

Dissociative fugue in the patient of maternity ward – case report

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SUMMARY.

Introduction: The dissociative fugue is a sudden and unexpected flight accompanied by loss of memory, disturbances of own identity, as well as impairment of functioning. It is usually triggered by severe stress. It needs to be discerned from disturbances caused by somatic illnesses, psychoactive substances use, depression, psychosis, and dissociative identity disorders.

Objective: to pay attention to the role of delivery-related stress in connection with obstetric history, and the pathologies in the infant as predictors of dissociative disturbances in the patient of the maternity ward.

Method: The case analysis .

Case description : A thirty-year-old woman with secondary education, married and employed had left the maternity ward with her baby unnoticed on the fourth day after delivery . The patient didn't remember this fact after finding her and the infant by the police. The patient had no genetic predisposition in her history. She had suffered head injury in her childhood. Her mother lost two of her siblings (miscarriage and early death of infant). The patient miscarried her first pregnancy, and then she had waited several years for the baby. The second pregnancy was at risk, the labor was premature and the infant was born with palatoschisis. In the maternity ward, the patient had difficulties with feeding the baby. She experienced fear about the baby's life, as well as the feeling of being neglected by the staff. In the psychiatry ward, the patient did not reveal any symptoms of mental illness. A memory gap covered the period of her flight. She had shown interest in her child and was motivated to nurse him by herself. The tendency to use immature defence mechanisms (denial and suppression), as well as mild cognitive dysfunctions were observed in psychological testing. Dissociative fugue was diagnosed.

Conclusions. The interaction of past and present traumatic experiences with cognitive dysfunctions and immature defence mechanisms could influence the patient's ability to cope with fear about the child negatively. It led consequently to dissociative loss of memory with

disintegration of perception, identity, and conscious control over the behavior in the fugue.

The case shows a need for early diagnosing and providing psychological support to patients of the maternity ward, especially those with bad obstetric history and laden with multiple stress factors.

Key words: post-partum / delivery-related stress, cognitive dysfunctions, dissociation

INTRODUCTION:

According to P. Janet dissociation is a subconscious psychological process in which, as a result of traumatic experiences, traumatic components of experiences are defensively separated from the consciousness, but are still active as unconscious psychic automatisms. In a situation of stress, they may temporarily take over the functions of memory, perception and motor activity of a person who begins to function automatically, regardless of the will. [1].

It manifests itself in a variety of psychiatric and pseudoneurological symptoms whose common feature is the participation of the dissociation mechanism shown. Dissociative disorders include (according to ICD-10): amnesia, fugue, stupor, trance and possession, movement disorders, seizures, anesthesia and sensory loss of sensation, Ganser syndrome, dissociative identity disorder (plural personality), mixed and other disorders.

In terms of contemporary classifications (DSM-IV and ICD-10) the common feature of dissociative disorders is partial or complete loss of integration between: memories of the past, a sense of identity, as well as perceptual and motor functions. Dissociative fugue is (according to the classification criteria in DSM-IV and ICD-10), the occurrence of sudden and inexplicable flight from residence, or work place with total or partial amnesia of the past, undermining of the sense of the existing or acquiring new identities. Dissociative fugue is triggered by a traumatic event causing stress condition exceeding coping capabilities of the individual.

The incidence is estimated at 0.2% in the general population [2, 3]. Fugue usually lasts a few hours or days, less frequently a few weeks or longer. Usually resolves spontaneously, leaving

