SIMULATED AMNESIA FOR IDENTITY TREATED BY ELECTRICALLY INDUCED EPILEPSY

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Inability to recollect identity is commonly complained of in hysterical fugue states, and sometimes by borderline hysterics and malingers. It is occasionally seen after an epileptic fit or with serious organic brain damage or wasting.

Clouding of consciousness (as in epilepsy and concussion) or intellectual impairment (as in senility) is characteristic of the organic type. As an organic phenomenon inability to remember one's identity implies such a profound disturbance of brain function that memory, judgment, and even simple intellectual processes are bound to be impaired.

Inability to identify oneself, with clear sensorium and intact intellect, cannot be attributed to a local brain defect. Thus a patient who persists that he does not know who he is and has no recollection of his life's history up to the time of the examination, but is otherwise intellectually clear, is either feigning or suffering from a true hysterical amnesia. In the latter case it should be possible to restore memory easily by hypnosis or other usual psychotherapeutic procedures within a few days, especially if full use is made of the associations of everyday life, such as press news, sporting events, and the like.

Almost certainly, all continuously resistant subjects are malingers. It is very doubtful if a genuine psychological amnesia persisting for years has ever occurred, although this idea has proved a plot for various successful novels and screen plays. A good account of amnesic states is given by Parfitt (1944).

Malingering

We have never seen a case of "primary malingering"—that is, deliberate denial of knowledge of identity without some previous hysterical state. We believe that it is very rare and that it is likely to be used only in situations where an individual wishes to escape recognition and is unable to establish another identity or think of a better excuse. For this form of amnesia is bound to bring the individual immediately to hospital—where his movements will be restricted and he will be under the notice of the police—and to stir up interest and stimulate research into his past. Thus it will not be used by a criminal with a previous police record who wishes to escape detection for a recent crime; the fingerprint service and the B.B.C. would make it useless. Nor will a malingerer simulate loss of identity near his home, where he can be recognized by others or confronted with his parents. The lie has purpose only if a patient wishes to make use of a hospital or plead a psychiatric excuse for conduct. Thus we find it used by hysterics who wander from home unable to face some situation, by ex-gaolbirds seeking temporary lodging, or by deserters from the Forces.

The pretence is difficult to keep up and can succeed only if the patient has had experience of being treated for hysterical amnesia and knows the kind of investigation that will be made and the questions he will be asked.

In our experience the simulation is always secondary, and is either the continuation of a hysterical episode—the patient keeping up the pretence after his memory has been restored because he finds it convenient to do so or because he cannot face the results of exposure—or is used by hysterics who have had previous attacks of genuine hysterical amnesia.

Hysterical behaviour is facilitated by previous attacks, and the pattern of each is usually the same. This is as true for psychic as for motor manifestations. Thus amnesic or wandering states are rarely isolated episodes in the history of the hysteric, and, after having occurred a few times, a very trivial stimulus may suffice to produce an attack. This probably accounts for the ease with which professional mediums pass into trances, for states of dissociation are easily induced by frequent repetition.

Hysterics feigning amnesia may even come to doubt their own reality and so develop a perplexed cloudy state. Our patient, for example, would repeat his name over and over again to himself, and told us subsequently that at one time he used to write down his real name on a small piece of paper and pin it to his pyjamas at night, lest he should forget it.

Simulated loss of identity is therefore a lie that comes easily only to the hysteric, and it may be a pattern of conscious behaviour in a certain situation established by a previous unconsciously motivated habit.

These cases are most difficult to treat. They handle hypnosis and narco-analysis in the most guarded way, and usually reveal false clues. They become more expert with every subsequent session. If the intravenous narcotic or ether is pushed they may feign sleep so that the drug will be withdrawn. They attempt to learn about contemporary life from the papers, the radio, and other patients, and are ready to point out that they have learned about past and current world affairs since entering hospital. This remarkable ability to learn and remember effectively rules out organic brain damage as a factor.

