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DISSOCIAL PERSONALITY DISORDER ANDPSEUDOLOGIA FANTASTICA: UNMASKING FACTITIOUS DISORDERS IN PSYCHIATRIC IN PATIENTS

C. Lazzari*[1], A. Shoka[2] and K. Kulkarni[3]
*[1]Corresponding author: Kingswood Centre, North Essex NHS University Foundation Trust, United Kingdom Turner Rd, Colchester, CO4 5JY, United Kingdom
[2]Kingswood Centre, North Essex NHS University Foundation Trust, United Kingdom, and Department of Health and Human Sciences, University of Essex, United Kingdom
[3]Kingswood Centre, North Essex NHS University Foundation Trust, United Kingdom

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Abstract
Patients withdissocial personality disorder (DPD)might welcome admission into psychiatric hospitals when in search of respite from or to escapefrom court cases. They likely aim to be provided with a "psychiatric diagnosis"to see their charges reduced or dropped. Therefore, when admitted into mental-healthwards, persons with DPD report complex stories which, in their mind, should suggestto psychiatrists that they are "insane" and that, hence, they should be treated as psychiatric patients rather than be put in jail or heldaccountable for their unlawful acts. These stories are well-ordered, well-articulated in their details, and strongly maintained with an intensity thatis not altered during hospitalization or psychiatric treatment. In reality, these reports have been calledpseudologia fantastica (PF). This article describes three cases of male patients with DPD and PF together with the diagnostic strategies that will help mental-health professionals discern these disorders.

Introduction

Dissocial personality disorder (DPD: F 60.2) has been diagnosedby the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) of the World Health Organization (WHO) as follows:

At least three of the following must be present:

1. "Callous unconcern for the feelings of others.
2. Gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations.
3. Incapacity to maintain enduring relationships, though having no difficulty to establish them.
4. Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.
5. Incapacity to experience guilt, or to profit from adverse experience, particularly punishment.
6. Marked proneness to blame others, or to offer plausible rationalizations for the behaviour bringing the subject into conflict with society"[1].

As people with DPDmight want to escape from their legal obligations or from a court case, early diagnosis of pesudologia fantastica (PF) is of paramount importance to reduce the risk that patients with challenging behaviors are kept withinpsychiatric wards for more time than is necessary; a correct diagnosis of PF will facilitate the course of the law.In fact, PF involvesa story thatpatients use to achieve the status of "psychiatric patients" and to be considered less accountable for their unlawful and criminal acts. Other times, they aim to utilize psychiatric hospitals as places of respite and refuge; in this case, a psychiatric diagnosis incorrectly prompted by the PF would grant this privilege. Nonetheless, PF does not find a true collocation in the psychiatric diagnostic criteria; rather, its definition varies according to the sources citing it. One source states that"Pseudologia Fantastica is a tendency to tell extravagant and fantastic falsehoods centered about the storyteller, who often comes to believe in and may act on them" [2].It is reported that pseudologues (people who report PF) often present with frequent job variations, self-importance, and a naïve and articulate use of dialogue; in addition, they might fake an illness as well, thus making PF comorbid with Munchausen syndrome[3]. As reported by Dupre, the story of PF must be likely and must

