Immigration Trauma, Substance Abuse, and Suicide

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CASE HISTORY

Bianca is a 35-year-old, divorced Brazilian woman with a history of depression, anxiety, trauma, and substance abuse who has made several serious suicide attempts. Before three years ago, Bianca had no history of mood or anxiety symptoms. In fact, most of her recent psychiatric symptoms have occurred in the context of heavy substance use.

Bianca was previously stable and gainfully employed as a legal secretary in the court system of Brazil. She functioned well until she came to the United States ten years ago looking for a better life. During the first seven years of her life as an illegal immigrant, Bianca struggled with the fear of deportation, issues of acculturation, and the lack of stable employment. Three years ago, Bianca married George, an American citizen, with the explicit purpose of obtaining legal immigration status. Despite the immigration ruse, Bianca hoped the marriage would work anyway. Before marrying, her life was "great." However, the situation quickly deteriorated. Bianca reported that her husband was controlling: he locked her in the house, took away her passport, used abusive language, and forced her to have sex with him. After about two and a half years of marriage, Bianca was finally able to find strength to leave him. Her friends and health care providers played an important role in this process. Even after leaving her husband, however, Bianca lives in fear of his retaliation.

Bianca has a 15-year-old son in Brazil and has been absent for the last 10 years of his life. He is currently under the care of her mother; nevertheless, Bianca states that being away from him causes her to have guilt, anxiety, and emotional pain too great to even describe. In treatment sessions, only when discussing her child does Bianca seem to be truly present and calm.

To complicate matters, she reports that her current, undocumented immigration status is still one of her most significant psychosocial stressors. Obtaining a visa has become the central focus of her life. Combined with substance abuse, her illegal immigration status prevents her from obtaining regular employment and consistent medical care. Most importantly, it prevents her from returning to Brazil to visit her son. If she were to do so, she would have to abandon her dream of succeeding in the United States. Bianca indicates that the intoxication of drug abuse allows her to escape the guilt and painful distance between child and mother. Due to the lack of immigration papers, her health care is compromised. Bianca currently exhibits poor dental status and is unable to afford care. An otherwise attractive woman, she is ashamed of, and humiliated by, her physical appearance. She blames her failed immigration status for most of her suffering and presents it as one of the driving forces behind her attempts to end her life.

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Bianca's substance abuse history is extensive. She smoked marijuana as a teenager, but the frequency has increased over the past few years. She specifically describes the onset of actual substance abuse as occurring only after her marriage. She began to drink alcohol regularly, use cocaine, increase her marijuana use, and exhibit severe symptoms of anxiety and depression. She reports that the abusive nature of her marital relationship led her to seek the companionship of friends who first introduced her to crack cocaine. After three years of using crack cocaine, she progressed to IV drugs this year. She now says, "My mind craves drugs more than my body, and my thoughts go something like 'do it one more time.' "

Bianca initially presented to our community health outpatient psychiatry service three years ago. She was referred by the emergency service because she presented a crisis of anxiety in the context of intoxication. When she met with us, she complained, "I cannot see a way out," and emphasized how disgusted she felt with herself. At the time of presentation, she exhibited severe signs of emotional distress. A young, tall, and attractive woman, she was very restless, pale, and anxious, with nails bitten down to the quick. Of all the features, anxiety seemed to be the most prominent and consistent element of her presentation—and was reflected in her overall appearance, rate of her speech, facial expression, thought content, and behavior. She also admitted, however, a history of paranoid ideation in the context of marijuana use.

Assessment revealed that Bianca had a familial predisposition for substance abuse and that her father had died due to complications of alcoholism. The initial differential diagnosis included agitated depression with comorbid generalized anxiety worsened by recent psychosocial stressors, and bipolar disorder (exacerbated by drug use), mixed phase with depression, plus irritability. Also considered was substance-induced mood disorder with psychotic symptoms present in the context of substance use/intoxication. She was assessed as a high-risk patient with little impulse control, limited judgment, and a severe problem with drugs and alcohol.

Bianca's first hospitalization occurred in 2009 after she impulsively cut her wrists in an attempt to "end my suffering." She improved in the hospital but quickly relapsed. One week after discharge from her first psychiatric hospitalization, Bianca overdosed on IV heroin and was found unconscious on the street. She later explained that it was not a planned suicide attempt but that she was so desperate that she did not really care about the potentially lethal consequences of her actions.

