

No evidence of pregnancy, but she is suicidal and depressed after ‘my baby died’

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Ms. R, age 50, is depressed and suicidal after she claims her newborn died suddenly 1 week ago; however, her medical history reveals that she had a hysterectomy 10 years ago. How would you treat her?



How would you handle this case?

Answer the **challenge questions** throughout this article

CASE Depressed after she says her baby died

Ms. R, age 50, is an African-American woman who presents to a psychiatric hospital under an involuntary commitment executed by local law enforcement. Her sister called the authorities because Ms. R reportedly told her that she is “very depressed” and wants to “end [her] life” by taking an overdose of medications after the death of her newborn 1 week earlier.

Ms. R states that she delivered a child at “full term” in the emergency department of an outside community hospital, and that her current psychiatric symptoms began after the child died from “SIDS” [sudden infant death syndrome] shortly after birth.

Ms. R describes depressive symptoms including depressed mood, anhedonia, decreased energy, feelings of guilt, decreased concentration, poor sleep, and suicidal ideation. She denies substance use or a medical condition that could have induced these symptoms, and denies symptoms of mania, anxiety, or psychosis at admission or during the previous year.

Ms. R reports a history of manic episodes that includes periods of elevated mood or irritability, impulsivity, increased energy, excessive spending despite negative consequences, lack of need for sleep, rapid thoughts, and rapid speech that impaired

her social and occupational functioning. Her most recent manic episode was approximately 3 years before this admission. She reports a previous suicide attempt and a history of physical abuse from a former intimate partner.

Neither the findings of a physical examination nor the results of a screening test for serum β -human chorionic gonadotropin (β HCG) are consistent with pregnancy. Ms. R’s medical record reveals that she was hospitalized for a “cardiac workup” a week earlier and requested investigation of possible pregnancy, which was negative. Records also reveal that she had a hysterectomy 10 years earlier.

Although Ms. R’s sister and boyfriend support her claim of pregnancy, the patient’s young adult son refutes it and states that she “does stuff like this for attention.” Her son also reports receiving a forged sonogram picture that his mother found online 1 month earlier. Ms. R presents an obituary from a local newspaper for the child but, on further

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Disclosures

The authors report no financial relationships with any company whose products are mentioned in this article or with manufacturers of competing products.

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Ms. R deliberately fabricated evidence of her pregnancy and manipulated family members, which indicated a low likelihood of delusions

Table 1

Differential diagnosis for Ms. R

Bipolar disorder
Conversion disorder
Delusional disorder
Factitious disorder imposed on self
Major depressive disorder
Malingering
Medical illness
Other psychiatric illness
Other somatic symptom disorder (pseudocyesis)
Somatic symptom disorder

investigation, the photograph of the infant was discovered to be of another child, also obtained online. Ms. R's family denies knowledge of potential external reward Ms. R could gain by claiming to be pregnant.

Which of the following diagnoses can be considered after Ms. R's initial presentation?

- somatic symptom disorder
- major depressive disorder
- bipolar I disorder
- delusional disorder

The authors' observations

Ms. R reported the recent death of a newborn that was incompatible with her medical history. Her family members revealed that Ms. R made an active effort to deceive them about the reported pregnancy. She also exhibited symptoms of a major depressive episode in the context of previous manic episodes and expressed suicidal ideation.

The first step in the diagnostic pathway was to rule out possible medical explanations, including pregnancy, which could account for the patient's symptoms. Although the serum β HCG level usually returns to non-pregnant levels 2 to 4 weeks after delivery, it can take even longer in some women.¹ The absence of β HCG along with the recorded history of hysterectomy

indicated that Ms. R was not pregnant at the time of testing or within the preceding few weeks. Once medical anomalies and substance use were ruled out, further classification of the psychiatric condition was undertaken.

One aspect of establishing a diagnosis for Ms. R is determining the presence of psychosis (eg, delusional thinking) (Table 1). Ms. R deliberately fabricated evidence of her pregnancy and manipulated family members, which indicated a low likelihood of delusions and supported a diagnostic alternative to psychosis.

Ms. R has a well-described history of manic episodes with current symptoms of a major depressive episode. The treatment team makes a diagnosis of bipolar I disorder, most recent episode depressed. The depressive symptoms Ms. R described were consistent with bipolar depression but did not explain her report of a pregnancy that is inconsistent with reality.

