A RE-EVALUATION OF THE FUGUE

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INTRODUCTION

THE fugue has received little recognition in the literature in recent years. Stengel (1941, 1943) defines the fugue state as consisting of "transitory abnormal behaviour characterized by aimless wandering, and more or less marked alteration of consciousness, usually, but not necessarily, followed by amnesia". According to Henderson and Gillespie (1944) the patient in a true fugue suddenly leaves his previous activity and goes on a journey which has no apparent relation to what he has just been doing, and for which he has complete amnesia afterwards. William McDougall (1926) states: "Fugue is the name given to those instances in which a person suddenly disappears from his accustomed haunts and re-appears at some distant place, astonished and puzzled to find himself there, and unable to give any account of himself in the period between his disappearance and his re-appearance." In a footnote McDougall adds: "This word is sometimes used in a wider sense to include wandering of a seemingly aimless kind for which the subject (generally a psychopath) can assign no adequate reason or motive, but of which, nevertheless, he can give some description." In our cases the criteria for a fugue have been sudden onset of wandering with clouding of consciousness and a more or less complete amnesia for the event.

Over the past 3 years we have collected 37 cases, either from the hospital records or from cases personally seen by us. Interesting features have emerged which, as far as we can ascertain, have not previously been described. A control group matched for sex, age and clinical diagnosis has been studied to exclude fortuitous associations. In the 37 cases of fugue under review, 31 are men and only 6 women. This incidence in favour of males is in accordance with the findings of other workers who have dealt with mixed groups, but differs from Stengel (1941), who picked his cases mainly from the female wards of Bristol Mental Hospital.

COMPARISON WITH STENGEL'S SERIES

Age distributions are compared in Table I. The age at onset of the first fugue is compared with the figures of Stengel (1941) and Kanzer (1939). The average age of Kanzer's group cannot be given as the total individual cases were not cited. It will be seen that the majority of Kanzer's group fall in the 3rd and 4th decade, Stengel's in the 2nd and 3rd, and ours in the 4th decade.

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As Stengel appears to have made the most comprehensive analysis of associated phenomena, the same features have been examined in our cases and are shown in Table II. Stengel's thesis is that the similarity of fugue states in

TABLE I

Age at Onset of First Fugue

Kanzer (1939) 71 cases		Stengel (1941) 25 cases		Present Study 37 cases	
Decade	No.	Decade	No.	Decade	No.
1st	0	1st	0	1st	1
2nd	7	2nd	12	2nd	6
3rd	25	3rd	8	3rd	5
4th	24	4th	2	4th	16
5th	11	5th	3	5th	5
6th	3	6th	0	6th	3
7th	1	7th	0	7th	1
		Average Age 22·7		Average Age 31·98	

TABLE II

Features Associated with Fugues

	Stengel (1941) (25 cases)	Present Study Fugues (37 cases)	Present Study Controls (37 cases)
Depressive setting	24	29	20
Attempted suicide	12	10	7
Unhappy childhood	24	17	17
Alcoholism	4	10	4
Pseudologia fantastica	8	13	5
Hysterical mechanisms	3	12	8
Precipitating factors	6	35	—
Head injury	1	16	3

different mental disorders suggests common aetiological factors. His main findings are the importance of a constitutional depressive element, the impulse to wander emerging from a state of depression and a gross disturbance of home-life in childhood.

Depressive element: This was present in 24 of Stengel's 25 cases. In 29 of our cases it was a mood of depression which precipitated and/or accompanied the fugue; in 7 cases it was anxiety and in 1 case the mood could not be ascertained. The control group contained 20 cases of depression. The association between depression and fugue states in our groups was significant at the 5 per cent. level of confidence (for $n=1$, $\chi^2=4\cdot89$).

Patients attempting suicide: 12 of Stengel's cases had attempted suicide, but none had done so during the fugue. We had 10 cases of attempted suicide, 2 of which occurred during the fugue. There were, however, 7 attempted suicides in the control group. The incidence of suicidal attempts amongst our fugue states did not differ significantly from either of the other groups.