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preserve a connectionto reality; nonetheless, although the plot of the story may vary, the patient maintains the role of champion or target in the plot[3]. Fish also reinforces the idea that PF is a form of lying that occurs inpeople with DPD; furthermore, people with PF describe various key events and distresses and usually tell these stories when facing legal prosecutions [4]. Fish adds that the person conveying PF accepts as true his/herown story with a blurringof the border between imagination and fact[4].Moreover, as Sadock and Sadock maintain, the attention and curiosity evoked in the auditors who listen to the story gratifies the patient and, therefore,strengthens PF [5].It is also added that PF should be classified as a symptom, as it is seldom found alone during diagnostic assessment[6]. Besides, there are important medico-legal implications in psychiatry in mistaking factitious disorders with true and enduringmental illnesses. In fact, when a psychiatric diagnosis is posed, a patient with DPD can escape prosecution from the law or seepolice charges reduced due to mitigations; this might happen when the judge establishes that unlawful events were triggeredby a mental illness. More specifically, a person will be deemed as less accountable if he or she committed a crime under the circumstances of an acute or enduring mental illness. In addition, there is the risk that a person with DPD will bekept at a psychiatric ward while, instead, in case of unlawful behaviors and breach of law, a prison might be the most suitable placement due to the lack of a mental illness. Other times, people with DPD aim to get access to psychiatric wards simply to escape from conflicts in their community, find a respite, reduce threats from neighbors and persecutors, or find a roof from vagrancy. Nevertheless, their behavior can become problematic once admitted to a psychiatric ward, as they do not like to be challenged or questioned, especially on their beliefs (PF). Other times, they threaten to harm themselves when thwarted. In this case, a behavioral game starts in the psychiatric ward instigated by the person with DPD disengaging from all activities and other assessments from psychiatrists during routine ward rounds. Additionally, difficultyin dischargingpatients with DPD back to the community is also posed at times by a bureaucratic system that halts psychiatric wards from discharging patients when they claim to be suicidal and homeless or maintain to have an active mental illness. For this reason, patients with DPD might remain inside psychiatric wards for a long time, unless their disruptive behavior is reported to thepolice for further investigations, such asdestroying hospital properties, verbal assault, racist remarks, and intimidation of staff and others.Finally, when these patients access inpatient psychiatric wards with PF, they present with very articulated stories; in fact, PF is createdby patients toreinforce the idea that they have a mental illness. Perhaps they have been misdiagnosed in the past and tend to reinforce the idea that they are mentally unwell. Nonetheless, individuals with DPD are eager tobe treated as psychiatric patients and not to beheldaccountable for their unlawful actions, which probably occurred in the community before admission. Additionally, patients with DPD tend to somatizemany symptoms to the point that exaggeration and Munchausen syndrome should always be considered as comorbid with PF.

Materials and methods

Structured and unstructured interviews were used to diagnose dissocial personality disorder. Additionally, the ICD-10WHO was used for classification. Moreover, the authors have created aPsychiatric Inpatients Observation Scale (PIOS). This is a very reliable tool for assessing patients'behaviors inside psychiatric wards and obtainingnonverbal confirmation of the existence of any psychopathology. The assessment is complemented by other scales, such as the Brief Psychiatric Rating Scale (BPRS).

Psychiatric Inpatient Observation Scale (PIOS)

This scale, created by Lazzari and Shoka in 2016 (Table 1),is a reliable tool forproviding evidence for discharge diagnoses of psychiatric disorders during staff observations. Itis a 28-item scale with a five-point Likert scale for answers from "Never" to "Almost Always."With the use of PIOS, mental health staff does not need to rely on the verbal account of psychiatric patients. Consequently, factitious disorders can be unmasked if they are present. Staff can use PIOSregularly, and then the data collected will be matched with the verbal accounts of patients.

Dissocial Personality Disorder and Pseudologia Fantastica Assessment Scale (DPD-PF-AS)

This is an ad-hoc questionnaire with 10 items thatsupplement the unstructured interview (Table 2 and 3). The points used for the assessment include the characteristics of the personal account, strength of beliefs, behavior, ward reviews, reaction to benign diagnoses and reassurance, focal thematic areas, reaction to discharge from hospital, nonverbal behavior and speech, relationships with staff members, somatizations, and psychological symptoms such as welcoming medication and section 2 or 3 of the Mental Health Act (MHA; 1983) in United Kingdom.Principally, there are two sections of the MHAthatallow obligatorytreatment: Section 2—duration of compulsory assessment and

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hospitalization up to 28 days—and Section 3—duration of obligatory treatment and hospitalization up to six months. A section of the MHA is also an indirect confirmation towards the law that the patient has an enduring mental illness which has thus required a mandatory assessment and treatment. Consequently, a patient can always claim that when he or she committed unlawful actions the reason was because he or she suffered (and is still suffering) from 'an enduring mental illness' and, hence, he or she could not be made accountable for these events.

