Dissociation – a preliminary contextual model

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Background. The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) system has certain limitations when applied to two South African examples of dissociation, because it is descriptive (non-explanatory) and focuses on intrapsychic (non-communal) processes. Even the existing Western explanatory models of dissociation fail to accommodate fully the communal aspects of dissociation in our South African context.

Objectives and methods. The aim was to explore an expanded perspective on dissociation that does not limit it to an intrapsychic phenomenon, but that accounts for the interrelatedness of individuals within their social context. Auto-ethnography was used. In this article a collective, socially orientated, contextual hermeneutic was applied to two local examples of dissociation. Three existing Western models were expanded along multicontextual, collective lines, for them to be more useful in the pluralistic South African context.

Results. This preliminary contextual model of dissociation includes a person's interpersonal, socio-cultural, and spiritual contexts, in addition to the intrapsychic context. Dissociation is considered to be a normal information-processing tool that maintains balanced, coherent selves-in-society, i.e. individuals connected to each other. In the South African context dissociation appears mostly as a normal phenomenon and seldom as a sign of mental illness. Dissociation is pivotal for the normal construction of individual and communal identities in the face of conflicting sets of information from various contexts. Dissociation may help individuals or communities to survive in a world of conflicting messages, where conflict is often interpersonal/cultural/societal in nature, rather than primarily intrapsychic.

Conclusions. This model should be developed and evaluated further. Such evaluation would require suitable new local terminology.

Although Western psychiatry has a rich tradition of models explaining how and why the phenomenon of dissociation occurs, including models based on information processing,[1] trauma[2-4] and conflict,[5,6] the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) approach[7] has been descriptive. The most commonly accepted symptoms of dissociation are derealisation, depersonalisation, identity confusion and alteration, and amnesia.[7] The *DSM-IV* dissociative disorders are descriptive formulations: dissociative amnesia, dissociative fugue, dissociative identity disorder (previously called multiple personality disorder), depersonalisation disorder, and a 'not otherwise specified' category that includes trance disorder, with or without possession. Furthermore, the *DSM* approach limits dissociation to an intrapsychic process – an unconscious defence mechanism by which some mental processes or contents are segregated from the rest, or whereby ideas or emotions get separated from each other.[7,8] When a person no longer has integration between memory, a sense of identity, and conscious awareness, such a person is said to suffer from a dissociative disorder.[7,8]

Notwithstanding the value that the *DSM* system has in facilitating international communication on mental disorders, both its descriptive approach and its intrapsychic focus on dissociation jeopardise its applicability in the South African professional psychiatric context.

Applying the *DSM* descriptive approach to dissociation in the multicultural South African context would require translation of the *DSM* terminology into our local languages. Such translation is problematic because in South Africa there are 11 official languages, and in some of these languages equivalent terms describing dissociation, e.g. 'unreal', do not exist. Moreover, each language represents a group of people that is further divided into smaller cultural groupings, and there are 'township languages' that are dialects of these official languages. These dialects represent subcultures within the cultural groupings. Furthermore, some of these languages and dialects exist only in spoken form and hence cannot be captured in questionnaires to study, for example, the prevalence and presentation of dissociative symptoms in South Africa. However, these challenges fall outside the scope of this article.

Although individual-psychological constructs provide valuable meaning-making paradigms, as in the current Western view of dissociation, it is postulated that dissociation in the South African context is not exclusively an intrapsychic phenomenon, but can also be interpersonal and communal, as will be demonstrated.

The aim was to explore an expanded perspective on dissociation that does not limit it to an intrapsychic phenomenon, but which accounts for the interrelatedness between an individual and her/his social context. To this end, auto-ethnography[9] was used to initiate the development of a contextual model. This social science research method refers to the ethnography of one's own group or autobiographical writing that has an ethnographic interest. Such research takes a personal, narrative path that connects personal to ethnic or cultural aspects. We anticipated that a close examination of our socio-cultural context, our own life- and worldviews, our perspectives on mental illness and spirituality, and our appreciation of healing, as they relate to dissociation, would help to inform a discussion of the problem described above.

