Considerations of *Esaurimento Nervoso*: A Cultural Model of "Nerves" for Italian-American Patients Suffering from Mental Illness

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Esaurimento nervoso (literally, nervous exhaustion)—along with the consequent condition *esaurito/a* (exhausted)—is a popular Italian expression, which encompasses most symptoms of mental illness. Despite its popularity, researching the topic of *esaurimento nervoso* has revealed to be quite challenging. *Esaurimento nervoso* falls into the larger category of *nerves*, a cross-cultural concept that embodies distress (Finkler 1989). While a great deal of literature exists on the cultural models of *nerves*, the peer-reviewed and scientific literature on the use of the expression *esaurimento nervoso* appears to be virtually nonexistent. Little agreement seems to exist on the nature of *esaurimento nervoso*, which is not listed as a mental health condition in the *Diagnostic and Statistic Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR).

This article provides a review of the literature, contextualizing *esaurimento nervoso* among many folk expressions that in different cultural contexts symbolize mental illness using nerve-related terminology. The discussion also describes the current situation in Italy, where an increasing number of mental health professionals is challenged in forming a therapeutic alliance with patients seeking help for *esaurimento nervoso*. Finally, using two clinical vignettes, the article provides suggestions for American mental health professionals faced with cultural challenges posed by Italian-American patients.

George Miller Beard was the first to write in English about nervous exhaustion in the article "Neurasthenia, or Nervous Exhaustion," which appeared in the *Boston Medical and Surgical Journal* in 1869 (Beard 1869). Beard described neurasthenia as the result of urban civilization, which, by means of inducing excessive stress, would cause the exhaustion of the nervous system's energy resources. Neurasthenia, according to Beard, would manifest as chronic fatigue and general symptoms of anxiety and nervousness. The diagnosis was popular in the early twentieth century. Then, as other classifications of mental illness, such as depression and anxiety, became more widely accepted, the diagnosis of neurasthenia was progressively abandoned in the United States.

While neurasthenia is no longer included as an official classification in the DSM-IV-TR, it still figures in the International Classification of Diseases,

ICD-10, as a neurosis. The ICD-10 distinguishes two types of neurasthenia. The first kind is a form of general fatigue following limited mental effort, associated with inefficient thinking, intrusive thoughts, and diminished daily performance. The second type manifests as physical exhaustion and body aches following minimal efforts. Both types of neurasthenia in the ICD-10 are accompanied by some degree of depression and anxiety, anhedonia, and reduced physical and mental well-being (World Health Organization 1992).

Essentially, as described in the ICD-10, both types of neurasthenia encompass a wide range of symptoms, making this diagnosis remarkably unspecific. In my view, a diagnosis of neurasthenia lacks clinical certainty to an unsettling degree. Depending on the general clinical picture and patient's psychiatric history, the symptoms listed in the ICD-10 as typical of neurasthenia could be just as validly argued as being manifestations of several other conditions, ranging from attentional disorders, to depression, and even to psychosis. Despite its vagueness, neurasthenia remains a popular diagnosis in some areas of the world, such as Asia, where mental illness is still not well accepted and corporeal manifestations seem to give the diagnosis a more physical, and therefore acceptable, connotation (Schwartz 2002).

In the DSM-IV-TR the term *neurasthenia* is used as a translation of the Chinese syndrome *shanjing shuairuo*. This condition manifests as mental fatigue, dizziness, headaches, pain, concentration difficulties, and various disturbances of the autonomic nervous system. A similar condition listed in the DSM-IV-TR is *nervios*, described as a manifestation of distress among Latinos, and known as *nevra* among Greeks in North America. The DSM-IV-TR stresses the wide range of meaning that *nervios* may encompass, ranging from psychical fatigue, to emotional distress, to symptoms as severe as dissociative and psychotic disorder (American Psychiatric Association 2000).

