

# RECOGNIZING BIPOLAR ILLNESS IN PATIENTS WITH DISSOCIATIVE IDENTITY DISORDER

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## ABSTRACT

*Severe psychic distress and multiple symptoms are hallmarks of Dissociative Identity Disorder (DID) and are central to many diagnostic and therapeutic dilemmas for clinicians working in this field. Although comorbidities are commonplace in DID, cases in which Bipolar Illness (BPI) is comorbid with DID often escape detection because dissociative symptoms obscure and distort the individual's self-perception and self-report. In addition, the severe symptoms consistent with comorbid BPI are often misattributed to "known" borderline problems or major depression. This article describes in detail three cases in which the diagnosis of DID was well-documented and longstanding, and in which persistent symptoms led to a new diagnosis of comorbid BPI. In these individuals, undetected BPI had contributed to severe symptoms, ongoing risk of violence, and therapeutic chaos. The authors discuss problems in identifying comorbid BPI and circumstances which indicate that BPI should be included in the differential diagnosis. Suggestions are offered for evaluation and treatment.*

The presence of severe psychic distress manifested through multiple symptoms is a hallmark of Dissociative Identity Disorder (DID) and central to many diagnostic and therapeutic dilemmas for clinicians in this field. The DID diagnosis implies high levels of multiple types of dissociative symptoms – amnesias, absorption, depersonalization, dere-

alization, identity confusion, and identity alteration. Individuals diagnosed with DID will have received, on average, three to seven prior psychiatric diagnoses (Putnam, Guraff, Silberman, Barban, & Post, 1986; Ross, Norton, & Wozney, 1989; Coons, Bowman, & Milstein, 1988). It is often assumed that these were misdiagnoses, but comorbidities are standard in DID, with Major Affective Disorder and Borderline Personality Disorder co-present, by *DSM-III-R* criteria, in over three-quarters of DID patients in some series (Ross, 1989). Goodwin and colleagues (Goodwin, Cheeves, & Connell, 1990) have used the BAD FEARS acronym to describe typical comorbidities in adults who describe multiple childhood traumata: BAD standing for Borderline, Affective, and Dissociative disorders; and FEARS standing for Fears and post-traumatic anxiety, Eating problems, Addictions, Revictimization, and Somatization.

This highly distressed, polymorphous, and at times, psychotic picture creates significant diagnostic obscurity in cases in which DID is comorbid with a psychotic condition, such as Bipolar Illness (BPI). Symptoms of BPI may escape detection because dissociative symptoms obscure and distort the individual's self-perception and self-report. In addition, severe symptoms may be camouflaged by common comorbidities; it may be assumed by the treatment team that persistent mood problems are explainable on the basis of "known" borderline problems or major depression.

This article describes in detail three cases in which the diagnosis of DID was well-documented and longstanding and in which persistent symptoms led to a new diagnosis of Bipolar Illness. In these individuals undetected comorbid BPI had contributed to severe symptoms (especially unremitting suicidality requiring repeated hospitalizations and refractory to medications), ongoing risk of violence (especially around sexual risk-taking), and therapeutic chaos with chaotic psychotherapy sessions and frequent disruptions in treatment planning.

## CASE NUMBER ONE

VB is a 50-year-old divorced, disabled woman who was diagnosed with DID at age 38. She was referred by a previous therapist who was moving away and had treated VB for six years. There was a history of multiple crisis hospitaliza-