During the resulting, second hospitalization, Bianca was acutely treated with clonidine for heroin withdrawal. She minimized her suicide attempts as "just drama." However, she consistently insisted upon having opiates for vague, severe, untreated physical pain "over my whole body." Staff indicated that her complaints of pain were inconsistent and appeared incongruous with her objective appearance. Moreover, she had no access to heroin for the preceding four to five days, so the probability of acute withdrawal was low. Largely due to her substance abuse and suspicious reports of pain, the inpatient physician declined to provide opiates until a pain consultation was completed.

Even though Bianca had initially denied suicidal ideation, shortly after being told she would not receive opiates, she went to her room and dramatically attempted to kill herself by tying surgical gloves tightly around her neck. Staff found her unconscious, having a seizure on a bathroom floor. A code was called, and she was transferred to the ICU. She quickly recovered but declined to cooperate with psychiatric assessment in the ICU. After medical clearance and transfer back to the psychiatric floor, she promptly attacked another patient and virtually incited a riot requiring the intervention of security staff. She later attributed her behavior to inadequate pain medication.

Since discharge last month, Bianca has achieved intermittent periods of stability and remission. She found support in a local church and daily prayer. She was released to a faith-based substance abuse program but quit after two weeks due to a rule prohibiting psychotropic medications. During a period of abstinence from cocaine, she became employed again as a health aide and was pleased with her own progress. She was able to remain abstinent from cocaine for periods but continued using cannabis daily. Even when using only cannabis, she now acknowledges paranoid ideation when smoking it. Also, despite abstinence from cocaine, Bianca continued to have feelings of high anxiety, ruminations about her precarious situation, and cravings for drugs. Eventually, she relapsed on cocaine.

Overall, Bianca has been treated for several years with psychotherapy and various psychotropic medications. She received trials of, in chronological order, sertraline, risperidone, quetiapine, trazodone, gabapentin, clonazepam, and fluoxetine. Her adherence to the requisite regimens, however, has been consistently poor. Moreover, her attendance at outpatient psychiatric appointments remains sporadic, with gaps of up to five months in the last year, and except for brief periods, she has not had a significant time free of illicit drugs. It has therefore always been difficult to assess her response to medications. She has consistently failed to follow through with outpatient recommendations for substance abuse treatment.

At her last outpatient psychiatric appointment, Bianca insisted that her psychiatrist prescribe clonazepam for anxiety. Since she had no history of abusing benzodiazepines, it was decided that another trial was safe and reasonable. In addition, she was prescribed fluoxetine, gabapentin,

quetiapine, and lithium. The hope was that lithium would offer additional mood stabilization while decreasing impulsivity and the likelihood of another impulsive suicide attempt. However, one week later, she was again in the emergency room intoxicated on cocaine. She had had a fight with her cousin, who would no longer allow the patient to live with her. Bianca was left homeless.[1]

QUESTIONS TO THE CONSULTANTS

1. What is the potential role of undocumented immigration status as a psychosocial stressor?
2. How does ongoing substance abuse affect diagnosis and treatment of anxiety/mood symptoms?
3. Discuss strategies for managing pain medications in patients with opiate addiction.
4. How does one appropriately set limits with psychiatric patients who decline substance abuse treatment?
5. Suggest possible approaches for managing suicide risk in patients with substance abuse.

Ed Trejo, MD

Bianca is a 34-year-old, undocumented woman from Brazil who presents with a wide range of symptoms, including depression, anxiety, irritability, and substance abuse. She has a history of trauma and psychosocial stressors, including illegal status, separation from her son, homelessness, unemployment, and no health insurance coverage. The patient has many stressors in her life; at a minimum, these can influence or exacerbate her presenting symptoms. She moved to the United States ten years ago, leaving behind a stable job in the legal system and a 5-year-old son. Approximately three years ago, Bianca married George, an American citizen, with the goal of legalizing her immigrant status. However, her husband was physically and emotionally abusive. Even though she is no longer married, Bianca continues to be afraid and worries about "his possible retaliation."

Bianca's psychiatric history dates back only three years. Her first contact with outpatient psychiatric services was due to anxiety, depression, and irritability. After a suicide attempt by cutting her wrists, her first psychiatric hospitalization occurred this year. Her second hospitalization occurred only a week after discharge, the result of overdosing on IV heroin. While in the hospital during this second admission, Bianca made a serious suicide attempt by suffocation that required transfer to the ICU. She also became physically abusive and disruptive, and assaulted other patients. The patient carries many working differential diagnoses: mood disorder, agitated depression, generalized anxiety disorder, bipolar disorder, polysubstance abuse, and, possibly, substance-induced mood disorder. Medications tried in the past to help control Bianca's symptoms have yielded only marginal results, possibly due to her lack of compliance.