As is the case with Ms. R, diagnostic clarity often requires observation and evaluation over time. Building a strong therapeutic relationship with Ms. R in the context of an appropriate treatment plan allows the treatment team to explore the origin, motivations, and evolution of her thought content while managing her illness.

Confronting a patient about her false claims is likely to result in which of the following?

- spontaneous resolution of symptoms
- improved therapeutic alliance
- degradation of the patient's coping mechanism
- violent outbursts by the patient

EVALUATION Confrontation

At admission, Ms. R remains resolute that she was pregnant and is suffering immense psychological distress secondary to the death of her child. Early in the treatment course, she is confronted with evidence indicating that her pregnancy was impossible. Shortly after



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Table 2

Diagnostic criteria for factitious disorder imposed on self

DSM-5

Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception
The person presents himself or herself to others as ill, impaired, or injured
The deceptive behavior is evident even in the absence of obvious external rewards
The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder

DSM-IV-TR

Intentional production or feigning of physical or psychological signs or symptoms
The motivation for the behavior is to assume the sick role
External incentives for the behavior (such as economic gain, avoiding legal responsibility, or improving physical well-being, as in malingering) are absent

Subtypes of factitious disorder

DSM-IV-TR

DSM-5

With predominately psychological signs and symptoms	Single episode
With predominately physical signs and symptoms	Recurrent episode
With combined psychological and physical signs and symptoms	

Source: References 3,4

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Factitious disorder and malingering can present with intentional induction or report of symptoms or signs of a physical abnormality

this interaction, nursing staff alerts the treating physician that Ms. R experienced a “seizure-like spell” characterized by gross non-stereotyped jerking of the upper extremities, intact orientation, retention of bowel and bladder function, and coherent speech consistent with a diagnosis of pseudoseizure.²

Ms. R is transferred to a tertiary care facility for neurologic evaluation and observation. Ms. R repeatedly presents a photograph that she claims to be of her deceased child and implores the allied treatment team to advocate for discharge. Evaluation of Ms. R’s neurologic symptoms revealed no medical explanation for the “seizure-like spell” and she is transferred to the inpatient psychiatric hospital.

Upon return to the inpatient psychiatric unit, Ms. R receives intensive psychological exploration of her symptoms, thought content, and the foundation of her pregnancy claim. Within days, she acknowledges that the pregnancy was “not real” and that she was conscious of this fact in the months prior to hospitalization. She cites turmoil in her

romantic relationship as the primary stimulus for her actions.

The authors’ observations

Ms. R’s reported pregnancy was not a delusion, but rather a deceitful exposition constructed with appropriate reality testing and a conscious awareness of the manipulation. This eliminated delusions as the explanation of her pregnancy claim. Although Ms. R initially rejected evidence refuting her belief of pregnancy, she recognized and accepted reality with appropriate intervention.

Factitious disorder vs malingering

Factitious disorder and malingering can present with intentional induction or report of symptoms or signs of a physical abnormality:

Factitious disorder imposed on the self is a willful misrepresentation or fabrication

of signs or symptoms of an illness by a person in the absence of obvious personal gain that cannot be explained by a separate physical or mental illness (*Table 2*).^{3,4}

Malingering is the intentional production or exaggeration of physical or psychological signs or symptoms with obvious secondary gain.

Malingering can be excluded in Ms. R's case: She did not gain external reward by falsely reporting pregnancy. Although DSM-IV-TR (*Table 2*) assumes that the motivation for the patient with factitious disorder is to assume the sick role, DSM-5 merely states that the she (he) should present themselves as ill, impaired, or injured.^{3,4}

Ms. R's treatment team diagnosed factitious disorder imposed on self after careful exclusion of other causes for her symptoms. Bipolar I disorder, most recent episode depressed, also was diagnosed after considering Ms. R's previous history of manic episodes and depressive symptoms at presentation.

Factitious disorder and other psychiatric conditions often are comorbid. Bipolar disorder, as in Ms. R's case, as well as major depressive disorder commonly are comorbid with factitious disorder. It is also important to note that factitious disorder often occurs in the context of a personality disorder.⁵

Which of the following medications are FDA-approved for treating factitious disorder?