Disturbances in family life: In only one of Stengel's cases could the family life be considered normal. Five were illegitimate, to whom one parent had always been unknown; one had lost both parents. In all, 6 patients lacked both parents either temporarily or permanently during childhood; 3 lacked the parent of the same sex and 13 the parent of the opposite sex. The figures for

our fugue states are: 20 cases with a happy home life and 17 cases with an unhappy childhood, 5 of which were separated from the parent of the same sex. Our control group figures are: 20 cases with a happy home life and 17 cases with an unhappy childhood, 7 of which were separated from the parents. An unhappy childhood was commoner in Stengel's than in either of our groups, in each case the association being significant beyond the 0·1 per cent. level of confidence (for n=1, χ^2=16·69). An unhappy childhood is not, therefore, an essential aetiological condition for the subsequent development of fugues.

The following additional features have been compared with those found in Stengel's cases: Relation to alcohol, occurrence of pseudologia fantastica, the presence of hysterical features apart from fugue, and the presence of precipitating factors.

Relation to alcohol: Four of Stengel's cases were alcoholic; in 10 of our cases there was evidence of frequent drunkenness, and in one the fugues took place only under the influence of alcohol. Alcoholics numbered 4 in the control group. The difference between our fugue and control groups was almost significant at the 5 per cent. level of confidence (for n=1, χ^2=3·17). Stengel's group did not differ significantly from either of our groups.

Pseudologia fantastica: Stengel found 8 cases. We had only one; but we did find definite evidence of a frequent tendency to lying in 13 cases and possible evidence in two. Of our 37 cases, 21 had the reputation of being truthful. There were 5 persistent liars among the controls. The association between lying and our fugue states is significant at the 5 per cent. level of confidence (for n=1, χ^2=4·70).

Hysterical mechanisms: Stengel found hysterical mechanisms in only 3 cases. In our series of fugue patients, hysterical features, apart from fugues, were present in 12, doubtful in 1 and not present in 24. In the control group they were present in 8 cases. There is, therefore, no significant association between fugues and the presence of other hysterical mechanisms. The difference between our fugues and Stengel's is significant at the 5 per cent. level of confidence (for n=1, χ^2=4·17) only if the one doubtful case of hysterical mechanisms be included. In connection with hysterical mechanisms Stengel states: "In the great majority of cases the fugue states did not appear to be reactions to recent psychic events, nor did these cases show hysterical personality." He quotes Fenichel as suggesting that "the mechanisms of compulsive wandering have much in common with symptoms of obsessive compulsive states and that the person attempts by wandering to protect himself against depression".

Precipitating factors: In only 6 of Stengel's cases were precipitating factors found, while in our cases they were present in 35, doubtful in 1 and not found in 1. This difference is significant beyond the 0·1 per cent. level of confidence (for n=1, χ^2=30·64). This appears to show that we are dealing with a different group of patients. Presumably the more psychotic the patient the less reactive the fugue. The compulsive element stressed in Stengel's cases is not as evident in ours, though it is undoubtedly present in several.

To sum up: we find ourselves in agreement with Stengel with regard to the association between fugue states and, on the one hand, a reputation for lying and, on the other hand, a depressive mood. In the frequency of suicidal patients and alcoholics our fugue states do not differ significantly from Stengel's; but neither do they differ from our controls. Unhappiness in childhood was significantly commoner in Stengel's group than in either of our groups; hysterical mechanisms (apart from the fugues themselves) were significantly rarer in

Stengel's group than in our fugues, who did not however differ significantly from our controls. Precipitating factors were much more frequently found among our fugues than among Stengel's.

Further findings: Perhaps the most important finding in our series is the incidence of head injury. Stengel had one case of cerebral trauma and that in an epileptic. In this series, prior to the onset of the fugue, severe head injury was experienced by 16 of our cases and in a further 3 cases there was a history of head injury the severity of which we were unable to judge. In the control group a history of head injury was elicited in only 3 cases. The difference between our groups is significant at the 0·1 per cent. level of confidence (for n=1, χ^2=11·97). In the severe head injuries consciousness was always lost and there was often a long period of post-traumatic amnesia. In some of these cases the fugue started in the same year as the head injury. Sargant and Slater (1941) mentioned that in a quarter of their cases trivial concussion or dazing seemed to have played a precipitating role in producing the fugues. They described 10 cases with head injury, 5 with and 5 without intellectual impairment. In no case of ours was there any clinical or psychological evidence of impairment. Parfitt and Carlyle-Gall (1944) made reference to head injury, but did not apparently regard it as of any importance. They state: "Four suggested a recent trivial head injury as the cause of the symptom, and several others mentioned some minor head injury received years before."

