INSTITUTE OF CURRENT WORLD AFFAIRS

JLS-11 LOOKING FOR SANITY (4)

A Day at Bronx State

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Mr. Richard H. Nolte
Institute of Current World Affairs
535 Fifth Avenue
New York, New York 10017

Dear Mr. Nolte:

"If you take the Pelham Bay Park line on the Lexington Avenue IRT to Middletown Road in the Bronx, and walk for about ten minutes, over the Hutchinson River Parkway, you'll be at Bronx State Hospital," said Dr. E. Christian Beels on the telephone. I had wanted to get more of a feel for how diagnosis is made in a state mental hospital, how it is used and how it is discussed. And Chris, a friend of a friend, offered to let me sit in on a case conference concerning a newly-admitted patient. Bronx State Hospital is a 700-bed psychiatric facility at the heart of a community mental health network providing services to a borough of 1,500,000 people. It is, I have heard, a well-respected teaching hospital, at least in its more innovative programs.

Chris's office, on the second floor of the modern Rehabilitation Building, is small but pleasant--gray cinderblock walls, blond wood chairs upholstered in orange and blue. I arrived an hour before the conference to talk with Chris, who had brought us a fried chicken lunch from the hospital cafeteria.

Jeffrey Steingarten is an Institute Fellow interested in the relevance of psychoanalysis, psychiatry, and law.

He is a nice-looking man, maybe forty years old, with a well-trimmed, salt-and-pepper beard and glasses. He wore a brown corduroy jacket over a light green shirt with narrow white stripes, a black knit tie, corduroy slacks, and olive Wallabees.

I asked about the typical involuntary admission to the hospital.

"A man, say a vagrant, will be found raving in a parking lot somewhere, or on a street corner, and there is a particular quality to his raving which suggests to the experienced policeman that he's a psycho, not your ordinary drunk," Chris began. "The policeman takes him into a city hospital in his precinct, and the man has one diagnostic interview with a psychiatric resident. Then, if the city hospital is equipped to intervene in his life, which only one or two of them are, the staff may start calling around to family and relatives and so forth. But if it is just a token service, the psychiatric resident will fill out a 2-P.C., a two-physician certificate, using himself as one signatory and a Q.P. or qualified psychiatrist on duty at the hospital as the other, call an ambulance, and ship him over to Bronx State. We admit from Fordham, Jacobi, Misericordia, and Montefiore. There will be a second interview here with a psychiatrist who fills out the admitting psychiatrist statement.

"The entire process takes six or seven hours. Many admissions are therefore in the middle of the night, and what you get is an exhausted, dehydrated, febrile person who has been through some kind of horrible experience and is justifiably suspicious. So you sign the admitting papers--you really have no choice--you let him get some sleep and in the morning somebody goes up and sees him and asks, what's the story. And then, with plenty of time, the social worker begins to poke around, find his family.

"An essential question to be asked is, have you ever been in a state hospital before. If you have, it is presumptive evidence that you are likely to be in one again. This has a social conditioning end to it and a clinical end, people's expectations about the patient and the patient's expectations himself."

Chris said that he and a number of psychiatrists like him have essentially devoted their professional careers to working against that presumptive bias. On the Family Service where Chris works, a person with problems will usually be seen first by someone in the community who seeks to mobilize the family, check out the entire social network, relatives and employers, before judging that the person is so unmanageable as to require hospitalization.

"But one of the things we find is that even with all the efforts to keep people out, you still get people who are a lot better adjusted but who from time to time may need to return to the hospital."

I asked about the use of the standard diagnostic nomenclature in deciding what to do with a patient, whether voluntary or involuntary. Chris said that it was useful in only a minor sort of way, especially on the Family Service, and described a more pragmatic division of patients into three groups.

"There are the 'first breaks' who experience a one-time psychotic episode and use their stay in the hospital as an occasion to grow. There are the chronic schizophrenics, with whom constitutional or hereditary factors appear to play a part. And there are the remitting schizophrenics, who return to the hospital from time to time. You don't see the chronics again because they're still in the hospital, and you

don't see the first breaks again because they're first breaks. The patients who come to public attention are the remitting schizophrenics for whom diagnosis--and legal rights--are continuing questions.

"We see relatively few first breaks on the Family Service--either they have relatives and money for private psychiatrists or they're taken by the city hospital to use in analytic training. But occasionally, when Jacobi or Montefiore are full, and the residents have all the analytic cases they need for training, along comes an attractive, intelligent person with a florid psychotic reaction--rejection in love or failure at a job, that kind of thing starts it all off--and he is sent over here. We use a crisis intervention approach and work with the family and sometimes send the patient to a sheltered residence. It works extremely well to take the patient away for awhile to live in a safe place while someone works with the family.

