

## CHAPTER FOUR

# Cross-temporal and cross-cultural perspectives on dissociative disorders of identity

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I swore never to be silent whenever and wherever human beings endure suffering and humiliation. We must always take sides. Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented. (Ellie Wiesel: Nobel acceptance speech, 10 December, 1986)

I first planned to write this chapter as a purely academic project aimed at reviewing culturally divergent manifestations of altered states of consciousness and identity that I saw as pertinent to dissociative identity disorder (DID). I knew, then, that the book was planned to include a first-person account of DID and that my chapter would be part of its scientific backdrop. However, when I read the memoir I realised not only the courage of the writer but also the atmosphere of secrecy, silencing, and scepticism that surround the experiences of victims of child abuse in general and ritual abuse in particular.

For a long time, an atmosphere of doubt and delegitimation has haunted survivors, their therapists, and scholars of dissociation. Memories of childhood abuse, rooted in serious crimes, have been labeled false by the accused families, therapists have been charged with implanting false memories, and scholars have been attacked for

propagating scientifically unfounded concepts, false diagnoses, and harmful therapies.

In the prologue to her memoir the anonymous author wrote: "The continued belief in false memories leads to shame-based self-esteems and limits opportunities for the mistaken belief that the self is bad, deserving and responsible for the abuse, to be challenged." After reading these words I decided that this chapter would be written as a response to the stigmatisation of severe dissociative psychopathology (and those who suffer from it) as iatrogenic, extremely rare, or even feigned. My commitment to this project doubled when I realised that the story of the memoir's author will not be included in this book because of fears of retribution from the perpetrators. Although the safety of the survivor-author was given priority here, the dissemination of knowledge on the reality of severe child abuse and its outcome cannot be silenced. This chapter is dedicated to the author of the unpublished memoir and to the countless victims of childhood abuse in Africa and around the globe.

DID has been reliably diagnosed in a variety of mental health settings in countries across the globe (Martínez-Taboas, Dorahy, Şar, Middleton, & Kruger, 2013). Epidemiological data show that up to 1.5% of the general population meet diagnostic criteria for DID (Şar, Akyüz, & Doğan, 2007). Despite the evidence showing that the disorder is neither rare nor limited to particular societies, arguments are still raised that because DID is "an absurd fad", it is ignored by most psychiatrists (Paris, 2013, p. 357). The socio-cognitive model of DID understands the disorder as a series of role enactments which are directed towards achieving social reinforcements by therapists who create and maintain these maladaptive behaviours (Lilienfeld & Lynn, 2003; Spanos, 1996) in susceptible individuals who are fantasy prone (Lynn, Rhue, & Green, 1988). The alternative post-traumatic model of DID maintains that the disorder is an outcome of childhood neglect and abuse and that traumatised children compartmentalise their intolerable and inescapable experiences into alternate personality states (Putnam, 1997; Ross, 1989). Proponents of the post-traumatic model of DID have tended to reject the socio-cognitive model and to ignore the various historical and cultural expressions of disorders of identity (e.g., Dell, 2006; Gleaves, 1996). I agree with Lilienfeld et al. (1999) that the existence of social, cross-cultural, and historical influences on the manifestations of identity alterations may represent an area of common ground between the socio-cognitive and the trauma models (ibid., p. 520). I also

maintain that this sort of influence cannot be unique to DID and that similar influences are probably exerted on other forms of psychopathology. Culture-bound disorders of identity probably reflect not only societal oppression and the personal trauma of the ailing individual but also those idioms of distress that are sanctioned in that particular culture (Somer, 2006).

In this chapter, dissociative disorders of identity are explored mostly from an etic perspective. Behaviours or beliefs will be presented not only from a socio-cognitive viewpoint, which regards the investigated psychological phenomena as products of the norms and expectations of the cultural milieu in which they occur, but also from a trauma and dissociation stance which will be more culturally neutral. Evidence to be presented in this chapter about the existence of dissociative disorders of identity in various cultures, some of which may have never been exposed to any systematic dissemination of knowledge regarding dissociative disorders, could suggest an independence of these syndromes from popular or specific professional Western influence. Evidence showing that disorders of the sense of agency and identity among oppressed segments in traditional patriarchal cultures could imply that these phenomena are less related to short-lived Western fashions but perhaps reflect attempts to cope with societal or personal oppression.