Our collective background represents a complex mixture of belief systems in post-apartheid South Africa that does not fit neatly into any of the categories routinely used to stratify the South African population (e.g. black, white, coloured or Asian). We are five South African women psychiatrists jointly employed by the Gauteng Health Department and the University of Pretoria. Our cultural heritage includes mainly a mixture of Sesotho, Setswana, Zulu, Xhosa, and Afrikaans traditions. In addition to these language backgrounds, some of us also received influence from Bhaca, Sepedi, Swazi, and South African English traditions. We all grew up in urban areas of South Africa, four of us in Gauteng and one of us in the Western Cape. Most of us have also been exposed to global urban cultural elements. Our primary religious backgrounds are Catholic, Methodist, Anglican, and Dutch Reformed. Additionally, our worldviews have been influenced by other world religious movements and by varying degrees of exposure to traditional African rites. In our worldviews we accommodate various sources of healing, including general medical healing, psychiatric and psychological healing, religious and other spiritual healing, and social healing. We also drew on our shared experience in the fields of medicine and psychiatry.

Instead of elaborating further on our background, we apply a collective, socially orientated, contextual hermeneutic to two local examples of dissociation that are not adequately captured by Western models. We build on three existing Western explanatory models of dissociation by including multiple contexts, such as people's interpersonal, socio-cultural, and spiritual contexts, in addition to the intrapsychic context. This inclusion yields a preliminary contextual model that might help to explain dissociation in the pluralistic South African context.

Dissociation in the South African context

The following two cases are taken as representing local examples of dissociation that are inadequately explained by the Western/*DSM* system. The cases are merely represented below, while their relevance to the contextual model is discussed later in the course of the article. Pseudonyms are used to protect the identities of the people in the case studies.

Case of Tshina Mahlangu

Tshina Mahlangu, a Gauteng attorney whose home language is English, recounted her experience of wearing different masks in the course of a single day: 'I feel every day is a challenge. After waking up in the morning, I need to put on my masks for the day. I apply the first mask as I descend the stairs to the kitchen to prepare breakfast for my husband and children, like a good African woman. Although I have achieved professional success, my place in the home is the way it has been for many generations of women in my family – subservient. Then it is a mad rush to get the children to school before I make my first appointment with one of my white clients. For this meeting I have to prepare my other mask – the professional mask that helps me through the day. It is designed to convey the message that being a 'black' woman does not give anybody licence to think and relate to me in a manner in which my intelligence and competence are ignored at best, and disputed at worst. By the time I go to bed at night I scarcely remember who I am and how I came to apply these masks. Parts of me scream, "Why should I have to tolerate this?". I want the world to see me as I am. Every day I try to show more of the parts of me that I have allowed to become buried under the masks as I fear one day I may not recognise my own reflection in the mirror.'

Case of Nomthandazo Grootboom

In this case dissociation involves the spiritual realm. Nomthandazo Grootboom, a Xhosa girl in a rural village in the Eastern Cape, fell ill and became confused for a few

days. There were no apparent acute precipitants or any ongoing stressors. 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 2 years earlier. Nomthandazo 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. No one was seen to have started the fire. Everyone was evacuated safely. Some claimed that the alleged witch had started the fire through magic, others believed that lightning had started the fire. The house burned to the ground and the alleged witch ran away. 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.

Building on existing Western models of dissociation

The following existing Western explanatory models of dissociation provided the focus for this article: the idea of everyday dissociation as processing of information and integration of mental contents,[1,7] dissociation as a disrupted information-processing reaction after traumatic events,[2-4] and dissociation as a disrupted information-processing reaction owing to intrapsychic conflict.[5,6]

According to the *DSM* model of dissociation as failed integration of mental contents[7] or failed processing of information,[1] one might think of every person as having two filters to aid in information processing. The first filter would be the brain resources, and the second filter the psychological resources for information processing. The first filter is in part made up of an intact brain, chemical homeostasis, cognitive abilities, and intelligence. The input to this brain filter consists of externally generated sensory information, i.e. sight, hearing, touch, taste and smell, as well as internally generated information such as proprioception, emotions, thoughts, and actions. The brain resources contribute to creating the person's consciousness and laying down memory.[10] The second filter, the dissociative filter, would be a normal psychological tool that filters sensory, emotional and thought-related information so that only a manageable selection of information occupies the person's consciousness. The information is sufficient for the person to construct a coherent sense of self, personal integrity, and personal identity.

