MULTIPLE PERSONALITY IN PUERTO RICO: ANALYSIS OF FIFTEEN CASES

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ABSTRACT

In this paper, fifteen cases of MPD detected in Puerto Rican patients are analyzed and contrasted with those reported by Coons, et al. (1988), Putnam, et al. (1986), and Ross, et al. (1989). The comparisons indicate that the Puerto Rican cases have striking parallels with the ones detected in Canada and the USA. It is tentatively concluded that MPD can emerge in a social and cultural setting quite different from that of the continental United States.

INTRODUCTION

Until recently, there was a dearth of information on the occurrence of multiple personality disorder (MPD) in countries outside the United States or Canada. Fortunately, nowadays we find some reports of MPD in India (Adityanjee, Raju, & Khandelwal, 1989), the Netherlands (Boon & Draijer, 1991), and Latin America (Martínez-Taboas, 1988, 1989, 1990; Ronquillo, 1991). Specifically, in 1989, I presented some preliminary data on three Puerto Rican female patients with MPD (Martínez-Taboas, 1989).

In the past two years, I have come in contact with additional psychiatrists and clinical psychologists who were treating MPD patients in Puerto Rico. Also, I have detected other cases while working in one of the largest private psychiatric hospitals in Puerto Rico. As a result of all this new information, my colleagues and I have collected sufficient information on fifteen cases of MPD in Puerto Rican patients.

I understand that the uncovering of more than a dozen cases in Puerto Rico is important because all of our patients come from a culture in which their language, beliefs, and social environment are quite different from that of Canada and the continental United States. As culture imposes mean-

TABLE 1
Patients with MPD

Characteristics	Martínez-Taboas	Coons, et al.	Ross, et al.	Putnam, et al.
Age (years)	27	29	30	31
Women	93%	92%	88%	92%
Married	47%	34%	37%	44%
Previous Diagnostics:				
Depression	60%	42%	64%	71%
Schizophrenia	20%	24%	41%	48%
Epilepsy	60%	—	13%	15%
Years in Mental Health System:	5			6.8
Sexual Abuse	73%	68%	79%	83%
Physical Abuse	60%	60%	75%	75%

ings and interpretations upon social acts, it is highly relevant to know how our MPD patients compare with the ones in the United States and Canada. To answer this question, I detail the clinical and phenomenological characteristics of our Puerto Rican patients and then compare the results with those previously presented by Coons, Bowman, and Milstein (1988), Putnam, Guroff, Silberman, Barban, and Post (1986), and Ross, Norton, and Wozney (1989).

METHOD

Psychiatrists/Psychologists

The fifteen cases have been detected by two psychiatrists and seven licensed clinical psychologists. The author has detected seven of the fifteen cases.

Procedure

All the psychiatrists and psychologists answered the Multiple Personality Disorder Questionnaire (MPDQ), developed by Dr. Philip M. Coons, which I translated into Spanish. Basically, the MPDQ inquires information on the patient and the alter personalities. Also, all the cases were diagnosed by *DSM-III-R* criteria (American Psychiatric Association, 1987).

RESULTS

In Table 1, we can observe the main characteristics of the patients in our caseload. Fourteen (93%) are female; thirteen (87%) of them have previously received other diagnoses including schizophrenia, major depression, and epilepsy. More than 70% were sexually abused during childhood, and 60% were physically abused, too. It is very important to note that in the cases in which I served as primary therapist, I took special care to document the historical accuracy of the abusive experiences. As a result, I obtained independent confirmation of such abuses in five of the six cases where there was an allegation of sexual abuse. On most occasions, my independent informants were the patient's brothers and sisters. In one case it was impossible to obtain an independent verification because the sexual abuse occurred at an early age and the patient never had told anyone of the abuse.

Most of the patients spent many years (x = 5 years) in the mental health system, and most have taken anti-convulsives, anti-psychotics, and anti-depressants for years. For example, one of the cases that a psychiatrist and I detected at a psychiatric hospital was given the following medications at her previous three-month hospitalization: Mellaril, Navane, Ativan, Valium, Desyrel, Tegretol, Dilantin, Benadryl, Cogentin, Restoril, and Halcion.

If we compare our results with those reported by Coons, et al. (1988); Putnam et al., and Ross, et al. (1989), we find an impressive corroboration of their results. The single main difference is that a seizure disorder was diagnosed more frequently in our patients. However, this finding could be an artifact of my caseload, because I identified various cases at the Puerto Rican Epilepsy Society, where I worked as a clinician for three years.