tions, numerous abusive sexual partners, several self-harm episodes, and at least four documented serious suicide attempts. Neither anti-depressants nor minor tranquilizers had modulated her symptoms, and she continued to require crisis-intervention on a regular basis. Efforts to map her internal system met with her absolute conviction that her scores of alters were "real people" who had nothing to do with her own history or developing self. After many years, her treatment plan had not progressed beyond the necessary initial focus on maintaining safety and developing skills for emotional containment; she had maintained few, if any, treatment gains, and her family and recreational functioning appeared to be deteriorating. Her anxiety worsened, and she began to express fears about going outside. Psychiatric consultation identified periods of seclusion and withdrawal which would alternate with periods of impulsive bar-hopping, making friends with strangers, and obsessive house-cleaning. Because of this symptom picture, she was referred for psychological testing to assist in diagnosis and treatment planning. Over a one-month period, she completed a test battery of cognitive and personality instruments which included the Wechsler Adult Intelligence Scale-Revised (WAIS-R), Rorschach Inkblot Technique, Minnesota Multiphasic Personality Inventory (MMPI), Dissociative Experiences Scale (DES), Structured Clinical Interview for *DSM-IV* Dissociative Disorders (SCID-D), measures assessing language capabilities, memory, concentration, and attention, and both structured-interview and self-report measures of post-traumatic stress.

Initial test results supported the longstanding diagnosis of DID. Her DES score was 34, and on the SCID-D she met full criteria for DID with moderate to severe depersonalization and derealization. Her MMPI reflected the F-8 profile pattern which has been reported in several series of DID patients (Allen & Coyne, 1995; Bliss, 1984; Coons & Sterne, 1986; Solomon, 1983). However, some features of her testing performance seemed atypical. Her mood and affective expression during testing fluctuated unpredictably from dysphoric and tearful to mildly euphoric and ebullient, with speech that was frequently pressured and ruminative. Despite extensive pre-testing preparation and rapport building, several testing sessions had to be terminated early because of the patient's escalating anxiety and/or agitation. On the Rorschach, she gave 56 spontaneous responses, many of which were ruminative and perseverative. During the inquiry portion (in which the examiner asks how responses were arrived at), VB's anxiety and agitation escalated, and her replies became increasingly perseverative, circumstantial, and disorganized. Because of concerns that continuation would be counter-therapeutic, the inquiry was terminated at Response 16 and thus could not be formally scored using the Exner system. However, even with the incomplete protocol, content analysis revealed a high percentage of Animal/Animal Detail responses, and Color Form and Space determinants, which, according to some authors

(Vincent, 1987; Vincent & Duthie, 1983) can be indicative of hypomanic tendencies.

This Rorschach protocol, together with VB's overall testing behavior, and her observed and reported mood lability and impulsivity, suggested the need to include BPI in the differential diagnosis. She had previously been diagnosed as having Major Affective Disorder and Borderline Personality Disorder. Once the bipolar diagnosis was confirmed clinically, her medication regimen of a minor tranquilizer (lorazepam) and an anti-depressant (fluoxetine HCL) was altered to include a mood stabilizer (divalproex sodium) and a low-dose neuroleptic (trifluoperazine) was added soon after to contain flashbacks of psychotic intensity. Although this regimen improved VB's racing thoughts, pressured speech, and irritability, additional adjustments were required before improvement was noted in her depressive and anxiety symptoms. Her anti-depressant was shifted to bupropion HCL and her minor tranquilizer to clonazepam.

After a stable medication regimen was established, VB had no further crisis hospitalizations or self-harm incidents, and reported a marked decrease in suicidal thoughts. She was able, with increasing effectiveness, to use cognitive strategies to dilute and resist self-destructive impulses, and she became actively engaged in treatment planning. Her relationships with significant others became less chaotic and crisis-driven, and she was able to establish appropriate boundaries that allowed her to maintain close contact without becoming overwhelmed. Having for the first time achieved a significant level of symptom containment and safety, she was able to begin addressing trauma issues constructively.

## CASE NUMBER TWO

BJ, a 35-year-old married unemployed woman, was seen in consultation three years after being diagnosed with DID. BJ's trauma history included the loss of her mother in early childhood and subsequent chronic physical and sexual abuse by her father. In early adolescence she began to use street drugs and alcohol, and made the first of over 30 highly lethal and rather dramatic suicide attempts, shooting herself in the chest. Over the next fifteen years, she overdosed both on street drugs and on prescribed medications, tried to hang herself, cut her wrists, drank household poison, shut herself in a locked garage with the car running, deliberately ran her car into a tree, tried to electrocute herself, ran in front of a moving automobile, and tried to trick a boyfriend into shooting her.

