

COMORBIDITY BETWEEN FACTITIOUS AND BORDERLINE PERSONALITY DISORDER: A NARRATIVE ANALYSIS

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SUMMARY

Background: Factitious disorder (FD) illnesses have increased recently, primarily due to comorbidity with borderline personality disorder (BPD). Psychiatrists, hospital doctors, and general practitioners are interested in and concerned about patients with comorbid FD-BPD.

Subjects and methods: We used a qualitative analysis of prototypical narratives collected as vignettes by merging individual contributions, case histories, naturalistic observations, and data from mental health practitioners into specific descriptions. Our study used a phenomenological and narrative method to illustrate the contents and behaviours in FD-BPD comorbidity.

Results: Fourteen case vignettes were created from our case studies. These categories included knowledge of symptoms and medical terms, dramatisation, symptoms ambiguity, unexplainable deterioration of symptoms, symptom inventiveness, craving for painkillers, conflicts with health carers, hospital migration, piling of medication and search for invasive diagnostic procedures.

Conclusions: The combined use of narrative analysis and naturalistic observation has helped identify a unique comorbid condition of FD-BPD, which is not yet clearly described in its behavioural components by the international literature. The current study presents novel findings into a condition becoming progressively popular in psychiatric and medical settings.

Key words: factitious disorder - borderline personality disorder – comorbidity – narrative - vignettes qualitative analysis

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INTRODUCTION

Borderline Personality Disorder (BPD) has a prevalence of 20% in inpatient psychiatric wards, 1.6-5.9% in the community, 10-12% in outpatient psychiatric services, and 50% among psychiatric inpatients with a diagnosis of personality disorder (American Psychiatric Association 2013, Ellison et al. 2018). A study found that fifty-two per cent of BPD are high-frequency users of mental health services, with seventy-six per cent being females (Comtois et al. 2003). The epidemiology of Factitious Disorder (FD) is a prevalence of female patients 65.4%, with a mean age of 33.5 years, most likely to present to emergency and psychiatric departments (Casellit et al. 2017). The co-occurrence of FD and BPD has been the subject of many investigations (Findaci & Ozturk 2016, Malatak et al. 2006, McEwen 1998, Mousailidis et al. 2019, National Health Service 2017). At least three of the following are present in the BPD (ICD-10 F 60.30), i) irregularities and ambiguity regarding one's self-image, objectives, and internal preferences (including interpersonal), ii) a propensity for extreme and unstable relationships that frequently lead to psychological crises, excessive attempts to prevent abandonment, *recurrent risks or practices for oneself*, and iii) persistent feelings of emptiness (World Health Organization 1992).

In the diagnosis of *Elaboration of Physical Symptoms for Psychological Reasons* (ICD-10 F68.0), a person's psychological condition causes physical symptoms initially attributable to medical conditions, disease,

or handicap to become exacerbated or protracted; a motivating element might also be unhappiness with the outcome of therapy or investigations or the level of individualised care provided in wards and clinics (World Health Organization 1992).

In the diagnosis of *Intentional Production or Feigning of Symptoms or Disabilities* (ICD-10 F 68.1), persons continuously and frequently fake symptoms without a recognised medical or mental condition, disease, or incapacity; this condition may even include self-inflicting wounds or abrasions to cause bleeding or self-injecting hazardous chemicals in the case of physical complaints; despite constantly negative results, further examinations and surgeries may be carried out at several hospitals or clinics due to the compelling and persistent subjective pain and insistence that bleeding is present (World Health Organization 1992). These persons' might assume an 'ill role' to get nursing and medical care and to attract others' attention by simulating or exaggerating physical or psychological problems (National Health Service 2017, World Health Organization 2009).

An American study of 379 patients with a diagnosis of BPD reports comorbidity of this personality disorder with Somatoform Disorders to the extent of 10% (Widiger & Weissman 1991). Several theoretical models have been suggested to explain the comorbidity of FD-BPD. For instance, it is recommended that once BPD symptoms have been identified, they may continue to interact more strongly or advance to developing new comorbidities (Choate et al. 2021). A dynamic movement between externalising and internalising (internal

vs external locus of control) behaviours might explain the comorbidities of BPD with other disorders (Choate et al. 2021).

