OPINION

Dissociative identity disorder: an attempt to understand the disorder in Malaysian context

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Abstract

Dissociation, including multiple personality disorder, has long been a controversial topic. Patients with suggestive symptoms are often misdiagnosed as malingering or even having schizophrenia. The former as a result of the overlooking of a clinician on the fact that suggestibility itself plays a key role in the emergence and perpetuation of this illness and the latter due to the lack of knowledge of the whole dissociative disorder spectrum, often resembling that of a psychotic disorder. Another contributing factor to the small number of patients with this diagnosis is due to the reluctance of a psychiatrist to do so because of his/her lack of experience and also fear of humiliation of being accused of seeking fame from diagnosing this somewhat glamorous phenomenon. In Malaysia, various culture bound syndromes often present with similar symptoms too. This article will attempt to understand this dissociation on the local context using case studies as a reference point.

Keywords: dissociative identity disorder, multiple personality disorder, culture bound syndromes.

Introduction

Dissociative states, including dissociative identity disorder (DID), are still hotly disputed conditions with much skepticism and disbelief from many psychiatrists. At one time with its origins from beliefs such as the wandering uterus, DID was even thought to be due to being possessed by two demons where the affected person presents with strange and unaccustomed symptoms that were not at all curable by ordinary or natural remedies. In the same context of beliefs, hypnotism a condition closely related to dissociation and DID was, and is still in certain places linked to the mysterious and supernatural [1]. It is impossible not to compare these now scientifically acceptable states to the ambiguous and relatively unknown phenomenon called culture bound syndromes. In Malaysia, with a multi-ethnic, multi-cultural population, there are numerous conditions that are attributed to possession and traditionally accepted conditions among others, Latah and Amok. Narcolepsy and related disorders, such as sleep paralysis, hypnogogic and hypnopompic hallucinations, too are attributed to many different forms of possession. In the era of modern psychiatry Pierre Janet at the Salpetriere Hospital in Paris hypothesized that dissociation was due to the lack of nervous energy that maintained integration in a person [2]. Hypnotism and suggestibility of patients are also controversial factors in the etiology and management of DID. Going back in history, Mar-

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quis de Puysegur, a disciple of Anton Mesmer referred to hypnotism as “perfect crisis” or “magnetic sleep”, something that was not accepted by Anton Mesmer himself [3]. Even as far back as the 17th century and probably much earlier the whole spectrum of hypnosis and autosuggestibility was already a phenomenon associated with much dispute. Where the culture bound syndromes we see world wide today stands in context to the above mentioned syndromes is still a question unanswered.

The fact that hysterical patients suffer from repressed memories of upsetting and traumatic events so distressing that they cannot face the associated emotions [4], one can only wonder if culture bound syndromes with the similar clinical presentation of amnesia and automatism and also recall of otherwise unknown events and memories is a spectrum of the same psychological reaction. Dissociation itself as much as it is a controversial psychological state is considered to be a normal reaction that occurs in otherwise healthy people. Occurring at different levels, the ability to do two things at the same time like driving a car or playing the piano and holding a conversation concurrently maybe be a milder form of dissociation, something a person may not be able to do if brought to conscious awareness. To dissociate means to sever the association from one activity to the other and in very often the case to dissociate one activity from another simultaneously occurring activity [5]. The cases discussed below are examples of how patients dissociated within the local cultural context in order to cope with possible conflicting socio-cultural beliefs. In all cases the problems were eventually resolved with the collective support from family and reinforced traditional beliefs.

Case Studies

Case 1 - M and her two alter egos

M was a 28-year-old single Indian woman who presented with a complaint of two-year history of headache. Over the last five months the headaches had increased in severity, associated with changes in behaviour and lapses in memory. She often misplaced things and left many house chores uncompleted, not being able to give an explanation for her behaviour. She was at times speaking like a little child who claimed to be her younger self, with her mother always in the kitchen and, at times as a very angry adult woman named K, who was seeking revenge for a broken relationship. M had no recollection of these episodes but always complained of a severe headache and blurring of vision before these changes occurred. On her eighth birthday, her mother committed suicide by drinking poison in front of her after an argument with her father. She was then labeled as the black sheep of the family, the cause of bad luck and also the cause for her mother’s death. The fact that this occurred on her birthday made it even more traumatic for her.

