

Amnestic Syndrome Presenting as Malingering in a Man With Developmental Disability

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The authors report an unusual presentation of amnestic syndrome mislabeled as malingering in a man with mild developmental disability. The case highlights the challenges to medical personnel in treating persons who visit emergency rooms often, particularly individuals with mental retardation. Diagnostic overshadowing was a primary factor in the failure to diagnose amnestic syndrome. Overshadowing occurs when a patient's problematic behaviors are attributed to mental retardation, and no attempt is made to search for the root causes of the problem. The case also highlights the need for emergency room personnel to

maintain links with agencies involved in the day-to-day care of persons with developmental disabilities. (*Psychiatric Services* 50: 966-968, 1999)

Emergency room personnel can find it challenging to diagnose and treat people who visit emergency rooms frequently, particularly patients with mental retardation. A diagnosis of mental retardation can lead staff to overlook underlying causes of presenting problems.

Mr. G, a 52-year-old homeless man, was notorious in emergency rooms throughout the city because of his frequent visits complaining of chest pain. He made as many as 20 emergency room visits a day. Whether he was admitted or discharged, he would reappear in the emergency room. Emergency room staff described his behavior as sneaky, manipulative, character disordered, and attention seeking. Many

of the staff believed he was malingering. He had been arrested many times for loitering around emergency rooms.

Multiple attempts at ongoing psychiatric evaluation were unsuccessful because he had no domicile and did not keep scheduled appointments. Evaluation finally occurred during a prolonged rehabilitative hospitalization in July and August 1994 for anemia, malnourishment, urinary tract infection, hypertension, and non-insulin-dependent diabetes.

A history was pieced together from relatives and hospital records. Mr. G was diagnosed with developmental disability as a young child. He attended school through the first grade and never learned to read or write. At age 12 he sustained a closed-head injury, although specific details were not available. Except for briefly working as a cashier, he had not been gainfully employed.

Mr. G had always lived with his

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mother. He started to drink heavily in his mid-30s and used alcohol excessively during his mother's terminal illness, but nonetheless took excellent care of her. Following her death in 1993, Mr. G became depressed and had a brief psychiatric hospitalization. He then moved to another state to live with relatives. In September 1993 he underwent emergency cardiac bypass surgery. A computed tomography (CT) scan performed before the surgery was negative. Testing in October 1993 did not identify any memory impairment.

It was after the surgery that Mr. G's wandering behavior, chest pain, and emergency room visits began to be noted. Evaluation revealed mediastinal infection, which was treated with surgical debridement, intravenous antibiotics, and muscle flap rotation. In 1994 a CT scan revealed an occipital infarct. He returned to his home state to live with different relatives, but he never stayed in any one place, and medical follow-up was minimal.

After Mr. G was admitted to the rehabilitation hospital in July 1994, a medical-psychiatric evaluation was performed. On the Wechsler Adult Intelligence Scale, Mr. G achieved a verbal IQ of 66, a performance IQ of 58, and a full-scale IQ of 58, with significant impairment noted on tasks requiring declarative memory (1). The results of the IQ test were the same as those of the 1993 test.

An electrocardiogram performed in the rehabilitation hospital revealed normal sinus rhythm, right bundle branch block, left anterior fasciculus block, and bifascicular block. A chest x-ray was normal. Thiamine levels were not obtained. Mr. G was treated with thiamine and multivitamins after admission.

On examination, Mr. G was a cheerful and engaging middle-aged man with good eye contact and rapport. He reported that he had less pain and was receiving good care in the hospital. Physically he was fit and without any motor abnormalities. He was alert and oriented to person. He could not identify the date and believed he had been in the hospital for a week when in reality he had been hospitalized for a month. There was no evidence of depression.

Mr. G's thinking was coherent and well organized. He could perform simple calculations relating to money but had difficulty with other mathematical calculations. Mr. G's language was fluent, and object naming was intact. He was able to recall events that occurred before the bypass surgery in 1993. For example, he reminisced about his mother's illness and his life before she died and recalled his move to the state where his surgery occurred. However, he confabulated answers to questions about recent history.

Observations of Mr. G's behavior suggested that he could not store episodic memories. He was pleasant and cooperative, but the staff described his social relationships as superficial. Mr. G remembered his primary aide's name for ten minutes and then reverted to calling him "Bob." He referred to all women on the staff as "Susan" and all men as "Bob." In one interview he acknowledged that he sometimes consumed alcohol, but he stated that it was a minimal amount. When asked more specifically about alcohol use, he reported he had the "shakes" and made them go away by drinking. The next day he had no recollection of this interview.

Mr. G. could not learn the information presented in the daily educational group sessions. He seemed to be "floating"— he did not know where he was. He never learned the location of the gym or cafeteria. When the examiner toured the facility with him, he navigated by following the wall until reaching the room he sought, a strategy that presented obvious problems. On many occasions, he became agitated and attempted to leave the hospital. The agitation and attempts to leave stopped abruptly when the hospital provided one-on-one supervision by an aide. In contrast, when Mr. G was outside the building, he immediately knew where he was and could provide detailed directions.