Comorbidity in psychiatry is the co-occurrence of two or more mental disorders and physical conditions (Bronisch 1992). Comorbidity arises when two diseases or disorders develop simultaneously or consecutively in the same person (National Institute on Drug Abuse 2010). As comorbidity affects all mental conditions, practitioners should be encouraged to record the whole spectrum of diagnoses for every patient to convey the complexity of psychiatric situations (Desai 2006, Pincus et al. 2004). It is also stated that more than fifty per cent of persons diagnosed with a personality disorder have several other personality illnesses (Herpertz 1994). In addition, splitting mental illnesses into many diagnoses may impede the holistic treatment of patients, while the word comorbidity should be avoided since it refers to multiple characteristics of a given psychiatric disease (Maj 2005). Patients with FD-BPD might also gain access to regular prescriptions for unofficial purposes by presenting to hospitals for painkillers, claiming Attention Deficit and Hyperactive Disorder, asserting to have lost the prescribed medication, stating to have side effects from prescribed medications, visiting various family doctors to obtain multiple prescriptions, and in extreme cases, faking surgical symptoms to get anaesthesia or invasive procedures (Smirnova & Owens 2017).

Consequently, presenting individuals with FD-BPD may lead to needless invasive therapeutic examinations and therapies, such as intravenous fluid therapy (Findaci & Ozturk 2016). In addition, patients with FD are frequently complex; they demand continuous care from healthcare providers to alleviate their alleged pain and insist on receiving medications or additional medications, intricate instrumental examinations, recommendations to other specialists, and costly medical diagnostic testing (Huffman & Stern 2003). The authors of the present research discovered that the growing occurrence of cases with the diagnosis of Borderline Personality Disorder in some geographical regions might assume an epidemic-like pattern resulting in a concurrent rise in FD cases (Lazzari et al. 2018, Lazzari & Nusair 2019).

FD-BPD can explain an increase in the use of psychotropic medications prescribed in primary care; this is likely due to the augmented severity of psychiatric cases diagnosed and the comorbidities of diagnoses leading to the increased prescription of antidepressants, antipsychotics, and sedative-hypnotic medications (Mojtabai & Olfson 2010). According to Spanish research, 30% of patients in primary care had comorbid depression, anxiety, and somatoform disorders (Roca et al. 2009).

The Dark Triad of Personality is a fusion of Machiavellism (e.g., controlling personality), together with narcissism (e.g., feeling of privilege) and psychopathy (e.g., highly irresponsible, risk-taking behaviours and low empathy); the triad can be assumed to share some

similarities with the maladaptive behaviours of FD-BPD (Paulhus & Williams 2002). The dark triad, as it relates to FD-BPD, is linked to the desire to exert control over the medical or psychiatric team, to rise to a certain level among other patients, and to influence the choices of the healthcare providers (Vedel & Thomsen 2017).

The biological sensitivity of BPD patients makes them predisposed to mood and anxiety disorders; comorbidity is more common than not among BPD patients making them more vulnerable to aggressive and suicidal behaviour (Marcinko & Vuksan-Cusa 2009). Alternatively, Bipolar II Disorder could be divided into two subtypes: one stable and functional between episodes and one unstable between episodes related to Borderline Personality Disorder; this would allow most or all Borderline patients to be included in the Bipolar spectrum under the unstable type (Agius et al. 2012). Thus, BPD should be moved to Axis I and merged into Bipolar II Disorder as a clinical subtype since it is a bipolar spectrum mood illness (Elisei et al. 2012).

The following paragraphs will examine the most typical behaviours seen in patients with FD-BPD, along with a phenomenological explanation. The present research also aims to provide a theoretical and phenomenological framework for interpreting the behaviours of FD-BPD patients.

SUBJECTS AND METHODS

Methodology

Case studies are a research approach used to investigate a particular phenomenon (the case) in a natural context using various techniques to get an in-depth understanding (Collis & Hussey 2014). In this instance, the exploratory case study is done inside an interpretivist theoretical framework with limited hypotheses and inadequate information (Collis & Hussey 2014). As the current study has a qualitative stance, the ontological assumption of reality is that persons construct their subjective interpretation of what is happening to them, supporting multiple personal truths in the adopted framework (Collis & Hussey 2014).