### *Cross-temporal perspectives on dissociative disorders of identity*

Cultures do not only vary across geographical and ethnic boundaries. A regional culture and its conceptual frames of reference typically evolve along the axis of time. In this section I review generational trends in the understanding of disowned psychological experiences. The oldest records of "alter" control of a human being by spirits that cause mental disturbances are probably those mentioned in the Old Testament. These spirits were understood to be sent by God to torment people. For example: "behold, the Lord hath put a lying spirit in the mouth of all these thy prophets" (1 Kings 22:23), or "But the Spirit of the Lord departed from Saul, and an evil spirit from the Lord troubled him" (1 Samuel 16:14). The belief in Satan and his army of demons first appears in Jewish writings after 300 BCE. At the time of the first century CE, it is a well-developed concept in the Land of Israel. There are literally dozens of passages referring to demon possession causing mental

and physical illnesses in the New Testament. A major feature of Jesus' ministry is portrayed as curing people of demonic possession through exorcism. For example:

Jesus rebuked the foul spirit saying unto him, "Thou dumb and deaf spirit, I charge thee, come out of him, and enter him no more." And the spirit did come out after shrieking aloud and convulsing violently. (St Mark 9, 25–27, cited in Moffatt, 2013)

A more detailed discussion of possession trance will follow.

Accounts of dissociative identity changes have been published in eras that preceded any knowledge about dissociative disorders. For example, the successful exorcism in 1586 of Jeanne Fery, a nun who was possessed not only by harmful "devils", but by benign devils who protected her in childhood when being beaten, and also by a cooperative personality alter named Mary Magdalene (Van der Hart, Lierens, & Goodwin, 1996). Another example is the tale of Italian nun Benedetta Carlini, who was possessed by three angelic boys who took over her body, spoke different dialects, produced specific facial expressions, and caused her chronic pain. Benedetta had amnesia not only for these appearances but also for her sexual relationship with Sister Bartolemea, who was assigned to her cell for protection (Brown, 1986). Sixteenth-century eyewitness accounts of dissociative identity alterations associated with dybbuk possession described women from Safed, Israel who were possessed by male spirits whose chosen loci of the entrance and exit were highly suggestive of sexual intercourse (Somer, 2004). Descriptions of identity alterations that were not presented as possession cases first emerged in the late eighteenth and the beginning of the nineteenth centuries.

Following are illustrative descriptions of dissociative disorders of identity from the last 200 years, all from an era preceding current popular or academic knowledge about dissociative disorders.

- In 1791 Eberhardt Gmelin published a case he named *umgetauschte Persönlichkeit* (exchanged personality) in which he describes the reaction of a young German woman from Stuttgart to her encounter with aristocratic refugees from the French Revolution (Gmelin, 1791). The woman suddenly exhibited a personality who spoke perfect French and otherwise behaved in the manner of a Frenchwoman of the time. She would periodically enter these states and then return to her

normal German state. Her new alter personality spoke in elegant, idiomatic French and struggled when she attempted to speak German. The two states had no direct knowledge of each other.

- A description of identity alterations during a brutal murder of a stranger followed by amnesia was provided by Anselm Feuerbach. In 1828 Sörgel, an epileptic young German shepherd, killed, butchered, and cannibalised a man he met in the forest while collecting wood. "He then returned to the village, quietly related what he had done, and returned a while later to his normal state of consciousness in which he seemed to recall nothing at all" (Ellenberger, 1970, p. 124). Similar cases were much discussed during the nineteenth century and were sometimes interpreted as instances of transient multiple personality.
- Despine, a general practitioner, described the successful treatment case of Estelle, an eleven-year-old Swiss girl, who demonstrated a dual personality (Despine, 1840). In one she was paralysed, suffering from intense pain, low appetite and showed respect to Despine, and in the other she was able to walk, run and play, and eat abundantly, and was disrespectful to both Despine and her mother.
- Another case was described in Kerner's notable description of the girl from Orlach (1834). Here is an excerpt of Kerner's description:

The girl loses consciousness, her "Self" disappears or rather leaves in order to make place for another "Self". Another spirit now takes possession of this organism, of its sense organs, of its nerves and muscles, speaks with this throat, thinks with these brain nerves ... It is just as if a stronger one appears and chases the owner out of the house and then looks comfortably out of the window as if it would be his own. Since it is not an unconsciousness which takes place, a conscious self inhabits without any interruption the body, the spirit which is now in her knows very well—even better than before—what happens around him, but it is a different resident that lives in there. (Kerner, 1834, p. 42, cited in Peter, 2011, p. 91)