Another feature prominent in our cases was that of escaping from some intolerable situation which appeared to be the immediate precipitating factor in the production of the fugue. Fourteen of the cases were escaping from justice, 3 from domestic stress, 7 from domestic and vocational stress, 1 from a love affair, 5 from a spouse, 1 from military authority, 1 from mental hospital, 2 from work and 1 from "work by compensation". The control group revealed that only one was escaping from justice but that 12 patients, prior to the onset of their illness, suffered from stressful situations similar in magnitude to those enumerated above. It is worth noting that of the 14 escaping from justice, 7 had had severe head injuries, 2 a doubtful history of head injury and 12 were liars and/or simulators.

Simulation was a further feature in our series. It was found in 10 cases, 9 of whom were escaping from justice. This feature is not specific as it was found in 8 of the control cases. It is worth noting that the simulation practised by these patients changed continuously and ranged from transitory weakness of movement to pseudo dementia.

Clinical diagnosis: The clinical diagnosis of these cases (Table III) throws

TABLE III

Diagnostic Categories of Fugue States in the Present Study

Psychopathic State	24
Hysteria	6
Reactive Depression	4
Involutional Depression	2
Schizophrenia	1

light on some of the above mentioned features. Twenty-four of our cases were suffering from psychopathic states, 10 from a psychoneurosis and only 3 could be considered psychotic. In Stengel's cases the patients were mainly epileptic or manic depressive, with some psychopathic cases. From a diagnostic point of view our fugue states fall into a predominantly psychopathic-neurotic

grouping, while Stengel's are mainly psychotic cases. Parfitt and Carlyle-Gall (1944) noted little in common between their own fugues and those of Stengel, and stated: "Stengel has written of fugues having in mind recurrent compulsive wandering rather than amnesia."

When our patients were further investigated, it was found that at the time of examination 24 had experienced more than one fugue and the remaining 13 one only. Of the 30 cases diagnosed as hysterical psychopaths, 23, or 77 per cent., had had multiple fugues; whereas of the depressives, whether psychotic or neurotic, only 1 out of 6, or 17 per cent., had had multiple fugues. The one schizophrenic had had a single fugue.

Psychopathology

In nearly all fugues there appears to be one common factor, namely, a depressive mood. Whether the individual in fugue be psychotic, neurotic, or even psychopathic, a depression seems to start off the fugue. It may be, as has been suggested, that the fugue is an attempt to ward off the depression. Some, such as Abeles and Schilder (1935), consider it to be a symbolic suicide. One of our psychopathic patients in his fugue took a route which would have brought him to his mother's home. On the way he attempted suicide while still in the fugue.

The role that head injury plays in our series appears to be particularly significant. We are not of the opinion that the organic trauma produced the fugue directly, but rather that it produced impairment which facilitated the occurrence of a psychogenic fugue, or that the concussion and subsequent amnesia formed the basis for the suggestion of a psychogenic amnesia at a later date. We incline to the latter viewpoint.

In support of this we quote Case 22 in our series: A salesman, aged 44 years, was admitted having been found wandering. He had disappeared from his home 5 days previously and had no idea of what he had been doing. In addition, he had a total amnesia for the past 16 years, dating from the time he was concussed in a professional boxing match. This injury, which was probably a middle meningeal haemorrhage, was a delayed one. On recovering his memory with us, under pentothal, he remembered starting his fugue from a coffee stall. He next recalled the fact that after the fight 16 years previously he had visited a coffee stall with some friends. It was here that he lost consciousness and remained unconscious for several days. He said: "I seemed to be back at the coffee stall after the fight—memories of the fight—at the same time felt I had to go to Hastings—walked and walked." It would seem, therefore, that the one coffee stall recalled the other 16 years previously and suggested amnesia. The patient remarked that until that moment he had not remembered the fight. There had been retrograde amnesia for it. As in many organic amnesias, there appears to have been a portion which was psychogenic and capable of being recalled.

These findings suggest that, where hystero-psychopathic personality and head injury co-exist, there is an increased likelihood of any subsequent breakdown taking the form of a fugue.

Stengel's theory concerning the production of the fugue has already been elaborated. Apart from this, the majority of the literature concerns the fugue occurring in war neuroses. There are few expert reports of persons actually seen in a fugue state. As in this hospital, they are usually seen after they have recovered from the fugue. The patient may be his normal self when he emerges

from the fugue, aware of his identity, with full memory of his past life (apart from the fugue period), or he may be unaware of his identity and of his past life. The awareness of personal identity does not appear to operate in the state of fugue. During this time patients appear to act in a kind of dream with only a few thoughts present in consciousness, for example, to get somewhere, to do something; or they ruminate over their specific problems. Many appear to have a feeling of guilt, often justified, sometimes fancied. When their reverie is broken by questioning or by some chance association, they may react normally; but they have partial or complete amnesia for the fugue, sometimes for their whole past life.