Results and discussion of narratives

Case 1

Case 1 involves a 45-year-old white British male(identified as Mr. A.).*Reasons for admission*: Under Section 2 of the MHA. *History of present illness*: According to the police report, a few weeks prior to admission he made several telephone calls to the police informing them that he was contaminated with plutonium, that he was working as an undercover MI5 agent, and that he was being persecuted by a former police officer. It wasalso reported by the police that he had telephonedthemto report that he was going to obtain a shotgun to shoot two concealedpolice officers in a kebab house in H area.During initial admission, Mr. A. was expressing bizarre ideas of a persecutory nature during the assessment. He had also refused to engage with the local mental health services in the past. Mr. A. was considered to bevulnerable and unpredictable in his behavior. *Past psychiatric history*: Mr. A. hadmultiple admissions to psychiatric hospitals with diagnosis of "psychosis."*Family history*: His parents were deceased, and Mr. A. describes having grown up in a military household, allowing him to have knowledge of arms and guns, hence being able to recognize plutonium. *Personal history/social circumstances*: He sold his parents' house when experiencing a breakdown and lived off the proceedings. Helivedand slept outdoor as a consequence of being homeless in M area. Previous reports indicate that he struggled at school and taught himself to read and write. It is unclear the type or level of support hehad from friends. *History of substance misuse*: Alcohol misuse. *Forensic history*: Nil from records. *Mental state examination on admission:* appearance and behavior—flamboyant and directive withlow social empathy and relation;speech—maintained a low tone, steady rate, normal volume; mood—subjectively low, objectively euthymic;thought content—no formal thought disorder withpseudologia fantastica;perceptions—nil abnormal;cognition—grossly intact.*Pseudologia fantastica:* He talked about his friend who had plutonium in his garage and had contaminated the whole village. He admitted that he had beencalling the police but that this was to help them investigate the murder of a friend who was killed two years prior. He denied that he had threatened to shoot a police officer with a gun but then talked at length about two police officerswho kept returning to the kebab shop in H area asking questions and for CCTV footage, which he had found worrying, as he felt they were operating undercover and hence he was "going to get a gun and shoot them."He denied that he had phoned the Airport Terrorism Unit but again admitted that he had called the police, as he believed he had witnessed a murder. He denied a police report that over the previousweekend Mr. A. had reported seeing someone with a handgun in their belt. During the interview,Mr. A. admitted that he had used drugs and been alcohol dependent but had been sober recently. He felt that his physical problems, which he had experienced latelyincluding shaking and sweating, were due to radiation poisoning rather than possibly to alcohol dependence. Mr.A.felt he had a mental illness that required medication or help. Psychiatrists explained to him that the police wereconcerned about him, sothey had made him a subject of safeguarding referral due to what they perceived asa deterioration in his mental health and his increased vulnerability. The results of the PIOS were unremarkable. He always interacted with staff and fellow peers, was compliant with medication, and the staff never observed signs of psychosis or paranoia or sawthe patient acting bizarrely.The BPRS showed high scores in uncooperativeness, somatic concerns, and hostility. More enlightening results were found in the DPD-PF-AStest,which was positive forall items. Mr. A.hadnever attended the ward reviews and sabotaged all attempts to be discharged. After a week of thorough and detailed assessment, the diagnosis of PF in DPD was posed. His account was articulated, and there was a sense that the whole reportwasabsurd. This patient constantly refused being challenged by staff about what he believed. Therefore, he tended to refuse benign diagnoses and the statement that he was "mentally well." He also had deserted every ward review except for the last one, when he was discharged from the Section 2 of MHA and hospital and when, instead, he strongly begged to remain in the hospital under Section 2. The focal thematic areas remaining were those of "MI5,""police,""international conspiracy," etc. He had always refused being discharged from previous psychiatric wards. Furthermore, soon after discharge, he approached another service and was readmitted thereafter into a private psychiatric hospital. His nonverbal behavior was flamboyant, he displayedlittle empathy, and was highly somatizing physical symptoms to the point that on numerous occasions, he required urgent medical attention

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which, however, had a positive outcome. In this case, a diagnosis of comorbid Munchausen syndrome was also considered. Treatment did not include psychotropic medication.