"But the Family Service sees mainly remitting schizophrenics. The general set of most families and most patients on this Service is, well, my husband's been sick before, I think he'll probably be sick again, but he has for long periods generally been okay. So there's an expectation that hospitalization will be brief and avoided where possible. We maintain contact all the time with these people for an early warning of trouble.

"What you find is that when you really get to know the people, diagnosis becomes irrelevant--except for the major categories. It does make a big difference whether someone is manic or schizophrenic or depressed because these are handled differently. And whether a depression is labelled neurotic or psychotic also makes a big difference--we have to make that

decision in order to decide how much medicine we'll give him. That's a decision with consequences."

I asked him how these decisions are made. He said that there are kinds of diagnostic decisions that are made with considerable confidence, and there are kinds that are not, but are essentially irrelevant--they are made for administrative purposes, for State statistical forms.

"The standard approach is to take a history, and you abstract certain elements from the history--duration and severity of symptoms and course of illness. Which means that you have to have a number of years of experience with the patient before you know what the illness is, and it's often impossible to tell a first break, a brief psychotic episode, from the first hospitalization of a remitting schizophrenic. If you find that the patient has never had close friends, always been very shy, his family always worried about him, if his movement into his predicament has been a very gradual one, if his interests have dropped off very gradually--all these are bad signs. Delusions and hallucinations are pretty far along the line and make the diagnosis rather easy. But in the absence of those, if you see this process early, a person may not have fetched up his delusion yet. A hallucination or a delusion is, after the first go around, his answer to what's happening, like the world's coming to an end. But initially he's simply terrified and perplexed."

He paused for a long moment. "The main clue I would use would be the patient's difficulty in integrating the interview situation, his inability to be very clear about who I am, what kind of place this is, or generally, more social disorientation than I would expect from this person given what I know about his background and education. The way we do an interview is to try and make it as easy as possible for the

person to be oriented."

"And if you fail to accomplish this," I asked, "you take that as a clue about the patient?"

Chris said that it helps to have a member of the family there to see how their conversation works. We talked about the first part of The Divided Self where R.D. Laing reproduces an account by Emil Kraepelin of a man exhibiting 'catatonic excitement.' Laing shows that the patient's ostensibly irrelevant, incoherent responses were in fact his special way of parodying the doctor and commenting on the social situation he found himself in, Kraepelin's demonstration to a group of medical students.

Of course: psychiatric diagnosis is a social occasion. There are at least two people involved, the doctor and the patient, and what the doctor writes down about the patient depends on what the doctor is like and what he picks up about the patient, and this, in turn, depends on this patient himself and this patient as he is affected by this doctor, who in turn is responding to what he is picking up. Diagnosis as a social occasion: this, I told Chris, was one of the things I would be interested in eventually puzzling out. We began to go down the list of classical indicators of schizophrenia, and as we discussed them, it appeared that each depended in some measure on the immediate relationship between the interviewer and the patient. 'Flatness or inappropriateness of affect,' for example, is of no use as a clue unless the patient is willing to talk freely. And the patient's simple anxiety, entirely apart from some global psychotic disturbance, is fully capable of producing an unexpected reading of a familiar proverb--a test for 'peculiarity of categorization' or 'concreteness of thinking.' Delusional systems? Many of the Puerto Rican patients at Bronx State believe in a spirit world that a psychiatric resident

might call a delusion. Once you get to know a patient, some of the symptoms may fall away, since they were the product of a difficulty in dealing with strangers. "And then again," Chris said, "when you really get to know the patient, you may begin to grasp that there is a mysterious, private way he has of solving his problems, and that his perceptions of what the trouble is, are shared by no one who should ordinarily share them. And this is a delusional system."

Chris looked at his watch and announced that we were overdue for the case conference. He led me down some bright hallways and a flight of stairs, out the door of the Rehabilitation Building, across a parking lot, and into a large, multi-story yellow brick structure disquietingly suggestive of a mental hospital. The corridors were dimly lit and painted an intense aqua, and the doors between parts of the building, between offices and wards, and the doors to the outside and to some of the elevators could be opened only with the large passkey that Chris and other doctors and staff carried with them. He tried one elevator with his key, but the elevator was broken, so we walked through the halls again to another elevator bank. Of the many people we encountered, some were easy to identify as patients because they looked that way: one young man with pale bluish skin and weird eyes, inwardly smiling, shuffled back and forth, his arms crossed, hands gripping his shoulders. (He's been doing that for two years, Chris told me.) Another, standing with a friend, did a convincing, non-stop imitation of Johnny Mathis singing his '50's hit 'Small World:'

> Funny, you're a stranger who's come here,
> Come from another town.
> Funny, I'm a stranger myself here.
> Small world, isn't it.
> . . . . . .
> We have so much in common
> It's a phenomenon....

