Factitious disorder in a Vietnamese woman imposed on her 2-month - old child: a rare case report with complicated socio - cultural implications

Tran Nhu Minh Hang[1*], Nguyen Huu Cat[1], Nguyen Vu Quoc Huy[1], Clayton Chau[2]
[1]Hue University of Medicine and Pharmacy, Hue University
[2]National Healthcare and Housing Advisors, USA

Abstract

Factitious disorder imposed on another (FDIA) is a psychiatric disorder in which a patient causes physical or psychological signs or symptoms or injuries in her/his child or dependent in order to intentionally deceive others. If not detected in time, a child or dependent's safety may be at risk. Presented here is a case study of a Vietnamese 26- year - old woman with FDIA, with a history of psychological violence and associated trauma, and the progression of her treatment. With this case, we would like to emphasize the profound impact of socio -cultural factors on the formation of disorders in patient. Patient presented with complaints about bleeding in her infant daughter. After several evaluations the patient was diagnosed with FDIA with co-morbid depressive symptomatology. Patient was treated with sertraline 50mg/day combined with Cognitive Behavior Therapy (CBT) for 12 weekly sessions and family therapy for 4 sessions. Patient had a good treatment progression with a marked reduction of symptoms. At the end of the treatment this patient was able to appropriately care for her infant. While FDIA is thought to be a difficult disorder to treat, often requiring years of therapy and support, in this case the patient progressed rapidly. It is important to treat both depressive symptoms as well as co-morbid psychiatric disorders, in addition to other psychological factors such as conflicts in the family, trauma events in the life, which should not be neglected in assessing the patients with FDIA and psychotherapies such as CBT and family therapy may be effective in this group of patients.

Key words: *FDIA, psychological profile, treatment, Vietnamese woman, case report.*

1. INTRODUCTION

Factitious disorder, previuosly called Munchausen syndrome is a mental disorder in which patients purposely create physical and psychological symptoms in themselves or in others [1]. This mental disorder is coded as 300.19 in the Diagnostic and Statistical Manual of Mental Disorders, the fifth edition (DSM 5) [1]. In factitious disorder, patients deliberately invent symptoms to deceive others not to gain practical benefits such as financial or law benefits or getting out of work. The gain is only about psychological gain [2, 3, 4, 5]. Factitious disorder is divided into two types: factitious disorder imposed on self (FDIS) and factitious disorder imposed on another (FDIA) [1]. Factitious disorder imposed on another (FDIA) is a psychiatric disorder in which a patient causes physical or psychological signs or symptoms or injuries in her/his child or dependent in order to intentionally deceive others [1, 2, 3]. If not detected in time, a child or dependent's safety may be at risk [2, 6]. The causes of factitious disorder are unknown, but patients with this disorder often have a complicated psychological profile. Diagnosis and treatment of factious disorder is often challenging to medical providers [4, 5]. We present the case of a 26-year-old Vietnamese woman with FDIA who imposed symptoms on her 2-month-old child and her treatment process, as well as discuss the role of socio - cultural factors in her disorder.

2. CASE PRESENTATION

2.1. The context of situation

A 26 - year - old Vietnamese woman brought her 2 months old daughter to the emergency department (ED) at Hue University Hospital of Medicine and Pharmacy, Vietnam, because of bleeding in the child's mouth. The ED physician examined the child and found that blood had stained around the child's mouth. However, surprisingly, after wiping off the stain, the doctor did not see any wound. The baby was then transferred to the pediatric ward for further monitoring. At the pediatric ward, the baby's mother continued to report bleeding in the child's body. As in the emergency department, the pediatrician did not see any wound in the child's body. After taking a specimen for testing from the child's body where the mother reported bleeding, there was not any blood cells identified in this sample. The baby sucked, slept well and had no abnormalities. Blood count and blood clotting function of the baby were

**Corresponding Author: Tran Hang Nhu Minh. Email: tnmhang@huemed-univ.edu.vn*
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within normal range. The pediatrician suspected the mother could have a mental health problem and requested a psychiatrist to exam the mother (from here on will be referred to as the patient) after 5 days of her child's hospital admission.

