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CASO CLÍNICO/CASE REPORT

Dissociative Fugue: A Case Report
Fuga Dissociativa: Um Caso clínico

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Abstract
A dissociative fugue occurs when an individual with dissociative amnesia wanders away from their familiar surroundings, maintaining self-care and apparently normal behavior to observers, lasting from hours to months in a row. New identities can be assumed and even organized travel can occur. While dissociative amnesia by itself may have a prevalence of around 7.2%, dissociative fugue is a rare entity, with unknown prevalence, and there are few reports in the literature. In this article, we describe a case of dissociative fugue in a 34-year old woman that lasted eight months. Dissociative amnesia with fugue remains an interesting topic for further research since it can present a diagnostic challenge, there are currently no evidence-based pharmacological treatments and prognosis varies greatly between patients.

Resumo
A fuga dissociativa ocorre quando um individuo com amnésia dissociativa viaja para fora do seu ambiente habitual, mantendo autocuidado e apresentando comportamento aparentemente normal. Este quadro pode durar horas a meses. Podem ser assumidas novas identidades e viagens organizadas podem acontecer. Apesar da prevalência da amnésia dissociativa ser estimada em cerca de 7,2%, a fuga dissociativa é uma entidade rara, de prevalência desconhecida e existindo poucos casos relatados na literatura. Neste artigo, descrevemos um caso de fuga dissociativa numa mulher de 34 anos, que durou oito meses. A amnésia dissociativa com fuga permanece um tópico interessante para investigação futura porque constitui um desafio diagnóstico, não existe tratamento farmacológico recomendado baseado na evidência e o prognóstico é altamente variável entre doentes.

Keywords: Amnesia, Dissociative Disorders

Palavras-chave: Amnésia, Perturbações Dissociativas

INTRODUCTION

Dissociative disorders are among the oldest described psychiatric disorders, appearing at the end of the 18th century.[1] Dissociative symptoms and disorders where first extensively studied in the late XIX and early XX centuries by Charcot, Babinski, Janet and Freud. Charcot and Janet viewed traumatic events as etiologically important for these disorders, whereas Babinski focused on suggestion, persuasion and hypnosis and Freud renounced that repressed memories of childhood sexual trauma caused hysteria. The fact that soldiers in World War I and subsequent major armed conflicts exhibited dissociative manifestations such as psychogenic amnesia, fugue, depersonalization/derealization and somatoform symptoms reinforced the link between trauma and dissociative disorders.[1] The precise neurobiological mechanisms that underlie dissociative amnesia need further exploring. However, top-down inhibition by frontal systems of hippocampal, temporal and occipital lobe areas involved in autobiographical memory may play a role.[1] Dissociation has also been linked to the interaction between traumatic experiences and genetic polymorphisms related to hypothalamic-pituitary adrenal

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axis, serotonergic and dopaminergic pathways and the brain derived neurotrophic factor system.[1]

Dissociative amnesia is a disorder in which there is partial, selective memory loss for recent autobiographical events, linked to a stressful or traumatic event, and not better explained by other disorder or normal forgetting. The degree of amnesia is variable, and can vary day to day. A more extensive, even global, memory loss can occur and semantic and procedural memory may be impaired.[2,3] A dissociative fugue occurs when an individual with dissociative amnesia wanders away from their familiar surroundings, maintaining self-care and apparently normal behavior to observers. It can last from hours to days, weeks or months in a row. There is loss of personal identity, new identities can be assumed and even organized travel can occur.[3,4]

Dissociative amnesia by itself has a prevalence of around 7.2%[2] and dissociative fugue has a prevalence of 0.2%.[5] In this article, we describe a case of dissociative fugue, hoping to add to literature, and to highlight this clinical entity, given its rarity, the risk of misdiagnosis, and its possible legal implications.

CASE REPORT

A 34-year old Portuguese woman living in the interior South of Portugal. She lives with both parents and older sister. The patient is single and has no children. She has a college degree and works temporary jobs, the last one at an olive oil factory. She is physically healthy, has no previous psychiatric history and takes no medications. She has a family history of schizophrenia from her maternal grandfather, paternal uncle and paternal half-brother.

When she was 34, upon the end of a job contract, declared her romantic feelings to a co-worker, but he did not feel the same. The day after, got rid of all of her belongings, left her home and disappeared for eight months. When she came back to Portugal, she was found by bystanders, bathing in a dam in a rather cold weather, and they contacted her family. Her family took her to the emergency room where she was evaluated by Psychiatry. She knew who she was, she was oriented, with maintained attention, but had no recollection of the previous eight months. The patient complained of insomnia, she was anxious and severely agitated, and therefore not cooperative. No other relevant psychopathological findings were obtained due to lack of cooperation. The patient refused care and had no insight regarding her clinical condition. In accordance with the Portuguese Mental Health Law, she was admitted involuntarily to the inpatient Psychiatry unit, for clinical stabilization and diagnostic study.

While in the Psychiatry ward, she remained calm, with a rather superficial contact, oriented with sustained attention, and gradually gained recollection of previous events, but the information she gave was always inconsistent and varied across interviews. She remembered living in friends' houses and living as a homeless person, she recalled traveling across Portugal and elsewhere in Europe, having been to Fátima, Santiago de Compostela, Paris, Bern, Dusseldorf. However, throughout different interviews she reported having been in different places every time and she could not recall which language was spoken in those places. She said she was painting in the streets of Paris, but did not know how she acquired the needed art supplies. She also spoke about having eaten a pie at the dam, but the flavor kept changing between interviews. Additionally, the patient presented derealization and depersonalization, described as a feeling of strangeness regarding her surroundings, which felt unreal, and a feeling of not really being herself, detached from her thought and actions, and doing things in an almost automated way. She displayed organized but monotone speech and poor and digressive thinking, with no hallucinations nor delusions. The patient had euthymic mood but her affects showed little resonance (*la belle indifférence*).

