Case Report

Dissociative Fugue Symptoms in a Middle-Aged Hispanic Man

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Retrograde amnesia is a form of memory loss generally preceded by brain injury or a psycho-traumatic event.[1] In the absence of brain damage evidenced by structural neuroimaging, it is often referred to as dissociative or psychogenic amnesia. Stressful or traumatic events known to have caused cases of dissociative amnesia include war, natural disasters, and physical assaults.[2]

Although limited data are available, published studies estimate an incidence of dissociative amnesia with fugue in 0.2% of the general population.[3] It more commonly occurs in the third and fourth decade of life with relatively equal incidence among men and women[4] and shares a strong genetic component, accounting for about 50% of cases.[5] Factors that can accelerate the rate of development of or worsen amnesia include longer duration, frequency, intensity, and age of exposure to a traumatic event.[6] We present a case of dissociative amnesia with fugue in a middle-aged man who experienced multiple psychosocial stressors.

Case Report

A middle-aged Hispanic man with unknown medical and psychiatric history admitted himself to the emergency department in a confused state. The last thing he remembered was being guided by the police toward the nearest hospital after reporting being attacked and hit on the head by strangers. At that time, he was unable to recall his name, his current whereabouts, or any remote or short-term history. There was no form of identification in his possession. He was unable to answer most questions and perseverated "everything is so hazy." Despite denying any drug use, the patient's urine drug screen was positive for cannabinoids at admission. During his brief admission on the medical floor, he had an interrupted suicide attempt. The patient endorsed hopelessness and worthlessness, expressing "I don't want to live anymore, I want to kill myself." A full medical and neurologic evaluation showed no positive findings, and the patient was medically cleared and transferred to the inpatient psychiatry unit for psychiatric stabilization.

On initial evaluation, the patient presented with social withdrawal, excessive cognitive rumination, and emotional avoidance and struggled with stress and negative affect while having difficulty expressing himself. No collateral history was available initially. He endorsed auditory hallucinations as "hearing voices" but could not make out what they were saying. He denied other perceptual disturbances. Throughout the admission, he continued to report various gaps in his memory including the days leading up to admission. He recalled very limited information about his work. With the consent of the patient, the team contacted his employer by using the Google search engine for contact information. His former employer subsequently provided information about his sister.

A selective serotonin reuptake inhibitor (SSRI) was started to target his depressed mood and anxiety. After initiation of medications, he was slowly able to report his name with confusion and hesitation at first but settled with improvement over time. The patient continued to endorse depressive thoughts, suicidal ideation without plan or intent, and anxiety.

The patient's sister revealed that he recently lost his job and had an ongoing history of alcohol use. He was briefly in rehabilitation but did not complete it. She further described that prior to admission he was paranoid and evicted his fiancé from his home, believing that she had an affair with his boss. This led to the patient installing cameras around his home. Shortly after, he went missing, and his family filed an official missing person report.

The primary team had a family meeting with his sister, and the autobiographical data were confirmed. He was able to recollect some of his history but still could not recall the incidents leading to him leaving his home and travelling to a different state, where he was located at the time of admission. He reported that the breakup with his fiancé caused him significant stress and anxiety, and thoughts and suspicion of infidelity brought up feelings of abandonment and paranoia, resulting in the installation of cameras in his house.

Following the family meeting, the patient endorsed less anxiety. His passive suicidal ideation faded as did his auditory hallucinations. A clinical interview and psychological testing were administered by the psychology team to understand the patient's personality, cognitive functioning, and memory loss. During the first clinical interview, the patient presented as dysthymic and guarded, had difficulty maintaining eye contact, and often repeated

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the same responses to the interviewer's questions and statements. Later, he became more forthcoming, pleasant, and cooperative. With the onset of amnesia relatively recent in the patient, amnesia was not as severe, as he could recall fragments of memory including his workplace with a variable degree of uncertainty.

