TRANSCULTURAL ISSUES IN PSYCHIATRY: THE *ATAQUE* AND MULTIPLE PERSONALITY DISORDER

Marlene Steinberg, M.D.

Marlene Steinberg, M.D., is an Associate Research Scientist at Yale University School of Medicine, Department of Psychiatry, New Haven, CT.

This research was supported in part by NIMH First Independent Research Support and Transition Award MH-43352. The author thanks Morton Reiser, M.D., for his comments on an earlier version of this paper.

For reprints write Dr. Marlene Steinberg, Yale University School of Medicine, Department of Psychiatry, 27 Sylvan Avenue, New Haven, CT 06508.

ABSTRACT

Due to the difficulty in detection of multiple personality disorder (MPD), this dissociative disorder is frequently misdiagnosed and ineffectively treated. In this case report of MPD in a Hispanic woman, the author compares and contrasts her presentation of symptoms with those of the culturally accepted ataque de nervios, or "Puerto Rican syndrome." It is theorized that the similarities may increase the incidence of misdiagnosis of MPD in Hispanics and it is recommended that the diagnosis of MPD be considered in Hispanics with histories of ataque.

INTRODUCTION

Ataque de nervios, "nervous attack," or "Puerto Rican syndrome" is characterized by a variety of transient symptoms including partial loss of consciousness, convulsive movements of psychogenic origin, assaultive hyperactivity, childlike regressed behavior, and/or psychosis, and may also include impulsive suicidal or homicidal acts (Fernandez-Marina, 1961; Garrison, 1977; Mehlman, 1961). While not well understood, this syndrome has been described in varying ways in the psychiatric literature. Frequently, individuals experiencing an *ataque* are amnestic for these episodes. The *ataque* has been hypothesized to be an acute dissociative reaction which can occur within a variety of psychiatric disorders, particularly hysterical syndromes, and is thought to be a culturally acceptable reaction to stress within the Hispanic community (Fernandez-Marina, 1961; Garrison, 1977; Mehlman, 1961).

Multiple personality disorder (MPD), the most severe and chronic of the dissociative disorders, occurs when two or more distinct personalities or personality states exist within one individual (DSM-III-R). Although it was thought to be rare, investigators recently have noted a sharp increase in the number of case reports of the syndrome (Bliss & Jeppsen, 1985; Coons, 1984; Kluft, 1987). Recent research has linked this syndrome to child abuse, with studies indicating that more than 90% of MPD patients suffered severe physical, emotional, and/or sexual abuse during childhood (Kluft, 1987). Current studies also indicate that MPD remains undetected for an average of 6.8 years following first psychiatric presentation, with an average of 3.6 previous psychiatric or neurologic diagnoses (Putnam, Guroff, Silberman, Barban, & Post, 1986).

To date, there have been few case reports of MPD or other dissociative disorders in Hispanics (Martinez-Taboas, 1989), the fastest growing minority group in the United States (Adams, 1984). In the following example, multiple personality disorder in a Hispanic woman is compared to the *ataque de nervios,* believed to be a relatively common syndrome among Hispanics, and which occurred episodically in this case. An association between MPD and the *ataque* has not been previously described.

CASE REPORT

Mrs. C., a 40 year-old divorced Hispanic woman, contacted a Hispanic clinic in Connecticut on the suggestion of her previous psychiatrist in Puerto Rico. Over an 18-year period Mrs. C had made numerous emergency room and follow-up visits to a Puerto Rican psychiatric hospital. Her previous diagnoses included psychotic depression, schizophrenia, post-traumatic stress disorder, schizoaffective disorder, and hysterical personality. A variety of neuroleptics and antidepressants in therapeutic dosages had been prescribed, but had provided no relief.

Mrs. C was the youngest of three daughters born to indigent parents in Puerto Rico and was raised among numerous relatives in an overcrowded setting. Mrs. C suffered extreme physical and emotional abuse from her mother, including administration of enemas and emetics every other day as punishment "if she was bad." Mrs. C's mother also engaged in inappropriate and bizarre behavior such as pouring glasses of water on the bed, crying and episodically laughing and pulling her own hair. Mrs. C also recalled being sexually abused by her father, and suffered recurrent dreams of this abuse. Married at age 17, she had three children by her first husband, who was physically abusive. After four years, Mrs. C left him and shortly thereafter married another man, whom she described as physically and emotionally abusive.

