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A Look at Factitious Disorder with Respect to Lost-Object Identification in response to "Epistaxis: An Unusual Presentation of Factitious Disorder"

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See the letter "An Unusual Presentation of Factitious Disorder".

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Dear Editor,

In the most lately published case report, titled "Epistaxis: An unusual presentation of factitious disorder", co-authored by Hadinezhad and Nasouhi (1), a practical, informational description of a single woman aged 42 years, definitively diagnosed with a factitious disorder (FD) and correspondingly undergoing treatments, was provided, in which no recurrence of this mental disorder had been detected on the trail of the one-year follow-up. Upon diagnosing a pathological grief reaction in this female case, pharmacotherapy together with supportive psychotherapy had been primarily practiced. The psychotherapy outcomes then revealed that the case had put a pin in her nose to fabricate the symptoms, demanding hospital care and medical aid. Accordingly, the treatments were maintained after FD diagnosis.

In regard to the related literature, the incidence rate of FD has yet remained unaccounted for a wide variety of reasons, including deception; however, it has been higher, as portrayed in the case reports of single women in their 30s, who have typically completed healthcare training courses or have been engaged in careers in the medical field (2-4). Assuming the vague etiology of FD, multiple causes have been taken into consideration to interpret various behaviors all through this mental condition. Generally, it has been supposed that the motivations underlying such behaviors are not conscious. Additionally, two key drivers have been mentioned to influence most cases with FD, namely (1) being oriented to healthcare systems and (2) having poor, maladaptive coping skills (2).

In the case report presented herein, a host of issues, including the female gender, being single, inconsistency between the disease symptoms and conventional medical complaints, no reaction to routine medical treatments, absence of companions, caregivers, or visitors, need for numerous laboratory tests, normal examination results, and insistence on the second-time hospital stay for supplementary diagnostic tests, even with the reassurance by the internal medicine physician regarding no physical problems, combined with her initial reluctance to submit oneself to psychiatric diagnostic evaluations, were along the lines of the psychiatric literature on FD (2-5).

In the early days, this case had pled ignorance about the main reasons behind her sudden nose bleeding (viz., epistaxis); however, the psychotherapy outcomes had revealed that she had put a pin in her nose, as a form of deception, to provide the core condition for FD diagnosis (2, 6). As reported in the existing literature, some questions needed to be addressed about this patient, who was not among the medical staff (e.g., "What family type was she born in?" and "Did she grow up in a very large family?"). In addition, the patient disagreed with being laid up with suicidal thoughts or suicide attempts. Throughout the physical examinations, the limbs also showed no symptoms of self-harm; therefore, the question raised here was: "Did she have any symptoms of self-harm on other parts of the body?". Furthermore, no mood conditions or personality disorders were spotted in this report; nevertheless, previous research showed the high prevalence rates of comorbid personality disorders and FD by 16.5 - 43.1% (2, 3, 7). Likewise, the next question

was: "How were her relationships with other family members and society?". Considering the history of positive reinforcement upon getting sick in childhood in some patients, as affirmed in behavioral theories (2), some questions needed to be answered (e.g., "Was appearing sick the best strategy to win much attention from her family?", "What were her coping skills?", "How did she deal with the grief caused by her father's death immediately after it?", "How was her job and social performance?", and "How did she respond to various diagnostic procedures?").

From one angle, the patient's consent to undergo loads of tests and examinations, in addition to her claim for more stay in the hospital for supplementary diagnostic tests, might have pointed to her request to do so; however, "What was the main reason for her discharge upon personal consent during the first-time hospitalization?". This question was accordingly brought up since patients living with FD are abnormally zealous to endure invasive medical procedures and operations, and the majority act in response to a planned discharge by making their symptoms worsen (2).

As declared in this report, the patient was not attended to by her mother as a companion, a caregiver, or even a visitor in the course of her hospitalization. In spite of this, her mother, providing more psychiatric background, cooperated at the same time, only once invited. Herein, one more question was raised, "Has the patient resisted the presence of another informant?". Additionally, among the main questions open to doubt regarding the patient's history were "How was the course of the fever?", "How was it validated?", "Did the patient induce the fever?", and In which manner?". Of note, many types of FD occur in the 20s and 30s (5) and improve in the 40s (2). Nevertheless, the case reported herein was subjected to the first episode of this mental condition at the age of 42 years.

At some stage in the first psychiatric interview, the patient unveiled that even though she had not shared a strong emotional connection with her father, she was still mourning him. Experiencing loss has been to date introduced as one part of FD etiology (2), which was apparent in this patient; however, the precondition for the diagnosis of this mental disorder based on the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5) failed to better describe the symptoms with regard to other disorders (2, 6, 8). Meeting the criteria for a pathological grief reaction (6, 9, 10) in the company of the symptoms presented by this case, such as carrying her father's denture with herself and talking about it and crying as an emotional reaction while describing her father, who had unfortunately and suddenly lost one's life in an accident 2 years ago, one more question needed to be addressed, namely "Does the patient wrestle with a pathological grief reaction alone or comorbid pathological grief reaction and FD?", as the main complaints filed about recurrent physical symptoms, more referrals to healthcare facilities, insufficient self-care, and high-risk behaviors are among the characteristics of patients living with a prolonged pathological grief reaction (6, 11). In addition, the question within psychoanalytic theories concerning a pathological grief reaction was raised, "Is a pathological grief reaction the main problem?".

