PRELIMINARY OBSERVATIONS ON MPD IN PUERTO RICO

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ABSTRACT

A considerable number of cases of multiple personality disorder (MPD) have been reported by clinicians working in the continental United States of America (USA). However, there has never been a documentation of MPD in a Latin American country. Here I report three cases of Puerto Rican patients with MPD whose symptom profile and etiological background are strikingly similar to the ones reported in the USA. It is recommended that Latin American mental health professionals should become more aware of and clinically sensitive to this increasingly recognized condition.

PRELIMINARY OBSERVATIONS OF MULTIPLE PERSONALITY DISORDER IN PUERTO RICO

In the last 20 years there has been an upsurge of interest in multiple personality disorder (MPD). Following this trend, a multitude of publications have discussed areas such as psychophysiological investigations (Coons, 1988; Putnam, 1984), diagnostic criteria (Coons, 1984; Kemp, Gilverston & Torem, 1988; Schafer, 1986), different therapeutic modalities (Braun, 1986; Kluft, 1984; Putnam, 1989), and various theoretical frameworks (Bliss, 1986; Kenny, 1986; Kohlenberg, 1973).

Apparently, this renewed interest in the reporting of patients with MPD is the product of a variety of factors. First, many professionals in the mental health field are now more acquainted with the clinical characteristics of the syndrome. This process has been facilitated by clearer specifications of the syndrome in DSM-III (American Psychiatric Association, 1980) and DSM-III-R (American Psychiatric Association, 1987) and by the numerous workshops and professional publications on the subject. Second, there is evidence that many of the risk factors that have traditionally been associated with the development of MPD (incest and physical abuse) either are on the rise or at least are increasingly recognized (Ammerman, Cassini, Hersen, & VanHasselt, 1986; Wolfe, Wolfe, & Best, 1988). Third, many influential authors are giving due weight to the dissociative aspects of many psychopathologies (Bower, 1981; Hilgard, 1977; Nemiah, 1984). This shift in emphasis has given rise to more careful attention to the impact of non-conscious processes upon human emotion and behavior.

Nethertheless, some authors have objected to the usefulness of the diagnosis of MPD because it appears to be a culture-bound syndrome confined primarily to the continental USA. As Fahy (1988) has noted: "Although supporters of the diagnosis can point to the wide distribution of cases in time and place . . . this distribution no longer extends outside the USA. Just one British case has appeared in the literature over the past 15 years" (p. 601). This impression was confirmed to me by Coons (personal communication, April, 1989) when he stated: ". . . some world experts believe multiple personality disorder to be a culture bound syndrome of the continental United States and possibly Canada."

Reviewing the literature on MPD largely confirms those impressions. So, although it is true that some cases of MPD have been documented in various European countries (see Ellenberger, 1970), nearly all of these were published in the 19th century or in the first decade of the 20th century. One important exception is the case study reported by Varma, Bouri, and Wig (1981) of a MPD patient in India.

The major purpose of this paper is to briefly record the occurrence of various cases of MPD that the author has studied in detail in Puerto Rico. It is important to highlight that, as far as I know, this is the first publication that documents the presence of MPD in a Latin American country.

ANALYSIS OF THE CASES

Characteristics of the patients

Between 1986 to the present the author has been working as a clinical psychologist at the Puerto Rican Society for the Assistance of Epileptic Patients. Typically, the Society's clinicians attend patients with a diagnosis of epilepsy or with symptoms that suggest the possibility of a seizure disorder. Our patients usually are persons of low socioeconomic and educational status.

During the last two years I have diagnosed MPD in three patients, using the DSM-III criteria. Table 1 shows the reader the clinical characteristics of these cases. It seems clear that all of them conform to the general pattern that has been documented in other clinical research in the USA (Coons, Bowman, & Milstein, 1988; Putnam, Guroff, Silberman, Barban, & Post, 1986). Such symptoms as persistent headaches, hallucinated inner voices, recurrent and rapid affec-

tive and expressive shifts and changes, psychogenic amnesia, and psychogenic seizures are repeatedly encountered. Also, from their history we find documentation of post-traumatic stress disorder and of trauma that occurred during childhood. In all cases I have been able to corroborate the patients' accounts from independent sources of information.

