Case Report:

Dissociative fugue - a rare case

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Abstract:
Dissociation is a protective activation of altered states of consciousness in reaction to overwhelming psychological trauma. Dissociative fugue is a rarely reported disorder. It is one of the most fascinating disorders in psychiatry. We found such a case of dissociative fugue in a 26-year-old housewife who was brought to hospital with patches of memory loss. Such case illustrates the need for timely attention and channelizes valuable professional time and also helps in avoiding expensive and unnecessary investigations.

Keywords: Dissociative fugue, memory.

Introduction:
Dissociation is a protective activation of altered states of consciousness in reaction to overwhelming psychological trauma. DSM IV TR criteria for fugue require that the predominant disturbance is sudden, unexpected travel away from home or one’s customary place of work, with, inability to recall one’s past. There is confusion about personal identity or assumption of a new identity. The symptoms must also cause clinically significant distress or impairment in social, occupational or other important areas of functioning. Prevalence of dissociative fugue is estimated to be 0.2%. The difference between fugue and other mental disorders in that the flight behavior is purposeful and usually preoccupied by a single idea that is accompanied by a wish to run away. Most fugues are brief and self limited and impairment is mild and short lived. Treatment involves hypnosis and drug assisted interviews. The differential diagnosis includes other dissociative disorders, amnesia, schizophrenia, dementia, epilepsy (TLE), substance intoxication, substance withdrawal, malingering and factitious disorder.

Case report:
A 29 years old lady suddenly found herself in the premises of a railway station at Haridwar. She reached local police and seeks help because she was not able to communicate and understand the language of the people because she only knew Guajarati language. She requested police that she is away from her home from last few days and now she would like to return home. She provided the contact number and residential address. After the return, her family observed that she was back to her daily routine but
she was still confused about where and how she had gone. On the other side she was able to furnish proof that she traveled by train to another state. Her patchy memory loss brought her family to consult a neurophysician for a neurological evaluation. A neurological evaluation revealed no signs of abnormalities. Routine blood investigations, CT scan of brain, EEG were within normal limits. MMSE score was 27. On clinical examination she was found to be depressed and she was advised with low dose antidepressants and was referred to a psychiatrist for further evaluation.

**Psychiatric Evaluation:**

In appearance she was a young, good looking lady who appeared to be sad and tearful. She reported that she was not able to remember what had happened. Her speech was slow, relevant and coherent. Her mood was sad and she reported guilt and ideas of hopelessness. No delusions and hallucinations were reported. Except deficits in semantic memory there were no disturbances in primary mental functions. Hypnosis sessions were attempted but she was not able to recall what had happened. Further a patient centered approach was considered with which she was more comfortable. After few sessions she recalled incidents of the preceding days. She reported that the argument with her husband was most distressing. She expressed that despite managing the house for many years and coping with other several psychosocial stressors, the husband was overly critical and was not giving time to her and occasionally made physical relations that to whenever he wished. She expressed the intense grief which she had, prompted her to walk away from home. One day she went to their village for some ritual work and while returning from there she traveled by train to another state. She traveled ticketless on certain parts of the travel. She did not plan her movements, and moved from one place to the other. She returned home with the help of railway police. She reported guilty over her "flight," and there was no intention to cause disturbance in the family. She even did not remember people whom she was in contact with, during the travel, but could produce some of the tickets she had used. There was no similar history in the past. There is no history of seizures and parasomnias. According to family, she was a quiet, responsible who had efficiently managed the house. Before her flight she had actively participated in the family functions and her functioning in all areas was fine. The diagnosis of fugue was considered because of the organized flight from home with significant distress in her social and occupational life, and also the absence of pre-morbid neurological or psychiatric problems with self-remitting altered behavior. The amnesia noted was episodic and circumscribed. Now in this case, the patient has returned to her pre-morbid level of functioning and comes regularly for her follow up. She is maintained on low dose anti-depressants and supportive therapy.

**Discussion:**

We all know that, traumatic events affect the processing of memory at the encoding stage. They create discontinuities with prior experience. They involve arousal of intense affect and may create conflicting patterns of association. According to psychoanalytic schools the defense mechanism individual’s use is splitting to cope with traumatic memories. Dissociation is sometimes referred to as splitting, as these thoughts, emotions, sensations, or memories are "split off" from the integrated ego.
According to one of study carried out on twins dissipative phenomenon may have strong biological roots, with genetic influences accounting for about 50% (4). The presence of smaller hippocampus and amygdale volumes in patients with dissociative identity disorder has been reported (5). In a developing country like India, who has limited financial access to health care, these are relevant issues for the clinicians to think about. In present scenario dissociative disorders are under diagnosed, undertreated, and insufficiently respected (3). The rarity of such cases can be overcome by diagnosing this entity with proper screening and diagnostic instrumentation; and a much higher prevalence may be encountered (6). A multi-disciplinary approach is the need for current time for understanding a dissociative episode.

References: