Recurrent Dissociative Fugue

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ABSTRACT

Dissociative fugue is a rarely reported diagnostic entity. It is one of the least understood and yet clinically one of the most fascinating disorders in mental health. Here, we describe a case of fugue in a 32-year-old man who was brought to mental hospital with complete loss of memory for events pertaining to identity of self. This case illustrates the nature of presentation in hospital setting like mental hospital and effort taken to reintegrate his identity and reunite with his family.

Key words: Recurrent, dissociative disorder, dissociative fugue

INTRODUCTION

The etymology of the word “fugue” comes from the Latin fuga, which means “flight.”[1]

Diagnostic and Statistical Manual of Mental Disorders fourth edition DSMIV criteria for fugue require that the predominant disturbance is sudden, with unexpected travel away from home or one’s workplace, coupled with the inability to recall one’s past.[2] The symptoms must also cause clinically significant distress or impairment in or other important areas of functioning. Fugue differs from other mental disorders in that the flight behavior is organized and purposeful. The prevalence of dissociative fugue has been estimated at 0.2%, but it is much more common in connection with wars, accidents, and natural disasters. The differential diagnosis includes other dissociative disorders, seizures disorder, amnesic disorder, schizophrenia, mania, dementia (Alzheimer’s type), malingering, and factitious disorder.

Psychopathology of fugue

Fugue was previously known as functional retrograde amnesia refers to a complete or partial loss of remote memories with a primacy of psychological factors in the absence of corresponding structural brain pathology.[3] Fugue is often associated with physical or mental trauma, depression, problems with the legal system, or some other personal difficulty.[4] The length of the fugue may last for several hours, days, and weeks or even several months.

CASE REPORT

A 32-year-old, right handed, Hindi speaking male was brought by police during emergency hours to mental hospital to get him admitted. He was produced before the court by the police who had taken him in their custody because he was found wandering aimlessly and could not give proper history on being probed. He had no identity card, cell phone or diary at the time of admission. He was of average build with “SHIVA” tattooed on his right forearm. He was conscious, cooperative, and communicative but appears dazed and had difficulty to maintain eye contact during examination. He spoke very little about himself and express his difficulty to recollect events, details of personal whereabouts, specifically of recent past. Other tests of cognition and judgment were normal. He denied history of hearing
voices, fall, and unconsciousness. He also denied history of alcohol, ganja, and bhang consumption. Systemic examination was normal. All investigations including electroencephalogram and magnetic resonance imaging (MRI) brain scan was found to be normal.

Successive mental status examination revealed improved orientation but failed to recollect his personal identity. Tablet Lorazepam 2 mg was started after complaining of difficulty in sleep.

Gradually he started socializing with other inmates, took interest in ward work and then started going to occupational department. He established good rapport with nursing staff and social worker.

He was by then diagnosed with dissociative fugue according to DSMIV TR Text revision and managed with supportive psychotherapy. After obtaining consent from the patient, Pentothal interview was done during which he had hazy memory of his children.

He remains unchanged until about 2 month when Pentothal interview was again repeated when he spoke about his wife who eloped with neighbor about 6 months back leaving behind two children.

Patient identified himself as Rajesh (name changed) who earns livelihood by selling bangles, he expressed concern about his children as well his identity of being unfair father who cannot sustain his children because of poverty.

Social worker then informed his brother at his village near Chhattisgarh, who informed that it, was his 3rd episode of fugue state. In the last 5 years he similarly lost his way and found in Haridwar and Jaipur in same way. Patient’s family members after a week took him home.

DISCUSSION

Dissociative fugue is the least studied and most poorly understood of the dissociative disorders. It may be an altered state, out of traumatic experiences, where the consciousness dominated by a wish to flee. The traumatic experiences include combat, rape recurrent childhood sexual abuse, massive social dislocation, and natural disasters. In most other cases, there has been a similar antecedent history, although a psychological trauma was not present at the onset of the fugue episode. In these cases, instead of or in addition to, external dangers or trauma, the patients were usually struggling with extreme emotions or impulses, such as overwhelming fear, guilt, shame, or intense incestuous, sexual suicidal or violent urge or a combination of these that were in conflict with the patient’s conscience or ego ideals.[3]

Dissociative phenomena may have strong biological roots, with genetic influences, accounting for about 50% of the variance in twin studies.[6] The presence of smaller hippocampal and amygdala volumes in patients with dissociative identity disorder has been reported.[7] Neurobiological theories postulate that N-Methyl-D-aspartic Acid (NMDA) blockade decreases the inhibitory tone, leading to increased glutamate release and subsequent dissociative symptoms, which also accounts for the structural brain changes in the hippocampus found in MRI studies.

Dissociative disorders continue to remain under diagnosed, undertreated, and insufficiently respected, more so ever the cases of recurrent fugue.

Recurrent fugue is least reported and so this case is the first to be reported.

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