

## Amnesia Seen in Schizophrenics

Michio YAMADA, Tamio OTA and  
Masato MURATA\*

*Department of Neuropsychiatry, Yamaguchi  
University School of Medicine, Ube*

*\*Division of Neurology, Yamaguchi Red Cross  
Hospital, Yamaguchi*

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### INTRODUCTION

As a rule, schizophrenics do not have their consciousness impaired or deteriorated as a result of their illness. The exception, if any, can occur during catatonic excitement, particularly catatonic stupor, when the patient falls into a dreamy state or a state of mental vacuum followed by disturbance of memory or inability to recall<sup>1)</sup>. In the wake of our preceding report dealing with a case of retrograde total amnesia<sup>2)</sup> in a schizophrenic, 3 cases of amnesia attributable to psychogenic factors are presented in this paper.

### REPORT OF CASES

Case 1: A 33-year-old, unmarried, former public service worker. Bereft of his parents, the patient has a half brother and a sister, both married and physically and mentally healthy. His hereditary history is not contributory and he has no previous history of brain injury or disturbance of consciousness.

After graduating from college he served in a public office. At the age of 25, he had the primary onset of paranoid type schizophrenia, which required 2 year hospitalization before remission was obtained. Soon thereafter, however, he had a relapse and was admitted again to a mental hospital, when he gave up his office. Treatment with neuroleptic drugs relieved him of much of the delusions he had so far had, however, abulia became prominent during blunting of the affect. At age 32, although he still remained somewhat defective, he was discharged on the ground of his being well enough to justify rehabilitation. Immediately after discharge, he began to work as a resident mechanic. Interpersonal problems, however, caused him to give up his job one month later. His experiences of the 10 days following that day until his subsequent third admission remains a blank in his memory. According

to the statement of his brother and friends, as well as the protocol drawn up in a police station, he made a visit to his friend on the night he quit his job. He claimed without reserve that he was being shadowed and that he felt anxious about his future although his colleagues were all very friendly to him because of his having a fortune left by his father. He stayed with the friend for two nights and with his brother for another two nights, during which time he displayed no behavioral abnormalities except the persistent delusion of persecution. On the night of the 5th day, after he left his brother's house without notice, he intruded upon a TV station intending to break the broadcasting equipment, computers, etc. with a hammer. He was arrested while absentmindedly lingering at the scene of his violence. He was taken to a police station and hospitalized the next morning.

At the time of admission he was restless, repeating that his memory had been pilfered by a UFO. No EEG abnormalities were noted. While being interviewed in a state of somnolence brought about by 10 mg diazepam given intravenously, he failed to bring back his lost memory. An inkblot test revealed his desire to be an acceptable member of society mingled with the negative attitude of being content with things as they were.

Now 4 months after admission the patient is doing well, without trouble in the ward, although he still remains somewhat apathetic and hypobulic. He has managed to avoid the matter of what he experienced just before his admission.

Case 2: A 23-year-old male university student. The patient's father is a high school teacher who is severe with his children. His mother is mild and faint-hearted. He is the youngest of four children. His hereditary history is somewhat contributory: his maternal uncle committed suicide in adolescence for no particular reason. His previous history is negative for brain injury, convulsions, or disturbance of consciousness.

The patient had hebephrenic type schizophrenia when he was in his second year at a senior high school. Three months of hospital treatment were required, subsequent ambulatory treatment was continued for a year with satisfactory results. During the summer vacation when he was a senior in college, he stayed in the laboratory till late at night for consecutive days, making an experiment for his graduate thesis. According to his tutor, he had at that time a reduced ability for concentration, being somewhat cursory in his experiment. One day in autumn after a new school term began, while on campus, he suddenly found himself at a loss for where he was. He felt uneasy as his class-

mates looked strange to him. Three days after the disquieting event, his memory broke off. According to the police record, as well as the statement of his friends and the housewife with whom he boarded at that time, he ran off the campus crying and bought some apples at a fruit store in the neighborhood before going back to his lodgings. He slept till night. Late at night he awoke and sliced the apples into pieces, which he threw from the window. Then he wandered into the street never to return. The next morning, since his whereabouts were unknown, the housewife informed his family of the fact together with his queer behavior on the night before. The day after next, he made an abrupt inquiry at a police box concerning the policeman's identity. He solicited the policeman to make inquiries about his own identity. The clothes he had on were torn at places; he had lost his spectacles as well as his wristwatch and purse. Being unable to recognize his parents who came to take over him, he said to his mother that he had "seen her somewhere before." He was hospitalized immediately, when he perplexedly muttered to himself to the effect that he was utterly at sea. The EEGs taken at the time of admission and on 3 subsequent occasions were consistently normal. Three days after admission, while being interviewed with 10 mg diazepam (IV), he could recall his experience of having bought some apples and wandering about a place like a park. No other experiences were recalled to his mind. He progressed so favorably that he was discharged after 2 months of hospitalization. He is now under ambulatory treatment. His memory of the experiences cited above remains blank. An inkblot test revealed suppression of the ego with an explosive personality.

Case 3: 33-year-old unmarried man. The patient, who was once a Self-Defence Force official, is now a car repairman. His parents are supported by their farm. He has two brothers, one older and the other younger; the latter is currently hospitalized for treatment of hebephrenic schizophrenia. The patient has no previous history of brain injury, convulsions, or disturbance of consciousness.