Next, dissociation is considered as a disrupted information-processing reaction occurring when a person is overwhelmed by traumatic events, such as natural disasters, interpersonal abuse, or any other trauma.[2-4] The person might experience a state of emotional shock and altered information processing. The brain resources for information processing might be overwhelmed by the additional input of traumatic sensory experiences along with usual sensory experiences, yet still attempt to process all the information. The dissociative defence mechanism might filter out the traumatic experiences, resulting in amnesia regarding the trauma, while memory might be fine for usual events.

Dissociation is also considered as a disrupted information-processing reaction due to intrapsychic conflict.[5,6] In this model a person's consciousness receives information from conflicting states of mind. For example, information relating to a person's desire not to be at work might be in conflict with information relating to the same person's need to be appreciated as a committed employee. The two sets of information cannot comfortably be held in consciousness at the same time without the person experiencing significant anxiety. This type of situation is reminiscent of Harry Stack Sullivan's parataxis.[11] Hence, at a given time, one of these conflicting sets of information might be filtered out of conscious awareness.

These Western models do not adequately explain the above two cases of dissociation. These models all refer to intrapsychic phenomena in a single individual, which are taken to explain certain mental symptoms, whereas in our South African context mental symptoms are often believed to be expressions of social problems, such as problems in relationships between family members, the community, the ancestors, or witchcraft. It should be noted that although the *International Classification*

of Diseases (ICD-10)[8] does refer to interpersonal difficulties as possible precipitants of dissociation, its emphasis remains on an individual's intrapsychic means of dealing with such external difficulties instead of on individual consciousness resonating with communal consciousness.

A preliminary South African contextual model of dissociation

We propose that the psychiatric discourse on dissociation be moved from an individual, intrapsychic level to a social level, where the roles of a person's interpersonal, social, cultural, spiritual, and environmental contexts, along with intrapsychic factors, are acknowledged explicitly in the development of dissociation.

All of the contexts mentioned above should be included in an expanded model of dissociation in which various types and sets of information contribute to and constitute an individual's consciousness at any time, as s/he moves about in these contexts. For example, the external physical environment of a person contributes information to that person's consciousness with regard to externally occurring events. These events are translated into sensory information. The person's intrapsychic make-up adds awareness of internally generated emotions, thoughts, and actions. Interpersonal relationships represent another context that contributes information to consciousness. Some of the information relating to these relationships may be traumatic in nature. The socio-cultural milieu of the person might contribute conflicting sets of information pertaining to conflicting socio-cultural values. The spiritual context might, for instance, contribute information about joyous experiences or incompatible belief systems.

The person's dissociative filter then selects from all the contributed information those sets of information that will be retained in consciousness at a given time. The information is therefore processed differentially, depending on the demands of the circumstances, and the person's sense of self is constructed from all of the material that remains in consciousness at a given time. Moreover, given the normal fluctuations in the constituents of consciousness it is to be expected that a person's sense of self might not be static.

Referring specifically now to conflicting socio-cultural values, an individual may ordinarily move about in conflicting 'worlds' during the course of a single day. For example, Tshina Mahlangu moves about in a professional world that values the endeavours of an independent career-minded individual ('world A'), as well as in a domestic world that requires the subordinate role of wife/mother ('world B'). Similarly, she moves about in her own 'black world' and in the 'white world' of her clients. Her brain resources process information from experiences relating to both 'world A' and 'world B'. In such a situation of gender role conflict, a woman like Tshina cannot be both a good career woman and a good wife/mother at the same time, as these categories are considered to be mutually exclusive by her patriarchal society. She then develops different personae/masks/identities for dealing with different situations. In order to ease the conflict between the two personae the dissociative filter segregates the conflicting sets of information, and may filter out some information from consciousness, depending on the circumstances. The price paid for this is a fragmented sense of self.

With regard to such fragmentation of self it should be noted that Carol Gilligan[12-14] has referred to dissociation as a common feature of the psychology of women living in patriarchal settings. This dissociation is forced by a relational paradox, viz. that girls and women, in their efforts to make and maintain relationships, take large parts of themselves out of relationship.

Furthermore, it is acknowledged that trauma or conflict can happen on a communal level. Conflict such as Tshina's not only represents an intrapsychic phenomenon, but also a social contextual phenomenon. To the extent that the dissociative process occurs in a similar manner in individuals constituting a community, it can be said to occur collectively in that community. In such instances shared individual intrapsychic dissociation becomes collective dissociation.