Bianca's substance abuse history includes tetrahydrocannabinol (THC), starting during her teenage years in Brazil. Her THC use is now more regular, with associated paranoia, and is combined with more frequent use of ethyl alcohol. She began abusing cocaine three years ago, and IV heroin this year. At times, Bianca has participated in substance abuse support programs in the community. Her family psychiatric history is remarkable for a father who died from complications of alcohol abuse. Bianca appears to be healthy overall, although she has "poor dental status" and complains of "general pain."

As an immigrant, Bianca has experienced many different stressors. By now, she most likely has gone through some or all of the known transitional stages experienced by immigrants and refugees. These stages of transition for immigrants and refugees, as described by Sluzki,[1] are as follows: impact/preparatory stage, migration stage, overcompensation stage, decompensation stage, and intergenerational and cultural-conflict stage. In the early "decompensation" stage, shortly after arriving in the new country, immigrants are faced with their new realities. Reacting to these challenges, immigrants may experience depression and anxiety.[2] In addition, as an immigrant, Bianca might have an understanding of health treatment different from our own system and beliefs. It is always helpful to explore these concepts with such patients in order to have a better individual understanding of their needs, goals, and expectations.

Leaving behind her country of origin and separating from her biological family and support network are important psychosocial stressors. Bianca specifically attributes her depression, shame, and guilt to separation from her 15-year-old son. Schen[3] describes how mothers can experience such separations as temporary or long lasting, and notes that symptoms vary, depending on the reasons and conditions that prompted the separation, the continuity of communication between mother and child, and the possibility for a future reunion. These symptoms of separation can include anxiety, depression, despair, and grief. Acknowledging, understanding, and supporting Bianca's uniquely personal struggle is crucial for the development of a working relationship with her treatment providers. If possible, the team should facilitate contact, communication, or visitation between Bianca and her son. Bianca can perhaps become more actively involved in her son's life, thus experiencing her role as a mother and validating her absence for the betterment of her family.

In general, immigrants are at greater risk of developing mental health problems.[4] Many factors, all present in

[1]Case history by Claudia Epelbaum, MD.

Bianca's life, have been identified as possibly etiological, such as the process of immigration itself, loss of social and professional status, and loss of social networks.[5–6] In particular, female immigrants experience separation from their families as the main factor associated with depressive symptoms.[7] In contrast, male immigrants primarily experience social marginalization. Bianca's undocumented status causes anxiety and interferes with her ability to find a job that will allow her to pay for basic health insurance coverage. Gwyn[8] and others[9,10] describe how barriers to diagnosis and treatment of depression can actually increase symptoms over time following immigration. It is therefore possible that the rate of psychiatric disorders in immigrants worsens as they spend more time in the United States. The prevalence of mental disorders in immigrants is similar to the prevalence of those individuals in their homelands, but perhaps for reasons such as new hardship, lack of seeking help for mental disorders, lack of health insurance coverage, and their legal status, among others, their cognitive and emotional well-being can be affected.[11]

These issues are relevant with Bianca as her symptoms of irritability predated her depression and anxiety, and then were followed by substance abuse and suicide attempts. Treatment providers must be sensitive to this possibility in immigrants and must continuously evaluate for the onset of new or worsened symptoms. Ideally, Bianca will engage in therapy with a clinician who is knowledgeable about Bianca's own culture and understands how it differs from her current milieu; an awareness of how these cultural differences might affect the therapy would facilitate the entire process.

Second, in addition to psychosocial stressors, Bianca has a family predisposition for substance abuse that increases her risk for drug addiction and relapse.[12] Specifically, her second psychiatric admission occurred after a heroin overdose. Bianca minimizes her substance abuse, however, and persistently "requested opiates for pain management," becoming disruptive and self-harmful when denied opiates. Pain management in a patient with a history of substance abuse is notoriously difficult. Distinguishing between drug-seeking behavior and the actual need for pain control presents a clinical challenge, as does assessing symptoms of mood lability, anxiety, and depression in patients under the influence of any substance since these symptoms can be the direct result of substance abuse. Polysubstance abuse can cause depression and increase the risk for suicidal ideation and suicide attempts.

