Dissociation in Cultural Context: from normal to pathological

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Dissociation is a state of consciousness, a definite and special state of awareness, feeling and experience, which transculturally we – with our European eyes – can observe in all cultures. In order to be able to conceptualise and speak about the phenomenon of Dissociation we have to use metaphors; and our metaphors are also specific to our view of the world, our culturally determined and personally developed scripts. Here professional socialisation also plays an important role and my own professional socialisation is undoubtedly influenced by the physical science of medicine on the one hand and by the essential hermeneutics of psychotherapy on the other hand.

Dissociation as a psychiatric concept was initially used by Pierre Janet. He used it to describe the unusual "different" condition of those hysterical patients whom he found to have been sexually abused in childhood. In Freud's case, Anna O, this condition is impressively described. Unfortunately psychoanalysis later replaced this concept with the construct of defence mechanisms.

Every person has the capability to intentionally or automatically, unintentionally, move into different states of consciousness, i.e. states of awareness, emotion or experience. Dissociation is the opposite of Association, that everyday state of consciousness in which we perceive the world through our own eyes, ears, nose, taste and touch and directly emotionally react to it; one could say like walking in ones own shoes. Normally the ability to dissociate first emerges in puberty. Child psychiatrists however observe that children who experience a Type II Traumatisation – repetitive, extreme – traumatic stress (like in chronic family violence or sexual abuse, but also persecution and war) develop this ability much earlier, as a survival skill.

Consciousness is influenced by perception. On the one hand it draws on "external" stimulation, that which comes in at us from the environment, and on the other hand it draws on "internal"

stimulation, that which emerges from inside our bodies. Consciousness is cybernetically connected to different interactive parts.

1. Consciousness is dependent on the social context: Perceptions are evaluated and interpreted in relationship to different social contexts. Here is also where one needs to consider the different aspects of cultural patterns, attributes, evaluations and interpretations.
2. Consciousness is further influenced by one's emotional-physiological state and by one's affective mood: a picture, a smell or a sound can be differently perceived dependent on whether or not I am hungry or satiated, happy or panicky and elicits then totally different reactions, reflexes and interpretations (Ciompi, 1993).
3. One's cognitions, that is the less affectively influenced thoughts and interpretations of external or internal perceptions, are a third important part of the development of consciousness. The core of dissociation is what one considers to be external and what one considers to be internal; that which one sees as their own in contrast to coming from outside one's self and how one then organises, interprets and perceives this.

A certain partially cultural, partially individually coded interaction of these various parts makes it possible for us to routinely handle the stimuli which constantly bombard us: certain stimuli are perceived culturally specific, perceived as being external or internal, are automatically excluded; others change one's physiology, thoughts or emotional state… or all of this together.
Every culture has specific settings in which different states of consciousness and the closely connected perceptual states can be activated and accepted; even when they are not allowed in other settings. Ideal examples of this are the specific states (of consciousness) which emerge in religious practices and then in our part of the world are studied by ethnologists.

In dissociation the interaction between psychological functions is removed from "real everyday life": the relationship between external or internal awareness is changed as well as one's thoughts, emotions and physical disposition; which can thus also elicit change in body perception, memory and identity. Automatic behaviour, motor ability, perceptual automatisms and scripted behaviour, self-other schema, and access to narratives… all change.

How much of this is generally true, is found in all humans, and how much is culturally specific? This question may seem to be unimportant at first glance, but it becomes central in that moment when we, as psychiatrists and psychotherapists, have to differentiate between what is sick and

what is healthy, when we have to make a diagnosis or maybe even want to or are supposed to change specific behaviours, that is, want within our culture to be therapeutically or educationally active. Not only in our culture is this sometimes attempted because a certain condition is seen to be too individually painful, "sick", "obsessive" etc. or as too dangerous for the public, because it is seen as being contagious, threatening to group cohesion or it upsets the group's elders. Here we generally delegate such change interventions to medicine; other societies might delegate it to religion, priests, healers, Shamans (men or women), educators or judges. But every society has its way of attempting to correct aberrant (involuntary, anxiety-provoking) behaviour. Such thoughts are particularly relevant to medical practitioners as they approach patients from other cultures, who are increasingly seeking our help or being referred to us, but they also broaden our horizon and enhance our awareness of cultural basics and of the relativity of our "natural science based" medicine.

