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Diagnostic difficulties and management challenges in a case of factitious disorder

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Abstract: Factitious disorders are among the most difficult to diagnose psychiatric cases due to its diversity of presentation. Due to their various presentations they used to receive multiple treatments. Here we are reporting a case of factitious disorder who attended our OPD with various psychological symptoms in her multiple hospital visits.

Keywords: Factitious disorder, Psychotherapy, Childhood trauma

Introduction:

Factitious disorder is characterized by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role (American Psychiatric Association, 2007). It is a disorder of illness behavior and there is a psychological need to assume the sick role with an absence of external incentive (Ranjan, 2008). Richard Asher in 1951 termed this disorder as Munchausen syndrome based on the exploits of an eighteen century figure Karl Friedrich Hieronymus Freihess Von Munchausen, who was famous for his travels and dramatic tales (Asher, 1951). Individuals with Factitious Disorder intentionally make or overstate symptoms of an illness in several ways. They may lie about or imitate symptoms, hurt themselves to bring on symptoms, or alter diagnostic tests (Cleveland clinic, 2013). Those with Factitious Disorders have an inner need to be seen as ill or injured, but not to achieve an external benefit, such as a financial gain (Cleveland clinic, 2013). People with Factitious Disorder are, notwithstanding ready to experience agonizing or hazardous tests and operations so as to get extraordinary consideration given to individuals who are really sick (Cleveland clinic, 2013).

Factitious Disorder is considered a mental illness because it is associated with severe emotional difficulties (Ranjan, 2008; Cleveland clinic, 2013; Thippeswamy, 2014). According to psychodynamic theories traumatic childhood experiences, where parental authority was confusing, rejecting, or unsatisfying, leads to development of hostility, bitterness, helplessness or resentment (Ranjan, 2008). Any precipitating daily life stress leads to a feeling of inadequacy, helplessness or rejection and the patient has a compulsive urge to re-enact his previous hospital experiences where he was cared for and was the center of attention, love and approval (Ranjan, 2008). Due to the dishonesty involved, diagnosing Factitious Disorder is very difficult (Cleveland clinic, 2013). Here we are reporting a case of factitious disorder who presented to us with diverse symptomatologies in her different visits and after various clinical and psycho diagnostic evaluations finally she was diagnosed and managed.

Case summary:

A 19 year old young lady was brought by a Non-Governmental Organization (NGO) to the out-patient department (OPD) of a tertiary Psychiatric institution in North-Eastern part of India with complaints of irritability, fearfulness, repeated attempts of self-harm decreased sleep for many months, following which she was. On admission, Physical examination revealed multiple linear self inflicted cut marks on her left forearm and serial Mental Status Examinations (MSE) revealed ideas of persecution, occasional helplessness, and periods of inappropriate smiling with adequate higher cognitive functions. Psycho diagnostic assessments (Rorschach Inkblot Test) was done. Psychodiagnostic tests like Rorschach test and Minnesota Multiphasic Personality Inventory (MMPI) were applies to explore her psychological status. Pharmacotherapy was started with atypical antipsychotic Risperidone 2 mg which was increased upto 4 mg in divided doses along with a Benzodiazepine (Lorazepam 2mg) at night. Adequate anti-suicidal measures were also taken both from the treating team and also from the hospital staffs. She responded slowly and was

discharged with a diagnosis of Unspecified Nonorganic Psychosis (F29) according to the ICD-10 Classification of Mental and Behavioural Disorders.

This young lady was taken back to the NGO who had brought her and she became non-compliant to her medication schedules. She was again brought back to our institution after few months of her discharge with new complaints of wandering here and there, fresh 4 attempts of suicide, restlessness, decreased sleep and poor socialization. She was admitted again and MSE findings revealed ideas of hopelessness, sad affect and she reported of hearing of voices of a boy who is threatening her. She also started to exhibit destructive behavior in the ward with breaking glass panes of the windows and slashing her wrist with the broken glass. Adequate measures were taken to reduce her harm and this time a detailed history of this girl was warranted. The NGO personnel who accompanied her to our institution knew little of her past life except that she was shifted from another NGO because she also showed some Self-harm gestures there. Taking a note to that, the treating team sat with her and she was told to speak about her symptoms, her past life, about her parents etc.

Further enquiry revealed that she was ignorant about her parents. From there she was adopted by a family who took her home. She grew up knowing them to be her biological parents. She was never sent to any schools and was made to do household works. A servant working in the same house took her to another family where she was badly treated apart from being forced to do household chores. Here she was sexually exploited by the eldest son of the family and she was threatened with dire consequences if ever she divulges his act. In spite of this, the news spread in the family and to hush up the matter, she was sent away to another house. Here she was treated well but she used to have recurrent thoughts of the tormenter who had sexually exploited her. She tried to commit suicide for the first time but was saved at the nick of time. Seeing her problem she was sent to an NGO for the first time where also she attempted such a behavior. She started to work in a beauty parlour where she was betrayed by a fellow colleague and she again attempted to commit suicide a 3rd time. She was shifted to another NGO where also she made repeated attempts to harm herself following which she was brought to our institution OPD for the first time as stated earlier.

A provisional diagnosis of F29 with depressive symptoms was again made this time and she was discharged with Risperidone 4mg, Sertraline 150 mg. During her stay this time in the ward she was also administered with Electro-convulsive Therapy (ECT) for her suicidal tendencies.

