INSTITUTE OF CURRENT WORLD AFFAIRS

JLS-14 LOOKING FOR SANITY (7)

To 2-P.C. Or Not to 2-P.C.?
A Harmless Case of Pseudologia Phantastica

29 West 17th Street
New York, New York 10011
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Mr. Richard H. Nolte
Institute of Current World Affairs
535 Fifth Avenue
New York, New York 10017

Dear Mr. Nolte:

For three months now I've attended diagnostic case conferences at a variety of hospitals and with a variety of purposes: to follow a number of patients' cases from the hospital into the courtroom; to learn more about psychiatric diagnosis as a social occasion, including the ways that the likely legal consequences of a diagnosis can affect psychiatric conclusions; to find out how my review of the medical and statistical literature lightly summarized in JLS-9 might be refined by the experience of seeing psychiatric diagnosis performed.

The majority of these case conferences were held at St. Theresa's,[1] a large university teaching hospital of the

[1] By agreement with the psychiatrist in charge of inpatient services, I have changed the names of the hospital itself and of all patients and staff, and will show the senior psychiatrist conducting each case conference an advance draft of what I write about the hospital in this and future newsletters.

I've christened the hospital after St. Theresa of Avila (1515-1582), foundress of the Carmelite Order of Descalzos, who rescued several of her Sisters from burning at the hands of the Holy Inquisition by advancing the then novel proposition that the nuns were not possessed by the Devil, but were sick. St. Theresa may justly be considered the patron saint of our Therapeutic Society, where any species of deviance may be relabelled as illness.

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highest repute. Since it is a voluntary facility with some choice in the types of patients it will admit, the yearly number of court hearings that St. Theresa's initiates in order to retain patients against their will does not average more than six or ten a year, an insignificant number compared with public hospitals like Bellevue or Manhattan State. And in contrast with these public hospitals, the psychiatric service at St. Theresa's follows an unofficial policy of retaining involuntarily only those patients who are thought to be imminently suicidal or violent--and not, as the law also authorizes, patients who are thought to require a hospital stay for their own general welfare. It is difficult to estimate the number of patients, whether dangerous or suicidal or neither, who stay voluntarily at St. Theresa's on account of the likelihood of legal action. In only two of the conferences I attended at St. Theresa's was the possibility of legal action even raised. In this newsletter I report on one of them.

"Interesting case today, with possible legal consequences," Dr. Herbert Fine said as he greeted me at a nursing station of the psychiatric service. Dr. Fine is a psychiatrist and a psychoanalyst with a private office a few blocks away, and according to the doctor at St. Theresa's who introduced me to him, he is a superb clinician. Dr. Fine has a lively face with high color and wore a tweed jacket and slacks of warm browns and greens. As he led me to the conference room where the usual group of psychiatric residents, social workers, and nurses awaited him around a long table, he told me that one issue for resolution at the conference was "whether we should 2-P.C. the patient."[1] When the patient had eloped from St. Theresa's two weeks before, Dr. Fine said, the staff were prepared to have the police bring him back on the grounds that, by his own report, he was potentially

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[1] Readers of JLS-11 will recall that in New York State law a "2-P.C." is a "two-physician certificate" that authorizes a named patient to be held against his will at a psychiatric hospital. Though I had never before heard "2-P.C." used as an active verb, this appears to be a common usage.

dangerous to others. But the patient returned voluntarily, saying that he had assaulted four people on the outside and was afraid he would do it again. Now he believed he had improved sufficiently to be discharged, but the staff had their doubts.

Dr. C., a young woman who is a first-year psychiatric resident, presented the case. The patient, Mr. P., is a divorced cab driver of Greek descent, in his forties, who had come voluntarily to St. Theresa's eight weeks before, saying he was afraid he would hurt someone. He complained of homicidal fantasies concerning his mother and his fiancee, blackouts, confusion, incontinence, forgetting, over-sensitivity to noises and light, nightmares, and voices calling his name. He attributed his symptoms to an incident he claimed to have occurred a few weeks before when, mugged and robbed in Harlem, he was struck with a 2-by-4 on the left side of his head. Since then, he reported, he had been irritable and afraid of crowds, and after he hit a passenger in his cab in a dispute over the fare, he quit his job. He reported two previous hospitalizations, the first for physical reasons when he was stabbed in the back by a bayonet during the Korean War and the second for psychiatric reasons in a veterans' hospital immediately after he returned from Korea. P. described his mother as domineering, his father, a construction worker , as aloof, and his sister as a diagnosed schizophrenic from the age of fifteen. P. said that he sometimes lives at his mother's house, and sometimes in the subways.

