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CASE REPORT

Missing memories of death: Dissociative amnesia in the bereaved the day after a cancer death

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ABSTRACT

Objective: The death of a loved one is one of the most stressful events of life, and such stress affects the physical and psychological well-being of the bereaved. Dissociative amnesia is characterized by an inability to recall important autobiographical information. Dissociative amnesia in the bereaved who have lost a loved one to cancer has not been previously reported. We discuss herein the case of a patient who developed dissociative amnesia the day after the death of here beloved husband.

Method: A 38-year-old woman was referred for psychiatric consultation because of restlessness and abnormal behavior. Her 44-year-old husband had died of pancreatic cancer the day before the consultation. On the day of the death, she looked upset and began to hyperventilate. The next day, she behaved as if the deceased were still alive, which embarrassed her family. At her initial psychiatric consultation, she talked and behaved as if her husband was still alive and in the hospital.

Results: Her psychiatric features fulfilled the DSM–V criteria for dissociative amnesia. The death of her husband had been very traumatic for her and was considered to have been one of the causes of this dissociation.

Significance of Results: This report adds to the list of psychiatric symptoms in the bereaved who have lost a loved one to cancer. In an oncology setting, we should consider the impact of death, the concomitant defense mechanisms, and the background of the families.

KEYWORDS: Bereavement, Dissociation, Retrograde amnesia, Cancer, Defense mechanism

INTRODUCTION

The death of a person (spouse or close relative, in particular) is one of the most stressful events in life (Holmes & Rahe, 1967). Such deaths can constitute overwhelming or intolerable events for those facing them. It is well known that the bereaved have a variety of distresses: physical (Prigerson et al., 1997; Buckley et al., 2009), psychiatric, psychological (Erlangsen et al., 2004; Cole & Dendukuri, 2003; Zisook & Shear, 2009; Ishida et al., 2012), and behavioral (Prigerson et al., 1997; Grimby & Johansson, 2009).

Dissociative amnesia is characterized by an inability to recall important autobiographical information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting. In addition, the onset of dissociative amnesia is usually sudden. Although overwhelming or intolerable events typically precede localized amnesia, its onset may be delayed by hours, days, or even longer (American Psychiatric Association, 2013). However, to the best of our

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knowledge, there have been no reports about dissociative amnesia in the bereaved who had lost a loved one to cancer.

In this communication, we report a patient who developed dissociative amnesia soon after the death of her husband. She lost all memory of this event the following day.

CASE REPORT

Methods

A 38-year-old woman was referred for psychiatric consultation because of restlessness and abnormal behavior after her husband's death. Her 44-year-old husband had died of pancreatic cancer the day before the consultation. The chemotherapy he had been receiving for five months proved to be ineffective, and palliative treatment was recommended by the attending physician. At this time, his wife attempted to get him transferred to another hospital for radiotherapy. However, he died of sudden massive hematemesis just before his transfer. On the day of his death, his wife looked very upset and began hyperventilating on the ward. Moreover, she refused to return home. The attending physician (a medical oncologist) for her husband promised her that he would follow up with her the next day, so she agreed to leave the ward.

The next day, her family was embarrassed by her because she behaved as if her husband was still alive. Her family brought her to the hospital and consulted her husband's attending physician about this behavior. The attending then requested a psychiatric consultation because of her unusual behavior.

Upon psychiatric referral, she talked as if her husband were still alive and in the hospital. She worried about her husband's medical condition and treatment, and she was concerned about the visiting hours on the ward. She often asked her children about her husband's medical condition and waited to hear from him by text message or phone. She asked them the following over and over again: "Did you get a text message from Dad?" "Why doesn't he make contact with us?" "Dad mustn't be able to make a phone call; he might be sick with fever." "Is he all right?"

When a psychiatrist questioned her about her recent concerns, her answers were about her husband's condition and the next treatment: "I'm just worried about his recovery from the illness. That's all." "I wrote out a list of the hospitals at which he can get treatment all over Japan," she continued. "However, the physician told me something ridiculous. Dad doesn't have much time. I'm really worried about him."

She had no history of prolonged use of alcohol or other substance-induced neurocognitive disorders, as well as no brain injury, seizure disorders, or catatonic stupor. She was also not taking any drugs.

Her psychiatric features fulfilled the DSM−V criteria for dissociative amnesia. The death of her husband had been traumatic and was considered to have been one of the main causes of this dissociation.

She was treated with 5 mg of haloperidol to ensure that she could rest and obtain adequate sleep, and was also treated with psychotherapy. With the psychotherapy, we treated her supportively, not with the goal of making her understand that her husband had died. We also explained her psychiatric symptoms and how to treat her behavior to her family.