She was again brought to our OPD after 4 months with relapse of her symptoms and making multiple suicidal gestures both in the form of trying to hang herself and slashing her forearm with sharp objects in front of onlookers. She tried many times to flee from the NGO hostel, tried to consume pulverized glass, assaulting people, stealing objects and also tried to consume alcohol on occasions. Lithium was added this time to the treatment regime upto a dose of 900 mg per day in divided doses, Sertraline was hiked upto 250mg in divided doses, Amitriptylline upto 75 mg and Lorazepam 2 mg. ECT was also given this time (3rd admission in 1.5 years) and adequate improvement was still not noted. During her stay in the ward, she used to start quarrel with fellow inmates daily on multiple occasions in a day. She also used to cut her wrist many times, disturb others, destroying hospital property, tries to hang herself with a noose made of her bedsheet. All this activities were done by her at places and times where she could be easily seen by the keeper staffs or the nursing staffs of the hospital. Such activities were also mainly done when the particular doctor who was actually seeing her was not in the vicinity. Each and every flurry of activities were followed by a string of commotion in and amongst the nursing and keeper staffs who used to attend to her keeping aside their work at hand, pacifying her, caressing her and calling the on-duty doctors and also the particular doctor who was seeing her. She would then receive verbal counseling from the treating team along with necessary medications and all her activities would decrease then. Such behavior of her would again follow now and then whenever she found no treating team besides her. Along with these she repeatedly complains of having recurrent flashback of those sexual exploitations. She received a diagnosis of post traumatic stress disorder along with Cluster B Personality Disorder in this time (Borderline Personality disorder and Histrionic Personality Disorder) and was sent back to the NGO that brought her.

She stayed there for only 2 days when she made fresh attempts to steal a money purse, throw away the money, throttling a child, breaking the glass panes of window and slashing her wrist afresh. She was again brought to our institution and was admitted again seeing the nature of her symptoms (4th admission in 1.5 years).During the present stay she also started to exhibit behaviors like the previous admission by which she could try to gain the attention of her treating team. Whenever she would not be attended by a doctor, she would make attempts in destructive ways so as to bring a doctor to her bedside. She also stole a mobile phone from one keeper staff, stole few ornaments from a fellow inmate, all of which necessitated summoning a doctor to counsel her not to do what is unacceptable. Her behaviors gradually shaped into one in which she would receive ample attention and care from the treating team.It so also happened that she tried to slash the neck of a fellow ailing patient with a glass piece when she found out that the treating team is showing increased care to this

ailing patient in the IPD just to divert the doctor's attention towards herself. Continued attention to her was then shown for few days which decreased her behavior (self-harm and destructive). Withdrawing attention and care from her would result in this girl to lock herself in the lavatory of the Rehabilitation centre attached to the institution and so on and so forth. No gross psychopathology was found in the present admission apart from repeated attention seeking behavior from the medical team. A provisional diagnosis of Factitious disorder was made, along with Mixed Personality Disorder (Borderline and Histrionic PD).

Discussion:

Factitious disorder patients may present with various physical and psychological problems. Among the physical complaints, abdominal pain, pyrexia of unknown origin, Malena, paraplegia, gingival injury, chronic diarrhea, dermatitis are commonly seen (Ranjan, 2008). Psychological symptoms comprises of depression, anxiety, post traumatic stress disorder, suicidal ideation are commonly seen (Ranjan, 2008). Many a time it creates lots of problems to diagnose a case of factitious disorder due to its diverse presentation. Regarding the course and outcome of this psychological problem, it is insidious in nature; multiple hospitalization and change of symptoms in subsequent visits are very common (Ranjan, 2008). Our case also presented to us with various psychological problems like depression, suicidal ideation, post traumatic stress disorder in her various visits. Various pharmacological and psychological interventions were applied, but they showed only temporary relief. Age of onset of factious disorder is in early 20s or early adulthood, which is consistent with our case (Ranjan, 2008; Cleveland clinic, 2013). Females suffer more as reported by recent studies (Ranjan, 2008; Asher, 1951; Cleveland clinic, 2013). However homicidal ideation in factitious disorder is not reported in any previous study (Ranjan, 2008; Asher, 1951; Cleveland clinic, 2013). On repeated inquiries our patient revealed that she used to harm her fellow patients to draw attention of hospital staffs towards her. Traumatic childhood experiences, loss, rejection, lack of emotional attachment of our patient have played an important etiological factor in our case (Ranjan, 2008; Cleveland clinic, 2013). The thought process behind the reporting of this case is to exhibit the trouble we confronted while diagnosing our case. During her initial visits, she presented to us with psychotic features, and received antipsychotic drugs. In her later visits, she subsequently presented with depressive and anxiety features. In the later part of her hospital admission she showed mainly suicidal and homicidal intentions. Due to these polymorphic presentations along with interplay of various psychological factors, we ultimately led to a diagnosis of factitious disorder.The exact cause of Factitious Disorder is not known, but researchers believe both biological and psychological factors play a role in the development of this disorder. Some theories suggest that a history of abuse or neglect as a child, or a history of frequent illnesses in themselves or family that required hospitalization, may be factors in the development of the disorder (Ranjan, 2008; Asher, 1951; Cleveland clinic, 2013; Hamilton et al. 2009).

The authors would like to hear similar cases from others.

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