

A Reverend's tale: Too tragic to be true?

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After his pregnant fiancée dies, Reverend R is strangely jovial. He dodges efforts to verify the highly implausible history he reports. What's going on here?

CASE A tragic tale

Reverend R, a 62-year-old Methodist minister, is admitted to a general surgical service for abdominal pain secondary to a recurring bowel obstruction. While there, he learns that his pregnant 24-year-old fiancée was struck and killed by a drunk driver as she was driving to visit him. Her medical team was not able to save her child. The surgical service requests a psychiatric consultation for Reverend R to assist him with grieving.

Our team interviews Reverend R 3 days after his fiancée's death. We did not have access to his psychiatric records before our evaluation, but his chart indicates Reverend R had been hospitalized for nearly 3 months after being transferred from another hospital. He has a history of colon cancer and cerebral palsy and has struggled with depression since college. He had 1 psychiatric hospitalization 26 years earlier and no history of suicide attempts. He has responded to pharmacotherapy and is taking sertraline, 100 mg daily.

Reverend R expresses grief, stating he has lost the love of his life. With prompting, he provides a few details about his fiancée but does not say much about the accident. He says he feels guilty and frustrated that he can't attend

his fiancée's funeral because "I have a nasogastric tube." He claims he has cried excessively in the last few days, repeatedly stating, "I soaked 4 towels." He is profusely apologetic for expressing his grief, as if doing so was inappropriate.

Reverend R acknowledges feeling sad but denies pervasively depressed mood or anhedonia, excessive guilt, or feelings of hopelessness, helplessness, or worthlessness. His affect ranges from mildly dysphoric to jovial and witty. His thought form and content are logical, linear, and goal-oriented. He denies having preoccupations, obsessions, delusions, or hallucinations. Attention and concentration are intact without evidence of waxing and waning. Cognition and memory also are intact. His Folstein Mini-Mental State Exam (MMSE) score is 29/30. Insight and judgment are assessed to be good, and intellect is above average.

We end our interview by asking Reverend R for permission to contact his psychiatrist for additional information. He stops making eye contact, begins to stammer, and tells us he is acutely short of breath. We seek out his nurse to check him, and within a few minutes his shortness of breath resolves without intervention.

What is the most likely diagnosis?

- adjustment disorder
- delirium
- recurrent major depressive disorder
- bereavement

Drs. Melin, Couser, and Reese are instructors and Dr. Somers is a resident in psychiatry, department of psychiatry and psychology, Mayo Graduate School of Medicine, Rochester, MN. Ms. Thanarajasingam is a fourth-year medical student at Mayo Graduate School of Medicine, Rochester, MN.

The authors' observations

Reverend R's presentation does not suggest that his fiancée died 3 days ago. Without prompting, he says little about her or the accident, but he provides a great deal of information about himself. He clearly enjoys our attention, several times enthusiastically asking, "What else would you like to know about me?" At times he focuses on irrelevant topics.

He does not appear depressed and, although Reverend R's voice breaks at times, we do not observe tears. His intermittent jovial, witty manner is inappropriate, but he is oriented and his MMSE provides no evidence of delirium. He does not elaborate on his frustration at being unable to attend the funeral and seems satisfied with the possibility of watching a video of the service.

Reverend R does not meet DSM-IV-TR criteria for major depressive disorder. We feel his emotions and conduct are unusual in response to the stress and therefore, based on what we have learned so far, we believe he best meets criteria for an adjustment disorder.

HISTORY A series of traumas

During our initial interview, Reverend R explains that his life has been characterized by a series of traumatic events (*Table 1*). He had been sexually assaulted twice: by an uncle during childhood and by a male nurse while hospitalized for depression 26 years ago. The nurse had HIV, but the Reverend tested negative.

Reverend R tells us he is ordained and was working for a church 15 years ago when a drunk driver hit him. Since then, he has lived in a nursing home. Although he can no longer work as a minister, he says the nursing home staff on occasion invites him to deliver sermons at the facility. He also serves as the nursing home's public relations director and writes faith-based literature for the residents.