M’s problems were numerous. Beginning from the trauma of being given away at the age of two and subsequently being physically and emotionally abused she also experienced two episodes of a recurrent intraorbital tumour that required surgical removal twice at a very tender age without supportive parents. M was also traumatized by the suicide of her mother on her eighth birthday and the subsequent blame for it. This may have been too much for her to bear consciously, leading to her eventual dissociative states that served as a protective response to both past and ongoing overwhelming trauma. Although not presenting with symptoms suggestive of depression, her dissociative states may have been serving as a barrier from working through her unresolved internal conflicts. Her apparent “self-effacing” good behavior also suggested unexpressed emotions. Her headache may have symbolized the repressed conflicts she faced as a child surfacing now as the “return of the repressed” as she faced more conflicts as an adult, possibly that of a broken down relationship.
with a colleague at work. The younger self that emerged may have been an alter ego that kept her happy at the age when her mother was still alive and K the person who helped her cope with the current emotional turmoil that she experienced. Her family believed that she was actually possessed by an evil spirit.

After exhausting much energy and finances in numerous unsuccessful exorcism rituals, she was eventually brought to a psychiatric unit for help. All investigations like blood tests, urine toxicology screening, computerized tomography scan (CT scan) of the brain and electroencephalogram (EEG) revealed no abnormalities. Subsequently the diagnosis of DID was made. Her changes in behaviour brought much attention to her. Her father and brothers began spending much time with her during this period. The initial plan of psychoeducation for her family and psychodynamic psychotherapy for her was short-lived as they all collectively requested discharge to go back to traditional treatment. Issues pertaining to her traumatic childhood and unhappy adulthood were eventually re-addressed by exorcism. With the new found social support and concern, the healing process was successful. Her alter egos of the young happy child and the vengeful adult had been successfully dealt with amicably.

The DSM IV diagnostic criteria for DID requires the presence of two or more distinct identities or personality states which recurrently take control of the patient’s behaviour, with unexplainable forgetfulness. These symptoms should not be due to direct effect of a substance or a general medical condition [6]. DID may present initially as anxiety or panic attacks or with multiple somatic complaints and other non-specific symptoms such as periods of amnesia, emotional lability, mood alterations and even hallucinations. Often missed are the periods of amnesia not spontaneously reported, and frequently minimized as they have come to be accepted or ignored.

[7]. Various types of dissociative experiences may manifest as a presenting symptom such as multiple suicidal attempts, self mutilation, intractable head aches, pseudoseizures, mood swings, cognitive lapses, periods of amnesia and changes in behaviour [8]. The fact to be noted here is that patients with DID may be easily misdiagnosed as having other psychiatric disorders due to the varying and ambiguous presentation. Early trauma or abuse, physical or emotional in nature, is a prominent predisposing factor leading to DID [9-12]. In this patient the emotional and physical trauma and perceived abuse she experienced was immense. Another issue that needs to be addressed is the various differential diagnoses that are often considered such as multiple sclerosis, epilepsy, narcolepsy and other organic conditions that are often over looked [14]. Schizophrenia has often been a common misdiagnosis due to the frequent complaints of hallucinations and apparent disorganized behaviour seen [7,14-16].

Case 2 – Love possession
Miss C was a 26 year old lady who suddenly developed severe headache. At times she spoke irrelevantly and experienced visual and auditory hallucinations. She believed that one particular man had caused her to be possessed by what she described as “Love Possession”.

She also felt that there was an invisible man sleeping beside her and at times she woke up surprised to see herself naked in bed. Similar to case one, she had distinct periods of recurrent amnesia. She first sought the help of a traditional Malay healer called “Bomoh” to no avail. She then was referred to a neurologist via the primary care services. All neurological investigations were negative. Subsequently she was referred to a psychiatrist. Numerous sessions with the psychiatrist proved futile as she denied having any conscious problem. Her stressors were possibly sexual in origin as she was lonely, single and under pressure from her family to get married. Premorbidly she was
described as an introvert with very few friends.

Her unexplainable problems persisted for a period of three months without relief. Her resistance to continue therapy only indicated the possibility of some form of resistance. Her family eventually came to see the psychiatrist six months later to thank him and update him on the patient’s progress. She was now totally well after a series of faith healing by a priest in church. She was said to have been possessed by the spirit of a dead young man.

Case 3 – The reincarnated
Miss L was 26 years old when she developed of amnesia and fainting spells. During these attacks she would lash out at the nearest person and scratch them. She claimed that she was a reincarnation of a prostitute who was dependent on drugs and alcohol. Miss L however never used alcohol or any illicit substance. This was eventually verified through blood and urine tests and corroborative information from family and friends. This particular woman who had been “reincarnated” as L had passed away at the young age of 26. L’s relationship with a particular male friend seemed to be the source of her woes as he denied any intimate relationship with her but she on the other hand demonstrated strong histrionic and disinhibited behaviour towards this “friend”. When possessed she would make strong sexual advances to this friend and later deny it all. This behaviour went on for a period of eight months.

