Clarification of pseudologia fantastica

A study of two cases of fantastic pseudology

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The term pseudologia fantastica has been fairly widely used despite the lack of consensus as to its definition. Little attention has been paid to its diagnostic significance. As a presenting symptom it can be confused with delusional psychosis, confabulation, malingering, or mere lying. In this article the literature is briefly reviewed, and the diagnostic significance of pseudologia fantastica in cases of neuropsychiatric, delusional, and personality disorders is illustrated with two clinical vignettes.

□ *Personality disorder, Pseudologia fantastica, differential diagnosis.*

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In this article we describe two cases of pseudologia fantastica (PF). They exemplify important variations of the features associated with personality disorders. As a presenting symptom PF can misguidedly be taken as evidence of delusionary psychosis. It can also be confused with confabulation, a common feature in various neuropsychiatric disorders, malingering, and mere lying. In addition to a careful clinical study of these cases, the literature was searched, using MEDLINE. Additional references were selected from the bibliographies of recent publications.

The concept of PF was initially described in 1891 by Delbruck (1). Although the term has been fairly widely used, there is no consensus as to the definition of PF, and little attention has been paid to its diagnostic significance. The term is not included in the ICD-10 classification (2). It is considered an associated feature in factitious disorders DSM-III-R and DSM-IV (3,4).

Kaplan & Sadock (5) define PF as a practice of habitual, uncontrollable lying in a manner intriguing to the listener. This pathologic lying is not limited to the history or symptoms of an illness. The patients frequently give conflicting accounts concerning other areas of their life. It has been described as a frequent form of acting out in patients with borderline or antisocial personality (6).

Case 1

The patient is a 39-year-old sailor, who due to an accident had a large epidural hematoma that was evacuated. The computed tomography (CT) scan indicated acute contusions in the right temporal and left frontal lobes. Postoperatively, the patient seemed to be having slight trouble with orientation. He was referred to another hospital for follow-up treatment. Two days later he was reported to be confabulating and to have run away from the ward of internal medicine twice. This caused concern, and the patient was seen by a psychiatric resident.

The idea of confabulation had arisen because it became obvious that the patient had told untruthful stories to the staff, to his friends, and to his girlfriend. He had, for instance, claimed to be studying law; "law student" was in fact his official status as recorded in the hospital records. He had also earlier told his friends that his mother had passed away. He claimed to his girlfriend that he owned the flat he had rented, to get money from her. These facts emerged when the girlfriend tried to contact the patient's relatives and to organize his affairs during his hospitalization. It was, however, mere chance that these facts became known at this particular moment; the stories the patient had told had accumulated

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during the past 3 years or more and dated back to a time earlier than his head injury.

In the department of internal medicine the consulting resident suspected a case of delusional psychosis and considered the stories evidence of a delusionary system. The patient was referred to the University Psychiatric Clinic within Turku City Hospital. In the preliminary psychiatric interview on the psychiatric ward, the patient was found not to have common delusions but to be slightly disoriented. He reported no hallucinations. He also said that for several years before this time he had had a drinking problem including delirious attacks, for which he had been treated in an institution for alcoholics.

In the interview the patient said that he had run away from home at the age of 15 years. He had, on several occasions, had arguments with his father concerning delinquent acitivities. In his young adulthood, while working as a sailor abroad, he had abused narcotics in addition to alcohol. After quitting his job at sea the patient worked on building sites. He also attended evening secondary school and graduated. He applied twice to the law school at the university but failed to get in. The patient admitted to lying, which he himself considered a bad habit.

After clinical psychiatric evaluation he was given a DSM-IV axis-I diagnosis of organic mental disorder, not otherwise specified. In addition, the patient satisfied six of nine of the criteria for borderline personality disorder (BPD). He satisfied five of the seven group-A criteria and criteria B, C, and D for antisocial personality disorder (APD). Both were enough to set these axis-II diagnoses. He received a score of 37 in the BPRS.

Psychologic and neuropsychologic tests were also carried out. The projective psychologic examination (for example, Rorschach) supported diagnostically the idea of a borderline-level disorder (7), which the patient had already had before the injury. No signs of delusional psychosis were found. "In difficult situations the patient employs PF and escape from reality as defensive operations or retreats into aggressive behaviour." Two independent psychiatrists interviewed the patient, using Kernberg's structural model (7). No significant features of any organic or nonorganic psychosis were detected. The patient repeated some answers slightly stereotypically and had a tendency to black/white thinking, including the use of splitting.

In the neuropsychologic examination the patient co-operated well. During the testing his orientation was intact. His full-scale IQ was 121. Compared with this, his capacity for abstract thinking was relatively limited. Mild impairment of his memory function was observed only when the task required organization and retrieval of visual and verbal events simultaneously. In well-organized and controlled test situations the patient's performance was generally within normal limits. In less organized situations, however (such as on the Wisconsin Card Scoring), he ran into difficulties. Such neuropsychologic changes can affect the patient's behavior in everyday life situations. As his premorbid personality also had abnormal characteristics (especially impulsivity), the effect of the contusion cannot be clearly differentiated.

