

Fantastical pseudology in forensic psychiatric exploration

Abstract

Psychiatrists are often requested for medical examination to assess children who may have been physically or sexually abused. An important clinical and forensic aspect in the evaluation of these children is the credibility of the children's testimony. In the reported case, fantastical pseudology is illustrated as a manifestation of infantile testimony, followed by discussion of its characteristics and the possible differential diagnosis

Keywords: sexual abuse, infantile testimony, fantastical pseudology

Volume 6 Issue 3 - 2018

María Teresa López Arteaga

Department of Psychiatry, Hospital Universitario de Guadalajara, Spain

Correspondence: María Teresa López Arteaga, Department of Psychiatry, Hospital Universitario de Guadalajara, C/ Donante de sangre S/N, 19002 Guadalajara, Carretera de Madrid, S/N, Talavera de la Reina, TO. 45.600, Spain, Tel +34 949 209 200, Fax +34 949 209 218, Email mteresala@sescam.jccm.es

Received: May 15, 2018 | **Published:** May 30, 2018

Introduction

Psychiatrists are often requested for medical examination to assess children who may have been physically or sexually abused. The purpose of the evaluation may be clinical, to determine if the child has an emotional disorder and the reason for this disorder; or forensic, to determine if the abuse occurred and who might be the abuser. An important clinical and forensic aspect in the evaluation of these children is due to the credibility of the children's testimony.¹ Fantastical pseudology goes by multiple different names including pathologic lying and mythomania.² According to Delbrück, the fantastical pseudology would be 'The urgent to pathological lying and exaggeration' and for Dupré, 'mythomania' is defined as 'Constitutional tendency to the alteration of truth, to fabrication, to lie and to the creation of imaginary fables', so both terms are used as synonyms.³ In the reported case, fantastical pseudology is illustrated as a manifestation of infantile testimony followed by discussion of its characteristics and the possible differential diagnosis.

Case report

A 15-year-old woman who was referred to the ER after claiming been sexually abused. Her guardianship is exercised by the State and she lives in a sheltered apartment in town, to which she has recently been transferred. She went to the ER accompanied by two monitors of the protected floor where she resides. She shares an apartment with four other adolescents and describe adaptation problems since their arrival. According to the information that we have on behalf of social services, the patient is an only child, her parents suffer from mental disorder due to the use of polysubstances and refused custody. She has not had medical history of interest, menarche at age 12 and denies toxic consumption. Since she was supervised by social services, she began monitoring for Mental Health since she presented impulsivity, aggressiveness, lack of assertiveness, affective fluctuations and behavioral alterations, even attacking the monitors of her home.

As the patient reported abuses, the Forensic Doctor decided to notify the psychiatrist on duty to provide more information about the patient's psychopathological status and because he suspects possible

lying in the testimony. The physical examination shows signs of abuse or physical/sexual aggression. When assessing the patient, she is calm, pretends to sleep and during the whole interview yawns, prevents the gaze, looks towards the floor or the ceiling avoiding the interviewer's gaze. She constantly repeats that she is sleepy and that she only wants to go home to sleep. When asked about what happened on that day, she explains that she does not remember anything, that she only knows that she had some cookies for breakfast. She does not describe a succession of events, but merely responds with monosyllables to the questions that are asked, presenting contradictory answers. Finally, she explains that she has allegedly suffered sexual abuse by an adult, about 50 years old, who she previously knew, but who she is not able to describe, and with whom she says she has left voluntarily, but says she doesn't remember where or for how long.

After the monitors testimony, the patient was aggressive since she woke up. She had a bandage due to a grade II sprain in the right forefoot, which she has suffered days before during an episode of agitation, when it started. Due to this, the monitors transferred her to his health center to check the lower limb lesion. During this trip, the patient suffered another agitation episode, she attacked the monitor and had to be restrained by the police. After leaving the health center, the patient was calm and cooperative, but on the way home, she escaped, disappearing for about two hours. The disappearance was reported to the police, who found her walking in a downtown street with an adequate appearance with no apparent signs of aggression. When she met the monitors again and asked where she had been she verbalized she had been sexually abused during the period that she was missing.

During the exploration of the patient about her current state and previous biographical experiences, the patient showed a puerile and regressive attitude, answering using a childish voice. She was emotionally indifferent towards her father, but changed her behavior when asked about her mother, whom she insulted and verbalized hating. She was not impressed by a greater affective aspects at that time, nor were sensory-perceptive alterations or psychotic semiology observed. Yes, the patient was impressed by primitive behavior, with poor impulse control, which cannot be related to personality traits,

due to age, but which may be influenced by the low educational level (she had not finished primary school) and the family breakdown and lack of care prior to his tutelage. However, the patient was pending measurement of intellectual coefficient by social services, after the behaviors observed in the supervised apartment. She did not present ideas of death or suicide during the exploration and there was no psychopathology that justified an admission in child psychiatry due to her behavior during the exploration. Finally, as a diagnosis in the emergency department, the patient was classified as behavioral alterations in a patient with partner/family dysfunction and, regarding the testimony, it was added that she was impressed by fantastical pseudology, which is not a diagnosis by itself.

