ATAQUES DE NERVIOS: PROPOSED DIAGNOSTIC CRITERIA FOR A CULTURE SPECIFIC SYNDROME

ABSTRACT. The authors propose a set of diagnostic criteria and report two cases of ataque de nervios, a syndrome of brief duration seen primarily in Spanish-speaking people of the Caribbean. Following a psychosocial stressor, the afflicted person demonstrates impulsivity, dissociation and communication and perceptual disturbances. The symptoms often begin in the presence of the family, allow a temporary relinquishing of social roles, and result in the mobilization of the social network in support of the person. Further research is needed to improve our understanding of this culture specific syndrome and its relationship to psychiatric disorder.

Ataque de nervios is a syndrome seen in people of the Spanish-speaking Caribbean (Cuba, Dominican Republic, Puerto Rico). Among the early reports were those of U.S. Armed Forces psychiatrists evaluating Puerto Rican recruits in the 1950's (Mehlman 1961). Since then, it has been observed in the Hispanic Caribbean population in their native countries and in those who have immigrated to the U.S. Yet, its epidemiology, symptomatology and treatment have never been studied systematically.

Ataque de nervios may occur in the absence of another mental disorder or concurrently with psychiatric disorders, ranging from schizophrenia to personality disorders. Its coexistence with such a wide gamut of psychiatric disorders has made it difficult to clarify the phenomenology of this culture specific syndrome. Reflecting this, there have been differing portrayals of the syndrome throughout the literature. For instance, Rothenberg characterizes ataque de nervios as a sudden onset of violence, uncommunicativeness and hyperkinesis (1984). He adds that swearing and striking out at others is common. Guarnaccia et al. and Grace describe how the afflicted person may fall to the floor and either convulse, or act as if dead (Guarnaccia et al. 1989; Grace 1959). Similarly, Thomas and Garrison describe a case presenting with unresponsiveness, hyperventilation, and tonic clinic movements (Thomas and Garrison 1975). Trautman describes another version of ataque de nervios, “the suicidal fit” (1961). The fit has two phases; one during which the patient flees a stressful scene and the other during which suicide is impulsively attempted (Trautman 1961). Though superficially distinct, these descriptions have important common denominators, namely the suddenness of onset, the disruption in ability to communicate and the action-oriented result.

The ataque de nervios usually begins at a funeral, at the scene of an accident or family fight, or at other times when strong emotional expression is culturally sanctioned. Among Spanish-speaking people of the Caribbean, it is considered an acceptable way of displaying distress.
Another prominent feature of ataque, which has rarely been noted, is its effect on the social support network. The ataque mobilizes the person's family and friends, all of whom come together and attempt to alleviate the stress as best as they can (Guarnaccia et al. 1989). This in itself may lead to symptom remission.

As currently constituted, DSM-III and DSM-III-R are not equally applicable across cultures. The absence of descriptions of culture specific syndromes such as ataque de nervios, limits the clinical utility of DSM-III and DSM-III-R in the rather large United States Hispanic population. In order to clarify the phenomenology of ataque, we propose a description and a set of diagnostic criteria for this syndrome. This would represent an important step towards a standardized definition of ataque de nervios. The use of diagnostic criteria would also foster research to refine the diagnosis of ataque de nervios and to clarify its relationship to other psychiatric disorders.

The following description is a synthesis of our own clinical experience and published accounts of ataque de nervios. The cases reported herein were seen on an acute inpatient unit serving northern Manhattan. The catchment area of our psychiatric service has a large Hispanic population, a significant portion of which is recently immigrated to New York City from the Dominican Republic, Puerto Rico, Cuba and other Latin American countries. This is reflected in the composition of the inpatient population, which is 60 to 70% Hispanic. The average length of stay is thirty days.

**DESCRIPTION AND DIAGNOSTIC CRITERIA**

*Essential Features*

This syndrome is seen in persons from the Spanish-speaking islands of the Caribbean. The essential feature is a sudden, though transient, change in behavior that occurs after a major stress. The stress may range from a break-up with a boyfriend or girlfriend to the death of a child. Though it is usually in the interpersonal arena, it is not invariably so.

Following the stress, psychotic symptoms may ensue, most frequently incoherence or auditory hallucinations of the voice of a loved one. Dissociative experiences are common and include changes in the level of consciousness and amnesia. Sudden or impulsive behavior such as suicide attempts, falling to the floor, assaultiveness and seizure-like activity may bring the person to medical attention.

Episodes of ataque occur along a wide spectrum of severity. Cases that come to medical attention may represent only the most severe end of that spectrum.