Patients with mood and anxiety disorders often present with comorbid substance abuse.[13] Use of alcohol or illicit substances can trigger or exacerbate these symptoms. For example, Bianca describes an increase in her paranoid ideas while using THC. Cocaine is especially notorious for depleting the neurotransmitters dopamine, norepinephrine, and serotonin, thus "facilitating" depressive symptoms. One can reasonably assume that abstinence from these substances helps to improve mood symptoms. Davis[14] suggests a "limbic dyscontrol," with an association between the cocaine use and violent behavior. Kilpatrick[15] describes an association between violence and risk for major depression, posttraumatic stress disorder, and substance abuse. The abuse of substances can also interfere with psychotherapy and psychopharmacotherapy.

It is well-known that patients may use substances to mitigate or "treat" primary psychiatric symptoms. It is therefore important to remember that lack of diagnostic confirmation does not always rule out the absence of legitimate pain.[16] As noted above, it is difficult to evaluate the limits between drug-seeking behavior and the actual need for pain control. Particularly in cases where the patient is known to be a substance abuser, there is always a possibility that "real pain" is being undertreated.[17] Paradoxically, undertreated pain can provoke drug-seeking behavior.[16] To demonstrate, Gavan[2] describes how somatization can be expressed in immigrants as a manifestation of psychological problems. Thus, Bianca's complaint of pain might be not only an attempt to obtain opioid medication, as was suggested, but also a symptom associated with depression and anxiety. Regardless of the origin, Bianca's pain is a symptom that needs to be addressed.

Are Bianca's depressive and anxiety symptoms due to her polysubstance abuse or due to a mood disorder such as major depression? Or are these symptoms the result of a combination of all these factors? Addressing both issues simultaneously will be fundamental when designing her treatment plan. Substance abuse must be addressed at the same time we treat Bianca's mood and anxiety problems in conjunction with her psychosocial stressors. These issues are intricately interrelated and should be dealt with as a whole rather than as independent issues.

A multidisciplinary approach should be considered when designing the treatment plan. A formal pain consultation is always a good resource in such cases, especially for helping to understand the origins and nature of these complaints and consequently for guiding treatment needs. Pain management and addiction should be addressed concurrently by a team and not as separate issues.[18–20] The treating physician should clearly explain to the patient what kind of treatment will be used for pain management—which medications, along with the indications and reasons for this approach. A physician may monitor for medication misuse in different ways, such as drug screening tests and strict control of prescription dates. When a pain specialist manages this component, it is imperative that regular, clear, and effective communication be maintained among the various treating physicians. All members of the treatment team must be aware of progress, or lack thereof, and of any changes in the treatment plan. It is also important

to address other complicating medical issues such as dental care.

As part of a comprehensive treatment plan, Bianca must receive support in the community. This structure can be in the form of a partial hospitalization program, substance abuse treatment, Alcoholics Anonymous, or Narcotics Anonymous. A referral for group therapy should be considered. Sharing her experiences with a similar group of patients could prove beneficial, facilitating the development of much-needed coping mechanisms and day structure. For many, rehospitalization is reduced with residential treatment.[21] Helping to identify, and to facilitate the use of, services for legal advice and ways to address her immigration status would empower Bianca and help improve her independence and self-esteem. Understanding her separation from her son and family, along with supporting ways that Bianca can improve that relationship, is a fundamental part of Bianca's treatment plan.

Treatment for her depression, anxiety, and mood lability using Bianca's current medications is appropriate. Periodic monitoring of her symptoms is necessary in order to adjust or modify her medications, including the use of augmentation strategies. A clear discussion of the plan for medications, monitoring, and limit setting should take place between the treating psychiatrist and Bianca early in treatment. Close attention should also be paid, on an ongoing basis, to formal risk assessment, compliance with outpatient treatment therapy, and the potential for comorbid substance abuse[22] (in which context, monitoring for the use of benzodiazepines would be advisable). Other ways to help achieve treatment goals include the use of legal actions such as court-mandated outpatient/inpatient treatment. For Bianca, in particular, medication noncompliance and substance abuse increase her chances of hospitalizations and violent behavior, including suicide attempts.[21]

In conclusion, engaging Bianca in a treatment plan with a multidisciplinary approach is important. With as much cultural awareness as possible, Bianca's caregivers need to acknowledge, treat, and help resolve her many psychosocial stressors. Her mood and anxiety disorders, substance abuse issues, and any other medical needs must all be addressed. Most likely, Bianca's symptoms are all intrinsically related to each other and should be addressed as such by her treatment providers, including outpatient and inpatient teams.

