



The Case of Maria and Me **Diagnosing the Ills of Western Psychiatry**

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Abstract: One day I was assigned a new patient. She was from Ecuador. The many meetings I had with “Maria” taught me how poor training, a lack of cultural sensitivity, an inability to fully grasp what it is like for an immigrant to adjust, and the all-too-frequently crude paradigm of modern psychiatry could lead to faulty, even dangerous diagnoses. At a deeper level I learned to understand Maria and her disorders in her own terms and context—and the perils of a therapist or doctor approaching a patient as an object, describing her according to an objective palette of western terms. What my experiences with Maria taught me is echoed beautifully in Jessica Benjamin’s and Rose Marie Perez Fosters’ works, namely that a mentally ill patient is a person whose personhood and subjectivity are centers in themselves and hold meaning irreducible to an objective model. The only way of truly understanding Maria was to see her in her “intersubjective context” in which meaning, but also disorders, are defined, understood, and addressed (Benjamin, 1995).

“Is it our new clients who are unworkable and unanalyzable or is it our method?”

—Perez Foster

One day I was assigned a new patient. She was from Ecuador. For the sake of privacy, I’ll call her “Maria.” The many meetings I had with Maria taught me how poor training, a lack of cultural sensitivity, an inability to fully grasp what it is like for an immigrant to adjust, and the all-too-frequently crude paradigm of modern psychiatry could lead to faulty, even dangerous diagnoses.

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terms and context—and the perils of a therapist or doctor approaching a patient as an object, describing her according to an objective palette of western terms. What my experiences with Maria taught me is echoed beautifully in Jessica Benjamin’s and Rose Marie Perez Fosters’ works, namely that a mentally ill patient is a person whose personhood and subjectivity are centers in themselves and hold meaning irreducible to an objective model. The only way of truly understanding Maria was to see her in her “intersubjective context” in which meaning, but also disorders, are defined, understood, and addressed (Benjamin, 1995).

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Maria ended up at Elmhurst hospital in Queens because her brothers knew that she could not be turned away. On paper, it must have seemed to her brothers a good place for her. Maria is an “undocumented” immigrant and as such lacked the basic American benefits such as Medicaid. But Elmhurst Hospital cannot deny anyone emergency medical services.

I was given the task of doing a psychosocial assessment of Maria, because of my adequate Spanish and experience with similar cases—or so my superiors thought. The morning I was to meet with her the psychiatrist and some nurses briefed me on her case, and between them and the chart I got the bare bones facts: she was an Hispanic female who had been living and working illegally in this country for three years. No one had to tell me that Maria, as an undocumented immigrant, was considered to be near the bottom of the rung in American society, even below refugees fleeing from persecution who are at least entitled to various government services such as supplemental security income and vocational counseling. As an economic immigrant, she was not even eligible for the amnesty program because she arrived after 1982, and could as such be picked up and expelled at any moment (Drachman and Shen-Ryan, 1991).

The chart told me she had two siblings in New York, one of whom was married. Her brother had checked her into the emergency ward because she had been talking to herself on the street. His wife, moreover, claimed that she was a danger to her baby. Maria’s siblings wanted to ship her back to Ecuador.

Finally, the chart told me about her unusual behavior after her admission in the hospital. Maria had befriended a fellow Hispanic woman, and the two would walk down the hallways arm-in-arm talking about Jesus and the Virgin Mary. The nurs-

es and the psychiatrist concluded this was a symptom of her mental disorder.

The psychiatrist’s diagnosis was that she suffered from psychosis (NOS¹), and prescribed to her anti-psychotic drugs.

With all that I had read that morning, combined with my previous experience and knowledge, I had three mental lists as I went to meet Maria for the first time: one contained her basic profile as an Hispanic illegal woman; another her disorders; and a third, a result of the second, which medication she had been prescribed.

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When I finally met Maria it didn’t take long for me to realize how inadequate the first list was. For starters, the description “Hispanic female” didn’t come even close to capturing the woman sitting alone in the room. Maria was a “Mestiza” woman, and her ethnicity—what Szane Yang calls the “acoustic field of verbal phenomena”—clearly fell outside the boundaries of what term “Hispanic” supposedly identified. As I would soon discover, lurking behind the labels “Hispanic,” was layer after layer of oppressive poverty and social injustice (Quintanales, 1983).

