

Factitious Disorder Presenting with Stuttering in Two Adolescents: The Importance of Psychoeducation

Nurullah BOLAT¹, Özhan YALÇIN²

¹Clinic of Child and Adolescent Psychiatry, İzmir Tepecik Training and Research Hospital, İzmir, Turkey

²Clinic of Child and Adolescent Psychiatry, Bakırköy Psychiatric Hospital, İstanbul, Turkey

ABSTRACT

A factitious disorder (FD) is a diagnostic entity in which patients intentionally act physically or mentally ill without obvious benefits and without being consciously aware of a clear underlying motive. Most pediatric FD cases have been reported as Munchausen syndrome by Proxy; however, pediatric disease symptoms can also be intentionally falsified by child and adolescent patients. To our knowledge, in the medical literature, an FD patient presenting with stuttering has not been previously reported. In this case report, we aimed to discuss the diagnosis

and treatment process of FDs in children and adolescents by reporting the cases of two FD patients presenting with stuttering according to the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition. Both patients improved with psychoeducation and early confrontation.

Keywords: Factitious disorder, stuttering, psychoeducation, Munchausen syndrome

INTRODUCTION

A factitious disorder (FD) involves the intentional falsification of physical or psychological signs or symptoms or the induction of injury or disease associated with identified deception even in the absence of obvious external rewards (1). As traditionally defined, FDs are fairly uncommon, but are likely to be underdiagnosed (2). Limited reliable prevalence data on FD are available in the pediatric literature (3,4). Ehrlich et al. (3) reported in a retrospective study that 0.7% of patients had been correctly diagnosed with FD among 1,684 patients who had been referred to a Child and Adolescent Psychiatry Consultation Liaison Service over a 12-year period. Most pediatric FD cases have been reported as Munchausen by Proxy; however, pediatric disease symptoms can also be intentionally falsified by child and adolescent patients. FD patients may have varying presentations, and no findings have been shown to be pathognomonic (4). To our knowledge, the case of an FD patient with presenting the symptom of stuttering has not been previously reported. In this article, we aimed to discuss the diagnosis and treatment processes of FDs in children and adolescents by reporting two patients diagnosed with FD presenting with stuttering according to the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5) (1).

CASE

Case 1

Case 1 was a 12-year-old male adolescent who was admitted the Child and Adolescent Psychiatry Outpatient Clinic of İzmir Tepecik Trainee and Research Hospital with the complaint of stuttering. The patient had begun to stutter 10 days ago in school, which led to the patient being admitted to the emergency room of a university hospital in İzmir. After a neurological examination, including electroencephalography (EEG-I200; Nihon Kohden, Tokyo, Japan) and cranial magnetic resonance (Magnetom Aera; Siemens, Erlangen, Germany), he was directed to the Child and Adolescent Psychiatry Outpatient Clinic. According to a psychiatric examination, the patient was in a depressive mood, the fluency of his speech was disrupted, and he was prolonging or repeating the first syllable of words. His thought processing and fluency were normal, and his thoughts consisted of his recent failure in his academic performance. We had a high level of suspicion regarding the diagnosis of FD as the patient had first started to stutter at 12 years old, the fluency pathology of his speech was in the same mode and intonation, and he had an inappropriate lack of concern for his stuttering such as "la belle indifference" as seen in a conversion disorder. As a result of our observation of the patient's symptom production without obvious external reward, our preliminary diagnosis was FD with a comorbid major depressive disorder. After a psychoeducation phase on FD, we confronted the patient in an empathetic and nonjudgmental manner, and the patient acknowledged that he was stuttering intentionally. Fluoxetine (20 mg/day) was prescribed to the patient for his depressive symptoms. We worked with the patient and his parents on family-adolescent interactions, appropriate problem-solving techniques, constructing study plans for academic problems, and having healthy and appropriate expectations from the child. The stuttering declined and disappeared after



Correspondence Address: Nurullah Bolat, İzmir Tepecik Eğitim ve Araştırma Hastanesi, Çocuk ve Ergen Psikiyatrisi Polikliniği, İzmir, Türkiye
E-mail: nurullahbolat@yahoo.com

Received: 21.04.2015 • **Accepted:** 27.07.2015

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the initial sessions. At the 1-year follow-up, the patient did not develop any symptoms suggesting FD. Case 1 and his parents provided their written informed consent to participate this case report.