A third ambled down the hall, greeting doctors, nurses, social workers and orderlies alike with a wide grin, a generous wave

of the hand, and a loud "Hi, there, doctor."

It was also easy to identify some of the doctors, also because they looked that way. But too often I found myself making mistakes, thinking that the nicely dressed black woman near the elevators was a social worker or a volunteer of some sort (until I saw that she clutched a large clear plaster zipper bag filled with a dozen multi-colored bottles and tubes and was told she was a patient), and thinking that the white, middle-class-looking woman in her late twenties talking guardedly with the nicely dressed black woman and looking awfully anxious was a patient (until she extricated herself from the conversation and joined a nearby group of fellow social workers in lively discussion).

Chris led me to Ward 16, where the case conference was to take place. We entered a room, ten feet by fifteen feet, filled with an assortment of worn plastic and metal chairs. One entire wall of the room was a one-way mirror, and four microphones pointed down from the ceiling. Seven or eight staff members drifted in, and I was introduced to the two second-year psychiatric residents individually and to the others as a group. One of the residents, a young woman, Dr. L., presented basic information on the case, gleaned from the admission interview, a phone call to the family, and another hour or so observing the patient on the ward.

I will call him Jerry Berman. Twenty-seven years old, Jewish, middle-class. One sister (happily married), both parents living. Uneventful birth, cheerful and outgoing until age of 16. Always given 25 cents to go to sleep, now gets 400 mg. of thorazine. Acted in high school, tap danced, wanted to be a comedian. Started smoking tobacco at 13, grass at 16, pills, tried heroin at 18. Entered City College, broke up with his girlfriend, moved to California--to finish school (say his

parents) or to escape from drugs (says Jerry). Caught hepatitis, lived with a girl who nursed him back to health for three months. Returned to New York, avoided the draft, and felt guilty about it. Took LSD repeatedly despite recurrent bad trips. Swallowed $13 worth of hashish before attending Who's Afraid of Virginia Woolf? and during the performance began to feel he was dead. Utter panic. Parents took him to Mr. Sinai Hospital. Electro-convulsive therapy and discharge. Admitted to New York Hospital in White Plains, admitted to Spring Lake Ranch, admitted to Burlington, admitted twice to Hillside, each time because his parents felt they couldn't handle him alone. Anti-psychotic drugs, megavitamin treatment, private psychiatric treatment ("Jerry won't even talk to me, you ought to have him put away "). For the past few years has stayed at home with his father (who sells novelties) and his mother, sleeping, walking around in his pajamas. Says that he is dead or wants to die or is as good as dead. Says that he's never really connected up with anyone, says he's always hidden his sadness.

Two nights ago Jerry asked his mother for a bottle of sleeping pills to do himself in, threatened her with a knife when she ignored him, and stabbed her in the wrist when she tried to call the police. Mr. Berman subdued him and telephoned the police, and they all went down to Montefiore Hospital. Jerry was admitted on a 2-P.C. and immediately referred to Bronx State, where he signed the forms for voluntary admission.

After twenty minutes' discussion, all of us except Chris and Dr. L. moved to the adjoining room where behind the one-way mirror we watched as Mr. and Mrs. Berman were shown into the room and then Jerry himself. When they were told about the observers in the next room, they briefly glanced in our direction, Mrs. Berman with an ingratiating smile, Mr. Berman suspiciously. I had never had the remarkable experience of watching other people through a one-way mirror, and at first I was afraid that they could see me taking notes in the dim light.

Jerry was pale and overweight and wore a blue-gray plaid flannel shirt, dark brown corduroy bell-bottoms, and sandals, and his dark hair came down almost to his shoulders. He chainsmoked, eyes on the space in front of him or on the floor, breathing in shallow, quick breaths. I wondered what part was Jerry, and what part was thorazine.