She sat quietly, looking detached. I asked her my stock questions, mostly surrounding the circumstances leading to her admission to the hospital. But when she answered, her Spanish contained a local dialect that I had trouble understanding. I called in a translator.

Now working with a translator with a better grasp on her dialect, I repeated my questions. This time she responded less with words than a look of desperation. I kept probing but to no avail. Why didn’t she want to speak? I asked myself. Was it

¹ Psychosis NOS or “Not Otherwise Specified” is generally used when there is inadequate information or conflicting information to make a diagnosis.

her mental disorder? Perhaps paranoia? Was she afraid of me for some reason? Did the translator frighten her? Did she think we might have her deported?

By the time I left the room an hour later I felt I knew a lot less about Maria than I had after perusing her charts.

For my next encounter with Maria I invited her family. This time Maria sat quietly, her eyes staring off into a corner, while her brothers told me her story, and theirs.

The first thing that surprised me about the meeting was the support she had behind her. Most patients either do not have a family support system, or at most one parent or sibling will show up for an interview. In Maria's case, twelve people trooped into the room.

Over the course of an hour I learned that Maria, her boyfriend, brothers and their wives live in one apartment. I asked them if they had green cards, and they only admitted to me that they didn't after I assured them I would not contact immigration. The men were construction workers and the women were nail beauticians. They were all undocumented and working for minimum wage. They pooled their funds to pay for the apartment. They also told me that they had promised to pay \$14,000 a head (with 10% interest) to a "coyote"—a human smuggler—in Ecuador who had gotten them over the border. As collateral for the debt was their families back home, who would be harmed if they stopped paying what had become a suffocating debt.

They therefore lived with two major fears: being caught by immigration officials, and the "coyotes'" extortion.

They seemed very protective of Maria, and asked about her diagnosis. I thought it best to get to know more about her first. They told me that Maria was happy when she had arrived in the US three years earlier, singing all the time. Over time she fell into a gloom. When I raised the issue of her harming the brother's child they at once assured me that she had not purposely tried

to hurt the baby. According to the chart, she had. Was this another problem of translation? The chart also stated she had been talking to herself, and had delusions that people were after her. Was this true? I asked. Again they denied it. She had only been talking to herself on the street, and they were afraid—in the words of her brother—"someone would catch her." He then repeated that the best option for his sister was to return to Ecuador.

I left the meeting once again confused. Why had they brought her in the first place? *Did they just want to get rid of her?*

I had several subsequent meetings with Maria, mostly alone with the translator. It was obvious to me that she was suffering from severe depression, though the psychiatrist's original diagnosis of psychosis NOS seemed incorrect. Wasn't there another way of interpreting her silence other than psychosis (Perez Foster, 1998.)? To rephrase Jadhav's provocative question (Jadhav, 1996), was her "indigenous" depression the same as western depression? I could not tell.

At first, trying to get to the root of her disorder, I looked to the obvious places: domestic abuse. Some immigrant women reportedly encounter sexual abuse from their husbands or partners due to a change in power relations, namely when they have jobs and the men do not (Perez Foster, 2001), but there was no sign of this. In fact, her family appeared to be genuinely caring for her. I still could not understand why they checked her in if they did not think she was mentally ill and a danger to the baby, or to herself.

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I started to understand Maria only when I took a different tack. I began, following Van Voorhis (1998), to look at the dialectical dynamic between her disorder, whatever it was, and the oppressive condi-

tions around her. I began to listen to *her* story.

The psychiatrist's original diagnosis did not say whether he thought her psychosis was a product of extreme environmental stressors or not. My hunch was that it was. I started by looking for the stressors, but also to see if there were cultural prejudices at work that had led the hospital to categorize her wrongly as being mentally ill.

The stressors in her life could easily explain what had sent Maria into a depression. Being cooped up in a small apartment with so many others was surely one stressor, though in my estimation a far graver one was money and fear of not paying back the smuggler. At one point she told me she was constantly worried about money, and began to obsessively clean all the time. On top of this was the constant fear of being caught by the INS and deported. As Rose Maria Perez Foster writes, the "threat of repatriation" can lead to a "high risk for psychiatric disorders" (2001). The first feeling Maria was taught when she arrived in the United States was distrust, distrust of the strangers who could bring her harm.

Another possible factor that did not find its way on to the chart but explained much about her case for me, was the sense of powerlessness of living on the margins of a society in which others control all the centers of power, leaving her no real choices.