Case 2

The patient is a 35-year-old single woman. During the past year she has had two brief hospitalizations because of anxiety, depression, and suicidal thoughts. According to the patient, these symptoms were provoked both by the psychotherapeutic process and by interpersonal difficulties. Despite them the patient is satisfied with her progress in psychotherapy, which continues twice a week. In clinical psychiatric evaluation the patient fulfilled axis-I criteria for generalized anxiety disorder of the DSM-IV. She also satisfied six of the nine criteria for BPD and five of the eight criteria for histrionic personality disorder, satisfying the criteria for both of these axis-II diagnoses.

The patient recalls that she was a wild, tomboyish child. At the age of 7 years she was examined in a hospital for abdominal pains. She was also hospitalized twice at a child-psychiatric clinic, because of school phobia, at the ages of 9 and 11. When the patient was 14 years old, her father died of cancer. After his death the patient became deeply religious. At the same time she started to tell lies to her classmates. She told them, for example, that she had had an appendectomy and that she had fatal leukemia. When she was accused by her classmates of being a liar, she became angry and irritated. The patient began to have difficulties in school. After finishing secondary school she lived with her mother in rela-

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tive isolation for 3 years, during which time she worked only during the summers, at a cemetery, where she told invented stories to her fellow workers.

At the age of 22 years the patient got a permanent job as a telephone operator. During the first 4 years the patient told all her fellow-workers that she had cancer. She gained considerable sympathy, and the others even collected some money for her. When they found out that the story was not true, she was admitted to a psychiatric day-hospital for 2 months, at the age of 26, because of anxiety and suicidal thoughts. During the hospitalization the patient was depressed and had feelings of emptiness and disintegration. She also had minor self-mutilation and brief hysterical states, during which she was disorientated as to time and sometimes also as to place. Projective psychologic tests showed low self-esteem and a masculine sexual identity, and her diagnosis was one of borderline state with hysterical features.

After the hospitalization the patient went back to her previous work for 3 years. At the age of 29 she moved to Sweden, where her symptom of story-telling was completely absent. After 2 years the patient moved back to Finland and got a job again as a telephone operator. She made the acquaintance of her superior, an older unmarried woman. The patient told her first that she herself had an incurable brain tumor and later that both her sisters and her mother had died. The patient received compassion and also some extra resting time at work.

When the patient was 34 years old, these stories were revealed as lies. She again became anxious, depressive, and suicidal and had severe insomnia. The patient was hospitalized for 1 month on an open psychiatric ward in a general hospital. She discussed her problems with the ward personnel and said that story-telling had diminished her anxiety. During the hospitalization the patient received mild neuroleptic medication, thioridazine, 100 mg/day, and afterwards she was referred to a private psychiatrist for psychodynamic psychotherapy.

Discussion

It is necessary to differentiate PF from delusion, confabulation, factitious disorder, malingering, and mere lying (Table 1). It is difficult to determine whether the lies are an actual delusional distortion of reality or are told in order to deceive (1).

Table 1. Relevant differential diagnostic aspects of pseudologia fantastica (PF) and associated disorders.

	PF	CF	M	FD	D
Voluntary	–	–	+	+	–
Conscious	–+	–	+	–+	–
Compulsive	+	–	–	+	–
Associated with	PD (borderline and antisocial)	OMI	PD	I	P,DR

CF = confabulation; M = malingering; FD = factitious disorder; D = delusion; PD = personality disorder; OMI = organic memory impairment; I = independent; P = psychosis; DR = delirious states.

PF is distinct from delusions because when confronted, the person may at least partly admit the implausibility of his claims. Also, in delusionary beliefs the boundaries of what the patient considers as belonging to his personal realm are enlarged (8); in situations such as Cases 1 and 2, on the other hand, no such shift is witnessed, and matters of external reality are dealt with by means of appropriate, though falsified, evidence.

Another problematic question is where the line should be drawn between daydreaming, "normal" lying and "pathologic" lying. Daydreaming is a form of fantasy that can be defined as the mental representation of a scene or occurrence that is recognized as unreal but is either expected or hoped for (5). Lying is by definition intentional and can be seen to rely on denial of internal or external sources of anxiety (9), whereas pathologic lying is a habitual venture disproportionate to the practical gain (1).

PF differs from daydreaming in that the person usually or intermittently believes in the reality of his fantasies and can even act on them from this viewpoint. In both our cases it was evident that the line between the hoped-for state of affairs and the existing one had become blurred. Telling false stories in both our cases also involved the risk of exposure, in contrast to the possible gain achieved through lying.