Case 2

Case 2 involves a 45-year-old white British male (identified as Mr. B.). *Reasons for admission*: During the MHA, Mr. B. reported that he had deliberately smashed up his mother's house in order to get sectioned and gain access to prison. He said he had never been as happy as during the two months he had recently spent in prison. There, he felt safe and enjoyed the solitude, as he was away from all the people conspiring against him. Mr. B. reported that he has not been taking his medication, as he did not need it and thatadding it has made no difference. Mr. B. reports he has lost 25 Kilos in weight since stopping the medication. He denied that he was under the Community Mental Health Team,saying that he had discharged himself. He was known to services with a diagnosis of "Schizoaffective Disorder." This was the same diagnosis he strongly maintainedand for which he threatened staff whenever this diagnosis was challenged. *Family history*: His father left when he was 11 years old, and he has hadno contact with him. His mother was 73 years old but he had a strained relationship with her. He had one sister, whom he has disowned and has had no contact with her for the past four years. He felt close to his grandparents, both now deceased. *Mental state assessment:* On admission, Mr. B. reported a complex and articulated story about being watched on the Internet like the"Turner Show." He felt that somebody had takena video of him whilst using drugs and uploaded it on the Internet. He said that he was convinced of this, because people he knew reacted as if they had viewed this video. However, as he himself declared, his intention in being admitted under Section 2 was to be locked into a prison or a psychiatric hospital forever. He added that he would do whatever was needed in order to achieve this goal. He believed that this would allow him to continue his exercises of relaxation and to live away from others. He scored low on the PIOS apart from being verbally abusive and racist toward staff during the whole stay. No psychotic behavior or symptoms were documented throughout his entireadmission. Alternatively, on the DPD-PF-AS test, he scored high on all items. Additionally, he remained intimidating and threatening throughout his admission. He escalated in his behavior whenever the team and psychiatrists challenged his beliefs and mentioned that he might not suffer from a schizoaffective disorder. However, as he himself confirmed, his intent was not to avoid jail, but the opposite—to be locked in isolation either in a psychiatric hospital or in a jail as "insane." Moreover, he tended to use his psychiatric diagnosis as a justification for any threatening and challenging behavior, such as"I have ADHD [Attention Deficit and Hyperactive Disorder], and I cannot stand people."Onother occasions, he confirmed that he extensively read books onpsychology, and this was believedby the team, as it could have been the source of the detailed story hehadgiven of himself and his beliefs. Treatment did not include psychotropic medication, which was, however, strongly requested frequently by the patient.

Case 3

Case 3 involves a 58-year-old white British male (identified as Mr. C.). *Reasons for admission*: Mr. C. was found by police on the sea front with the intention to drown himself. He reported increased distress due to recent events. These included stalking by his previous employer, who was chasing him for an alleged financial debt. Although he reported this fact to the police, he felt that he was not receiving enough support. He said that his family was also being chased by this person and that by dying he might be able to save his family. At the time of admission, the police were still investigating the matter of his financial debt. Mr. C. added that all his accounts were frozen and that he had already sold his house. He added that his ex-employer has threatened to kill him. He commented that he felt imprisoned in his own house because of his ex-employer, who was constantly banging on the doors and knocking on the windows with the aim of gettinghis money back. Mr. C. commented, "This gentleman started to threaten my daughter. He came to the camp site and was picked up by CCTV. I called the police, and they came three hours later. The police said that he wasout of area and that he wasnot a threat at the moment. He was always picked up by CCTV while in his vehicle. I have put a freeze on all my assets. My bank accounts are frozen. I cannot go away [becomes tearful]. I drank a whole bottle of vodka (I never drink), I sharpened a knife, and they [police] found me on the beach. I took three doses of insulin [Mr. C. is diabetic] with the intention to kill myself at the time. He [the boss chasing him] is a millionaire. I don't see a way forward. I have been in prison twice for receiving stolen goods."'When I was young, I was involved in lots of fights, too. If I kill myself, he will not touch my family. The law is not working in my favor. He is going to court. I am due in court next week. He has legal papers. I don't want to kill myself."*History prior to present admission:* Recently discharged from our ward. It is reported that he has been blackmailing staff because of the discharge. Then, he moved to another part of the country to seek admission