The day before our visit was not only the Reverend's birthday but also was to be his wedding day. The Reverend had met his fiancée,

Table 1**Reverend R's life story:
A series of traumatic events**

Period	Event
Childhood	Sexually assaulted by an uncle
Young adulthood	Develops depression; 1 hospitalization in his 30s; sexually assaulted by male nurse while hospitalized
Adulthood	Motor vehicle accident results in traumatic brain injury and leads to nursing home placement in his late 40s
3 months ago	Hospitalized for abdominal pain secondary to recurring bowel obstruction; medical history includes colon cancer, cerebral palsy
Presently	Loses pregnant, 24-year-old fiancée in a traffic accident

a nurse, at the nursing home where he lives. At times, she took him on outings for dinner and other activities.

We ask the Reverend precisely why he needed 24-hour care and why he had been in the nursing home for 15 years. He is not able to provide a reasonable explanation.

What additional information do you need to establish the diagnosis?

- collateral information from the patient's psychiatrist and nursing home staff
- laboratory tests and head imaging
- psychological testing, including projectives and personality battery
- sodium amytal interview

The authors' observations

Reverend R talks almost incessantly about the atrocities he suffered throughout his life. Times of happiness and success are the exception.

We begin to doubt the veracity of certain details of his story. We question the plausibility of a young nurse having an intimate relationship with and becoming pregnant by a 62-year-old nursing home patient who

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Reverend R does not talk much about his recently deceased fiancée but speaks at length about his own life and clearly enjoys our attention

Clinical Point

A collateral history is imperative to establish a diagnosis in a patient whose history seems unbelievable

was an ordained minister. Reverend R's claim of being the nursing home's public relations director and performing sermons there seems unlikely. His stories are inconsistent; whenever we question him, he creates a reply that he is convinced seems believable. A collateral history is imperative for us to establish a diagnosis.

FOLLOW-UP His story starts to fray

At a follow-up visit the next day, the Reverend states that he has been sad and at times he will "fall apart" in response to his fiancée's death. He says that a video of the memorial service his fiancée's father gave him had been "hard to watch." We ask if he has the video; he says that he sent it back to the nursing home.

He reports being upbeat since his nasogastric tube was removed, and he is able to tolerate a clear liquid diet. Reverend R says he is looking forward to returning to the nursing home but expresses trepidation. He is concerned that his conversations with us might jeopardize his return: "I hope I haven't said anything that will get me into trouble." He also acknowledges that he was diagnosed with a traumatic brain injury following the motor vehicle accident 15 years ago.

The authors' observations

It seems strange that Reverend R is concerned that talking with us could compromise his return to the nursing home. His questions and behavior are paranoid; we did not observe this type of behavior during our initial interview.

We investigate Reverend R's claims. A hospital dismissal summary from 13 years ago documents that Reverend R had been caught pulling out his NG tube. Addition-

ally, he was observed drinking out of the sink when he was advised to take nothing by mouth.

Within days of that hospitalization, he presented to our outpatient gastrointestinal clinic for a second opinion regarding his abdominal pain. His father demanded that the Reverend be admitted. When told that hospitalization was not warranted, Reverend R and his father became angry and abruptly left the office.

Our hospital's nursing staff is a vital source of information because they observed Reverend R often during his 3-month stay. They are suspicious of his history because they noticed discrepancies, such as Reverend R telling one nurse his fiancée died on a Thursday and another she died on a Friday. He spoke of people visiting him, but the staff never saw any visitors.

The nursing staff reports that at times he would use profanity and was quite hostile. A member of our team saw him yelling at a female chaplain. In our initial interview he told our team that the chaplain had reprimanded him for having premarital relations with his fiancée.

We find no evidence of an accident that resulted in the death of a 24-year-old pregnant female. Obviously, there was never a funeral or visits from the fictitious fiancée's father. The sexual assault by the male nurse while hospitalized is possible but not probable, given the other falsehoods Reverend R told.

The seminary Reverend R told us he attended exists, but we are not able to determine if he was educated there. He told some staff members he had obtained a Master's degree and others a PhD.