In the first case the internist had suspected confabulation, which can be defined, according to Kaplan et al. (5), as a paramnestic form of disturbance of memory (falsification of memory

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by distortion of recall). It is linked with amnesia, but severe or elaborate confabulation betokens disease also outside the memory system, particularly the failure of self-monitoring that is characteristic of frontal disease (10). PF can be distinguished from confabulation by the absence of an appreciable memory defect. Case 1 presented only minor memory deficits after his insult, whereas Case 2 presented no signs of an organic lesion.

PF should be also differentiated from factitious disorders. Factitious symptoms are physical or psychologic in nature and are intentionally but compulsively produced, to assume the role of a patient (4). In PF the distortion of the truth is not limited to the history of illness symptoms; limited factual material is mixed with extensive and colorful fantasies. We can say that in both of our cases the main objective was not consciously intentional as such and was not that of becoming a patient. In fact, that is what Case 1 was trying to avoid. Furthermore, in the case of PF telling an untrue story cannot be considered to be an intentionally produced psychologic symptom, if the patient is not aware that lying is a symptom. Case 1 mainly told stories relevant to other areas of life than his health. Case 2 told stories related to her health to her friends and superiors but not to the personnel of health care facilities. Thus, we did not consider PF a symptom of factitious disorder in either of the cases.

The voluntary production and presentation of false or grossly exaggerated physical or psychologic symptoms to achieve a purpose is defined as malingering (4). The presence of a delineated conscious goal is the main factor differentiating malingering from a factitious illness. In both of our cases the symptoms involved a conspicuous compulsivity; deliberate as their stories were, their uncontrollability was evident. Case 1 did not produce symptoms as such, but lies, which were his symptoms. They had a goal of which he was not aware: to boost his self-esteem. In Case 2 the patient insinuated about serious somatic illnesses to gain sympathy and unconscious psychologic benefit: introjection of the lost father. For her, too, telling stories was not a device for producing a psychologic symptom.

Factitious disorder is an independent category of disorders in both the DSM-IIIR and DSM-IV. PF is a phenomenon that can appear in a factitious disorder with physical symptoms. It is then a sign of this disorder (objective finding observed by the clinician) (5), not a symptom (subjective complaint of the patient) (5). Although feigning of psychiatric disorders happens, this is usually done by simulating signs and symptoms of psychiatric disease.

From a psychodynamic point of view, PF can be considered an effort to maintain a viable self (9). PF is at least partly a conscious mental construction, in which lying has become an automatic and chronic characterologic response to anxiety provoking interpersonal situations to such an extent that the patient from time to time starts to believe his own stories. In both of our cases it was evident that the patients themselves took their stories for granted, and pseudology was indeed an automatic and chronic characterologic response for both of them. They both had problems of poor self-esteem. Especially in Case 1 the effort to gain self confidence through lying was conspicuous. Winnicott's idea of maintaining a viable self (9) is a useful tool for understanding the logic of pseudology in the aspirations of Case 2. Our observations support Snyder's (6) idea of PF as a form of acting out in borderline or antisocial personality disorders.

The term "pseudologia" has been less often used during the last few decades (1,9). In DSM-III-R, however, it is included as a criterion for factitious disorder, somatic type, or Munchhausen's syndrome. So far, there does not seem to be another term besides PF to name and define the phenomena described above. The sign of PF can be helpful in differentiating borderline or antisocial personality disorders from delusions, malingering, confabulation, and factitious disorders.

References

1. King BH, Ford CV. Pseudologia fantastica. Acta Psych Scand 1988;77:1–6.
2. ICD-10 classification of mental and behavioural disorders. Clinical descriptions and diagnostic guidelines. Geneva: World Health Organization, 1992.
3. Diagnostic and statistical manual of mental disorders, DSM-III-R. Wasington (DC): American Psychiatric Association, 1987.
4. Diagnostic and statistical manual of mental disorders. 4th ed. Washington (DC): American Psychiatric Association, 1994.
5. Kaplan HI, Sadock BJ. Synopsis of psychiatry; behavioral sciences, clinical psychiatry. 6th ed. Baltimore (MD): Williams and Wilkins, 1991.

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6. Snyder S. Pseudologia fantastica in the borderline patient. Am J Psychol 1986;143:1287–9.
7. Kernberg O. Structural Interviewing. Psychiatr Clin N Am 1981;4:169–95.
8. Spitzer M. On defining delusions. Compr Psychiatry 1990;31:377–97.
9. Dithrich CW. Pseudologia fantastica, dissociation, and potential space, in child treatment. Int J Psychoanal 1991;72:657–67.
10. Ovsiew P. Bedside neuropsychiatry: eliciting the clinical phenomena of neuropsychiatric illness. In: Yudofsky SC, Hales RE, editors. The American Psychiatric Press textbook of neuropsychiatry. 2nd ed. Washington (DC): American Psychiatric Press, 1992.

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