

Psychogenic Amnesia: A Case Involving Amobarbital Interview and The News Media

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Abstract

A young man was admitted to an urban general hospital psychiatric unit after being brought from a local shopping mall unable to remember his name or any other personal information. He was alert and oriented and demonstrated no cognitive impairment. He agreed to an amobarbital interview and agreed to letting local news media display his picture in hopes that someone would recognize him. The amobarbital interview yielded information allowing identification of the individual, with the help of the news media. News media coverage also led to the discovery that the individual was wanted for a violent crime in another state and that the amnesia apparently set in after his commission of that crime. Implications for diagnosis and management of amnesia are discussed.

Psychogenic amnesia is a psychiatric disorder characterized by a sudden loss of memory covering a variable period of time, with an absence of underlying brain disease, and an awareness by the patient that a memory disturbance is present (1). Most frequently, it has been associated with severe stressors with extreme cases including natural disaster and military conflict. Over 1000 cases of psychogenic amnesia have been reported since the late 1800's (2) and memory loss continues to be a presenting problem in the psychiatric emergency setting today.

Psychogenic amnesia is most often seen in adolescents and young adults who have no prior history of psychiatric illness. Case studies have shown that this loss of memory has occurred in association with a distressing event that involves or is perceived to involve serious threats to health or life (3,4). It may also occur following physical trauma and may involve conflicts over sexual or aggressive drives (5). In psychogenic amnesia, a suspected internal conflict is manifested by memory loss and subsequent dissociative state. The most common form of this amnesic state involves only a few hours of loss of recall following the traumatic event. However, the amnesia may be total with a lifetime of memories lost (2).

Kaplan and Saddock emphasize that the prominent feature of psychogenic amnesia is loss of memory associated with perplexity and disorientation though full

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alertness (6). This presentation may be suggestive of brief reactive psychosis, but hallucinatory and delusional material is absent. DSM-III-R criteria for psychogenic amnesia include:

- the predominant disturbance is an episode of sudden inability to recall important personal information, that is too extensive to be explained by ordinary forgetfulness, and
- the disturbance is not due to multiple personality or organic mental disorder (e.g., blackouts during ETOH intoxication). (7)

In the differential diagnosis of a patient presenting to the emergency room unable to identify him or herself, a host of possibilities including organic mental disorder, dementia, somnambulism, psychotic states, fugue, and malingering must be considered. Of the 30 cases of unidentified patients presenting to the Psychiatric Emergency Service as reviewed by Parks et al, the most common diagnosis was psychosis (15/30); the second most common was intoxication (6/30) followed by malingering (3/30). Two of 30 met criteria for psychogenic amnesia (8).

The prognosis for improvement is good with aggressive treatment leading to rapid recovery. The most widely accepted pharmacologic approach for treating the patient with psychogenic amnesia involves the intravenous use of intermediate and short-acting barbiturates in combination with supportive interviews at restoring memory (9,10). Patients who do not respond to general interviewing or hypnosis may ultimately recover following amobarbital interview. The use of amobarbital interview and cooperation of the news media is illustrated in the following case report.

CASE REPORT

S.B. presented to the Psychiatric Emergency Service (PES) at University Hospital after being treated at a local hospital for traumatic amputation of his left middle distal phalanx. He had no memory of events prior to three days before admission, when he was found wandering within an area mall. He recalled awakening on a mall bench and asking people if they knew who he was. He was unaware of his name and was unable to give any other identifying information. No identification was found on his person; he did have a locker key from an unknown source. Police directed him to the hospital.

In the PES, S.B. appeared markedly concerned about his deficits. On mental status exam, he appeared to be in his mid to late twenties, unkempt with a few days beard growth and multiple distinctive tatoos. He appeared bewildered, tearful and frustrated because he was unable to remember any of his past. He did not attempt at any time to minimize, rationalize, or deny any deficits. He was cooperative, with no unusual motor behavior noted. Speech was normal rate and tone. He showed no psychotic features in thought process or content. He denied suicidal or homicidal ideation. He was assessed as having retrograde amnesia in that he was unable to give his name, address, or any personal information, and unable to recall life events prior to admission. He was alert and able to maintain focus during the interview. He was able to perform serial sevens and report back date, place, and time after he was told. He recalled 3 of 3 objects in 5 minutes. There was no evidence of inability to learn or retain new information. He had not assumed a new identity (as in fugue). Neurological consultation showed no focal deficits and the exam was unremarkable except for signs of amnesia. A

comprehensive toxic screen was performed which was negative except for trace marijuana. Alcohol level was zero. A CT scan of the head was also negative.

