Case Report

Recurrent Episodes of Dissociative Fugue

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ABSTRACT

Dissociative fugue is rare entity to encounter with possible differentials of epilepsy and malingering. It is one of the dissociative disorders rarely seen in clinical practice more often because of the short lasting nature of this condition. This might also be because of organized travel of the individuals during the episodes and return to their families after the recovery from episodes. This is a case description of a patient who has experienced total three episodes of dissociative fugue. The patient has presented during the third episode and two prior episodes were diagnosed as fugue episodes retrospectively based on the history. Planned travel in this case by the patient to a distant location was prevented because of early diagnosis and constant vigilance till the recovery. As in this case, it may be more likely that persons with Dissociative fugue may develop similar episodes if they encounter exceptional perceived stress. However, such conclusions may require follow-up studies.

Key words: *Dissociative stupor, fugue, recurrent episodes*

INTRODUCTION

The common theme shared by dissociative disorders is a partial or complete loss of the normal integration between memories of the past, awareness of identity, immediate sensations, and control of bodily movements. In the dissociative disorders, it is presumed that the ability to exercise a conscious and selective control over memories and sensations is impaired, which can vary from day to day or even from hour to hour. Dissociative fugue has all the features of dissociative amnesia, plus an apparently purposeful journey away from home or place of work during which self-care is maintained. In some cases, a new identity may be assumed, usually only for a few days.[1] There are very few community-based psychiatric epidemiological studies in India and particularly community-based dissociative disorder prevalence studies are absent. However, a study about prevalence in hospital settings in India revealed that among dissociative disorders more common was dissociative motor disorder, followed by dissociative convulsions. Female preponderance was reported in this study.[2] It was observed that dissociative disorder patients are more likely to have comorbid borderline personality disorder, somatization disorder, major depression, posttraumatic stress disorder, and a history of suicide attempt than patients without a dissociative disorder. Childhood sexual abuse, physical neglect, and emotional abuse were also cited as significant predictors of a dissociative disorder diagnosis.[3] Two conceptual approaches were described to understand the causation of dissociative disorders. In the first one, these were viewed as a complex reaction to external trauma, which is similar to the genesis of acute stress reaction. In the second approach, dissociative tendencies are considered within the context of normal personality constructs like other tendencies such as hypnotisability, mental

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absorption, and tendencies to fantasize. However, apart from exposure to trauma, certain primary personality attributes may contribute to the propensity to develop dissociative disorder.[4] Based on neuroimaging it was postulated that hysteria might not involve an exclusion of sensorimotor representations from awareness through attentional processes. However, it might be related to a modulation of such representations by primary affective or stress-related factors[5] if the onset of dissociative disorder is during the young age then the recovery may not be stable over time.[6] Dissociative symptoms can be chronic in nature and at times these can be fleeting affecting different systems of body at different times.[7]

CASE REPORT

Mr. K is 35-year-old married bangle seller. He was brought to the psychiatry outpatient department with a history of sudden onset of amnesia for the recent past with an alleged new identity for himself. Apparently well till a day before the presentation, in the morning hours he complained headache and slept for some time. After awakening, he started behaving in odd manner to the family members. He refused to accept the identity of his wife and other family members. He declared another name and residential address in Hyderabad for himself which is far away from his residence. He was stopped forcibly by the family as he was trying to travel to Hyderabad. When interviewed in the outpatient clinic he was conscious, alert, and well oriented. During the initial and repeated interviews, which were carried out over 5 days he remained firm on his new identity. He refused to accept that accompanying members were his relatives. He was telling that the accompanying lady and other persons were trying to act as his relatives. When he was shown the family pictures carrying his photo taken in the past, he said that they were of a similar person and not his own. When he was asked about how he reached the home where he was living, he remained puzzled and answered that he would like to know that. He was saying that his residence lies in Hyderabad, he was married and having two daughters. When he was asked to provide the address of his home in Hyderabad and his phone number he said that he forgot and he would like to know the address. Further, he stated that once if he is taken to the old city of Hyderabad he would recognize his residence. His family members have provided the history that his last visit to Hyderabad was many years back and the address and the names he was telling were related to his bangles business. As part of his business, he buys bangles in old city Hyderabad and sells them in his town. He stated few names as his brother in laws. Family members have provided the information that those names were of personnel who were in business. He was stopped by his family members forcibly from traveling as they have a similar experience in the past. Family members provided the history of three incidence of altered behavior in a span of 4 years preceding the presentation.

