

Diagnosis and Hypnotic Treatment of an Unusual Case of Hysterical Amnesia

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Abstract

This article reports on the use of hypnosis to facilitate the diagnostic process and the treatment of an unusual case of adult psychogenic amnesia. An Iraqi citizen living in the U.S. developed an atypical case of Dissociative Amnesia, Systematized type, post-automotive collision. The amnesia presented with features encompassing complete loss of the patient's native language. Dissociation theory as a conceptualization of hysterical reactions was employed as the basis in the formulation of this case. The differential diagnosis was facilitated by the Hypnotic Diagnostic Interview for Hysterical Disorders (HDIHD) Adult Form, an interview tool specifically designed for cases such as this. Treatment consisted exclusively of ego strengthening and time projection approaches in hypnosis. It was hypothesized that, as the coping capacities became more viable, the dissociative symptoms would remiss. After 6 weekly visits the patient regained complete command of his native language. Follow-up at 6 months indicated that the patient remained devoid of symptoms.

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Dissociative Amnesia

Classified as a Dissociative Disorder, Dissociative Amnesia is included in the DSM-IV-TR (American Psychiatric Association, 2000) in the category or cluster of disorders which involve dysfunctions in the normally integrative functions of memory, identity, perception, or consciousness. The Dissociative Disorders are usually associated with trauma in the recent or distant past, or with intense internal conflict such that the patient's memory is disrupted and may be forced to separate from incompatible or unacceptable knowledge, information, or feelings (Spiegel & Cardena, 1991). In Dissociative Amnesia, patients forget important personal information or events usually connected with trauma or severe stress. The information that is lost to the patient's memory is usually too extensive to be attributed to ordinary absentmindedness or forgetfulness related to aging (American Psychiatric Association, 2000). This disorder is characterized by a blocking out of critical personal information, usually of a traumatic or stressful nature. Dissociative Amnesia, unlike other types of amnesia, does not result from other medical trauma (e.g. head trauma) (Coons, 1986; 1998). Dissociative Amnesia appears to be caused by stress associated with traumatic experiences endured or witnessed, including but not limited to, physical or sexual molestation, assault and rape, wartime combat, disasters of nature, major life stresses, parental abandonment, death of a loved one, or financial hardships (Coons, 1986; 1998).

Subtypes of Dissociative Amnesia (Maxmen & Ward, 1995):

- Localized amnesia can present in an individual the absence of memory of specific events that took place, usually traumatic. The loss of memory is circumscribed for a specific segment of time.
- Selective amnesia occurs when a person can recall only fragments of events that took place in a demarcated period of time.
- Generalized amnesia is diagnosed when a person's amnesia encompasses his or her entire life.
- Systematized amnesia is characterized by a loss of memory for a specific category of information. A person with this disorder might, for example, be unable to remember how to speak a language for which he or she had total fluency.

There are few case reports of psychogenic amnesia or Dissociative Amnesia, Systematized Type, circumscribed to loss of a language. Glisky et al. (2004) reported on a case of psychogenic amnesia in which the individual lost access not only to his autobiographical memories but to his native German language. Results from the neuropsychological, behavioral, electrophysiological and functional neuroimaging tests conclude that this individual suffered an episode of psychogenic amnesia during which he lost explicit knowledge of his personal past and his native language.

Tsuruga, Kobayashi, Hirai, and Kato, (2008) reported on a case of foreign accent syndrome (FAS) without organic brain syndrome. The patient was a 44-year-old woman who developed panic disorder a year after her father's death. She then developed aphonia. Organic brain diseases were subsequently ruled-out and she was diagnosed with Dissociative Disorder. This is a unique and clinically interesting report because case reports of dysprosody are unusual and often involve organic brain diseases. These authors (Tsuruga, Kobayashi, Hirai, & Kato, 2008) formulated the foreign accent syndrome (FAS) in the patient as a variant of aphonia, and they attributed psychodynamic interpretations to patient's presenting condition.

Although it is clearly understood that the Dissociative Disorders are “functional” in nature this does not mean that they lack an organic basis. Black, Seritan, Taber, and Hurley (2004) asserted that all mental states and conditions are ultimately rooted in neural activity. This point is driven further by recent advances in brain-imaging technology which offer the promise of revealing the neural correlates of the hysterical reactions (Ward, Oakley, Frackowiak & Halligan, 2003; Vuilleumier, 2005).