The epistemological basis of the research is that the evidence derives from the personal accounts of participants and their case studies (Collis & Hussey 2014). The axiological assumption is that findings are linked to the researcher's interpretation of the subjective realities of the target population hence having a unique and biased background (Collis & Hussey 2014). Methodologically, qualitative research is inductive as the theories or middle-range theories (as extracted in the current study) are pulled out from the case studies (Collis & Hussey 2014).

Case studies are more indicated to answer 'how and what questions' (Yin 2017). The *research question*, in this case, is 'What are the characteristics of the comorbidity of FD with BPD? How do they manifest?'

Purpose statement

The study aim of this qualitative narrative approach based on prototypical case narratives, collected as vignettes, is to explore the comorbidity between FD and BPD for patients accessing primary psychiatric services in the United Kingdom. The central phenomenon being studied will be the symptoms and behaviours of the comorbidity of FD and BPD, defined as the array of beliefs, behaviours, and personal experiences of patients with both BPD and physical symptoms of unexplainable nature (see Creswell & Creswell 2019).

Population and settings

The current study offers a theoretical-inductive explanation for the behaviours of BPD patients accessing psychiatric services in public and private hospitals in the United Kingdom. We created fourteen prototypical case vignettes by merging patients' characteristics and ad verbatim accounts, which presented with related stories suggesting FD-BPD. Therefore, our 'cases' are not real individuals but a collection of stories that the authors summarised into prototypical narratives or vignettes, as we will explain in the subsequent paragraphs. As we mentioned, our national hospitals and emergency departments have referrals of about five patients daily with FD-BPD. This approach (clinical vignettes) also has an ethical advantage as there are fewer ethical restrictions in reporting stories and cases that do not relate to real and identifiable people.

Inclusion criteria

Patients scrutinised represented an opportunistic sample. The study anonymised the cases and did not include biographical descriptions; therefore, anonymity was preserved. The inclusion criteria were a diagnosis of BPD. Exclusion criteria were other personality disorders.

Phenomenology and data collection

Phenomenology studies how individuals give meaning to their lived experiences (Bryman 2016). The notion might be extended to include individuals' inner lives. Additionally, phenomenology investigates the perception and formation of existential expertise and the continued comprehension of such experience (Remler & Van Ryzin 2015). Typically, maladaptive actions result from maladaptive cognitions, which are a method of thinking damaging to the individual since it impedes or prevents the individual from making a decisive adjustment in their cognitions while also hindering their life achievements (Kreuter 2016).

People often present with maladaptive or irrational thoughts, which lead to maladaptive or illogical self-talk and, ultimately, maladaptive or hazardous actions (Manning 1991). Persons often articulate their beliefs and cognition via narratives about their phenomenological

environment. During regular psychiatric interviews and observations, we gathered narratives and categorised behaviours for our research. The patient's mental history was acquired through computerised notes and informal psychiatric evaluations. Observer participants were both psychiatrists and mental health nurses. The authors then coded the narratives and actions and categorised the results that were expressed as vignettes. Multidisciplinary discussions and knowledge sharing were fundamental for confirming the diagnoses. In addition, the present study might be understood as built on an action research framework with a recommendation-making objective to enhance clinical practice (Hek & Moule 2006).

The present research presupposes that the behaviour of a particular individual is the result of rules that are true for the entire population with similar characteristics, thereby making the study's findings empirically generalisable (Gibbs 2007). Phenomenological ideas and research evaluate human behaviour, emphasising subjective 'I' experiences and self-reflective narratives (Abettan 2015). In addition, since the present study is also a naturalistic observational study, we categorised the observed behaviours of FD-BPD through field investigations, including regular patient monitoring in psychiatric or medical wards. The ultimate objective of the study was to develop behavioural categories for comprehending the phenomenology of both narratives and observable actions. The phenomenological types of the findings are described in the following paragraphs.

The narrative approach in psychiatry

Narrative theory has become essential for understanding human meaning-making in the humanities, social sciences, medicine, and psychology (Lewis 2011). Narrative psychiatry may assist in understanding how individuals use their knowledge and other cultural resources to make sense of their psychological issues and differences (Lewis 2011a). Narratives, especially first-person narratives, are crucial because they reflect the perspective of persons with disabilities and provide a method of understanding the social environment and social determinants of that disability (Garden 2010).