The man whose case is described below kept up his act for many weeks and in three different hospitals. He behaved true to type, improving in co-operation with every session, supplying more and more useless information. He was bold enough to describe real episodes of his life, withholding essential details. He spoke of his experiences in the R.A.F., of accidents and illnesses, described hospitals where he had been treated, and even suggested that he had been a male nurse. All these statements were true, but were given without dates or names of hospitals, so none of his clues could be followed up.

He suggested a name for himself which was false, but it was by this false name that he agreed to be known when he was admitted to hospital.

Case Report

The patient, a man aged 24, was admitted as a voluntary patient to Barrow Hospital, Barrow Gurney, near Bristol. His medical history as known to us at the time of his first examination there was as follows. On the night of June 22, 1948, he reported to the police in Bath, saying that he had a headache with loss of memory. He was taken to a hospital, and stated that he did not know who he was or where he came from, nor could he recollect any facts of his life before reporting to the police. He had some money, but was without identity card or ration book; there was no name or mark on his garments, except a name—afterwards found to be incorrect—on his tie. He was dressed in flannel trousers, sports coat, shirt and tie, shoes, socks, and underclothes. He had no hat. Narco-analysis was attempted on several occasions at this hospital, and he was afterwards transferred to another hospital, where he underwent ether abreaction and other psychotherapeutic procedures. He

informed us that he was still unable to recollect anything relevant in spite of all attempts.

Examination on his admission to our hospital revealed no organic disease or change in the central nervous system, and the electroencephalogram was within normal range. He had a well-healed operation scar of the left forearm, and his nose had been broken.

He gave a clear account of all events subsequent to being brought in by the police about six weeks before. He related episodes of his past life, which he said had been told him by doctors after sessions of ether abreaction and narco-analysis. He stated that he had been an orderly in the R.A.F., and had had an injury to his left arm, for which he was treated. He was discharged from the R.A.F. on psychiatric grounds, and later was a male nurse at a hospital "somewhere in the country." He gave the name and number of the ward in which he worked, but not the name of the hospital. He gave the Christian names of many relatives, but not their surnames.

He persisted that he was most anxious to ascertain who he was, and stated that his desire was to be made well so that he could return to work. While in hospital he read industriously. He showed no obvious concern about being in hospital, and his indifference to the seriousness of his condition was in marked contrast to the concern that he stated he felt.

Obviously further psychotherapeutic sessions were contraindicated, and we were able to prove that the patient was lying. He probably did not have an important criminal record, for he willingly allowed fingerprints to be taken and a description circulated in the *Police Gazette*. Proof of feigning was supplied in the following conversation.

Q.—What would you do if I discharged you from hospital to-day with ten shillings?

A.—I suppose go back to the doctor in Bath.

Q.—But if I warned you that no hospital would accept you, how would you make a start in the world?

A.—I suppose I would have to go to the police.

Q.—How would you set about getting an identity card?

A.—I suppose from the police.

Q.—How would you get food?

A.—I do not know.

Q.—You must know. Please think. What would you do about paying for food as soon as you left hospital?

A.—I do not know. I cannot remember. I suppose I would get help.

Q.—Would you get a ration book, and if so where?

A.—I would have to ask the police where to get it.

Q.—What is rationing?

A.—A system for the fair distribution of food.

Q.—Then what is a ration book?

A.—You forget that since I came to hospital I have read a lot to find out what I am and what I should do. I have studied *Picture Post* and other papers since 1939.

Q.—Why 1939? What has that got to do with it?

A.—I do not know. I cannot remember.

In this way he was caught. He probably knew about identity cards and certainly knew about rationing and the outbreak of war, although pretending that he did not.

He gave his consent to any measure being employed that could restore his memory, including electric convulsion therapy. We are not aware that induced epilepsy has been applied in this way before.