They separated four months later. Recently, she moved to Connecticut to be near her grown daughter.

Mrs. C's first presentation in Connecticut was with a classic episode of an *ataque*. She described an acute onset of distressing auditory and visual hallucinations, experiencing the voices as originating both within herself and from "spirits," and stating that the voices were commanding her to harm herself. Mental status exam was remarkable for her disorientation to year, overall histrionic demeanor, agitation, depersonalization, and feels of being "possessed." The initial diagnostic impression at the clinic was of a psychotic depression and she was given a prescription for perphenazine. Four days later, in a follow-up visit, she had not used the medication, denied having had auditory or visual hallucinations, and was free of any psychotic symptoms. She described rapid mood swings, "out of body experiences," and amnestic episodes which she had experienced since childhood. At this time, Mrs. C was scheduled for biweekly supportive therapy with a mental health worker. She attended sessions irregularly. Her demeanor, level of functioning, and symptoms fluctuated radically. Spontaneous age regression (Spiegel & Rosenfeld, 1984) occurred several times. Frequently she presented to therapy referring to herself by another name and did not remember previous sessions. During this period Mrs. C was brought to the Hispanic clinic by her boyfriend for an emergency consultation due to the acute onset of bizarre behavior. She was childlike and disoriented, suffered auditory and visual hallucinations of a suicidal and homicidal nature, and rapidly became restless and agitated. She stated her name was "Rosa." The evaluating psychiatrist referred her to the ER for possible admission since she had been "found with a scarf trying to hang herself."

At that time the emergency room psychiatrist noted the similarity of her symptoms to the *ataque* and described her presentation: "When she came into the screening area, she took one of the balloons and began to play with it and asked me if I had a doll for her; she also said she was hungry and wanted some cookies and milk." His diagnostic impression was "atypical psychosis." She was given 8 mg of perphenazine. Re-evaluation several hours later revealed a "dramatic change in state." She said she was not Rosa, was not 6 years old, had no interest in playing with a doll, and that she did not feel like someone was following her or was telling her to hurt herself. The precipitating stressors remained unclear, and Mrs. C was discharged from the ER.

At this time Mrs. C began a new course of weekly psychotherapy sessions which she attended fairly regularly. Mrs. C's sense of identity, her demeanor and the content of each session varied significantly. During this treatment, five distinct personalities emerged with different names, ages, memories, and characteristic behaviors. Frequently she would state that she was "unable to remember" what she discussed in a previous session. Recurrent themes included identity confusion and severe abuse by both parents. Throughout this year she remained off medication.

Mrs. C's symptoms, past history, and presentation are consistent with the diagnosis of multiple personality disorder. The observed alteration of identity, the presence of perceptual disturbances, intersession and intra-session amnesia, and the history of severe physical and sexual abuse throughout childhood are characteristic features in individuals with MPD (Kluft, 1987; Putnam et al., 1986).

It is hypothesized that Mrs. C developed alternate personalities in an attempt to cope with overwhelming abuse. The frequent episodes of depersonalization as a child represent an attempt to remove herself emotionally from abuse from which she could not escape physically. Clinical material not presented here suggested that her retreat to an internal world had allowed her to have the experience, within her imagination, of a nurturing parent. Continued elaboration of this internal world may have resulted in the formation of more organized personalities. The exact stressors in the development of Carmen's alternate personalities await clarification in long-term therapy.

To date, there has been only one published report of MPD in Hispanics (Martinez-Taboas, 1989). Due to cultural differences, misdiagnoses of a range of psychiatric disorders occur more frequently among Hispanics than in the population in general (Adams, 1984; Marcos, 1979; Mukherjee, (Skukla, Woodle, Rosen, & Olarte, 1983; Rendon, 1974). Several studies of the Hispanic population have noted the increased incidence of misdiagnosis of bipolar disorder as schizophrenia (Jones, 1983; Mukherjee, 1983). Although there are no studies on the incidence of dissociative disorders such as MPD in Hispanics, Rendon (1974) warns that dissociative phenomena may also be misdiagnosed as schizophrenia in this group of patients.