The police filed a missing persons report. The local state institution for mental illness was called to check for missing persons. S.B. was admitted to the inpatient psychiatric unit at University Hospital. He appeared suspicious and anxious while in the hospital. He was hypervigilant and unsure of what various common objects were and how to use them (e.g., television, salt shaker). He showed complete retrograde amnesia but was able to learn and retain new information without difficulty. He showed no depressive or manic symptoms and no evidence of hallucinations or delusions. It was suggested to the patient that an amobarbital interview be performed to help him try to regain his memory. The patient was readily agreeable. A total of 750 mg. of amobarbital was given intravenously over a 30 minute time period. The patient became more relaxed and talkative, but was unable to state his name. He did report that he thought he was from Cincinnati and was able to name a local elementary school and former second grade teacher. No further information was obtained.

The next day, news media were involved to help identify the patient. Pictures were taken for the newspaper, and local television came to report. Later that day, the media tracked down the patient's second grade teacher, who arrived on the ward with pictures of all her prior second grade classes. S.B. recognized the teacher immediately, as well as pictures of former classmates. His memory gradually began to return and he recounted that he had recently come to Cincinnati from another state. He was able to identify himself among the pictures and state his name. He was tearful at this revelation. His paranoid stance and hypervigilance dissipated and he immediately appeared more relaxed. Soon afterwards, however, he began to be increasingly insistent that he be discharged from the hospital.

Once his memory returned, S.B. told a story of his finger jamming in a door, resulting in the injury, noting "I lost all memory after that." The patient's family was called to obtain collateral information. It was learned that the patient was a "drifter" and unable to hold a job for any length of time. He had often been truant from school and was a high school drop-out. He had a history of misdemeanor charges, was involved with drugs and alcohol, and had received treatment at age 14 for alcohol abuse.

S.B. claimed to have had \$11,000 taken from him during his amnesic state. He noted that the only traumatic thing that he could think of that may have precipitated his amnesia was a break-up with a girlfriend of 4 years. Family claimed that the patient had no more than \$200 and no girlfriend.

While discharge was being considered, the University police reported that a police officer visiting from another state had tentatively identified the patient on the basis of his tattoos and finger injury after having seen him on television. A woman from another state had filed a complaint about a man fitting the patient's description, saying that approximately a week prior to his hospital admission, she had been abducted, beaten, and raped by this man. In the course of the struggle, she had bitten off the tip of her attacker's finger, and the fingertip was in evidence in the police department. Matching the patient's fingertip records with those of the severed fingertip provided definitive identification. The patient was taken into police custody with discharge diagnoses of psychogenic amnesia, resolved, drug and alcohol abuse by history, and antisocial personality.

DISCUSSION

We maintain that S.B. suffered from transient psychogenic amnesia. Although he had engaged in purposeful travel, he did not assume a new identity as in fugue. His

premorbid personality was likely antisocial but he had no formal psychiatric history. He did have a history of substance abuse. Though he had a history of misdemeanor charges, he had no known violent offenses. Psychoanalytic theory suggests that psychogenic amnesia may represent an unconscious attempt to avoid an intolerable conflict (2). Freud has written that "it is an undoubted fact that disagreeable impressions are easily forgotten" (11). Repression of memory provides protection from emotional pain that arises from either disturbing external circumstances or anxiety-provoking inner drives.

In keeping with psychoanalytic theory, the abduction, beating and rape that S.B. allegedly committed, as well as the traumatic injury to his finger, may have been so intolerable that the amnesia developed as an unconscious attempt to avoid the conflict. S.B. had no prior history of sexual assault or violent crime. Probably in an intoxicated state, he reportedly attacked a woman and had his finger bitten off in the struggle. This highly emotional experience may have been repressed with resultant memory loss to that traumatic event as well as all events of his earlier life. The forgotten feelings and disavowal of ownership of S.B.'s experiences and identity may have been an attempt to protect the ego by concealing it from the superego (1). As Fisher said in 1945, "It is as if the patient says, 'I did not commit this crime because I am not I; I am nobody, I have no name and no past'" (12).

