Transcultural Aspects of Dissociative and Somatoform Disorders

April 15, 2004 | Somatoform Disorder [1], Comorbidity In Psychiatry [2], Cultural Psychiatry [3], Dissociative Identity Disorder [4], Histrionic Personality Disorder [5], Mania [6], Addiction [7], Amnesia [8]
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While the symptoms of somatoform and dissociative disorders are influenced by the patient's culture, these syndromes are heterogeneous and may have overlapping features. Although more frequently reported in non-Western cultures and thought of as exotic and culture-bound, multiple personality disorder may be a North American example of one such disorder.

A major goal in this article is to convey that the repertoire of traditions, belief systems, expectations and attitudes we call *culture* profoundly influences the formation, presentation and management of dissociative and somatoform symptoms. As Kleinman (1987) has articulated with eloquence, "Culture not only shapes illness, but also determines the ways one conceives of illness." Even in similar countries such as those of the western hemisphere (Europe and North America), dramatic differences can be documented in areas such as the way patients present, how medical tests are interpreted, and type and formulation of treatments provided (Payer, 1990). It is therefore expected that even deeper differences may exist for Africans, Asians and Latin Americans that persist following migration.

Because symptoms of dissociation and somatization often follow exposure to traumatic events and may coexist in the same individual (Saxe et al., 1994), it is likely that these syndromes share similar origins and pathophysiological mechanisms. Dissociation and somatization are perhaps the most commonly described sequelae of psychological trauma, and their presence augurs posttraumatic stress disorder and other major psychiatric disorders (Andreski et al., 1998). Somatoform Disorders

Hysteria and hypochondria, the forerunners of the DSM-IV's somatoform disorders, had a distinguished tradition in psychopathology, joining mania and melancholia as psychiatry's four classic syndromes (Foucault, 1961). Medically unexplained somatic presentations have been documented throughout the years, baffling the medical establishment and metamorphosing as medicine changed paradigms (Shorter, 1997, 1994). It has been argued that the concept of somatization may have arisen from the Cartesian dualism prevalent in Western societies, a dichotomy that also led to the cleavage of mental health care from "medical care" (Fabrega, 1991). Individuals affected with somatization display a tendency to amplify physical sensations and endorse multiple physical symptoms involving various body areas that leads to health care seeking. These patients show a tendency to over-report not only physical symptoms, but also psychiatric symptoms when prompted, hence the high levels of psychiatric comorbidity that has been documented for them. Besides over-reporting symptoms, these patients also seem to over-report negative experiences such as adverse life events, sexual abuse and other misfortunes (Morrison, 1989). Among somatization symptoms, the pseudoneurologic (fainting, fits, paralysis, lump in throat, deafness, blindness, paresthesias and several other presentations that mimic neurological disease) constitute the largest and most distinctive set, and they reliably provide psychopathological imprimatur to the syndromes. These symptoms are all implicit in the notion of conversion and the old concept of hysteria. They are also frequent correlates of trauma and dissociation, predictably appearing in response to stressful events or psychological conflict (Escobar, 1995).

*Transcultural aspects.* A well-accepted tenet in cross-cultural psychiatry is that the transformation of personal or social distress into somatic complaints is the norm in most cultures (Kleinman, 1987). According to Shorter (1994), the cultural influx on symptom presentation follows socially correct models of proper behavior in the various societies and the prevailing medical paradigms. Thus, patients tend to develop symptoms that are "medically correct," that is, symptoms that physicians expect and understand. Because somatizing individuals are relatively easy to characterize, they provide a useful construct for international comparison. For example, somatic symptoms are easier to recognize and their scrutiny proves less intrusive than that of psychological constructs. Thus, they
can be reliably elicited with little resistance offered by the subject because they tend to be less stigmatizing than psychological symptoms.

Some of the large-scale epidemiological surveys, such as those using the Diagnostic Interview Schedule (DIS) or the Composite International Diagnostic Interview (CIDI), have included detailed lists of somatic symptoms. Worldwide, the most common medically unexplained symptoms appear to be gastrointestinal complaints and abnormal skin sensations (World Health Organization, 1992). The Epidemiologic Catchment Area study revealed that the most common medically unexplained somatic symptoms in the United States were gynecological complaints, followed by gastrointestinal and cardiovascular symptoms (Escobar et al., 1987). A number of U.S. studies have documented higher levels of somatization among Latinos, particularly Puerto Rican respondents both in Puerto Rico and on the mainland (Canino et al., 1992; Escobar, 1995; Escobar et al., 1992, 1987). An international study reported frequent somatic presentations in primary care worldwide, with patients at the Latin-American sites reporting the highest number of somatization symptoms (Gureje et al., 1997). In a primary care study of a multiethnic sample in the United States, we found that Central-American immigrants had significantly higher rates of somatization than other ethnic groups (Escobar et al., 1998) and that war exposure was the single most significant predictor of medically unexplained somatic symptoms in these patients (Holman et al., 1996). Interestingly, in that study we also found that recent immigrants had lower rates of PTSD than U.S.-born patients despite the immigrant patients’ higher trauma exposure. This resilience of recent Latino immigrants has been well documented for Mexican-Americans and extends to several other health and mental health dimensions (Escobar, 1998). Cross-cultural studies of depressed patients have documented higher levels of somatic complaints among depressed psychiatric patients in Asia (Kleinman, 1982) and Latin America (Escobar et al., 1983) compared to depressed patients in the United States. There are also anecdotal reports suggesting that the type of symptoms presented by somatizing patients may differ in various cultural settings. For example, in Nigeria and India common somatic symptoms are “feeling of heat,” “peppery and crawling sensations,” “numbness,” “burning hands and feet,” and “hot, peppery sensations in head”—symptoms that seem extremely rare in Western countries.