From the mid-nineteenth century onward, occurrences of multiple personalities began to be described objectively and discussed in writing by European physicians (e.g., Azam, 1887; Camuset, 1882; Flournoy, 1900; Moreau de Tours, 1845; Myers, 1887). The most influential early contributions to modern understanding of pathological dissociation

came from France (Jean-Martin Charcot and Pierre Janet) and the United States (Morton Prince):

- Some of Jean-Martin Charcot's most famous lectures at the Salpêtrière Hospital in Paris focused on cases involving alterations of identity and loss of the sense of agency and amnesia (Charcot, 1889). For example: a fifty-four-year-old midwife was on her way to assist with a delivery one night in 1885. She fell on the staircase and lost her conscious awareness briefly, came to, proceeded to the patient's apartment, delivered the baby and went back home and fell asleep. Hours later, after she had been called by the mother, the midwife reacted with violent shivers and then regained her former identity, only to be deeply perplexed as to how the baby had been delivered, recalling nothing about the complex procedure she had performed only hours earlier.
- Pierre Janet is considered to be the first to explicitly conceptualise dissociation and dissociative disorders of identity and to describe them as psychological defences against overwhelming trauma (Van der Hart & Horst, 1989). Janet claimed that the integrative capacity of the mind can be challenged by stress and lead to the splitting off (*dédoublement*) of nuclei of consciousness which can continue to lead lives of their own, as demonstrated by his famous patient Lucie/Adrienne (Janet, 1886).
- Morton Prince (1906), an American neurologist with an interest in abnormal psychology is best known for his classical description of the case of the traumatised twenty-three-year-old Miss Beauchamp. In his report he identified four alternating personalities. Prince pointed out that all conscious states, "belong to, take part in, or help to make up a self" (*ibid.*, p. 76) and coined the term "co-consciousness".

The rich history of documented cases displaying disordered senses of agency and identity suggests that Western healers had been aware of these mental aberrations and the associated suffering, long before the modern era debate on the validity of DID surfaced. These very similar cross-temporal descriptions of dissociative phenomena were presented with divergent meanings reflecting the prevailing zeitgeist and contemporary knowledge. An examination of historical and current non-Western manifestations of DID-related phenomena can

help determine the extent to which dissociative disorders of identity are specific to present-day North America and the West, as the detractors of this field would argue.

*Cross-cultural perspectives on dissociative disorders of identity*

*Dissociative disorders—not just Western phenomena*

My approach in writing this chapter is both universalist and relativist, or time- and culture-specific. In line with Kim and Berry (1993), I maintain that it is possible to reach a universalist formulation of similar illness expressions (derived etic) described from a medical anthropology (emic) point of view. As posited earlier in this chapter, the universal existence of DID and other forms of mental health are clearly influenced by social and cultural forces which determine the specific local idioms of distress and their behavioural manifestations. This realisation and the unfortunate, yet understandable, defensive stance against it is concisely reflected in the title of a book published a decade ago: *Trauma and Dissociation in a Cross-cultural Perspective: Not Just a North-American Phenomenon* (Rhodes & Şar, 2005). This section of the chapter will present data on the universal validity of dissociative psychopathology by demonstrating cross-cultural occurrences of dissociative disorders of agency and identity, primarily as manifested in various forms of dissociative trance disorder (DTD).

The epidemiology and phenomenology of dissociative disorders have been documented in non-clinical populations in Canada (Ross, 1991), Turkey (Akyüz, Doğan, Şar, Yargic, & Tutkun, 1999; Tutkun et al., 1998), and the USA (Murphy, 1994; Ross, Duffy, & Ellason, 2002), and in clinical populations in Australia (Middleton & Butler, 1998), Canada (Ellason, Ross, Sainton, & Mayran, 1996), China (Fan et al., 2011; Xiao et al., 2006), Germany (Gast, Rodewald, Nickel, & Emrich, 2001), India (Adityanjee & Khandelwal, 1989; Chaturvedi, Desai, & Shaligram, 2010); Israel (Ginzburg, Somer, Tamarkin, & Kramer, 2010; Somer, Ross, Kirshberg, Shawahday Bakri, & Ismail, in press), Japan (Uchinuma & Sekine, 2000); Norway (Knudsen, Draijer, Haselrud, Boe, & Boon, 1995), Puerto Rico (Martínez-Taboas, 1989), South Africa (Gangdev & Matjave, 1996); Switzerland (Modestin, 1992), and the Netherlands (Friedl & Draijer, 2000).