Dr. C. said that the patient's mental status (as determined by his interpretation of proverbs, his ability to repeat series of numbers that were read to him and to count by 3's and 7's, his orientation to time, place, and person, and so forth) is generally all right, that he is warm and engaging, and that his symptoms have abated in the course of his hospital stay, with the help of medication. Dr. C.'s general impression, though, was that the patient's story does not hold together, that he often refuses to go into details about matters he had talked about moments

or days before. She cited several examples. And, she added, while P. insists that his symptoms started with the mugging, he sometimes concedes that they had been present for some time previously.

Dr. Fine noted that the patient's schizophrenic sister may indicate "heavy genetic loading," a hereditary tendency for the patient himself to become schizophrenic. Dr. Fine was also deeply skeptical about the details of P.'s story. He lies, Dr. Fine said, and this lets us see P.'s entire history in a new light. Symptoms like his, the inconsistencies and tendency to secrecy, do not occur as part of a sudden change in personality unless a patient is suffering from an organic psychosis, which the neurological exam tended to show he was not (although P. had refused to submit to a spinal tap). Consequently, P. may be an old schizophrenic and his hospitalization after the war may have been prompted not simply by what P. had called "shell shock and the usual problems adjusting," but by schizophrenia. P.'s recent symptoms seemed to Dr. Fine to have begun with P.'s affiancement to a Haitian woman of whom his mother obdurately disapproved. The mugging in Harlem, he pointed out, may never have occurred.

Dr. Fine asked the group if they thought P. were psychotic or not, or sometimes psychotic. There was general disagreement. P.'s secretiveness and the apparent inconsistencies and falsehoods in his story seemed to make a definitive diagnosis doubtful.

The group was also skeptical about the truth of P.'s story that he had assaulted four people when he eloped from the hospital two weeks before. The doctors and staff were faced with a dilemma: to 2-P.C. or not to 2-P.C.? If they believed P.'s tales about his own violence, they would feel bound to go to court to retain him at the hospital against his will. And while they were generally inclined not to believe him, could they safely ignore P.'s own account of his violent disposition?

Dr. Lewis, a senior psychiatrist in charge of inpatient care, suggested an alternative diagnosis to schizophrenia:[1] that P. is a sociopath, an antisocial personality lacking a sense of personal responsibility or capacity for guilt, with low tolerance for frustration and difficulty in forming ties of loyalty to persons or institutions. Additionally, Dr. Lewis suggested that this might be a case of pseudologia phantastica, in which an individual constructs a web of falsehoods and fantasies to make up for a reality that seems to him prosaic or onerous. Alternately boasting and secretive, the pseudologic character spins so many tall tales that in the end he may not himself be sure what the truth is.

Dr. C. left the room briefly and returned with P., who sat next to Dr. Fine at the head of the long table. P. was of slight build and medium height, wore a knit sports shirt and slacks, and had a friendly face. Dr. Fine, speaking at first with evident compassion, asked him some questions about his childhood. Failing to elicit any useful information, Fine then inquired into P.'s service in Korea, where he had fought and for how long. P. replied that he had been in combat for over two years. "An awfully long time," observed Dr. Fine. P. mentioned the towns of Taejon, Pusan, Kaesong, Panmunjon, Taegu, and Inchon. "You saw quite a bit of action," Dr. Fine said. To which P. modestly replied, "We all did our part."

Dr. Fine asked about the bayonet wound. "You were pretty lucky, a bayonet in the back can be fatal." P. said that the bayonet had entered from the side and only grazed him. Dr. Fine asked about P.'s previous psychiatric hospitalization. "Shell shock, just the usual kind of thing," was all P. would say. Dr. Lewis told P. that "shell shock" was an expression from World War I. When Dr. Fine asked if P. would object to having his VA records sent over to St. Theresa's to aid in his treatment, P. adamantly refused. He said he was getting better and did not want

[1] It was not clear whether Dr. Lewis intended his alternate diagnosis to preclude schizophrenia. DSM-II, the standard psychiatric nomenclature, appears to intend that the broad disease categories be mutually exclusive, but many psychiatrists use them differently.

"to cause complications." Dr. Fine protested, without prevailing.

So it went for ten or fifteen minutes, until Dr. Fine saw no use in persisting and excused P. from the room.