**Ataque de nervios (attack of nervousness).** This acute, drama-laden clinical syndrome that typically follows stressful events has been described in inhabitants of Caribbean countries and in Caribbean immigrants to the United States. It includes clusters of somatization and dissociative symptoms that appear together with rather dramatic behavioral correlates. Ataque seems highly prevalent, with one out of five community respondents interviewed on the island of Puerto Rico reporting having experienced at least one of these episodes during their lifetime (Guarnaccia et al., 1993). While attempts to frame these syndromes into the more conventional mainstream categories may constitute a category fallacy (Kleinman, 1977), studies of patients in New York City indicate that symptoms of ataque are often associated with diagnoses of panic attacks and panic disorder (Lewis-Fernandez et al., 2002). Clinical manifestations of ataque include headache, trembling, heart palpitations, stomach disturbances, a sensation of heat rising to the head, numbness of extremities and, at times, pseudoseizures, fainting or unusual “spells”—all symptoms suggestive of somatization.

**Dissociative Disorders**

Dissociation is a classical phenomenon in psychopathology that has been well studied for many decades. Investigators distinguish pathological from non-pathological forms of dissociation to underline that some individuals may have a unique ability to dissociate under special circumstances; therefore, these are not always symptoms of a mental disorder but may be normative in some cultures. Dissociative phenomena may have strong biologic roots, with genetic influences accounting for about 50% of the variance in twin studies (Jang et al., 1998). Dissociative disorders in the *DSM-IV* include dissociative amnesia, dissociative fugue, depersonalization disorder and dissociative identity disorder (multiple personality disorder [MPD]). The latter diagnosis is very controversial, with fewer than 40% of U.S. psychiatrists surveyed supporting its inclusion in the nomenclature and less than one-third attesting to its diagnostic validity.

**Dissociative disorders cross-culturally.** A number of dissociation and possession states have been reported in various countries (Table). These culture-bound syndromes have been viewed by some investigators as variations of the normal startle response. A study in Japan suggested that the clinical features of dissociative disorders among the Japanese are very similar to those reported in North America (Umesue et al., 1996). A study in South Africa suggested that dissociation was rare in blacks and that the syndrome was not clearly related to traumatic experiences such as sexual abuse (Gangdev and Maxwell, 1996). In an Indian study, it was observed that most patients with dissociation presented with a “brief dissociative stupor” that coexisted with anxiety and panic.
symptoms. No fugue, amnesia, possession or identity disorders were observed (Alexander et al., 1997). Regarding the cross-cultural aspects of MPD, more than 60% of the cases originally reported came from North America (Golub, 1995). Several investigators have suggested that MPD is an iatrogenic disorder largely confined to North America (one of the few culture-bound syndromes in the region), and that it is rare or nonexistent in Great Britain, Sweden, Russia, India and Southeast Asia (Golub, 1995). Moreover, in the United States, MPD is rarely described among Latinos, and it seems to be even rarer among Asian-Americans. Interestingly, in a study in Canada, 20% of the alternative personalities reported by MPD sufferers belonged to a different race, perhaps reflecting the higher levels of ethnic integration reached in that country. **Summary**

In this brief review, it has been proposed that somatoform and dissociative syndromes are heterogeneous, incorporating many overlapping features as well as symptoms of several other disorders. These syndromes are at the core of the stress reactive syndromes and appear to be present in all cultures as the most typical sequelae of trauma. Dissociation and somatization phenomena are more frequently reported from non-Western, developing societies and have been generally framed as rather exotic culture-bound syndromes. The only exception is dissociative identity disorder or MPD, a controversial entity that seems endemic to North America. Among the problems faced by this area of research, a key obstacle is the reliance on individual accounts that are largely retrospective and not verifiable with more objective sources. Also, the need to remember events that took place a long time previously places a heavy load on the accuracy of human memory, a faculty that can be rather fragile and impressionable. Future research will need to focus on prospective, longitudinal observations, using several informants and objective sources to verify the information, as well as carefully selected control groups.

**References:**

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