

What a Group of Clinicians Have Learned About Multiple Personality Disorder in Puerto Rico.

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Abstract

During the last eight years a number of Puerto Rican psychologists and psychiatrists have been accumulating extensive clinical experience with patients with multiple personality disorder (MPD). In this article we compare some of our most significant findings with the ones reported in North America and Europe. Although our social milieu is quite different, in terms of values, language and national heritage, we still obtain a clinical configuration that is similar, though not identical, to the one informed elsewhere. Lastly, we emphasize that our clinical research and experience is at variance with the view that all MPD cases can be explained by iatrogenesis, misdiagnosis and other diagnostic artifacts.

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There is no doubt that multiple personality disorder (MPD) is one of the most fascinating and challenging syndromes that a clinician can encounter in his/her practice. Fascinating because more than any other mental disturbance it exemplifies the complexity of our consciousness (Hilgard, 1977; Klein & Doane, 1994). Challenging because it defies our clinical expertise and the effectiveness of our usual methods of treatment (Kluft & Fine, 1993).

At the same time, MPD is one of the most controversial clinical syndromes in psychiatry. There is empirical documentation that many clinicians are antagonistic toward MPD as a nosological entity (Dell, 1988a), some to the point of being deeply incredulous (van Praag, 1993). Others, it is alleged, may be overcredulous and may be diagnosing MPD where other standard diagnostic categories (e.g., borderline personality disorder; bipolar disorder) are better indicated (Merskey, 1992).

In this article our intention is not to offer a solution to the current nosological debates, but a more humble one. For the past seven years a group of clinicians have been actively involved in the diagnosis, treatment and research of MPD in Puerto Rico. One of us (AMT) has written a book (Martinez-Taboas, 1990) and more than ten articles on MPD (Martinez-Taboas, 1986, 1988, 1989, 1991a, 1991b, 1991c, 1993, 1994, 1995a, 1995b; Martinez-Taboas & Cruz-Igatúa, 1993; Quiñonez & Martinez-Taboas, in press) and has coordinated various symposiums and workshops on the subject. Some of the other authors have also participated in various conferences, have diagnosed and treated at least one MPD patient and another one worked with the subject as part of his doctoral degree. In this paper we intend to compare our clinical knowledge and experience with MPD patients in Puerto Rico with the one reported by European and North

American clinicians. We hope that this act of sharing information will be useful to all those with an interest in dissociative disorders.

MPD in Puerto Rico

To organize thematically our point of view we have decided to present them in ten major arguments.

(1) MPD appears to be an uncommon disorder in Puerto Rico but it is not as extremely rare as some assume.

Although we had not conducted any epidemiological research to sustain our point, other data confirm our suspicion. For example, two of us (AMT & ACI) diagnosed and treated 5 cases of MPD in a two year period (1989-1990) at a large psychiatric private hospital in Puerto Rico. Also, while working at a large Mental Health Center (Salud Mental de la Capital) all of us have at least diagnosed or treated a case of MPD in the last two years. As a matter of fact, in the last three years the authors have identified and treated fourteen cases of MPD, diagnosed according to the DSM-III-R plus the amnesia between personalities as an additional criterion. So, our clinical experience is consonant with the view that MPD is not a common disorder but neither it is as rare as once thought (Taylor & Martin, 1944).

It is important to establish that some of the authors know of colleagues that had seen in treatment other cases of MPD in Puerto Rico. Because AMT is widely known in Puerto Rico for his expertise in MPD, he has served as a consultant and supervisor to a number of clinicians about the differential diagnosis and clinical management of MPD. In this way AMT had been in close contact with more than 25 cases of MPD in the last eight years. Three of them had been described in detail in his book (1990) and another two cases will appear in a forthcoming monograph.

(2) Childhood trauma and/or abuse is highly prevalent in our patients with MPD.

In a previous publication, Martínez-Taboas (1991a) presented the clinical configuration of 15 MPD patients in Puerto Rico. One relevant finding was that 73% were sexually abused and 60% were physically abused. In the last ten cases that we independently have seen we noted that seven (70%) have been sexually abused as a child and six (60%) have been physically abused. Interestingly, in three cases the persons were not physically nor sexually abused. It is important to emphasize that in eight of these ten cases we obtained independent corroborative evidence of the abuse, mainly through the social workers that had worked with the case at the time of the abuse or through some member of the extended family.