In the discussion that followed, the group offered their hunches. All thought that P. had been lying about practically everything. The two senior doctors, one of whom had himself served in Korea, suggested that the towns P. had listed were so well-known to those in the war that P. might well have seen no combat at all. Dr. C. noted that every question asked of P. in the interview seemed to make him suspicious, and she mentioned that when P. had been let out of the hospital on weekend passes, he had been secretive about where he had gone. Another resident suggested that P. may be trying to hide something, homosexuality perhaps. Others agreed that this was a possibility. A third resident thought that P.'s grandiosity, manipulativeness, and his desire to get people's attention are all signs of a serious personality disorder or even schizophrenia. Dr. Fine pointed out that on the basis of this interview alone P. does not appear to be suffering from a thought disorder, and that this would exclude schizophrenia; he added, however, that on the basis of P.'s history, his guardedness, childishness, and overvaluation of self schizophrenia should not be ruled out.

Dr. Lewis summed up. Apart from the legalities of the case, he said, there are five possibilities. First, P.'s lying may be a sign of a paranoid delusional system, and sodium amatol can be used as an interview technique to determine if this is true, so long as P. goes along with the idea, which he probably would not. Second, P. may have been using the hospital as a temporary hideout from the Mafia--or from the subways. Third, this may be a personality disorder marked by <u>pseudologia phantastica</u>. Fourth, P. may have an organic psychosis, but this is unlikely given the results of the neurological exam. And fifth, P. may be a Ph.D. candidate in psychology trying to trick the staff, as in the well-known Rosenhan experiment.[1] There was

[1]See JLS-4 and -5.

general merriment.

The group disagreed about whether to keep P. in the hospital against his will. Dr. Fine concluded that the only valid purpose in retaining him was to evaluate his dangerousness. Some details in P.'s story might be checked with his mother, who had not yet been closely questioned. But if P. had in fact assaulted four people when he eloped from the hospital, he must have a police record. If he had no record, the staff would probably decide to disbelieve P.'s story--and let him go. And if they could verify the story, then they would have to 2-P.C. him. On this contingency, the conference broke up.

A week later I was told that P. had been released. Although the police department refused to disclose whether P. had a record of assaults, P.'s mother had denied several elements of P.'s story, and the staff decided not to believe much of the rest.

In contrast to what I've typically observed at St. Theresa's, what had begun as a psychiatric diagnostic conference came to resemble a legal trial. Every question asked of P. was meant to test whether or not he was a liar. Dr. Fine may also have been probing to understand P.'s thought processes and to discover when and how P. became evasive, but this project was quickly lost in the excitement of the group's detective work as they carried out what they took to be their legal responsibility. P. was understandably suspicious, though for the wrong reasons: he was afraid that the staff would decide to hold him at St. Theresa's, but he probably did not realize that his <u>lack</u> of believability would mean he could have his way and leave the hospital. While Fine had skillfully masked his skepticism, P. undoubtedly sensed it. P.'s suspicion was treated not as a response to the threat of involuntarily retention, however, but as a symptom. As in other conferences I've attended, it seemed as if the staff saw P.'s wariness as an unwarranted sign of ingratitude.

As I pointed out in JLS-3, the psychiatric profession is pretty much in the dark about predicting the potential for violence

in individuals. One reason for this is that psychiatrists rarely discover how their predictions turn out: patients who are released are rarely followed up, and there is no way of knowing whether patients who are retained would otherwise have committed violence. But the law in New York and most other states asks psychiatrists to make such predictions, and psychiatrists, often reluctantly, perform this duty with their traditional tools. P. was a recalcitrant patient who would not allow himself even to be diagnosed. But the reasoning behind the staff's decision in his case nonetheless followed the logic of diagnosis.

Certain types of behavior observed in a patient are characterized as symptoms. Familiar collections of symptoms are thought to imply the existence of entities or disease types, which in turn are thought to imply a series of further facts or probabilities regarding the patient: how the disease operates, what the outcome is likely to be. In most areas of physical medicine, the reasoning works well enough, but in psychiatric medicine each link of the chain may come into question. In P.'s case, the suspicion, inconsistencies, and reticence were thought to imply the existence of a personality disorder, pseudologia phantastica, from which a host of probabilities about P. were inferred, including the belief that P. had lied about his past tendency to violence. The validity of this logical chain, from behavior to prediction, depends on the strength of its central link--the existence of a particular disease entity.

In psychiatric testimony in courts of law, the disease entity concept can play a central part in validating the psychiatrist's prediction about what a patient can be expected to do in the world outside the mental hospital. It will be useful, therefore, to continue in a future newsletter our exploration of the entity concept begun in JLS-9.

Jeffrey Steingarten

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