A culture-bound syndrome is an array of aberrant behavior phenomena often recognized as illness by most participants of a particular culture. Although considered uncommon in the United States (US), various culture-bound syndromes have been reported in Hispanic populations. The population of Hispanic immigrants in the US is on the rise, and the presence of such syndromes should not be overlooked. Presently, published literature describing culture-bound syndromes, specifically Brujeria—the Spanish word for witchcraft—is very limited. The aim of this report is to provide a detailed description of a patient with Brujeria, including presentation and subsequent psychiatric and medical management.

**Case Description**

A 27-year-old Honduran woman with a medical history significant for chronic migraines presented to our Emergency Department (ED) with an intractable headache. The patient immigrated to the US 6 years prior and spoke little English. Through a Spanish-speaking, hospital-based interpreter, the patient reported severe (10, on a pain scale of 10), intermittent headaches, usually located in her bitemporal regions, that progressively worsened 4 days prior to ED presentation.

The headaches were uncontrolled by over-the-counter naproxen and caused photophobia, blurry vision, and pain around her right eye. The patient also complained of bilateral leg weakness with sharp, stabbing, and squeezing pain in both legs. She was admitted to the medical service and underwent a head CT (computed tomography), lumbar puncture with cerebrospinal fluid exam, syphilis screen, thyroid panel, comprehensive metabolic profile, complete blood count, urinalysis, urine drug screen, and urine pregnancy test—all of which were inconclusive of any acute medical problems.

Within a short time (1–2 days), the patient started displaying symptoms of depression and Psychiatry was consulted. The patient reported anhedonia, poor concentration, guilt, and low energy, which she attributed to financial constraints and unemployment. She also reported paranoia that her neighbors and friends from Honduras were talking about her. She denied any manic symptoms, any history of suicidal or homicidal ideations, and any alcohol or illicit substance abuse.

The patient’s boyfriend said that during her episodes at home she would hold onto the walls to walk, did not appear to know where she was, and would often talk to people who were not present and motion as if speaking to someone on the telephone. The patient acknowledged having visual hallucinations, specifically of a young child with a pale face lying next to her in bed.
At this point, one of the hospital interpreters disclosed an earlier event when the patient was visited by her spiritual advisor. According to the interpreter, shortly after the spiritual advisor’s visit, the patient began writhing and twisting as if being attacked or stabbed. The interpreter went on to explain how this reaction was consistent with Brujeria from their home culture. The patient admitted to feeling possessed during her advisor’s visit and later disclosed that her aunt practiced witchcraft and had persecuted others in a similar fashion.

Mental status examination revealed the patient to be in mild distress, but cooperative, alert, and oriented to person, place, and time. There were no fluctuations in consciousness, and no deficits were noted following the mini-mental state examination. Differential diagnosis included Brujeria, somatoform disorder, conversion disorder, major depression disorder, generalized anxiety disorder, and panic disorder.

Both patient and boyfriend believed in Brujeria as a culture-bound syndrome and associated her current symptoms with this syndrome. The patient elected prayer (led by the Psychiatric consultant team) and spiritual healing over medication management; no psychotropic medications were administered. Following the prayer, the patient’s headache and leg weakness improved significantly. The patient was discharged on hospital day 4 and encouraged to pray with her boyfriend, seek the help of their spiritual advisor, and follow-up with her primary care physician.

Discussion

Each human society has its own distinct body of beliefs. Brujeria is a specific type of witchcraft associated with Afro-Latin religious systems that frequently entails invocation of various spells and deities for either good or evil.3 It is believed that life problems and/or psychosomatic complaints may result from Brujeria. The practice of Brujeria (eg, rituals, spellwork, healing, etc.) is diverse and dependent on location and dominant religion. Published literature on the treatment of culture-bound syndromes is sparse, especially in the US. Reported treatments, however, include psychoanalysis, cognitive behavioral therapy, and incorporation of culture-specific treatments from values prevalent in the population (eg, shaman, priest, curandero, spiritual leader, family, etc.).4

In this case report, the value of the interpreter should not be underestimated. If available, hospital-based and/or professional interpreters should be utilized, as one of our interpreters provided valuable information regarding the symptoms that became manifest in the presence of the patient’s spiritual advisor, ultimately leading to the identification of the cultural association. Knowledge of the social context is central to diagnosing the syndrome. Without understanding contextual association, many similar presentations could go unrecognized. If a symptom cluster does not represent a normal response and testing is inconclusive, we recommend that clinicians consider asking patients if they have a preconceived notion of a cultural cause for their condition. The clinician should also assess if there are any language barriers in eliciting symptoms or understanding the patient’s expressions. If so, once again, we recommend use of an interpreter.

We do, however, recognize that our case was unique, as most professional interpreters do not have the training or expertise to conduct an assessment of complex psychological issues, nor should they be expected to assess the patient’s religious behavior. Most hospitals have the ability to consult staff chaplains; this group may prove helpful to the clinician and patient, as they typically have expertise and experience in working with diverse religious populations and persons presenting with various spiritual values and beliefs.

Another important aspect exposed in this case report was the need for open communication between the clinicians (psychiatry and medicine) and the patient. Once our patient believed Brujeria to be the cause of her illness and symptoms, specific conversations regarding her expectations and preferences for medications or therapy followed, ultimately ending in no medications being administered. Some patients may believe the psychological disorder to be somatically based and should be treated with medication, while others may view medication as too simplistic and prefer psychotherapy. The earlier the clinician can involve the patient in a treatment/management conversation so as to establish realistic expectations for rate of recovery, the better.

Conclusion

In conclusion, we present a case of patient suffering from Brujeria, a culture-bound syndrome considered uncommon in the US and rarely described in the literature. As the US immigrant population continues to grow, so does the need for clinicians to increase their cultural awareness of possible culture-bound syndromes.
References