In Table 2, we can note the principal symptoms of our patients. Troublesome amnesias (93%), depression (93%), headaches (100%), mood instability (87%), suicide attempts (80%), multiple somatic complaints (73%), seizures (67%), and hearing voices (60%) were fairly common. If we compare our patients with those of Coons et al. (1988), Putnam et al. (1986), and Ross et al. (1989), we can notice many striking similarities. The two main differences are: *all* of our patients reported persistent and intense headaches; and 67% reported some bizarre convulsions that were erroneously diagnosed as epilepsy by their previous doctors. In fact, one of our patients was sent to New York by her neurologist with an urgent recommendation for brain surgery. Fortunately enough, the neurologists at New York found cogent reasons to doubt the diagnosis of epilepsy and sent her back to Puerto Rico.

Maybe we can explain the extreme incidence of headaches in our patients if we allude to the fact that Puerto Rican female patients have a marked tendency to somatize their problems (Guarnaccia, Good, & Kleinman, 1990). As for the high frequency of seizures, let us remember that some of

TABLE 2
Clinical Symptoms and Characteristics

Symptoms	Martínez-Taboas	Coons, et al.	Ross, et al.	Putnam, et al.
Headaches	100%	55%	72%	66%
Amnesias	93%	100%	95%	98%
Depression	93%	88%	64%	90%
Mood Swings	87%	94%	—	70%
Suicide Attempts	80%	—	72%	71%
Somatization	73%	36%	—	57%
Seizures	67%	14%	—	12%
Voices	60%	72%	72%	30%
Depersonalization	53%	—	—	54%
Drug Abuse	53%	46%	31%	48%
Sexual Dysfunction	50%	84%	73%	58%
Mutilations	47%	48%	—	56%
Fugues	40%	48%	—	56%

our cases were detected at a center which specialized in epilepsy.

In Table 3 we can observe that the Puerto Rican alters are very similar to the ones reported by Coons et al. (1988); Putnam, et al. (1986); and Ross, et al. (1989). Most of them have idiosyncratic tones of voices (80%), different handwriting styles (53%), report co-conscious states (80%), and, at times, are amnestic of others (73%). Also, we find most patients have child personalities (60%), have protectors and persecutors (87%), and the majority have names of their own (87%). It is interesting to note that, although there is in Puerto Rico a widespread belief in spiritism (Hohmann et al., 1990), only 13% of the alters claimed to be supernatural beings.

In Table 3 there is a finding which is somewhat discordant with the other series of cases. Our patients had a mean number of only four alters, whereas in the other studies, it usually was in the range of fourteen. There are various possible reasons for this discrepancy. First, maybe our psychologists/psychiatrists did not explore the systems of personalities in the way that clinicians more experienced with MPD might proceed. It seems pertinent to note that many of our respondents have a very limited experience with MPD. Secondly, nearly half of our patients have been in psychotherapy for a year or less. Kluft (personal communication, October, 1991) indicated that in the Putnam, et al. (1986) and Ross et al. (1989) series, the cases were more well-known to their therapists and were longer in treatment. Kluft suggests: "It stands to reason that more and more of the system becomes known in the course of treatment." In order to clarify this issue, it is essential that other Latin American colleagues report their cases so that we can contrast their results with ours.

TABLE 3
Characteristics of the Alter Personalities

Symptoms	Martínez-Taboas	Coons, et al.	Ross, et al.	Putnam, et al.
Personalities Identified (x)	4	6	15	13
With Proper Names	87%	98%	—	—
Protector	87%	30%	84%	—
Persecutor	87%	80%	84%	—
Different Tone of Voice	80%	68%	—	—
Co-consciousness	80%	84%	—	—
Different Age	73%	66%	85%	—
Amnesia of Others	73%	100%	—	72%
Depressed	73%	74%	—	70%
Suicidal	73%	62%	—	71%
Opposite-sexed	60%	26%	63%	53%
Child Personalities	60%	—	86%	86%
Different Handwriting	53%	34%	—	—
Spirits	13%	—	21%	—
Demon	—	—	29%	—

Presently there is a growing number of studies that suggest that MPD is not a rare disorder in some countries (Martínez-Taboas, 1991). Our work in Puerto Rico reveals that at least some of our psychiatrists and psychologists can detect and successfully treat MPD patients. Because our fifteen cases have been collected in the last eighteen months, and mainly through personal contact with their primary therapists, I strongly suspect that there is a substantial minority of clinicians in Puerto Rico who have treated an MPD patient at some point in their careers.

