# COMMENTS ON: TAKAHASHI'S: "IS MPD REALLY RARE IN JAPAN?"

Colin A. Ross, M.D., FRCPC

Colin A. Ross, M.D., FRCPC, is Associate Professor of Psychiatry at the University of Manitoba, in Canada.

It is good to see investigators in other cultures treating the epidemiology of the dissociative disorders as a serious scientific problem. I will define the key conceptual and methodological issues in such studies, and propose a methodology Dr. Takahashi might consider adopting in Japan. I will focus on multiple personality disorder (MPD) but my remarks apply to all the dissociative disorders.

I have seen one case of classical MPD in a woman born in Hong Kong, and therefore know that the disorder exists in the Orient.

The first two questions to ask about any given culture, in forming a preliminary estimate of the prevalence of MPD, are these: 1) what is the prevalence of severe, chronic childhood trauma in that culture, and 2) were preindustrial, indigenous forms of dissociation such as possession states common in that culture?

Dr. Takahashi advises us that the prevalence of child abuse in children under 12 years of age in Japan is 6.6 per 100,000. If this is correct, one would expect MPD to be about 1000 times less common in Japan than in North America. However, Dr. Takahashi provides a discussion of Japanese cultural norms which suggest that this estimate might be several orders of magnitude too low, due to reticence to disclose.

T.K. Oesterreich in his book *Possession Demoniacal and Other* (1974) states that belief in spirits and demon possession was "extraordinarily widespread" (p. 224) in traditional Japan. Possession by fox spirits was particularly common. The demand for exorcism was sufficient to give rise to a specific religious sect, the Nichiren, who were specialists in exorcism. Complex dissociative disorders are probably relatively common in contemporary Japan, though their form has probably evolved over the last two hundred years as it has in Judeo-Christian cultures (Ross, 1989).

To determine the prevalence of MPD in Japan an investigator must use a translated version of the Dissociative Disorders Interview Schedule (DDIS) (Ross, 1989; Ross, Heber, Norton, Anderson, Anderson, & Barchet, 1989) or the Structured Clinical Interview for DSM-III-R Dissociative Disorders (Steinberg, Rounsaville, & Cicchetti, 1990), and the Dissociative Experience Scale (Bernstein & Putnam, 1986). Simply doing clinical interviews will not suffice.

Based on Dr. Takahashi's information, it is possible that the seven cases with changes of identity he diagnosed as schizophrenia had classical MPD. If this is correct then 14 patients out of 489 (2.9%) had a dissociative disorder. This may be the case, because Schneiderian symptoms are actually more characteristic of MPD than schizophrenia (Kluft, 1987; Ross, Miller, Reagor, Bjornson, Fraser, & Anderson, 1990). Diagnostic Interview Schedule criteria for schizophrenia do not differentiate MPD from schizophrenia, whereas, DDIS criteria do (Ross, Anderson, Fleisher, & Norton, unpublished data). Likewise, a standard clinical interview using DSM-III-R criteria will misdiagnose MPD. Another misconception in Dr. Takahashi's paper may interfere with diagnosis, namely that MPD arises in adulthood rather than in childhood.

In North America, findings in high risk groups demonstrate that 88.2% of women (N-51) presenting to community agencies for treatment of the longterm effects of childhood sexual abuse have a DSM-III-R dissociative disorder, including 54.9% having MPD (Anderson, Yasenik, & Ross, unpublished data); 39% of individuals in treatment for chemical dependency problems (N=100) (Ross, Kronson, Koensgen, Barkman, Clark, & Rockman, unpublished data) have a dissociative disorder including 14% with MPD; and 12.6% of general adult inpatients (N=405) (Ross, Anderson, Fleisher, & Norton, unpublished data) have a dissociative disorder including 5.4% with MPD. Dissociative disorders are also common in prostitutes and exotic dancers (Ross, Anderson, Heber, & Norton, 1990).

Dr. Takahashi's Department has a very thorough diagnostic assessment protocol in place. If the DES and DDIS were administered to 100 consecutive patients and diagnostic assessments were done by clinicians blind to those results, I predict that the prevalence of MPD among general adult inpatients would be at least 3% by DDIS criteria, and zero by clinical criteria. Clinical reassessment in the light of positive DDIS diagnosis, combined with greater familiarity with recent research findings in North America, would allow for validation of the DDIS. As long as diagnostic decisions in favor of schizophrenia are made by criteria outlined by Dr. Takahashi, MPD will be rare or nonexistent, however.

Such a study could be replicated at most teaching hospitals in North America, since most rarely or never diagnose MPD. I hope that Dr. Takahashi will take this next step in the study of dissociation in Japan.

Hopefully there are cultures in which severe childhood trauma and MPD are rare. There are probably cultures in which chronic, complex dissociative disorders take forms other than MPD. I doubt that any highly industrialized countries are deficient in child abuse, however. The jury is out on the prevalence of both child abuse and MPD in Japan, but serious study has begun. ■

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