During hospitalization for one of her suicide attempts, BJ was diagnosed with DID and subsequently began individual psychotherapy with a therapist experienced in treating dissociative disorders. In addition, she was seeing a psychiatrist for medication management. An initial dramatic response to anti-depressants was not sustained, and despite ongoing treatment, she continued a pattern of unremitting

suicidality, self-mutilation, recurrent hospitalizations, and threats of violence toward others, including her therapist. Two prior consultants engaged by her treatment team suggested that her lack of improvement was best explained by the severity both of DID and typical comorbidities (borderline personality and depression) which rendered her untreatable. Certainly it was frustrating to try to focus either on her sense of internal chaos or her images of childhood trauma, as either course might lead to emotional dyscontrol and hospitalization.

At the time of re-evaluation, BJ's symptom picture included an inability to sleep, irritability, racing thoughts, buying sprees, and obsessions with completing a mission. This symptom cluster would be followed by episodes of "crashing" with ensuing self-mutilation and/or suicide attempt, often accompanied by a psychotic phase, requiring hospitalization, which occurred every six to eight months. Reassessment of this symptom pattern led to a tentative diagnosis of Bipolar Disorder, and a lithium trial was started. The addition of the mood stabilizer decreased the amplitude of both her manic and depressive episodes, but several additional hospitalizations took place before it was realized that she was most stable when all anti-depressants were withdrawn except the mood stabilizer. Her suicidal behaviors resolved, and she was able to return to technical school and to work in a more focused way in trauma-based psychotherapy.

## CASE NUMBER THREE

KR, a 38-year-old single woman, presented with a history of multiple psychiatric hospitalizations, beginning during her mid-twenties, as a result of intense suicidal preoccupation and severe, melancholic depression. Over the ensuing eight years, she had maintained a pattern of intermittent crisis hospitalizations, medication overdoses, and numerous episodes of self-cutting and burning. During this period she carried diagnoses of Major Depression, Agoraphobia with Panic, Borderline Personality Disorder, and DID, characterized by severe depersonalization with derealization and dissociative amnesia. Numerous medication trials had been unsuccessful in ameliorating depressive symptoms and anxiety, and her response to psychotherapy had been erratic. She had also received one 14-treatment course of ECT and had been moderately responsive. However, she had also experienced severe chronic memory loss and personality change after the ECT.

During a consultation for re-evaluation, she was asked to select sandtray figures to depict alter states. Two very different figures were always selected for each alter. KR explained it was necessary to have two figures, one for when she was depressed, and a second for when she was "normal." For example, to represent her "creative" alter, she chose a Wonder Woman, paired with Death-with-a-Scythe. At first it was thought that her major depression had exacerbated and

was out of control, and that this, together with the habitual splitting associated with her borderline personality disorder, necessitated the use of double images for each alter. However, on further review it was noted that all of the "normal" images were not only non-depressed, but either grandiose, exalted, or comic. When asked to choose a third image for each alter, she was able in each case to describe a more balanced state; for example, the "creative" alter was represented by a fully human female figure dressed as a forest ranger. Further assessment supported the developing hypothesis that the patient's severe mood disorder was bipolar rather than unipolar, and she was placed on mood stabilizers. Over the next two years, her impulsive self-harm behaviors resolved, but she continued to require hospitalization for depressions, occurring about every six months, which did not respond to medication. As the severe, atypical, medication-unresponsive mood disorder became better understood and acknowledged, the focus of psychotherapy shifted to coping with this illness independently, while pursuing this complex treatment plan.

## DISCUSSION

Although the presence of complex symptom profiles in DID has been well documented in the literature (Putnam et al., 1986; Ross et al., 1989; Coons et al., 1988), very little has been written about cases in which bipolar illness is comorbid with DID. When the clinical picture is dominated by a dissociative disorder, the recurrent bipolar pattern of mood cycling can be obscured by perceptual gaps and can be misattributed to identity alterations, borderline impulsivity, and unipolar depression, especially in cyclothymic or Bipolar II patterns where hypomania occurs rather than more globally disruptive frank manic episodes.