As a child the patient was taciturn, stubborn, and fond of tampering with machines. After completing senior high school, he joined the Self-Defence Forces to be a member of a ground crew. At the age of 30, due to his lack of proficiency and rather blunderous performance, he was asked to leave. It was at that time that he had the onset of illness, according to a member of his family. After discharge, he served at auto repair shops. As a car repairman, he changed his employment quite frequently because it was not his nature to stick to his job. At age 33 he left home without notice and then got lost. His family paid

no particular attention to this, as he had stayed out many times without the knowledge of his parents. A week later he was found in the cockpit of a helicopter moored in an airfield. He was placed under police protection and then hospitalized. Upon admission, he had clear consciousness with no EEG abnormalities. However, he could not remember what had happened to him for the last week. He merely repeated that he had long dreamed of piloting a plane. Manifestations of hebephrenic type schizophrenia came to the foreground in the course of his subsequent 6 month hospital stay. An inkblot test disclosed failure of self-control.

### DISCUSSION

A feature common to all 3 cases illustrated above is episodic amnesia that developed in a male, unmarried, schizophrenic in the second or third decade of life. No abnormal EEG patterns were noted in these patients, who were all of average or above-average intelligence.

Schizophrenics rarely have disturbances of consciousness developing in the course of illness. Such disorders may occur, if ever, only during catatonic stupor. Under such circumstances the phenomenon of blocking may more often place the patient in a state of mental vacuum rather than deteriorated consciousness, a state which is occasionally manifested itself as an amnesia-like symptom<sup>1)</sup>. More common is clouding of consciousness associated with "temporal lobe epilepsy" which is due to a focus present in the temporal lobe. This form of disturbance of consciousness may express itself as fugue or running away<sup>3)</sup>. Fugue or runaway reaction may also be seen in personality disorders with lability of mood, abnormal psychogenic reactions, acute confusion, or adolescent crisis. In the 3 patients under investigation, epilepsy may reasonably be ruled out in view of the fact that no abnormal EEG patterns of epileptic origin were observed on any of several occasions; moreover there was no neurological evidence in support of organic changes in the brain, e.g., trauma, intoxication, inflammation, or circulatory failure. It is true that all these patients did display some deviate behavior. The deviation, however, is not of the innate type postulated by Schneider<sup>4)</sup>, rather, it is attributable to schizophrenia itself. Disturbances of consciousness often develop in "symptomatic psychoses", i.e., mental disorders accompanying somatic illness not involving the CNS<sup>5)</sup>. It is evident that our patients are not of the exogenous reaction type, since they developed no serious diseases of somatic nature. Adolescent crisis results from the conflict between ego and superego that arises in the course of psychosexual and

emotional development coinciding with the appearance of secondary sex characteristics in adolescence. Psychologically, it has been taken for a manifestation of identity crisis<sup>6)</sup>. In such a situation, running away can occur clinically as a primitive reaction or behavioral aberration. In our patients, no significant role can be supposed to have been taken by psychological factors characteristic of adolescence, although, it is quite probable that there was a conflict involved in bringing the psychological mechanism of fugue into operation.

If epilepsy can be excluded from the list of possible causes for disturbances of consciousness not associated with organic changes in CNS, then the mechanism by which memory is retracted or repressed comes into question first. This mechanism is equivalent to what Freud called defense mechanism<sup>7)</sup>. Defense mechanism serves the purpose of diminishing or even extinguishing the changes that may jeopardize the security and homeostasis of the psychophysiological individual. It works on some representation, including memory and illusions, which are connected with impulses drives. In our 3 patients, their autistic tendency and difficulties in interpersonal relationships as fundamental symptoms of schizophrenia, which made their social adaptation difficult, probably called such a psychological mechanism into play with the result that retrospective revocation of memory took place. Defense mechanism is made operative by the ego, although it remains debatable whether this presupposes the presence of a well-organized ego. Disturbance of self-consciousness, if it is among the cardinal symptoms of schizophrenia, also remains to be examined in this connection.

Amnesia in our patients, assuming that it was in the sphere of schizophrenia, can be taken for negativism arising in a selective manner: "négativisme mnésique" or "elektiver Negativismus."<sup>8)</sup> There are a limited number of cases, so far reported, in which the symptom developed in a schizophrenic<sup>2,9)</sup>. In these cases the symptom persisted long, for more than 10 years in some of them. Negativism is probably an expression of disturbance of will due to blocking in schizophrenics: it is "intellektueller Negativismus" that prevents memory from being retrieved<sup>10)</sup>. Whether this is also the case with our patients, in whom the symptom was episodic and of short duration, is somewhat difficult to determine. In view of the clinical course following admission in our patients, the possibility of their having feigned amnesia may be ruled out, although not a few patients complaining of disturbance of memory have been diagnosed as malingery<sup>11,12)</sup>.

The possibility of the symptom representing "negative Halluzination

des Gedächtnisses" or Illusionen der Erinnerungen"<sup>13)</sup> should also be assessed. In the former, however, the blank in memory will be filled up as psychic symptoms are ameliorated, while the latter is rather partial negation of recollection and, hence, somewhat divergent from the symptomatologic picture in our patients. Akin to these symptoms is "délire de négation"<sup>14)</sup>, in which negation is both intentional and conscious. Some instances have been made public, in which the symptom developed without concurrent psychotic manifestations. "Katathyme Amnesie" is more psychogenic in origin<sup>13)</sup> and also seems to be partial in involvement: the patient strives to run away from reality, which is difficult to deal with, into the realm of autism or a world of reminiscence of the past.

Disturbance of memory or amnesia in our patients may be regarded not as a symptom of schizophrenia but rather as a psychogenic reaction of the type that presupposes a defect of personality caused by the illness. The symptom appears to have stemmed from the ambivalent desire to be an accepted member of society while at the same time retreating into an autistic world of sheltered peace.

#### SUMMARY

Episodic amnesia seen in 3 cases of schizophrenia has been reported. The symptom in these cases is considered to represent a psychogenic reaction developing in schizophrenics and not a result of clouding of consciousness. It is not peculiar to schizophrenia but rather akin to catathymic amnesia of emotional origin.

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