The Lie Effect: A Factor Responsible for Perceived Therapeutic Response

Sir,
Therapeutic effects of pharmacotherapy and somatic treatments are mediated through biological mechanisms. Other than the biological effects of medications, patients respond to pharmacotherapy or somatic treatments due to various other nonspecific reasons.\(^1\) Recent evidence suggests that the therapeutic changes produced by the placebo too can be explained by definite psychobiological mechanisms.\(^2\) Various other factors that contribute to therapeutic response may be spontaneous remission of the illness, underrating of the symptoms reported to the clinician, setting of the assessment, decrease in the stress level of the patient, good psychosocial support, and simultaneous use of other treatment measures.\(^3\)

Schizophrenia is a complex illness in terms of its etiology, pathogenesis, and outcome.\(^4\) In schizophrenia, the response to treatment is assumed to be a complex phenomenon. I am discussing a case in which an unusual factor contributed to the perceived therapeutic benefit.

A 32-year-old male, diagnosed with schizophrenia for past 10 years, used to complain of persistent auditory hallucinations (voices commenting on his action and commanding him to do certain acts). He would report the hallucinatory voices to be present for the most of the day, as a result of which he was in significant distress. The persistent hallucinations caused significant impairment in his work and activities of daily living.

He was being treated with multiple antipsychotics in adequate dose and duration at various points in time, with adequate compliance, but with little benefit. In the past, he had also received ten sessions of electroconvulsive therapy without any significant therapeutic response. Due to intolerable side effects, clozapine could not be continued for long.

Along with the ongoing antipsychotic treatment (ziprasidone 160 mg/day), he was given 20 sessions of repetitive transcranial magnetic stimulation (rTMS) at our center using low-frequency (1 Hz) TMS over the temporoparietal junction. He reported complete cessation of the auditory hallucinations by the end of 20 rTMS sessions. During follow-up visits, he had also received booster sessions of rTMS, at monthly intervals, for 6 months. He reported no auditory hallucinations for the next 2 years. However, in a subsequent follow-up visit, he reported the auditory hallucinations. On exploration, he also reported that the hallucinations were persisting since the beginning of his illness with fluctuations in severity and duration, but they had never stopped. He confessed that he was lying in the past about clinical improvement, as he believed that the hallucinations would never stop. He also reported that the voices tell him that no treatment can stop them.

In this case, lying by the patient was perceived as a therapeutic response by the clinician. If the confession during the follow-up could be considered the truth, then he could be considered a nonresponder to treatment. On the other hand, if his past reports could be considered the truth and the follow-up confession a lie, then he could be considered a responder to TMS who relapsed in follow-up. It is difficult to ascertain which part of the patient’s reporting about his symptoms is the truth. Clinicians may encounter such dilemmas where the perceived clinical improvement (pseudo response) may be due to lying by the patient.

The therapeutic response, beyond medication and placebo effects, can be understood broadly in the perspectives of the therapist, the client, the illness, and the environment. Their complex interaction determines the therapeutic response.\(^3\) The perceived therapeutic response may be different from the real therapeutic response. Perceptions of the clinician and the family about the therapeutic response could be based on objective evidence of improvement (improvement in functioning, disability, distress, and behavior) as well as the subjective reporting by the patient.

The effect of lying regarding the therapeutic outcome could not be ruled out even in psychotic illnesses such as schizophrenia. Patients may lie about their symptoms, which can be in two broader forms: first, reporting a symptom which is not there; and the second, denying a symptom which is present. The patient may have complex attribution to their lying, which broadly refers to their present narrations or remote past narrations.\(^5\)
The effect of lie on the perceived therapeutic response is undeniable. Lying by the patient about improvement or deterioration in symptoms often misguides the clinician. The clinician needs to consider this factor while judging the therapeutic response, though it may not be applicable in every case.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Neuropsychiatric Symptoms as Early Manifestation of Progressive Supranuclear Palsy

Sir,

Progressive supranuclear palsy (PSP) is a neurodegenerative extrapyramidal syndrome characterized by motor symptoms such as postural instability, rigidity, akinesia, supranuclear gaze deficits, and behavioral and cognitive symptoms, which usually occurs from 55 to 70 years of age. The neuropsychiatric symptoms of PSP include apathy, depression, sleep disturbances, personality changes, disinhibition, and cognitive impairment. There have been very few reports of PSP cases who presented with neuropsychiatric symptoms. Here, we report a case of a 60-year-old patient, who initially presented with depression and behavioral symptoms and was later diagnosed with PSP. The novelty of this case report is the rarity of presentation and importance of neurologist–psychiatrist team approach in the diagnosis as well as treatment of such cases.

CASE REPORT

A 60-year-old female, with no past or family history of psychiatric problems, presented to the outpatient psychiatric clinic with persistent and pervasive sadness of mood, loss of interest in daily activities, decreased sleep and appetite, easy fatigability, ruminative thoughts, anxiety symptoms, and death wishes for the past 18 months. The patient did not have a