Neuroticism and its «miracles» A cross-cultural or an anachronist matter?

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El neuroticismo y sus «milagros», ¿anacronismo o transculturalidad?

Summary

Rare behaviors, extravagant beliefs and some sort of social isolation frequently put the clinicians on the trail of a psychotic disorder. If we add sudden onset and end, plus the existence of certain stressors that are thought to be precipitant, the initial hypothesis could be referred to with specific surnames: «brief» or «acute and transient». The present case shows the need to weigh the adjectives applied to behavior and ideation (i.e. «extravagant» or «weird») according to biographical and cultural references of «normality». By means of this contextualization, what initially might have seemed to be a psychosis has a neurotic explanation or, using a rather anachronistic term, «hysterical» explanation in which the spectrum of beliefs plays a crucial pathoplastic roll.

Key words: *Differential diagnosis of the acute psychotic disorders. Dissociative disorders. Transcultural pahtoplasty. Hysterical psychosis.*

Resumen

Conductas bizarras, creencias extravagantes y un cierto aislamiento o incluso desconexión del entorno con frecuencia ponen al clínico sobre la pista de una psicosis. Si a estos ingredientes añadimos un comienzo y fin bruscos y la presencia de estresores desencadenantes, la presunción inicial adquiere el apellido de «transitoria aguda». El presente caso ilustra la necesidad de ponderar los adjetivos aplicados a conducta e ideación («bizarra» o «extravagante») de acuerdo con las referencias de «normalidad» biográfica y culturales. Al llevar a cabo este esfuerzo por contextualizar lo que inicialmente pudo parecer una psicosis encuentra una explicación neurótica o, utilizando un término tal vez anacrónico, «histérica» en la que el espectro de creencias de la paciente tiene un papel patoplástico crucial.

Palabras clave: *Diagnóstico diferencial del trastorno psicótico agudo. Trastornos disociativos. Patoplastia transcultural. Psicosis histérica. Sobrecogimiento neurótico.*

CLINICAL CASE

L. M. was walking aimlessly in the rain last November 24, 2002 when the Emergency Medical Care Service (SAMUR) took her to the Emergency Service without being able to get a word out of her to explain what was happening to her. After organicity was ruled out, it was decided to keep her under observation in the psychiatry service. She spent days in silence, neither ate nor drank and was oppositional in her interaction with the staff, at intervals with her eyes closed, in a curled up position and covering her head with the sheet. This rejection behavior increased (according to the notes of the nursing staff) during the visit of her family, in which she did not establish visual contact or accept physical closeness. It was at seven p.m. on the fifth day (she then had to be fed by nasogastric probe, that she pulled out on several occasions, so that she had to be tied down) when, during the visit of a sister from her Church (the Evangelist), there was, what L. M. called «a miracle» and the responsible nurse called «a spectacular change». After that time, the staff recorded: «smiling, communicative, in good spirits, receptive to the taking of oral medication, eats a good dinner». The transformation continued in the following days, so that the neuroleptic initiated at 24 hours of admission was withdrawn. The case was discussed in the clinical session, diagnosing «acute transitory psychotic disorder secondary to stress» and she was sent home without medication but with an appointment in the area mental health center.

Having reached this point, it should be asked how and why. Choosing her family as the only useful informers after verifying the intention of the patient to minimize what had happen, we obtained an account of the last year, and especially of the last month, in which L. M. was totally devoted to the care of an elderly person with advanced dementia (for whom she sacrificed her rest) and to her faith as a sister in the Evangelist of Pentecost. The family story included fragments such as that of a day that L. M.

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called her son and, lying in bed, she told him that God was operating on her or the afternoon when, with her head smeared with oil, she assured that «God» had rubbed her with ointment to prevent the devils from entering through her mouth and nose; she also showed total belief that she was receiving orders from Jehovah. Psychosis as the most likely hypothesis was adopted based on a «how» loaded with bizarre behaviors, withdrawal, soliloquies, possible delusional beliefs and auditory hallucinations, the absence of a sufficiently explanatory «why», the diagnosis of schizophrenia of her mother (who required several psychiatric admissions after the death of a son) and the history of 5 hangings in the family of her father (including her father).

