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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 feelings 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, denying 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 amnesia 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


