DISSOCIATIVE DISORDERS

Dissociative Amnesia

DA

DSM-5-TR 300.12 (FUGUE 300.13) | ICD-10-CM F44.0, F44.1

Inability to recall important autobiographical information, usually traumatic, that far exceeds ordinary forgetting and has no neurological cause.

12-MONTH PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~1.8% (US community sample)	Any age; peaks in adulthood	~2.6:1 female:male	Acute; recall often returns

CLINICAL PICTURE

- Presents as a gap rather than a complaint: patients often do not know what they have forgotten, and family or police identify the missing hours, days, or years.
- Localized amnesia for a circumscribed traumatic interval is most common; selective amnesia leaves fragments of the event intact while erasing the remainder.
- Generalized amnesia for identity and entire life history is rare, dramatic, and typically brings the person to an emergency department alert but disoriented.
- Dissociative fugue adds purposeful travel or bewildered wandering, occasionally with assumption of a new identity, lasting anywhere from hours to months.
- Semantic and procedural knowledge stay intact: patients drive, read, cook, and use language normally while autobiographical retrieval fails completely.
- Depersonalization, depressed mood, self-injury, and suicidality cluster around the amnestic episode, especially in the period when memory begins to return.

DIAGNOSTIC CRITERIA AT A GLANCE

- Inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is far beyond ordinary forgetfulness.
- Most presentations are localized or selective for specific events or periods; generalized amnesia for identity and life history is recognized but uncommon.
- The memory loss causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Not attributable to a substance, seizure, head trauma, or another neurological or medical condition, all of which must be actively excluded.
- Not better explained by dissociative identity disorder, PTSD, acute stress disorder, or a neurocognitive disorder; specify if dissociative fugue is present.

NEUROBIOLOGY & PHYSIOLOGY

- Functional imaging during amnestic states shows heightened prefrontal inhibitory activity alongside reduced hippocampal recruitment on autobiographical retrieval.
- Markowitsch's mnestic block syndrome model localizes the deficit to right temporofrontal networks, with regional hypometabolism reported on FDG-PET.
- Acute stress floods glucocorticoid and noradrenergic systems, impairing hippocampal encoding and consolidation while strengthening amygdala-based emotional traces.
- Structural studies in chronic dissociative disorders report smaller hippocampal and amygdalar volumes, paralleling findings in severe childhood maltreatment.
- No neuronal loss is demonstrable; the amnesia is a reversible retrieval blockade, which explains abrupt and sometimes complete recovery of memory.
- Early, chronic, interpersonal trauma is the dominant risk factor, with genetic contribution to dissociative capacity modest relative to environmental adversity.

PSYCHOLOGICAL MECHANISMS

- Betrayal trauma theory holds that amnesia preserves attachment to a caregiver who is also the source of harm, making not knowing temporarily adaptive.
- Retrieval suppression, demonstrated experimentally in think/no-think paradigms, offers a mechanism by which repeated avoidance degrades voluntary access.
- State-dependent and context-dependent encoding means material laid down under extreme arousal is poorly accessible in ordinary states of consciousness.
- Avoidance of trauma reminders is negatively reinforced by immediate relief, entrenching the amnestic barrier and blocking corrective emotional processing.
- Detachment and compartmentalization are distinct dissociative processes; amnesia is compartmentalization, in which intact material is walled off from access.

DIFFERENTIAL & COMORBIDITY

- Exclude transient global amnesia, complex partial seizures, traumatic brain injury, hypoxia, and Wernicke-Korsakoff syndrome using history, exam, imaging, and EEG.
- Alcohol blackouts and benzodiazepine or anticholinergic effects produce anterograde gaps, unlike the retrograde autobiographical loss of dissociative amnesia.
- In dissociative identity disorder amnesia is recurrent and paired with identity discontinuity; PTSD includes amnesia limited to parts of the traumatic event.
- Malingering and factitious presentations arise in forensic and disability contexts; look for selective gain, inconsistent effort, and below-chance test performance.
- Comorbid PTSD, depression, somatic symptom disorder, and substance use are the rule, and suicide risk rises sharply as blocked memories become accessible.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication treats the amnesia itself; pharmacotherapy targets comorbid PTSD and depression, most often an **SSRI** such as **sertraline 50-200 mg/day**.
- **Prazosin 2-15 mg at bedtime** reduces trauma nightmares and nocturnal hyperarousal that destabilize patients during any memory-focused work.
- Avoid standing benzodiazepines: they impair new encoding, deepen dissociation, and carry dependence risk in a chronically traumatized population.
- Drug-facilitated interviews using **amobarbital** or lorazepam are largely historical, carry a real risk of false memory, and are not standard care.
- Treat sleep disruption and chronic pain aggressively, since exhaustion and physiologic stress lower the threshold for further dissociative episodes.

PSYCHOTHERAPY

- Phase-oriented trauma treatment is the standard per **ISSTD** guidelines: safety and stabilization first, then graded processing, then reintegration.
- Grounding, affect regulation, and dual-awareness skills are taught before any memory retrieval, since premature abreaction reliably worsens outcome.
- **Cognitive processing therapy** or **prolonged exposure** apply once dissociation is contained, targeting trauma appraisals rather than chasing lost content.
- **EMDR** is used in later phases with modified protocols and a slowed pace to prevent flooding and re-dissociation during bilateral stimulation.
- Hypnosis may serve trained clinicians for containment and controlled recall, with explicit caution that hypnotic recall is not evidence of historical accuracy.

ADJUNCT & SUPPORTIVE

- Screen and track with the **DES-II**, and confirm the diagnosis with the **SCID-D**, which remains the reference standard structured interview.
- Do not pursue forensic corroboration inside the therapy; recovered memories should not be treated as verified fact without independent evidence.
- Safety planning is essential at the point of memory return, when suicide risk and self-injury spike as previously walled-off affect becomes accessible.
- Coordinate with family on identity confirmation, financial and legal protection, and reorientation during fugue and generalized amnestic presentations.
- Inpatient or partial hospital care is indicated for generalized amnesia, fugue with disorientation, or acute suicidality with ongoing dissociation.

CLINICAL PEARLS

- Retrograde autobiographical loss with intact new learning is dissociative; the reverse is neurologic.
- The patient rarely reports the gap; collateral history is what uncovers it.
- Suicide risk peaks when the memories return, not while they are absent.

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NOTE

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