

IS MULTIPLE PERSONALITY DISORDER REALLY RARE IN JAPAN?

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ABSTRACT

Despite the recent high number of reports on multiple personality disorder (MPD), especially in the United States, Japanese psychiatrists still believe that MPD is a very rare psychiatric problem. A review of 489 inpatients diagnosed DSM-III or DSM-III-R criteria was used to determine the incidence of MPD among all inpatients in a Japanese medical college hospital during the period of five years between October 11, 1983 and October 10, 1988. No diagnosis of MPD was made. Further study based on the same diagnostic criteria should be conducted to determine differences in the incidence of MPD across different cultures.

According to the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition-Revised (DSM-III-R, American Psychiatric Association, 1987), the criteria for multiple personality disorder (MPD) are as follows:

- A. The existence within the person of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
- B. At least two of these personalities or personality states recurrently take full control of the person's behavior.

Since the time of Janet (1893) and Freud (1898) at the end of the 19th century, MPD has been considered a clinical entity among psychiatric disorders, although interest in it has waxed and waned. At the beginning of this century the number of case reports about MPD suddenly decreased, but since the 1970s there has once again been a dramatic rise in the number of case reports of MPD especially in the United States of America. In his foreword to the *Psychiatric Clinics of North America* special 1984 issue on MPD, Braun reported knowing of "approximately 1,000 cases" then being treated by various therapists (Braun,

1984). This figure has certainly been eclipsed by more recent reports of large series of such patients (e.g., Putnam, Guroff, Silberman, Parlan, & Post, 1986).

However, a wide disparity exists between the American and Japanese literature, there having been very few case reports on MPD in Japan. Ogino (1964) and Saito and Miyazaki (1978) described cases similar to those recently reported in the United States. However, Japanese psychiatrists were skeptical about these reports and virtually ignored them.

Although some cases of suspected MPD have been reported, some authors have concluded that apparent multiple personality phenomena actually should be interpreted as symptoms of schizophrenia. Mita et al. (1984) reported two female patients who suddenly began to speak in male voice and use the male third person singular pronoun instead of the first person singular pronoun when they talked about themselves. The cases were not described in detail and the authors concluded that the patients suffered from schizophrenia since they developed several of Schneider's first-rank symptoms and deteriorated personality and social maladaptation. These patients reported by Mita et al. might have suffered from MPD, since Kluft (1987) pointed out that high occurrence of first-rank symptoms is rather common in patients with MPD.

However, recent consensus among Japanese psychiatrists is that MPD is a very rare disorder. Many of them are even skeptical of the validity of its existence. There have been a few empirical case reports on MPD, but no systematic research has been conducted on this topic based on a uniform set of diagnostic criteria.

In this study, I intended to clarify whether the traditional Japanese view that MPD is a rare psychiatric disorder is valid, using the same diagnostic criteria as those used in the United States. If this view was confirmed, I did not anticipate that it would be definite proof of that point of view. Instead I intended to interpret the difference in MPD incidence between the two countries from a cross-cultural viewpoint with the aim of initiating in-depth research on MPD in different cultures.

METHOD

Yamashita Medical College, established in 1977, is one of the newest national medical schools in Japan. The Adult Psychiatric Unit with 40 beds in the College General Hospital was opened on October 11, 1983. The 489 subjects in this study were all patients hospitalized in the unit during a period of five years between October 11, 1983 and October 10, 1988.

Since its opening, diagnosis at the Adult Psychiatric Unit has been done on the basis of the criteria given in the Diagnos-

tic and Statistical Manual of Mental Disorders, Third Edition (DSM-III, American Psychiatric Association, 1980) along with traditional diagnostic methods. After publication, the criteria of DSM-III-R (American Psychiatric Association, 1987) came into usage.

At least three psychiatrists who are responsible for treating a given patient make a final diagnosis according to the DSM-III-R before the end of the hospital treatment. In order to make the final diagnosis, these three psychiatrists are required to reach an agreement. As for cases in which diagnosis is difficult to determine, the chairman of the Department of Neuropsychiatry interviews the patient in the presence of all the teaching staff and residents, who then discuss the case and make the final diagnosis.

Among the 10 teaching staff of the Adult Psychiatric Unit, five psychiatrists have had experience of studying in Europe or America for an extended period of time of further clinical training or research (two in the United States of America, one in the United Kingdom, one in the Federal Republic of Germany, and one in France). In addition, one attended the course "Multiple Personality: An Advanced Workshop" organized by Kluff and Braun and their colleagues at the 141st Annual Meeting of the American Psychiatric Association, Montreal, Canada, May 7-12, 1988. Therefore, we consider that we have a more than average knowledge of MPD in comparison with other Japanese psychiatrists.

Thus, diagnosis for all the inpatients in the Adult Psychiatric Unit of Yamanashi Medical College Hospital have been made on the basis of the DSM-III or DSM-III-R by psychiatrists who are familiar with this diagnosis system and MPD.

RESULTS

The results are summarized in Table I. Four hundred eighty-nine patients (aged 16-84 years) were hospitalized during this period. Seven cases (1.4%) were diagnosed as dissociative disorders. Among them, 5 were psychogenic fugue and 2 were

psychogenic amnesia. No case was diagnosed as MPD according to the DSM-III-R.