Neurasthenia, *nervios*, *nevra*, *shanjing shuairuo*, and *esaurimento nervoso* all can be considered part of the general model of *nerves*, a term widely studied as being associated with emotional and mental distress across cultures (Finkler 1989). The two most evident features of nerves are: (1) the wide range of possible symptoms, resulting in vagueness of the definitions, and (2) the correlation with disturbances of the nerves. The stigma of mental illness that is a shared element of Italian, Latino, Chinese, and Greek cultures helps explain why such vague and nerve-related syndromes remain so popular in those regions where they are preferred to more specifically identifiable mental conditions (e.g., Vezzoli et al. 2001; Schwartz 2002; Economou et al. 2009; Papadopoulos, Leavey, and Vincent 2002; Vega,

Rodriguez, and Ang 2010). While the vagueness of the term avoids naming a specific—and therefore stigmatized—mental condition, the medical nature of the symptoms (and origin of the word) make the model of *nerves* more acceptable and legitimate to the general public.

The cultural model of *nerves* is not unique to Italian, Greek, Latino, and Chinese cultures. In fact, several populations throughout the world, of diverse ethnicities and cultural backgrounds, have been found to adopt "nerve-related" terms to indicate emotional distress (e.g., Barlett and Low 1980; Davis 1984, 1989; Davis and Guarnaccia 1989; Salgado De Snyder et al. 2000; Dunk 1989; Finkler 1989; Jenkins 1988; Foss 2002; Guarnaccia and Rogler 1999; Low 1985; Traverso-Yepez and de Medeiros 2005; Van Schaik 1989). In their study of twenty-seven older primary care patients in the Baltimore area, Dahlberg et al. (2009) indicate how individuals in financial distress, African Americans, women, and patients suffering from evident depressive symptoms were especially inclined to refer to their affected nerves as a manifestation of external, uncontrollable, negative events. I concur with Low's (1985) and Dunk's (1989) argument that the widespread usage of the concept of *nerves* to describe emotional and social distress across cultures make nerves better defined as a "culturally interpreted" symptom, rather than as a "cultural-bound syndrome."

As to the specific connotation of *esaurimento nervoso* in the Italian cultural context, although official research on its use has not yet been conducted, unofficial sources provide an understanding of what meanings are attributed to this term. On the web, the references to *esaurimento nervoso* are abundant and quite diverse, indicating that the term continues to be widely used within the Italian cultural context.[1] Numerous discussion forums and online articles claim to provide detailed descriptions of this "condition" and offer suggestions and support for men and women (especially women) concerned with being *esaurito/a* (e.g., Turetta 2001; Cardos 2007; Reginadicuorix 2004). An entire website devoted to general mental health information uses the term *esaurimento* in its URL (www.esaurimento.it). Furthermore, *esaurimento nervoso* features a dedicated Facebook page, with 907 subscribers as of July 2011 (Esaurimento Nervoso ca. 2010).

The unofficial, online source Wikipedia (www.wikipedia.it) provides the following definition of *esaurimento nervoso*:

> È una espressione impropria, sorta nei primi anni sessanta, che stava ad indicare un insieme non ben definito e generico di situazioni patologiche o semi-patologiche psicologiche e neurologiche quali astenia fisica e/o mentale (nevrastenia), depressione, a volte cefalee, disturbi del sonno, dell'attenzione e dell'umore. (Wikipedia contributors 2011)

> Improper expression, first used in the early 1960s, which indicated a not-well identified and generic combination of psychological and neurological pathological or semipathological conditions such as mental and/or physical asthenia (neurasthenia), depression, at times headaches, sleep disturbances, mood disorders, and attention deficit. (my translation)

Thanks to its vagueness and broad meaning, *esaurimento* means everything and nothing at the same time. Each person can interpret the condition according to his or her liking. This avoids labeling the identified patient with a definite mental illness or psychological symptom, which is still often viewed negatively within Italian culture. Unfortunately, by means of the same vagueness, the term *esaurimento* also unifies all forms of mental illness into one, unknown, daunting entity. Meanwhile, by means of being identified as a nerve-related condition, *esaurimento* supposedly bypasses the stigma that is related to mental illness. As a condition of the nerves, and not of the mind, *esaurimento* acquires the status of a legitimate physical condition.