After thorough medical investigations and neurological assessment, she was referred to a psychiatrist. Unfortunately she failed to return for more psychological assessment after the first session. In this case the unexplainable symptoms were possibly a manifestation of yet again unresolved or unacceptable unconscious drives. Attribution to a culturally acceptable cause such as possession gave her an outlet to vent her feelings.

Case 4 – Satan
A young man began experiencing tightness around the chest and as if being pushed from behind at the age of 13. He also saw the image of a man calling him and beckoning at him. He believed that this man was the Satan. He also experienced many other visual hallucinations such as flashes of fire and bright lights. While in the classroom at school he often felt someone was peeping at him from outside and this person could drain his energy. This was his explanation to why he often felt very weak. He also felt that the person was challenging him about his belief in Jesus.

He and his family were devout Christians who believed in the existence of Satan. Therefore collectively they believed that he was being affected by Satan. They questioned his faith in god and attributed all the abnormal experiences as caused by the Satan to his lack of conviction. Similar to the other case describe above all medical and neurological tests were negative. This young man was not referred to psychiatry as his parents refused due to the stigma attached to psychiatry. His contact with the hospital was via a fellow church member who was a neurologist.

No stressor or conflict was identified in this young man except for the speculation of his religious expectation from the family. With simple reassurance and clarification about his symptoms and prayer the abnormal feelings and hallucinations eventually stopped occurring. He has since been perfectly well.

Case 5 – The pagan (the word ‘the pagan’ is an addition)
Miss L, a 26 year old woman began having involuntary movements of her upper limbs and shoulders associated often with a sharp shriek. She was first seen at a neurology clinic and subsequently by a psychiatrist. She had no medical or substance use history. All routine and specific investigations were normal. Both the neurologist and psychiatrist agreed that she may have a com-
plex tic disorder with both motor and vocal tics. However the nature of her tics, which included flailing of her upper limbs and the type of scream that often accompanied the so-called tics made both the physicians doubt the accuracy of diagnosis. They both seriously considered a strong differential of a conversion disorder. She was empirically prescribed a psychotropic drug called ‘Risperidone’. Her compliance to the medication was good as her family supervised the drug intake. Despite the medication there was no change in her symptoms. Her family actually felt that her tics had worsened.

Her friends from a church believed that this problem was due to her previous ‘pagan’ beliefs. She had recently converted from Buddhism to Christianity with a very charismatic church sect. Her family on the other hand believed that this problem was due to her conversion to Christianity. She was convinced that her problem was due to her previous “pagan” believes as a Non-Christian. There was great controversy within the family regarding her choice to convert to Christianity as her whole family was devout Buddhists.

In this case neither spiritual healing nor exorcism worked. She continues to have these symptoms. Various medications have been used without a favourable outcome. Why she felt the need to convert, and what other unresolved issues that she carries with her are still unknown.

**Discussion**

In DSM IV, culture bound syndromes denotes recurrent, locality specific patterns of aberrant behaviour [6]. Although some of these syndromes can be directly compared, symptom-wise, with a DSM IV diagnosis, many are not diagnosable. Similarly, although from a different locality thousands of miles away, some of these syndromes seem very alike but with different names and attributed causative factors. In Malaysia, some of the commoner known culture bound syndromes are like Latah and Amok. Latah is a syndrome where a person begins to do things automatically if they are surprised or shocked. Koro, a phenomenon where a male feels that his penis is retracting into his body, is uncommon now. It is believed to have originated from Malaysia. Amok or “Mengamok” in Malay, was once a conscious form of violent behaviour regarded as a useful phenomenon in war and defense when in danger, and hence considered “ego integrated”. It has since become an unconsciously motivated syndrome, possibly due to the negative sanctions of society. At one time it may have been a “standardized” form of emotional release accepted by society and even expected of an individual who was placed in a difficult situation [17]. Similarly nowadays, similar forms of emotional responses are regarded as simply dissociative states where in the individual with intense and unmanageable emotions finds catharsis alone without the support or collective beliefs of many individuals. Latah and Koro also seem to be fading away possibly due to the changing cultural beliefs. Latah may in fact be a less deep and more easily triggered partial form of dissociation.

However the syndrome of possession, which is relevant some forms of religion, is still very much encountered. This may be due to the fact that religious beliefs worldwide have common ideologies. This would suggest that cross-cultural syndromes, which share a common belief, may have that supporting and maintaining factors of religion. Hindu beliefs in polytheism and reincarnation are assumed to have a pathoplastic effect on believers that results in possession syndrome in India, representing the parallel to dissociative disorders in the west [18]. People with dissociative states of all nature have sought treatment from both psychiatrists and religio-cultural or otherwise known as traditional healers. Both forms of treatment have had positive outcomes when dealing with the affected person. The difference here is the boundary
between sciences and religions. A traditional healer approaches the problem in conventional terms, which is more traditional and spiritual in nature [19]. The lack of permeability of boundary between sciences and religions often prevents either healer to successfully heal and maintain mental well being in their patients due to the dichotomous attitudes. Modern scientific medicine has been described as mechanistic, impersonal, organ-oriented and individualistic emphasizing on the disease process rather than the total man [20].

