

M. L. Catalina  
L. de Ugarte  
C. Moreno

# A case report. Factitious disorder with psychological symptoms. Is confrontation useful?

Psychiatry Department  
Hospital de Móstoles  
Madrid (Spain)

Factitious disorder is defined by the intentional production or feigning of physical or psychological symptoms with the objective of assuming the patient role. It is frequently difficult to adequately diagnose this disorder, above all, when the faked symptoms are those of a psychological or a psychiatric disorder. In these cases, there is often high comorbidity with other mental disorders, thus making it difficult to differentiate between real and factitious symptoms. Moreover, the lack of clear objective markers makes assessing the diagnosis even more difficult.

In this article, we have aimed to clarify how a correct diagnosis of factitious disorder with psychological symptoms can be reached, to observe the different therapeutic strategies described in the literature and to analyze the utility of each one of them in a given case report.

**Key words:**

Factitious disorder. Psychological symptoms. Diagnosis. Treatment.

*Actas Esp Psiquiatr* 2009;37(1):57-59

### Trastorno facticio con síntomas psicológicos. Diagnóstico y tratamiento. ¿Es útil la confrontación?

El trastorno facticio se caracteriza por la producción o invención intencional de síntomas físicos o psicológicos de una enfermedad con el objetivo de asumir el papel de enfermo. Es difícil realizar un diagnóstico adecuado de este trastorno, sobre todo cuando los síntomas simulados son los de una enfermedad psicológica o psiquiátrica. En estos casos suele existir una elevada comorbilidad con otros trastornos mentales, por lo que en ocasiones es complicado diferenciar cuáles de los síntomas son reales y cuáles son facticios. A esto se añade la inexistencia de pruebas objetivas que faciliten la tarea diagnóstica.

En este artículo se pretende esclarecer cómo llegar a un correcto diagnóstico del trastorno facticio con síntomas psicológicos, revisar los abordajes terapéuticos descritos en la literatura y analizar la utilidad de cada uno en un caso clínico seleccionado.

**Palabras clave:**

Trastorno facticio. Síntomas psicológicos. Diagnóstico. Tratamiento

## INTRODUCTION

Factitious disorder is characterized by the invention, production or falsification of physical or psychological symptoms that feign a physical or mental disease. Although the purpose of assuming the role of patient is conscious and the behaviors that lead to feigning the disease are voluntary and require some degree of planning, the reasons why one feels driven to do so are unconscious. In the medical literature, a series of characteristics common to the factitious disorders and that facilitate its diagnosis such as incongruence of the signs and symptoms with the syndrome, erratic course with improvement and worsening contingent to admission or perspective of discharge, incongruent response to the treatment and the appearance during admission of new somatic or psychiatric symptoms similar to those of other patients have been described.

There is not much experience existing on the treatment of factitious disorder with psychological symptoms. Since many of these patients have depressive symptoms, it is appropriate to try treatment with antidepressants. Antipsychotics have also been used with different objectives such as detaining the impulsivity and associated behavior disorders and, above all, treating brief reactive psychotic symptoms that may coexist with the factitious disorder<sup>1</sup>.

The utility of confrontation versus non-confrontation is debated in the factitious disorder with physical symptoms. This discussion is also applicable to the factitious disorder with psychological symptoms. Many authors consider that confrontation induces the patient to escape without treatment and may favor the appearance of psychotic symptoms

**Correspondence:**

María Luisa Catalina Zamora  
Servicio de Psiquiatría  
Hospital de Móstoles  
Río Júcar, s/n  
28935 Móstoles (Madrid) (Spain)  
E-mail: mlcatalina@eresmas.com

and suicidal behaviors. Up to now, most of the treatments performed in factitious disorders have avoided the need to confront the patient with his/her factitious behavior, performing psychoanalytic treatments and behavior interventions such as avoiding positive reinforcement of the disease behaviors and even negatively reinforcing them.

In this article, it is aimed to clarify how a correct diagnosis of the disorder can be reached through the presentation of a clinical case and to review the therapeutic approaches described in the literature.

## CLINICAL CASE

A 41 year old woman diagnosed of bipolar disorder (mixed or depressive phases with preponderance of irritability and tendency to withdrawal and mutism) and with background of numerous psychiatric admissions.

The patient came from a very destructured family. She had been physically abused by her father and was the victim of a rape attempt at 11 years of age. She had undergone several voluntary abortions. She has an 11-year old daughter from a 4-month relationship with a married man. She has attempted suicide many times since she was 20 years old, two of them having high lethality. During the 8 years following the first suicide attempt, she was admitted to psychiatry five times. She was diagnosed of reactive psychosis, histrionic personality disorder, depressive picture and finally bipolar disorder with atypical presentation.

The patient has laboratory assistant and clinical assistant studies. She worked as an assistant in a general hospital and psychiatric hospital for many years. She has been on permanent sick leave for the last year and a half, either due to psychiatric problems or multiple pains. She has also been hospitalized due to bronchospasm with respiratory insufficiency that was related with inhalation of chemical substances, which were not identified, and prolonged fever of unknown etiology.

