A dissociative fugue is a specific form of dissociative amnesia that is characterized by the memory loss of one’s identity and past life, in addition to the unexpected and purposeful travel away from home. The patient might also create a new identity to compensate for the severe memory loss. Fugue has been suggested to be caused by severe traumatic life events or stressors. Patients with fugue might respond to cognitive therapy or hypnosis. Barbiturates might be used for a medicated-interview to reveal more information about a suppressed traumatic trigger.

Overview

Dissociate fugue is an acute episode of severe and overt dissociate amnesia that is characterized by the sudden memory loss with the leaving of one’s surroundings and unexpected travel away from one’s home. The episode is usually acute and is characterized by autobiographical memory loss and the inability to recall essential information such as the person’s identity.
Epidemiology of Dissociative Fugue

The estimated prevalence of overt dissociative amnesia or fugue is 0.2% in the general population. These patients usually have a previous history of a significant social or life trauma. Additionally, a fugue is usually more common at times of wars, natural disasters, and accidents.

Patients who have fugue are later found to have more complex forms of dissociative amnesia in most cases.

The risk of fugue seems to be higher in certain populations such as drug addicts, women who work in prostitution, and strippers or exotic dancers. This can be related to the lifestyle of these populations which are more likely to suffer from emotional or psychological trauma, i.e., rape of a woman who works in prostitution might lead to a fugue state for instance.

Clinical Presentation of Dissociative Fugue

Patients who develop fugue are usually brought to the emergency department to exclude alcohol intoxication or drug overdose, two common causes of bizarre and abnormal behavior.

History taking is an essential tool in establishing the diagnosis of fugue because the diagnostic criteria per DSM-5 are largely based on the clinical features of the disorder.

Patients are usually confused and have amnesia. Amnesia can be associated with the creation of a new identity.

Fugue is different from dissociative amnesia as patients usually travel suddenly and get away from their home with the inability to recall past events about their lives. Patients with dissociating amnesia do not show this kind of behavior. Therefore, cases of severe amnesia without unexpected travel are diagnosed as overt dissociate amnesia rather than fugue. Suicidal risk should be assessed in any patient with fugue.

Diagnostic Criteria for Dissociative Fugue

For the diagnosis of the dissociative fugue to be made, the patient needs to show an apparently purposeful travel or wandering, in addition to amnesia for identity and other autobiographical information.

Patients with dissociative amnesia might also have a generalized amnesia for identity and life history, but they usually have selective amnesia of a certain traumatic or stressful event in their lives.

For the diagnosis of the fugue to be made, the symptoms need to be severe enough to cause significant social, occupational, or other functional impairment in life. Alcohol use, drug abuse or the use of medication need to be excluded. Additionally, medical conditions such as seizure’s disorder, transient global amnesia, traumatic brain injury, or Alzheimer’s disease should be excluded.

It is important to differentiate between fugue and other disorders such as posttraumatic stress disorder, acute stress disorder, somatization or malingering.
Brain Imaging in Dissociative Fugue

Neuroimaging studies can shed more light on the differences between normal people and those with psychiatric disorders such as dissociative fugue. The current status of neuroimaging applications in patients with dissociative fugue makes such modalities only research-based and not clinically oriented.

**Positron emission tomography (PET) scans** of patients with fugue showed two important differences compared to healthy subjects.

First, while healthy subjects showed right frontotemporal activation in response to showing familiar objects and items from the patient's past, patients with fugue showed **left frontotemporal activation**. This finding supports the notion that psychiatric disorders are related to impaired neuronal circuits rather than a gross brain pathology.

The other important finding which was also obtained from PET scans showed **decreased glucose intake, i.e. hypometabolism**, in the right frontotemporal regions in patients with fugue.

While these results are not helpful clinically speaking, i.e. they cannot alter the management plan in our current practice, they have huge implications for the future care of such patients. If we understand which neuronal circuits are impaired in these patients, we will have a better understanding of the pathology and perhaps develop better therapeutics one day.

Treatment of Dissociative Fugue

Most patients with dissociative fugue will go back to normal without significant pre-sequalae but the risk of recurrent episodes of a fugue is high.

The most important aspect of the treatment of fugue is to **help the patient to identify the traumatic events or stressors** that lead to this state in the first place. Unfortunately, most forms of psychotherapy and cognitive therapy in Dissociative disorder are based on the individual work with few number of patients and not on randomized clinical trials due to the rarity of the disorder.

Cognitive disorder might be successful in these patients because some psychologists believe that dissociative fugue is a response mechanism to irrational thinking patterns.

Patients who undergo extreme physical, sexual or emotional abuse might develop dissociative fugue. Such patients might have some misconceptions such as they are bad people and they brought this on themselves. Because of this, their mind can make them develop amnesia and they can later create a new identity, which is commonly seen in severe cases of a fugue. It is important to address this with the patient.

**Hypnosis has been also tested in few cases** of the dissociative fugue with some good results. Again, it is important to remind you that most of these treatments are not evidence-based.

**Family therapy is also indicated because it is important for the victim and the family to understand the traumatic events** that might have led to this state. Additionally, it is important to educate the family about the patient's condition and teach them how to deal with the patient. Group therapy is helpful in patients with traumatic stress disorder and other types of anxiety disorder and has been shown to be effective in dissociative amnesia and fugue before.
Finally, antidepressants or anti-anxiety medications have been also used in the management of fugue with some good results. Benzodiazepines might help with anxiety which can be severe due to the traumatic event. Additionally, benzodiazepines can be also used with barbiturates for a medicated-interview. A medicated-interview might provide new insights into the traumatic events that the patient has suppressed.

References


[http://psychology.jrank.org/pages/262/Fugue.html#ixzz4hp0CfOog](http://psychology.jrank.org/pages/262/Fugue.html#ixzz4hp0CfOog)

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