amnesia of the events from the period of its duration [3]. Travelling during the fugue is futile, but the behavior and statements are coherent and rather do not draw attention of the milieu. Sometimes during fugue there is a feelings of confusion, loss of memory or awareness of memory loss inducing to seek medical assistance. During the long fugue a person can travel, acquire a new identity and start a new life in a remote location. After fugue has resolved there may appear anger, shame, depression and even thoughts of suicide [2,3]. Fugue is rarely diagnosed in the period of its duration, more often after its resolution - on the basis of history on the events and behaviors preceding or accompanying fugue. Fugue should be distinguished from simulation. In both cases the action taken allows to avoid risk, responsibility, conflict or other difficulties, however, fugue appears in contrast to simulation in a way that is not planned and is not pretended. Dissociative fugue is not diagnosed in the course of dissociative identity disorder (plural personality), in the states arising from the action of drugs, narcotics and somatic disease. In therapeutic proceedings attempts to restore memory through hypnosis or drugs do not give clear results. In therapy of people who had fugue, it is essential to acquire skills to identify and modify situations, conflicts, emotions and patterns of response, preceding or triggering fugue.

Among the factors predisposing to dissociative reactions genetic factors are taken into account [4] and serious psychic trauma in history such as sexual abuse, violence, war, a dramatic loss of the beloved ones, disasters, cataclysms. Similar importance may have unresolved chronic emotional and interpersonal conflicts. Dissociation can be both a defense mechanism and escape from unendurable anxiety associated with a traumatic experience. It was noted that persons with a predominance of immature defense mechanisms especially repression, denial and splitting, as well as those with borderline personality traits and stress-related disorders are especially prone to dissociative disorders [1]. The literature highlights

the significance of neuropsychological cognitive dysfunctions for susceptibility to develop stress-related and dissociative disorders - particularly amnesia and dissociative fugue [5,6].

Kopelman MD. and N. Kapur [7] analyzing cases of psychogenic (dissociative fugue and amnesia) and organic (varying degrees of damage to the frontal and temporal lobes of the brain) amnesia put forward the thesis of the interaction of psychogenic (dissociative) and organic (neuropsychological deficits) in the formation and resolution of both organic and psychogenic (dissociative) amnesia.

C. Amrhein and colleagues [5] by comparing the results of the testing of cognitive functions in healthy subjects and with no traumatic experiences in history with high and low ratio of occurrence of dissociative experiences (the DES scale Dissociative Experiences Scale) found that people with high rates of dissociative experiences achieved significantly worse results in tasks investigating functions of visual spatial, operational and associative contextual memory in verbal material, as well as control and executive functions. These people made perseverative and false positive errors. According to the authors these mild cognitive dysfunctions in healthy subjects, but prone to dissociation may be a predictor of stress-related and dissociative disorders.

Stress and dissociation in post-partum period.

In literature more attention has been lately paid to psychological and psychiatric consequences of traumatic experiences associated with pregnancy and post-partum period. Particularly in the post-partum period there are numerous biological and psychological factors affecting significantly the emotional state of the woman. These include hormonal and body weight changes as well as the confrontation with the maternal role and sleep deprivation associated with child care. These factors make the postpartum period associated with an increased risk of recurrence of pre-existing psychiatric disorders, as well as an increased risk of disorders in persons who hitherto have not suffered from mental illness.

Brokington I. [8] on the basis of the literature from 1996 to 2004 classified postpartum psychiatric disorders in women as: psychoses, mother-infant relationship disorder, depression, and the largest group of specific post-partum disorders including acute stress disorder (ASD) and posttraumatic stress disorder (PTSD), and specific, thematically focused on anxiety about the infant and obsessive compulsive disorders. The author does not mention dissociative disorders in the article. However, other authors describe in women after delivery acute reactions to stress (ASD) with dissociative symptoms. Their significant intensity in the first week after delivery is associated with more frequent occurrence in the later period posttraumatic stress disorder (PTSD) [9,10, 11].

Acute stress disorder (ASD) and dissociative symptoms in the post-partum period are statistically significantly more frequent in the cases of : premature birth, prolonged , very painful, complicated delivery, as so in cases of delivery ended with emergency Cesarean section, including the case of mother's illness following the labor and diseases or inborn defects in the infant, moreover in women with a difficult situation in family life, and with high levels of negative emotions in the period of pregnancy [9,10, 13].