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again into a psychiatric hospital via another police station. Soon after, he was readmitted after being seen in the General Hospital. At the time of assessment, he was under police investigation for stealing *x* from his former boss. The ongoing diagnostic impression was that he might be malingering and intensifying his presentation with the intent to avoid the court case. During the whole admission, whenever a discharge from the psychiatric ward was mentioned, he started to report suicidal ideation which, however, was never mentioned as long as a discharge was not discussed. *Past psychiatric history*: Two suicidal attempts with overdose related to life events. Recently, he has been moving from one ward to another with long admissions and difficulties with being discharged. There was a general perception among the treating team that he was trying to avoid the court case by intensifying his emotional reactions to the police accusations. Staff reported that he was heard mentioning to other patients that if he was diagnosed with a mental illness and could remain under Section 2 or 3 of the MHA, this would help to drop his actual charge for theft. There were several attempts to discharge him back to the community. However, initially, he agreed to take the offer of a temporary accommodation provided by the City Council. Nonetheless, soon after discharge, he started to be abusive towards staff on our ward with phone calls threatening that he was drunk and that he would jump from the pier or hang himself. Then, he moved to another part of the country to seek admission via another police station. *Diagnostic impression and formulation*: Adjustment reaction in subject with DPD. *Explanation*: During the whole admission, staff did not observe behaviors indicative of low mood, and no suicidal attempt was ever mentioned or observed. However, whenever a discharge plan was cited, he and his family started to blackmail the staff on our ward. Furthermore, the patient himself threatened staff and medics that he would kill himself should he be discharged again wherever he was admitted. He was readmitted into different wards of the same trust, as he tended to go directly to the Accident and Emergency department immediately after each discharge with the intent to be readmitted, each time claiming suicidal ideation. In this case, the story (PF) seemed absurd although having some connection with reality. In this case, the sequence of events suggested that the Karpman Drama Triangle was inverted, and he tended to appear as a victim instead of an aggressor toward his former boss.

Summary of case presentations

It would appear from the cases discussed, and the assessment instruments, that there are common traits surfacing in DPD sufferers, which suggest diagnoses of factitious disorders and PF.The major points are provided as discussed in Table 2 when it is associated with DPD; the points can be used as a diagnostic test (Table 3).

Table 1. Psychiatric Inpatients Observation Scale (PIOS) (by Lazzari & Shoka, 2016)

Diagnosis ICD-10:	Intensity of items				
	Never	Rarely	Every once in a while	Sometimes	Almost always
1. Interacting well with staff	5	4	3	2	1
2. Interacting well with fellow peers	5	4	3	2	1
3. Spending most of the time in his or her room	1	2	3	4	5
4. Appearing socially isolated evenin common areas	1	2	3	4	5
5. Maintaining a good fluid and food intake	5	4	3	2	1
6. Compliant with medication	5	4	3	2	1
7. Side effects from medication	1	2	3	4	5
8. Sleeping well	5	4	3	2	1
9. Incidents during leave	1	2	3	4	5
10. Use of illicit substances in the ward	1	2	3	4	5
11. Use of illicit substances whilst in on leave	1	2	3	4	5
12. Incidents during leave	1	2	3	4	5
13. Patient reporting odd beliefs	1	2	3	4	5
14. Staff observing patient behaving peculiarly	1	2	3	4	5
15. Patient reporting symptoms of paranoia	1	2	3	4	5

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16. Staff observing patient being paranoid	1	2	3	4	5
17. Patient reporting low mood	1	2	3	4	5
18. Staff observing symptoms of low mood	1	2	3	4	5
19. Patient reporting suicidal ideation	1	2	3	4	5
20. Staff observing suicidal acts	1	2	3	4	5
21. Staff observing deliberate self-harm	1	2	3	4	5
22. Patient presenting with signs of hypomania	1	2	3	4	5
23. Patient presenting with grandiose ideas	1	2	3	4	5
24. Staff observing signs of hypomania	1	2	3	4	5
25. Staff observing signs of mania	1	2	3	4	5
26. Staff observing signs of self-neglect	1	2	3	4	5
27. Staff perceiving patient as being at risk for self	1	2	3	4	5
28. Staff perceiving patientas being at risk for others	1	2	3	4	5
Scoring for PIOS: [ ]					

Table 2.Dissocial Personality Disorder and Pseudologia Fantastica Assessment Scale (DPD-PF-AS)