For example, in previously colonised countries such as South Africa, a community of individuals of African origin might be said to live in two 'worlds' at the same time. Moving about in the 'white Western world' might be associated with experiences confirming a message of 'I am a second-rate human being'. Moving about in the 'traditional African world' might be associated with experiences confirming a message of 'I am okay as I am'. These individuals' dissociative filters might then segregate these conflicting sets of information, creating a 'double consciousness' (see the work of Fanon and Lugones, as discussed by Nancy Potter[15]). Given the incompatibility of these conflicting ideologies, this pernicious double consciousness would lead to a fragmented collective identity, which might manifest in different ways depending on the circumstances.

This idea could be extended to psychiatric practice in South Africa, where we also move among disparate contexts all the time. Apart from moving in different cultural worlds, we also move between affluence and poverty in the course of a day's work. We practise medical, psychiatric and psychological healing, while accommodating traditional healing of patients. For instance, whereas one of the authors' parents are 'Westernised', her grandmother is a trained traditional health practitioner. Such contextual discrepancies would influence the way we practise psychiatry locally, and represent challenges to the existing Western paradigm of intrapsychic dissociation.

The suggested preliminary contextual model of dissociation includes a person's interpersonal, socio-cultural and spiritual contexts, in addition to the intrapsychic context. We consider dissociation as pivotal in the process of normal construction of an individual sense of self and of communal identity in the face of conflicting sets of information from various contexts. In this regard, see also Braude's[16] philosophical study of multiple personality disorder for a thorough discussion of the implications of dissociation for concepts of self, agency and personhood, as well as Beahrs,[17] who views multiplicity on a normal-pathological continuum.

Thus, according to this contextual model, dissociation may help an individual or a community to survive in a world of conflicting messages, where the conflict is often interpersonal/cultural/societal in nature, rather than primarily intrapsychic. Dissociation may therefore be an appropriate tool that maintains a balanced, coherent self-in-society. If, for an individual, there is a good balance between the contributions from the various contexts to that individual's conscious awareness, then the person's sense of self that emerges from the other side of the dissociative filter is likely to be a balanced, coherent, self-in-society, i.e. an individual connected to other people. Similarly, if, for a community, there is a good balance between the contributions from the various contexts to the community's collective consciousness, then there is likely to be harmony and communalism in the community. Conversely, traumatic events or conflicting values may precipitate communal dissociation.

Social healing of communal dissociation?

The case of Nomthandazo Grootboom described above might fit in with the *DSM-IV* descriptive category of dissociative trance disorder with spirit-possession, provided that her symptoms had not been substance induced or caused by a general medical condition.[7]

In contrast to a psychiatrist, a South African traditional health practitioner might have diagnosed *amafufunyana*, which has been described among Xhosa, Zulu and Tswana people in South Africa.[18] *Amafufunyana* is a local idiom of distress, or culture-bound syndrome, not listed in *DSM-IV*. It may correspond to various *DSM-IV* disorders, depending on its exact clinical presentation, e.g. dissociative disorder, adjustment disorder, or schizophrenia.[18] As with other local idioms of distress, the explanatory model takes precedence over the descriptive model. Notwithstanding its possible benefits, the *DSM* term 'culture-bound syndromes' is problematic in so far as it is used to describe phenomena that do not seem to fit in nicely with Eurocentric culture.[19] The category seems to differentiate on the basis of culture, with the Eurocentric presentation considered the norm, and presentations outside this fold considered to be 'out there' and 'culture-bound'.

Nevertheless, the term *amafufunyana* literally means 'the evil spirits'. The cause is thought to be the anger of the ancestors, which leads to their angry spirits entering the patient. The syndrome usually starts with an emotional disturbance such as social withdrawal. This may be followed by somatic symptoms such as listlessness and loss of appetite, and next by behavioural disturbances such as grunting, falling down, and aggressive behaviour. This phase of behavioural disturbance may resemble 'switching' behaviour. Subsequently, verbalisations may follow in which the *amafufunyana* speak. These voices may speak in a foreign language and may belong to someone of the opposite sex. The patient is seen to undergo an altered state of consciousness and is amnesic regarding the event.

The response of Nomthandazo's community illustrates how explanations for indigenous South African idioms of distress are often social in nature. Rather than ascribing Nomthandazo's symptoms to an individual mental illness, her community seemed to interpret her behaviour as a manifestation of a problem in the community, viz. witchcraft. The practice of witchcraft might have been rejected by the community because it was considered evil and in conflict with their value system. Such contextual conflict might have led to communal dissociation, and Nomthandazo might merely have expressed the community's dissociative problem.

