AN UNUSUAL CASE

Dissociative fugue

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Fugue is derived from a Latin word *fugere,* meaning to flee or run away.[1] Fugue states can have different aetiologies, being either dissociative/psychogenic, organic, malingered or related to other psychiatric disorders of mixed aetiology. Dissociation has been described as a disruption of the normally integrated functions of consciousness, identity, memory or perception of one's environment.

In the *Diagnostic and Statistical Manual of Mental Disorders* (1st edition) (*DSM-I*)[2] the American Psychiatric Association (APA) listed fugues under dissociative reactions, which included somnambulism, amnesia, dream states, stupor and depersonalisation. Later on in *DSM-II*[3] fugues were grouped under hysterical neuroses. *DSM-III*[4] categorised fugue states under dissociative disorders. According to *DSM-IIIR,*[5] the essential feature of a fugue (psychogenic) is sudden unexpected travel away from home or one's customary workplace, with the assumption of a new identity (partial or complete) and a loss of ability to recall one's past. In *DSM-IV*[6] psychogenic fugue was replaced by the new term 'dissociative' fugue. The assumption of a new identity is no longer required, because confusion about personal identity has been found to be more predominant. A new identity may be assumed, usually only for a few days[7] but occasionally for prolonged periods of time and to a degree of completeness that is unexpected.[8] A person in a fugue (dissociative) state maintains basic self-care and social interaction with strangers in a simple way.[9]

Throughout literature the main feature in the aetiology of dissociative fugue is the presence of heightened emotional tension or trauma arising from conflicts in a person's personal or career life.[10] It is most often precipitated by stressful events such as financial problems, psychic or physical trauma, or exposure to combat, torture, rape, or emotional and physical abuse.

The majority of researchers, especially in the 1940s, found that most fugue episodes were relatively short-lived, without elaborate assumption of a new identity.[11] A well-known case of dissociative fugue involved Reverend M R Ansel Bourne[12] whose history and clinical picture were almost the same as those of our patient.

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Mrs X, our patient, was brought to the psychiatric clinic by her daughter after she had gone to report to her former work place after an absence of 1 year. She was then 45 years old. Mrs X left home in July 1996, withdrew some money from the bank and from there left town on foot for the next town 200 km away. On arrival she sat next to a shop to relax for a while. A young boy asked her to accompany him to his home as his mother was sick and needed somebody to help her. Mrs X left with the boy and adopted a completely new identity. She was unaware of where she came from, or that she was actually married with children. She lived with the family and worked there as a domestic worker for a period of 1 year. Her employers never noticed any abnormal behaviour. One day as she was sitting in her room she recollected vaguely that she came from Welkom, went to the telephone directory and traced her home phone number. She phoned but there was no reply. She then travelled back to her home only to find that her husband had passed away and that her younger children were in the custody of her oldest child.

Mrs X did not have any relevant medical history. She had delivered a live baby by caesarean section 2 months before her fugue. On three occasions she had had a burst abdomen which was repaired. The baby was cared for by his father and other siblings in the absence of his mother. He is still alive and well. According to information obtained from the patient and her family, during the 2 months postpartum she did not have any psychotic nor depressive symptoms. The patient is the only child in her family and she was born normally without complications. Her milestones were normal and she had no unusual childhood illnesses or stressors. Her sexual development was normal and she had her first baby during her first year of marriage at the age of 15 years.

Mrs X never attended school. She worked as a cleaner in a hospital for 11 years. She was married for 25 years and was blessed with four children, with no prominent psychiatric symptoms after any of the deliveries. The oldest child is 32 years old and the second child is 26 years old; they are both married. The third child is 14 years old and the youngest 5 years old. Mrs X lived with her husband and children harmoniously. They had no unusual problems and were financially stable. Her husband passed away from natural causes after she had left but was still healthy at the time she left home. She did not smoke nor drink alcoholic drinks, neither was she on any medication. Premorbidly she was a spontaneous and outgoing person.

Clinical picture

Mrs X came into the consulting room accompanied by her daughter. She was well groomed and appropriately dressed. She made good eye contact and seemed relaxed and was very co-operative. She gave a good account of why she was visiting the clinic. She was well oriented to person, place and time, and we could easily attain and keep her attention. Subjectively, her short-term memory was poor while objectively the short-term memory was impaired. She mentioned impairment of memory with regard to recent events. Impairment of short-term memory was confirmed with mental state examination.

Her affect was warm and appropriate, but she said she felt saddened by her husband's passing away in her absence. Clinically, the mood was dysphoric. Her abstract thinking was intact and her general knowledge, insight and judgement were good.

When asked what she thought had happened to her, she said she believed she was bewitched. According to her culture it is not regarded as a thought disorder. Apparently there were people who did not wish her well, and who wanted her to wander away from her home. On questioning she did not report any auditory or visual hallucinations or other perceptual disorders.