These findings provide support to the notion that MPD patients generally have suffered traumatic abuse in their childhood or early adolescence. On the other hand, there is a minority of patients that also developed their alter personalities in response to other stressors. For example, Lourdes developed her alters because she was extremely isolated and rejected by her peers for her fragile and short height. Juan developed his alters because his mother is a bipolar patient with recurrent crisis and breakdowns of her condition. Alicia had three alter personalities that appeared when her mother assumed a promiscuous lifestyle and felt rejected and unloved. So, in our experience, deeply traumatic experiences are frequent in our case-loads but they don't appear necessary nor sufficient in the development of MPD. Although this finding is somewhat at variance with the North American experience, it accords well with MPD in India (Adityanjee, Raja & Khandelwal, 1989) and Turkey (Tutkun, Yargic & Sar, 1995).

(3) We have obtained verification of the abusive experiences in the majority of our cases.

With a previous case-load, Martínez-Taboas (1991a) obtained independent corroboration of the traumatic experiences in five of six cases where he was the primary

therapist. In ten recent cases that the authors had examined in detail, we obtained independent verification of the alleged abuse in seven of them. In the other three cases, the abuse was a deeply family secret and until now we had encountered resistance and poor cooperation to confirm the abuse. We think that a 70% confirmation of the abuse in the cases just mentioned contradicts some recent claims that the abusive experiences recalled by MPD patients are iatrogenic and fanciful creations of hysterical women (Frankel, 1993). In five cases the abusive experiences were confirmed by some other family member (usually sisters/brothers), and in the other two by police or other official records.

With these comments we don't want to easily dispatch the notion that in some circumstances some people can create false or misleading memories of events. In fact, we are somewhat inclined to suspect that the proponents of the False Memory Syndrome have some evidence in their favor (Coons, 1988; Gardner, 1993; Ofshe, 1992; Yapko, 1994). Our main argument is that we have invested considerable efforts to trace the historical truth of the abusive trauma and that our efforts have been amply rewarded.

(4) We have not encountered a single case where a MPD patient had alleged that he/she was abused in a satanic ritual.

In Puerto Rico there is a long tradition of spiritism and "santería" that is deeply ingrained in our culture (Yañez, 1963). Nevertheless, we don't know of any locally underground movement of satanism or demonology. Maybe for these reasons we never had encountered a case where a patient or his/her alters claim that the abuse was perpetrated by satanic worshipers.

Nevertheless, RCG had a female MPD patient where some alters alleged that as part of their traumatic history of abuse, the patient had been submitted to certain rituals where there were beheadings of chickens and spilling of blood over her body. The patient relived these experiences

in a dissociative crisis. ACI also had another patient who alleged she had been subjected to ritual abuse, but she didn't have a dissociative disorder.

We read with sympathy Putnam's (1991) article where he admonished that the recent upsurge of interest in linking dissociative disorders with satanic ritual abuse be analyzed cautiously. We agree with Bowers (1991) that MPD patients may be highly susceptible to incorporate the traumatic zeitgeist of the moment and even claim experiences that are in the realm of phantasy. Although Bowers' arguments are appealing, we concede that they need to be validated in a more rigorous way.

(5) The mean number of alter personalities per patient is somewhat less than the one reported in North America and Europe.

When Martinez-Taboas (1991a) wrote about the first 15 detected cases of MPD in Puerto Rico, he noted that the mean number of alter identities was only four. These, at first sight, was incongruent with the experience of many North American clinicians. The mean number of reported cases in Ross, et al (1989) and Putnam, Guroff, Silberman, Barban & Post (1986) was 15 and 13 respectively. Martinez-Taboas at that time commented: "There are various possible reasons for this discrepancy. First, maybe our psychologists and psychiatrists did not explore the systems of personalities in the way that clinicians more experienced with MPD might have proceeded. 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" (p.191).

Nevertheless, although our clinical experience has expanded considerably and the great majority of our cases have been studied by more than a year, we still obtain a mean number of alter personalities relatively close to our 1991 findings. In fact, the mean number of alter identities in our last ten cases is six. We don't have conclusive

answers for this discrepancy, but strongly suspect that cultural influences are at work. For example, compared to North America and Canada our culture is less rooted in an individualistic ideology (Triandis, Bontempo, Villareal, Asai & Lucca, 1988). We have posited in a previous publication (1991b) that culture impose meanings and configurations on the sense of the self. Maybe for that reason our Latin American patients experience the fragmentation of their dissociative self in a less polymorphous way. Taking as our conceptual basis the social construction of reality, we can predict that the countries and nations where the self is more interpersonal and less individualistic, MPD will manifest itself in a more idiosyncratic manner. An example would be a diminution in the manifestation of the alter personalities. Interestingly, the data that exist of MPD in Japan, India and South America, although scarce, sustains this view (see the excellent reviews by Golub, 1995; Krippner, 1994).

