TJTS Turkish Journal of Traumatic Stress

DOI: https://doi.org/10.63175/tjts.44
ISSN: 3062-2336

Turkish Journal of Traumatic Stress
2026; Vol. 2, No. 1, 51-55

CASE REPORT

Is a Traumatic Event Necessary for Dissociative Fugue? An Older Adult Case Associated with Chronic Psychosocial Stress and Caregiving Burden

Meliha Rehnuma Karaca Colaker [1,*]
Seda Kiraz [1]
Erol Göka [1]

1. Department of Psychiatry, Ankara Bilkent City Hospital, Ankara,Turkiye

Received : 12.12.2025
Revised : 29.01.2026
Accepted : 30.01.2026

*** Correspondence:** Meliha Rehnuma Karaca Colaker
Address: Department of Psychiatry, Ankara Bilkent City Hospital, Ankara,Turkiye
Email: drrehnumakaraca@gmail.com

ABSTRACT
Dissociative amnesia refers to the inability to recall life events triggered by stressors, in the absence of a medical condition or substance use. Dissociative fugue, in contrast, is characterized by this amnesia accompanied by purposeless and bewildered wandering. Because the condition is rare and may present with psychosis-like features, dissociative fugue can easily be overlooked in clinical settings, which may negatively affect treatment outcomes. In this report, we describe a dissociative fugue episode in a 56-year-old woman. Although she was conscious when found, she refused to disclose her identity and exhibited cognitive disorganization and markedly disorganized behavior. Toxicology screening was negative for alcohol and substances, and no neurological pathology was detected on Cranial Magnetic Resonance Imaging (MRI), Computed Tomography (CT), or Electroencephalography (EEG). She was subsequently admitted for differential diagnosis and evaluated as having dissociative fugue. This case underscores that dissociative fugue may also occur in later life and highlights the importance of distinguishing it from psychotic disorders in the acute phase.
Keywords: Dissociation, Dissociative Fugue, Trauma, Stress, Psychotic Disorder.

Introduction

Dissociative disorders are clinical conditions characterized by disturbances in consciousness, memory, identity, and environmental perception, occurring in the absence of an underlying medical condition and potentially leading to functional impairment.[1] Although dissociation has traditionally been viewed as a response to sudden, life-threatening trauma, contemporary literature emphasizes individual vulnerability and psychosocial context.[2] Trauma is not limited to discrete or dramatic events; chronic stress and caregiving burden may weaken self-continuity and increase dissociative symptoms.

According to the *DSM-5* (*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*), dissociative disorders are classified into five main categories: dissociative identity disorder, dissociative amnesia, depersonalization /derealization disorder, other specified dissociative disorder, and unspecified dissociative disorder.[1] Dissociative amnesia is characterized by an inability to recall important autobiographical information that cannot be explained by a medical condition and is typically associated with traumatic

Citation: Karaca Colaker MR., Kiraz S., Göka E. Is a Traumatic Event Necessary for Dissociative Fugue? An Older Adult Case Associated with Chronic Psychosocial Stress and Caregiving Burden Turkish Journal of Traumatic Stress 2026;2(1):51-55. Doi: https://doi.org/10.63175/tjts.44

or stressful experiences. In the DSM-5, dissociative fugue is no longer considered a separate diagnostic entity but is conceptualized as a specifier of dissociative amnesia. Dissociative fugue is defined by sudden and purposeful travel away from one's usual environment, accompanied by confusion regarding personal identity or amnesia for the fugue episode. This condition is rare, with an estimated prevalence of approximately 0.2% in the general population.[3]

In emergency settings, dissociative fugue may be misinterpreted as a psychotic disorder, an organic neurological condition, or a substance-related state. Therefore, careful history-taking and assessment of psychosocial stressors are essential in the differential diagnosis.[4] While dissociative fugue is most commonly reported in early adulthood and often follows an identifiable traumatic event,[3,5] cases emerging in later life in the absence of acute trauma and in the context of prolonged psychosocial stress and caregiving responsibility remain rare in the literature. This raises questions regarding whether a dramatic traumatic event is necessary for the development of dissociative fugue or whether cumulative chronic stressors may produce a similar clinical presentation.

This case describes an elderly woman with no history of regular psychiatric follow-up who had provided long-term care for her mother, experienced increasing social isolation, and underwent recent changes in living conditions. In the absence of a clear traumatic event, she developed a clinical presentation consistent with dissociative fugue in the context of chronic psychosocial stress and caregiving burden. This case highlights the importance of considering chronic stress and adopting a broader framework for trauma when evaluating dissociative symptoms, particularly in older adults.

