

## Will The Real Abby Please Call?

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Abby's first crisis call came to me 2 years ago, shortly after I'd established her as a patient. She called me "to set things straight." She'd cut her wrist but didn't know exactly where she was.

Abby is a 40+ year-old African-American female with multiple medical problems: essential malignant hypertension, cerebralvascular accident (CVA), hypothyroidism, seizure disorder, anemia, alcohol abuse, and major depression. She has four children and two grandchildren who are the joy of her life. She is estranged from her spouse and extended family.

I kept her on the phone until our clinic's psychiatrist could talk with her, and the police could be summoned. She eventually disclosed her location, but the police couldn't find her. In the middle of our conversation, the phone went dead and I feared the worse. We tried desperately to trace the phone call, but all was in vain. It was one of the lowest moments in my practice of medicine. I felt like I had failed her. But, what could I have done differently?

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Nothing my pastor, my former residency director, and behavioral science director said could ease my anguish. I was inconsolable. Then—a phone call from the police officers who had found her, but they'd taken her to the county jail! Again, multiple phone calls and transfers; I finally found the section where Abby was being detained. I was able to contact the medical director of the jail, who immediately rectified the situation and arranged for her to be admitted to a psychiatric facility.

Upon her release, Abby followed up with me and with an outpatient county mental health facility. During her medical visits, her blood pressure remained very high. She insisted that she was taking her medicines, bringing me the empty medication bottles. She admitted drinking and described instances where she forgot how she got to certain places or why she was sleeping in her car. We discussed possibilities of alcohol addiction and community facilities where she could get treatment on an outpatient or inpatient basis. She assured me she would go.

Three months later Abby was admitted to the hospital for a CVA. Upon her discharge, she resumed her medical appointments until she suddenly stopped coming. Letters were sent requesting that she schedule an appointment. A month after the last letter, she called to apologize, tell me goodbye, and thank me for everything I'd done. Her voice sounded different,

and I had a hard time keeping her focused. The phone conversation ended abruptly. Again, we called the police, who again were unable to locate her. I tried contacting her spouse, whose main interest focused on attending to the needs of their children.

Life moves on, patients are seen; she is out of my attention span. Then 3 months later, she presents in our clinic with cookies and cakes. She was feeling much better and was concerned that she gained some weight. She looked very well. Her blood pressure (BP) was finally in the 160/90 range (Her usual BP was in the 210/110 range). I thought she was finally getting help through an outpatient psychotherapy program.

The cycle began again. We'd speak on the phone, it would be a crisis, we would contact the police to locate her, she would be hospitalized and upon discharge she would return to our clinic for medical care. My emotional reserves to coordinate her care were running low. Consultations with mental health prescribed setting limits and mandating collaborative care with psychiatry. She thrived with the structured plan. She kept more of her appointments, complied with her medication regime, took more pride in her appearance, and brought the staff baked goods.

Late in the fall, a colleague who covered my clinic informed me that Abby had reported seeing worms coming from her arms. She took multiple showers "but couldn't

wash the worms off.” She also reported voices telling her to do “bad things.” This was new. The Psychiatric Emergency Team was called, but Abby ran from the clinic before she could be detained.

A couple of days later, I received an early morning call from Abby, who agreed to come into the clinic that same day. She arrived dressed nicely, but something was very different in her manner. As we began to talk, her affect and mannerisms changed suddenly and drastically. She became tearful and said, “They haven’t let me drink or eat in 5 days, I’m so afraid. I thought I was getting better. Do you think I’m crazy?” Before I could respond, her demeanor changed again. She looked very strong and sat up straight in the chair. In a stern voice she said, “She is so weak, I hate her and her cooking. We’re going to take care of her.” The little hairs on the back of my neck began to curl up. I asked, “Who am I speaking too?”

She said, “I know you, Dr Curley, but I’m not going to tell you who I am. If I do, you’ll know everything. I need to go to the bathroom.” I told her that I would take her because the bathroom was locked. She replied, “Why do you need to take me to the bathroom, is there a window in the bathroom?” and she began to laugh. I did everything I could do to keep my composure. I then called Abby by her name. Abby returned, slumping down in her chair and

asking what was happening. Her face looked tortured. She rubbed her forehead and hands furiously and tearfully asked if she was going crazy.

We had to keep Abby from fleeing the clinic and took turns leaving the room to facilitate the PET team’s and police’s arrival. At one point, we placed a medical assistant in the room. We returned to find our medical assistant at the door, confronted by the most dominant personality, who had risen in the chair and said, “You’re afraid of me aren’t you?” Our medical assistant kept her composure until she left the room. She began to cry as she had never felt so helpless and seen someone change into three different people. She told us that one of the personalities said that Abby had something growing inside of her and “they” wouldn’t let it live.

Finally the PET team arrived, followed shortly by the police. Abby had mentally returned and was very afraid. I explained to Abby that she was not well and that she needed to go to the hospital. I followed up with the psychiatric facility and communicated with the case manager who shared that Abby was diagnosed with alcohol withdrawal. I reiterated my last encounter and clinical impression of Abby, which helped to explain staff observations of Abby’s “staring off in space and mumbling to herself.” Arrangements were made for Abby to receive intensive case

management and psychotherapy upon her discharge.

Abby’s possession of several identities may account for her lack of medical adherence, memory loss, suicide attempts, and alcoholism. Although there is a lack of consensus regarding the validity of Dissociative Identity Disorder (DID) within the North American psychiatric community, I have seen the manifestations first-hand. I understand and believe in Abby’s psychological torture and her fear of “the others” who torment her on a daily basis. Further, there are truly medical mysteries surrounding this condition. Medically, patients with DID can exhibit variations across identity states in their symptoms of asthma, sensitivity to allergens, and even response of blood glucose to insulin (American Psychiatric Association, DSM-IV, 1994, page 485).

I’ve come to appreciate how taking care of ourselves as family physicians is vital; otherwise, we ourselves are in danger of becoming fragmented as we are drawn into our patients’ psychological traumas and personalities.

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