The same assumption was reached three days after her discharge when, in compliance of the threat that either she ate or she would be taken to the hospital, she was taken to the Emergency Service again against her will. On arrival, L. M. was conscious, oriented and explained, with fluid, spontaneous and coherent speech, that «I don't eat because I have no appetite» and expressed her lack of agreement with the hospitalization. According to her family, she was only well until her husband returned from work on the same day of the discharge. Then she began to say that Jehovah was inside her (other times the devil) and refused to eat or drink anything, fasting that she maintained up to the time. The family explained, alarmed, that she had rejected those from the Church who had come to visit her that afternoon (the sister that catalyzed «the miracle» among them) and did not want to see the ecclesiastic TV channel. Hospitalized again for observation, she continued to refuse to eat or drink and recovered her silent and oppositional attitude of the first time, so that serum therapy and a neuroleptic were initiated. As in the previous occasion, this symptom abated suddenly (42 hours after), this time with no apparent cause. L. M. spoke to the nurse to ask to go to the bathroom, then said she wanted to have a snack and asked if she could remove the line, that bothered her. She avoided the questions of the psychiatrist on duty that required any type of introversion and she responded briefly to the questions made (she accepted oral medication, said she was uncomfortable in the emergency ward, etc.). The next day, when she was questioned on what had occurred since she had left the hospital, she stated, with a dismayed expression: «this time I was not ill. I simply did not feel like eating; I was overwhelmed because the family of the elderly patient came to see me and I cannot return to work there, but I promised them that I would not abandon her» and she continued between sobs «I had become fond of her, she was like my mother, etc.)».

We found an explanation to this ambivalence in the bibliography of the patient: L. M. had taken care of two elderly women and in different sense «demented»; of her mother-in-law, who died after 5 years of Alzheimer's and of her own mother, a mental patient. And it is in this second hospitalization that the need to go deeper in the biographic contextualization arises.

Of Cuban origin, our patient is 52 years old and has been in Madrid since 1998. This is not the first time that she has abandoned her roots in pursuit of a better life; daughter of a shoemaker and a peasant woman, she abandoned the rural setting at fourteen years with her parents and siblings in inner migration to Havana. She had gone to school little and began to work at once (she completed her primary studies when she was over twenty years of age). When she met her husband, she was 19 years old and employed in a sports shoe factory. They married after 1 year of relationship and ten months later she gave birth to her first son. The daughter came ten years later. Shortly after the wedding, they moved in with her husband's mother, with whom she maintained a relationship that her husband defines as «a war». L. M., in Havana was, according to her husband, «a woman with many friends, very extroverted, etc., the house was always full of friends, when some left others came». It seems that she was «a very good negotiator. When someone in the neighborhood wanted to sell or exchange something on the black market, they came to her». In addition, according to her husband, she faced difficulties by «resolving them, directly facing them» and he assured that «in her family, everything resolved about her». However, she always had problems sleeping and also sometimes needed anxiolytic medication during the day. Another one of her great supports has always been her beliefs. She entered in the Evangelist of Pentecost Church through a friend in 1990 (also her daughter), however, prior to that, «she was interested in sorcery and the worship of saints», her son said, «invoking deaths, telling fortunes with cards, etc. in the witchcraft as in the Church» and he remembers, irritated, a time that his mother took him, when he was 13 years old, for «a shedding, to remove the malignant spirits». Regarding her marriage, her husband states: «We have always had problems, I have had girlfriends all my life but then we have always made up.» In 1995, he had the opportunity to leave Cuba, and after, the rest of his family came to Spain, first their son, then her and then their daughter (in 1998).

Madrid meant a change in her life tendency, her family considers her «more alone, more obsessed with God, she only has friends within the Church». She has had several jobs over these years: in a telephone call center, she cleaned stairs and took care of several ill persons, but none were so absorbing as the demented woman whom she even stayed with at night without charge, as an «offering to God». After some time, her daughter left the Church and this was a hard blow for L.M. who, according to her son with visible anger, became «more insistent that we should convert to the Church». Her husband was surprised by her first rejection at an attempt to reconciliation that has resulted in that they have been «separated» for two years, although they continue to share the same house. The reason? She used the condition that he had to convert. They exemplified this insistence explaining that on the day of her admission, she called each one of them to say that God wanted to speak to them. To her husband, with a somewhat changed voice, she stated that it was Jehovah who was speaking to him and that «I had to rectify the bad things and convert to the religion»; it seems that she said that she knows he has a girlfriend that he is going to have a son with her and that this would be «the greatest

happiness of his life». He confesses: «I have a friend, but I have not told her.... it is not true that she is pregnant.»