In contrast to the above-presented evidence on the occurrence of dissociative disorders internationally, some scepticism about the validity and universality of these disorders persists. According to the socio-cognitive model of dissociation, dissociative disorders are a product of a popular Western psychological discourse. According to this model dissociative disorders are rare and typically emerge in response to cultural influences and role demands made by therapists (e.g., Piper & Merskey, 2004a, 2004b). The socio-cognitive model excludes, of course, the trauma model for dissociative disorders. An elegant refutation of the social contamination model of dissociative psychopathology was demonstrated with data collected in China (Ross, et al., 2008). The authors compared two samples with similar rates of reported childhood physical and sexual abuse: one from Canada and one from China, where no popular or professional knowledge about DID exists, precluding iatrogenesis and social persuasion processes from contaminating the clinical phenomena. The results were inconsistent with the socio-cognitive model for pathological dissociation as both samples reported similar levels of pathological dissociation.

The occurrence of dissociative experiences and the belief in possession by “non-me” entities has been widely documented in the anthropological literature. For example, in 488 societies studied, Bourguignon (1970, 1973) identified various forms of institutionalised altered states of consciousness in 90%, possession beliefs in 74%, and possession trance in 52% of societies. Lewis-Fernandez (1992) argued that most non-Western cultures, which make up 80% of the world’s total, exhibit culturally patterned dissociative syndromes, typically manifesting major discontinuities of consciousness, memory, identity, and behaviour. In fact, possession trance disorder has actually been part of the DSM-IV-TR Dissociative Disorder Not Otherwise Specified (American Psychiatric Association, 2000) and defined (“where the dissociative or trance disorder is not a normal part of a broadly accepted collective cultural or religious practice.”) as a:

single or episodic disturbances in the state of consciousness, identity, or memory that are indigenous to particular locations and cultures. Dissociative trance involves narrowing of awareness of immediate surroundings or stereotyped behaviors or movements that are experienced as being beyond one’s control. Possession trance involves replacement of the customary sense of personal identity by a new identity, attributed to the influence of a spirit, power, deity, or other



person, and associated with stereotyped “involuntary” movements or amnesia and is perhaps the most common Dissociative Disorder in Asia. (APA, 2000, p. 301)

Although experiences of pathological possession are very common expressions of DID in cultures around the world, they were not included in the DSM-IV-TR diagnostic criteria. The dissociative disorders work group recommended including language that encompasses possession disorders, to assist diagnosis in cultures where the “diagnostic niche” of dissociative disorders related to identity alteration is filled by possession-related symptoms (Spiegel et al., 2011). In the DSM-5 (American Psychiatric Association, 2013) the APA formally incorporated possession as part of the theoretical framework of the dissociative paradigm to state that dissociative identity disorder is a:

Disruption of identity characterized by two or more distinct personality states or an experience of possession, as evidenced by discontinuities in sense of self, cognition, behavior, affect, perceptions, and/or memories. (APA, 2013, p. 292)

This accomplishment for the field of dissociative disorders was underscored by recent data published showing that possession trance disorder (PTD) symptoms measured in Uganda meet DSM-5 criteria for DID (Van Duijl, Kleijn, & de Jong, 2013). The authors expressed their reservation, however, about APA’s colonial stance by arguing that “ranking PTD (described in over 360 societies) under DID (described in considerably fewer societies) expresses a Western ethnocentric approach” (ibid., p. 1428).

A comprehensive survey of reported dissociative disorders of identity in non-Western cultures is beyond the scope of this chapter. For the sake of conciseness, I will focus on select reports on PTD from Asia and Africa to illustrate non-Western (“culture-bound”) manifestations of dissociative psychopathology involving alterations of identity.

### *Possession Trance Disorder (PTD)*

Goodman (1988) suggested that we might think of possession trance as representing a range of experience spanning from the socially sanctioned, construed, learned, and ritually controllable possession by

revered deities at one end of the spectrum, to the unauthorised, unruly, and threatening occurrences of demonic possession, representing PTD, at the other.