2.2. The first interview with the patient by the psychiatrist

The patient appeared neat with normal appearance and was cooperative during the examination. She lived with her husband and parents in Ha Tinh Province, far from Hue, about 300 kilometres to the north. She used to work as a waitress in a restaurant and had been out of work for one year since becoming pregnant. She denied any traumatic or psychological events in her life. She reported a happy marriage and that her husband loved her very much. Her husband was a 40 years old construction worker. The baby was her first daughter, born at full term by caesarean section because of breech presentation. Her birth weight was 3 kilograms. Two weeks before this admission the patient took her daughter to another hospital for her child's vaginal bleeding, but at the hospital, the physicians told the patient that her daughter did not have any injuries. We requested another appointment with her, her husband and her family members.

2.3. The second interview

Two days after the first meeting, we had the second interview with the patient and her husband. During the meeting, the husband frequently accused his wife of being clumsy, stupid and unable to take care of their child. While the husband spoke, the wife just sat quietly with a sad face and tears in her eyes. This was in contrast to what the patient told us two days ago in the first interview in which she reported that she has a happy family. Despite her husband's accusations that she was "a fool" and didn't know how to take care of their child, during the week in the hospital, she demonstrated good care of the baby by herself. Except for the mother complaining of bleeding in the baby, the baby was growing well and clean. We asked the husband about his wife's psychological and mental health history but he stated he did not know anything about that. We asked the husband to take good care of his wife and daughter, especially the child. During her husband's stay in the hospital, the pediatrician told us that the patient still reported her child's bleeding two more times.

2.4. The third interview

Three days after the second interview, we conducted the third interview with patient, her husband and her mother. The mother said that the patient was the younger child in the family with 2 children: a son and a daughter. Her brother was 2 years older than her. From a young age, she had very few friends and was a sensitive girl. She graduated from high school but failed the entrance examination to university level. Her mother also reported that, growing up, there was no family financial difficulty and that they were able to give the patient gifts or anything she needed. Three years ago, the patient went to live with an aunt to help with her aunt's business. During that period, the patient did harm to herself twice by cutting her arms. When asked about this behaviour, she explained that her aunt often yelled at her when she made mistakes. Her parents took her back home. A year ago she met her husband and got pregnant before she got married. Her parents were embarrassed , so they sent her to live with her grandmother. Her grandmother was a conservative person, therefore could not accept the pregnancy and verbally abused her. The grandmother called her by bad nicknames such as "the slut." The patient often felt sad and cried at night. She did not sleep well and suffered a loss of appetite. Sometimes, she thought if she died, she would be better off. The wedding took place when she was 4 months pregnant. After the wedding, she and her husband moved in with her parents. Her mother also reported that her husband often went out early in the morning and came home late in the evening due to work. However, her mother said she rarely saw the couple quarrel. She believed that her son-in-law was a good person. The mother provided us some information that the patient often had some strange signs during the full moon days such as red face, sitting alone or crying. She assumed that these behaviours were due to demonic possession.

In the third interview, we told the patient that we knew the red stains on her daughter's body were not blood. She cried and admitted that they were just lipstick stains. At that moment, she talked about her sadness, her hopelessness, and helplessness. She thought that no one would understand her.

3. DIAGNOSTIC ASSESSMENT

After three interviews with the patient, her husband and her mother along with monitoring the child's condition and how she cared for the child and the patient's behaviour during the child's stay in hospital, this case was considered as a FDIA that meets DSM 5 criteria: (1) She induced injuries in her daughter associated with identified deception; (2) The patient presented her child to others such as pediatricians, psychiatrists, medical students as

injured; and (3) Her behaviour to deceive others not to gain practical rewards [1]. Besides FDIA, she also had some depressive symptoms including sadness, feelings of hopelessness, helplessness, loss of appetite and insomnia. We also considered this case as a malingering by proxy, although she met two first criteria of Factitious Disorder Imposed on Another, she did not appear to be engaging in the abusive behavior in order to satisfy an internal psychological need. The feigned signs of illness she created in the child did not physically harm her child. However, we are more inclined to diagnose FDIA in this case because of the following two reasons: first, we did not find any obvious financial, legal benefits or other practical rewards in this woman; Second, we think that the act of taking the baby from one hospital to another, resulting in the child being hospitalized and having to undergo many different tests to diagnose the disease, is a abusive behaviour to the child.

