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CULTURAL FORMULATION OF PSYCHIATRIC DIAGNOSIS

Case No. 02
Diagnosis and Treatment of Nervios and Ataques in a Female Puerto Rican Migrant

CLINICAL HISTORY

History of present illness. 49 year-old widowed Puerto Rican woman with well-managed hypothyroidism who presented to an out-patient Latino Mental Health Clinic in New England after a 3-year history of prolonged hospitalizations due to recurrent Major Depressive Disorder with diagnosed psychotic features and chronic impulsive suicidality. Except for partial recoveries lasting less than two weeks, the patient reported several years of chronic sadness, anhedonia, tearfulness, psychomotor retardation, suicidality, guilty ruminations, and decreased sleep, appetite, interests, energy, and concentration. She also suffered from restlessness with pacing, “nervousness,” trembling, increased startle, anguish, and severe unmitigated headache. Patient’s “psychotic” diagnosis was due to the occurrence of the following during her affective decompensations: hearing her name called out when alone, glimpsing a darting “shadow,” and “feeling” someone behind her. Despite past traumas (physical abuse, husband’s murder), she denied intrusive reexperiencing, affective numbing or stimuli avoidance of Post-Traumatic Stress Disorder. There was no history of substance abuse and her thyroid studies had remained well-controlled throughout the course of her psychiatric symptoms.

In-patient psychotherapy, anti-depressants, and anti-psychotics produced a gradual but minor improvement of her depression and suicidality and no change in her “psychotic” symptoms. Her hospitalization was prolonged by a pattern of increased suicidality each time discharge was contemplated. She was eventually transferred to the Latino Clinic on Phenelzine and Molindone.

Psychiatric history and previous treatment. Patient was first hospitalized for depression and suicidality at age 32 in the context of her youngest son’s school truancy. She received a diagnosis of Major Depressive Disorder and

was treated with an incomplete trial of tricyclic antidepressants. At 36, she suffered an acute episode of agitation and impulsive suicidality (started to drink bleach) immediately following the murder of her second husband. She required physical and chemical restraints and ER observation for several days but was then discharged and lost to follow-up.

**Social and developmental history.** Born in rural Puerto Rico, patient dropped out of school during the 5th grade to help raise her siblings and has never worked outside the home. Father was seasonal agricultural migrant, spending several months every year in the United States, where he became an alcoholic. When intoxicated, he was verbally abusive and physically threatening toward patient’s mother, but patient denied witnessing overt physical or sexual abuse; she also denied being the object of any abuse during childhood, though she complained of mother’s cold distance. At age 16, patient married a man 11 years her senior; they had 6 children, one of whom died at 3 months of age from pneumonia. Husband’s drinking gradually increased until he became very physically and emotionally abusive towards patient. At 31, after he cut her with a razor and broke her arm with his fists, patient ended the marriage by migrating to the Eastern United States. She took only the youngest of her 5 surviving children, leaving the others behind with relatives, a decision that provoked her parents’ rejection. After 5 years in the United States, she returned to Puerto Rico in the wake of the murder of her second husband in a street fight. After her youngest son entered residential drug abuse treatment eleven years later, at age 47, she migrated to a different East Coast city to be near her oldest son from whom she felt estranged.

**Family history.** Alcohol abuse in father, brother, and two sons. Intravenous heroin and cocaine abuse in one of these sons and a daughter. Depression and anxiety in mother and daughter.

**Course and outcome.** As part of the Latino Mental Health Clinic out-patient evaluation, the patient’s “psychotic” symptoms were reassessed by several Latino clinicians as normative Puerto Rican “spiritual” expressions of demoralization and her treatment with Molindone was discontinued. While still on Phenelzine during evaluation for family therapy, the patient suffered an ataque de nervios (“nervous attack”). In the midst of an argument with her son, she attempted an impulsive overdose with Phenelzine after a brief period of brooding and “numbness.” She experienced transient dissociative symptoms (“darkness of vision” and “mind going blank”) as she took the pills. Minutes later, the patient “came back to herself” and
went on her own to the ER. She required ICU treatment and a brief inpatient stay, and was taken off all psychiatric medication. Patient remained intermittently suicidal upon discharge, threatening the stability of outpatient psychotherapy. After several emergency family therapy sessions and as a condition of further therapy, patient’s son and daughter-in-law agreed to assume responsibility for her ongoing safety and adherence to treatment.

