PSYCHIATRY

DOI 10.35630/2022/12/psy.ro.23

Received 14 December 2022;
Published 14 January 2023

FACTITIOUS DISORDERS – CHALLENGES IN PSYCHIATRIC DIAGNOSIS

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ABSTRACT

Introduction: Factitious disorders is a group of psychiatric pathologies in which a person acts as if he has an illness by deliberately producing or exaggerating symptoms on them, or sometimes they use a "victim" in order to catch the attention of the others. Usually, the real causes for this kind of behavior are emotional impairments and personality disorders. Munchausen syndrome and Munchausen by proxy syndrome are the most known of these disorders.

Aim: The aim of this paper is to raise awareness for this kind of disorder because they are an extensive problem for the medical system and in many cases, they are hard to diagnose and manage.

Method: We started by observing and documenting an unusual case of Munchausen syndrome at a patient from Infantile Neuropsychiatric Clinic of Psychiatry Institute "Socola", Iasi and her mother with Munchausen by proxy syndrome. We compered this pair of cases with data reviews on the subject to see what are the challenges that are common for this kind of pathologies and how we can manage them.

Conclusions: We concluded that factitious disorders are more common that is thought they are. Doctors tend to let this diagnose on the last place because the priority is to resolve the somatic symptoms of the patient. That is why we must acknowledge and understand how to manage this kind of mental disorder.

Keywords: Factitious disorders, Munchausen syndrome, Munchausen by proxy syndrome

INTRODUCTION

Factitious disorders (FD) are a group of psychiatric pathologies in which a person acts as if they have an illness by deliberately producing or exaggerating symptoms on them, or sometimes they use a "victim" to catch the attention of the others (Chirita et al., 2012; Sandu et al., 2017). The patients are with FD usually fabricate symptoms, "act out" medical conditions and even intervein with medical diagnostic investigation or trying to manipulate them. Sometimes they self-induce injuries putting themselves in a real danger. This kind of patients costs the healthcare system considerable amount of money. In United States a patient with FD can bring to the healthcare system cost between 200.000 and 1.000.000 $ (Bright et al., 2001; Romano et al., 2014) because they are so difficult to detect and that is why there is a need for improving and speeding up the diagnostic and therapeutic methods.

Because of these impairments the exact prevalence of FD is hard to establish, but the general date suggests that between 0.6 and 3% of referrals from general medicine to psychiatry and between 0.02% and 0.9% of cases reviewed in specialist clinics (Caselli et al., 2017). A study conducted on physicians reported that the prevalence of FD on their patients is 1.3% (Fliege et al., 2007).

In the anamnestic examination of patients with FD there are usually found emotional traumas, family disorders, abuse, unresolved/active grief, familial conflicts (Jimenez et al., 2019). Therefore, we can also

see that FD could be a coping mechanism to which the patients reach to fulfil the emotional needs they have. It is difficult to imagine how someone can reach to painful methods or invasive procedures for attention-seeking, but we must see the FD in all their socio-behavioral variables (Baroiu et al., 2021).

Another aspect that we should consider when we are evaluating a potential patient with FD is the clinician's responses to them. Sometimes the clinicians compulsively find or demonstrate that is something indeed physically wrong with that patient (Rădulescu et al., 2020).

DIAGNOSE CRITERIA FOR FD

There are 2 guidelines of diagnosis currently used: one is the European guideline ICD-10 (World Health Organization, 1992) and DSM-5 (American Psychiatric Association, 2016), the American guideline.

In ICD-10 FD are under the code F68.1 in the category "Other personality and behaviour disorders of the adult". Here, the criteria of diagnosis is that the patient is inventing symptoms on himself repeatably and consequentially without him suffering of somatic incapacities or mental disorders. The motivation for this behavior is almost always obscure, these individuals with this behavioural pattern have substantial abnormalities in personality and social skills. It is important to mention that malingering is not on this category because, even if the behaviour of the patient is the same, the motivation oh it is usually for external reasons like juridical reasons, obtaining illicit drugs or be excluded from military service. This category includes hospital hopper syndrome, Munchausen syndrome and wandering patient syndrome (World Health Organization, 1992).