Sam Migliore (2001), in his account of illness narratives among Italian-Canadian immigrants, explains how folk terms such as *nerves* are commonly used to construct and deconstruct reality, to interpret and give meaning to experiences that are otherwise intangible. Migliore also argues that not all people within a given cultural group necessarily share the meaning of such terms. To the contrary, the expressions acquire different connotations, which reflect individual processes of construction and deconstruction of reality. Migliore explains that any attempt to generalize the meaning of terms such as *nerves* would be fruitless, because of the potentially infinite connotations they can acquire within the realm as physical and emotional distress.

In Italy, psychologists are increasingly becoming a significant presence, figuring within the public health-care system, in schools, and in private practice. Furthermore, the government is promoting campaigns for the prevention and early treatment of mental illness (Ministero della Salute 2006). As seeing a psychologist is becoming more widely accepted, especially in urban areas, Italian legislators are currently considering introducing primary care psychologists into the public health-care system. According to this bill, which has yet to become law, primary care psychologists would represent the mental health equivalent of primary care physicians (Camera dei Deputati 2010).

Despite the undeniable progress that has been made in Italy toward overcoming the stigma of mental illness, the mentally ill remain strongly stigmatized within Italian culture, particularly in rural regions and among older generations (Vezzoli et al. 2001). Within Italian society, it is not only the individual but also his or her family members who must bear the stigma

that is attached to mental illness. In the Italian cultural context, family relationships are often enmeshed. For example, it is not unusual for children to live at home long into their thirties and even into their forties. Furthermore, after marrying, children often live within close distance of their family of origin, which in many cases remains strongly involved in their daily lives. In many Italian families, when a couple has children, parents and grandparents alike share the responsibility for their upbringing.

Because of the close physical and emotional proximity of family members, for many Italians being labeled a mental illness sufferer is not only perceived as a malfunction of the person but as a fault extended to the family as a whole. Under this assumption, psychological and psychiatric symptoms become inevitably shameful, with shame being a magnifying lens of the patient's symptoms. As the patient perceives the self as causing shame to the family, a heavy portion of guilt is added to his or her baggage of symptoms. When I worked in two Italian medical and rehabilitation facilities as a psychology intern and as a psychometrician, I quickly discovered that the biggest obstacle to helping my patients was their fear of being deemed "crazy," simply because they had received a referral to visit the psychology department. As a result, it was not uncommon for patients to keep the psychology referral from their families, who were usually otherwise actively involved in their treatment.

It is not unusual for Italian parents and families in general to interfere with a patient's expressed intention to seek help from a mental health professional. For example, web visitor 28509 to the medical website www.medicitalia.it, a twenty-five-year-old male with a Master's Degree, reports that for six months he fought his parents' resistance to his decision to seek help for his symptoms of depression and anxiety before he actually pursued medical attention (Web user 28509, 2007). I personally know of a child who was not treated for what appeared to be an evident case of dyslexia because of his grandfather's resistance to the idea of treatment in 2006. Consequently, in consideration of the personal and family stigma that is associated with mental illness, when suffering from some kind of psychological and or psychiatric condition (i.e., *esaurimento nervoso*), it is easier for Italians to seek help from neurologists rather than from psychiatrists or psychologists. This reduces the perceived shame and makes the treatment more acceptable to the patients and their loved ones. In fact, the two physicians who reportedly diagnosed web visitor 28509 with *esaurimento nervoso* were neurologists (Web user 28509, 2007).