The patient was then treated with out-patient psychotherapy for a total of 5 years without need for medication and with no recurrence of Major Depressive Episodes or suicide attempts. After a few months of initially intensive individual, family, and group therapy, patient reduced her participation in psychotherapy. She withdrew from group and family therapy, preferring individual supportive psychotherapy 3–4 times a month. Over the 5 years of follow-up, she had transient but distressing exacerbations of depression, anxiety, dissociation, and somatization that did not meet duration or symptom criteria for Dysthymia, Generalized Anxiety Disorder or a Somatoform Disorder. Though she continued to perceive “shadows” and hear her name called out, these experiences produced only temporary concern. In contrast, the patient displayed a durable pattern of extreme sensitivity to the possibility of abandonment by significant others, chronic feelings of emptiness, occasional suicidal urges when anxious, recurrent affective instability (sudden depression or irritability), unstable and intense relationships with caregivers alternating between idealization and devaluation, and persistent difficulty in controlling her anger expressed as exquisite susceptibility to perceived slights, meeting criteria for Borderline Personality Disorder.

In 1993, at age 54, patient migrated back to Puerto Rico. Psychiatric evaluation at the time of outpatient discharge revealed reactive anxiety and depression and transient dissociation, usually occurring in response to interpersonal and environmental stressors. These symptoms caused significant distress and impairment (e.g., not eating, isolating self) but only lasted two or three days. Patient then returned to usual baseline state. There was no evidence of formal thought disorder nor loss of generalized reality orientation. There was no suicidality or homicidality.

**Diagnostic formulation**

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CULTURAL FORMULATION

A. Cultural identity

1. Cultural reference group(s)
Patient is a rural Puerto Rican who migrated twice to the United States since 1969 for a total of 13 years’ residence as part of the “circular” Puerto Rican migration that intensified in the 1960’s and 70’s. The “circularity” of this migratory stream consists of recurrent “back and forth” moves between Puerto Rico and usually the East Coast of the United States in search of better economic and health care opportunities and in order to reestablish family and cultural links. Like many of these migrants, she was only mildly acculturated despite this extended stay, given the barriers to integration into the United States’ mainstream caused by chronic unemployment and limited housing options outside of encapsulated Latino neighborhoods. For the last 2 years of out-patient treatment, patient spent nearly a quarter of the year in Puerto Rico, signalling her impending return migration.

2. Language
Used Spanish predominantly in daily affairs and doctors’ appointments. Poor English fluency and rare use.

3. Cultural factors in development
Patient’s childhood contacts were limited to her extended kin group, given the rural isolation of her family compound and her early school termination. This may have intensified the negative impact on her personality development of her father’s disruptive and abusive behavior and her mother’s affective distance despite the stated absence of witnessed or experienced actual physical or sexual abuse during childhood. These personality
patterns were probably reinforced by later adult episodes of physical abuse and traumatic loss. Patient's marriage to a much older man is not atypical for her class and age cohort, and may not have contributed to her symptomatology.

4. Involvement with culture of origin
Predominant. Patient lived in the midst of a Latino neighborhood and travelled frequently to Puerto Rico, where she kept in close contact with several siblings. She had few friends, mostly Latinas, apart from her family.

5. Involvement with host culture
Limited, though able to maneuver some aspects of United States urban life well, such as obtaining elderly subsidized housing (though only in her 50's) and disability benefits. She used the public transportation system freely in search of bargains of sundries all over town, from which she made cultural knick-knacks (e.g., Puerto Rican flag key chains) for sale to neighbors.