In DSM-5, FD are under the section of Somatic Symptoms and Related Disorders. Here, FD includes 2 different pathologies: FD imposed on self (Munchausen syndrome) and FD imposed on another (Munchausen by proxy syndrome) (American Psychiatric Association, 2016). The criteria of diagnose are basically the same for ICD-10, but the difference is that Munchausen by proxy syndrome, in which the patient uses a victim in order to seek attention, making harm or fabricate symptoms on the victim, not on self is included in the diagnose category of child abuse (under the code T74.8) in ICD-10. In DSM-5, Munchausen by proxy syndrome is a mental health problem of the patient, not the victim.

Nowadays, ICD-11 (the 11th edition) tend to regulate this difference between the guidelines mentioned above because in this new edition FD contains only 2 entities: factious disorder imposed on the self and factious disorder imposed on another (that are currently on DSM-5) (Gaebel et al., 2017), basically removing FD from the old category "Other personality and behavior disorders of the adult".

In clinic, realistically it is very difficult to diagnose FD because there are no objective criteria. People with FD tend to be expert at faking symptoms and usually have strong medical knowledges and with every new episode they tend to use more complex strategies. Sometimes they can fake a whole new identity just that the doctors cannot access previous medical records (Caselli et al., 2018).

That is why, the doctor can take into consideration that the real diagnose for a patient is a FD when that person's medical record are hard to find or don't have logical course of action or the person resist getting information from previous medical records. Also, when the symptoms that the person presents or the course of the illness are abnormal or there are no objective criteria (like inconsistent lab test result), FD could be the only explanation for that person. If the person is caught in the act of lying or causing an injury, then the clinician has a very strong argument for the diagnosis.

CASE REPORT – ASSOCIATION BETWEEN MUNCHAUSEN SYNDROME (MS) AND MUNCHAUSEN BY PROXY SYNDROME (MPS)

To understand and have a real imagine of what FD are we documented an unusual case of MS and MpS association in the same family. This association between a MS on a young patient and her mother with MpS presented on Infantile Neuropsychiatric Clinic from "Socola" Institute of Psychiatry in March 2019 because after a long history of pediatric medical service abuse, the clinician from pediatric clinic calls social services to investigate this bizarre relationship between the daughter and the mother. Their initial supposition was that the mother was abusing her daughter, inflicting numerous symptoms of symptoms in order to seek medical and social attention.

The person diagnosed with MS was a 13-year-old girl that had 34 presentations in the pediatric service care in two weeks. The reason for these presentations varied from minor complains like diffuse leg pains, or lack of vision accuracy to real injuries such as post-traumatic inflammation of the joint, epileptic-like seizures, traumatism of the mouth, different skin alterations (scratches, bruises). Every time the patient was investigates with full set of blood test. In some of the presentation on the patients was conducted EEG's, ophthalmological, neurological, orthopedic exams and even IRMs. None of the investigation could establish a real cause that could justify the symptoms, except the post-traumatic lesions. Studying the evolution of this 34 pediatric care presentations of the patient we observed that the first ones were for minor complains like:

diffuse leg pains or lack of vision accuracy, but because the doctors could not find anything wrong with the patient that could justify that symptoms, the patient started accusing epileptic-like seizures, fainting, acute pains and migraines, but also the doctors could not find a real cause for them. Finally, the last presentation was for various post-traumatic lesions in which the doctors could see a real injury on the patient: traumatism of the mouth, joint inflammation, skin lesion like wide extended bruises.

The pediatric doctors observe tests that every time that they told the mother that on her daughter there is no clinic reasons for the symptoms, she would get angry, started making a scandal and demanding more test for her daughter. That is why they decided this could be a case of child abuse and called social services.