Compounding powerlessness was being unwanted in the society she had done so much to become a part of. She had left friends, her social status in the village, and security for a society that regarded her as unwanted. Her legal status, racial identity, and inability to speak English placed her on the margins, where there was severe competition for low-paying jobs (Drachman and Shen-Ryan, 1991).

This could help explain depression, but what about the label of psychosis? The doctors regarded her preoccupation with reli-

gion as a manifestation of mental illness. But could this have been a case of creating mental illness when there was none? As Gorkin points out, secular western assumptions may lead one to misunderstand a patient's statements (Gorkin, 1986). Similarly, Roland Littlewood suggests that "local, usually non-western, patterns of experience, action, and belief" are often dismissed as pathological because they do not fit into a categories recognized as "normal" by western standards. Normalcy and mental illness shift according to culture, and what may appear to be raving madness to one may be normalcy in another (Littlewood, 1996).

In Maria's case, what may seem to some as a sign of her disorder—religion—could equally be seen as one of the few threads connecting her to sanity in very difficult times. The more I watched Maria with her friend the better I understood that in their culture in South America it was normal to pray and invoke the Virgin for help. I remember looking for Maria in her room and seeing another patient blessing her.

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I was still puzzled about the family. My first instinct, once again due to my western orientation, was to look for the pathology in her family as a contributor to her current behavior. I thought that health could only come if Maria were able to talk about the events that led to her admission. She had to be autonomous, to stand on her own two feet. However, each time she was with her family the brothers spoke for her.

After two more meeting with the entire family, I began to toy with a different hypothesis. Yuhwa states quite sensibly that societies use different styles to accomplish the same thing. In Japan, for example, a major aspect of culture is achieved through participation with others (Gorkin, 1986).

Maybe Maria's family was an important part in her therapy, and our individualism was by contrast a source of the disease?

My conceptual breakthrough took place during the last meeting with the family. At one point, I asked one of her brothers directly why he had brought her into the hospital. Did he think she was mentally ill? I wanted to know. "Of course not," was his answer. "Then why did you check her in?" He finally admitted that they did so not because she was *loco* but because they were afraid that, praying aloud to herself in the United States, she would draw attention to the police or immigration officials. It was better to get her off the street by bringing her into a hospital than endangering her and the entire family.

I was astounded. Her melancholy and addled mind, itself the result of fear, led her family to put her somewhere safe until they could arrange for her to return to Ecuador. Their collectivist solution pinpointed the cause of the breakdown—being in America—and came up with a simple solution. Their cure was to restore her to the place where intersubjectivity was possible even within a deeply imperfect system. To rephrase Hughes's catalogue of non-western diagnostic (Hughes, 1996), they observed Maria's behavior, pinpointed the cause, and came up with an appropriate treatment. In this respect Maria's family did a lot better job of diagnosing their sister than the doctors, who had put her on heavy medication.

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"We must no longer delude ourselves and assume that the psychotherapeutic frame can cloak either the clinician's world view or subjective inner life."—Perez Foster, 1998

The experience with Maria allowed me to rethink many previous assumptions. In addition, Maria's case directly illustrates

some of the flaws in the western model of medicine.

Elmhurst prides itself on being a multi-cultural institution, and yet it shares a widespread prejudice throughout the American medical profession that differences in culture are treated as an impediment necessary to get over in order to arrive at a uniform diagnosis. As Hughes puts it, culture is little more than "another variable" (Hughes, 1996). Reducing a person's rich life-world to a couple of words on a chart, and interpreting Maria's religious expression as a form of psychosis, is what Jadhav calls a "cultural cleansing" of a person's narrative (Jadhav, 1996). A depressed American male may go fishing, while a depressed Ecuadorian woman might pray openly to the Virgin. Who has the authority to declare which of these practices is normal?

Another conclusion is that the propensity to address mental issues with anti-psychotic medication is not always the result of empirical experience but may, in fact, be a lack of trained multi-cultural mental health facilities (Lu, 1994).

Meeting Maria also taught me something about the brutal reality of what it means to be an undocumented immigrant. Who would not suffer under the pressures of debt, overwork, and living in a foreign place where you are as likely to be picked up by immigration or corned by smugglers out for their money?

I also learned to take stock of my own North American "ethnocentric biases" (Perez Foster, 2001) revolving around individualism. Working with Maria and her family required from me to negotiate the "cross-cultural traffic" between, her, me, the inpatient facility, and her family (Perez Foster, 1998).

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