The diagnosis of amnesic syndrome was made. Critical treatment issues included closer supervision of Mr. G's medical illnesses, management of chronic pain syndrome, and management of anxiety and disorientation in unfamiliar environments. An integrated interagency management program that provided regular medical care was

developed. Treatment with nonsteroidal anti-inflammatory agents successfully controlled his chest pain.

Mr. G was placed in a host home setting where he has received one-on-one supervision. He has remained in this setting for the last four years. No further cognitive deterioration has been noted, but his memory impairment is unchanged. In this setting, he is comfortable, and his anxiety and agitation have been substantially reduced. He neither wanders nor abuses alcohol, and his pain is well controlled.

Discussion

Multiple factors in this case made it difficult to arrive at a correct diagnosis and treatment plan.

Diagnostic overshadowing (2–4) was one factor. Overshadowing occurs when a patient's problematic behaviors are attributed to mental retardation, and no attempt is made to search for the root causes of the problem. Ferreting out the underlying causes can be even more challenging because it is sometimes difficult for individuals with mental retardation to communicate effectively. Problem-solving skills and coping skills are often limited. In this situation the onus of eliciting information and developing management strategies clearly falls on the professional.

Another factor was Mr. G's memory deficit. Amnesic disorder is characterized by an inability, in the absence of other significant cognitive impairments, to learn new information. Memories acquired before the etiologic insult are intact. As described in *DSM-IV*, the memory disturbance causes a significant impairment in social or occupational functioning and represents a significant decline from a previous level of functioning (5). Amnesic disorder should be differentiated from situations in which memory impairment occurs in association with other cognitive dysfunction such as dementia and delirium.

The development of amnesic syndrome could be attributed to a number of factors in this case: poor nutrition, alcoholism (with secondary thiamine deficiency), treatment with vitamin B₂, head trauma, hypoperfusion during cardiac bypass surgery, and infarction of the posterior cerebral

artery. Vascular insults can selectively damage areas of the brain in which memory is stored, such as mamillary bodies, hippocampus, and fornix (5,6). However, the most likely factor is related to events surrounding cardiac bypass surgery, particularly when the patient's previous level of functioning and his functioning after treatment are taken into consideration (7).

Memory deficits are not characteristic of mental retardation. Patients with mild mental retardation, in the IQ range of 55 to 70, are capable of self-support and independent community living (5). Mr. G should not have had any problems remembering specific episodes, particularly those with a strong emotional overtones, such as a hospitalization, an arrest for loitering, or confrontations with emergency room staff. His history clearly indicated that before cardiac surgery his episodic memory was relatively intact.

There was little reason to attribute Mr. G's behavior to malingering. He was not motivated by medicolegal gain, did not exaggerate his symptoms, and did not intentionally fail to cooperate with evaluation and treatment. No evidence of an antisocial personality disorder was found (5, 8–10). His emergency room visits were prompted by chronic pain. Although his developmental disability may have impaired his ability to explain his concerns adequately, his frequent emergency room visits were clearly related to his inability to remember. In fact, a malingerer would be extremely unlikely to return to the emergency room once he was admitted to the hospital, and Mr. G sometimes wandered from the hospital unit where he was placed back to the emergency room.

Although the health care and social service agencies dealing with Mr. G expended considerable time, energy, and funds, they had not been successful in reducing his utilization of emergency rooms or in providing effective management. After he was hospitalized, a detailed evaluation was able to identify the etiology of his chest pain and the severity of his amnesic syndrome. Only then could appropriate interventions be developed. It is not surprising, given his memory impairment and inability to read, that Mr. G forgot follow-up visits. Emergency

room personnel are not usually in a position to explore this kind of complex medical-psychosocial situation, and his random interactions with different health care organizations made it difficult for the emergency room staff to appreciate the full picture.

Physicians need to be aware of the organization of other service systems and to have resources within the emergency room to contact relevant agencies. Most individuals with mental retardation require case management assistance to meet their day-to-day needs. The case manager typically knows the person's biopsychosocial history and thus can provide a critical link between physical and mental health systems and the developmental disability system. For Mr. G, successful intervention occurred through a coordinated effort and redefinition of the problem.

Conclusions

Individuals with mental retardation can be a challenging group to serve successfully, particularly in the rapid-paced setting of the emergency room. When an individual with mental retardation presents with significant psychiatric symptoms, attributing them to mental retardation results in prematurely closing avenues worthy of exploration. Emergency room personnel will find it extremely helpful to join forces with agencies serving persons with developmental disabilities. Such agencies may be unfamiliar to medical personnel, but they represent an important resource, particularly when dealing with a "problem" patient. Nei-

ther the medical system nor the developmental disability system has the knowledge or the resources to provide needed care for these patients, and coordination is thus essential. ♦

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