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Exaggerating, mislabeling or simulating obsessive–compulsive symptoms: Case reports of patients claiming to have obsessive–compulsive disorder

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Abstract

Background: There are no reported cases of factitious or simulated obsessive–compulsive disorder (OCD). However, over the last years, our clinic has come across a number of individuals that seem to exaggerate, mislabel or even intentionally "produce" obsessive and/or compulsive symptoms in order to be diagnosed with OCD.
Methods: In this study, experienced clinicians working on a university-based OCD clinic were requested to provide clinical vignettes of patients who, despite having a formal diagnosis of OCD, were felt to display non-genuine forms of this condition.
Results: Ten non-consecutive patients with a self-proclaimed diagnosis of OCD were identified and described. Although patients were diagnosed with OCD according to various structured interviews, they exhibited diverse combinations of the following features: (i) overly technical and/or doctrinaire description of their symptoms, (ii) mounting irritability, as the interviewer attempts to unveil the underlying nature of these descriptions; (iii) marked shifts in symptom patterns and disease course; (iv) an affirmative "yes" pattern of response to interview questions; (v) multiple Axis I psychiatric disorders; (vi) cluster B features; (vii) an erratic pattern of treatment response; and (viii) excessive or contradictory drug-related side effects.
Conclusions: In sum, reliance on overly structured assessments conducted by insufficiently trained or naïve personnel may result in invalid OCD diagnoses, particularly those that leave no room for clinical judgment.

1. Introduction

Intentionally simulated illnesses can be classified, on the basis of awareness levels and specific motivations, into factitious disorders and malingering [1]. While factitious disorder result from an unconscious need to assume the sick role, malingering behaviors are deliberately produced to achieve external secondary gains such as economic rewards, improved physical well-being, or cleared legal responsibilities [1]. For these reasons, factitious disorders are listed among the psychiatric disorders in the Diagnostic and Statistical Manual-IV-Text Revision (DSM-IV-TR) [2], whereas malingering is considered a condition not attributable to a mental illness [1]. The same diagnostic approach was adopted in DSM5, which classified factitious disorders as a somatic symptom related disorder.

The literature contains hundreds of cases of individuals with feigned psychosis, post-traumatic stress disorder, bereavement, dissociative identity disorder, and claims of child abuse [3]. However, to the best of our knowledge, there is no published literature that has attempted to address the issue of non-genuine forms of obsessive–compulsive disorder (OCD).

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In recent years, our OCD clinic has come across a number of individuals, either self- or clinician-referred, who held the intention of being diagnosed with OCD, and at the same time manifesting an abnormal symptom pattern or clinical course of OCD symptoms.

While most of these patients were apparently motivated by the psychological need of assuming a sick role, it was sometimes difficult to exclude the possibility of concomitant secondary-gain issues (or vice versa). In this report, we describe 10 cases of patients who, despite responding affirmatively to OCD-related questions in structured diagnostic interviews, present with unusual clinical expressions suggestive of exaggerated, mislabeled or even feigned OCD.

2. Methods

Experienced clinicians working on a university-based OCD clinic ($n = 8$) were requested to provide clinical vignettes of patients who, despite having a formal diagnosis of OCD, were felt to display non-genuine forms of this condition. Our OCD clinic, located within the Institute of Psychiatry of the Federal University of Rio de Janeiro (IPUB/UFRJ), is part of the local Anxiety and Obsessive–Compulsive Disorder Research Program and the only specialized public service for the diagnosis and treatment of OCD spectrum disorders in the great metropolitan Rio de Janeiro city area. In general, it receives suspected or confirmed OCD cases screened by the IPUB/UFRJ admission service, sent from other IPUB/UFRJ specialized services, referred by the local OCD support group, or informed about us by word of mouth.

The local OCD clinic started on 1998. Currently, it assesses about one new case every week (around 50 potential new patients per year), unless there are specific research protocols requiring the recruitment of a larger number of subjects, in which case the rates of new patients increase. Our clinical staff includes residents under supervision and clinicians with expertise in the assessment and treatment of OCD spectrum patients, including psychiatrists or psychologists doing their PhD thesis, staff psychiatrists with a PhD degree, and medical school faculty members. In general, the diagnosis of OCD is based on a consensus between the resident and a more experienced staff or faculty member.

On a practical level, clinicians' diagnostic impression has greater weight as compared to diagnoses generated by structured instruments. Thus, patients with OCD according to clinicians' opinion are always retained, regardless of their SCID or MINI results (based on DSM-IV criteria). That is especially relevant for OCD patients with poor insight who do not endorse clinically significant symptoms on structured interviews. Despite being fully aware of the limitations associated with strict adherence to very rigid diagnostic instruments, our clinic also sometimes retained patients without OCD according to our clinical impressions but who received a diagnosis of OCD when structured interviews were employed, as there were limited alternatives for referring these patients in the local mental health system. The cases of several of these patients are described in the present study.

While a total of 420 medical records from the OCD clinic were reviewed, our clinicians were also allowed to describe patients fitting the description provided in other settings. Eventually, eight patients from the OCD clinic and two patients seen elsewhere (e.g. clinicians' private practice) were identified. Basic socio-demographic and clinical information was collected whenever available, with specific focus on reason for referral, symptoms' description, comorbid axis I and II mental disorders, patterns of treatment responses, and drug-related side effects. However, since some patients were referred to other specialized services and were not traceable at the moment of our assessment, a few pieces of clinical information were found missing. The local ethics committee approved this research protocol.

3. Case reports

Case #1: The former clinician of Mr. A, an 18-year-old medical student, became concerned about the apparent lack of therapeutic response and requested a second opinion from our OCD clinic. The patient complained of "repetitive and obsessive thoughts" that dominated his mental life. Specifically, Mr. A reported seeing disturbing homosexual scenes in his mind during the sexual relations with his girlfriend, leaving him worried about whether or not he was homosexual. Curiously, Mr. A's appearance, body language, mannerisms, voice inflection, and style of clothing were quite effeminate. Our attempts to further clarify the characteristics of the "distressing obsessions" were met with irritability. Mr. A was convinced that he had "sexual-related obsessions," which were reportedly acknowledged by his former attending psychiatrist and confirmed by his readings in the internet. Assessments with the SCID established the diagnoses of OCD and major depressive disorder. Mr. A also reported several previous suicide attempts, mostly by overdose of his own medications. His symptoms were resistant to different trials of serotonin reuptake inhibitors, employed in maximum tolerated doses for at least 12 weeks each.

Case #2: Mr. B, a 20-year-old single biology student, sought treatment for being "severely" worried about contamination issues, especially in relation to tuberculosis, and associated "compulsive" washing. Attempts at clarifying the nature of his symptoms, with questions about time spent, interference in daily activities, resulting anxiety, and other OCD features, were frequently answered with irritability. He reported being offended by these queries and complained that he was disappointed with his clinician who seemed to consider him "untruthful." Mr. B attributed his symptoms to OCD. They remitted almost completely after only 2 weeks of treatment with paroxetine (20 mg/day). However, Mr. B remained under treatment for several years, due mainly to