The rationale for induced epilepsy was as follows. During the post-convulsive phase of an epileptic fit neural function is re-established according to Jacksonian rules. Thus, after breathing has returned and while unconsciousness is still deep, spontaneous movements and motor restlessness appear. Speech functions return, with a period of aphasia; knowledge of parts of the body is restored before that of external objects (Hemphill and Walter, 1941). The patient becomes aware of himself and therefore is able to establish his identity before he can be aware of his surroundings or has any other recollection of antecedent events. Thereafter there is an increasing awareness of external reality, with diminishing amnesia; finally, the amnesia contracts until it covers little more than the period from the onset of the fit until cerebral function has been fully restored.

Having regard to the order in which psychic functions return, it was fairly certain that our patient would recollect his name and address, and probably something of his family affairs,

before brain function was sufficiently restored to enable him to remember that he must lie; in other words, to apprehend the situation which demanded the lie and the implications of restored identity requires a much higher degree of cerebral integration and activity than merely to recollect name and address.

It was therefore probable that if the patient disclosed his identity in the post-epileptic state he would be unable to recollect that he had done so—for with cerebral function still low he would be unable to form clear memories, as is seen in alcoholism and in concussion—and that he would persist in his lie as soon as he had sufficiently recovered from the epileptic state. This is in fact what occurred.

Treatment

A major epileptic fit was induced electrically. As soon as breathing was re-established and he was responsive to external stimuli, questions about his identity were repeated until finally he gave his name. As brain function improved he was able to give his home address, his brother's name, and his father's occupation. He then slept. He was interviewed 1½ hours later, when he was completely free from the effects of the epileptic fit. He then said he could not remember anything about the treatment except that the electrodes had been applied to his head. When the name and address he had given were told to him he stared blankly and said they meant nothing to him. The interview then terminated. Check-up proved that he had disclosed his correct name and address. He was informed of this and told that in his own interests he must remain in a closed ward in case there should be a further fugue state. He still denied that the remembered name was correct. The following day he sought an interview, stating that he realized "the game was up," and he then gave a detailed account of his early life. Briefly this was as follows.

The Patient's Previous History

He had been employed in a large electrical firm in the Midlands. A few days before leaving home he had been offered promotion to a responsible post. He felt inadequate to take the post, but as his colleagues knew of the offer he felt that he could not refuse without loss of prestige. Further, he lived in constant dread of his father, whom he could not face. He decided to get away from his place of work and his home. There appears to have been a genuine fugue state similar to what had occurred on previous occasions. He stated that there had been a period of amnesia following mental stress in 1945, when the amnesia was cured by narco-analysis. There were other incidents of a similar nature. Early in 1948 he left home after a quarrel with his father, and was apprehended by the police in another town, where he was standing alone on a river bank. He appears to have feigned loss of memory, and was subsequently admitted to the county mental hospital, where he said he had difficulty in convincing the authorities of his correct name. He admitted that he had once been in the hands of the police as a juvenile for some minor civil offence.

From our assessment and his history, which was confirmed by his parents, he was above the average in intelligence, but always self-centred and prone to hysterical reactions. His home was comfortable. It appeared that the father had always expected much of the son. On the whole the patient enjoyed being in the R.A.F., and it is probably true that there was no amnesic episode until his arm had been injured.

Points of clinical importance in his history are: (1) The patient's basic personality was hysterical and immature, but in spite of poor adjustment at home there was no history of an amnesic episode until he actually came under medical treatment in the R.A.F. (2) The first attacks seem to have been true hysterical dissociation, with true loss of memory, and these were cured quickly by narco-analysis. (3) The patient improved on his medical knowledge by serving as a male nurse even after he had had hysterical fugue states. (4) His apparent loss of memory for identity appeared only after a wandering state had brought him well away from home. (5) It was easy for him to simulate loss of memory for identity, because he had had previous true hysterical episodes with hospital treatment. (6) His carefully conducted defence became stronger as he became more adroit at evading the issues with every attempt at psychotherapy.

Discussion

Induced epilepsy is likely to be of value only in the case of simulated inability to remember identity. The usual procedures should be employed in true conditions of psychogenic amnesia. Induced epilepsy is valueless in restoring truth in any other kind of lie (except perhaps hysterical mutism, deafness, or blindness) because it uses a neural phenomenon which makes the patient able to identify himself correctly before he is capable of remembering external events and sorting them out.