By capturing these narratives, practitioners know their patients well and provide optimal care while stimulating self-reflective thought in patients and opening their hidden meanings and needs (Lijoi & Tovar 2020). By tuning in to the person's story as a goal in and of itself, narrative psychiatrists create an atmosphere in which the patient may be recognised and their difficulties appreciated (Sachdev 2011). This may be one of the most beneficial actions a therapist can perform (Lijoi & Tovar 2020). When physicians enable the patient to be known in this approach, they build a relationship that instantly lessens the patient's sense of isolation since they are no longer alone with their problems (Lewis 2011b), as its intrinsic nature is clarified and understood by the mental health practitioner.

Methods of data summarisation and clinical-case vignettes

Based on George Lakoff's cognitive linguist theory, members of any category may be connected to an abstract prototype of that category by illustrative narratives (Steiner et al. 2010). Typical prototypical narratives can be utilised to infer information about the category members (Steiner et al. 2010). One method for creating familiar prototypical narratives is to weave information from reports, briefings, contextual descriptions (from patients), and notes into an account or story that reflects a unitary typology of patients and resonates with the interests and concerns of healthcare professionals (Sundin et al. 2018). A final narrative may provide proper context for reviewing outcomes and aid healthcare professionals in deciding how and when to participate and act (Sundin et al. 2018). We constructed prototypical vignettes and cases from patients' similar stories, clinical observations, psychiatric practitioners' reports, naturalistic observations of psychiatric and medical settings, medical and surgical reports, and team discussions. The reported vignettes were extracted from anonymised prototypical narratives and our reflective diaries. They are here adapted to the aims of the current study and do not refer to actual patients. The ethical approval was thus waived as unnecessary as we did not report actual patients' stories. Instead, we used our reflective diaries and clinical notes to generate prototypical narratives here summarised as 'vignette' (Figure 1).

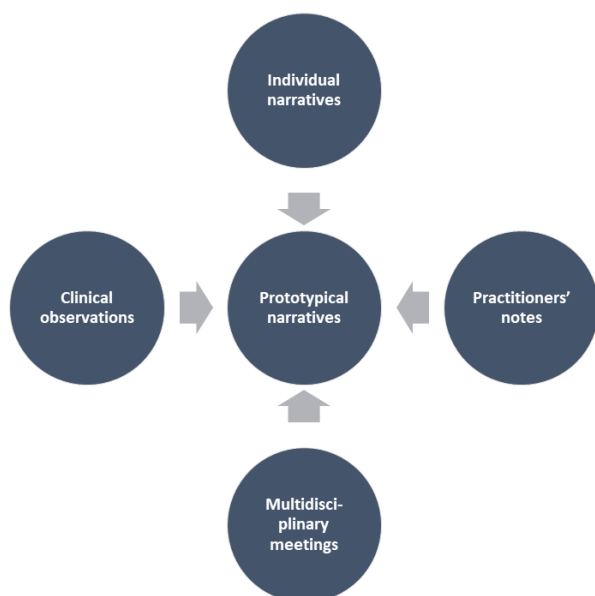


Figure 1. The prototypical and conclusive narratives reported in the current study derived from merging individual case stories, clinical and naturalistic observations, practitioner notes and patients' accounts

We used case vignettes to illustrate prototypical real clinical cases. In the analysis or discussion groups, there was always one consultant psychiatrist (CL), one senior psychiatrist, one clinical psychologist, one ward

manager and one or two staff nurses. Any disagreement in the interpretation was solved by re-discussing each vignette. Once finalised, each vignette was again re-discussed in multidisciplinary meetings or weekly educational learning by accepting colleagues' suggestions about modifications and accretions of the prototypical vignette until saturation was reached in detail to describe each case with clarity. Vignettes are constantly used in our clinical understanding as prompts for medical education for assessing and promoting knowledge of undergraduate medical and nursing students during their psychiatric attachment. By merging similar clinical cases into typical vignette cases, we maintained anonymity while emphasising essential concepts and supporting our theories more clearly. One of the authors (CL) has experience writing narrative plots and finalising vignettes.