Mrs. Berman, not unattractive in her early fifties, did most of the talking. She still wore a small white bandage on her left wrist where Jerry had stabbed her. Mr. Berman, bald, stolid, also in his fifties, wearing a light blue sports jacket, looked down and said little. Mrs. Berman said that Jerry is schizophrenic, at least that's what the doctors have said. He is full of guilt complexes, and they've got the best of him. He stabbed me, she said, to get to his father. Mr. Berman agreed, repeating what his wife said without elaborating.

Jerry said that something is wrong with his brain, something went 'click' once, and now everything is different. Now he is dead.

When Chris asked him whether he thought he was physically dead or metaphorically dead, Jerry replied that it was the same thing. Chris said that it was not the same thing. Jerry said he might as well be dead. Chris told him that if he thought he was actually dead, he might be schizophrenic, but that he was not. He was just very depressed. Jerry said he didn't understand the term 'schizophrenic,' pronouncing the word easily. After each of Jerry's answers, Mrs. Berman looked complicitously at Chris, as though to confirm an alliance between them.

From the dayroom down the hall came the sound of a patient banging out random chords on a piano and singing without words. And every so often the building's heating system would start up, sending an unnerving whine through the room. The

Bermans seemed not to notice the sounds or not to be troubled by them or by the patients' shuffling back and forth in the corridor outside. They seemed to me curiously comfortable in the hospital. Neither of them was angry at Jerry for stabbing Mrs. Berman, for dominating their lives with his illness. They seemed to me a family united in illness.

Chris asked Jerry about his stay at Spring Lake Ranch, his time in California. Jerry said it was okay, that's all. Mrs. Berman began to volunteer. Chris asked Jerry about an incident he had described to Dr. L. about communing with God. Jerry said he wouldn't understand. Can anyone understand? Chris asked. Nope. No one.

The hour was up. Jerry returned to his ward. Dr. L. showed the Bermans out. The rest of us left the observation room to join Chris and Dr. L. on their side of the mirror. No sooner had we settled in our chairs than Mrs. Berman reappeared at the door to speak with Chris. Would he be willing to take on Jerry's case in his private practice? Chris said he'd telephone her to discuss it and ushered her out the door. Family therapy, as practiced in the Family Service at Bronx State and elsewhere, tries to discover the ways that the illness of one member is maintained by the network of relations within a family. It looks at the structure, not at the content, of communications among family members, the way they habitually interact, to detect what it is that keeps one of them sick. Then it seeks to disrupt this pattern, I wondered if the Berman's lack of discomfort in the hospital, their lack of irritation with Jerry, and Mrs. Berman's collusive attitude toward Chris and her use of psychiatric terminology weren't clues.

Chris turned to the group of residents, interns and social workers. Is there any basis for a diagnosis of schizophrenia? Apathy, someone suggested. Chris pointed out that

Jerry was able to follow everything that had been said in his presence. Someone suggested that Jerry's belief in a private communion with God that no one else could understand might be a delusional system. Chris agreed, said it was hard to tell without further exploration, and that besides this possibility there was no evidence at all of schizophrenia.

He asked the group what could be done to assess Jerry's potential for getting better and how Jerry could be kept from becoming a professional patient. He stated his tentative theory of the case, that the Bermans provided Jerry with too many interesting experiences. Family therapy with the parents could be used to teach them to lead their own lives without the eternal focus on Jerry's illness. If Jerry were made to get bored with his apathy and withdrawal, he might begin to act up again, as he had briefly when he stabbed Mrs. Berman. Then he might respond to therapy. Repeated violence did not seem a likely prospect because the Bermans were basically a low-key family. Chris and Dr. L. agreed that Jerry would be released from Bronx State within a few days. The conference was over.

When Chris returned to the Rehabilitation Building for another appointment, I stayed behind to ask Dr. L. if I might see the hospital file on Jerry. We walked down some corridors, and she sat me down in a secretary's office, reappearing a few minutes later with the file. I was especially interested in the written justification for involuntary hospitalization given on Jerry's 2-P.C. from Montefiore, but this document was missing, transferred to another file when Jerry agreed to become a voluntary patient. I looked next at the diagnostic form filled out by the admitting resident, coincidentally also Dr. L., who had been on duty the night Jerry was transferred to Bronx State. There was a list of standard diagnostic categories, similar to the one I reproduced in JLS-9, and Dr. L. had circled

"Chronic Undifferentiated Schizophrenia." When I asked how she had chosen this diagnosis, she said she had simply used the diagnosis on the 2-P.C. from Montefiore, and I asked why. She thought a moment and asked whether she should have written instead "Diagnosis Deferred." I told her I didn't know what she should have done and asked what diagnosis she would record when Jerry was released a few days hence. "Personality disorder, passive-agressive personality, mostly passive--with a neurotic depression," was her reply.