Indeed, Puerto Rico is a country where we find an impressive number of high-risk situations and environments that are supposed to contribute to the development of this type of disorder. For example, there are studies that document a high incidence of physical and sexual abuse of children (Izcoa, 1991; Martínez-Taboas, 1991). Also, in Puerto Rico, many persons believe that people can be possessed by external agencies (usually spirits or demons) if one is faced with too much trauma and suffering (Núñez-Molina, 1990).

It is also my impression that MPD is not so rare in many other Latin American countries. Unfortunately, our Latin American colleagues have displayed little interest in dissociative disorders, and MPD in particular. As evidence of this, I can point to the fact that, until 1986, there was not a single article in which MPD was

discussed in a professional Latin American journal. I hope that some recent articles published in Spanish will gradually change this situation (see Kluft, 1991; Martínez-Taboas, 1986, 1988).

In conclusion, MPD can be detected in a social and cultural setting quite different from that of Canada, the Netherlands, and the United States. The fifteen cases depicted in this paper correspond in many striking details to the ones detected in those other countries. This tentatively suggests that the development and manifestation of MPD is fairly dependent on some environmental and idiosyncratic personal characteristics that, if kept invariable, will probably culminate in a dissociative disorder. I hope that this impression will be rigorously tested in the near future by researchers and clinicians in other countries of the world. Only then may we answer in a definite way if MPD is a sort of culture-bound syndrome or a more universal pathological entity. ■

REFERENCES

Adityanjee, R., Raju, G., & Khandelwal, S. (1989). Current status of multiple personality disorder in India. *American Journal of Psychiatry*, 146, 1607-1610.

American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders.* (3rd Ed.). Washington, DC: Author.

Boon, S., & Draijer, N. (1991). Diagnosing dissociative disorders in the Netherlands: A pilot study with the structured clinical interview for *DSM-III-R* dissociative disorders. *American Journal of Psychiatry*, 148, 458-462.

Coons, P.M., Bowman, E.S., & Milstein, V. (1988). Multiple personality disorder: A clinical investigation of 50 cases. *Journal of Nervous and Mental Disease*, 176, 519-527.

Guarnaccia, P.J., Good, B.J., & Kleinman, A. (1990). A critical review of epidemiological studies of Puerto Rican mental health. *American Journal of Psychiatry*, 147, 1449-1456.

Hohmann, A.A., Richeport, M., Marriott, B.M., Canino, G.J., Rubio-Stipec, M., & Bird, H. (1990). Spiritism in Puerto Rico. *British Journal of Psychiatry*, 156, 328-335.

Izcoa, A.E. (1991). El incesto: Un tabú que urge atención. *Revista Intercontinental de Psicología y Educación*, 4, 13-28.

Kluft, R.P. (1991). La violencia familiar y el desorden de personalidad múltiple. *Revista Intercontinental de Psicología y Educación*, 4, 29-56.

Martínez-Taboas, A. (1986). Personalidad múltiple. *Avances en Psicología Clínica Latinoamericana*, 4, 19-41.

Martínez-Taboas, A. (1988). Casos de personalidad múltiple en Puerto Rico. *Revista Interamericana de Psicología*, 22, 57-66.

Martínez-Taboas, A. (1989). Preliminary observations on MPD in Puerto Rico. *DISSOCIATION*, II, 128-131.

Martínez-Taboas, A. (1990). *Personalidad múltiple: Una exploración psicológica.* Hato Rey, Puerto Rico: Publicaciones Puertorriqueñas.

Martínez-Taboas, A. (1991). Abuso físico durante la niñez: Hallazgos, conceptualizaciones y consecuencias. *Revista Intercontinental de Psicología y Educación*, 4, 57-86.

Martínez-Taboas, A. (1991). Multiple personality disorder as seen from a social constructivist perspective. *DISSOCIATION*, IV, 129 - 133.

Núñez-Molina, M. (1990). Therapeutic and preventive functions of Puerto Rican espiritismo. *Homines*, 12, 240-252.

Putnam, F.W., Guroff, J.J., Silberman, E.K., Barban, L., & Post, R.M. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry*, 47, 285-293.

Ronquillo, E.B. (1991). The influence of "espiritismo" on a case of multiple personality disorder. *DISSOCIATION*, IV, 39-45.

Ross, C.A., Norton, G.R., & Wozney, K. (1989). Multiple personality disorder: An analysis of 236 cases. *Canadian Journal of Psychiatry*, 34, 413-418.