Generalized Dissociative Amnesia Versus Transient Global Amnesia

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Dissociative amnesia, a type of dissociative disorder, is characterized by autobiographical memory loss.[1] A previous study[2] in a population-based sample from Canada reported a lifetime prevalence of 6% for this condition. Although the etiology is still unclear, current evidence[1] suggests a strong connection between history of psychological trauma and dissociative amnesia. In support of this connection, previous research showed that the majority of patients who presented with this condition had a history of traumatic experience.[3] Depending on the magnitude of memory loss, dissociative amnesia can be classified as localized (lack of memory for a period of time or an event), selective (lack of memory for specific parts/aspects of an event), or generalized (lack of memory for the life history and identity). The differential diagnosis of dissociative amnesia involves substance use disorder, malingering, cognitive disorder, and neurologic conditions such as seizure disorders and transient global amnesia.

Case Report

This is the case of a woman in her 40s with no previous history of medical disorders. The police, who had found the patient purposelessly wandering the streets, brought her to the emergency department. She had autobiographical memory loss and loss of memory for global events prior to police contact. She had no identification.

In terms of her psychiatric assessment, she did not appear to be very concerned about her memory loss. She remained pleasant, calm, and cooperative throughout the interview. She was well kempt and appropriately dressed for the weather. Her speech was normal in tone, rate, and volume. She made good eye contact. She reported her mood to be good. Her affect was congruent, reactive, and euthymic. She appeared to have linear and organized thought processes. She denied any delusions or hallucinations. Cognitively, we completed a Mini-Mental State Examination,[4] and she scored 0/10 on temporal and spatial orientation and 20/20 on the rest of the examination.

She was seen by the neurology department for a headache, neck pain, and memory loss. With a tentative diagnosis of transient global amnesia, she underwent a complete medical and neurologic workup to rule out the differential diagnosis including transient ischemic attack/stroke, seizure, or transient global amnesia. Her initial neurologic examination, drug screening test, complete blood count, sepsis screening, complete metabolic panel, and kidney, liver, and thyroid function tests were all unremarkable. Neuroimaging scans including computed tomography and magnetic resonance imaging with gadolinium were normal. She underwent a lumbar puncture, which revealed normal cell counts and chemistry. Her electroencephalogram (EEG) revealed some abnormal activities in the left temporal region, mostly the anterior area, and a sleep-deprived EEG was pending.

We involved the local police department, and they were able to rapidly identify the patient and establish her address. Her roommate was able to make contact with her. Following the patient's conversation with her roommate, she was able to identify herself and recall parts of her autobiographical memory. Collateral history from her neighbor suggested that the patient had been behaving unusually for a while with bizarre behaviors such as laughing to herself. The patient was admitted to the psychiatry unit for further assessment and diagnostic clarification. The initial differential diagnosis included dissociative amnesia, malingering, or disorganized schizophrenia. She was started on a low dose of antipsychotic (ie, risperidone 1 mg/d that was gradually increased to 2 mg/d). During her admission, she was able to remember more details about her past. She reported a history of being in an abusive relationship. She alleged that members of a religious group in the United States harassed her. She stated that because of these issues, she traveled to Canada as an asylum seeker. She stabilized with intact cognition over the next few days. She was discharged from the hospital after 3 weeks with a diagnosis of generalized dissociative amnesia. Risperidone was continued after her discharge; however, the patient declined follow-up care post discharge, as she was planning to move to another city.

Discussion

The diagnosis and treatment of dissociative amnesia, in particular the generalized subtype, can be challenging, especially since our understanding of the underlying pathophysiology of this condition is very limited.[5] However, some clues in the history such as past history of psychiatric disorders and psychological traumas can support a diagnosis of dissociative amnesia rather than medical causes.[6] As with

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most other psychiatric disorders, it is important to rule out organic causes first before considering psychiatric etiologies. A thorough sequential history and collateral information are key components in effective diagnosis and management of this condition. The core feature of memory loss in dissociative amnesia is inability to remember autobiographical information, which makes it distinctive from other conditions such as transient global amnesia.

Transient global amnesia is a neurologic condition characterized by acute-onset memory impairment.[7] Although it usually manifests as anterograde amnesia, which makes it distinguishable from dissociative amnesia, retrograde amnesia is also common. The majority of patients experience recovery within 24 hours of onset of symptoms.

In conclusion, this case report highlights that the diagnosis of dissociative amnesia can be challenging, and comprehensive history and collateral information are essential for an accurate diagnosis.

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