Some workers have recognized two types of fugue state: those with awareness of loss of personal identity and those with retrograde amnesia, the latter being aware of their identity but having amnesia for the fugue. Some workers, including Parfitt and Carlyle-Gall (1944), consider that this amnesia is feigned; others that it is hysterical in that it is suggested by the questioner and reinforced by secondary gain. According to McGeoch (1939), the person in a state of fugue cannot give true information about himself; but few have been questioned at this time. Describing the fugue state, Janet (1907) writes: "Things happen as if an idea, a partial system of thoughts, emancipated itself, became independent and developed on its own account. The result is, on the one hand, that it develops far too much, and on the other hand, that consciousness appears no longer to control it." This limitation to a circumscribed set of ideas is very reminiscent of the mental state of some of our psychotic depressives.

Gill and Rapaport (1950) observed a patient in a state of fugue. In the period of fugue, which was preceded by financial trouble, the subject was obsessed by the idea that he was out to find a job. He was in touch with his surroundings but did not recognize them. Though his personal identity was forgotten, he was not concerned over this loss and appeared to be unaware of it; instead, a single striving "to get a job" regulated his behaviour. Upon recovering spontaneously he forgot everything that had happened. This case supports Janet's (1907) description, but it does more than this. The case history, according to Rapaport (1950), shows that the striving was equivalent to escaping from responsibility to his family. This striving was guilt-laden and so forbidden. He could, as it were, only carry out the single striving to get work if at the same time he forgot the family whom he had left behind. How can this striving become so powerful as to effect the dissociation? "These isolated memories of the fugue which were recovered," says Rapaport (1950), "were organized around a set of unacceptable strivings. It is possible that when sufficiently strong and numerous strivings can find expression through one striving, and when the nature of these strivings is such that the relevant memories must be repressed, then the full body of memories containing the meaning of the various strivings (expressed now by a single striving) is forgotten. The striving which condenses the various strivings becomes paramount and rules consciousness, and this is the motif around which the fugue is built."

It will be noticed that Rapaport is not so much talking about forgetting as painting a picture of memories organized around strivings, emerging or receding with the predominance or repression of these strivings. It appears to be a positive, not a negative, process.

Rapaport finds that emotional factors lend persistence to certain ideas, impelling them steadily into consciousness. These emotional factors appear to be the basis of the blotting out of memories of certain periods of life which were organized around specific strivings, when later these strivings were super-

seded by others or became unacceptable. He states that he is unaware of the exact nature of these emotional factors. It is suggested by the present authors that a depressive affect may be the most important. There is something wholly consuming about depression. The imagined guilt of the agitated depressive occupies his thoughts to the exclusion of all others. We have seen that fugues appear to be the result of intense conflict. The person in a fugue is always in a situation in which he can neither escape from an anticipated danger nor has he the power to fight against it; he cannot fight any longer because he feels he is beaten; he cannot escape because his conscience forbids it. He becomes depressed, his ideas become centered around his problem and his depression lends force to this pre-occupation which excludes other thoughts. He may depart one morning to work but he is not really thinking of where he is going; his movements are almost automatic; he attends neither to himself nor to those around him. It is then that dissociation occurs. His "little system of ideas" takes possession of consciousness and with this he is in a fugue state.

The model for his loss of identity is perhaps often supplied by the previous head injury with its resultant amnesia. In some cases this may be reinforced by a predisposition to alcohol which, when taken in excess, serves for another amnesic model.

Summary

1. Thirty-seven cases of fugue are presented, of which 24 had multiple and 13 single fugues.
2. Severe head injury was found in 16 cases and doubtful head injury in 3 cases, as against 3 in the controls. Ten of the patients were also alcoholic.
3. Depression was noted as a prominent feature in both fugue and control groups. When compared with the control group, a broken home life was not found to be specific.
4. Hysterical mechanisms were found to be fairly common and compulsive features rare. Clinically, most of the cases fell into a psychopathic-neurotic grouping.
5. The probable roles that head injury, depression and alcoholism play in the production of fugues have been discussed.

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