Hypnosis in Diagnosis and Treatment

The role of hypnosis in the treatment of Dissociative Amnesia has received empirical support and validation from studies in functional neuroimaging (Arias, 2004). In an expansive review of current neuroimaging studies, the author divided psychogenic disorders into: a) dissociation (with memory, consciousness and self-identity impairment), and b) disturbances with somatizations, divided into somatoform (unconscious), factitious (voluntary search for patient’s role) and malingering (searching for material gain). Special emphasis was placed on conversion or hysteria included in somatoform disorders. Arias (2004) reported that the data suggested an important role of unconscious and involuntary inhibition in the loss of volition (similar to hypnosis and different from malingering). It is different in that normal activity in certain brain areas (motor or sensory cortex) is blocked by other areas related to emotional integration (anterior cingular and orbitofrontal cortex). He further compared the neuroimaging profiles of individuals with psychogenic disorders to neuroimaging profiles of subjects in hypnosis. The imaging results indicated a similarity between psychogenic reactions and hypnotic states (and showed no similarities to imaging profiles of malingerers) (Arias, 2004). By reporting the findings of similarity between the two phenomena, Arias set the tone for further investigations of the role of hypnosis in the care of psychogenic reactions.

The Hypnotic Diagnostic Interview for Hysterical Disorders (HDIHD)

The HDIHD interview method draws from the model for ideodynamic signals of Ewin (2002) and Cheek and Rossi’s (1988) ideomotor methods for analysis and questioning. It was also influenced by Hammond (1998a & 1998b) who incorporated ideas from Cheek and LeCron (1968), and Barnett (1981) to develop his handout “Ideomotor Exploration: The Seven Keys.” An additional source that the HDIHD was modeled after was the “how-to” manual by Ewin and Eimer (2006), an instructive manual in the use of ideomotor techniques. The HDIHD questionnaire is included in the Appendix.

Clinical Case

The patient was a 28-year-old male from Iraq who was employed by an independently wealthy family as their chauffeur and general assistant. The patient’s family was in Iraq and, as a result of the violence and unrest in that country, he had lost two cousins who were killed by roadside bombs. He sought psychiatric help to deal with anxiety and panic attacks secondary to fears and worries for his family’s well-being. He was taking Lexapro 30 mg. and Alprazolam 0.5 mg 3 times a day.

The precipitating event leading to his amnesia was a minor automobile collision while acting as chauffeur to his employers. He did not sustain any injuries nor was he unconscious. The patient immediately developed a fugue state with disorientation and feelings of derealization which lasted 15 minutes. He did not need to go to the hospital and was able to drive his employers home after the accident/police report was completed. Later that evening when he tried to make a call to his family he realized that he was unable to

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understand and speak his native language. The following day he saw his psychiatrist who referred him for a neurological consult. The neurological examination including MRI and EEG measures were completely negative except for the obvious loss of his language skills. He did not present with other disorders of memory and all neurological signs were intact. He was given a working diagnosis of R/O Dissociative Amnesia and was referred for diagnosis and treatment with hypnosis.

Mental Status Examination

The Mental Status Examination indicated a respectful and cordial Iraqi citizen who was fluent in English and who was a legal resident working in the U.S. He was oriented and had compromised attention and concentration faculties mostly due to anxiety associated with the presenting problem. His memory was intact except for the amnesic reaction and resulting loss of his native language. He was being treated psycho-pharmacologically for depression and anxiety adjustment reactions secondary to the perils his family faced in Iraq as a result of the civil unrest and war. His psychiatrist's report ruled out psychotic disorders and bipolar psychopathology. There was neither family history of psychiatric disorders nor a history of alcohol and drug abuse, nor did the patient consume alcoholic beverages or use illegal drugs. The consulting neurologist ordered radiological and neurological studies which were negative. He was diagnosed with Adjustment Disorder with Mixed Emotional Features. The referring psychiatrist requested assistance with the diagnosis and treatment of the loss of language.

The patient met the criteria for Dissociative Amnesia which included:

- A. The symptoms or experiences cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- B. The disturbance is not due to the direct physiological effects of a substance or general medical condition.
- C. The predominant disturbance is one or more episodes of inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
- D. The disturbance does not occur during the course of other Dissociative Disorders (Maxmen & Ward, 1995).