Therefore, *esaurimento* seems to be better explained as an especially successful folk term that—like many other similar expressions across the world—falls within the culturally interpreted category of *nerves* in

encompassing most conditions of mental illness and embodies the Italian culture's resistance to overcoming the stigma that is attached to mental illness. One striking phenomenon regarding the term *esaurimento nervoso* is that it is also confusingly adopted by professional sources. For example, the professional website www.ipsico.org, sponsored by the Istituto di Psicologia e Psicoterapia Comportamentale e Cognitiva, lists one entry titled "*esaurimento nervoso*," which provides a description of clinical depression, without including any clarification of the link between *esaurimento* and depression (IPSICO 2010). The website www.inpsico.it, also maintained by professional sources, equates *esaurimento* with neurasthenia (InPsico 2010). The above-mentioned web visitor 28509 is another alleged case of a patient with symptoms of depression and anxiety being diagnosed with *esaurimento nervoso* by physicians (Web user 28509, 2007). These examples lead to the assumption that some Italian mental health professionals may fuel the belief that *esaurimento nervoso* is an actual condition.

Following Migliore's (2001) discourse, instead of focusing on attaching a particular meaning to the term *esaurimento nervoso*, it is worth concentrating on understanding how people use the term within a particular context. Here, I focus on the use of the term *esaurimento nervoso* among mental health professionals. My intent is to foster understanding of how the improper use of this folk expression by professionals may negatively affect the stigma of mental illness in Italy and among Italian Americans. Meanwhile, I propose, through the use of clinical vignettes, that a thoughtful and culturally sensitive clinical use of the term *esaurimento nervoso* can potentially carry therapeutic value with Italian-American patients.

Why, if we take this information at face value, did the two neurologists diagnose web visitor 28509 with *esaurimento nervoso* and give him first an antianxiety and then an antidepressant prescription as a cure for it? This made him even more confused and frightened about his symptoms. Why did the two neurologists not refer 28509 to a psychiatrist or a psychologist instead (Web user 28509, 2007)? According to Migliore (2001), a similar situation appears to have taken place in North America. One of Migliore's accounts of Sicilian-Canadian immigrants' experiences conveys that health-care professionals in Canada often tell Sicilian immigrants that their problem is due to "nerves" (Migliore 2001, 117). These issues fall into the ample discourse presented by Dahlberg et al. (2009) about the bridging of psychiatric and anthropological approaches to the use of the term *nerves*. Reynolds and Swartz (1993) in their account of how medical practitioners in a South African village use the term *nerves* as a medium to discuss psychosocial issues with their patients, argue that different usages of the term among professionals reflect different approaches to patient care. Cultural

sensitivity is extremely important when dealing with any specific group. Davis (1984) provides an eloquent example of how a lack of cultural sensitivity can be detrimental to treatment. In his article Davis describes the case of a woman from a fishing village in Newfoundland who was discouraged from seeking further medical attention for her symptoms after her doctor misinterpreted her report of suffering from "nerves." This resulted in the patient missing a chance for treatment.

One way to understand this complex cultural matter is to adopt a pragmatic perspective. Explaining to a reluctant patient that he or she is, for example, affected by severe clinical depression—a mental illness that requires long-term therapy and pharmacological management with psychotropic drugs—may result in him or her being scared away from all mental health professionals. It is understandable that, in the face of a perspective that stigmatizes mental illness, some Italian professionals may choose the most practical way to get through to their patients. Attempting to engage a patient clueless to terms such as "depression," "anxiety," and "panic disorder" with time-consuming psycho-educational interventions may not necessarily be successful. This is especially true when shame and fear go against the development of trust. Therefore, telling an anxious or depressed patient that he or she is simply *esaurito/a* may be the most likely way to foster treatment compliance by means of increasing the patient's willingness to accept the "diagnosis." Nonetheless, this is obviously not the most ethically sound solution. Certainly, this approach neither fosters the patient's understanding of his or her condition nor contributes to reducing the Italian stigma against mental illness. To the contrary, it fuels it.