(6) The use of the Dissociative Experiences Scale (DES) appears to be a promising instrument in the detection of MPD.

The DES is one of the most researched clinical scales in the detection of dissociative states (Bernstein & Putnam, 1986; Carlson, et al (1993). Recently, Martínez-Taboas (1995a) realized an investigation where the total DES score was computed from MPD patients, panic disorder patients, and a group of undergraduate female participants. The results revealed that not one of our 16 MPD patients obtained a score of less than 35 on the DES. In fact, the mean score for the three groups was 55, 26 and 16 respectively. Our results are strikingly consonant with the ones reported in Canada, the United States, Turkey, Colombia and the Netherlands.

Although our experience with the DES have been considerable, we have also used the MMPI in some patients. As documented in a recent investigation

(Quiñonez & Martínez-Taboas, in press), the use of the MMPI in our patients have striking similarities with the ones presented by North American clinicians (Coons & Fine, 1990; North, Ryall, Ricci & Wetzel, 1993).

(7) Most of our patients have been in the mental health system for more than five years without remission of symptoms and with diverse diagnosis such as epilepsy, depression with psychotic traits and schizophrenia.

This was verified in our previous paper (Martínez-Taboas, 1991a), where we found that nearly 80% of the patients had been so diagnosed and treated. Our more recent experience dramatically confirms our previous conclusion. For example, at the time when her psychiatrist detected MPD in Evelyn, she had been in treatment for more than ten years with different therapists and diagnosis (schizophrenia, borderline personality disorder, complex-partial epilepsy). It was her psychiatrist who, after *seven years* of psychotherapy and pharmacotherapy, began to suspect a dissociative disorder after she witnesses a dissociative crisis in her office when she asked to talk with a male voice that threatened to kill Evelyn.

In another recent case, one of us detected MPD in a young female patient with a long history of dissociative crisis. Until that moment she had been diagnosed as "epileptic". When one of her alter personalities tried to harm the patient's daughter and threatened to kill "her", our unit recommended to the family a psychiatric hospitalization. They all consented and went to the emergency unit with an extensive report from our psychiatrist that clearly described her MPD. The psychiatrist that attended the case at the emergency unit interviewed her for about 30 minutes, made a Mental Status Examination and, after consulting with another colleague, sent her to an epilepsy unit explaining to her that she had "a neurological disease".

We can repeat case after case where mental health workers in Puerto Rico generally have shown poor knowledge and sensitivity to the special needs of MPD patients. In one case of our previous case-load, a 27 year-old female MPD patient had been diagnosed as "schizophrenic" from her early adolescence and treated unsuccessfully as such. In fact, in one of her numerous previous hospitalizations she received the following medications in a three month period: Mellaril, Navane, Ativan, Valium, Desyrel, Tegretol, Dilantin, Benadryl, Cogentin, Restoril and Halcion. This same patient became totally asymptomatic after an intensive psychodynamic treatment by one of us (ACI)

(8) We rarely use hypnosis in the clinical detection of MPD. Our use of hypnosis is mainly reduced to the latter stages of treatment.

We have consistently found that hypnosis and cathartic methods are not necessary in the clinical detection of MPD. Two of us (AMT & ACI) had used hypnosis in some cases but mainly in times of dissociative crisis or in special occasions such as when the patient is near a "fusion". We are somewhat reluctant to use hypnosis in the initial phases of treatment because we coincide with Coons (1988) that hypnosis can produce spurious identity alterations, such as the ones produced in hypnotic past-lives regressions (Spanos, Menary, Gabora, DuBreil & Dewhirst, 1991) . We have used hypnosis with notable success at times when an alter personality is overly aggressive or out of control (Kluft, 1983).

It is important to highlight that most of us don't have used hypnosis with our MPD patients (MFM, RC, JRC, EGM). So, our clinical experience is totally at variance with some critics who maintain that hypnosis is a necessary and sufficient condition to "manufacture" MPD.

(9) Our limited experience with MPD in children and adolescents highlight the fact that their clinical course is more benign than the clinical course in adults.