The major decisions on how to deal with her were as follows: (1) ensure that she gets the rest that she requires physically and mentally; (2) there is no need to make her understand the fact that her husband has died; (3) when she asks about the death, describe it step by step; (4) let her attend the funeral service, whether or not she can host the funeral; and (5) for a while, make sure that she is accompanied by someone.

The day after the consultation, she gradually recalled memories from before her husband's death. She told her children, "I've gradually understood what happened to him ... he died," and "I'm okay. Sorry for making you worry."

Subsequently, she started consulting psycho-oncologists (a psychiatrist and a clinical psychologist) once a week with supportive psychotherapy. Two weeks after the death, she recalled almost all the situations associated with the event.

Medical History

The patient (a bereaved family member) was a housewife who had no medical history of psychiatric illness or alcohol or drug abuse. She had spent one year nursing her husband while caring for three children (an 18-year-old son and 15- and 12-year-old daughters).

During her childhood, she had experienced violence from her father when he was drunk. After she got married, she was normally cooperative and kind to others. However, she tended to have a dependent character.

Medical History of the Cancer Patient

Her husband had been diagnosed with pancreatic cancer (T4N1M0, stage IV) one year earlier. He had received chemotherapy with tegafur, gimestat, and otastat potassium (TS-1) as well as gemcitabine for five months. About two months before his death, he had required immediate hospitalization because of

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vertigo and prolonged melena following tarry stool that had continued for two months. On his last day of life, he had just arranged a transfer to another hospital for radiation treatment. After a meal, he suddenly vomited blood and died. None of his family members were at his bedside when he lost consciousness. He was pronounced dead after an attempt to revive him was unsuccessful.

DISCUSSION

We experienced a case of dissociative amnesia in a bereaved family member who had lost a loved one to cancer, the day after this death. To the best of our knowledge, there are no reports of dissociative amnesia in the bereaved who have lost a loved one suffering from cancer. Our findings add to the list of their potential psychiatric symptoms.

Dissociative amnesia is usually caused by psychologically stressful events. Distinguishing dissociative amnesia from other disorders is very important, since it is sometimes caused by organic conditions—for example, Korsakoff's syndrome and infection (Kaplan & Sadock, 1995). However, in these cases, laboratory findings, inexplicable psychiatric signs, and stressful life events, such as a death in the family, may help distinguish dissociative amnesia.

When considering why she developed dissociative amnesia, her husband's "unexpected" death is one of the factors. However, this cannot fully explain the development of amnesia because sudden death sometimes occurs in advanced cancer patients.

There are at least three other factors related to the development of dissociative amnesia. One is "denial" and its breakdown. Denial as a defense mechanism has been shown in oncology settings to reduce distress (Vos & de Haes, 2007), even during the terminal phase (Rousseau, 2000). In our case, the attending physician had frequently told the subject that there were no more effective treatments and recommended palliative treatment for her husband. However, she could not accept the recommendation and sought other treatments, and finally requested radiotherapy as further treatment. This might be classified as her "denial." She reduced her own distress by denying the hopeless situation of her husband and the certainty of losing him. However, she suddenly had to face his unexpected death. This might have broken her denial.

The second factor is her character. She is dependent, cannot decide things by herself, and has always asked her husband's advice. After his death, she seemed to depend on her children. Her dependent character might have made the thought of life without her husband more difficult, and might have been one of the factors explaining her symptoms.

The third factor is her life history. She had experienced violence in her childhood. This might be an environmental risk factor for her psychiatric symptoms (American Psychiatric Association, 2013).

For the treatment of dissociative amnesia, we should be careful because intrusive attempts to retrieve dissociated memories can result in retraumatization if the patient has not been properly prepared. In addition, we should control the pace of suggested recollection, usually within the framework of broader psychotherapy applied to resolve the complex events producing the amnesia (Kaplan & Sadock, 1995). For families, we need to explain how to deal with such patients' psychiatric symptoms and their predictable progress towards recovery.

We should consider the character of such affected individuals and their life history. Furthermore, we should be aware of the use of denial as a defense mechanism in patients and their families, which is sometimes exhibited in the oncology setting. Awareness of such information might lead to early detection and early treatment or prevention of psychiatric symptoms in the bereaved.

In conclusion, psychiatric intervention by psycho-oncologists (psychiatrists and psychologists) may be needed soon after the death of a loved one for some at-risk bereaved. In an oncological setting, clinicians should consider the impact of the death, even some time after family members have been informed of it.

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