Case

A 56-year-old single woman, a retired teacher living with her mother, was brought to the emergency department by police after being found naked and confused. She was initially registered as an "unknown person," and her identity was later confirmed following a missing-person report and contact with her family.

Physical examination revealed no signs of trauma. Toxicological screening was negative. Cranial imaging and EEG findings were within normal limits. After exclusion of organic causes, she was admitted for further differential evaluation.

On the second day of hospitalization, the patient began to speak. Anamnesis revealed that her mother had suffered a cerebrovascular accident in 2018 and continued to live with significant functional impairment, for which the patient was the primary caregiver. It was noted that she transitioned to a home-centered lifestyle following her retirement. She had previously presented once to a psychiatric outpatient clinic with complaints of loss of interest, insomnia, and decreased appetite, and discontinued antidepressant treatment after a short period.

She had recently moved to a new residence and had difficulty adapting to her neighborhood, reporting increasing fear of being harmed by unfamiliar people and becoming progressively reluctant to leave the house. Approximately two days before the event, she abruptly stopped speaking; her sister noticed this and temporarily assumed care of their mother. The day before the incident, the patient visited her sister without displaying any overt behavioral changes.

On the morning of the incident, she woke up early, spent a prolonged period praying, and

left her home without informing anyone. She was observed wandering the streets in a confused state. Her family was unable to reach her for approximately nine hours until they were contacted by the hospital. According to police reports, she was found kneeling as if praying, with her clothes removed, in a vacant lot approximately six blocks from her home. She refused to provide her name or engage in conversation and was subsequently transported to the emergency department.

Interviews revealed progressive loss of interest, frequent crying spells, appetite and sleep disturbances, loneliness, and future-related worries. She had no personal or family history suggesting mania, psychotic disorder, epilepsy, head trauma, alcohol misuse, or substance use.

Mental status examination at admission showed appropriate self-care, age-consistent appearance, and euthymic mood. Speech was within normal limits; content was predominantly religious. She was fully oriented to time, place, and person. No hallucinations or delusional perceptions were observed. She reported no memory of the day's events. Although she described occasional confusion, her thought content did not include clear psychotic features.

Electroencephalography findings, in addition to Magnetic Resonance and Computed Tomography, did not reveal any pathology. Psychological testing was performed. On the Minnesota Multiphasic Personality Inventory assessment, a marked tendency toward overly favorable self-presentation was observed, along with prominent hysterical traits and an increased vulnerability to somatization under stressful conditions. These findings suggest that the patient may be inclined to express emotional distress through somatic or behavioral channels. In the Beier Sentence Completion Test, religious themes were frequently noted, and the patient generally expressed positive feelings toward both herself and others. The Dissociative Experiences Scale (DES) score was 20%, which does not indicate severe dissociative pathology but is more consistent with subclinical dissociative tendencies. This level of dissociation appears compatible with transient dissociative reactions emerging particularly during periods of acute stress.

Therapeutic interviews suggested that years of providing care alone had become increasingly burdensome, that her social life revolved entirely around caregiving demands, and that she felt unsupported by her family. The cultural expectation placed on her as "the only unmarried daughter" contributed to feelings of entrapment, worthlessness, and exhaustion.

Given her refusal to disclose her identity, leaving home, purposeless wandering, partial amnesia for the episode, and the absence of an organic or substance-related etiology, the clinical presentation was considered consistent with dissociative amnesia with a dissociative fugue specifier, associated with chronic psychosocial stress and caregiving burden. Supportive psychotherapy was initiated, and family meetings were conducted to redistribute caregiving responsibilities and enhance social support. Although a primary psychotic disorder was not suspected, low-dose olanzapine was prescribed temporarily to reduce anxiety, improve cognitive organization, and facilitate cooperation.

The patient provided both verbal and written informed consent for the publication of this case report and all accompanying clinical information.

Discussion

Dissociative symptoms are conceptualized along a spectrum ranging from commonly experienced phenomena such as attentional lapses and absorption to more severe clinical presentations characterized by amnesia, fugue states, and discontinuities in identity.