Hypnotic Interview

The hypnotic interview with the HDIHD provided corroborating evidence to support the differential diagnosis of Dissociative Amnesia, Systematized type. The patient, while in hypnosis, spontaneously and without prompting by this examiner, responded to the items on the HDIHD in his native language. A repeat of the HDIHD interview was recorded, with the patient's authorization, and examined and translated by a college professor of languages. His verbalizations in the recording were recognized as the Arabic language. The hypnotic interview with the HDIHD provided material that corroborated the formulation that unmitigated stresses related to his family's situation had exceeded the patient's coping resources. The information obtained from the HDIHD interview further indicated that the hysterical reaction was an effort to limit the degree of ominous information being experienced by him. The patient's ability to speak his native language supported the neurological impression of Dissociative Amnesia. Post-hypnotic amnesia for these findings was suggested at the culmination of the session.

Formulation

The nature and extent of this patient's stress levels stemmed from the perils that his family faced in Iraq. The stress levels exceeded the limits of his coping capacities and precipitated a hysterical reaction which manifested as Dissociative Amnesia, limited to his ability to speak and understand his native language. This hysterical reaction was apparently created to provide the patient an insulating barrier and a protective shield against additional traumatic news reaching him. It was further formulated that as his coping capacities strengthened, the amnesic reaction would remiss.

Treatment

Treatment consisted of 2 months of weekly visits for therapy with hypnosis. The Abstract Technique for Ego Strengthening originated by B. J. Gorman and reported in Hammond (1990) was the model employed for this patient's treatment. This model adheres to an indirect and non-authoritarian orientation and allows the patient, under hypnosis, to select from the available suggestions presented to him those which his unconscious deems most necessary and useful. This approach began with the indication that there will not be direct suggestions regarding removal of the presenting problem. Instead, a host of *key words* with a salutary orientation are provided, under hypnosis, with an indication for the individual to think about their meaning and associations. The key words in this method are *good health, success* and *motivation*. The author provides a host of inquiries, questions and leading thoughts intended to indirectly generalize the healing capacity of these key words to encompass all of the characteristics of the problem area. For instance, among the host of messages associated with what constitutes good health the following are conveyed: "good health can mean not only physical health, but also a healthy attitude of mind, stronger nerves, greater feeling of self-esteem, greater feeling of well being, complete control of thoughts and emotions" (p. 134). The author goes on to include messages involving multiple elements of body, mind and spirit under the additional key words *success* and *motivation*.

A variant of the model suggested by Gorman (Hammond, 1990) was designed for this patient's case. The following is an abbreviated version of the protocol used with this patient after induction of hypnosis was accomplished using eye fixation and deepened using a "safe place" method (Hammond, 1990).

"I am going to ask you to think about certain words and their associations for you. I want you to think lazily of these words, to turn them over in your mind, to examine them, to let them sink deeply into your subconscious mind until they become woven into the very fabric of your substance and of your self-image. Think of the words health, success, and motivation" (Hammond, 1990, p. 134).

Inquiries, questions and leading thoughts intended to indirectly generalize the *healing* capacity were offered. These included good health of body, mind and spirit, psychological balance and the ability to meet crises in healthy terms. Moreover, Gorman's reference to a capacity to have control of the thoughts and emotions was employed (134).

With regard to the key idea *success*, references were made to various areas of the patient's past life when he had overcome particular problems. Again, the key to this approach is to provide the patient with a host of salutary suggestions, in a "shotgun-like" fashion with instructions that the subconscious mind will select and accept those most necessary for its well being.

With regard to *motivation*, it was suggested that he develop the ability, desire and determination to achieve a certain objective; to develop a progressive strengthening of one's desire to be in charge of one's life; to develop a stronger and stronger desire to

overcome particular challenges; and to develop the motivation to follow through and generate new and healthier modes of responding to stresses in life. Finally, the patient was asked to imagine being projected ahead in time and to see and feel himself as the recipient of the hypnotic suggestions of *good health, success and motivation*. Theoretically, the concept of age progression and all techniques that feature this orientation are designed “to act as an antidote to the patient’s sense of futurelessness” (Frederick & Phillips, 1992, p. 82). Moreover, age progression techniques contribute to the enhancement and strengthening of the individual’s ego structures (Hartland, 1965, 1971; Stanton, 1989; Torem, 1990). Phillips and Frederick (1992) elaborated on this point and added, “when an individual achieves a positive view of the future, in a hypnotic state, she/he is already viewing an ego that has been positively enhanced in the mirror of the mind” (p. 100).