Our bodies (and thus our brains and sense organs) react more or less the same to external and internal stimuli, to self or other, independent from culture or surroundings. Reflexes, physiological reactions, pain = uncomfortable, pleasure = comfortable… all are part of being human. Whether or not there are so-called "Basic Feelings" (joy, happiness, anxiety, anger and grief), which are true of all cultures, is a subject of heated debate among Culture Psychologists (Wierzbicka, 1995, Rattner, 2000, Shweder, 1993). I tend to view this concept as imperialistic because the 5 Basic Feelings which are named come from the Euro-American culture and the Indo-European understanding of language.

The neuro-psychological processing of stimuli, which come at us, begins simultaneously and automatically for each person in a specific physiological and social context. The tendency to focus oneself on certain aspects of a perception or emotion, the assignment of importance and interpretation are dependent on different kinds of alignment: social level, religion, extended family, professional group, nationality, etc. … in short depends on culture, as psychological functions, which according to Vygotsky (1998), are "embodied, or incarnate" social facts. The ability to intensify or to ignore certain stimuli, to elevate or lower excitement, is common to all humans. It is however influenced by the individual psyche and the cultural context. Whether an experience is assimilated or kept as a foreign body, - as in trauma- depends as much on the communal context as it does on the individual psychological context.

Now what does this mean specific to the phenomenon of Dissociation:

The neurophysiology of dissociation is closely connected to the stress response: our "evidence-based" measurable way of observing finds that everywhere in the world people react to massive stress in the same way: stress hormones are mobilised via the cortical hypothalamus axis. The body reacts by increasing muscle power and decreasing sensibility (anaesthesia). On the psychological level perception is elevated and focussed, either internally ("blunting") or externally ("monitoring", Miller, 1980) and emotionality is restricted (Foa, 1991, Yehuda, 1997). The limitation of body awareness and emotionality correlates closely with the increase in release of stress-related endorphin; whereas perceptual focussing correlates directly with the release of adrenalin-noradrenalin.

Perceptual focussing and changes in feeling (i.e. physical and psychological functions) are the foundation of every dissociative state. But perception, social context, interpretation and acceptance of these phenomena are dependent on the environment, the culture and its ways of handling the phenomena.

When in our part of the world a woman produces a condition in which she can no longer move and reacts to this paralysis with a happy facial expression instead of panic, we call it a hysterical paralysis (after first checking for somatic symptoms of course) and then we delegate changing her (to elicit experiencing of discomfort and to regain mobility) to a psychiatrist. If a woman "loses her nerves", screams, throws a fit, swears…and then cannot remember doing that, we call it dissociative loss of control and recommend a psychotherapeutic intervention. In our culture both ways of behaving are seen to be a personal problem and are privatised and medicated. Even from a systems perspective the behaviour is seen to be pathological, the "designated patient" seen to be expressing family system dysfunction and this perception determines then the treatment strategy. Our culture reacts strongly normative to unusual behaviour.

"Attaques de nervios" in Caribbean women about 40 years old are viewed as being "normal" and temporary: then on closer look these women are usually single parents, whose children are going through puberty and are making their mothers helpless. The attacks disappear when the children grow up.
Hysterical-depressive semi-conscious states in young, child-less, married Madagascar females are viewed as a sign that they are being asked if they want to serve the community and to choose a life as a healer. The decision, for or against, offers different ways to deal with the condition.

It is not necessary to throw out our psychiatric-psychotherapeutic approach to dissociative "psychopathological phenomena", as long as patient and therapist belong to similar cultures and share a common understanding of the phenomena. It becomes important to question oneself however when the concepts of therapist and patient are not even close to each other and when sublimated power – of the therapist – comes into play… like it can, for example, when a patient is viewed as being resistant to therapeutic change.

