THE CROSS-CULTURAL OCCURRENCE OF MPD: ADDITIONAL CASES FROM A RECENT SURVEY

Philip M. Coons, M.D.
Elizabeth S. Bowman, M.D.
Richard P. Kluft, M.D.
Victor Milstein, Ph.D.

Philip M. Coons, M.D., is an Associate Professor of Psychiatry at Indiana University School of Medicine, Indianapolis, Indiana. Elizabeth S. Bowman, M.D., is an Assistant Professor of Psychiatry at Indiana University School of Medicine, Indianapolis, Indiana. Richard P. Kluft, M.D., is Director of the Dissociative Disorders Program at the Institute of Pennsylvania Hospital and Clinical Professor of Psychiatry at Temple University School of Medicine, Philadelphia, Pennsylvania. Victor Milstein, Ph.D., is Professor of Psychiatry at Indiana University School of Medicine, Indianapolis, Indiana.

For reprints write Philip M. Coons, M.D., Larue D. Carter Memorial Hospital, 1315 West 10th Street, Indianapolis, Indiana 46202.

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ABSTRACT

Multiple personality disorder (MPD) has been described as a culture-bound phenomenon, primarily indigenous to the United States. In order to test this hypothesis, we performed an extensive literature search and developed an MPD questionnaire which was mailed to 132 individuals outside of North America. The literature search found case reports in thirteen other countries in addition to the United States and Canada. Data from the questionnaire revealed the existence of MPD in an additional six countries. Altogether thirty-two new cases of MPD were reported in nine countries and the territory of Puerto Rico. The symptomatology of these new cases was remarkably similar to that of the cases previously reported in North America. Several new cases of DDNOS are described. We conclude that MPD is definitely not a culture-bound phenomenon and that it probably has a worldwide distribution.

INTRODUCTION

Recently Aldridge-Morris (1989) and Fahy (1988, 1989) have asserted that multiple personality disorder (MPD) is a culture-bound phenomenon found primarily in the United States. A number of clinicians have testified to the virtual absence of MPD in England (Fahy, 1988, 1989), Japan (Takahashi, 1990), and Russia (Allison, 1991). MPD has not been listed as an official diagnostic entity in a recent draft of the new *International Classification of Diseases*, or *ICD-10* (Sartorius, Jablensky, Cooper, & Burke, 1988; Coons, 1990). However, a careful review of the literature reveals that since 1950, MPD has been reported in ten other countries including Australia (Maddison, 1953), Brazil (Krippner, 1987), Canada (Ross, 1989; McKee & Whittkower, 1962; Curtis, 1988), England (Fahy, Abas, & Brown, 1989; Cutler & Reed, 1975), France (DeBonis, Charlot, Hardy, & Feline, 1988), Holland (Ensink & van Otterloo, 1989; Boon & Draijer, 1990; van der Hart & Boon, 1990), India (Adityanjee, Raju, & Khandelwal, 1989; Varma, Bouri, & Wig, 1981; Alexander, 1956), Italy (Morselli, 1946, 1953), Japan (Saito & Miyazaki, 1978; Mita, Okamoto, Saiki, Emura, Kawamura, Ikui, Nakajima, & Kirikae, 1984; Takahashi, 1990) and New Zealand (Chancellor & Fraser, 1982) in addition to the territory of Puerto Rico (Martínez-Taboas, 1988, 1989, 1990). Between 1840 and 1950 MPD was reported in another four countries including Czechoslovakia (Boleloucky, 1988), Germany (Taylor & Martin, 1944), South Africa (Laubscher, 1928), and Switzerland (Despine, 1840; Taylor & Martin, 1944; Fine, 1988). In fact, in Taylor and Martin's classic review of MPD in 1944, seventy-six cases were reported worldwide. Although 57% of these cases were American, the rest were French (18%), British (16%), German and Swiss (9%). Finally, many cases of what appear to be dissociative disorder not otherwise specified (DDNOS) have been reported in Brazil (Pressel, 1982), Germany (Goodman, 1988), India (Adityanjee, Raju, & Khandelwal, 1989), Japan (Goodman, 1988), and Mexico (Goodman, 1988).

Because of the controversy about whether MPD is a culture-bound phenomena, we conducted a cross-cultural survey of the occurrence of MPD.

METHODS

We constructed a 95-item questionnaire which we sent to 132 individuals in twenty-seven countries outside of North America. These individuals had requested reprints of articles on MPD from us during a three and one-half year period between 1986 and 1989. The questionnaire inquired about clinician identification data, number of cases of *DSM-III-R* (American Psychiatric Association, 1987) MPD and DDNOS seen, and professional attitudes towards MPD and child abuse. The remainder of the questionnaire asked the clinician to list the characteristics of a single case of MPD including demographic data, history of abuse or other trauma, symptomatology, and coexistent diagnoses. If a clinician had observed a case of DDNOS, he or she was asked to describe that also.

