

## A CASE OF FACTITIOUS DISORDER: RED HERRING OF PSYCHIATRY

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received: 16.10.2020;

revised: 28.12.2020;

accepted: 7.1.2021

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### INTRODUCTION

Factitious disorder (FD) is a condition in which the patients intentionally fabricate physical or psychological symptoms to assume a sick role in the absence of any obvious gain (American Psychiatric Association, 2013). Since FD leads to a huge burden of unnecessary investigations, hospital admissions, and treatment, its early detection is very important (Hoertel et al. 2012). The cases of FD can present with the most baffling symptomatology, the diagnosis of which must be confirmed after continuous monitoring and careful exclusion of other conditions. Here, we are reporting a case who presented initially with symptoms suggestive of schizophrenia, but during her hospital stay, the symptomatology drifted from psychotic to dissociative in nature. She was finally diagnosed with Factitious disorder with borderline personality disorder (BPD).

### CASE REPORT

Mrs. S., a 28 years old married female, was brought in the Out-Patient Department (OPD) with complaints of aggressive behavior and suspiciousness for ten days, with a history suggestive of multiple similar episodes over the past four years. She was admitted with a provisional diagnosis of Recurrent Acute and Transient Psychotic Disorder. However, during her detailed work up on the first day, she acknowledged having suspiciousness towards her husband and sister-in-law for the last four years. Mental Status Examination revealed delusion of reference and persecution, bizarre delusion, delusion of control as well as visual and third person auditory hallucinations. She believed that her husband and in-laws had implanted multiple blades in her throat and abdomen due to which she could not eat or defecate. She claimed that two women controlled her actions through black magic and that she could also hear some unknown people discussing how her husband was planning to kill her. Given her complaints, a diagnosis of Paranoid Schizophrenia was made, all routine investigation reports along with Non- Contrast Computed Tomography Scan of Brain came out to be normal, and Olanzapine was started in the oral form (10 mg daily, in two divided doses).

When her case record was reviewed, it was found that she was diagnosed with Obsessive-Compulsive Disorder (OCD) and Somatization Disorder during her first and second visits, respectively. She was started on Fluoxetine after her first visit. She took the medication for two weeks, without subsequent follow-ups. Her next visit was after six months, and she insisted on getting non-pharmacological treatment for her somatic complaints. However, she did not visit for the scheduled session. Her husband admitted that meanwhile, the patient had visited several Psychiatrists with variable complaints.

During her hospital stay of three weeks, the complaints were inconsistent, and the history provided by the patient, her husband, as well as other family members displayed major discrepancies. Premorbid personality was suggestive of a chaotic lifestyle, identity crisis, and disturbed interpersonal relationships. During the hospital stay, after starting antipsychotics for two days, the symptomatology changed, and the patient claimed to be possessed by a goddess who helped her overcome the voices. After day five of admission, she had developed four episodes of altered consciousness with complete disappearance of presenting complaints. She, however, complained of headaches, stomachache, constipation, and generalized body aches on several occasions after this. On the administration of International Personality Disorder Evaluation (Loranger et al. 1997), she was found to have an Emotionally Unstable Personality Disorder (Borderline type). Antipsychotics were stopped, and management was focused on non-pharmacological interventions. Her condition improved and was discharged with the plan of continuation of psychotherapy on follow-ups. Subsequent follow-ups were irregular over the next three months, with variable complaints, none of which included symptoms of psychosis.

### DISCUSSION

Index patient initially presented with psychosis, which subsided abruptly within two days of admission and disappeared completely on the fifth day. She later developed dissociative episodes and variable somatic complaints. During the hospital stay, the serial mental status examination was inconsistent with the com-

plaints, and discrepancies in history warranted revision of the initial diagnosis. On follow up visits, she never developed psychotic symptoms and presented variable complaints indicative of a desire to maintain the 'sick role.' Apart from this, no external incentives could be established to consider malingering as an alternate diagnosis, although few symptoms were present but were insufficient to fulfill the criteria of Somatization Disorder. The fact that psychotic symptoms were in the absence of any obvious stressor and were continuously present for five days helped rule out the micropsychotic episodes commonly seen in Emotionally Unstable Personality Disorder. So, after exclusion of all other possibilities, a diagnosis of factitious disorder with predominant psychological symptoms was made. Men with FD commonly present with physical, whereas the women mainly present with psychological complaints (Feldman and Eisendrath 1996), which is consistent with our report. Our patient had a comorbid, Emotionally unstable personality disorder. This observation is supported by other studies that suggest personality disorders (specifically emotionally unstable personality disorder-borderline type) to be the most common comorbidities with FD (Caselli et al. 2018). According to another view, symptoms of factitious disorder are considered as a subgroup of the borderline characteristics (Nadelson 1979). These individuals respond to stressful life events by resorting to pathological behavior as a coping mechanism (Merrin et al. 1986). It is difficult to comment on whether FD is comorbidity or a simple exacerbation of emotionally unstable personality characteristics in this patient. It is, therefore, a prerequisite to screen every Factitious Disorder case for Borderline Personality Disorder (BPD) because the patients with comorbid BPD can benefit from additional non-pharmacological interventions like dialectical behavior therapy, mentalization-based therapy, and schema-focused therapy (Gordon & Sansone 2013).

### **Acknowledgements:**

The case was reported as a poster in the Annual National Conference of Indian Psychiatry, 2019 and the abstract was published in the Indian Journal of Psychiatry (E-Poster. Indian J Psychiatry 2019;61, Suppl S3:521-631)

**Conflict of interest:** None to declare.

### **Contribution of individual authors:**

Vatsala Sharma: concept, literature review, initial draft, final approval.

Samrat Singh Bhandari: concept, literature review, final drafting, revision and final approval.

Anukriti Chandra: concept, data collection, revision and final approval.

Vijender Singh: concept, literature review, revision, final approval.

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