Eulon Ross Taylor, MD

In such an exceedingly complicated case, my first impulse is to reconsider the entire history and formulation. The major areas to be addressed are how to get the patient engaged in treatment, what exactly is being treated, and what treatment might maximize results. This process will require a team effort to address several issues, and it will have to be coordinated by the treatment team leader. Engaging the patient in treatment will be difficult because of her illegal immigrant status. Bianca's situation is stressful in itself but is exacerbated by her immigration status; being an illegal immigrant prevents her from using many treatment modalities and programs ordinarily available to citizens and legal immigrants.

Studies of illegal immigrants have shown that they tend to be significantly younger than the legal population and are more likely to be male. Illegal immigrants tend to be relatively new to the United States and tend to live in immigrant communities. A study of Fuzhounese illegal immigrants showed that, compared to the general population, they had six times the risk of being hospitalized for psychiatric conditions. This rate was twice that of the Fuzhounese who were legal immigrants.[23] The illegal group also had more frequent rehospitalizations and utilized more walk-in and emergency services.[23] Illegal immigrants often do not avail themselves of treatment for fear of arrest and deportation, and tend to delay treatment and to underutilize services that are available.[23] A study by Perez-Rodriquez[24] noted that, compared to native populations, immigrants tended to complain more and suffered more from "neurosis and suicide attempts, and fewer psychoses, organic mental disorders, and affective disorders." Thus, Bianca is automatically in a high-risk group simply by virtue of her immigrant status—which may account for her lengthy periods of absence from treatment and her sporadic attention to treatment.

There are also specifically Brazilian cultural issues and attitudes toward illness and psychiatric conditions that need to be considered. Many South American cultures attach great stigma to mental illness. Attitudes about substance use also need to be explored in this population. The difficulties associated with her status may affect her willingness to keep appointments, and fear of deportation probably enters into her response to efforts to intervene and to help her deal with her anxiety and other symptoms.

Treatment team members will have to be able to reassure Bianca that their major concern is her well-being and that they are not part of the Immigration and Naturalization Service. It might also help to educate her that, if she is not in treatment, she runs the very real risk of arrest and deportation due to her drug use. The team should consider an aggressive community treatment plan that could include home visits; seeing her in her home may reduce her anxiety about her status. Some may object to the cost of such an intensive program, but it is much less expensive than hospitalization in an ICU or in a psychiatric inpatient program. Furthermore, it is the ethical stance to treat a human being who is in need of services that we can provide.

The next considerations in reformulating the case are two major issues that were identified but not fully explored:

the trauma in her past and complaints of chronic pain. If Bianca has been traumatized, a diagnosis of posttraumatic stress disorder must be considered. It is, of course, an anxiety disorder and could be the genesis of some of her psychiatric problems, particularly anxiety and drug abuse. If traumatic experiences are at the root of her problems, then the treatment plan will have to include treatment for that, too. Some obvious traumatic issues to be addressed include her upbringing in a dysfunctional household with an alcoholic father and the loss (via her own immigration) of her child.

Bianca's chronic pain complaints should be fully and appropriately explored—which would require a thorough, judicious medical workup. She should be referred to a pain specialist or internist for this evaluation. Her complaints must be taken seriously even though they may be a ploy to obtain narcotics. It is the physician's duty to make sure that such complaints have been evaluated and properly addressed. I often remind colleagues and students that, since I cannot feel a patient's pain, I cannot possibly know what a patient is thinking. I have to have some degree of trust that the patient is making his or her best effort to accurately report symptoms to me. It is my duty to rule out possible explanations for a problem first. If a physical problem is found, it should, of course, be addressed. If no obvious physical problem is found, then one is left with the high likelihood that this presentation is part of the narcotic-dependence problem, but I always caution practitioners to keep an open mind since a physical etiology of such chronic pain may become apparent as the underlying disease progresses.