For instance, a perfect collection of case vignettes would include descriptions that would resemble actual case histories and varied solely by the particular clinical characteristics under investigation (Heverly & Newmann 1984). Vignettes aim to provide reports of behaviours that unmistakably mirror practice (Heverly & Newmann 1984). However, text vignettes were preferred to video or simulated patients because they let healthcare students study the material at their own pace without having to fast-forward or remember everything that was said (Klein et al. 2019). Vignettes can show developmental and phenomenological similarities (Bayes et al. 2017). The educational impact of a vignette can be higher as multiple and similar cases can be condensed and proposed in the areas where medical teachers, learners and readers, focus their attention. Like other authors, we created vignettes by abstracting information from patient files selected retrospectively (Rousseau et al. 2015) or assembling self-reflective accounts from narratives or facts from different patients into a logical case vignette representing a specific and realistic typology of patients. To be authentic and convincing, vignette stories need to be based on specific diagnostic characters, such as persons with BPD and FD comorbidities. Plots as we constructed them must have a title indicative of the subject matter or primary character (e.g., 'the solitary homeless man'), different co-acting or secondary characters (e.g., 'health carers and society'), a location (e.g., 'a psychiatric ward') a central behaviour or action (e.g., 'factitious behaviour'), consequences or epilogue of the significant action (e.g., 'hospital admission'), a writer's commentary (e.g., 'distress in the ED departments'). Secondary characters and their interactions with the primary character bring tension to the story (Anon 2022). In our case, an FD disorder links primary and secondary characters and creates tensions in diagnosis and treatment. The vignette method has been used to examine differences in how each health practitioner recognises and handles issues such as depression and other comorbid illnesses (Fick et al. 2007). Opposite to standardised patients or chart

abstraction, clinical vignettes are brief, straightforward texts that describe realistic clinical situations so that practitioners can evaluate similar scenarios (Rousseau et al. 2015). Vignettes assess practitioners' knowledge and actual practices (Rousseau et al. 2015).

Furthermore, for ethical reasons, as clinicians, we have restrictions in the diffusion of personal details of actual patients and their publications; unless strictly necessary for novel clinical cases, we selected case vignettes as a more pedagogical method in qualitative exploratory research on the topic of interest. Creating a story's universe and stories in general frequently calls for developing characters with specific attributes (Lebowitz 1984). Therefore, a method is needed to identify a set of stereotypes that accurately defines a character given a set of trait values. Although creating the ideal set of stereotypes is challenging, employing heuristic techniques and creating a believable story is an approachable method (Lebowitz 1984). Hogan's theory of poetics sustains that narrative elements in stories can map how the emotional system in humans operates in everyday life, from situations that trigger emotions in the reader to actions prompted by our empathic system, which guides our emotional responses (Aldama 2015).

We also used a method that reflects the one adopted by Jardon et al. (2018), where meaningful linguistic units or words are condensed and categorised into a single item or narrative. For example, patients might inform us that they 'wanted more [...],' 'paracetamol,' 'ibuprofen,' or 'codeine,' which we condensed into the prototypical narrative 'wanting more painkillers.' Therefore, the quoted records are not from actual people, as the vignettes are concentrated case stories of FD-BPD persons with similar presentations.

After the pathophysiology had been identified, we incorporated other decisions, including conclusive instrumental diagnosis, interdisciplinary practice and clearance of the case (see Wadowki et al. 2015) reported at the end of the article.

RESULTS

Without an individualised interdisciplinary and psychological intervention, the phenomenology of FD-BPD is characterised by cognitive attitudes that are hard to change. Despite several medical, surgical, and psychiatric treatments, impulsivity, high levels of psychological arousal, and emotional distress are still apparent, with no change. All of these aspects may make the clinical presentation of FD-BPD a perpetual challenge and enigma for any healthcare provider, with little opportunity to develop a comprehensive strategy for addressing the underlying emotional upheaval, which is the objective of therapeutic interventions. The following are the most prevalent cognitive frameworks and behavioural manifestations of FD-BPD patients presented as prototypical vignettes and themes (Table 1, 2).