With reference to psychoanalytic theories, Freud (1917) has described proper mourning as an intrapsychic process whose main function is withdrawing libido from a lost object (i.e., decathexis) and then cutting bonds with this object to feel psychologically balanced and reconstruct one's pre-morbidity (12). Based on Freud , lost-object identification can be the single prerequisite for the most primitive part of the human mind, the id, to cast aside its objects (12, 13). As reiterated by Freud, mourning can further turn into a pathological grief reaction if relationships with a lost object are emotionally ambivalent. Accordingly, someone might perceive a lost object as something that harms their ego. Furthermore, Freud has asserted that the precondition for this type of skewed personality development is a sense of frustration at the earliest stage of life (14).

In this context, Freud defines melancholia as an emotional reaction to the death of loved ones, in which someone knows about the loss but fails to consciously perceive it. Melancholia is somehow associated with a lost object that is out of consciousness (15). In the course of melancholia, the conflict provoked by ambivalence confounds the relationship with the object. Therefore, endless internal conflicts typically occur between hate and love that fight over the same thing in a person's unconscious during melancholia, one seeking to detach the libido from an object and the other planning to hold onto the libido in this posture regardless of being attacked (15). When love for an object, love that cannot be given up even if the object itself is given up, takes refuge in narcissistic identification, hatred begins to take hold of that substitutive object, denouncing it, humiliating it, making it suffer, and taking sadistic pleasure from its pain. Self-inflicted injury in melancholia, which is definitely enjoyable, here means fitting sadistic and hateful tendencies toward an object that have both been returned to oneself. Patients with this disorder usually manage to torment loved ones and get revenge on their main goal with their illness, using this to avoid being overtly hostile toward them.

Therefore, melancholic erotic cathexis about an object undergoes a double vicissitude; one regresses toward

identification; nevertheless, the other forces back to the sadistic stage, which is closer to ambivalence-induced conflict (15). In this case report, the patient admitted that she was still mourning her father, although she had not felt emotionally connected to him as he was frequently away. The patient additionally stated that she was closer to her mother than her father. Additionally, her mother acknowledged that she had a bad marriage in which she suffered many beatings in front of the patient since the patient was a young child (1).

In accordance with psychoanalytic theories, the ego can only kill itself due to the return of object-cathexis if it is able to treat itself as an object and direct the hostility associated with an object against itself, which symbolizes the ego's original reaction to objects in the outside world. Therefore, the object is eliminated in the regression from the narcissistic object choice; however, the ego is defeated by the object (15).

According to the theory proposed by Freud on melancholia and mourning, a person with a pathological grief reaction could have conflicting relationships with one's beloved object. Upon the loss of the beloved object, abandoned libido from the object was withdrawn into the ego and served to establish an identification of the ego with the abandoned object; consequently, the object's shadow would fall on the ego, allowing the latter to be judged going forward as though it was the forsaken object. As a result, the object loss would become the ego loss, and the struggle between the ego and the loved one would turn into a cleft between the ego's critical ability and the ego as altered by identification (15).

In this case report, it is assumed that the object of the patient, with whom the conflicting relationships were established, was unconsciously internalized in her ego and then showed identification with the object as a repetition of the object's behaviors (i.e., the father who had beaten the mother). In view of that, self-punishment and self-aggression could be demonstrated as identification with the aggressive behavior of the conflictual object (viz., father) to punish it. Therefore, this self-harming behavior is not regarded as a deceptive form of FD but as the consequence of the patient's aggressive tendency to identify with the object.

As is evidenced, patients with other psychiatric disorders, such as borderline personality disorder, sometimes engage in self-harming behaviors to meet some goals, such as pain management, stress relief, or distress withdrawal, which are independent of this mental disorder (16, 17). Moreover, patients sometimes do not report some behaviors that are typically expected to be disapproved by healthcare providers or rejected socioculturally or legally, which are apart from the deception required for FD diagnosis (2). As recommended by Bass et al. (2014), diagnosing deceptive behaviors in patients as a disorder is less important than realizing their underlying causes (2, 18).

As a whole, this case report was a practical, informational description, highlighting the utmost importance of giving much focus on psychiatric diagnoses in patients referred to healthcare facilities with physical complaints, specifying FD diagnosis, considering other disorders (e.g., pathological grief reaction, mood conditions, and personality disorders), and having a biopsychosocial perspective in examining and treating such patients.

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Footnotes

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