Tests administered during his hospital stay included the following:

Test of Premorbid Functioning: The patient's standard score was 85 (16th percentile, which is consistent with low average range).[7]

Wechsler Abbreviated Scale of Intelligence-Second Edition (WASI-II): The patient had limited engagement testing during the first few weeks of admission, and his full-scale IQ was 60 (fourth percentile). A few weeks later, his verbal scores increased, with a *t* score of 37 (standard score = 80, ninth percentile).[8]

Rorschach Inkblot Test: The patient had no evidence of impaired reality testing or thought disorder. Interpersonally, he felt that his needs were not being met, and he was left feeling alone as a result. He had a negative self-evaluation and was self-critical and likely to dwell on past failures and lost opportunities.[9]

Personality Assessment Inventory: The patient may have experienced mild, maladaptive behavior patterns aimed at controlling his anxiety. His responses were related to a significant amount of distress, rather than a deliberate attempt to exaggerate symptoms.[10]

The patient was scheduled for discharge, as he showed significant improvement in psychiatric symptoms, although he still could not recall the missing pieces of information. Safe discharge planning was done with the patient and his sister with outpatient psychiatry follow-up. But the night before discharge, he had seizure-like symptoms and a catatonic presentation and was transferred to the medical facility. Once stabilized medically, he was discharged on an SSRI and an atypical antipsychotic to his family for outpatient follow-up. The patient's sister followed up with the team that he was doing better after discharge.

Discussion

Dissociative amnesia, also referred in tandem with dissociative fugue, is associated with traumatic life events or stressful psychosocial environments that act as stressors to initiate the onset of amnesia. The *DSM-5* defines dissociative fugue, a variant of dissociative amnesia, as bewildered wandering or purposeful travel for identity or other important autobiographical information due to amnesia.[11]

The retrograde amnesia hindering our patient's ability to recall personal information and creating gaps in his memory acted as a defensive mechanism, serving to exclude painful memories from his conscious awareness. Increasingly intense and multiple psychosocial stressors are a strong indicator of the cause of amnesia.

When evaluating a patient presenting with acute amnesia, clinicians must determine whether the amnesia is due to true dissociation versus an underlying psychiatric disorder or other organic cause. Potential psychiatric etiologies that should be considered in the differential diagnosis include depression, which could have been present in relation to our patient's recent breakup; alcohol dependence and abuse, also present in our patient and confirmed by his sister; or substance abuse. Some examples of organic causes that may induce amnesia are dementia, head trauma, epileptic seizures, infection, and cerebrovascular pathologies among others. A key distinguishing feature seen in organic amnesic etiologies is that these patients often experience amnesia anterograde in nature rather than retrograde,[6] as seen in our patient. To definitively rule out potential organic causes, a complete physical and neurologic examination, including laboratory tests and electroencephalography, should be performed. Laboratory tests and radiographic imaging of the patient were conducted, revealing no such visibly acute changes.

Other potential causes must be considered in patients experiencing dissociative amnesia. Underlying neurologic and developmental pathologies should be examined and considered to narrow the differential diagnoses. Testing of premorbid functioning was conducted, and the patient received scores consistently within the low average range. The patient's *WASI-II t* score was 37, which is in the ninth percentile. This demonstrates a lower-than-expected cognitive capacity of the patient, which may have added to the already triggering stressors that could have been the root cause of the patient's amnesia.

Once amnesia is confirmed, clinicians are still posed with the challenge of assessing the patient with dissociative fugue. Patients often do not complain about the amnesia itself, likely due to limited insight and an inability to recall critical moments leading to the event. A complete patient history cannot be documented, including any ongoing medical conditions, medications, previous amnestic episode occurrences, and past relevant medical/psychiatric history.

Despite there being no definitive form of treatment, management must include a range of pharmacotherapy to address underlying psychiatric pathologies (ie, depression, anxiety) while implementing the use of psychotherapy or "talk therapy" to deal with the trauma and stress related to recovering forgotten memories. Filling in the gap in memories as much as possible can also aid in restoring continuity in a patient's sense of self and identity. Family-involved therapy and implementation of newer techniques such as meditation, relaxation, and clinical hypnosis are important, as is focusing on providing a safe environment for the therapy, which has been shown to enable spontaneous retrieval of memory.[12,13]

Conclusion

Management of a case of dissociative fugue must be done in a careful manner, considering the psychosocial stressors that induced the onset of amnesia in the first place. The more recent the incidence of amnesia, the greater

likelihood it is to be resolved.[10] However, clinicians should be prepared for risk of reactivation of the trauma that led to the amnesia in the first place when trying to piece back the patient's memory, which is why psychological support should be highly emphasized and structurally set. Empathy rather than skepticism should be used in creating a safe environment and making the patient feel comfortable and at ease for better therapeutic alliance. Other modalities include group therapy, family therapy, medication management, and hypnosis, which has shown promising results and can be utilized by clinicians.[14] Using a multidisciplinary approach can aid in overcoming challenges faced by clinicians in the management of patients with dissociative amnesia and help them return to a functioning condition.

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