Differentiating between bipolar and unipolar affective illness can be difficult in any case, and especially with DID patients, who, because of dissociative amnesias, are often unable to provide detailed family and historical data that would alert the clinician to the possibility of BPI. Often clinical practice has been to make a diagnosis in favor of either DID or BPI, but rarely to diagnose both. However, if only one diagnosis is addressed, the other major illnesses are left unmonitored and undertreated. Post-traumatic and dissociative symptoms will intensify under the traumatogenic impact of mood swings, leading to further decompensation of trauma-induced dissociative defenses. When only the bipolar illness is acknowledged, uncontrolled dissociation may make it difficult for the individual to anticipate or recognize mood swings, or to have insight about the nature and meaning of the mood disorder. Without containment of both problems, the individual becomes increasingly vulnerable to both environmental and internal stressors, and the escalating frustration and decompensation may produce psychosocial crises, hostility, psychophysiological disruptions, and psy-

chotic levels of symptomology which further complicate the diagnostic picture.

Grandiosity and paranoia may be prominent features of hypomania and mixed states. Unless the therapist is well-informed by collateral sources that document the patient's catastrophic course of illness, these defenses may aid the patient in minimizing and denying intrapsychic and behavioral problems, blaming difficulties, instead, on extremely malevolent and well-organized external forces. For example, "cult" abuse had been considered in the first two cases prior to the diagnosis of BPI. Once severe symptoms were explained and controlled, the quest for additional explanatory traumata faded away, and treatment focused more productively on traumatic material that had been known for many years.

The varied clinical presentations of BPI can additionally complicate the diagnostic picture. BPI can occur on a continuum from mild cognitive, behavioral, and perceptual disturbances to hypomania, acute mania, and manic psychosis, sometimes culminating in a chronic manic state. Milder forms of the illness, or episodes occurring earlier in its course, may be especially difficult to detect. Although the prototypical symptom of BPI is elevated mood, in some patients, such as the first two discussed in this article, the predominant clinical manifestation is anger and irritability, often in response to seemingly harmless provocation (Janicak, Davis, Preskorn, & Ayd, 1993). These patients may be verbally abusive, and prone to hostile comments, complaints, and angry tirades. Like the subclinical or subsyndromal mood disorders described by Akiskal (1987), these patients often are impulsive, have stormy interpersonal relationships, and frequently receive Axis II personality disorder diagnoses.

Clinical and anecdotal experience suggests that comorbid Bipolar Disorder should be included in the differential diagnosis when the following constellation of circumstances are present in a difficult-to-treat DID patient:

- 1) Unremitting suicidality, requiring
- 2) multiple hospitalizations, and
- 3) unresponsive or atypically responsive to medication – (e.g., initial positive response to anti-depressants, followed by exacerbation of symptoms; or lack of response to multiple trials of appropriate medication regimens);
- 4) multiple crises, excessive risk-taking, and/or ongoing involvement in violence;
- 5) chaotic psychotherapy sessions (e.g., patient is unable to develop techniques for containing and regulating arousal or maintaining safety as a necessary precursor to tolerating the affect generated by exploration of traumatic experiences and symptom

development; patient unable to develop or adhere to crisis plan, or to cooperate in developing treatment goals), with

- 6) frequent disruptions in treatment plan (e.g., the frequent need to divert treatment focus to cope with crises, and need for constant revisions in short-term goal setting), and
- 7) atypical Internal Structure (e.g., ego states may be split or bi-furcated, shifting and unstable, and/or difficult to access).