- olanzapine-fluoxetine combination
- lurasidone
- valproic acid
- all of the above
- no medications are approved for treating factitious disorder

TREATMENT Support, drug therapy

Treatment of Ms. R's factitious disorder consists of psychological interventions via psychotherapy and strengthening of social

support. She participates in daily individual therapy sessions as well as several group therapy activities. Ms. R engages with her social worker to facilitate a successful transition to an appropriate support network and access community resources to aid her wellness.

The treatment team feels that her diagnosis of bipolar I disorder, most recent episode depressed, warrants pharmacologic intervention. Ms. R agrees to begin a mood stabilizer, valproic acid, instead of medications FDA-approved to treat bipolar depression, such as lurasidone or quetiapine, because she reports good efficacy and tolerability when she took it during a major depressive episode approximately 4 years earlier.

Valproic acid is started at 250 mg/d and increased to 1,000 mg/d. Ms. R tolerates the medication without observed or reported adverse effects.

The authors' observations

Managing factitious disorder can be challenging; patients can evoke strong feelings of countertransference during treatment.^{3,6,7} Providers might feel that the patient does not need to be treated, or that the patient is "not really sick." This may induce anger and animosity toward the patient (therapeutic nihilism).⁸ These negative emotions are likely to

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The patient should be made aware of the treatment plan, in an indirect and tactful way, so that the patient does not feel 'outed'

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Unmasking the patient—the process of instilling insight—is a delicate step and can be a stressful time for the patient

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- Bursch B. Munchausen by proxy and factitious disorder imposed on another. *Psychiatric Times*. <http://www.psychiatrictimes.com/special-reports/munchausen-proxy-and-factitious-disorder-imposed-another>.
- Feldman M. *Playing sick? Untangling the web of Munchausen syndrome, Munchausen by proxy, malingering, and factitious disorder*. New York, NY: Brunner-Routledge; 2004.

Drug Brand Names

Lurasidone • Latuda	Quetiapine • Seroquel
Olanzapine-fluoxetine • Symbyax	Valproic acid • Depakote

disrupt the patient–provider relationship and exacerbate the patient’s symptoms.

It is generally accepted that the patient should be made aware of the treatment plan, in an indirect and tactful way, so that the patient does not feel “outed.” Unmasking the patient—the process of instilling insight—is a delicate step and can be a stressful time for the patient.⁹ A confrontational approach often places the patient’s sick role in doubt and does not address the pathological aspect of the disorder.

It is rare for a patient to admit to fabricating symptoms; confronted, the patient is likely to double their efforts to maintain the ruse of a fictional disease.^{10,11} It is important for the treatment team to be aware that patients frequently leave the treatment facility against medical advice, seek a different provider, or even pursue legal action for defamation against the treating physician.

Treating comorbid medical and psychiatric conditions is important for successful management of a patient with

factitious disorder. Initiating valproic acid to address Ms. R’s bipolar depression contributed to her overall psychiatric stability. Initial treatment with a medication that is FDA-approved for treating bipolar depression, such as lurasidone, quetiapine, or olanzapine-fluoxetine combination, should be considered as an alternative. We chose valproic acid for Ms. R because of its previous efficacy, good tolerability, and the patient’s high level of comfort with the medication.

Which of the following are risk factors for factitious disorder?

- lengthy medical treatments or hospitalizations as a child
- female sex
- experience as a health care worker
- all of the above

OUTCOME Stabilization

Successful treatment during Ms. R’s inpatient psychiatric admission results in improved insight, remission of suicidal ideation, and stabilization of mood lability. She is discharged to the care of her family with a plan to follow up with a psychotherapist and psychiatrist. Continued administration of valproic acid continues to be effective after discharge.

Ms. R engages in frequent follow-up with outpatient psychiatric services. She remains engaged in psychotherapy and psychiatric care 1 year after discharge. Ms. R has made no report of pregnancy or required hospitalization during this time. She expresses

Bottom Line

Factitious disorder is a diagnostic and treatment challenge for psychiatrists. Identifying and treating comorbid psychiatric conditions is paramount for symptom resolution. Treatment consisting of acute intervention, psychological care, and frequent follow-up is effective and contributes to a good prognosis.

trust in the mental health care system and acknowledges the role treatment played in her improvement.

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