Mental State Examination	*Dissocial Personality Disorder (F 60.2)*	*Psychoses and Delusional Disorders (F 20; F 22)*
Characteristic of the personal account	Articulated and clear. Each detail makes sense in the whole story.	There are loose associations and bits of stories that are tiedtogether by poor logical associations.
Strength of beliefs	Beliefs are strongly held. Patient refuses being challenged by staff about what is believed.	Although beliefs and delusions are strongly held, patient does not attack staff if these beliefs are challenged.
Behavior during ward reviews	Tends to desert ward reviews for fear of being unmasked or with the intent to avoid further assessment or confrontation.	Patient attends ward reviews and does not refuse reality testing, or she or he does it in a minimal way
Reaction to benign diagnoses and reassurances	Patient refuses benign diagnoses and strongly holds that there is "something" wrong in his or her presentation.	Patient welcomes benign diagnoses and feels relaxed about improvement and less-than-serious diagnoses.
Focal thematic areas	In the story, there are frequentreferencesto "police,""law," and"jail" as if they arevery rootedin the patient's own cultural milieu.	Very rarely does patient mention "police,""law," or"jail."These topics do not belong to patient's cultural milieu and delusion.
Reaction to discharge from hospital	Patient categorically refuses being discharged from hospital. Makes threats whenever a discharge plan is mentioned. Can make attempts to sabotage discharges or tends to be readmitted shortly after being cleared, mostly with suicidal attempts or breaching the law.	Patient welcomes the opportunity of being discharged from hospital. Does not sabotage discharge plans, and readmissions are mostly due to relapses in presentation.
Nonverbal behavior and speech	Loud, flamboyant, threatening, or superficially friendly toward a specific member of staff.	Normal tone and volume of voice; speech can be tangential or derailed.
Nonverbal interpersonal behavior	Might become intimidating and overfriendly at the same time. Little knowledge of interpersonal rules. Misinterprets social stimuli that are neutral.	Tends to seek empathy and to find social support to overcome feelings of loneliness.
Relationships with members of staff	Tries to find a strong alliance with a specific member of staff with intent to have support	Might be socially isolated and detached: other times welcoming of staff and

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	for his/her own condition or story.	others.
Somatizations	Tendency to somatize and to use a complex array of physical symptoms to attract attention or sympathy. Physical symptoms might appear dramatic and apparently requiring urgent medical attention.	Somatic symptoms might be an elaboration of the delusional disorder: e.g., formication or internal infestation, little self-care.
Psychological symptoms	Might intensify symptoms of depression and appear miserable with intent to deliver the idea that s/he is highly suicidal and needs special attention or cannot be discharged.	Low mood is mainly in the form of flattened affect. Verbalizes depression more frequently than suicidal ideation.
Psychopharmacological treatment	Strongly requested.	Patient believes s/he does not need psychotropic medications.
Victim role in Karpman Drama Triangle	Tendency to appear "the victim" in the plot of events.	There is no impact of Karpman Drama Triangle.
Welcoming detention under Section 2 or 3 of Mental Health Act	Accepting to be under Section 2 or 3 of the Mental Health Act.	Often appealing against Section 2 or 3 of the Mental Health Act.

Table 3.Dissocial Personality Disorder and Pseudologia Fantastica Assessment Scale(DPD-PF-AS) with scoring

Presentation:	Almost always	Sometimes	Every once in a while	Rarely	Never
1. Detailed and complex story	5	4	3	2	1
2. Victim role in the story	5	4	3	2	1
3. Thematic areas of the story on "Police,""law," and"jail"	5	4	3	2	1
4. Rejecting "benign" diagnoses	5	4	3	2	1
5. Rejecting discharge	5	4	3	2	1
6. Intimidating and flamboyant	5	4	3	2	1
7. Selective alliance with some members of the staff	5	4	3	2	1
8. Somatizations	5	4	3	2	1
9. Welcoming medications	5	4	3	2	1
10. Welcoming detention under Section 2 or 3 of Mental Health Act	5	4	3	2	

Discussion

The topic of PF might appear to be bizarre and intense in its presentation [7]. However, contrary to the stories of other patients, these stories might appear plausible and apparently challenge-proof in the sense that the patient reporting PF seems to have matured an internal and self-convincing mechanism where the story appears into a logically armored"cocoon."The possible speculation is that in order to defend him or herself from being challenged on the truth, the factitious story will also end in becoming a reality to the patient. For a sort of cognitive process where dissonance is avoided, the storyteller continues to improvehis/her own story to the point of becoming enmeshed in it, part of it, and a victim of it. Therefore, although at the beginning the story is used for achieving an external goal, by means of internal defense mechanisms it will end in convincing the patientthat from creator becomes the principal character of the plot described in the PF. As is reported by other authors, patients presenting PF proceed from the initial lying to a complex story in which they are totally entangled; at this stage, it is no longer possible for the patient and the psychiatrists to distinguish where the veracity ends and where the lie starts [8].In addition, PF can lead to lengthy and unnecessary investigations and false allegations. Police involvement might be the norm, together with difficulties in clarifying the real facts that PF is trying to mask. As reported by other authors, frequently this particularized story has been articulated and exposed to psychiatrists and other mentalhealth and legal