In the case of Olga, whom I have seen for only five sessions, there is apparently no history of physical or sexual abuse. Nevertheless, one of the alter personalities was created around the age of five years, when she witnessed a tragic accident that occurred to her mother.

It is important in the context of transcultural observations to indicate that these patients had not been raised in the continental USA and then relocated to Puerto Rico. They were born and raised in Puerto Rico, and resided there.

TABLE 1
Clinical Characteristics of the Patients

	Migdalia	Diana	Olga
History of sexual abuse	+	+	?
History of physical abuse	+	+	?
Post-traumatic stress disorder during childhood	+	+	+
Use of fantasy as a coping mechanism	+	+	-
Tendency to repress feelings	+	+	+
Psychogenic amnesia	+	+	+
Psychogenic seizures	-	+	+
Recurrent and persistent headaches	+	+	+
The hearing of hallucinatory voices	+	+	+
Rapid and recurrent changes of affect and expression	+	+	+
Previous unsuccessful psychiatric treatment	+	+	+

TABLE 2
Characteristics of the Alter Personalities

	Migdalia	Diana	Olga
Number of alters (including host personality)	4	4	3
Child personalities present	+	+	+
Depressed personalities present	+	+	+
Anger personalities present	+	+	+
Different handwritings	-	+	+
Opposite gender personalities	+	+	-
Different tones of voice	+	+	+
Different facial expressions	+	+	+
Protector personalities present	+	+	+

Characteristics of the alters

As can be seen in Table 2, in nearly all cases the alters demonstrated different tones of voices and different handwritings. What has impressed me most forcefully, however, are the different bodily expressions of each alter. For example, Diana has three other alters. One is of a child eight years of age, another is a man, and the remaining one is a woman a little younger than the patient. The child personality always trembles from head to toe, constantly has a bowed head, rubs her hands in a nervous way, and looks at me a very fearful manner. Additionally, on occasions she presents with a type of acute coughing attack that occurred very frequently when Diana was a young child. The male personality usually is very calm. He speaks in a very soft voice, constantly looks at my eyes, and rarely blinks. Finally, the younger woman *never* looks at the eyes of her interlocutor. She usually likes to smoke one cigarette after another, and has a constant tremor in her hands.

In all cases, there is at least one personality who displays much anger, another who reports severe depression, and a child-like personality.

Case illustration

I will briefly discuss the case of Migdalia to illustrate some of the clinical characteristics of my caseload. Migdalia is a 30 year old woman with only a sixth grade school education. During her childhood years there were frequent and violent quarrels in her family that usually included physical aggression. On various occasions her father beat her so strongly that he disfigured her nose and broke some bones in her chest. Also, she was sexually attacked on two different occasions by an uncle. She usually coped with the abuse by imaging that deep inside her was a strong and forceful man who can handle any difficult situation. She named this personage "Pedro." In her adolescent years she noted that when her father attacked her, she suddenly and uncontrollably responded in a violent way. Sometimes she had no consciousness or memory of her aggressive actions.

When she first came to my attention she was very depressed and exhibited suicidal ideation. During administration of the Thematic Apperecention Test (TAT) she insisted that she didn't want to see the cards because some of them brought back memories of her unhappy childhood. Unexpectedly, while she was looking at card #6, she bowed her head for some seconds. When she lifted it, she told me in a forceful voice: "Why do you want to make her suffer?" I didn't understand her remark and I said so. This time she said: "You want her to suffer

but I will not permit that. And I am not Migdalia. I am Pedro. I am here to protect her against people like you!"

Pedro's principal function is to protect Migdalia from suffering any external or internal stressful situation that might provoke emotional instability in her. He describes himself as rude and stern. Fortunately, he has usually been quite cooperative in the psychotherapy process.