Veracity it is not the role of the psychiatrist on duty to determine the patient testimony, but it does mean that our exploration contributes to completing the forensic examination, as a second expert. That is why, in this case, we not only pay attention to the clinical exploration of the minor, complex by itself, but we associate the methodology SVA (System of Analysis of the Validity of the statements) and Criterial-Based Content Analysis (CBCA). Criteria that made us suspect that it was fantastical pseudology consisted of: the lack of logical structure in the succession of events (“did not fit”); the elaboration was unstructured, not linear, there were spontaneous digressions and changes in focus; the details were given vaguely on trivial matters; there was no contextual gear, no description of interactions or replication of conversations. In addition, the patient had superfluous, inaccurate details, even angry and wanted to change the subject when asked for something specific, her answers were diffuse. Asked for motivation, the patient insisted that she did not want to be there, she only wanted to sleep, but showed no concern about the fact itself of the abuses, did not describe them or describe the supposed aggressor. Sometimes she answered that she did not remember, not only the hours of the disappearance, but everything that happened during the day, ignoring the fact that she had attacked the monitor, which is what worried her most.

Discussion

As previously mentioned, it is not the role of the emergency psychiatrist to determine the truth of a testimony of sexual abuse, but clinical examination can help to clarify doubts about forensic examination. This is one of those cases, in which the psychiatric exploration works as a “the second expert”. The System of Analysis of the Validity of the declarations (SVA) is a psychometric instrument, frequently used in Spain in the forensic field, which evaluates the credibility of the statements of the sexually abused minors by analyzing the content of their stories. In fact it is the technique most used in verbal statements. It is a support instrument and not a unique tool for children between 2 and 17 years old. The SVA Methodology, the CBCA-SVA test is a semi-standardized method for assessing the credibility and truthfulness of the statements. It is a specific development of the Statement of Reality Analysis, SRA (Analysis of the Reality of the Declaration) and is based on the so-called hypothesis of Undeutsch according to which: “the true stories of the victims of sexual abuse differ from the imagined stories or created.” The SVA is composed of three elements:

- a. The semi-structured interview with the victim.
- b. The analysis of the content of the interview according to certain criteria (CBCA).

- c. And finally, the integration of the CBCA and the criteria corresponding to the Validity List.

Once the three steps that make up the SVA are completed, the interviewer should catalog the statement as: credible, probably credible, indeterminate, probably incredible or incredible. It is a complex technique, not a psychometric one, it is actually a structured guide that analyzes information and lacks clear rules to reach the conclusions of a credible or not credible story. Since it is basically a method of interpretation, it is recommended that it be carried out by two experts independently, in order to reduce interpretative subjectivity. CBCA is the main component of the SVA. It is a highly structured evaluation system based on the assumption that there are certain characteristics of the testimony that can be evaluated objectively. Its purpose is to determine if the quality and the specific contents narrated are indicative of a narration generated from memory registers or if they are a product of invention, fantasy or the influence of another person. This phase is carried out on the transcription of the interview through the so-called Criteria of Reality of the CBCA (Criterial-Based Content Analysis). These criteria are 19 and are grouped into 5 areas in order to determine credibility. It is scored with 0 if not fulfills criteria or 1 if it fulfills some criterion established in the CBCA, so that 0 is the minimum score and 19 the maximum. It is worth mentioning that other authors rate 0, 1 and 2 according to whether it is not present, is present or strongly present. The greater the number of criteria, the more truthful will be given to the testimony, not waiting for the valid declaration to include all the criteria, since the absence does not necessarily indicate falsehood.⁴

Despite the advantages, that it is considered the most elaborate and valid procedure for assessing credibility and its acceptance in the legal field, it should not be forgotten that there are no valid techniques for detecting lies. So we agree that judicial decisions should not fall exclusively on the results provided by the CBCA-SVA. In addition, there is no structuring of the different forms of allegations of child abuse testimony. According to Bernet, according to the review of testimonies, several terms to be taken into account could be described and, in turn, after their standardized use by the interviewers (clinical/forensic), the reliability of their use would be improved.

- a. The claim is true. The child and the parent can be accurate and true. This is usually the case, maybe 90% of the time.
- b. Suggestion or misinterpretation of the parent. The parent may be anxious, fearful and histrionic. They could have picked up an innocent comment or a fragment of neutral behavior, turn it into something worse and inadvertently induced the child to endorse their interpretation.
- c. Misinterpretation of physical conditions. A parent who is vindictive or very anxious, or even a mental health professional who is misinformed may make a jump in the conclusion of some injury or illness of the child as being caused by sexual abuse rather than considering a more benign explanation.
- d. Delirium of the parent. In this case the parent is severely disturbed, a paranoid person.
- e. Parental programming. The parent makes the allegation and instructs the child in what to talk about.
- f. Interviewer’s suggestion. Previous interviews with the child may inadvertently contaminate the evidence by asking suggestive or tricky questions.

