An Archetype of the Collaborative Efforts of Psychotherapy and Psychopharmacology in Successfully Treating Dissociative Identity Disorder with Comorbid Bipolar Disorder

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ABSTRACT

We present a case where dissociative identity disorder was effectively treated with memory retrieval psychotherapy. However, the patient's comorbid bipolar disorder contributed to the patient's instability and fortified the amnesiac barriers that exist between alter personality states in dissociative identity disorder, which made memory retrieval difficult to achieve. Implications from this case indicate that a close collaboration between psychologist and psychiatrist focused on carefully diagnosing and treating existing comorbid conditions may be the most important aspect in treating dissociative identity disorder. We present our experience of successfully treating a patient with dissociative identity disorder and bipolar disorder using this collaborative method.

INTRODUCTION

The diagnostic criteria for dissociative identity disorder (DID) are summarized in Table 1.[1] The

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disorder is often found to be present in individuals that have been subjected to sexual or physical abuse early in childhood (5–10 years of age),[2] is mostly found in women, and has a prevalence of 1.5 percent.[3] When a young child is abused, he or she may feel helpless and delude that what is being done to him or her is instead being done to another person, causing an independent identity to be born,[4] possibly due to the exceptional ability of children to fantasize.[5] Usually patients with DID have numerous personality states—even up to ten—that can all be unaware of each other, making this complex disorder extremely difficult to diagnose.[6] It is theorized that a given personality presents itself when the individual is in a distressful situation and does not feel able to face it, therefore the individual chooses instead to let another personality handle the anxiety. Dormant states are also known to manifest themselves as auditory or visual hallucinations.[7]

DID is considered to be unrelated to any electrophysiological dysfunction[8] and there is no known effective psychopharmacology treatment for it.[9] Consequently, psychotherapy has been the most widely used form of treatment for DID.[10] The goal of treatment is to integrate the separate states of consciousness.[11] DID cases in the literature have indicated that medications are effective only if they are prescribed for conditions present across the human being, in all identity states.[12]

Here we describe the successful treatment of a case where the patient had two distinct personalities in addition to a diagnosis of bipolar disorder. Bipolar disorder is rarely reported as a comorbid feature of DID. Some of the most commonly reported Axis I comorbid disorders of DID are major depressive disorder,[13, 14] posttraumatic stress disorder (PTSD),[13] and substance abuse disorder.[15] The most commonly reported Axis II comorbid disorders are borderline and avoidant personality disorders.[13]

TABLE 1. Diagnostic criteria for dissociative identity disorder

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
B. At least two of these identities or personality states recurrently take control of the person's behavior.
C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
D. The disturbance is not due to the direct psychological effects of substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

American Psychiatric Association, DSM-IV-TR: 529[1]

CASE REPORT

Our patient was a 45-year old, married, Caucasian woman. She described having multiple blackouts, lasting no more than one day, from which she had no recollection. Her family members reported that during her blackouts she would spend money uncontrollably, shoplift, meet strangers in bars, and engage in sexually promiscuous behavior, all of which were out of character for her. Over the course of two years, she was involved in seven vehicle accidents during these blackout periods. Three of these accidents were serious and on one occasion she was found nude. The family reported that during blackouts her voice would change from her usual tone to a more malicious one that she could not control. She and her family gave this alter personality its own name; for our purposes here, we will refer to the alter personality as "Kim."

The patient presented to treatment suffering from severe insomnia, constant anxiety, nervousness, and week-long mood episodes of depression and mania, in addition to the blackouts. She initially sought out psychiatric treatment where she received several medications for depression that she reported were not of any help. The patient denied any history of suicide attempts or ideation. Though she would often self-medicate with Vicodin (hydrocodone bitartrate-acetaminophen), Xanax (alprazolam), and Soma (carisoprodol) off and on, she did not abuse these drugs on a regular basis. Further collateral history from her husband indicates that the patient was not intoxicated with alcohol or other drugs during the blackout episodes, ruling out that the DID symptoms were caused by substance abuse. She also denied any history of seizure disorders. The only medical diagnosis she had at the time of the initial evaluation was gastroesophageal reflux disease (GERD).