When a DID patient continues to have poor response to appropriate treatment planning (i.e., treatment that adheres to currently acceptable standards of care, such as the guidelines provided by the International Society for the Study of Dissociation, 1997), the possibility of comorbid diagnoses must be considered and evaluated, especially if the patient is seen in a specialty tertiary setting. The authors suggest that even when a patient has been in long-term treatment, clinicians should consider responding to treatment failures/symptom exacerbation with a comprehensive reassessment and review of problems. Standard psychological testing is often helpful in identifying hypomania or mania; however, DID may be missed unless the psychologist has specialized training and/or adds the Structured Clinical Interview for *DSM-IV* - Dissociative Disorders (SCID-D) (Steinberg, 1993) to the standard battery. Multiple administrations may be required as the patient shifts through different mood states. If it is necessary to hospitalize the patient, the clinician should make full use of in-patient diagnostic facilities, including the availability of specialized consultants (psychological assessment, biological psychiatrists, medical sub-specialists, occupational or functional assessment, laboratory testing of blood levels of medications and substances).

Organic mood disorder was considered in all three of the described cases because of concern that serotonergic anti-depressants had triggered hypomania. Re-evaluation of problematic DID patients should include the possibility of organic conditions of all types. Exposure to violence, both ongoing and in childhood, and impulsive and self-destructive behavior patterns increase the risk of head injury. The hypothalamic injury syndrome described in "dementia pugilistica" has a number of characteristics similar to those observed in severe DID – "twilight" states of consciousness, source amnesia, confusion of nightmares or reverie with episodic reality, and impaired stimulus discrimination. Late-onset psychosis, sexual risk-taking, atypical response to medications, and/or abuse of substances in a problematic DID patient should alert the clinician to consider the possibility of organicity (Larson & Richelson, 1988).

Although the prevalence of BPI is about equal for both

men and women, i.e., 1% (Kessler et al., 1994), gender may differentially affect the course of the illness. Based on a comprehensive review of the literature, Leibenluft (1996) concludes that women with BPI may be more likely to develop rapid-cycling disorder, to experience mixed-states, to experience onset of the illness at ages 45 - 49, and to be at high risk for post-partum episodes. Very little empirical data exist to explain the effects of the female reproductive cycle or endocrine changes on the course and symptoms of BPI. These atypical features of BPI in females may explain part of the diagnostic difficulties encountered in the group of (predominantly female) patients where DID is diagnosed prior to bipolar disorder.

Current estimates of the prevalence of DID among psychiatric patients range from 1% to 10% (Steinberg, Bancroft, & Buchanan, 1993; Ross, 1991), with Ross and colleagues concluding that 5% is a realistic estimate of the frequency of DID on general adult inpatient psychiatric units (Ross et al., 1991). Among the general population, lifetime prevalence of DID is estimated to be about the same as for BPI, i.e., 1% (Lowenstein, 1994; Ross, 1991). This means that, in the general population, approximately one in every 10,000 individuals has both DID and BPI. Although a number of investigators have described concomitant psychopathology in DID, the lack of uniform methodology makes it difficult to make conclusive statements about actual comorbidity. However, as noted by Kluft (1993), affective "highs" have been described in 15% to 73% of DID patients studied, with depressive symptoms observed in 90% of the DID patients (Kluft, 1993). Preliminary data from the authors' current research describing psychometric profiles of a series of patients with severe trauma/dissociative disorders, who were seen in the authors' specialty tertiary unit, indicates that BPI was comorbid in 11 out of 21 of these patients. Although it would be premature to draw conclusions about actual rates of comorbidity from the current data, there is evidence to suggest that screening for BPI should be an integral part of diagnostic evaluations of DID patients. In the authors' clinical experience, the single most effective evaluation tool is a standard psychiatric interview performed during a manic or hypomanic episode, followed, secondly, by a careful record review to map the natural history of the patient's symptoms, and thirdly, by psychological testing which includes the MMPI-2 and Rorschach.

Extremely severe DID, especially when it co-exists with other major psychiatric disorders such as BPI, can become difficult to assess and manage for the clinician who works in isolation. When diagnostic dilemmas arise, such as those described in this article, additional consultations should be sought and continued until a satisfactory explanation is obtained for the unusual severity of the clinical picture. ■

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