Conclusion

This most interesting and unique case of Dissociative Amnesia was treated successfully with an indirect approach (Gorman, 1990) in 8 sessions of weekly visits. The resolution of the problem and total recall of the patient’s native language was as sudden and dramatic as its onset. On the sixth visit the patient reported a spontaneous recovery and the ability to speak and understand Arabic. He was seen for 2 subsequent visits and discharged with a referral back to the primary psychiatrist. His psychiatrist reported that the patient was devoid of Dissociative Amnesia symptoms 6 months later.

This case report, as with all non-randomized, non-experimental case reports, suffers from limitations in its predictive value. The spontaneous resolution of symptoms may have been attributable to other elements of the treatment including the characteristics of the therapeutic relationship (Ahn & Wampold, 2001; Chwalisz, 2001). Furthermore, the psychometric validity of the diagnostic measure employed, the HDIHD, is yet to be determined and as such, relying on it for diagnostic purposes may have led to an unfounded diagnosis. The intent of presenting this case was to further awareness about a most unique condition.

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Appendix

The Hypnotic Diagnostic Interview For Hysterical Disorders: Adult Form

After hypnosis is induced by the practitioner's preferred method, the following direct suggestions are given:

You can now go to your favorite place and keep busy while taking part in (the individual's favorite activity). You will be so completely busy and distracted enjoying (favorite activity) that at times my voice will seem very far away and at other times you may not even hear it. The unconscious or deep part of your mind will hear me and will be able to follow along with my questions even though you will be doing what you like so much (activity).

(At this point, a very brief explanation of the function and role of the unconscious or deep part of the mind is given.) I like to speak in terms of the ever vigilant and all knowing qualities, characteristics and functions of the unconscious or the deep part of the mind.

You will be able to answer questions without having to interrupt your favorite task. You will use this finger to answer Yes and this other finger to answer No and this is the I don't know finger.

I am going to speak with the deep part of your mind and ask it questions about this problem that you have. All the questions that I will ask are medically necessary and are designed to help with your care and treatment.

- 1) Is it alright with the deep part of your mind for me to ask questions regarding the problem you are having? Do I have permission from the deep part of your mind to proceed with questions about (the problem)?
- 2) Does the deep part of your mind know if this problem is a real problem with your (part of body or function affected by hysterical reaction)?
- 3) Does the deep part of your mind know if this problem was created by your mind? Did your mind create this situation or condition?
- 4) Does the deep part of your mind know if this problem was created to specifically help you? Was it created for your benefit?
- 5) Is it helping you with something that you were not able to live with?
- 6) Does this problem serve a needed purpose? Does it contribute in a helpful way?
- 7) Is there some benefit from it? Are you better off because of it?
- 8) Does it get in the way or prevent you from doing something? Is it a hindrance to you?
- 9) Does it protect you from something you fear? Is it a source of safety to you?
- 10) Does it allow you to avoid something, or keep you from doing something?
- 11) Does it allow you to control or influence someone or something? Is it a means to have power and control and influence?
- 12) Does it punish someone? Is it a way to get back at someone? Do you use it as a form of retribution?

13) Does it protect an image that you have of yourself? Is it a protector of your reputation?

14) Does it help you to save face? Does it protect you against embarrassment or shame?

15) When I count to three the problem will come to your mind and you will be able to tell me how this problem is trying to help you. You are still in hypnosis yet you can speak to me. You can tell me now how this problem is trying to help you. You can now go back to (safe place). I have some more questions for the deep part of your mind.

16) Does the deep part of your mind know what has to take place for this problem to be able to go away?

17) When will the deep part of your mind decide to stop this problem?

18) When I count to three the deep part of your mind can tell me what needs to happen before the problem will go away. You are still in hypnosis yet you can speak to me. You can tell me now what needs to happen before the problem will go away. You can now go back to (safe place). I have some more questions for the deep part of your mind.

You are in hypnosis and in hypnosis you can do things that are impossible for you when you are awake. For instance, you are unable to (hysterical symptom) yet if I asked you while in hypnosis to (remove hysterical symptom), it is very likely that you will be able to (remove hysterical symptom).

19) Will the deep part of your mind allow you to perform this activity to establish the fact that you are in control of your life?

When I count to three the deep part of the mind will allow you to (perform the action). You can now go back to (safe place). I have some medical suggestions for the deep part of your mind.

The deep part of your mind will help you by not allowing you to remember any of the questions and your answers and the information that has been received. There is plenty of time for you to be able to remember this information when you are ready to and not any sooner.