Frequent occurrence of high levels of post-partum stress in women who previously suffered a perinatal loss (spontaneous abortion, dead fetuses, and post and intra-partum deaths) is emphasized [13,14,15]. Perinatal loss is associated not only with the loss of the expected child, but also undermines the self-esteem associated with the role of a mother and woman able to give birth to a healthy offspring. In the family the atmosphere of confusion and disappointment often emerges. Thus, there is a need to deal with emotions in the process of mourning. Counseling or the assistance of support group after perinatal loss, may be needed to reduce vulnerability to stress during the next pregnancy and delivery.

OBJECTIVE :

to draw attention to the importance of family history, perinatal loss, and current obstetric and infant pathologies resulting in, along with immature defense mechanisms and cognitive dysfunction in the mother, significant difficulties in her coping with anxiety leading to triggering dissociative disorders in the form of fugue.

CASE DESCRIPTION

History.

A 30- year-old woman working on an independent position, married, secondary vocational education, not yet treated psychiatrically, delivered at 34 weeks gestation, by cesarean section (premature rupture of the amniotic fluid), a child with palatoschisis (2750g/50cm). On the fourth day after delivery, the patient left the maternity ward imperceptibly taking the child. The police notified found the live infant in the parking lot outside the hospital, and his mother on a bench in a nearby park. She did not remember how she had got there, claimed that the child had died in the hospital, she was distressed, anxious and tearful. With suspicion of postpartum depression, she was sent to a psychiatry ward.

In the psychiatric emergency room the patient was in a logical, somewhat superficial contact, comprehensively oriented, with no signs of drive and mood disorders, there were no hallucinations, delusions, nor somatic deviations. The patient manifested surprise at the situation, but she spoke about it strikingly calmly. The period of the critical incident was covered with amnesia. She agreed to observation in a psychiatry ward. On history taking, the patient reported that she had a younger sister. In the family there were no mental illness, neurological disorders or alcoholism. Her parents lost two children (spontaneous miscarriage and early infant death). At home these losses were not discussed. She recalled her family home as warm, caring, and family relationships as good and cordial. She denied any family conflicts.

The patient during the early-school period sustained a head injury; afterwards she was 2 weeks in hospital (no documentation). In the past, there were no seizures, losses of consciousness, dissociative symptoms. She has been married for several years. She lives with her husband and in-laws in a small town. At 6 weeks of her first pregnancy, spontaneous miscarriage occurred. Only after several years of efforts to have another child, during diagnosing infertility, it turned out she was pregnant.

In the early period of this pregnancy, bleeding occurred, following which on her doctor's recommendation she stopped working and avoided heavy housework. She tolerated it poorly despite the loving help of her family. At the 20th week of gestation she was deeply affected by the information on an anatomical defect in the child. The child born with palatoschisis had difficulty in sucking, ate little. The patient experienced increasing concerns about his health and life, not sleeping at night, she felt helpless and exhausted. She had a feeling of lack of support from the staff of the maternity unit, which, as she reported: trivialized her problems, did not share the anxiety about the child and motivated to breastfeed.

Observing other children who were tube fed, she concluded that her child would not survive if he was not fed likewise. However, she received the information that the child had no indications to the tube, but to breast feeding. The fact that she left the hospital with the baby, abandoned the child in the parking lot, and when found in the park by the police claimed that the infant had died in hospital – she does not remember.

Observation in the psychiatry ward:

no disturbances of consciousness, psychotic symptoms, anxiety, depression were observed in the patient. Initially she was in superficial contact, trivializing the incident, perfunctory in her statements, displayed no vivid emotions. She neither remembered that she had left the hospital with the infant nor what she had been doing until she was found by the police. She seemed not to be affected emotionally by child's health and life hazard to which she had exposed the baby

nor be aware of possible legal consequences for her and the child (the option of questioning her capability to care for the child). She declared, nevertheless, interest in the child, his necessary rehabilitation and surgical treatment of palatoschisis. She wanted as early as possible to take personal care of her child. She thought that her care and conduct are best, she related critically to the care of the neonatal unit.