As with most complex cultural issues, helping Italian patients reduce their perceived stigma of mental illness requires patience and might not be conducive to immediate success, but it is nonetheless possible. Italian mental health professionals, as well as primary care physicians, could refrain from feeding into the stigma and spreading bias against mental illness by educating their patients and their families about the meaning of terms such as *depressione* (depression) or *disturbo da panico* (panic disorder). This would contribute to normalizing the experience of mental illness in the eyes of the public. Explaining to a patient that he or she suffers from depression, something that is sometimes referred to as *esaurimento nervoso*, is very different from telling the patient that he or she is *esaurito/a*. The diagnosis *esaurimento nervoso* should be explored as part of the treatment, and it should be one of the goals of therapy to progressively help the patient not be ashamed of mental illness or depression. It is first and foremost the responsibility of mental health professionals to set aside the mentality of *vivi e lascia vivere* (live and let live) and continue to fight against the stigma that still exists toward mental illness.

Mental health professionals in the United States, working with Italian-American patients, may face a slightly different situation than their Italian colleagues. Not all Italian-American patients speak Italian and not all of them are familiar with the term *esaurimento nervoso*. Nonetheless, some Italian-American patients that I treated as a psychology trainee in public psychiatric inpatient units in New York City used the term *nervous* to describe an array of mental health symptoms. Like *esaurimento nervoso*, the term *nervous* falls into the general category of *nerves*. It is linked to the nervous system and can be used vaguely to indicate different symptoms. As part of their cultural heritage, Italian-American patients may perceive mental illness as shameful for the individual and for the family, experiencing guilt with regard to their condition. This is eloquently described in Migliore's (2001) interviews with members of a Sicilian-Canadian community in which culturally bound terminology and beliefs remain a major component of people's understanding and expression of emotional distress.

To provide examples of how the clinician's culturally sensitive use of folk terms, such as *nervous*, can benefit the treatment of Italian-American patients, I wish to briefly describe the treatment of two adult patients whom I saw for a few individual sessions in an acute inpatient psychiatric unit, where I completed part of my doctoral training in clinical psychology.

Gaetano (clients' names have been changed) is a forty-one-year-old single male, born and raised in Queens. Gaetano's parents had emigrated from Italy prior to his birth. Two months before his hospitalization, Gaetano had moved into an apartment, where he lived alone. Prior to this move, Gaetano lived with his parents in Queens. For most of his adult life Gaetano worked in the maintenance department of a large company; his job required minimal interpersonal contact. Gaetano was shy and preferred to be alone or in the company of his parents. He had few friends, whom he saw on rare occasions.

At age forty-one, Gaetano was transferred to a different department within the same company, where his new responsibility required increased interaction with other people. Soon after moving out of his parents' house and starting the new job, Gaetano was hospitalized for the first time for demonstrating disorganized behavior (excessive scratching and confused speech) while at work. In his intake interview in the inpatient unit, he appeared extremely anxious. At times, his speech became a confused whisper, while at other times he repeated my questions under his breath before giving an answer. During this conversation, Gaetano kept repeating that lately he had been "nervous," although he was not able to explain why he felt nervous.

Gaetano and I met for three sessions during his brief stay in the inpatient unit. Over the course of these meetings Gaetano became more relaxed in my presence and no longer whispered his answers nor repeated my question under his breath. Together we explored the sources of his nervousness. With my guidance, he was able to identify that moving out of his parents' house at age forty-one, soon after accepting a new job that involved a higher degree of interpersonal contact, might have been a reasonable source of distress for a person who, like him, had lived an overall sheltered life. Together we developed a plan for him to temporarily move back with his parents, while he adjusted to his new job. Progressively, Gaetano would then go back to live independently. Finally, having developed initial trust with me during the course of our three encounters, Gaetano became less resistant to the idea of seeing a mental health professional. He agreed to see a psychologist for individual outpatient therapy after his discharge and to see a psychiatrist on a monthly basis for medication management. Gaetano concurred that the combination of therapy and medication would support him through the transitions that he was undergoing at this point in his life.