Before her current treatment, the diagnosis of MPD had never been considered in Mrs. C. Several factors may have contributed to misdiagnosis. First, the variability of symptoms and erratic presentation of the patient to the many therapists may have obscured her diagnosis. Ms. C exhibited identity confusion, spontaneous age regression, depression, and mood swings: intermittently, she would appear to be psychotic. These symptoms and the absence of ongoing observation by a single evaluating clinician resulted in misdiagnoses of schizophrenia, psychotic depression, atypical psychosis, and a post-traumatic stress disorder. Disorientation and amnestic episodes, typical of MPD, also complicated diagnosis. In addition, Mrs. C was reluctant to reveal the existence of alternate personalities; evidence of these personalities emerged only over the course of one year of psychotherapy. All these difficulties are common with MPD patients.

In addition, in Mrs. C's case cultural differences may also have contributed to the difficulty in diagnosis. Evaluating clinicians understood her symptoms as presentations of the commonly recognized and culturally accepted *ataque*, or "Puerto Rican syndrome," and not as symptoms of an underlying dissociative disorder. Aspects of Mrs. C's behavior were clearly congruent with the *ataque* syndrome. Transient alteration in consciousness with amnesia, disorientation, childlike behavior, self-mutilation, and psychotic symptoms are characteristic of both the *ataque* and MPD. The primary defense mechanism used in both conditions is dissociation. In Mrs. C's case, however, the acute episode of an *ataque* appears to be a manifestation of one of her alternate child personalities.

Mrs. C's case demonstrates a typical history of numerous misdiagnoses prior to the accurate detection of MPD. In addition to the usual difficulties in diagnosing MPD due to variability of symptoms, erratic presentations of personalities and amnesia, someone of the Hispanic culture suffering from MPD may be seen as having isolated incidents of *ataque*. Due to the overlap of symptoms and the dissociative character of the *ataque*, evaluating clinicians should rule out the presence of an underlying dissociative disorder such as multiple personality disorder in the presence of episodes of *ataque*. Failure to do so may lead to misdiagnosis and result in inappropriate and ineffective treatment. ■

REFERENCES

Adams, G.L., Dworkin, R.J., & Rosenberg, S.D. (1984). Diagnosis and pharmacotherapy issues in the care of Hispanics in the public sector. *American Journal of Psychiatry*, 141, 970-974.

Bliss, E.L., & Jeppsen, E.A. (1985). Prevalence of multiple personality among inpatients and outpatients. *American Journal of Psychiatry*, 142, 250-251.

Coons, P.M. (1984). The differential diagnosis of multiple personality - A comprehensive review. *Psychiatric Clinics of North America*, 7, 52-67.

Fernandez-Marina, R. (1961). The Puerto Rican syndrome: Its dynamics and cultural determinants. *Psychiatry*, 24, 79-82.

Garrison, V. (1977). The "Puerto Rican syndrome" in Psychiatry and Espiritismo. In V. Crapanzano (Ed.), *Case Studies in Spirit Possession*. New York: John Wiley & Sons.

Jones, B.E., Gray, B.A., & Parson, E.G. (1983). Manic-depressive illness among poor urban Hispanics. *American Journal of Psychiatry*, 140, 1208-1210.

Kluft, R.P. (1987). An update on multiple personality disorder. *Hospital and Community Psychiatry*, 38, 363-372.

Marcos, I.R. (1979). Effects of interpreters on the evaluation of psychopathology in non-English-speaking patients. *American Journal of Psychiatry*, 136, 171-173.

Martinez-Taboas, A. (1989). Preliminary Observations on MPD in Puerto Rico. *Dissociation*, II (3), 128-131.

Mukherjee, S., Skukla, S., Woodle, J., Rosen, A.M., & Olarte, S. (1983). Misdiagnosis of schizophrenia in bipolar patients: A multiethnic comparison. *American Journal of Psychiatry*, 140, 1571-1574.

Mehlman, R. (1961). The Puerto Rican syndrome. *American Journal of Psychiatry*, 118, 328-332.

Putnam, F.W., Guroff, J.J., Silberman, E.K., Barban, L., & Post, R.M. (1986). The clinical phenomenology of multiple personality disorder: 100 recent cases. *Journal of Clinical Psychiatry*, 47, 285-293.

Rendon, M. (1974). Transcultural aspects of Puerto Rican mental illness in New York. *The International Journal of Social Psychiatry*, 20, 18-24.

Spiegel, D., & Rosenfeld, A. (1984). Spontaneous hypnotic age regression: Case report. *Journal of Clinical Psychiatry*, 45, 522-524.