Bianca's severe anxiety will also have to be addressed. It is likely her anxiety is due to her drug dependence. Nevertheless, she also has a history of trauma, and her anxiety seems to linger even in her brief periods of sobriety. Psychotherapeutic modalities should be employed, and psychopharmacologic intervention is warranted. It appears that she has been prescribed multiple medications. There are some algorithms for the treatment of anxiety and panic disorder, and her treatment should be reevaluated.[25–26] One eventually has to confront the prescribing of benzodiazepines to control her symptoms. Psychiatrists commonly loathe prescribing these medications in the face of ongoing alcohol and drug abuse. Alcohol and benzodiazepines do have a synergistic effect that can greatly increase sedation and lead to respiratory depression. This effect may lead to coma and possibly death. One study found little evidence of crossover addiction problems between alcohol and benzodiazepines;[27] the possible use of benzodiazepines will therefore have to be carefully considered in this case.

This brings us to the issue of her substance-dependence problems—which present yet another complicating factor that could account for many of the symptoms that she describes. One could argue that an accurate diagnosis cannot be made during active substance abuse because of these factors. I believe that if we wait to engage patients for psychiatric treatment until after their substance use stops, then we have guaranteed the "no treatment" option. Placing such conditions on treatment ensures that the patient will never be fully engaged. Depending on the severity of the various problems, treatment for the patient's substance abuse/dependence and psychiatric symptoms should take place simultaneously. As the patient responds, then the clinician will have to continuously reevaluate and adjust the treatment plan to fit the current situation. For example, if one is able to detoxify and help the patient maintain sobriety, some of the symptomatology, such as the severe anxiety, may lessen, and adjustments to therapy and medication can be made.

In Bianca's case, she should be in a drug-dependence treatment program. I also think that the use of methadone or buprenorphine should be considered. Use of these agents, which can be clinically controlled, removes one of the major barriers to engaging a patient in treatment; it eliminates discussions about opiates and pain control. These programs have the added benefit of having many safeguards in place to monitor drug use, and they also provide counseling to help maintain sobriety. It may be difficult to enroll Bianca in such a program, however, because of her immigration status. If she can be enrolled, strict limits should be set; monitoring should be at its most intense; consequences for nonadherence should be carefully enumerated and strictly enforced. The psychotherapeutic portion of the treatment program should include medication management of her psychiatric conditions. This part of the program should not be as stringently managed, however, since it would serve as the patient's safety net.

If Bianca refuses to participate or cannot enroll in such programming, many strategies can be tried, but any use of potentially addicting drugs must be carefully considered and even more carefully monitored. If I gave her such medication, it would be with the understanding that she would have to come for weekly prescriptions; if she used more than her weekly allotment, she would not get a refill early. It would be mandatory for her to discuss with me any breakthrough symptoms, and I would make dosage changes. Finally, she would have to promise not to doctor shop to obtain medication. As part of this program, I would require periodic urine tests. If possible, it would also help to get periodic levels of medication to monitor compliance and to see if medication levels are appropriate. I would make it clear to her, however, that her ability to continue to see me for treatment would not be affected by her continued alcohol or drug use.

Suicide is a very real possibility in Bianca's case. She is impulsive and, under the influence of drugs, may impulsively harm herself or even take her own life. The primary treating professional will have to monitor her for

factors that would indicate the possibility of developing suicidal ideation/intent. Suicide risk assessment should be periodically performed. Such an assessment should also be conducted when Bianca's routine or her clinical state changes. Bianca should be comfortable enough in her care that she feels free to bring up potentially self-destructive feelings—which is best accomplished by making such discussion a routine part of care.

I caution that treatment of her psychiatric condition should not be contingent on her success or even participation in a drug treatment program or her success at staying drug free. I believe that when one sets conditions on treatment, one has, in reality, chosen the "no treatment" option. Bianca is impulsive and has been suicidal. She needs to have at least one place that she knows that she can turn to and be accepted. Our ultimate obligation to patients is to accept them as they are and work with them.

Kenneth B. Dekleva, MD

Bianca's tragic story, including a descent into drug addiction and emotional despair, is not unfamiliar to psychiatrists who work with migrants—including illegal aliens—who fall through the cracks of the social welfare and medical care systems.[28] Bianca's psychiatrists, social workers, and psychotherapists have struggled to engage her in treatment for several years, utilizing a variety of psychotropic medications, psychotherapies, and social service interventions in a variety of inpatient and outpatient treatment settings. In spite of admirable efforts on the part of her caregivers, Bianca has repeatedly failed treatment, and one would surmise that something is dreadfully wrong—something is missing in this narrative of sorrow, loss, deprivation, and degradation.