Social services, as the law imposed, brought the daughter to a psychiatric and psychological expertise in order to establish her mental status.

The psychiatric and psychologic exams showed that the patient was a teenage girl with an IQ of 124 that possess a large spectrum of medical information. Evaluating her emotional state, the only abnormal thing that could be found was the tendency for emotional lability, but this could be seen as normal reported to her age (she is a 13-year-old teenager). But we also find out that her father left her and her mother when she was 5-6 years old because he went to become a surgeon in other country. When she was speaking about her father, her behavior was unstable: she had many anxious breakdowns, and even if she was not expressing good feelings about him, the fact that she believed he was an important doctor somewhere justified for her his actions.

In the time she stayed at Infantile Neuropsychiatric Clinic she was once more somatic investigated and the lab test, neurologic examination, EEG were with no modifications, and when she found out that she is still not ill, she started producing on self-traumatic lesions like: scratches on her leg that could justify her leg pains, she was self-harming her to get bruises, and this behavior was seen by the staff that was supervising her on many occasions. When she was asked about these actions, she every time denied them, telling the doctors and psychologist who interview her that other kinds from the clinic, or just casual accidents (like falling off the stairs because of her impaired vision) provoked the lesions. It is important to mention that on her time in the Clinic, she didn't have contact with her mother, and in one interview she told us that her mother, when she was little, she went many times with her to the hospital, but she then didn't understand why because she didn't have any pain or lesions.

Meanwhile, the investigation for child abuse on the mother was on, and when we have the chance to speak with her, we found out that she also has strong resentments on her daughter's father, and the assumptive medical problems of the daughter started after he left them. We asked for medical records of the daughter from that period, but every time the mother found a reason not to bring them and she never told us a concrete diagnosis that her daughter had received. We could observe at her a strong obsession on the fact that her daughter is sick, that she will prove that fact to all of us and the judge and social services and for this situation the one who is responsible is the father who abandoned them.

The real challenge in this case was that the first assumption of the examination team was indeed that the mother committed psychical child abuse, but the fact that we saw the patient provoking on herself different kind of lesions in absence of her mother, we started to see that the problem is with both, and the mutual cause of them is to justify the implication and the trauma that her abandoning father had produce. It is interesting to observe this mother-daughter bounding in which the mother accepts harming her child, and the child gladly does that in the name of their trauma. But the social, behavioral and health implication of that behavior is that in the end, the child suffers physically and emotionally, and it could but his life in real danger.

Regarding all of this, and establish that the child does not have any real somatic problem or psychological disorder, having proof that she was self-inducing psychical trauma and the motivation for that is a deep emotional disruption we could put the diagnose of Munchausen Syndrome, and because the mother, with no mental pathologies, encouraged this behavior and used her child in order to obtain medical attention, without having a material or social gain, but having unresolved conflicts with her daughters father we could say that she suffers from Munchausen by proxy Syndrome.

PROFILING THE PATIENTS WITH FD

As we saw above, the difficulties that a clinician could come upon in diagnosing and managing a FD case are on many levels because of the polymorphism of this pathologies. This is also important because early detection could limit harm to patients.

In 2017, Caselli et al, conducted a systematic review on FD based on clinical cases reported worldwide. The only exclusion criteria where cases by proxy, aged under 18 and articles that were not presented in English. 577 reports were included in the review. Based on the results of this metanalyses created the profile of the patient with FD: married female, at the age of 32.8 years. Another aspect that this review shows is the fact that in 43,1% cases the patients had a personality disorder and in 37,7% cases a depressive disorder, but

at 39,5% cases psychiatric comorbidity was excluded. Somatic comorbidity was presented at 28.4% of the cases. But overall, many of the cases didn't have any other real somatic or psychiatric pathological associations. Another aspect that is worth mentioning is that, from all the cases analyzed, 35% of the patients had a positive history for multiple surgical procedures. Stressful events in correlation with FD were followed and the outcome was that: 20.2% of the patients show stressful or traumatic events, 14.6% had physical or sexual abuses or neglect in childhood, 16.9% showed substance abuse, 10,7% had conflicting and/or unstable interpersonal relationships, 7.2% reveal premature familial bereavements, and maybe the most considering fact is that 13.4% presented a suicidal behavior (Caselli et al, 2018).