In the first instance about 4 years back there was a history of sudden onset of one episode of behavioral disturbances characterized by unresponsiveness to the external stimuli. This was preceded by financial stress in his business. He was observed to be withdrawn and brooding for few days prior to this. He remained stuporos for 3 days during which he was hospitalized in a nearby tertiary care hospital, and it was said that there was no apparent aetiology for his stupor. He was treated symptomatically and on the 3rd day suddenly he started talking normally as if nothing has happened. Family members did not bother much to evaluate this as they felt he was doing fine whatever the reason was.

In the second one, which was 2 years prior to the current episode he has traveled to Mumbai without any intimation to his family. His family members tried to locate him as he suddenly disappeared from home. About 2 days later the family members were called by him after his reaching to Mumbai which is about 1000 km from his residence. He called them to tell that he was not sure why he was in Mumbai and he could not recollect how he traveled to reach Mumbai. However, he reported a vague recollection that he traveled to Mumbai in train without any ticket. Soon the family members brought him back from Mumbai. This was preceded by financial hurdles during his house construction. During this episode also he was observed to be withdrawn and dull for 2 days prior to his travel.

The third episode was 2 months prior to the current episode. He has called family members saying that he was in a train to Chennai and he did not know how and why he was on that train. In this incidence, he himself came back to home. Wife has reported a similar financial problem in his family 2 days prior to this episode. There was no history of any substance intoxication or usage in the dependence pattern. There was no history of seizure disorder in the patient and his family. There was no significant head trauma history. There was no history to suggest any first rank symptoms or mood syndrome. Premorbidly, he was described as having anxious avoidant traits.

His physical examination including neurological examination did not reveal any significant findings. His routine blood investigations, computed tomography of the brain, and electroencephalogram were normal. He was diagnosed as having dissociative fugue and tablet lorazepam 1 mg twice a day was prescribed on an outpatient basis with specific instructions to the family to prevent any travel. On the 5th day suddenly he

regained his memory saying that he could not recollect what happened in the 5 days. However, he recollected that he met the therapist. He revealed that he was under intense pressure to repay his debts related to his business.

DISCUSSION

Even though there is no organized travel in this case, this is diagnosed as dissociative fugue based on International Classification of Diseases-10 criteria, because in this case the planned travel was prevented by family members by constant vigilance and forced restriction within the house. Differential diagnoses in this would include temporal lobe epilepsy, dissociative amnesia, and malingering. All the four episodes of behavioral disturbance including the current one are sudden in onset and termination. There was nothing to suggest any aura or postepisodic confusion. In all these instances except for the first one he was apparently conscious, alert, oriented, and organized in his actions and plans. Even the first one, taken retrospectively fits for the description of dissociative stupor. All the four were preceded by financial stressors either in the family or in the business. Preceding each episode, in all these four instances there was a significant financial stressor. Following this he was observed to be withdrawn, dull, and brooding with the low mood for few days. There was no disturbance in his consciousness and in his higher mental functions in repeated mental status examinations, and his electroencephalogram was normal during this episode. Hence, the diagnosis of epilepsy was not considered. Though this case description would fit for dissociative amnesia, in this case, in addition to amnesia there is a self-declared new identity and the attempt for travel to distant location, which was of course, prevented. Hence fugue was considered rather amnesia. There was no inconsistency during his repeated examinations, and there was no obvious gain in all the instances. And in two of four instances there was organized travel to unknown location and in the third it was prevented. Hence the malingering was not considered.

CONCLUSION

Dissociative fugue is a rare clinical entity which can recur like any other dissociative disorder when the individual faces exceptional perceived stress. Furthermore, the person with dissociative fugue might experience other dissociative symptoms like stupor as in this case. However, such conclusions might require studies with larger sample sizes.

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