

Pseudologia Fantastica and Factitious Disorder: Review of the Literature and a Case Report

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Pseudologia fantastica is sparsely defined in the psychiatric literature, and has not been reviewed in the English-language psychiatric literature since 1988. To redefine the role of pseudologia fantastica in factitious

disorder, the case of a 56-year-old man with factitious disorder is discussed.

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THE DSM-IV DIAGNOSIS of factitious disorder with predominately physical signs and symptoms has been described by a variety of labels such as "peregrinating problem patients," "hospital hoboos," "hospital vagrants," "hospital addicts," and such subcategories as "haemorrhagica histrionica," "laperotomophilia migrans," "neurologica diabolica," "hyperpyrexia figmentatica," and "dermatitis autogenica."¹⁻³ The disorder was first described by Asher⁴ in 1951 as Munchausen's syndrome, named after the German Baron von Munchausen who wrote many travel and adventure stories in the 18th century. Asher's original definition of Munchausen's syndrome emphasized physical categories with neurologic, abdominal, or hemorrhagic presentations (Appendix).^{1,5,6} In 1965, Bursten⁷ described a triad of one or more physical/medical complaints, pseudologia fantastica, and wandering as the diagnostic criteria for Munchausen's syndrome.⁷

DESCRIPTIVE ISSUES

Patients may "feign" symptoms suggestive of a disorder that may involve any organ system.⁸ In Munchausen's syndrome, the events that occur in a patient's immediate environment are relevant and important to their interactions, and the patient tries to control the environment to his or her best advantage.⁶ Individuals with factitious disorder usually present their history with dramatic flair, but are extremely vague and inconsistent when questioned in greater detail. Once in the hospital, such patients are often demanding or difficult.^{3,6} They may require an inordinate amount of professional time, yet never seem to be satisfied.⁹ Patients with factitious disorder frequently break hospital rules to gain attention from the staff, and they often demand medication, surgery, and other interventions for "symptom relief."^{2,10} After an extensive workup of their initial concerns has proven negative, they often start to complain of other physical or psychological problems. There is usually a

conspicuous absence of visitors during the patient's hospitalization.^{2,5,6,9}

Associated clinical features include substance abuse and onset of the disorder in the early adult years.^{2,3,7,9,10} Often, a comorbid personality disorder is present.^{11,12} Typically, there is an inability to hold steady employment, and therefore a tendency for downward socioeconomic drift.⁹ Reliable family and social histories are often unattainable. Impostership may be observed, and many patients assume the identity of a well-known or famous person.^{3,7,13} Munchausen's syndrome is thought to be a chronic disorder.^{3,9}

DIAGNOSTIC ISSUES

The DSM-IV diagnostic criteria¹ for factitious disorder with combined psychological and physical signs and symptoms include the intentional production or feigning of physical or psychological signs or symptoms, and behavioral motivation to assume a sick role (Appendix). There is also a lack of external incentives for behavior, such as economic gain, avoidance of legal responsibility, or improvement of physical well-being. Although both psychological and physical signs and symptoms are present, neither predominate in the clinical presentation. The intentional production of physical or psychological signs or symptoms may include fabrication of subjective complaints, self-inflicted conditions, exaggeration or exacerbation of preexisting conditions, or any combination of these.

SOCIAL/NORMATIVE LYING

Pseudologia fantastica as a psychiatric symptom has not been adequately studied. The only modern

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review of this symptom was by King and Ford¹⁴ in 1988; before that article, the topic had not been reviewed in the English literature for over 50 years. It is important to distinguish between telling a lie as a “normal social skill” and pseudologia fantastica. Lies are distinguished on the basis of motive, malignancy, and degree of pathology. Motives for telling a lie may include (1) self-enhancement or glorification, (2) economic motives, (3) sexual motives, or (4) political motives. An extraneous factor that influences lying is the presence of an audience.

“Normative lying” or “being economic with the truth” may exist at an individual level, a group level, or a national level. For an individual, lying may occur at an interpersonal level, for example, in a relationship. This type of lying may depend on the level of intimacy one person has with another. Another example of lying at an individual level would be with a parent in relationship to a young child. Lying at a group or national level is also commonly observed, and “being economic with the truth” is a common expression used in contemporary political disclosure.

PATHOLOGICAL LYING (PSEUDOLOGIA FANTASTICA)

Lying as a pathological process has been defined as disproportionate to practical gain, often extensive or complicated, and manifested over several years or even a lifetime. This type of lying includes people who lie for the sake of lying and take pleasure in this process. Pseudologia fantastica has been described as a way to act out fantasy. Questions are answered with fluency, and the story appears to be believed by the pseudologic himself.¹⁵

In pseudologia fantastica, limited factual material is mixed with extensive and colorful fantasies. Dupre described the following three essential criteria for pseudologia fantastica: (1) the story must be probable and keep a certain reference to reality, (2) the imaginary adventures must manifest in multiple circumstances and in a durable manner, and (3) the themes of these “adventures” are varied but the hero or victim is almost always the subject. The stories are not used for personal profit, and a proper distinction is not made between fiction and reality. The distortion of truth is not limited to the history or illness symptoms, and patients often give false and conflicting accounts about other areas of their lives.¹⁴ These patients may present with (false)

important academic or political ties.⁶ They tell stories of falsely elaborate systems and histories that intrigue the medical listener, thus reinforcing the symptom.^{7,14} They may claim colorful occupational histories such as deep-sea diver, fighter pilot, and professional athlete.^{7,13} Men may report being war heroes.³

There is no information available on the epidemiology of this psychiatric symptom. Most of the information is from anecdotal case reports. The prevalence of this symptom in the general population is not known. The purpose of this report is to describe a case of factitious disorder with combined psychological and physical signs and symptoms. In addition, aspects of pseudologia fantastica, an important feature of this case presentation, will be discussed.

CASE REPORT

Presentation

A 56-year-old divorced man was admitted to an inpatient psychiatric unit after threatening to “drink himself to death.” He initially presented to the hospital emergency department, claiming that his outpatient psychiatrist informed him he would be hospitalized upon arrival. His initial complaint was severe back pain, and he was informed that radiological studies would be required to determine the necessity of admission. The patient was evaluated and subsequently refused hospitalization for his “severe backache” from the emergency department. Claiming that he had suicidal thoughts, the patient went to a nearby cemetery, where he reportedly drank two six-packs of beer and planned to take a “bottle of Valium.” He was found by police and once again brought to the emergency department.

On psychiatric evaluation, the patient feigned sleep. When aroused, he was verbally abusive and threatening and would give only his name, service rank, and serial number. Later, the patient claimed that his daughter had brought him from his home approximately 100 miles away and left him in the hospital with his medications. The patient commented that he had symptoms of posttraumatic stress disorder (PTSD), mainly nightmares and flashbacks from Vietnam, and that these symptoms had worsened due to the events of the day. The patient also claimed that his daughter was “traumatized” by the way her father (the patient) was treated in the emergency department.

Psychiatric History

A historical review of the patient’s records revealed multiple psychiatric and medical hospitalizations. Past psychiatric diagnoses included PTSD, anxiety disorder, somatization disorder, hypochondriasis, alcohol abuse, and personality disorder with passive-aggressive, paranoid, and narcissistic traits. He additionally gave a history of marijuana use beginning in the late 1960s, consisting of two to three joints daily. He admitted to using cannabis currently, and claimed that it relaxed him and alleviated his pain. He has a long history of stammering, but has been observed to talk without stammering. His stammering tended to worsen when he was being observed. The patient also has a history of several suicide attempts. In 1977, he was committed

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