In the case of the first patient described, the initial traditional approach failed numerous times possibly due to the absence of adequate family supports and collective beliefs. On subsequent admission and the successful congregation of her support system and further fuelled by the mechanical rigid approach of the doctors, she was eventually and successfully healed by a subsequent traditional healer. An important point to note here is the deletion of the term neuroses in psychiatric classification, which eventually leads to the loss of the term ‘character neurosis’, which emphasized more on the psychosocial aspects of a disorder rather than the clinical presentation and symptoms alone [21]. Hence the shift of diagnostic trend to DSM-IV criteria rather than an approach to an illness from the cultural background from which it came. The patient experienced the dichotomous approach of both worlds eventually finding comfort and relief from that with the traditional attributes.

A study done at the University Malaya Medical Centre showed that more than 50% of psychiatric patients sought traditional help before coming to the hospital.

Malaysia, a multi-cultural society, has numerous types of traditional treatment. One type often negates or even undermines another, claiming to be better or safer. There is no doubt that traditional healing plays an important role. But, when patients are told not to take hospital medicine because of the alleged toxicities, the patients suffer. Psychotherapeutic interventions too become less effective when patients are repeatedly told by others that their problems are purely culturally sanctioned manner in which this could happen. By attributing the phenomenon to a particular causative factor, often spiritual in nature, the causative factor in medical terms is often undisclosed. The past traumatic event, if present is masked or buffered by the cultural belief enabling a particular community to go on functioning intact and smoothly. Global modernization has led to the changing of social and family structure, which in turn has possibly caused the changes in psychopathology of culture bound syndromes. What used to be a communal phenomenon now lacks the social backing. Thus we see a reduction in many previously common culture bound syndromes. Miss M in more than one way lost her social and family support, leading to the need for an intra-psychic level of dissociation rather than the culturally sanctioned possession syndrome. This lead to the failure of the initial attempts of traditional interventions. The psychiatric approach, not being adequate for her and the family eventually lead to successful traditional healing, finally. Miss M and her family got back together to bind and resolve this issue culturally where the psychiatric services failed. Similarly, the other three patients discussed experienced similar emotional pressures in terms of unresolved emotional, sexual and religious conflict that were resolved when reassurance and attribution objects were effectively dealt with. The fifth patient however did not improve with either form of treatment suggesting the need for closer teamwork between the culture-magical and medical worlds.
super-natural in origin.

In conclusion, the syndrome of dissociative disorders seems to be facing increasing skepticism in Malaysia and also in modern psychiatry in many other countries worldwide due to various reasons, including the hesitation of psychiatrists to make such a diagnosis due to peer pressure and the lack of supporting investigational evidence. The lack of understanding of this phenomenon in the context of cultural beliefs and the tendencies to adhere to the rigid, common practice of using internationally accepted diagnostic criteria also plays a big role in the under diagnosis of this disorder with psychiatrists slotting patients into the pre-empted diagnosis. The view that dissociation occurs only in one person and not at different levels involving a group of people or a whole community only further complicates the issue of whether dissociative disorders are after all only culture bound syndromes of different communities worldwide. Whether they are one of the same or totally different entities is highly controversial and perhaps not of any clinical importance. What psychiatry needs in Malaysia and perhaps in other countries where traditional healing still plays an important role and influence is a system where the traditional-cultural approaches are incorporated in the bio-psycho-social approach for healing the mind. The discussed cases are examples of how psychiatric syndromes and culture bound syndromes may cause confusion therapeutically from the bio-psycho-social aspect. The lack of permeability of boundary between sciences and religions needs to be redefined in order to enable either healers to successfully heal and maintain mental well being in their patients, overcoming the dichotomous attitudes still encountered, clearly described in these case reports. The described cases are examples of the ‘tip of the Iceberg’ phenomenon of a whole plethora of psychiatric syndromes that are restricted in terms of therapy due to rigid diagnostic criteria and possible lack of emphasis on the cultural and traditional approaches to mental health. The syndrome of dissociative disorders and culture bound syndromes may need to be re-classified in order to enable psychiatry to deal with issues diagnosis, management and also co-morbidities. Where is the line drawn? Is there a line to be drawn? More analysis needs to be done on a larger scale to enable new views and approaches in therapy of these syndromes.

References
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