Officially, of course, such a diagnosis is self-contradictory. The standard nomenclature does sometimes permit a psychiatrist to use more than one diagnostic category in classifying a patient, particularly in cases of alcoholism and drug addiction, where an underlying disorder will also be diagnosed. But the standard nomenclature is for the most part based on the notion of types or exclusive classes, not on qualities or characteristics--as Dr. L. was intuitively using it. A patient is not a little neurotic and a little psychotic, he is one or the other. The categories "neurosis" and "personality disorder" are also mutually exclusive. Within a week's time, Jerry Berman had been classified in all three of the major diagnostic divisions: psychosis, neurosis, and personality disorder. In Jerry's case, there were no legal consequences to this confusion because he would soon be let out. In other cases the distinction between psychosis and the other broad categories can be crucial to a judge's decision about whether or not to let a patient go.

I thanked Dr. L. and we shook hands, and she let me out of Ward 15. To find out a little more about the practical legal consequences of a diagnosis, I decided to pay a visit to the Mental Health Information Service before leaving the hospital. With an office in many of the public psychiatric hospitals in New York State, MHIS's mission is to protect the legal rights of mental patients, under supervision of the Appellate Division of

the State Supreme Court.

I walked to where I thought the elevators would be. In their place was a door marked 'Library,' which I entered. The room was empty except for the Librarian, a middle-aged woman who looked like a librarian and did not notice me until I had drawn to within two feet of her. She let out a little cry, said that I had scared her, and directed me to an elevator. Someone, presumably a patient, had written in magic marker a message on the elevator door:

> If you are a visitor read this!
> (It may save your life.)
>
> Turn back! You may have thought that
> this place is a hospital. YOU ARE
> WRONG! This institution and its cover
> story of being a place where people are
> helped is a complete lie. This "hospital" is
> actually the front office for a company that
> supplies fertilizer and animal feed to farmers.
> The source of this 'feed'? YOU!
> I kid you not! Run! You may yet make it.
> Good luck & God speed.
>
> A Morsel

Safely on the ground floor again, I got briefly lost in the aqua corridors (and not a little anxious, wandering unarmed in a mental hospital where patients went around disguised as social workers and vice versa), arriving at last at the Mental Health Information Service suite--two tiny rooms for four young attorneys, a secretary, and a thumbnail law library.

Three of the staff were in, and we talked awhile about psychiatric testimony in involuntary commitment cases. Thinking of Jerry's file, I asked how much weight a simple notation of diagnosis carried and was told that most judges will demand considerably more information than a conclusory label.

Most cases never get heard by a judge--either the lawyer persuades the hospital psychiatrist into letting the patient go or the patient's case is so hopeless that the lawyer

can persuade him to drop his petition. If the psychiatrist or the patient is adamant, there is a hearing, and it is usually the patient's word against the psychiatrist's, because a patient in a state hospital can rarely afford his own expert witness. The judge will either believe the hospital psychiatrist or sometimes appoint one of his own from a special panel.

One lawyer told me about an unusual case he had argued a few days before in the conference room down the hall that serves once a week as a courtroom , when the judge assigned to Bronx State holds hearings there. The client had previously been acquitted of some serious crimes in a verdict of not guilty by reason of insanity, and now was fighting the commitment action that must, by statute, follow a successful insanity defense. There were five psychiatrists on the stand before the hearing was over. Four of them offered diagnoses and all four were different. And the fifth refused to give a formal diagnosis but said it looked to him like 'secondary psychosis,' a category the printer must have left out of my copy of DSM-II. The judge reserved decision.

My mouth watered as I considered what meaty testimony that must have been, with five psychiatrists' disagreeing about a possibly dangerous man, and how instructive it would be to read their words and look for clues about what conventional diagnosis was actually about. I asked if I might read the transcript.

First of all, I was told, the record will not be transcribed from stenotype unless the client appeals--which he may not have to do--or unless I were willing to pay the $1.50 a page (often with larcenously wide margins) that a copy costs. And anyway, the judge or the patient's lawyer might object to an outsider's reading such intimate testimony arising

from the privileged communication of doctor and patient. I asked if I could attend a session of Supreme Court Term at Bronx State or another hospital. I was told that I would have to follow the prescribed procedure for admission to a hearing--write to the Administrative Judge, state my purpose, pledge to preserve the confidentiality of the participant's identity, and request permission to attend. Which is what I have done, and I await his reply.

Sincerely,

Jeffrey Steingarten

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