Her somatic state, basic laboratory testing and neurological examination revealed no significant abnormalities. The MRI examination of the head visualized enhanced cerebral fluid spaces over the frontal, temporal and parietal lobes, other anatomical elements within normal limits. The EEG recording: normal. During her stay in the ward she became more communicative, cooperating, emotionally more vivid, interested in the results of diagnostic tests. Her husband accompanied her to the neonatal ward where she actively dealt with the child, she had a good mood. No psychotropic medications were administered. The patient was discharged home without symptoms of mental disorders under the care of her husband. Recent dissociative fugue was diagnosed.

Psychological Assessment:

The patient's history and observation drew attention to her tendency to give very general answers, present herself in a favorable light and not disclose any problems or difficulties. The predominant theme in discussions was her desire to be discharged from hospital to take care of her child, as well as critical opinion of the obstetric unit. Striking was the patient's underestimating the fact of amnesia and loss of conscious control of the proceedings. Her statements indicated that she did not discern and was not affected emotionally by the connection between her conduct during fugue and the resulting serious threat to life and health of the child.

She did not deny the conveyed information about what she had done during fugue, however, she did not remember her actions and utterances from this period, she did not respond to them

emotionally, she charged the obstetrics ward staff with responsibility. As she claimed the staff did not respond to her difficulties with feeding and her concerns about her child's life justified by palatoschisis, poor sucking and loss of weight. She stated that the attitude of the staff led to her "nervous breakdown". Nevertheless, she had no doubts about her ability to care for the child. Such an attitude could be a manifestation of the current cut-off of emotions and consciousness of the patient from her identity from the period of fugue, or result from a reduction in insight and criticism of other origin. (eg, personality, organic)

Psychological tests and questionnaire testing:

In personality questionnaires (WISKAD Test, the Rotter Incomplete Sentence test, Eysenck Personality Questionnaire EPQ - R) control scales were significantly increased that undermined the credibility of the results obtained, but also testified to the high tendency to dissimulation, social conformism, the possible displacement and / or denial and a lack of insight, which confirms the tendency observed in talks to avoid a critical self-evaluation, and presentation of herself in a good light.

According to the DSQ 40 questionnaire most commonly used by the patient defense mechanisms were beside mature mechanisms (sublimation, anticipation) the immature ones: rationalization, denial, as well as elements of neurotic thinking: undoing. Taking into account an observed in the patient tendency to trivialize stressful life events, denial, and displacement of related emotions, the presence of susceptibility to activate dissociation as a defense mechanism against the accumulation of traumatic experiences in her can be assumed.

The results of neuropsychological tests. The result of Clock drawing test was appropriate, the score in an MMSE was of 30 points. The result of the Bender - Gestalt test ($z = 79$) was borderline normal. In the Benton Visual Memory Test the patient committed three errors (displacement and perseveration) in 7 figures, which does not fall outside the norm. However, the test results: Serial Sevens Subtraction Task (the slow pace of work, 4 errors), Trail-

making test_(Part A: 38 sec. - 30 percentile, Part B: 54 sec. - 75 percentile), Paired Associate Learning test of 10 pairs (5.0, 3.2 and 5.1) and the Rey complex figure test (copy of 31 + / 36 type IV points, 16 points reproduction type IV) were below normal limits. The verbal fluency test (within 1 minute 20 names of animals and 21 words beginning with K, 4 perseverations) gave the result below the expected, and the digit span test (forwards – 3, backwards - 42) results in the lower limits of the normal range. The test results indicated a reduced manipulation and graphomotor efficiency, concentration difficulty, reduced direct memory scope and significantly impaired working memory, moreover - the impermanence of memory trace, impaired verbal fluency, weaker visual memory and difficulties in visual-spatial abilities.