Two years ago, her father died and the father of her daughter reappeared when she began to have frequent admissions to psychiatry (two or three yearly). All of them were with atypical symptoms, these varying from one moment to another, which were not explainable by any known syndrome. She suffered sudden affect changes, going from apathy, anhedonia and inhibition to total euthymia. These changes were related with environmental situations, such as desire to go on therapeutic permission. Catatoniform symptoms with absolute withdrawal, refusal to eat drink and to wash herself were associated. At times, she reported ideas of harm in relationship with the health care staff and auditory hallucinations in form of voices that criticized her. These symptoms did not cause her any anxiety and disappeared spontaneously. Other times, the patient had difficulty speaking and had body tremors and clumsiness when walking. These beha-

viors worsened when any observer was present and disappeared when the patient wanted to smoke. The patient became worse whenever faced with the perspective of discharge.

She took her medication irregularly, demanded certain treatments that she then refused to take. She asked for a detailed explanation about everything prescribed to her. During the admissions, she had numerous somatic complaints, continuing demanding the attention of other specialists.

This hospital admission was prolonged to four months since her treatment approach was complicated. At first, an attempt was made to work with the patient on her living experience. However, only partial and short-lasting improvements were observed. After, the patient was confronted-pointing out the voluntary nature of the symptoms to her, and obtaining the practical disappearance of them (catatoniform behaviors, psychotic symptoms, etc.). However, the exaggerated demands and frustration when they were not satisfied, as well as intense feelings of emptiness, persisted. All of this led us to diagnose the patient with borderline personality disorder and factitious disorder with psychological symptoms, ruling out the previous diagnoses.

## DISCUSSION

It has been observed that some of the characteristics described as indicators of suspicion of factitious disorder stood out in the last admissions in the above presented clinical case. These were symptoms such as the fact that she became worse when faced with the perspective of discharge, symptoms that were not congruent with the syndrome, incongruent response to treatment and request for more medication associated at the same time with her refusal to take it and appearance of new symptoms during the admission similar to those of other patients. It is also important that the patient had some knowledge about psychiatry, since she had been a clinical assistant for several years in the psychiatric hospitalization unit. On the contrary to that observed in other cases of factitious disorder, the patient remained withdrawn during most of her admission without establishing intense relationships with other patients or with the staff. In addition, no pseudologia fantastica was observed.

There is little experience on the treatment of factitious disorders. The use of confrontation in the cases of factitious disorder with physical symptoms has been greatly criticized, mainly because this had been done aggressively, causing the rejection of the patient to any type of psychiatric treatment. Non-punitive confrontation, in which the disorder is reformulated as a request for help, favors the adherence of the patient to a psychiatric treatment<sup>2-4</sup>.

Factitious disorder with psychological symptoms has been studied less and there are no data existing on the efficacy of the treatment. No cases that have used confrontation have been described have been described, possibly because there

are no objective tests to verify that the symptoms have been consciously and voluntarily invented by the patient. It is recommended to treat intensely the real underlying psychopathology, such as personality disorder or toxic abuse<sup>5</sup>.

Non-punitive confrontation may make it possible to treat the real underlying psychopathology and avoid the continuation of treating the false complaint or symptoms of the patient.

In the case described, both the pharmacological measures and the cognitive and behavior techniques failed. Clear improvement was observed after confrontation was performed in a non-punitive way and the factitious behavior was reinterpreted as a request for help and incapacity to face the serious life problems. After the factitious symptoms that prevented any type of therapeutic approach disappeared, the real symptoms of the patient that were those characteristic of a borderline personality disorder could be treated.

In the case described, we conclude with the suggestion that confrontation is a useful treatment if used non-aggressively and that it offers the patient an interpretation of his/her behavior (request for help, difficulty to face any

problem). If it is decided to use confrontation, it is advisable to give the same etiological explanation to the family and to involve them in the treatment. In any event, the treatment should focus on the underlying motivations for the factitious behavior and on the real symptoms, avoiding the reinforcement of the factitious symptoms.

#### REFERENCES

1. Eisendrath, Rand DS, Feldman MD. Management of factitious disorders. En: Feldman MD, Eisendrath SJ, editors. The spectrum of factitious disorders, 1.<sup>a</sup> ed. Washington: American psychiatric Press, 1999; p. 65-81.
2. Hollender MD, Hersh SR. Impossible consultation made possible. *Arch Gen Psychiatry* 1970;23:343-5. Nicholson S, Roberts G. Patients who need to tell stories. *Br J Hosp Med* 1994;51:546-9.
3. Hirsch M. The body as a transitional object. *Psychother Psychosom* 1994;62:78-81.
4. Plassman R. Inpatient and outpatient long-term psychotherapy of patients suffering from factitious disorders. *Psychother Psychosom* 1994;62:96-107.
5. Popli AP, Masand PS, Dewan MJ. Factitious disorders with psychological symptoms. *J Clin Psychiatry* 1992;53:315-8.