A week before this visit Mrs X reported experiencing an impaired sleep pattern. She complained of initial insomnia. Her appetite was good, despite some weight loss. Her libido was good, and she did not have any autonomic signs.

On physical and neurological examination nothing abnormal was detected.

We made a provisional diagnosis of dissociative fugue pending laboratory investigations and further collateral information. The diagnosis of psychotic disorder not otherwise specified (NOS) with postpartum onset was also considered. However, this could not explain her vague recollection of events that had taken place during the previous year and the change of identity.

Blood investigations for full blood count, liver function, urea and electrolytes, rapid plasma reagin (RPR) and HIV were all normal. No abnormalities were found on computed tomography (CT) of the brain or electroencephalogram (EEG).

Collateral information was obtained from the lady who employed her and with whom she lived while in her fugue state. This woman mentioned that during the year Mrs X worked for her she did not observe any abnormal behaviour.

Discussion

We had to determine whether Mrs X's memory deficit was of a psychogenic, organic, malingered, or mixed aetiology. We first ruled out organic causes of a fugue state.

Delirium and dementia were ruled out as memory loss is usually associated with several recognisable cognitive symptoms[13] and personal identity memory loss is usually not found in the absence of marked disturbance in many domains of cognitive function.[14]

Transient global amnesia involves a sudden onset of both anterograde and limited retrograde amnesia, retained memory with regard to personal identity, preoccupation and concern about the symptoms and an association with vascular problems.[12] This did not fit the clinical picture of our patient.

Posttraumatic amnesia was excluded as our patient did not have a history or clinical evidence of brain injury and the brief retrograde amnesia usually found.

Epileptic fugue was not the case as the epileptic's behaviour is usually brief, semi-purposeful, stereotyped and usually recognised as abnormal by others.[14] Epileptics may also have perceptual alterations and motor abnormalities and usually do not assume a new identity. Our patient had no history of seizures or unexplained behaviour before or during the fugue state. Her EEG was also normal. Electroconvulsive therapy (ECT), which the patient never received, may cause temporary or persistent memory problems.[15,16]

Postoperative amnesia was excluded as it usually is of short duration and the person does not change identity. Postinfective and anoxic amnesias were also excluded. No metabolic abnormalities, indications of vitamin deficiency or deficiency abnormalities were found in our patient. Alcohol and other drugs[17] were excluded as a possible cause as the patient had no history of their use.

Fugues can occur in schizophrenic patients as a means of defence against the anxiety accompanying psychosis.[18] However, patients with dissociative fugue do not generally manifest any of the psychopathology associated with schizophrenia (e.g. thought and perceptual symptoms).

Fugues in affective disorders differ from the dissociative fugues. The purposeful travel or wandering that occurs in manic patients is usually associated with grandiosity, other manic symptoms and behaviour that may call attention. Nor do they take on a new identity. Depressed patients may experience fugue states, which are almost always accompanied by other symptoms of depression. Fugues can also be malingered,[19] posing a diagnostic problem especially where there is no clear secondary gain. This was also excluded in our case, as there was no indication of possible secondary gain.

Certain culturally bound psychiatric syndromes can present as fugue states,[20,21] such as *amok* in Malayans and *piblokto* in Inuit. Our patient does not belong to any of the cultures that have fugues, nor did she present like them.

Somatoform disorders were ruled out as the history and objective clinical findings indicated that the patient did not have any physical nor conversion signs and symptoms.

Posttraumatic stress disorder criteria did not fit the clinical picture of our patient. Depersonalisation and dissociative identity disorder were also excluded.

We evaluated Mrs X monthly for 6 months and thereafter 6-monthly for one and a half years. Her clinical picture did not change over this period. Her recollection of the fugue is now partial, she is still functioning well at work and has been back home with her children.

We finally confirmed a diagnosis of dissociative fugue. The possible precipitating stressor in this case could have been the birth of the child, as well as repeated hospitalisations for caesarean section complications.

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AIDS FOCUS

Rape survivors and the right to emergency medical treatment to prevent HIV infection

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The South African Constitution provides that 'No one may be refused emergency medical treatment'.[1] The question arises whether rape survivors qualify for emergency medical treatment in terms of the Constitution, and if so who is responsible for providing such treatment. The decision by the South African Cabinet to implement antiretroviral treatment for rape survivors[2] seems to indicate that the government recognises that this duty lies with the state.

We therefore examine the meaning of emergency medical treatment; the duties of police officers, medical practitioners, state health institutions and private health institutions; and the role of non-governmental organisations with regard to rape survivors.

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Meaning of 'emergency medical treatment'

In the case of *Soobramoney v. Department of Health, KwaZulu Natal*[3] the Constitutional Court held that 'emergency medical treatment' means treatment arising from a 'sudden catastrophe which called for immediate medical treatment'. The Court held that in such instances a patient should not be refused ambulance or other available emergency services and should not be turned away from a hospital able to provide the necessary treatment. Remedial treatment that is necessary and available must be given immediately to avert harm.[3]