Intelligence quotient IQ = 84 (WAIS-R test renormalized version) was within normal limits, but was lower than the average. The strong point of the patient is the capability of complex form perceiving and analyzing, spatial visualization ability. She recognizes and understands the verbal stimuli, has the ability to perceive relationships between notions. Her weak points are her memory and resistance to distractors that may result from the identified deficits in other neuropsychological tests.

Summing up – psychological testing results demonstrate a clear cognitive dysfunction, which may be related to the irregularities occurring in the area of the frontal and temporal lobes visible in the NMR image. However, since the patient had done well at school, work and marriage - the impact of the current situational emotional burden on the results of the testing should be considered. It is also significant that the testing was conducted in the second week after delivery, thus at a time of neuroendocrine and metabolic imbalance in the woman, which may significantly affect functional state of the central nervous system and the results of neuropsychological tests. The results should be interpreted with caution. It is advisable to repeat neuropsychological testing in about 6 months.

COMMENT

In the patient there was an accumulation of the factors described in the literature as predisposing to the risk of severe post-partum stress [12, 13, 14, 15]. These included: in the generational family remaining silent over the perinatal loss and early childhood loss of two siblings of the patient and in the patient spontaneous miscarriage, several years of her endeavor failure to have another baby, current endangered pregnancy, information about the anatomical defect in her child with preterm termination of her pregnancy by emergency Caesarean section, and feeding difficulties associated with palatoschisis in the newborn.

In conversations with the patient it was discernable that she used a family pattern to dissemble difficult problems – trivialized or denied emotions associated with experiences in both pregnancies and their complications. This could favor the accumulation of non-verbalized emotions and increased susceptibility to traumatization. Following delivery, the patient's anxiety focused mainly (similarly as described by Brockington I. [8]) on the child, his feeding, weight, and consequently – on the fear for his life and losing him.

Anxiety concerns of the patient were not shared or understood by the rationally evaluating the situation staff which together with the family pattern of non-discussing difficult issues, deprived her of the sense of emotional support. With the use of immature mechanisms of displacement and denial, as well as the inability to communicate her fear and obtain support, growing difficult to bear anxiety, in accordance with psychodynamic concepts, could lead her to the protective memory loss and liberation of activities and experiences from conscious control - which was manifested in the form of dissociative fugue. According to the observations of Amrhein et al [5] in a patient could occur increased susceptibility to dissociation associated with cognitive dysfunctions identified in testing.

However, abnormal test results could be due to her situational emotional state and the influence of post-partum endocrinometabolic disregulation of CNS functions, and therefore –

be transient. On the other hand, a history of her childhood head injury and the brain MRI picture may suggest the existence of a well-established neuropsychological deficits in the patient. However, independently of the cause and nature of the currently identified cognitive dysfunctions, it may be considered, which suggests the literature [5] that they constituted a predictor of the occurrence of dissociative disorders under stress. In short: triggering dissociative fugue in a patient corresponds to a Kopelman and Kapur's model [7] – the interaction of psychological and neuropsychological deficits. In the patient interaction of traumatic past experiences (perinatal loss, endangered pregnancy), the family pattern of non-disclosure of emotions, pregnancy and delivery related post-partum stress as so congenital defect of the infant could along with immature defense mechanisms, cognitive dysfunctions and lack of emotional support from the surrounding people significantly impair the ability to cope with anxiety about the child. This led to a defense cut-off of the memory with disintegration of perception and executive functions, sense of identity and conscious control over the behavior during fugue.

Conclusions

- Perinatal losses in the history of the woman and her family in conjunction with complications in the course of the current pregnancy and delivery and her child's health state are significantly important for coping with stress and post-partum adaptation in the maternity ward.
- There is a need for early diagnosing in patients predisposed to high risk of post-partum stress-related disorders in order to provide them with adequate support and where necessary specialist psychological aid prior to being discharged.

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