- g. Fantasy. The child can confuse fantasy with reality. This is more likely to happen with small children.
- h. Delirium. Although rare, delusions about sexual activities may occur in older children and adolescents in the context of psychosis.
- i. Misinterpretation. That can also occur from a false belief, but it is derived from something that occurred first.
- j. Bad communication. A false allegation of sexual abuse can arise from a verbal misunderstanding. The child may misunderstand adult conversations, the adult in turn may misinterpret what the child says or remove the child's speech from the context.
- k. Confabulation. This term was defined as "the act of replacing the loss of memory by fantasy or by a reality that is not true for the occasion". The concept of confabulation usually implies that the patient tells stories to answer questions about events in which the person does not remember.
- l. Fantastical Pseudology. Fantastical pseudology is called lying fantasy, pathological lie.
- m. Innocent lie. Young children, especially around 4-5 years old, often make false allegations when it seems to be the best way to deal with the situation in which they are involved.
- n. Deliberate lie. This item refers to intentional fabrications and for own use that are common among children and adolescents. Older children can fully understand the moral issues that involve an allegation of abuse but choose to dodge or distort the truth for revenge or personal gain.
- o. Hyperstimulation. Schetky and Green (1988) eloquently described how some parental practices, such as genital touch and nudity, can result in chronic sexual hyperstimulation.
- p. Group contagion. Parents and children may be victims of an epidemic of hysteria, where rumors spread and frightened people modify what they heard in a manner consistent with their emotional needs.
- q. Substitution of the figure of the aggressor. One of the puzzling aspects of this type of evaluation is that the child may have been sexually molested (and for that reason manifests symptoms consistent with abuse) but identifies the wrong person as an abuser (making a false claim).⁵

Fantastical Pseudology was first coined by the German physician, Anton Delbrueck, in 1891 to describe the phenomenology of a group of patients who said what was obviously extreme and fantastic with a clear departure from reality to the observer, the realm of possibility. Delbrueck described a case series of five such patients that could not be attributed to ordinary lying, false memory, or delusions. I have coined the term "pseudologia fantastica" to describe patients who tell complex stories such where delusions seemed to coexist with lies.² This author conceived pseudology as a "hybrid of lies and self-deception". The pseudolog has a high capacity for fantasy, hyperfantasy for Ziehen, but pathological liars try to impose their lie to get the esteem of others. For them Schneider includes the pseudologs, along with the hysterical, fantastic pure, vain, etc., among the psychopaths in need of estimation, characterized according to Koch by the desire to be noticed and shown to themselves and others as more than they are. Jaspers includes fantastical pseudology within the so-called hysterical characters that has classically been associated

with factitious disorder.^{2,5} But the truth is, the chronic pattern of the story telling in fantastical pseudology cannot be wholly accounted for by any single standard DSM 5 diagnosis and, in fact, in the context of multiple DSM 5 diagnoses.²

Since then, fantastical pseudology has undergone subsequent further study, and while there is no current gold- standard definition of this entity, subsequent reviews have identified key characteristics, including the following:

- i. Chronic lying/storytelling that is unrelated to or out of proportion to any clear objective benefit;
- ii. Qualitatively the stories are dramatic, detailed, complicated, colorful, and fantastic;
- iii. The stories typically feature the pseudologue as the hero or victim and seem geared to achieve acceptance, admiration, and sympathy;
- iv. In terms of insight, the pseudologue lies somewhere along a spectrum between conscious deceit and delusion, not always conscious of motives and seeming at least intermittently to believe the stories, yet never reach the level of conviction that would indicate a loss of reality-testing.²

Conclusion

In any case, the assessment of alleged sexual abuse is complex. Even more, so if it is the case of a minor. In these circumstances, the psychiatrist can help the forensics process to contextualize the testimony of the alleged victim, not to determine the veracity of the testimony and less in emergencies, but to be able to frame it within a possible psychopathology, if any. In the case of minors, in addition, the lie and the truth are not well defined and a testimony "not true" does not imply intentional intent nor explicit secondary gain. That is why, despite being a little documented entity, it is necessary to take into account fantastic pseudology in this type of case.

Acknowledgement

None.

Conflict of interest

Author declare that their is no conflict of interest.

References

1. Brockhausen T. False complaints and differential diagnosis of allegations of sexual abuse. *Psic Rev São Paulo*. 2010;19(2):263–288.
2. Thom R, Teslyar P, Friedman R. Pseudologia Fantastica in the Emergency Department: A Case Report and Review of the Literature. *Case Reports in Psychiatry*. 2017.
3. Janssens S, Morrens M, Sabbe BGC. Pseudologia fantastica: definiëring en situëring ten aanzien van as I- en as II-stoornissen. *Tijdschrift voor psychiatrie*. 2008;50(10):679–683.
4. Presentación JA, Medina JP, Soriano L, et al. System of Analysis of Validity of Declarations (Protocol SAV) in a case of sexual abuse among minors. Description of criteria and their application. *Gac int cienc Forense*. 2014:12.
5. Villagran MJM, Diez PA, Sanchez VV, et al. A case of pseudology. *RAEN*. 1990;10(35):1990.