To treat Bianca, one must understand her; to care for her, one must recapture what has been lost, so that she can slowly begin to regain her dignity and hope. Understanding begins with her story, and only then can healing follow. Her personal narrative is incomplete, and with it, Bianca's humanity, sense of self, and dignity. In this commentary I will touch upon issues related to her ongoing substance abuse in the context of comorbid mood and anxiety symptoms, and upon strategies for the management of pain—and her opiate-seeking behavior—in the context of her drug addiction. I will focus, however, on two key issues: (1) psychosocial stress generated by her undocumented immigration status and (2) countertransference issues with respect to her culture, immigration status, substance abuse, and suicidal behaviors.

Many migrants—whether their emigration was forced or necessary due to war, political instability, economic deprivation, disaster, terrorism, torture, criminal violence, or hopelessness—feel a nagging sense of guilt and loss. Psychoanalysts write of how migrants relive their most primitive dreams, hopes, and fears—of separation anxiety, grief, attachment, and loss—when the migrants depart their homeland.[29] The Ethiopian taxi driver in London, the Bosnian restaurateur in Germany, the Pakistani construction worker in Dubai, the Mexican dishwasher in Texas, the Haitian baggage handler in Miami, the Russian prostitute in Italy, and the Filipino domestic worker in Doha would instinctively understand each others' stories. They would be able to speak of Bianca's loss of her son, whom she left behind, seeking to build a better life in America; her journey would also be their journey and their tale of travels afar. They would nod their heads in appreciation of her pluck, her desperation, her shame, her fear of deportation, her bodily aches and pains, her humiliating physical appearance due to poor dentition (what immigrant does not desire the white-toothed beauty of a smile?), and the marital violence suffered by her in a forlorn attempt to obtain a coveted green card.

For migrants, there are many dreams. There are dreams of financial security, of freedom, of life's joys and sorrows, and—fittingly—of the sweetest (albeit unspoken) dream of all, that of reunion and return. The latter has a mythical quality, but that dream is familiar to every immigrant because it is laden with emotional resonance and fantasy. However, the dream of reunion and return is a conjurer's trick because the experiences of migration—and of adaptation—change one, both consciously and unconsciously. Bianca does not yet realize that were she to return to Brazil, both it and she—and those she left behind, including her son—have changed irrevocably. As Dr. Frederick Summers writes, helping her to understand that going home—"reverse culture shock"—is the hardest task of all, and it may be her helpers' most pressing challenge.[30]

Until Bianca's hopes, fears, sorrows, losses, and shame are understood in a deep, fundamental way, healing cannot occur. No evidence-based treatment or therapy will touch her soul, and she is likely to remain noncompliant with all such treatments. Healing must incorporate a narrative, a telling and many retellings of her story, in word, deed, song, prayer, and (therapeutic) touch. Bianca might also gently be asked a series of paradoxical questions: "How would you want your son to see you? What—if you could—would you wish to tell him? And what would he say if he saw you in this state? Surely no mother would desire that—and so, therefore, you must now begin to heal." Bianca needs to wed her fantasy with hope. Consequently, referrals to individual and group psychotherapy, eye-movement desensitization and reprocessing, faith-based programs, art/music therapy, prayer, meditation, mindfulness training, acupuncture, bodywork, Qigong, massage, and yoga may be of help to her.[31]

While the above-mentioned alternative, somatic, and mind-body approaches—as well as other "integrative"

approaches to Bianca's mental health care—lack the evidence base of many traditional psychiatric therapies, these approaches would have an appeal for this patient and may not only prove helpful, but also serve to establish a more productive and lasting therapeutic alliance. According to Perry's "neurosequential model of therapeutics,"[32] traumatized children—and traumatized adult patients such as Bianca—often operate at a primitive (e.g., brainstem-mediated) level of hypervigilance, anxiety, fear, and impulsivity, all of which are better addressed by patterned, repetitive, brainstem activities such as dance, tactile experience, music, and massage, which can allow for neurobiological reorganization and improved functionality. Perry cautions clinicians that "all the best cognitive-behavioral, insight-oriented, or even affect-based interventions will fail if the brainstem is poorly regulated."