In addition to the above patients, 7 others claimed a change of identity, such as insisting on having a different name from their own, denying their personal history, ignoring their family members and so on at some comparatively short period of time in the course of illness. However, all of them had some form of overt disturbance in content and form of thought, perception, and affect, impaired interpersonal functioning and relationship to the external world, deterioration of personality and social functioning, and all showed some of Schneider's first rank symptoms. Therefore, all of the cases were diagnosed as schizophrenia.

DISCUSSION

About 120 years ago, Japan introduced modern medical methods from Germany, and since then traditional Japanese psychiatry has been especially influenced by German schools of psychiatry. However, since its inception, our department has adopted the DSM-III or DSM-III-R for diagnosing all psychiatric inpatients. It has often been debated whether a therapist's ignorance of MPD or denial of MPD is the primary reason for underreporting of MPD, but clearly this cannot apply to our department.

Many patients are referred to us by local psychiatric institutions or private practitioners. At this stage, referring therapists do not have much knowledge of MPD and it is difficult to deny that diagnosis of MPD might not be considered. Also, for most of the outpatients of our college hospital, each treating psychiatrist is responsible for making the diagnosis. Thus it is also difficult to rule out the possibility that some outpatients should have been diagnosed as MPD.

However, as for patients who are hospitalized, we make diagnosis according to the DSM-III or DSM-III-R and the diagnosis is evaluated by various psychiatrists. Using this system, no single case of MPD has been diagnosed among all inpatients in the five-year study period. Symptoms which looked like those of MPD in 7 patients only lasted in a short period of time compared to the whole clinical course. All of them showed Schneider's first-rank symptoms. Although I recognize Kluff's report (1987) pointing out that high occurrence of the first-rank symptoms is rather common in patients with MPD, all the patients also showed marked deterioration of personality and social functioning and they were finally diagnosed as suffering from schizophrenic disorders.

It is interesting to note that a recent study conducted in India by Saxena and Prasad (1989) there was no case of MPD among 62 patients with DSM-III dissociative disorders, the incidence of MPD thus being the same as in our study. Adityanjee, Ruju, and Khandelwal (1989) also reported the infrequency of the diagnosis of MPD in India. In addition, according to Fahy (1988), only a small number of cases of MPD have been reported in Britain, and his review of numerous recently published case reports, especially in North America, revealed a poverty of information on reliability of diagnosis, prevalence, or the role of selection bias and iatrogenic factors.

The roles of disorganization of the family system and child abuse in the etiology of MPD in later life have been emphasized

TABLE I

DSM-III-R Axis I diagnosis¹
(n=489, aged from 16-84 years)

Diagnosis	N
Organic Mental Disorders	39
Schizophrenia	150
Delusional Disorder	10
Mood Disorders	176
Anxiety Disorders	50
Somatoform Disorders	10
Dissociative Disorders	7
Adjustment Disorders	22
Other Diagnoses	50

¹ Some patients had more than one diagnosis. For fifteen inpatients, a diagnosis of personality disorder in Axis II alone was made.

by American researchers (Kluft, 1985). Although how traumatic events in childhood might lead to development of MPD in later life is unclear (Fahy, 1988), it has often been pointed out that traumatic childhood experiences, especially those involving physical and sexual abuse or neglect, are common in patients with MPD (Coons, Bowman, & Milstein, 1988; Putnam, Guroff, Silberman, Barban, & Post, 1986; Wilbur, 1984). Our data did not reveal child abuse in any of our patients. Furthermore, the family bond is still strong, children are generally valued in Japan, and the Japanese divorce rate in 1988 was 1.26 per 1,000, about one third of that in the United States. According to a survey conducted by the Japan Bar Association (Asahi Shinbun, 1989), the annual incidence of child abuse in Japan, including sexual abuse, has been gradually increasing, but is still very low, estimated to be 6.6 per 100,000 children under the age of 12 years. These factors might partly explain the very low number of reported cases of MPD in Japan.

Although admittedly no hypothesis can be derived from this study to explain the wide disparity of MPD incidence between the American and Japanese literature, one possibility is the Japanese concept of self. In Japan, one's ability to get along with others in society is highly valued (Doi, 1971). In sharp contrast to the American belief in self-independence, the Japanese esteem highly "interdependence," or dependence on others appropriate to a given situation. For one to be too independent, or indeed, too dependent, is considered a sign of immaturity. According to Japanese logic, a person who is too selfish and thinks only about one's own benefit is a maverick, whereas a person showing excessive dependence is not a mature adult in society. From early childhood, Japanese are disciplined to be appropriately interdependent in any circumstance, which is part of the social code. They tend to give harmony or welfare within the group top priority, although they may have to change their thinking of belief to meet this requirement. In such a culture where one's thinking, or identity in the sense of western cultures, is altered to fulfil society's needs, the need for an individual to develop a psychiatric disorder such as MPD might not be very strong.

Since the sample used in this study was rather small, the findings should be considered only preliminary. Further study should be conducted based on the same diagnostic criteria or method, such as the Dissociative Experience Scale (Bernstein & Putnam, 1986), in order to confirm whether MPD is, in fact, underreported or whether it is a very rare clinical entity in other cultures dissimilar to the United States. ■

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