The patient detailed a history of sexual abuse occurring between the ages of 8 and 14 years by a neighbor and an uncle, and being physically abused as a child by her mother. Her five siblings and her mother all have substance abuse disorders. One of her sisters and her mother have bipolar disorder.

After an approximately seven-year break from her unsuccessful psychiatric treatment, she decided to

resume clinical treatment with us; she was begun on concurrent psychotherapy (R. Meier) and psychopharmacology (R. Lakshmanan) treatment. Upon initial evaluation, she was diagnosed with two disorders: DID due to her blackout episodes with voice tone changes; and bipolar I disorder, most recent episode depressed, severe without psychotic features,[1] due to her severe mood episodes between depression and mania without psychotic features, history of racing thoughts, high energy levels despite insomnia, irritability, 30-pound weight gain in five years, fatigue, depressed mood, and a score of 13/13 on the Mood Disorder Questionnaire.[16] Although DID is often mistaken for borderline personality disorder (BPD),[17] the patient had no history of sudden and intense changes in relationships that would warrant the diagnosis of BPD.[1]

She was prescribed 300mg of lithium carbonate three-times per day, 150mg of lamotrigine twice per day for bipolar disorder, and 100mg of trazodone at night for severe, resistant insomnia; lorazepam, 1mg twice per day, was later added for her insomnia and anxiety as trazodone alone and several other hypnotics were not effective. In spite of the addictive nature of lorazepam,[18] the family reported that the patient did not abuse the drug. Moreover, the patient and a family member were asked to sign a contract stating that she would not abuse lorazepam before it was prescribed to her.

This prescription regimen led to the remission of the symptoms of bipolar disorder two months later. Shortly after, the patient unexpectedly began hearing a voice, which she claimed belonged to Kim, in her head urging her to cut herself ("like a war going on in my head"). She was then prescribed 10mg per day of aripiprazole. Not long after the onset of Kim's voice in the patient's head, psychotherapy treatment started to progress significantly as she began to better recall the traumatic events of abuse from her childhood.

With the surfacing of these more elaborate recollections of the distressing events of her childhood, the patient was instructed to re-visualize them as being isolated events of her distant past so that she could effectively deal with them without reliving the emotional trauma. The patient was very adherent to the 16 planned, evenly spaced psychotherapy sessions over a two-year period. Sessions were not scheduled more frequently due to patient preference and because of the support the patient was already receiving from her family. Along the lines of the protocol detailed by Pace,[19] the psychotherapy exercises included gentle recall of pleasant life events from her childhood, both before and after she had been molested as a child. She was led to chart the dates and her age when she recalled both pleasant and painful memories. Additional therapeutic interventions used included having the patient write emotional letters to her offenders and burn the letters; bury a doll that represented Kim; and bury two objects that belonged to her deceased mother who had beaten her as a child. Much of the time used in psychotherapy focused on positive experiences from the patient's childhood that had been suppressed.

The positive memory retrieval techniques combined with the help of aripiprazole appeared to successfully integrate the patient's two states of consciousness and lead to the remission of the DID within about two months after she began hearing Kim's voice. When the patient was asked about the aspects of treatment that were most helpful, she stated that she felt both pharmacology and psychotherapy were integral in her recovery. She expressed that the thought-provoking exercises in psychotherapy empowered her to feel like an active participant in her recovery and helped her gain some feelings of control and release some of the terror she continued to carry throughout her teen years and adult life.

At the time of the remission of the DID, the patient felt less overwhelmed, was sleeping better, and had no episodes wherein the alter personality emerged on its own. Her family reported that she no longer experienced blackouts nor changes in personality states. She has been stable now for two years on the medication regimen discussed.

The patient strictly adhered to her medications as prescribed, actively participated in psychotherapy sessions, worked on her psychotherapeutic homework as assigned, monitored her stress levels, and returned for psychotherapy four times a year, then twice a year, and now annually. She was always accompanied by a family member for psychiatric visits and sometimes for psychotherapy visits. She was aware that her behaviors were a problem for her family and she was motivated to change. In addition, the patient stated that having a supportive husband who actively listened to her was also a very important factor in her recovery. Finally, she also credited improved sleep as playing a crucial role.

