may make the person more likely to allow the doctor to encounter other personalities or to reveal information about a period for which there is amnesia. However, some doctors feel that hypnosis and drug-facilitated interviews should not be performed because they believe the techniques can themselves generate symptoms of dissociative identity disorder.

Treatment and Prognosis

Some symptoms may come and go (fluctuate) spontaneously, but dissociative identity disorder does not clear up on its own. The goal of treatment is usually to integrate the personalities into a single personality. However, integration is not always possible. In these situations, the goal is to achieve a harmonious interaction among the personalities that allows more normal functioning.

Drug therapy can relieve some specific coexisting symptoms, such as anxiety or depression, but does not affect the disorder itself.

Psychotherapy is often arduous and emotionally painful. The person may experience many emotional crises from the actions of the personalities and from the despair that may occur when traumatic memories are recalled during therapy. Several periods of psychiatric hospitalization may be necessary to help the person through difficult times and to come to grips with particularly painful memories.

Generally, two or more psychotherapy sessions a week for at least 3 to 6 years are necessary. Hypnosis may be helpful.

The prognosis of people with dissociative identity disorder depends on the symptoms and features they experience. For example, people who have additional serious mental health disorders, such as personality disorders, mood disorders, eating disorders, and substance abuse disorders, have a poorer prognosis.

DISSOCIATIVE IDENTITY DISORDER AND CHILDREN

About 97 to 98% of adults with dissociative identity disorder report having been abused during childhood. Abuse can be documented for 85% of the adults and 95% of the children and adolescents with dissociative identity disorder.

Although childhood abuse is a major cause of dissociative identity disorder, that does not mean all the specific abuses alleged by people with this disorder really happened. Some aspects of some reported experiences clearly are not accurate. In addition, some people were not abused at all, but rather, suffered an important early loss, such as the death of a parent, a serious physical illness, or some other very stressful experience.