### *PTD in a Hindu context*

The world's third largest religion with an estimated one billion followers, Hinduism promotes belief in reincarnation, the continuity of life from one birth to the next until the soul is realised and reaches nirvana (Juthani, 2001). Illness and misfortune are frequently regarded in India as the result of possession by a spirit, or *bhut bhada*. Brockman (2000) reported that, in India, to be possessed is to be the victim of a chance event and not about failures or conflicts that arise from within. It serves as explanations for sudden changes in behaviour such as "voices" heard suddenly, these being understood as the voice of a spirit which has entered the body by pushing out the spirit which usually resides and "talks" within. Despite the purported chance causality in PTD among Hindus, evidence suggests a strong link between PTD and stress. For example, at the time of a smallpox epidemic in India, 400 admissions to a psychiatric hospital presented with disowned identity due to possession (Varma, Srivastava, & Shahay, 1970). Treatment from a traditional healer is usually sought first when a demon or a harmful spirit is the possessing agent (Castillo, 1994; Varma, Bouri, & Wig, 1981). Practitioners of the ancient Hindu system of medicine, the Ayurveda, often use their own possession states for diagnosis and confrontation with their patients' possessing spirits (Gadit, 2003). It was reported that 75% of psychiatric patients in India consulted religious healers about possession (Campion & Bhugra, 1994). The unique clinical pictures presented by Indian psychiatric patients renders many of them unclassifiable by the DSM or the ICD manuals (Alexander & Das, 1997). Recently, however, anthropological research reported a homogenisation of the identities of spirits and the use of psychological idioms, a change interpreted as signaling an erosion of context and the ascendance of universal categories (Hallibrun, 2005). A description of PTD in India was offered by Akhtar (1988):

A woman in her twenties and faced with an affect-laden situation, starts having periods of altered states of consciousness. During these spells, she behaves as if she is a different person, as if a religious deity, or the spirit of a dead relative or neighbor has taken

over her mind and body. Her demeanor changes markedly and her face acquires an entirely new repertoire of expressions. Body movements of various kinds occur and she starts talking. The possessing spirit then, through her, makes various demands on the surroundings, usually from near relatives who humbly comply with them. This sometimes brings a single episode of possession to an end ... Often at this stage, the patient is taken to a faith-healer believed to be capable of conversing with and driving away the spirit in question. (ibid., p. 71)

This account portrays how in a culture alien to Western psychotherapy, the stressed woman expresses her suffering in a disowned manner which is adaptive, in the sense that it signals the support system to appease her.

#### *PTD in a Confucian context*

In China, Taiwan, and Korea, religious beliefs are mostly influenced by Confucianism, an obedience- and conformity-promoting faith, and by Taoism, a creed that embraces the principles of dual energies (yin and yang) and of a spirit world of immortal creatures that could intercede for devotees. Reports from rural areas in these parts of the world, where people cling to their religious convictions, describe possession agents representing spirits of deceased individuals, deities, animals, and devils, and describe possession as developing abruptly and manifested particularly among distressed women (Gaw, Ding, Levine, & Gaw, 1988). In Japan, most of the nation's many horticulturalist-, Shinto-, and Buddhist-derivative religions are said to attract individuals who have stress-related illness. Believers often consider illness as caused by *dojo* possession: evil spirits, unhappy ghosts, or dangerous spirits of animals (Davis, 1980). A description of divine possession presented by a twenty-seven-year-old Korean immigrant in the USA was presented by Yongmi Yi (2000):

Following a stressful acculturation period and a prolonged conflict with her sister the woman suffered from waist bending, nightmares and olfactory hallucinations. She had difficulty breathing, and felt that some kind of *ki* (energy or spirit) had entered her body. When these symptoms continued for several weeks with no sign of abatement, her older sister ventured an observation that these symptoms happened to other people when a *shin* (god) was trying to enter

them. The two women then arranged to visit a Korean shaman in the city. The shaman explained that Anna's symptoms were caused by haan-laden dead ancestors trying to enter into her. (Haan is a Korean word describing accumulated and unresolved feelings of resentment, anger, and grief over experiences of victimisation or oppression.) The shaman told Anna that the ancestral spirits chose her to be their carrier because other members of the family either were too stubborn or were otherwise unsuitable. In order to be rid of her symptoms, the shaman instructed her to receive the spirits and become a shaman. Anna was frightened of this prospect and protested against it. The shaman then suggested a way out of this fate by prescribing a goot (shamanic ritual) to comfort the spirits. Anna was convinced that during this ritual her dead relatives entered the shaman's body and spoke out their haan through the shaman's mouth. The stories these dead relatives told via the shaman seemed to Anna to be very real and convincing. At the end of the ritual, Anna was told that the spirit of one of her dead uncles was her protector and that with his protection she now would not be required to become a shaman. Anna did not have new severe bouts of the symptom following the goot. (ibid., pp. 472–473)