4. THERAPEUTIC INTERVENTION

We diagnosed her with FDIA with some depressive symptoms. We explained to her family about her disorder. We discussed treatment with her, her husband and mother. Because they lived in another province far from Hue, online treatment was the best option.

We treated her with 50 mg sertraline per day combined with 12 weekly CBT sessions and 4 family therapy sessions. After the first 10 days of treatment, she exhibited self -harm behaviour with cutting her arm. Other than this behaviour she did not report any other side effects or problems. She refused hospital admission but expressed desire to contact us by video call. We continued with the same treatment regimen. After 4 more weeks of treatment of 4 CBT sessions and 2 family therapy sessions, her condition had improved. She felt happier and had fewer negative thoughts. The treatment concluded after three months with a total of 12 CBT sessions and 4 family therapy sessions and we still kept in contact.

CBT was delivered over 12 weekly sessions (60 minutes) to target cognitive distortions, emotional dysregulation, and maladaptive behaviors (e.g., applying lipstick to simulate bleeding in her child). The intervention followed four phases:

- Assessment and Psychoeducation: Established rapport, assessed cognitive and emotional patterns using the Beck Depression Inventory (BDI), and provided education on FDIA and the CBT model.

- Cognitive Restructuring: Identified and challenged negative beliefs (e.g., "I'm a failure as a mother") using thought records and Socratic questioning, promoting self-compassion and realistic self-assessment.

- Behavioral Activation and Coping Skills: Encouraged engagement in rewarding activities (e.g., socializing) and taught problem-solving, relaxation techniques, and assertive communication to replace maladaptive behaviors.

- Relapse Prevention: Consolidated skills, developed a relapse prevention plan to address triggers (e.g., marital criticism), and supported long-term goals (e.g., returning to work).

Family Therapy was conducted over 4 biweekly sessions (90 minutes each) involving the patient, her husband, and her mother to improve communication and support. The intervention included:

- Engagement and Assessment: Explored family dynamics using a genogram, FAST tool (Family System Test) and circular questioning, with psychoeducation on mental health and FDIA.

- Communication and Conflict Resolution: Reduced the husband's critical behaviour through active listening and role-playing, encouraging the patient to express her needs.

- Strengthening Support: Redefined family roles using structural techniques and assigned collaborative tasks to enhance support for the patient and child.

- Maintenance: Reinforced positive changes and developed a family relapse prevention plan to sustain support and ensure child safety.

5. FOLLOW – UP AND OUTCOMES

During the treatment process, we taught the patient skills to solve problems, deal with various situations, change negative thoughts, and manage emotions through exercises in CBT. With family therapy, we explained her disorder to her parents and her husband. Fortunately, they cooperated in the treatment to help her. As a result, her husband started to come home earlier after work, helped her in caring for their baby and shared emotions with her. Her parents interfered less in her life but continued helping her in caring for the baby and with any financial issue. After three months of treatment, the patient felt much better and she decided to learn to become a hair stylist. All methods of treatment have helped her to gain self-esteem and motivation. She realized her values and found meaning in life. It is also important to note that the 50 mg sertraline per day also helped improving her symptoms.

6. DISCUSSION

The first strength in this clinical case was that the patient and other family members (the husband, her parents) were very cooperative so we could obtain a lot of information related to the patient's socio-cultural background, especially the influence of Confucianism on the clinical picture of patients. We analysed these cultural and social characteristics carefully below. The second strength was that the patient adheres well to treatment and the family cooperates in supporting the patient. Third, the research team had established a good relationship with the patient and her family, which helped facilitate the diagnosis, intervention and monitoring process and achieved good outcomes.

The limitation of this clinical case is that because the patient was far away, her psychological treatment had to be conducted online, not in person. During treatment, the patient showed self-destructive behaviour, but because we were far away, we could only advise the family on what to do to prevent suicidal behaviour from occurring. With family therapy, we could not reach the patient's grandmother, who had strong Confucian and feudal ideas, so the intervention was not thorough.