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professionals for many years and in diverse places[9]. This happened in the cases reported. Frequent readmissions occurred in different hospitals, where the access was granted as a result ofthe story at the center of PF. In this case, the goal was to use psychiatric hospitals as resorts and escape from reality or the law. As separate geographical areas do not allow easy inter-professional consultation and exchange of diagnoses, these patients were always admitted with diagnoses that did not consider DPD but rather "psychosis,""schizoaffective disorder,""severe depression," etc.Furthermore, when psychiatrists start to suspect PF, the patient might resort to Munchausen syndrome and might start a complex array of physical symptoms, which, in their mind, should be sufficient to halt any process of confrontation between themselves and psychiatrists. In case number 3, Munchausen syndrome was of a psychological nature, and admission of depression with suicidality was a factitious presentation to stop being discharged from the hospital. Dupre described the characteristics of PF as the following: 1) the account must be credible and retain a specific reference to life, 2) the unreal events must appear in numerous situations and in long-lasting fashion, and 3) the topics are mixed but the champion or target is almost constantly the patient [10]. PF has also been reported as being a primitive defense mechanism of denial of reality of someone who escapes reality instead of adjusting to it [11].In any case, there are important legal implications linkedto PF, especially when associated to DPD. Authors have suggested collateral history and past psychiatric history together with other psychological tests[7]. The authors of this article use the Levenson Self-Report Psychopathy Scale, which can be found online, to support the diagnosis of DPD [12].In any case, insight is always present although pathological lying might have an impulsive and obsessive scheme, while the patient may judge their lies as if they were real[13]. The authors of this article believe that this might become true, especially when the PF is highly functional andwhile the dismantling of PF and the acceptance of its irrationality would putthe patient at risk of being prosecuted by law, of the likelihood of a court case, of discharge from the hospital, or of becoming a victim of true aggressors. Another hypothesis explaining the strength of PF is that the person who reports the liestries to reduce the cognitive dissonance of providing a true account of events; in fact, the lying appears more convenient, while the risk implicit in the truth (in this case, promoting a diagnosis of the absence of a mental illness) does not reinforce the behavior of becoming honest. At the center of Festinger's theory of cognitive dissonance are two aspects: 1) the presence of dissonance, being emotionally painful, will encourage the individual to reach consonance; and 2) when dissonance is existing, the person will energetically evade circumstances and knowledge that might augment dissonance [14].As in the cases reported, the patients avoid the dissonance of facing reality and the unfeasibility of their stories by reducing the conflict withinthemselves; this would eventually ensue when self-reinforcing the belief that their stories are not defensible. Besides, individuals with DPD evade circumstances, suchas ward reviews or direct assessment by psychiatrists, that might jeopardize their stories and put them in front of the cognitive dissonance that they truly have no enduring mental illness. Nonetheless, globally considered, people with DPD creating PF are true inventors of a subjective rather than an objective reality. Therefore, as a product of the mind, PF has the practical goal of protecting the individual with DPD from adversities thatshould present if a story of reality is provided whenever they are in a psychiatric hospital. As one author comments:"In the dawn of the world, before the recording finger of history began to mark the progress of time and civilisation, man's inventive faculties were chiefly exercised in providing for his comfort and safety"[15].Therefore, the person with DPD protects him- or herself from something, and the PF is the way by which protection is exercised. As seen above, claiming to be the victim instead of the harasser is a characteristic of PF [16]. Furthermore, the resentment, lack of planning, and tendency toward projection lead people with PF to accuse others ofactions for which they are the responsible [16].The treatment is not easy. Starting a psychotropic medication would reduce the liability of these subjects and reinforce the idea that they are "mad," when the records are screened by the police. At the same time, challenging behaviors remain constant, and psychiatrists should regularly record that treatment is not given for an enduring mental illness but to control behavior. Nonetheless, the diagnosis of PF and a factitious disorder does not preclude other diagnoses and should be constantly complemented by regular psychiatric testing, both structured and unstructured [17]. Therefore, psychiatric illnesses such asadjustment disorder, reactive depression, and post-traumatic stress disorder can be present and may complicate the diagnostic processes. Moreover, the risk that these patients might try extreme behaviors and even suicidal attempts to prove them right should always be kept in the minds of psychiatrists, as it is not unusual that in the extreme effort to support their truth, they might try unexpected, perilous, and risky acts that will seriously endanger themselves and others. This is a subtle game; in fact, there is the risk that the psychiatric staff feels endangeredby this behavior (PF), thus reviewing their diagnosis, which is the sought outcome of these acts.