Summary

A case is described in which induced epilepsy was employed to establish identity in a patient who feigned amnesia for his name and the total previous period of his life. This type of amnesia and the neuro-physiological rationale of the treatment are discussed.

REFERENCES

Hemphill, R. E., and Walter, W. Grey (1941). *J. ment. Sci.*, **87**, 256.
Parfitt, D. N. (1944). *Ibid.*, **90**, 511.

AN UNUSUAL CASE OF CHRONIC MYELOID LEUKAEMIA

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The interesting feature of the following case is the response to treatment devised for a mixture of cirrhosis of the liver and myeloid leukaemia.

Case History

The patient, a man aged 61, was admitted to this hospital on March 13, 1946, with chronic myeloid leukaemia, marked splenomegaly, and ascites. A careful history revealed that he had been treated for pernicious anaemia since 1931, but the report of a blood count taken on Dec. 8, 1931, failed to substantiate this diagnosis. It was as follows: haemoglobin, 76%; red cells, 3,820,000; colour index, 1; white cells, 9,600 (polymorphs 75%, lymphocytes 15%, eosinophils 1%, basophils 2%, large hyaline cells 2%, transitional cells 5%).

The next report to which we had access was dated March 11, 1941, and the blood count was as follows: haemoglobin, 98%; red cells, 4,300,000; colour index, 1.14; mean diameter of red cells, 7μ ; nucleated red cells, 1,000 per c.mm.; poikilocytes and polychromatic cells; white cells, 26,000 (polymorphs 56%, eosinophils 1%, basophils 2%, lymphocytes 9%, monocytes

6%, neutrophil myelocytes 20%, eosinophil myelocytes 1%, basophil myelocytes 3%, myeloblasts 2%). The report stated: "The white cell picture tends towards that of chronic myelogenous leukaemia."

On June 14, 1941, the white blood count had increased to 36,000, but the differential percentages remained constant.

No further reports were available until Nov. 3, 1944, when the blood picture was: haemoglobin, 69%; red cells, 3,420,000; colour index, 0.99; nucleated red cells, 1,270; reticulocytes, 2.2%; white cells, 35,700 (polymorphs 44%, eosinophils 1%, lymphocytes 25%, monocytes 12%, myeloblasts 4%, neutrophil myelocytes 11%, eosinophil myelocytes 1%, basophil myelocytes 2%). Blood counts were then taken at fairly regular intervals; these are recorded in Chart 1. In the differential counts the percentage of myelocytes varied between 6 and 30%, while that of the myeloblasts varied between 1 and 23%.

The most characteristic blood count was that taken on Aug. 24, 1948, and is therefore given in detail: red cells, 3,100,000; haemoglobin, 61%; colour index, 0.99; white cells, 17,130. Differential count was as follows: neutrophil polymorphs, 9,350 (55%); basophils, 510 (3%); neutrophil "staffs," 850 (5%); neutrophil metamyelocytes, 1,800 (10.5%); neutrophil myelocytes, 3,150 (18.5%); myeloblasts, 950 (5%); lymphocytes, 340 (2%); monocytes, 0; normoblasts, 90 (0.5%); erythroblasts, 90 (0.5%).

On March 14, 1946, paracentesis abdominis was performed and 12 pints (6.8 litres) of ascitic fluid were removed. The very marked and extensive oedema of both lower limbs was not affected in any way even after massage. On March 15 a blood transfusion of 2 pints (1.14 litres) of blood was given, and this was repeated on March 29, April 4, and May 24. The patient also received massive doses of iron daily.

Paracentesis abdominis was repeated on April 16, and 14 pints (7.95 litres) of ascitic fluid were removed. This process was repeated at rapidly diminishing intervals during the next three months, until as much as 24 pints (13.6 litres) were being removed every five days. The exact dates and amounts are

CHART 2.—Amounts of ascitic fluid withdrawn.

CHART 1.—The blood count.