Until now, our clinical experience with children and adolescents had been limited to an 8-year-old boy, a 14-year old female and a 16 year-old female. Consistent with previous investigations, we have found that the number of alter personalities is smaller when compared with adult patients (Vincent & Pickering, 1988). In our case-load the number had been 4, 3 and 3 respectively. Also, the first two patients were successfully fused in less than 20 weekly psychotherapeutic sessions. This also accords well with the experience of North American clinicians (Hornstein, 1993).

We noted that the alter personalities had less narcissistic investment in their existence and that the dissociative periods were less pervasive. So, our experience indicates that the early detection of children with dissociative disorders is important as they respond rapidly to the recommended interventions.

(10) Most of us had encountered colleagues with marked hostility and irrational resistance to the MPD diagnosis of our patients.

In Puerto Rico, before Martínez-Taboas' book, there was scarce information about MPD. Four of us (AMT, JRC, ACI & EGM) have participated in various conferences and seminars about MPD and had interacted directly with other clinicians and hospital personnel. Our deep impression is that the majority of the clinicians that have attended our conferences had demonstrated a deep interest and motivation to learn about MPD. But there are some marked exceptions. Some examples will illustrate our frustrations. For example, recently two of us (AMT & JRC) had to hospitalize one 26 year-old female MPD patient because various alters were seriously mutilating our patient's body. Both of us, in written and verbal communication, talked with the staff psychologist

and psychiatrist and strongly suggested to auscultate her dissociative system. After six days as inpatient, none of the hospital staff had talked or questioned the patient about her MPD. She was left simply on her own. After a ten day stay she decided to leave the hospital.

Another case is that of a 18-year-old female with MPD who made a serious suicidal attempt. Three of us (AMT, JRC & EGM), decided to hospitalize the patient. In the referral process JRC emphasized that she had an MPD diagnosis and recommended the clinical staff to consider this information in her individual treatment plan. When the psychiatrist in charge saw the patient, he talked with a child alter and instantly considered this as "proof" that she was "schizophrenic". The three of us were dismayed, but not surprised, by the approach taken by the psychiatrist. We knew that the patient would not be helped if treated as a "schizophrenic" so we arranged for clinical privileges to continue the treatment at the hospital. Two of the clinical psychologists that worked in the setting developed an interest in the case, so we gave them a brief orientation about this condition and delegated the treatment to them. Two days latter the psychiatrist told to these psychologists to desist treating our patient as MPD because "it is well known that MPD is an invention of psychologists" (?). The same psychiatrist decided to treat the patient with mega doses of anti-psychotic agents. She was shortly discharged with a diagnosis of "schizophrenia".

Examples such as these could be multiplied *ad infinitum*. What is noteworthy of such examples is that those clinicians who had shown an antagonistic stance toward MPD patients are also outdated in their knowledge about MPD and other dissociative disorders. We had not yet met a colleague who had read skeptical and documented articles like Fahy (1988) , Merskey (1992) or Spanos (1989) to sustain their points. We must reluctantly coincide with Dell's (1988b) appreciation that "this extreme skepticism is usually not a product of either due consideration or even an informed difference of opinion.

Instead, it is typically uninformed, instantaneous, reactive, and unyielding" (p.537).

Conclusion

After having observed and studied closely MPD in our patients, we are totally convinced that MPD is a severe, debilitating and potentially chronic dissociative disorder which cannot be reduced to iatrogenesis, malingering or a misdiagnosis. We are deeply concerned with statements such as Merskey, et al (1994), when they categorically and flatly state: "We conclude that MPD is either a factitious diagnosis or a fictitious one" (p.246). The dramatic suffering, anguish and dissociative phenomenology of MPD cannot be dismissed in such a disdainful and supercilious way. We think that the science of psychopathology is better well served by a curious and cautious attitude, rather than assuming a dogmatic incredulity stance with a subject matter that strongly invites systematic inquiry (see the more careful and meticulous approach taken by Saks 1994).

Our clinical experience and research with MPD in Puerto Rico appears to be fairly similar to the one encountered in some parts of Europe and North America. Main differences are the absence of satanic ritual abuse, a lower number of alters, and the lack of sexual or physical abuse in about 20% of our case-load.

With this report we intend to document how MPD is being studied and documented in Puerto Rico. Much remains to know and be done as MPD concerns. We hope that this status report highlights how a group of clinicians from a Latin American culture have combined their efforts with the purpose of studying a relatively rare and profoundly important psychopathology of the self.

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