S.B. was genuinely confused, frustrated and frightened in the emergency room and early in his hospitalization. He showed relief when he learned his identity. He was so troubled by his memory loss that he was willing to do whatever was possible to help regain his memory. He readily agreed to an amobarbital interview, as well as involvement of the news media. This behavior strongly bodes against malingering, though does not rule it out. S.B.'s memory loss was nearly global. He had no recollection of his past though he was able to learn and retain new material. In Ganser Syndrome, approximate answers are given to questions in order to assume the role of the patient (13). One could argue that S.B.'s presentation was Ganser-like in that he did not give approximate answers, but claimed initially not to know what a salt shaker or a television was. Did S.B. suffer from psychogenic amnesia or was he malingering? Perhaps S.B. presented a mixed picture. The DSM-III-R states that malingering should be strongly suspected if a combination of the following is noted:

- medicolegal context of presentation, e.g., the person's being referred by his or her attorney for examination;
- marked discrepancy between the person's claimed stress or disability and the objective finding
- lack of cooperation during the diagnostic evaluation and complying with prescribed treatment
- the presence of Antisocial Personality Disorder (7)

If S.B. were malingering only, why would he agree to amobarbital interview and to being seen on television? Malingerers tend not to be cooperative and symptom relief is rarely obtained from amobarbital interview. S.B. appeared genuinely distressed by his memory loss and relieved to determine his identity. He had experi-

enced a traumatic event and an escape mechanism may have been the principle drive for his amnesic state. Parwatikar et al found alcohol and/or drug intoxication to be more common in so-called "true" amnesia for violence rather than in malingering (14). S.B. had been intoxicated on the night of the traumatic event.

The amobarbital interview yielded limited information in our case, yet what was disclosed enabled the news media to ultimately determine S.B.'s identity. The television media along with the amobarbital interview led to S.B.'s identification and later to his conviction for a crime. We propose that the local media be considered early in attempts to identify the amnesic patient in the hospital setting.

The following approach is recommended when attempting to obtain personal data from the person with amnesia who presents to the emergency room setting: 1) search for identification on the amnesic patient 2) begin an organic work-up which should include a thorough physical/neurological examination, laboratory tests, toxin screen, head CT scan and EEG 3) the police should also be notified for missing persons report 4) continue to interview the patient with suggestion and reassurances that he will regain his memory 5) have the patient sign consent for an amobarbital interview and conduct the interview 6) obtain consent for involvement of the news media to help identify the patient.

BIBLIOGRAPHY

1. Talbott JA, Hales RE, Yudofsky SC: The American psychiatric press textbook of psychiatry. Washington, American Psychiatric Press, 1988, 560-566
2. Brna TG, Wilson CC: Psychogenic amnesia. *American Journal of Family Practice* 1990; 41:229-234
3. Markowitsch HJ: Transient Psychogenic amnesia. *Italian J. Neurol Sci Supp.* 1988; 9:49-51
4. Domb Y, Beaman K: Mr. X—a case of amnesia. *British J of Psychiatry* 1991; 158:423-425
5. Guojonsson GH, Petursson H, Skulasen S, et al: Psychiatric evidence: a study of psychological issues. *Acta Psychiatri: Scand* 1989; 80:165-169
6. Kaplan HI, Sadock BJ, eds. *Comprehensive textbook of psychiatry*, 5th ed. Baltimore: Williams & Wilkins, 1989: 1031-35, 1512
7. DSM-III-R (3rd edition), American Psychiatric Association, 1987: 275, 360
8. Parks J, Hillard JR, Gillig PM: Jane and John Doe in the psychiatric emergency service. *Psychiatric Quarterly* 1989; 80:165-169
9. Ruedrich SL, Chu CC, Wadle CV: The amytal interview in the treatment of psychogenic amnesia. *Hosp Comm Psych.* 1985; 36:1045-1046
10. Perry JC, Jacobs D: Overview: clinical applications of the amytal interview in psychiatric emergency settings. *Am J Psychiatry* 1982; 139:552-559
11. Freud S: *Introductory lectures*. Harmondsworth: Penguin, 1915-17
12. Fisher C: Amnesic states in war neuroses: the psychogenesis of fugues. *Psychoanalytic Quarterly* 1945; 14:459
13. Feinstein A, Hattersly A: Ganser symptoms, dissociation and dysprosody. *J Nerv Ment Dis* 1988; 176:692
14. Parwatikar SD, Holcomb WR, Menninger KA: The detection of malingered amnesia in accused murderers. *Bull Am Acad Psychiat Law* 1985; 13:97-103