Reverend R refuses to sign a release of information form for the nursing home. We speak with the nurse who worked with Reverend R's psychiatrist, who confirms that the patient's diagnosis was depression. She tells us that the Reverend said he relocated to that area to live closer to a man with whom he had a romantic



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relationship. Reverend R confided to her that his father never approved of the relationship, but his mother accepted it.

What is your diagnosis at this point?

- malingering
- factitious disorder
- somatoform disorder
- cognitive disorder secondary to traumatic brain injury

DIAGNOSIS A rarely seen symptom

Reverend R meets the DSM-IV-TR criteria for factitious disorder (*Table 2*).¹ The presentation of a patient with this disorder may include:

- fabrication of subjective complaints
- self-inflicted conditions
- exaggeration or exacerbation of pre-existing conditions
- any combination of these.

In addition, we determine Reverend R has pseudologia fantastica, a rarely seen form of pathological lying characterized by telling elaborate lies that may have a kernel of truth (*Table 3*).² The syndrome often is associated with cognitive dysfunction, learning disabilities, factitious disorder, and childhood traumatic experiences.^{3,4}

Differential diagnosis for pseudologia fantastica includes dementia, delusional disorder, antisocial personality disorder, borderline personality disorder, factitious disorder, malingering, hypochondriasis, substance abuse/dependence, and schizophrenia/schizophreniform disorder.³

A patient with pseudologia fantastica effectively weaves a fabric of lies in a dramatic style. When challenged, he or she improvises yet another story. Inconsistencies can be detected by spending time with the individual. The patient is consistently vague when asked to provide additional details. The reward is the attention.

Because of an unstable self image, the pseudologia fantastica patient constantly battles to regulate his or her sense of self.

Table 2

DSM-IV-TR criteria for factitious disorder*

Intentional production or feigning of physical or psychological signs and symptoms

Motivation for the behavior is to assume the sick role

External incentives such as economic gain, avoiding legal responsibility, or improving physical well-being are absent

* Specifiers include with predominantly psychological signs and symptoms, with predominantly physical signs and symptoms, or a combination of both

Source: Reference 1

Table 3

Characteristics of stories told by patients with pseudologia fantastica

- not entirely improbable
- long-lasting, often repeated over years
- self-aggrandizing
- not told for personal profit
- not delusions (when confronted with facts, patient can acknowledge the stories as falsehoods)

Source: Reference 2

The dramatic production of symptoms due to this constant battle is thought to be a way for the patient to stabilize the self by making the experience of distress concrete and legitimate.⁵ It was fascinating to see Reverend R's defense mechanisms work.

Confronting patients such as Reverend R likely is not the best approach. Showing them respect and empathy is important. Creating a safe, supportive environment in which they can express themselves will encourage them to consider ongoing psychiatric care.^{3,6}

OUTCOME Return to nursing home

Approximately 1 week after our follow-up visit, Reverend R was discharged to the nursing home where he had resided prior to the

Clinical Point

A patient with pseudologia fantastica tells elaborate lies that may contain a kernel of truth

Related Resources

- Epstein LA, Stern TA. Factitious illness: a 3-step consultation-liaison approach. *Current Psychiatry* 2007;6(4):54-58.
- Birch CD, Kelln BRC, Aquino EPB. A review and case report of pseudologia fantastica. *Journal of Forensic Psychiatry and Psychology* 2006;17(2):299-320.

Drug Brand Name

Sertraline - Zoloft

Disclosure

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

hospitalization. Several attempts to contact him to obtain additional information and col-

lateral history were unsuccessful, but clearly we had enough information to refute the reason we were asked to evaluate him.

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Treating pseudologia fantastica patients with empathy and respect may encourage them to seek ongoing treatment

Bottom Line

Patients with pseudologia fantastica—a characteristic of factitious disorder—tell enduring, repetitive false stories that combine elements of reality with elaborate fantasy material. Consider developmental disturbances, personal history, and current stressors. Provide empathy and respect to encourage patients to seek psychiatric treatment.

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