During the last months, two other alter personalities have made their appearance. One is of a woman (María) who is constantly crying. She says that she hates Migdalia and her family, but Pedro does not permit her to take any harmful action toward them. María is usually weak and says that she takes a more dominant role when Migdalia is suffering from some disappointment or depression. In those instances she can influence Migdalia in a more marked way. Lastly, there is a very little girl (Vicki) who only likes to play and who refuses to talk about Migdalia's family.

During the last year I have seen this patient about twenty-five times. My approach has been akin to that described by Caddy (1985) and until now has mainly consisted of amplifying her coping skills and of confronting her with the past.

On October 28, 1988 in collaboration with Dr. Luis Rivera Reyes, a neurologist, Migdalia was admitted to a video-EEG monitoring unit. The reason for this admission was to try to establish whether the patient and her alters have the same EEG pattern. The results indicated the "during the transition from Migdalia to 'Pedro' no abnormal electrical activity was observed and the background activity remained unaltered except for increased muscular activity." This result is entirely consistent with the EEG study of Cocores, Bender and McBride (1984): "Our investigation demonstrates that the EEG is not changed by the dissociation in the multiple personality case studies. Although electrical artifacts were often present as a result of the muscle activity . . ." (p. 437).

Iatrogenesis?

Some critics of the diagnosis of MPD contend that the disorder is subtly shaped by the psychotherapist, especially when the use of hypnosis is involved (Fahy, 1988; Kenny, 1986). I contend that in the cases of Migdalia, Diana, and Olga this sort of criticism is improbable. First, I have never used hypnotic techniques in Migdalia's case. I used them once in the case of Olga, and very sporadically in Diana's case. In other words: over 90% of my communications with the alter personalities were not mediated by the use of hypnosis. Second, and as can be seen in Table 1, when the patients came under my care, all of them were already suffering from recurrent psychogenic amnesias, "blackouts," and other clinical signs that are usually associated with the appearance of MPD prior to its clinical recognition. Third, in the case of Migdalia the alter personality contacted me in the very first session in a totally unexpected manner. In the case of Olga she was continuously having a rare variety of psychogenic seizures in which her character and behavior changed in a dramatic way. Hours later, she woke up totally confused and with no memory of her actions. Also, in Diana's case it was after six months of an unsuccessful behavioral intervention for her anxiety/depression that I suspected MPD. The turning point in this case was a session in which the patient suddenly changed her expression and tone of voice and discussed in detail many traumatic memories of her childhood years. At the next session, the patient had absolutely no memory of talking to me about that aspect of her life.

Consequently, I am confident that the iatrogenic hypothesis is neither a reasonable nor a sufficient explanation for the cases that I am reporting in this communication.

DISCUSSION

The question of why there is an "epidemic" (Boor, 1982) of MPD in the continental USA and not in other countries is not an easy one to answer. I think that part of the answer may lie in the fact that many clinicians from other countries do not diagnose MPD because they have not become sufficiently sensitized to the disorder to recognize its varied and subtle manifestations. For example, the patients discussed in this paper have had previous psychiatric treatments. In all cases they received the diagnosis of major depression and were treated with a wide variety of antidepressants. In fact, when one of Olga's former psychiatrists saw the personality changes in his office, he merely instructed her husband in methods to extinguish such behavior, without searching for its meaning or exploring its dynamics. He appears to have been unable or unwilling to identify the phenomena more thoroughly, even though he had observed them quite clearly.

Although the report of these three cases in and of itself cannot prove that MPD is a transcultural disorder, I think that it highlights the fact that: a) MPD does occur beyond the continental USA; and that, b) the clinical configuration of the Puerto Rican cases is strikingly similar to that of cases reported in the American literature.

Admittedly, what we need is a series of transcultural studies in which mental health professionals are trained to detect MPD in their native settings and among high risk populations. I am heartened to learn that some preliminary efforts of this nature are under way (Kluft, personal communication, June 1989) and look forward eagerly to their findings. ■

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