Bianca warrants referral to a primary care physician to deal with her somatic complaints and possible medical illnesses—including sexually transmitted diseases, endocarditis, hepatitis, and HIV—from her IV drug abuse; ample data suggest that many patients with comorbid psychiatric illnesses and substance abuse are better served in a primary care clinic, which can decrease stigma. Dealing with Bianca's somatic complaints presents challenges because we also know from the work of Maltsberger[33] that body-self disturbances are commonly seen in suicidal states. In addition, referral to a dental clinic is in order, to address issues of dentition and cosmetic appearance. The latter referral will likely offer succor, as she is apt to see rapid results in terms of her self-image.

Bianca demonstrates an impressive array of comorbid psychiatric disorders, with a history and differential diagnosis suggestive of substance-induced mood disorder, posttraumatic stress disorder, borderline personality disorder, adult antisocial behavior, and substance-induced anxiety disorder. Although she has never been sober long enough to establish her diagnoses with certainty, the possibility exists that she may also have an underlying mood/anxiety disorder. She has had trials of numerous combinations of antidepressant, anti-anxiety (including benzodiazepines), antipsychotic, and mood-stabilizing medications—all to no avail. She has never truly connected with any of her physicians or therapists, and hence her ongoing substance abuse and noncompliance with psychiatric care are the sine qua non of her failed treatment. Without first addressing her substance abuse, Bianca's other psychiatric symptoms are likely to persist or worsen. Moreover, her combination of ongoing substance abuse, mood instability, anxiety, and impulsivity place her at extremely high risk of completed suicide.

The description of Bianca's medical care omits any mention of her possible interactions with the legal system; one would be hard-pressed to imagine a female IV drug addict who did not resort to criminality—for example, prostitution, theft, robbery, or drug dealing—to obtain money as a source for drugs. A referral to an immigration attorney is also needed; given her history of victimization and abuse, she may qualify for asylum in some jurisdictions. Concurrently, she might merit referral to a diversion program or a forensic substance-abuse treatment program (with mandatory drug testing) if available; the latter might include a methadone or buprenorphine program or a residential treatment program. Asylum would, in turn, open up other avenues of social support such as housing assistance, disability, Medicaid, welfare, educational loans, and job-creation assistance.

All of the clinical concerns in Bianca's care involve potential countertransference: her illegal immigration status, homelessness, *perceived* abandonment of her child, victimization, drug-seeking behavior, suicidality, impulsivity, drug abuse, and emotional instability. Psychiatrists who work closely with patients with borderline personality disorder may indeed feel a kinship with Bianca's clinicians; likewise, addictionologists and substance abuse counselors will be familiar with those aspects of Bianca's life. But without a cultural context, the above treatment efforts are doomed to be continuingly ineffective if other more subtle and nuanced countertransference issues are not considered. In this age of economic downturn, undocumented immigrants can generate ugly passions, hate, and disgust. It is easy for a clinician to perceive the care of undocumented immigrants as a misuse of precious medical and social resources. Migrants are acutely sensitive to perceiving that they are unwanted or unwelcome, and therefore they are quick to perceive slights and misunderstandings.

And then there is the issue of Bianca's attachment—or lack thereof—to her son, whom she has not seen in years. Clinicians may wonder (this particular wonder is in itself a countertransference issue), "How could a loving mother abandon her child? Where is the source of her maternal, protective, and empathic instincts?" In Bianca's mind, however, she has never abandoned her child, for he lives on in her memory. We remember those whom we love. Her loss is of physical presence, but she clings to the memory of her son and to the hope of eventual reunion. But her memory lacks that nameless "something"—*there is something missing*—and Bianca reveals a childlike innocence in clinging to such a memory. Her yearning is real and must be tempered by Bianca's qualities of faith, desire to serve others (in the health care field), and dignity. Bianca sees herself as damaged and unloved—or unlovable. Therefore, she clings desperately to a dream of reconnection to her long-lost son, and that must be recognized as her lodestone.

In the essay "The Poem as a Reservoir of Grief," Gallagher[34] writes of how poetry taps into such grief, by allowing "imaginative returns to the causes, the emblems of loss—returns which do often involve regret and longing toward a hoped-for embrace." Healing for Bianca must

eventually tap into those deep, profound emotions. In the article "Biblical Job," Andresen[35] writes of a sequence of events in Job's suffering, including deprivation, unknowing, and transformed awareness. For Bianca, like Job, restoration of what has been lost—a capacity for soothing, calm, and reverie, along with her sense of self—is crucial. To understand Bianca, one must hear her tale; to heal Bianca, one must walk with her, accompanying her on her journey.

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