After this brief biographic incursion and short family background, we pay some attention to the account of what happened by the patient herself. In the first interview with the doctor after the «miracle», she described a discussion with her daughter on the day of the admission because of her attitude towards religion, after which she had to return to work: «mine was a release, because this woman greatly stressed me, I left the apartment and began walking and I began to feel more relieved.... I was anxious and stressed, I was ashamed of what happened» and referring to the days of silence: «I was not normal, I knew what was happening but I had no will. Most of the time I was clear, I heard what was said to me, but other times, I was disconnected ... when my two sisters prayed for me, I woke up, I believe that it was a miracle of Good». Also in her second hospitalization, she refers to the reason of admission as the inner conflict caused by her abandoning work, but this time she did not call the «spectacular change» (according to the nursing staff) as a «miracle». And us, do we continue to call it «psychosis?»

DISCUSSION

Following the diagnostic classification of the ICD-10, the first episode that caused the admission of the patient fulfills the characteristics of an acute and transitory psychotic disorder (F 23). We review the acute onset of the symptoms, the previous days of stress and insomnia, the presence, according to the family story, of weird behavior in relationship with religious beliefs and the sudden recovery of the picture.

However, after, and with the caution that is generally taken on making the diagnosis of dissociative disorder, different data seemed to support us in this second hypothesis. Her previous personality, vulnerability to stress expressed by periods of her biographic history in which she needed the help of benzodiazepines to alleviate her anxiety; the social and cultural context of the patient; the extraordinary confessional style with which she also was devoted to the practice of witchcraft and religion, even at the cost of the relationship with her husband and children; the clear time relationship of the episodes with the relational stress situations; the strong expressive content of the symptoms and her sudden end in a «miracle» could occur only for the sake of a not scornful suggestionability, made neurosis a more convincing explanation.

Most of us would agree that anxiety is an omnipresent human experience. However, its clinical forms vary considerable. A state of alert can precipitate reactions that go from sudden shock to being terrified, described by Lopez Ibor in 1950[1]; from the uproar of movements to the cadaveric immobility reflect. With an essential value for the individual survival, anxiety becomes a pathology when it occurs with insignificant stimuli, it has exaggerated intensity or persists beyond the necessary. This bring us close to the field of neurosis.

In the psychiatric practice, most of the patients classically diagnosed as neurotics (term coined by William Cullen in 1784 and that no longer appears in the SDM-IV but does appear in the ICD-10) would be diagnosed today as having anxiety disorders. These, together with the adaptive, dissociative, somatoform and neurasthenia disorders are precisely diagnostic groups swarming with cultural influences. Thus, many of the syndromes classified as linked to culture have components of somatization and/or dissociation. The clinical descriptions of some of them can be useful in the case in question.

The so-called «attack of nerves» described in Puerto Ricans and other groups of Hispanics by Guarnaccia[2] includes a socially accepted staging of affliction or great conflict characterized by difficulty to move the limbs, loss of consciousness or that the mind goes blank, loss of memory and motor hyperactivity times in which the individual begins to shout and hit others, falling to the floor and experiencing body convulsions or remaining «as if dead». Although the episode is generally self-limiting and generally lasts only a few minutes, it can extend for days when it is serious. Recent authors[3] have advocated the classification of this syndrome under the general category of dissociative disorders. We have also found similarities between our case and other pictures such as the trance states and possession syndromes of which the amok syndrome is an example. This is frequent in Malaysia, Puerto Rico («mal de pelea») and other countries and occurs with an initial episode of withdrawal followed by episodes of violence, persecution ideas, autonomism, amnesia and return to premorbid normality after a period of exhaustion.

Psychiatry of the XX century has made great progress in relationship with the diagnosis and treatment of neurotic disorders and in the articulation of the biopsychosocial model as explanatory models[4]. The task of explaining the impact of the culture in the genesis and/or resolution of the neurotic behaviors in their multiple manifestations will correspond to the XXI century, that is faced with global migrations without precedent[5].

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