Results of this study were compared with the results of the Coons et al. (1988) study of fifty patients with MPD. Fisher's exact test for 2 by 2 contingency tables was used and the probabilities that were calculated were two-tailed with one degree of freedom. Results were considered significant for $p < .05$.

RESULTS

A total of thirty-four responses were received for a response rate of 26%. Completed questionnaires were returned from thirty-one clinicians including twenty psychiatrists and eleven psychologists. Two individuals returned the questionnaires unanswered and said that they had no experience with MPD. One individual indicated that he was not a clinician. Two questionnaires were returned as undeliverable.

Although fully half of the clinicians said that MPD was accepted as a diagnosis in their country, nearly half (47%) said that they were met with much professional skepticism if they diagnosed MPD. In contrast, only three individuals (9%) indicated that reports of child abuse were met with professional skepticism in their country.

Of the thirty-four clinicians responding, fifteen (44%) reported previous experience with at least on patient with MPD. These fifteen clinicians reported thirty-two new cases of MPD in the nine countries and one territory listed in Table 1.

Of the fifteen cases of MPD described in detail, fourteen (93%) were female. Their mean age was thirty-three years and mean educational level was 12.8 years. Marital status included seven (47%) married, four (27%) single, three (20%) divorced, and one of unknown marital status. Occupational levels included four (27%) professional, four (27%) homemakers, two (13%) disabled or unemployed, and one of unknown occupation. Race included ten (67%) Caucasian, four (27%) Hispanic, and one (7%) Oriental.

Demographic data reported above were not significantly different except for race—Caucasian ($p = .013$) and Hispanic ($p = .002$). There were relatively more hispanics in the study sample than the North American sample. The mean number of personalities was 7.9 (range 2 - 20) with a median of 5 and mode of 3.

The symptoms that these fifteen patients with MPD presented were remarkably similar to symptoms of MPD reported previously in the United States and Canada (Bliss, 1980; Putnam, Guroff, Silberman, Barban, & Post, 1986; Coons, Bowman, & Milstein, 1988; Ross, North, & Wozney, 1989; Ross, Miller, Reagor, Bjornson, Fraser, & Anderson, 1990). Of the thirteen symptoms tabulated, only the occurrence of visual hallucinations was significantly different from the 1988 Coons et al. study, hereafter referred to as the North American sample. This data is shown in Table 2.

Although the majority of the attributes of different personalities were similar between the two studies, there were significant differences in four of the eleven items. These data appear in Table 3.

Child abuse was reported in every case. Types of childhood abuse suffered by these individuals include physical abuse (67%), neglect (60%), and sexual abuse (47%). Perpetrators of child abuse included fathers/stepfathers (73%), and mothers/stepmothers (80%). Neglect was more common ($p = .009$) outside of North America and was more often ($p = .009$) perpetrated by mothers/stepmothers than in the North American sample (32%). The women in this series suffered from a high incidence of both rape (50%) and wife abuse (43%) in adulthood. Wife abuse was more common than in North America ($p = .014$). Coexistent diagnoses included sexual dysfunction (50%), personality disorders (50%), depression (36%), post-traumatic stress disorder (36%), eating disorders (20%), somatization disorder (21%), drug abuse/dependence (13%), and alcohol abuse/dependence (13%). The co-existent diagnoses of personality disorder ($p = .008$) and alcohol abuse ($p = .004$) occurred in higher proportions in North America.

Six of the clinicians reported atypical cases of MPD. Clinicians from Holland and Belgium reported five and nine

TABLE 1
The Cross-Cultural Occurrence of MPD

Literature Case Reports				Study Results	
Pre-1950		Post-1950		1990	
Czechoslovakia	(1)	Australia	(1)	Belgium	(11)
England	(12)	Brazil	(2)	Bulgaria	(2)
France	(14)	Canada*		Columbia	(1)
Germany	(10)	England	(4)	England	(2)
Italy	(1)	Holland*		Guatemala	(1)
South Africa	(1)	India	(5)	Holland	(4)
Switzerland	(2)	Italy	(1)	Israel	(5)
United States	(65)	Japan	(3)	Japan	(2)
		New Zealand	(1)	Mexico	(2)
		Puerto Rico	(3)	Puerto Rico	(20)
		United States*			

** Number includes case reports too numerous to count and/or large MPD series.*

cases respectively, but did not characterize their cases further. A clinician from Mexico described a sixteen-year-old male who was amnesic for his single alter personality, a priest from 1525. A clinician from France had seen "numerous" women who behaved like animals including a cock, dog, and a wolf. This clinician had also seen a male who alternated and cross-dressed as his girlfriend. In Israel, a clinician reported patients with altered identities of Jesus, John the Baptist, and Mary Magdalene. Finally, a Japanese clinician reported a female who talked in her dead brother's voice and behaved like the daughter of a sixteenth century warlord.

