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

Arghavan Fariborzifar, Forouzan Elyasi

1Psychiatry and Behavioral Sciences Research Center, Addiction Institute, Mazandaran University of Medical Sciences, Sari, Iran
2Department of Psychiatry, Mazandaran University of Medical Sciences, Sari, Iran
3Sexual and Reproductive Health Research Center, Mazandaran University of Medical Sciences, Sari, Iran

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 undergone a double vicissitude; one regresses toward overtly hostile toward them. Patients with this disorder usually manage to torment loved ones and get revenge on their returned to oneself. Patients with this disorder usually manage to torment loved ones and get revenge on their...
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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