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Conclusion

This theoretical paper highlights the importance of having proper instruments to unmask PF and factitious disorders in people who have been admitted into inpatient psychiatric wards. In fact, the clarity of diagnosis is important for several reasons—initially, to reduce the risk to self and others from making wrong diagnoses. As seen in the cases reported, if PF is confused with a true delusional disorder, thenpsychiatrists will start a psychotropic medicationthat is not needed for the case treated. Then, a person with DPD and PF tends to enter into a conflict with the staff. Challenging behaviors can throw the whole ward environment into an atmosphere of vulnerability. In fact, psychiatric nurses start to feel endangered and feel that they should have the proper backup for protecting themselves from the attacks and blackmailing of a person whose agenda does not match the therapeutic milieu in which he or she is kept. Then the prolongation of the admission with the confusion deriving in diagnosing factitious disorders reduces the likelihood that the patient with DPD could be assessed by the police. This will ensue in delays in court cases or even in the reduction or cancellation of the chargesagainstthe patient due to the presumption of his or her mental illness deriving from a mistaken psychiatric diagnosis. Therefore, the medico-legal implication is such that a person posing risk to the community could again become a threat toothers being protected by any interference from the law as having been provided with a "psychiatric diagnosis." In the cases discussed, all patients were trying to escape court cases. At the same time, due to the slowness of the bureaucratic machine of the health service, their discharges can become almost impossible. In other words, they knew "how to play the system." This is an unpleasant situation, and even when the games of the DPD are discovered, the psychiatric staff feels let down by a system thatdoes not provide fast solutions fordealing with people in conflict with the society. Finally, there is a need fora collateral history and the collaboration of all members of the staff to clarify the real nature of the presentation of patients with DPD and PF. In fact, nursing and supporting staff occupy key positions in the process of diagnosis. It is thus not infrequent that the diagnosis can be confirmed when the staff can overhear something thatclarifies the whole picture, such as"I heard the patient saying to others that if he stays in a psychiatric hospital long enough, then his court case will be dropped."For this reason, the PIOS and the DPD-PF-AS scalesare robust instruments to reveal PF and factitious disorders. Moreover, as all psychiatrists know, it is not "what the patient says" that makes the diagnosis but "how the patient behaves."This is to say that, in regard to factitious disorders, nonverbalformsof diagnosis find their prominent camp of application.

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Author Bibliography

	**Carlo Lazzari** Carlo Lazzari is a general-adult psychiatrist. He has a special interest in the use of narrative analysis in psychiatry and in the application of discourse inquiry to disentangle the dynamics of unexplainable behaviors in people with rare mental illnesses. Dr. Lazzari has also done extensive research on personality disorders and has provided alternative ways to diagnose and treat people with this problem.
	**Ahmed Shoka** Ahmed Shoka is a consultant in general-adult psychiatry in Colchester. Dr. Ahmed Shoka is a member of the psychopharmacological committee at the Royal College of Psychiatrist in the United Kingdom and an honorary lecturer at the University of Essex. Dr. Shoka has extensive experience in forensic psychiatry and mentalhealth tribunals.

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KapilKulkarni

Kapil Kulkarni is a junior psychiatrist. He was trained in psychiatry in Mumbai, India, and currently works as aMedical Training Initiative fellow at the Royal College of Psychiatrists in London. He has also worked as a psychiatrist in the Republic of Maldives. He has published articles and case reports in reputed journals and has a passion for clinical studies and research.