Since societies' attitudes towards deviance from their norm influence what is or is not considered mental illness, mental illness cannot be regarded as merely an individual, intrapsychic problem. This point is also made by Martinez-Taboas,[20] according to whom many psychiatric disorders are not only shaped by culture, but are actually constituted by culture, history, and society. However a thorough discussion of what does or does not constitute mental illness, and of the role that society plays in defining mental illness, falls outside the scope of this article.

The above community's management of the 'Nomthandazo problem' might then be understandable in the light of the above preliminary contextual model of dissociation. They managed the problem in the context of the community, using a spiritual kind of approach. They confronted the alleged witch with regard to her unacceptable behaviour. The problem of Nomthandazo's *amafufunyana* was solved through this community-based intervention/social healing, albeit at the cost of the witch's position in the community.

It is to be noted that although Nomthandazo's case might potentially be explained by the contextual model of normal dissociation, it still represents an example of a pathological reaction in terms of its severity, as well as the impairment of individual and social functioning that occurred.

Conclusions

The *DSM* system has certain limitations when applied to these two South African examples of dissociation because it is descriptive (non-explanatory) and focuses on intrapsychic (non-communal) processes. Even the existing Western explanatory models of dissociation fail to accommodate fully the communal aspects of dissociation in our South African context. This preliminary contextual model of dissociation was developed through an expansion of existing Western models along explanatory, multicontextual, collective lines in order for them to be more useful in our pluralistic South African context.

Note that although the above preliminary contextual model of dissociation was developed mainly with reference to three of the existing Western models, viz. the processing of information and integration of mental contents, and disrupted information-processing reactions after traumatic events or intrapsychic conflict, we had also considered other models, each of which captures a range of dissociative phenomena. For example, we considered a model of transcendence,[1] Hilgard's neo-dissociation theory of a 'hidden observer',[21] a model of deception,[22,23] a model of iatrogenic artefact,[24] a substance-induced model,[25,26] and an epileptic model.[27-29]

The contextual model explored in this article aims to account for the South African interrelatedness of individuals within their social contexts. We consider dissociation to be a mostly normal information-processing tool that operates to maintain balanced, coherent selves-in-society, i.e. individuals connected to each other. In our context, dissociation appears most often as a normal phenomenon (as in the case of Tshina Mahlangu) and seldom as a sign of mental illness (as in the case of Nomthandazo Grootboom). Dissociation is pivotal in the process of normal construction of individual and communal identities in the face of conflicting sets of information from various contexts. Thus dissociation may help an individual or a community to survive in a world of conflicting messages, where the conflict is often interpersonal/cultural/societal in nature, rather than primarily intrapsychic.

The issue of distinguishing between normality and mental illness remains a challenge, especially in the light of the cultural determinants of the various ways in which groups of people tend to think (c.f. Emrich and Schiefenhövel's[30] discussion of the broader approach of cognitive anthropology). The cases described in this article might serve as practical illustrations of what other authors, such as Astor and Sherman[31] (referring to the works of Gergen and Lifton), have alluded to, viz. that maintaining a single integrative self may be impossible or dysfunctional in our current social milieu, and that a person needs to be creative enough to develop constantly evolving multiple selves in each situation and system.

Another unresolved issue is the question of generalisability. Since both of the cases reported above happen to be people of African origin, this article might contribute to Dan Mkize's suggestion to develop an Afrocentric approach to psychiatry.[32] However, our culturally complex South African context probably defies the usual definitions of 'Afrocentrism'. Moreover, the complex collective cultural background from which the two above cases were interpreted suggests that the preliminary contextual model of dissociation presented here might be applied more broadly than only to the so-called 'black' cultures within the South African context. Furthermore, this contextual model of dissociation should not be taken only to represent a 'black-white' (racial) issue. The two cases were interpreted as potentially illustrating what might happen in any situation where there are contextual discrepancies. The question remains whether this model might be applicable in other non-South African cultures or contexts.

Future directions might also include further development of this model with reference to the large body of literature on trauma, conflict, consciousness, memory, self and identity. Ideally, this model or a further development thereof should also be evaluated for its applicability to the whole range of known dissociative symptoms. For this purpose, in the South African context, suitable terminology should first be created in our most commonly used local languages.

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