This PTD account describes dissociative alterations of agency and identity that allowed for disowned feelings of anger to be expressed within animistic and Confucian paradigms. The shaman provided the patient with a corrective reparative relationship with her ancestral caregivers while addressing issues that were psychologically pertinent to the dissociating patient. The relationship between PTD and psychological stress and trauma was also demonstrated in a wider study in Singapore (Ng & Chan, 2004). All the participants with PTD from a sample of ethnic Chinese patients (adhering to a blend of Confucianism, Buddhism, and Taoism) described at least one overwhelming psycho-social precipitator, primarily: conflicts over religious and cultural issues, military life, and domestic disharmony.

#### *PTD in a Muslim context*

The model for understanding illness or personal problems in the Muslim context is jinn possession. The Qur'an and Sunnah indicate that jinn exist and that there is a purpose for their existence in this life, which is

to worship Allah. However, jinn invading humans are essentially bad because they tend to inflict maladies. Often spirits are thought to physically strike or possess a person incidentally with the person ignorant of the reason for the affliction in the first instance (Crapanzano, 1973). The word jinn comes from an Arabic root meaning "hidden from sight". The ability to possess and take over the minds and bodies of other creatures is one of the powers attributed to the jinn.

Muslim tradition dictates that the individual expresses only love and positive regard for his or her parents. Expression of frustration, anger, or hatred is forbidden, even if the children are neglected or maltreated. The individual can expect to enjoy familial support and to have his or her needs met by the family. In return, one relinquishes needs pertaining to actualisation of the self. Aggressive feelings towards members of the immediate and extended family are functionally repressed. The conformist choice actually condones intra-psychic dissociation and repression as a means of circumventing conflict between the person and society (Somer, 2001). Traditions in these societies allow for dissociated and somatised distress to be expressed in ways that reinforce the supremacy of male-dominated society and validate religion. The solution is for a religious healer to exorcise the spirit, or to appease God or the possessing agents, which then frees the person from the affliction (Abdullah, 2007).

Below are excerpts from a case study of Sheila, an Urdu-speaking twenty-four-year-old married woman possessed by djinnati in Iran (Kianpoor & Rhoades, 2006):

She presented with the chief complaints of irritability, apprehension, impaired memory and episodes of compromised consciousness and change of identity. The problem had developed gradually six months after her obligatory marriage at age thirteen to an age forty wealthy widower (father of two). The attacks, as her brother explained, would start with a trance state after staring for a while. The patient would exhibit escape-like behavior, accompanied by screaming ... The patient would calm down after three to five minutes (with the help of her family, ES) and would begin to speak in a different voice in fluent English. During the attacks, the patient would introduce herself as a female djinni named Flora. Flora noted that she lived in England, but liked Sheila and her beautiful features and so would sometimes capture Sheila's body. When

possessed, Sheila behaved and spoke in a disinhibited way with the family, especially the son and daughter of her husband. The attacks would last up to an hour. The family would usually take the patient to the local healers to “push out” the djinn ... She had no memory of the attacks or of Flora, but was aware that there are many episodes of amnesia when she didn’t know what had happened. (ibid., pp. 151–152)

This case description illustrates the universal features of this dissociative disorder: potentially traumatic circumstances in the life of a member of an oppressed group; Schneiderian first-rank symptoms such as made feelings and actions, alteration of identity, amnesia; as well as its shaping by the specific cultural milieu in which it is expressed. This case demonstrates how PTD can allow a child-wife the expression of otherwise self-endangering behaviours (challenging her stepchildren, symbols of her oppression, in a disinhibited way) in a socially condoned manner that preserves the local male-dominated social structure (she is brought to religious male healers by her brother).