Previous research indicates that DID can only be overcome with psychotherapy, but in this case, psychotherapy was not effective until the patient was stable enough to deal with the anxiety that came with recollecting a traumatic event. The need for medication in treating comorbid disorders with DID as a supplement to psychotherapy should not be overlooked.

DISCUSSION

Psychopharmacology treatment was specifically focused on treating the patient's bipolar disorder. It is interesting to note that the patient began hearing a mysterious voice, similar to having auditory

hallucinations after her bipolar disorder symptoms improved. That is, in the remission of the bipolar disorder, an unrelated and previously unobserved symptom developed. Yet, because this new symptom coincided with the patient's improved capability to recall memory, it is thought that once the patient's bipolar disorder was stabilized, the exoneration from the bipolar disorder symptoms allowed the patient to better access her painful childhood memories. This enhanced ability to access traumatic memories began the process of integration of the two separate states of consciousness, of which hearing Kim's voice was a manifestation. Moreover, lorazepam is known to facilitate recall through the control of secondary anxiety that may inhibit the retrieval of distressing memories.[20]

In this case, the pain of re-living traumatic events caused memory retrieval to be difficult until other electrophysiological dysfunctions were treated. One of the overarching features of DID is that amnesiac barriers exist between alter personalities.[21] It is likely that Kim, the alter personality, bore the burdens of the patient's traumatic childhood recollections until the patient began hearing Kim's voice. The patient had been using her alter personality as a defense against dealing with the abuse inflicted on her as a child for so long that she had difficulty recalling much of it. Only once barriers to memory retrieval are overcome is integration of the personalities possible through memory retrieval and revisualization of the traumatic events. It may be that the voices of alter personalities that DID patients claim to hear, such as in this case, provide a form of interidentity communication[11] rather than a true auditory hallucination.

This case exemplifies the significance of collaborative efforts of psychotherapy and psychopharmacology and the importance of patient adherence and family support. Previous research indicates that DID can only be overcome with psychotherapy, but in this case, psychotherapy was not effective until the patient was stable enough to deal with the anxiety that came with recollecting a traumatic event. The need for medication in treating comorbid disorders with DID as a supplement to psychotherapy should not be overlooked.

When the patient initially sought out psychiatric treatment that she found ineffective, her DID symptoms may have even been exacerbated as a result of her being misdiagnosed with depression. Some psychopharmacology treatments have the potential to hinder psychotherapy by causing severe mental changes.[3] Therefore, the patient's DID symptoms may have been aggravated by her previous treatment with antidepressants. In particular, it has been shown that antidepressant-induced mania can destabilize cases of bipolar disorder.[22,23] In addition, the antidepressants would have worked to contribute to the already manic behavior of Kim, the patient's alter identity. Consequently, misdiagnosis of comorbid disorders makes treating DID with psychotherapy extremely difficult.

Furthermore, we obtained a thorough history and an extensive report of the patient's behavior, as well as monitored her progress with the help of her family members who accompanied her for many of the appointments. This support may have also been instrumental in the patient's adherence with taking prescribed medications and working on psychotherapy homework. Some of the most widely-reported obstacles to treating DID patients is that they are often unable to sufficiently recall their history or other symptoms, they are too ashamed to speak about them, or they are too unstable to independently adhere to prescribed medication or psychotherapeutic homework assignments.[24] As a result, the support of family and friends in treating DID also serves as a valuable tool in treating the disorder.

CONCLUSION

In treating DID, it is crucial for the psychologist and psychiatrist to initially focus on treating any existing comorbid conditions. In this case, our patient's bipolar disorder was responsive to medications. Only once symptoms of bipolar disorder were controlled did the DID-targeted psychotherapy become effective. In addition, the patient's social support system provided the necessary framework that she needed to implement the clinical treatment into her daily life. Therefore, the timing of the efforts of the psychologist and psychiatrist in treating the patient's disorders and the sustained support from her husband impacted her progress to remission of DID.

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