An important component of Gaetano's treatment consisted of involving his family. Gaetano's parents visited him twice a day for the length of his stay in the inpatient unit. For the success of Gaetano's aftercare, it was key to involve his parents and make sure that the whole family understood what had led to Gaetano's hospitalization and the significance of continuing treatment. It was important to address their questions and concerns with regard to the patient's symptoms, prognosis, and options for treatment. In order to be on board with his aftercare plan and agree to partake in it, it was especially important for Gaetano to perceive his parents' support and know that his condition was not shaming his family.

Assunta, a fifty-five-year-old Italian-American woman, also used the term *nervous* during her intake interview in the inpatient unit. Assunta had immigrated to the United States from southern Italy before marrying and had settled in Queens with her husband. The couple had a son and a daughter who were, respectively, twenty and seventeen years old at the time of Assunta's hospitalization. Assunta was hospitalized after expressing suicidal ideation while her sister, who was already concerned about the patient's recent bizarre statements and behavior, was visiting from Italy. During her intake interview in the inpatient unit, Assunta did not elaborate on her bizarre statements or behaviors, nor did she describe the feelings that had led her to becoming suicidal. She simply reported that she had been "nervous." She cried and kept asking if she "had not been punished enough." The allusion to her perceived shame was apparent; however, she would not elaborate any further on her feelings.

In the three sessions that I had with Assunta before she was discharged, and that she chose to conduct in Italian, similarly to other mental health professionals, I initially chose to use the term *esaurita*, with which Assunta was familiar. This helped Assunta relax and feel understood. Then I worked with her at comprehending what the source of her *esaurimento* might be. She hypothesized that her children's imminent move out of the family home, and consequent shift in her traditional role of mother, may be related to her recent nervousness. In addition, Assunta shared that her usual sense of guilt for not being close to her elderly mother, who lived in southern Italy, had been worsening as her parent was aging. During our last session, we worked on understanding what the diagnosis of depression that she had been given by her psychiatrist meant to her and what it meant in psychiatric terms. We talked about the stigma that she perceived and tried to build a bridge between depression and *esaurimento*. Upon discharge, Assunta expressed the desire to continue working with an outpatient therapist, as she "had a lot to talk about."

In summary, in agreement with Dahlberg et al. (2009), I argue that anthropological and psychiatric perceptions should be bridged in the interest of patients' well-being. Italian-American patients are no exception among other cultural groups: Their status of cultural difference is an integrative part of their identity. Regardless of the type of treatment that is to be endorsed—pharmacological, psychotherapeutic, or other—an important first step is to understand the patient's needs and how these are tied to his or her cultural background. If the patient is comfortable calling his or her symptoms *esaurimento nervoso*, or nervousness, this might be the place to start. However, it is equally important to then progressively guide the patient to a place of growth and understanding. This process will slowly allow the patient to develop a personal narrative and to construct meaning for his or her illness within the therapeutic discourse. An example of this type of culturally sensitive approach is described in Traverso-Yépez and De Medeiros's (2005) account of a Brazilian housewife suffering from nerves, who was given the opportunity to explore and understand her suffering over the course of twenty-two interviews. Eventually, the patient developed her own narrative and was able to elaborate on the circumstances that might be related to her nerves.

As with all culturally related matters, it is important for the clinician to set all assumptions and preconceived notions aside, instead approaching the treatment with curiosity and an open mind. A primary goal of the clinician should be to inquire and understand as much as possible about the patient's uniquely constructed meaning of illness. Some of the questions a clinician should ask himself or herself as part of the therapeutic process are:

What does this illness mean for this person? How does this illness affect this person's sense of identity? How can I help this person frame his or her illness in a way that is tolerable for him or her? Furthermore, in order to increase social acceptance of the mentally ill within Italian-American communities, it is key—once the therapeutic alliance has been developed—to also educate the patient's family. When the circumstances do not permit involving the family, the issue of family support should be explored with the patient, as this is likely to play a central role in the patient's degree of compliance to treatment.

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Notes

1. For example, an Italian rap group is named Esaurimento Nervoso (Esaurimento Nervoso 2007).

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