In this case, we would like to discuss her complicated socio - cultural profile and its role in her disorder. First, she was the youngest child in her family so she was overprotected by her parents. She lacks coping skills in complex and vulnerable, frustrated situations. This explained the fact that when living with her aunt and away from her parents, the patient cut off her hand when she was yelled at. Studies show that an overprotected child is more prone to anxiety and depression [7, 8, 9]. To learn effective coping skills, the child should be exposed to some risks and challenging experiences in order to mature. Overprotective parents prevent their children from these opportunities so the children are unprepared to deal with unhappiness, adversities, failures, and heartbreaks. Besides higher prevalence of depression and anxiety, overprotected children also have some adverse psychological manifestations such as low self-esteem and self-motivation, target of bullying, and maladaptive narcissism[9]. Second, she had a premarital pregnancy. Vietnam and other Asian countries including China, Korea, Taiwan, Japan are strongly influenced by Confucianism. Confucianism views premarital sexuality as a taboo [10, 11, 12]. Confucianism also focuses on a woman's virtue of chastity, which means remaining a virgin before marriage [10, 11, 13]. Getting pregnant before marriage was a shame for her family especially with her paternal grandmother being a native of Hue. Hue was the capital of the Nguyen Dynasty, the last monarchy in Vietnamese history, where Confucian moral values had strong influences, even among the elder generation in modern time. Personal and family reputation are so crucial in Vietnamese culture. It was these old Confucian thoughts that led to her grandmother's harshness and verbal violence towards her when she was pregnant before marriage. Third, perhaps she had an unhappy marriage. In the second interview, her husband often blamed her. Besides that, according to her mother, her husband often left for work early came home late. Although they rarely quarrel, they did not share feelings for each other so she told us that no one understood her. Due to the influence of Confucianism, harmony is one of important virtues in Vietnamese families [10,13]. Besides, Vietnam also has a saying that "show the good, hide the bad", family conflicts still exist but not revealed. Moreover, her husband lived with her parents in the same house. According to Confucianism, the role of men is always more important than that of women [10, 11, 12, 13]. After getting married, women must return to their husbands' houses. It is reason that for most Vietnamese men, living with their in-laws is like being "a dog under the closet." They consider that living arrangement is shameful and they must suffer from this situation. Maybe, it was this thought that made the husband stay away from home often to avoid his inner conflicts and not share his feelings with his wife. As an overprotected child, she did not have the necessary skills to solve conflicts or problems in marital life and the premarital pregnancy put her in a lower position than her husband did in the family. Although the cause of factitious disorder is unknown, the disorder may be caused by psychological factors and stressful life exposure. With our patient, we think all factors analysed and discussed above have contributed to the disorder. The last thing we would like to discuss that many Vietnamese families still believe that manifestations of psychiatric disorders are caused by demonic possession, which makes treatment difficult or delayed. With this case, although the patient showed some symptoms of mental disorder even having self - harm behaviour from three years ago but she had not received any treatment because of the belief that these signs were caused by ghost entry.

Our case highlights the importance of considering the patient's socio - cultural factors and stressful life experience(s) in the assessment and treatment of Factitious Disorder. FDIA is a diagnosis that is

easily confused with malingering so it is necessary to carefully examine the underlying motives and secondary benefits when examining these patients to differentiate.

7. PATIENT PERSPECTIVE

The patient trusted the medical team and cooperated well throughout the treatment process. Except for one self -harm behaviour by cutting her arm after 10 days of treatment, she actively participated in discussing the treatment process. She practices exercises well during treatment. She was also compliant with medication treatment. She recognized the relationship between the symptoms she created in her daughter and her internal emotional conflicts. Through the treatment process, she realized her own value, had a huge change in cognition and behaviour, learned new skills and was confident in relationships. All of these are the premise for her happy life.

8. INFORM CONSENT

This case report has the patient's written consent, we will provide it upon request.

CONFLICT OF INTEREST

There is no any conflict of interest to be declared

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AUTHOR CONTRIBUTORS

HNMT had a major role in interviewing and in reporting clinical information of the patient. CNH and VQHN provided clinical information of the patient and litterature in this topic. CC was supervisor of the clinical case and revised the manuscript. All authors had substantial contributions to conception and design of the case report, wrote and revised the manuscript as well as have approved the final version.

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