B. Cultural explanations of the illness
1. Predominant idioms of distress and local illness categories
Patient's illness was described by herself and her community as nervios ("nerves") and ataques de nervios ("nervous attacks"). Patient's view of her nervios was typical of traditional Puerto Ricans, for whom nervios is a vulnerability to experiencing symptoms of depression, anxiety, dissociation, somatization and rarely psychosis or poor impulse control given interpersonal frustrations. The idiom is held together conceptually by the cultural understanding that all its presentations reflect an "alteration", acquired or inherited, of the nervous system, and specifically of the anatomical nerves. Patient had suffered from all the symptoms of nervios except psychosis. Her acute fit-like exacerbations of nervios are known as ataques de nervios, and were characterized by paroxysms of anxiety, rage, dissociation, and impulsive suicidality followed by depression and exhaustion in response to acute interpersonal conflicts. Ataques de nervios are very prevalent expressions of emotional distress and psychopathology among Puerto Ricans; their prevalence in Puerto Rico has recently been established at nearly 14%. In patient's case, nervios and ataques were associated with her character pathology, but many Puerto Ricans suffer from similar folk syndromes without showing characterological deficits, though the exact relationship between these clinical conditions has not been ascertained. Another aspect of patient's nervios was the high frequency and distressing nature of the culturally specific dissociative symptoms (hearing voices, feeling presences, seeing shadows [known as celajes]). These experiences
are very prevalent among Puerto Ricans with and without nervios, but sufferers of ataques are markedly more distressed by them.

2. **Meaning and severity of symptoms in relation to cultural norms**
Patient's symptoms at the time of presentation were seen by her community to reflect a severe form of nervios because they could precipitate rage and dissociation ataques with impulsive suicidality and because they had "penetrated deeply," causing her character pathology. Her characterological symptoms were understood indigenously as a consequence of her nervios, rather than as a cause (i.e., a form of bitterness due to her continued suffering), and thus were seen as another sign of severity. Patient was expected to ward against this complication by "controlling" her needs and desires and focusing on the needs of others, such as her children. The community thus validated patient's understanding that reestablishing positive affective links with her family would improve the outcome of her nervios. Her achievement of this goal, as well as her coming off psychiatric medications and preventing further ataques, were considered signs of improvement.

At first, patient's children rejected the patient's and the community's understanding that her character pathology stemmed from her nervios and ataques. Her children felt that her symptoms, especially her chronic suicidality, were willful ploys directed at forcing them to put aside their anger at what they perceived as her neglectful parenting. They experienced the patient as manipulative and selfish, uncaring of the effect of her coping mechanisms on them. Family therapy helped patient's son and daughter-in-law to recognize patient's suffering as genuine and to appreciate the limited nature of her past options and current coping skills. In turn, this led them to accept her explanation of the etiological role of nervios and ataques in her character pathology. Nevertheless, her family continued to be aware that her personality conflicts exceed the norm even for nervios, calling her "una persona tremenda" (a difficult, overwhelming person).

3. **Perceived causes and explanatory models**
Her condition was seen fundamentally as a medical problem caused by an "alteration" of her nervous system due to the suffering produced by chronically unresolved family conflicts. Primary among these were the physical abuse by her husband, the parental rejection, and her separation from several of her children during most of their childhood, which led to their ongoing anger toward her. Patient did not feel she was "born with" nervios, an alternate cultural etiology, in light of what she considered to have been her "normal childhood." Her dissociative symptoms were attributed to the visitations of deceased relatives, distressing mostly when she was weak-
ened by her nervios. Even when improved, however, patient remained leery of these experiences, preferring to pay them minimal attention.

4. Help-seeking experiences and plans
Seeing her condition as medical, patient sought help first from internists, who referred her to in-patient psychiatric care. Patient always understood this as being sent to the medical specialists of the nervous system ("the doctors for nervios"). Family therapy met patient's need for improving her relationship with her son, but other forms of psychotherapy directed more at intrapsychic change, such as group therapy, were made impossible due to her exquisite sensitivity to offense and her intense and unstable valuation of the group therapist. Rather than day hospital care, patient sought daily visits with her daughter-in-law. After her family relationships were reestablished, patient left family therapy but suffered only from minor symptoms while her family relationships remained intact. She sought individual supportive psychotherapy with a Latino psychologist and the general "medical supervision" of a Latino psychiatrist. She was also helped by finding a role in the Latino "underground economy" as a seller of homemade cultural artifacts. Patient felt no need to seek help from folk healers for her dissociative symptoms once improved from nervios, saying "I don't believe in any of that."