TABLE 2
Symptoms of MPD

Type of Symptom	Present Study N = 15 N (%)	Coons, et al. 1988 Study N = 50 N (%)	p Value
Amnesia	15 (100)	50 (100)	ns
Mood swings	14 (93)	47 (94)	ns
Depression	13 (87)	44 (88)	ns
Depersonalization	12 (80)	—	—
Sexual Dysfunction	11 (73)	42 (84)	ns
Headache	11 (73)	28 (56)	ns
Fugue	10 (67)	24 (48)	ns
Somatization	9 (60)	18 (36)	ns
Auditory hallucinations	8 (53)	36 (72)	ns
Alcohol abuse	8 (53)	21 (42)	ns
Visual hallucinations	7 (47)	8 (16)	p=.02
Self-mutilation	5 (33)	17 (34)	ns
Drug abuse	4 (27)	23 (46)	ns
Conversion	4 (27)	20 (40)	ns

TABLE 3
Attributes of Other Personalities

Attribute	Present Study N = 15 N (%)	Coons, et al. 1988 Study N = 50 N (%)	p Value
Different age	13 (87)	33 (66)	ns
Angry personality	12 (80)	40 (80)	ns
Different voice	10 (67)	34 (68)	ns
Protector personality	10 (67)	15 (30)	p = .016
Different handwriting	10 (67)	17 (34)	p = .036
Different dress	10 (67)	16 (32)	p = .033
Depressive personality	8 (53)	37 (74)	ns
Different sex	8 (53)	13 (26)	ns
Co-consciousness	7 (47)	42 (84)	p = .006
Suicidal personality	7 (47)	31 (62)	ns
Rescuer personality	6 (40)	8 (16)	ns

DISCUSSION

As the results of this study indicate, MPD is clearly not a culture-bound phenomenon found only in the United States. Since 1840, MPD has been reported in twenty-one different countries plus one territory. In this study alone, thirty-two new cases of MPD were reported in nine countries and one territory outside of North America. This study reports MPD in seven countries where it had not previously been reported in the literature.

We suspect that the experience of diagnosing MPD outside of North America will parallel our own experience in the United States (Goodwin, 1985; Dell, 1988). That is, MPD will be presumed to be extremely rare or non-existent and clinicians will be skeptical and/or reluctant to make the diagnosis for fear that they will be ridiculed by their peers. Gradually more and more diagnoses of MPD will be made and MPD will finally gain worldwide acceptance as a diagnostic entity.

Recent correspondence with Paul Brown (personal communication, 1988) supports this last point. Clinicians in Australia have been debating the diagnosis of MPD. In an admittedly biased sample of letters from nine clinicians, ten cases of MPD were diagnosed by six clinicians. The other three clinicians were "skeptical," profoundly cynical, and insisted that MPD was an "iatrogenically created pandemic" in North America.

The differences between MPD in North America and elsewhere are interesting. Demographically there are no differences except for race, which is as expected. Patients with MPD outside of North America

have a somewhat greater mean age (thirty-three years compared to twenty-nine years) in this study compared with the North American sample. This age difference may reflect a later age of diagnosis due to the relative inexperience of the treating clinicians. We are unable to explain why more patients in this study had visual hallucinations (47%) than in other studies (Putnam, et al., 30%; Coons, et al., 16%). Possibly the clinicians equated visual hallucinations with post-traumatic flashbacks which are extremely common in MPD. The mean (7.9), median (5), and modal (3) number of personalities reported in this study are quite similar to the mean (6.3), median (4), and modal (3) number of personalities in the North American sample.

Although there are significant differences among four of the alter personality attributes, this may not be evidence of a true cross-cultural difference. For example, Ross, et al. (1989) found that 28% of MPD patients exhibited different handwriting styles and this is not significantly different from the present sample (34%). In addition, in three of the four alter personality attributes (different handwriting, different dress, and co-consciousness), the non-North American sample had more of each type of psychopathology than did the North American sample. In other words, the non-North American sample consists of more obvious MPD patients. This situation may be similar to the situation in North America prior to 1980, where only the most obvious cases of MPD were diagnosed. The non-North American clinicians have less experience in the diagnosis of MPD, so what they diagnose is more obvious. Further research is definitely required in this very interesting area.

There may be cross-cultural differences in the type and occurrence of child abuse since, in this study, mothers/stepmothers were abusers more often than in the North American sample. This deserves future research. Although there was a significant difference in the occurrence of neglect between the two samples reported in this paper, there is no significant difference in the occurrence of neglect between the present study group (47%) and the group of one hundred MPD patients (about 60%) reported by Putnam, et al. (1986). The differences in incidence of personality disorders is interesting and may reflect different diagnostic conventions between North America and elsewhere. On the other hand, *DSM-III-R* personality disorders are diagnosed with less accuracy than are other mental disorders (Frances & Widiger, 1986). The lower reported incidents of alcohol abuse/dependence in this study is perplexing since these clinicians reported alcohol abuse to be a fairly common symptom of MPD (i.e., 53%). Again, different diagnostic conventions may prevail outside of North America.

CONCLUSIONS

We conclude that MPD is not a culture-bound phenomenon and that it likely has a worldwide distribution. Further research is indicated to determine if true cross-cultural differences exist between MPD found in North America and that found elsewhere. ■

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