Case 2

Case 2 was a 13-year old female adolescent who attended the Child and Adolescent Psychiatry outpatient clinic of Izmir Tepecik Trainee and Research Hospital with the complaint of stuttering that had been observed for approximately two months. According to psychiatric examination, her mood and affect was depressive. Her speech fluency was disturbed and she was prolonging and repeating the first syllable of words. She had no worries about the disruption of her speech. There had been ongoing serious marital conflicts in the family over the past year. One month before she began to stutter, she had experienced a sudden loss of balance and sudden falls several times. After the disappearance of neurological findings, stuttering emerged. In her medical admission, no pathology had been detected in neurological and cardiac evaluations. Before the admission to our clinic, the patient had been diagnosed with major depressive disorder in a distinct psychiatry clinic, and had been using an antidepressant for one month that did not lead to any improvement in her speech. We were suspicious of FD comorbid with major depressive disorder as the preliminary diagnosis because of the severe patient psychosocial problems, our observation of symptom proliferation, and the lack of an obvious external reward. After our construction of trust in the doctor-patient relationship, we used psychoeducation and a non-punitive confrontation, and the patient admitted that she was stuttering consciously. Fluoxetine was prescribed to the patient at the dosage of 20 mg/day and the patient was taught cognitive-behavioral techniques (problem solving techniques, constructing an activity plan, constructing healthier beliefs and perceptions about herself, others, and the world, and not minimizing self-coping skills). FD findings and depressive symptoms of the patient improved after the initial sessions, probably because of the medication and psychotherapeutic interventions that focused on psychosocial problems, family related difficulties, and her demands about attracting attention to herself rather than focusing on stuttering. In the 7-month follow-up, stuttering did not relapse. Case 2 and her parents provided their written informed consent to participate this case report.

DISCUSSION

Practical difficulties in the diagnosis of psychiatric disorders in people with FD include factors such as atypical, dramatic, vague, and inconsistent presentation of symptoms in different medical specialties. Suspicion is the key point to diagnose FD (5). Although it may be upsetting to suspect a patient of violating the basic and implicit patient–doctor contract, which is based on mutual trust, it seems necessary to maintain an index of suspicion for factitious causes of medical and psychiatric diagnoses, even in children and adolescents. In both our patients, the atypical onset age for stuttering and the presence of “la belle indifference” were the main reasons for suspicion. Observing the stuttering style without any change constantly during the interview was also significant for the preliminary diagnosis. As our patients were intentionally and consciously fabricating stuttering symptoms, we excluded conversion disorder (1). Making a differential diagnosis from malingering was the last step for an accurate diagnose. There was no obvious reward in our patients. Although the “assuming a sick role” criteria are excluded in DSM-5, we observed this fact in our patients.

FD patients can be challenging to manage (4,6). Patients often drop out from follow-ups, especially after the diagnosis of a FD has been raised as a possibility (4). Case reports of suicide have confirmed that the decep-

tive behavior does not preclude the presence of serious psychopathology (7). Comorbid psychiatric diagnoses are mentioned in most of the reported cases (4). Comorbid major depressive disorder was evident in both our patients. Fluoxetine was used to treat comorbid depression for both patients. In some cases, FDs are conditions in which a person acts as if he or she has a psychiatric disorder, but a real depressive syndrome may be observed with a patient suffering FD (8). The chronic nature of FD might be prevented by the early treatment of a comorbid depressive disorder.

Until now, most of the treatments performed in FDs have avoided the need to confront the patient with his/her factitious behavior (4,6). In both patients, we used psychoeducation before confrontation. Our psychoeducation phase included: explaining the definition and nature of the disorder; defining the clear distinction from malingering; reformulating the stuttering symptom as a request for help; informing the patient about the treatment process; and finally, the management of family reaction to the illness. After the psychoeducation phase we, used a non-punitive confrontation. Early comments may have a negative influence on therapeutic alliance and treatment, and as a result, the timing of the confrontation is very important in FD. We confronted both of the patients in the initial sessions when we sensed the patients were ready for our comments about their symptoms. In our opinion, using the psychoeducation phase prepared our patients for an early confrontation. We do not recommend clinicians to confront FD patients unless they sense that their patients are ready for the confrontation. Although limited, follow-up data on children who admit their deceptions suggest that there is less risk of repetition, particularly when the fabrications are dealt with at an early stage (4). Our follow-up was also consistent with these data.

The fabrication of stuttering symptoms in our patients who were experiencing the early stages of adolescence may be a result of their inadequate knowledge of psychiatric and medical conditions. For our patients, who were in the early stages of adolescence, the proliferation of stuttering symptoms was relatively easier than the fabrication of a more complicated psychiatric or medical symptom.

Majority of people with this FD, unfortunately, remain undiagnosed and may be subjected to extensive medical investigations. Every year, a considerable amount of time and money is spent to treat FD patients who make extensive use of medical services without a real medical situation (9). In our opinion, early psychiatric intervention in adolescence using confrontation after psychoeducation may increase the success of treatment and may prevent costly and potentially harmful diagnostic procedures.

Informed Consent: Written informed consent was obtained from the parents of the patients who participated in this study.

Peer-review: Externally peer-reviewed.

Author contributions: Concept - N.B., Ö.Y.; Design - N.B., Ö.Y.; Supervision - N.B., Ö.Y.; Resource - N.B.; Materials - N.B.; Data Collection and/or Processing - N.B.; Analysis and/or Interpretation - N.B.; Literature Search - N.B., Ö.Y.; Writing - N.B., Ö.Y.; Critical Reviews - N.B., Ö.Y.

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: The authors declared that this study has received no financial support.

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