Physical examination was unremarkable and there were no signs of dehydration nor malnutrition. Blood and urine analyses were performed. Full blood count, thyroid, liver and kidney function were normal and the patient tested negative for illicit drugs. She was tested for SARS-CoV-2 and presented a negative result. A head computed tomography was done and showed no pathological findings. An electrocardiogram was performed and revealed no changes. No personality nor psychological assessments were performed.

She was medicated with risperidone 1 mg per day and diazepam 5 mg per day, with good response and tolerability. She kept improving, transitioning to voluntary care, and was discharged after 18 days to outpatient care. On discharge, she had regained partial memory and admitted to being inconsistent. The patient stayed calm and cooperative, showed improved contact and affect, with remission of depersonalization and derealization. She developed partial insight regarding the episode.

The patient had a follow-up appointment one month after discharge, where she told her doctor she was not taking any of the prescribed medications since she felt healthy and considered the treatment to be pointless. Although she dismissed the fugue episode, recognized it could happen again if a new stressful event arose and agreed to keep outpatient follow-up. At this time, there were no psychopathological findings apart from amnesia for part of the previous events, and no medications were prescribed.

The timeline of events is summarized in the following Table 1.

Table 1: Timeline of clinical hallmarks

Day 1	Stressful event
Day 2	Leaves hometown
8 months later	Returns to hometown, is found bathing in a dam. Emergency room: The patient knew who she was, was oriented, with maintained attention, but no recollection of the previous eight months. Complained of insomnia, was anxious and severely agitated, not cooperative. Involuntary admission to Psychiatry inpatient ward
Stay in Psychiatry Ward – 18 days	Day 1 - Admission: Calm, with superficial contact, oriented, with sustained attention. Gradually gained recollection of previous events. Derealization and depersonalization were present. Organized but monotone speech and poor and digressive thinking. No hallucinations nor delusions were present. Mood was euthymic with little affective resonance (*la belle indifférence*). Treatment initiated Clinical improvement Transition to voluntary care Day 18 - Discharge: Recovered partial memory, admitted to being inconsistent, stayed calm and cooperative, showed improved contact and affect, with remission of depersonalization and derealization. Partial insight regarding the episode.
1 month later	Follow-up appointment: Not taking any of the prescribed medications since she felt healthy. Recognized this could happen again if a new stressful event arose, agreed to keep outpatient follow-up. There were no psychopathological findings apart from amnesia for part of the previous events. No medications were prescribed.

DISCUSSION

The presented case portrays a classical picture of dissociative amnesia accompanied with a rather long fugue that lasted months.[3] The patient, a previously healthy 34-year old woman, experienced a stressful event when faced with the rejection of her love interest. Afterwards, she got rid of all of her belongings and left her home. Eight months later, when she returned to her hometown and was taken to the emergency room, she presented amnesia regarding the whole period she had been away. During her stay in the Psychiatry inpatient ward, she gradually recalled past events, stating that she had traveled through various European countries. However, the reported information was inconsistent and fluctuating, with details changing from interview to interview. It is not possible to ascertain if there were personality changes during the fugue. As far as can be known, the patient maintained her identity throughout the episode. Self-care was kept and the patient showed no signs of dehydration nor malnutrition. Derealization and depersonalization were also present. Upon investigation, there were no findings that suggested neurologic or other somatic disease. The patient showed a quick and global recovery to her previous functioning state. One month after discharge, she presented an unremarkable mental state examination apart from amnesia for parts of the previous events.

Dissociative amnesia with fugue is a rare entity, but must be kept in mind as a possibility in order to be correctly identified and avoid misdiagnosis. Differential diagnoses for amnesia can include neurocognitive disorders and other neurological diseases, substance-induced amnesia, psychotic disorders and factitious disorders.[2] For example, one could argue that a patient with a family history of psychosis, with a stressful life event and periods of ill characterized disease could be diagnosed with an acute and transient psychotic disorder. However, the patient has no history of psychotic symptoms, namely delusions or hallucinations, and these symptoms were never observed upon repeated clinical interview. What dominates this clinical picture is memory impairment following a stressful event. Besides, the patient disorder had a duration of 8 months, retaining amnesia for some events, while a diagnosis of an acute and transient psychotic disorder would require a maximum duration of 1 or 3 months,[6,7] (according to the Diagnostic Statistical Manual of Mental Disorders, 5th edition,[6] and

the International Classification of Diseases, 11th revision,[7] respectively), followed by complete recovery.

Although there is no recommended pharmacological treatment for dissociative amnesia, risperidone and diazepam were started in this case to control acute and severe agitation that would prevent appropriate patient evaluation and care.[2,3]

In term of prognosis, there is a high variety of outcomes. Some patients with dissociative amnesia show complete recovery, spontaneously or after treatment, others decrease in symptom severity and still others exhibit a chronic or even deteriorating course.[2,4,8-10]

Additionally, dissociative fugue can present legal implications for the patient, namely traveling without documentation and crossing controlled borders during a pandemic.

In conclusion, dissociative amnesia with fugue is a rare but relevant entity due to the possible diagnostic challenges, the absence of evidence-based pharmacological treatment and legal implications of the fugue episode. Future research to further understand this phenomenon is necessary.

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