#### *PTD in the African syncretist context*

Traumatic stress resulting from civil conflicts, poverty, and epidemics may be manifested in Africa through symptoms that are locally understood to originate from spirits or witchcraft. Reis (2013), for example, has argued that in Northern Uganda, “Children’s externalization of evil in the notion of contagious revengeful spirits, and their internalization of evil in the notion of child-witches exemplify their problems in dealing with the grief, guilt, anger, and anxiety which result from a severely damaged moral fabric which can no longer sustain and nurture them” (ibid., p. 635). Contemporary literature on the phenomenology and treatment of African PTD includes descriptions of possession by Zar spirits among Ethiopians. These spirits are said to favour victims subjected to psychosocial stressors. Zar possession is often perceived as a situation in which the spirit has a sexual relationship with the victim who is of the opposite sex; often a woman sleeping alone at night is attacked by a male Zar spirit (Witztum & Grisaru, 1996) and exorcism ceremonies involve chanting, drumming and dancing (e.g., Somer & Saadon, 2000). Another source of information on indigenous African forms of PTS emanates from South Africa (e.g., Swartz, 1998).

*Amafufunyana* (literally, “the evil spirits”) can be contracted by chance or through witchcraft.

Following are excerpts from a description of *amafufunyana* presented by a Xhosa girl in a rural village in the Eastern Cape of South Africa (Krüger, Sokudela, Motlana, Mataboge, & Dikobe, 2007):

Nomthandazo fell ill and became confused for a few days ... Her family consulted a traditional healer but this did not help. Her symptoms of restlessness, fever, and confused speech worsened. Her behaviour became odd. She started walking on all fours. Her voice changed to that of a young man, and she called herself by this young man’s name. Her family recognised the name and voice as those of a young man known to have passed away two years earlier. The girl described the events that had led to his death. He alleged that one of their neighbours had bewitched him and was using him as a slave. He said that he was not quite dead but could not come back to life as he had been bewitched. As a means of healing and resolution the family decided to take Nomthandazo to the neighbour that the male voice had reported to have bewitched him. A crowd gathered in the house. The alleged witch was confronted with the information gathered and the girl, through the male voice, openly accused the neighbour of witchcraft. As they all stood inside, the house suddenly caught fire, starting at the top of the thatched roof ... The girl and her family returned home, at which time her symptoms resolved and her voice returned to normal. She was, however, amnesic regarding these events. She was subsequently able to return to school and remained well. (ibid., pp. 14–15)

Ensink & Robertson (1996) report that stress was the feature most commonly mentioned as associated with *amafufunyana* by healer respondents. The authors identified support for the notion that *amafufunyana* is a dissociative disorder, in which abusive or traumatic experiences are regarded as causal. In line with observations in other cultural contexts of PTD, Zar possession and *amafufunyana* can provide meaningful explanations which are consistent with a broader religious belief system and social structure, ensures continued social support for the disenfranchised patient, provides an acceptable explanatory framework for the patient as to why his or her condition arose, offers a means of minimising

stigma for the oppressed patient, and an apportioning of blame for the condition elsewhere (Lundt, 1994; Somer & Saadon, 2000).

### *Conclusion*

The evidence presented in this chapter does not support claims that dissociative disorders of identity are iatrogenic, cultural artifacts due to transient social influences, rare or simulated (Spanos, 1996). The consistency of core elements in documented cases of pathological conversion and possession trance throughout history and across cultures speaks volumes to the stable validity of dissociative psychopathology and its traumatic genesis. In fact, the core elements of “culture-bound” syndromes are not unique to non-Western societies. For example, by administering the Dissociative Trance Disorder Interview Schedule to 100 predominantly Caucasian, American, English-speaking trauma programme inpatients at a hospital in the United States, Ross, Schroeder, and Ness (2013) found a wide range of possession experiences and exorcism rituals, as well as the classical culture-bound syndromes of *latah*, *bebainan*, *amok*, and *pibloktoq*, suggesting that the classical culture-bound syndromes are not really culture bound but rather universal. At the same time, I acknowledge in this chapter the emic perspectives on emotional distress and illness and its unique manifestation in dissociative disorders of identity, such as DID and PTD. The data reviewed in this section of the book weakens attempts to polarise the trauma versus the socio-cognitive models of DID (Boysen & VanBergen, 2013) because it supports previous assertions that post-traumatic and dissociative disorders, as indeed all psychopathological phenomena, are always coloured by cultural and societal processes (Şar, Krüger, Martínez-Taboas, Middleton, & Dorhay, 2013; Swartz, 1998).

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