An example from Gaza may help to illustrate the point: a 17 year old female is brought to a psychiatric-psychotherapy session by her parents. The presenting problem, which made the girl unmarriable and which she had had for some time already, was a secondary Enuresis, diurna et nocturna. The Mullah had naturally already attempted to ban the "symptoms". The approximately 40 year old male therapist, who had been trained in behaviour modification, attempted – in vain – to remove the urine incontinence. To him the resistance of the patient seemed to be huge so he transferred the case to a younger colleague, whose approach was more interpretive. Whereas the patient had been closed off and rebellious, she suddenly became cooperative and friendly; she behaved in a manner which can only be described, "As having fallen in love". In supervision the following picture emerged: the young woman had maintained a childish sexual concept of elimination: with the onset of menstruation, as the blood started to flow uncontrollably, urine continence disappeared. The loss of urine was especially strong at the end of menstruation. We often see such somatoform disassociations in our part of the world with anorexics of the same age. Now this young lady exhibited the same, but due to inadequate information about anatomy and menstruation. It is unclear whether a background of familial sexual abuse or this family's specific approach to the female body (Muslim-dominated culture) caused this. The *male* interventions, behaviour modification and interpretive psychotherapy, had less impact than did the informational intervention of a female staff member, who taught the patient sexual education.

A second vignette from my own therapeutic practice: this young 18 year old female was referred to me by the family physician and her mother brought her to me in a wheelchair. For a couple of weeks she experienced "hysterical" paralysis of her legs (which had been checked out somatically in the interim). The mother was willing to see an – as yet unknown – reason behind the disturbance and left her daughter in my hands. In 12 hours of therapy over approximately 6 months with this young woman the paralysis itself was never once discussed. Instead clarification of her life plans, professional goals, relationships to family and friends and what things she wanted to change were discussed. As these issues became so clear that she could

independently accomplish the next steps, the paralysis disappeared. And since she had been taking swimming lessons in the interim, her leg muscles remained functional, although she had not used them for walking.

It is hard to say whether my increased observation of dissociative phenomena in women is culturally specific or whether it emerges due to the influence feminism and women's liberation have had on my perceptions. Could it possibly be that women, after the onset of menstruation with it's constant cyclic hormonal swings – intensified by pregnancy and giving birth – "produce" dissociative states easier; or could it be a sign of social repressions, power – impotence positions (like in the hysteria Pierre Janet and Sigmund Freud saw in the 19th century). These are questions which remain open. As well as the question of whether or not it is simply easier to introduce medical concepts for deviant behaviour in women than it is men, when they present abnormal behaviour?

How come that dissociative phenomena in men, without which male behaviour in war and human rights violations cannot be explained, have never been explored, neither at a medico-psychological nor at an ethnological level? In what connection is that with the delegation of research to men, especially in medicine and psychiatry?

Could it be that dissociative phenomena emerge more during critical phases of personality development? Then when due to certain societal expectations individuals experience more stress – by us and in the Mediterranean area during adolescence, in the Caribbean women during the time, when children are in puberty, in Madagascar after several years of childless marriage? Could it be that "the symptom" in this case the dissociative phenomenon, is the simplest, least painful way for people to remain somewhat integrated in their societies and to rescue a relative sense of well-being?

When one thinks about the phenomenon of dissociation one discovers more questions than answers and in my opinion fascinating research issues emerge - both in medical/psychological and in ethnological areas.

A consequence which emerges for us as therapists is that we should critically evaluate the need for therapy. Are the behavioural change (and this includes insight which is also behavioural change, Rappaport, 1942) and the gradual change of awareness which psychotherapy always pursue, really a response to the needs of the patient, in the sense of emancipation, or are they

more a response to society's pressure for adjustment? Is the informed consent of patients based on a critical questioning of and evaluation of societal conditions, at least on the part of the therapists?

The phenomenon of dissociation in our culture is a good test of therapist's capabilities to re-think their own cultural orientation. Even if the neurophysiology is always the same, should we be so willing to always treat dissociative conditions - psychotherapeutically. Do we today in Middle Europe offer the only accepting cultural framework in which this phenomenon can emerge? That is, must our society medicate, individualise and privatise this phenomenon, which other cultures perceive in a religious context? How much do we want to/can we contribute to putting existential questions, which often express themselves in this phenomenon of dissociation, into another more appropriate context than that of our medical practices? When one looks at dissociation one comes to the conclusion that we here today have more questions than answers.

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