C. Cultural factors related to psychosocial environment and levels of functioning
1. Social stressors
The main stressor for patient at the time of her presentation was her estrangement from all of her children, which contradicts traditional values regarding an extended and close family centered around a matriarch. Patient felt this was a deserved punishment for abandoning 4 of her children in childhood. Feelings of rejection by her oldest son precipitated her initial admission and one of her most lethal ataques. Once stable, patient tried to increase her contact with her other children but found it too painful since her drug abusing daughter had lost custody of her own children.

Seen over the course of her lifetime, patient's stressors were severe, and included the family disruption caused by her father's alcoholism, her husband's physical abuse, the dispersion of her nuclear family and the consequent discord with her parents and children, difficulties in acculturation to the United States, ethnic discrimination, chronic poverty and unemployment, the murder of her second husband, and her children's substance abuse and subsequent loss of child custody.
2. Social supports
Precarious. As a recent migrant, patient's supports beyond her son, daughter-in-law and caregivers only consisted of community drop-in centers and a few elderly Latinas. Her lack of supports probably contributed to the length of her hospitalizations, as her fear of going home seemed to worsen her suicidality whenever discharge was discussed. Clinicians' efforts to expand her support system through group therapy membership and psychiatric social clubs were hindered by her character pathology. Most of patient's symptoms, including her suicidal ataques, may be understood as attempts to expand her social support network by engaging the attention of family members as well as professional caregivers. The patient always retained the belief that in the face of her overwhelming social limitations and the original recalcitrance of her children, only the full expression of her symptomatology could have produced a positive outcome.

3. Levels of functioning and disability
As a result of her improvement, patient came to see her condition less as a progressive illness without cure than as a permanent vulnerability. However, she attained little insight into her character limitations. Given good family relations and "respect," patient expected to retain her improved state, but she feared decompensation. She felt permanently disabled and expected the government to continue to provide subsidized housing and financial support.

D. Cultural elements of the clinician-patient relationship
Patient's psychiatric care prior to her referral to the Latino Clinic was hindered by the absence in the diagnostic and treatment process of a culturally normative assessment of patient's character structure as well as of cultural information on nervios and ataques. Patient's ethnicity was taken into account by assigning her a Latino in-patient caregiver and the use of interpreters, but accurate diagnosis of her character pathology was prevented by the cultural mismatch between the patient and the in-patient unit, which overemphasized her Axis I symptomatology. The joint input of multiple Latino caregivers was able to attain a more comprehensive cultural evaluation and intervention with more successful clinical results.

E. Overall cultural assessment
Patient's identity is that of a rural Puerto Rican migrant, speaking Spanish exclusively, who has only lived for limited periods in the US, resulting in minimal acculturation. Her dysphoria is expressed in the traditional Puerto Rican idioms of nervios and ataques de nervios. She attributed
her relapsing course to unresolved conflicts with her children and did not improve until their affective breach was addressed in family therapy.

Patient's initial treatment proved ineffective partly because of the misattribution of a psychotic label to the patient's dissociative symptoms, which are normative idioms of distress for this population. These experiences were never associated with any loss of reality orientation or formal thought disorder; moreover, they remained, usually with only transient distress, once her overall affective picture improved. They functioned as a kind of diagnostic "red herring." Misdiagnosis exposed patient to the potentially toxic effects of anti-psychotic medication and interfered with referral to family psychotherapy. In addition, lack of cultural information also hindered the identification of patient's underlying Axis II pathology and obscured the relationship between her character disorder and her pervasive and persistent Axis I symptoms, including her chronic suicidality and its exacerbations in the form of ataques. Pharmacologic treatment of the patient's refractory depression – dangerous anyway, due to her impulsive suicidality – proved unnecessary once intensive family intervention was underway. Her remaining intermittent Axis I symptoms led to periodic distress, warranting NOS diagnoses. But the patient's primary psychopathology proved to be characterological, fulfilling criteria for Borderline Personality Disorder. Like many patients with this disorder, she displayed recurrent dysphoria, though in her case she did not meet strict criteria for Dysthymia. Unlike many Borderline patients, however, her course was remarkably uneventful once appropriate psychotherapy was instituted, perhaps reflecting cultural variation in the treatment response of Borderline Personality Disorder.

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