Also in 2017, Yates and Bass, concentrated their attention on the Munchausen by proxy syndrome and tried to profile the oppressors. They realized a review on the subject analyzing a sample of 796 case reports of MpS (Lazzari et al., 2018). Their metanalyses showed that 97.6% of the cases were women and 95.5% of them were mothers. 75.6 % of them were married. The clinical characteristics of them showed past or current depression in 14,4% of cases and personality disorder in 18.6% of cases (Lazzari et al., 2018). The report showed that 23.5 % had history of obstetric complications and 30% of childhood maltreatment (Lazzari et al., 2018). The methods of abuse on the victim were fabrication by words in 45.9 % of cases, simulation in 22.3% of cases, induction of symptoms on victim in 63.1% of cases, fabrication that continued during hospitalization in 54.4% of the cases. The report also showed that in 14.2% the victim collaborated with the oppressor (Lazzari et al., 2018).

MANAGING FD

For the healthcare professionals it is hard to face FD patients. Their tendency to be involved in every step of medical process, constant complaints about the medical care or procedure and the fact they usually report signs and symptoms that cannot be clinical objectified (pain, seizures, fainting, suicidal behavior) create for the clinician a real challenge in dealing with the patient. Usually, the evolution of this kind of patient doesn't improve despite treatments and medical procedures they receive. Anything that healthcare professions are trying to do in order to reestablish the health balance of the patient is not enough. That is why, when clinicians delay the diagnosis of FD a chain reaction starts that involves unnecessary procedures, investigations, inter-clinical consults and examinations, drug administrations.

What can we do in managing this kind of relation between a FD patient and the medical system?

First, every clinician that has contact with the patient should have all the past medical information on the patient that he could get. Secondly, it is important to collaborate with a medical team to see the patient from every angle. Listening to the patient's needs and complaints could make him more collaborative with the team because the clinician could discover the emotional reasons behind the patient's behavior. Also, a psychiatrist and psychologist should be apart because usually the pharmacological treatment of the underlying depression and anxiety is needed, and the most important, the managing of the emotional disruption should start with individualized psychotherapy.

A very useful tool for the clinician is The Factitious Disorder Self-Assessment Scale (FDSAS) that Lazzari et al developed in 2018 that has 17 items that the patient evaluates on a scale from 5 to 1 (5-almost always true; 1-almost never true) that can help in clarifying patient's distress and behavioral components of FD (Lupu et al., 2017; Păduraru et al., 2019; Vendemmia et al., 2019).

CONCLUSIONS

Comparing the case, we documented and reported with literature review summarized in this two important metanalyses presented above we can observe that the consistency of FD cannot be ignored. Even if for the general practice it is hard to manage these patients, it is important to understand how to do it and to accept the fact that FD are a real medical problem that involve only abnormal behavior, but also deep emotional imparities. Once we develop a complex, but strong interprofessional collaboration we can reduce the hospital admission and unnecessarily medical procedures and investigation for these patients and focus on the real solution that implies psychiatric and psychotherapeutically managing.

Raising awareness and trying to establish clear diagnose steps in order to bring the patient with FD in his health and social balance.

Doctors tend to let FD as the last possible diagnose because the somatic symptoms are usually a priority and mostly there is no time to see the whole picture of the patients complains, leading to expansive medical procedures, costing the healthcare system important resources. That is why protocol of diagnose and education of healthcare providers should be conducted. Only when a proper diagnosis is made it is possible to improve the outcome in the treatment.

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