Among dissociative disorders, Dissociative Identity Disorder (DID) is defined by the presence of two or more identity states, accompanied by a disruption in identity continuity and recurrent amnestic gaps. Dissociative fugue, in contrast, is conceptualized as a specifier of dissociative amnesia and represents a rare clinical presentation characterized by an inability to recall autobiographical information, accompanied by purposeful wandering.[1] Although the present case involved both fugue and amnestic features, the absence of persistent identity fragmentation or recurrent identity transitions supported a diagnosis of dissociative amnesia with a fugue specifier rather than DID.

While dissociative fugue is most commonly associated with acute traumatic events, accumulating stressors—such as caregiving burden, social isolation, and limited coping resources—may also precipitate fugue episodes.[6,7] In this case, no acute traumatic trigger was identified; instead, prolonged caregiving demands, social withdrawal, and environmental changes emerged as chronic stressors contributing to the onset of the episode.

Although fugue is usually reported in early adulthood, this case occurred in later life. In older adults, new-onset confusion, behavioral changes, and disorientation typically lead clinicians to prioritize the evaluation of organic causes.[4] In this patient, normal neurological and laboratory findings supported consideration of a dissociative process.

At emergency presentation, the patient exhibited disorganized behavior, religiously themed and tangential speech, refusal to share her identity, and minimal cooperation features that may be mistaken for psychosis.[8] However, during follow-up, orientation remained intact, mood was euthymic, perceptual disturbances were absent, and amnesia persisted, findings more compatible with dissociative fugue.

Dissociative disorders often respond well to appropriate intervention. Core treatment elements include psychoeducation, psychotherapy, restructuring of stress-inducing life circumstances, and strengthening of social support. In this case, addressing caregiving burden and family expectations, along with facilitating environmental adaptation, contributed to clinical improvement.

Low-dose antipsychotic medication was used as a short-term adjunct to manage acute cognitive disorganization and anxiety rather than to treat a psychotic disorder.[9] Ultimately, treatment in dissociative fugue should emphasize mitigating chronic stressors and supporting restoration of a coherent sense of self.

This case illustrates that dissociative fugue does not necessarily require a single traumatic event; chronic psychosocial stress and caregiving burden may also produce a comparable clinical presentation. A broader understanding of trauma is essential when evaluating dissociative symptoms in older adults.

Acknowledgment: None

Funding: This research received no specific grant and financial support from any funding

agency in the public, commercial, or not-for-profit sectors.

Conflict of Interest: The authors declare that there is no conflict of interest.

Ethical Considerations: Written informed consent was obtained from the patient for publication of this case report. All identifying information was removed to ensure anonymity.

Informed Consent: Informed consent was obtained from all participants.

Use of AI for Writing Assistance: Artificial intelligence–assisted technology was used during the writing process to improve language clarity. All content was reviewed, edited, and verified by the author, who assumes full responsibility for the accuracy and integrity of the manuscript.

Peer-review: Externally peer-reviewed.

REFERENCES

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed. Washington D.C.: 2013.
2. Vermetten E, Schmahl C, Lindner S, Loewenstein RJ, Bremner JD. Hippocampal and amygdalar volumes in dissociative identity disorder. Am J Psychiatry. 2006;163(4):630–636.
3. Igwe MN. Dissociative fugue symptoms in a 28-year-old male Nigerian medical student: a case report. J Med Case Rep. 2013;7(1):143.
4. Gwandure C. Dissociative fugue: diagnosis, presentation and treatment among the traditional Shona people. Open Anthropology J. 2008;1(1):1-10.
5. Gill G, Dumlao N, Singh G, Susaimanickam B, Korenis P. Dissociative amnesia with fugue in a middle-aged man. Prim Care Companion CNS Disord. 2023; 25(2):46530.
6. Kolozsvári LR, Rekenyi V, Garbóczy S, et al. Effects of health anxiety, social support, and coping on dissociation with mediating role of perceived stress during the COVID-19 pandemic. Int J Environ Res Public Health. 2023;20(8):5491.
7. Loewenstein RJ. Dissociation debates: everything you know is wrong. Dialogues Clin Neurosci. 2018;20(3):229–242.
8. Lewis-Fernández R, Martínez-Taboas A, Sar V, Patel S, Boatin A. The cross-cultural assessment of dissociation. Cross-cultural Assessment Of Psychological Trauma And PTSD. 2007;279-317.
9. Pacciardi B, Mauri M, Cargioli C, et al. Issues in the management of acute agitation: how much current guidelines consider safety? Front Psychiatry. 2013;4:26.