A Case of Dissociative Amnesia With Dissociative Fugue and Treatment With Psychotherapy

To the Editor: Dissociative fugue is a subtype of dissociative amnesia. Per the *DSM-5*, dissociative amnesia with dissociative fugue is the "purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information."[1(p156)] As the name fugue implies, the condition involves psychological flight from an overwhelming situation.[2] The onset is usually sudden and predicated by a traumatic or stressful life event.[3] Severely traumatized patients with a history of sexual abuse are highly likely to use dissociation as a primary psychological defense.[4] The prevalence of dissociative fugue disorder is very low, estimated at 0.2%.[5] It becomes prudent for health care professionals to make themselves aware of this disorder to prevent misdiagnosis and unnecessary investigations. This case shows a need for early diagnosis and psychological support for these patients in a timely manner.

Case report. Mr A, a 20-year-old man with no past medical and psychiatric history, was brought to the emergency department by his mother (Monday). He had difficulty remembering things for the past 2 days. According to his mother, he was doing fine until 2 days ago (Saturday). The next day (Sunday) when Mr A was at work, the mother got a call from Mr A's supervisor at his office stating that he did not recognize his friends and that he was asking what he was supposed to do at work. Considering the situation, Mr A's supervisor sent him home at 9:30 AM. When he reached home, Mr A failed to recognize his mother, dog, siblings, and belongings. He slept until 1 PM on Sunday, woke up, and left the house without telling anybody. Later in the evening, his mom got concerned and started calling and sending him text messages, which went unanswered. She called his friends, and they were able to locate him in the parking lot of a convenience store. Mr A did not recall how or why he came to the parking lot.

At admission to the inpatient psychiatry unit, Mr A's urine drug screen tested negative for any illicit substances. Findings of a head computed tomography scan and magnetic resonance imaging were within normal limits. Results of other routine investigations including complete blood count, complete metabolic profile, ammonia level, B_{12} level, thyroid function tests, and liver function tests were also within normal limits. The human immunodeficiency virus and rapid plasma reagin tests were also negative. When asked how he was doing, Mr A said, "confused." His mood was "okay," and his affect seemed flat and somewhat guarded with no concern for his memory loss (*la belle indifference*). He was oriented in time, place, and person but had impaired attention and concentration at the time of the examination. The immediate recall was intact, but he was unable to provide important details pertaining to his life. He denied hallucinating and had no intentions to harm himself or anyone else. Mr A scored 27/30 on the Mini-Mental State Examination[6]; he lost 3 points in the attention domain.

Mr A had slept a lot in the last 2 days. His mom denied symptoms of depression, anxiety, mania, and/or psychosis. He had no history of seizure or head trauma. When asked about any recent stressor, the mother recalled that about a week ago Mr A had broken up with his partner. They were in a relationship for about 1 year, but his mom did not notice emotional changes in Mr A after the breakup. The family was not opposed to Mr A's sexual orientation.

During hospitalization, the neurology department was consulted, and after complete neurologic workup, including electroencephalogram and brain imaging, the neurology team ruled out organic causes of transient amnesia. Malingering was also an important differential diagnosis; therefore, psychology consultation was requested. The results of the Miller Forensic Assessment of Symptoms[7] and Coin-In-Hand test[8] showed no evidence of feigned symptoms. The Personality Assessment Inventory[9] showed no evidence of overreporting. During his psychiatric inpatient stay, Mr A continued to have no autobiographic memory. The treatment team did not force Mr A to recall the stressor that might have led to the dissociative amnesia and fugue. The family was allowed to have conversation with Mr A and show him the family photo album, but at his ease. Throughout the hospital course, Mr A was calm, and the memory loss did not seem to bother him. It was evident that he was forming fresh memories and could recall most events after he was found in the parking lot of the convenience store, which is an important feature of dissociative amnesia, in which the patient has no anterograde amnesia.[10,11] After ruling out other causes of transient amnesia, Mr A was diagnosed with dissociative amnesia with dissociative fugue (*DSM*-5 criteria) and was discharged with close psychotherapy follow-up.

Mr A was followed as a psychotherapy patient in our outpatient clinic. During the first few sessions, he continued to have difficulties remembering events from his past, stating, "I am a new person." However, he did not have any problem with forming new memories (no anterograde amnesia). The psychotherapy team used persuasion and suggestive techniques and tried to provide a sense of safety and security. He was given a home assignment to look at his family photo album and review details of his job with his coworker. Simultaneously, the psychotherapy team continued supportive psychotherapy and empathic validation. Initially, Mr A felt good about being a "brand new person" so that he did not have to think about the painful aspect of the past.

After multiple sessions, Mr A started to recall memories about his past. He talked about how "painful" his previous relationship was when he broke up with his partner because Mr A had been unfaithful. This incident happened 2 weeks prior to his admission to the inpatient unit. His partner refused to continue the relationship, even after several attempts at reconciliation by Mr A. He said he felt "numb" when he woke up on Sunday morning. Mr A said, "I lost everything, shame, guilt, being rejected and wished to be a new man," so that he could be accepted by his ex-boyfriend. After a series of sessions over a period of 12–16 weeks, Mr A continued to show progress by returning to his job and started remembering details from his past.

At present, the diagnosis of dissociative amnesia with dissociative fugue depends on the identification of severe retrograde amnesia in the absence of anterograde amnesia or other cognitive impairments, and the absence of a causative brain lesion.[12] As depicted in this case, the most consistently successful treatment appears to be removal of the patient from threats; providing psychological support, gentle suggestion and cuing; and "reteaching." Empathy rather than skepticism is essential to create a safe and effective environment for better therapeutic alliance.

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