Knowledge

Persons with FD-BPD describe hospitals, medical terminologies, and diseases in detail. They also tend to question and provide specific information regarding their stated illness, necessary treatment, and available medications when challenged on their beliefs. As a result, they seem to be 'experts' in the alleged organic disease that afflicts them. Furthermore, there is a disposition to influence and guide the judgments of healthcare professionals on the correct diagnosis and necessary therapy for the 'presenting' sickness.

Vignette No. 1

'I have a specific blood disease that doctors have been unable to explain. They say that I always need painkillers to reduce my bones' pain. My red blood cells are small, and I have an iron deficiency which makes me depressed.'

Dramatisation

Persons with FD-BPD report an impressive medical history; but are often unreliable, reporting confusing clinical indicators that healthcare experts cannot falsify objectively, such as neurological symptoms, paralysis, epileptic fits, generalised aches, convulsions, sleeplessness, gastrointestinal discomfort, and respiratory crises, among others.

Vignette No. 2

'I suffer from epilepsy, but doctors never were there when my fits occurred. The neurologists said they are not real. These episodes last a few minutes, and Lorazepam can help me reduce the fits.'

Vagueness

It indicates that FD-BPD persons report symptoms that are not quantifiable and that worsen or change as healthcare providers suggest a clinical improvement. Consequently, individuals with FD-BPD tend to experience a paradoxical worsening of their symptoms whenever healthcare experts advise them that their clinical state is improving or is not as severe as first believed. Consequently, a new symptomatic escalation generates anxiety amongst the personnel, who respond by augmenting the medicine, attention, and investigations already included in the patient's treatment plan and occurred. Occasionally, people with FD-BPD may report that their mental or physical symptoms have worsened or that new signs have emerged that were not initially evident. There seems to be a migration of targeted organs whenever a presumed pathology is ruled out.

Vignette No. 3

'I have been suffering from this disease for years, and the only thing that surgeons did was to prescribe me painkillers. They and you say I have nothing, but I do not believe you as I always feel worse and weaker, and I have pain everywhere. I have found benefits with Pregabalin but need a higher dosage as the current one is no longer effective.'

Table 1. Symptoms of FD-BPD

- Self-inflicted wounds and diseases, in addition to intentional self-harm.
 - The consistent need for invasive diagnostic and therapeutic procedures.
 - Pain exaggeration or medication-seeking behaviours.
 - Medication addiction.
 - Worsening of symptoms resulting in emergency hospitalisation and admission to medical or surgical wards.
 - Continuous solicitation of health carers' attention and support.
 - Worsening of physical and psychological symptoms when healthcare providers question individuals about their symptoms or presenting diseases.
 - Claiming various allergies to medications to see what treatments are available.
 - In-depth familiarity with organic diseases, medical procedures, symptoms, and hospitals.
 - Exaggeration of presenting symptoms, including somatic and psychological symptoms with paradoxical complexity.
 - A paradoxical deterioration of the patient's condition after initiating adequate treatment, despite early signals of improvement.
 - Apparently, unexplainable presentation characterised by waves of improvement and worsening of any observable disease.
 - Migrating symptoms with moving target organs once healthcare practitioners report that the treated pathology and organ have improved.
 - Seeking invasive therapy or examinations by exaggerating physical and psychological complaints that do not correspond to negative clinical and surgical investigations.
 - The prevalence of pain prompts doctors to use a large diversity of analgesics and sedatives.
 - Neuropathic complaints that are difficult to confirm using traditional diagnostic and clinical techniques; diffuse pains, musculoskeletal discomfort, headaches, etc.
 - A metabolic syndrome characterised by morbid obesity and enhanced reactivity to many pathological diseases.
 - Insomnia or claimed insomnia is often the result of poor sleep quality rather than a lack of sleep duration.
 - Asthma and inhalers might be the respiratory reaction to underlying stress.
 - Emotional emphasis on symptoms rather than engaging in a collaborative therapeutic approach.
 - Reluctance to switch medications, overmedication and many regular prescriptions.
 - 'Experts' in their pathology and extensive explanations of their diseases as 'from manual', but with individual interpretations of what is necessary for diagnosis and treatment.
 - Migrant behaviour to numerous hospitals and GP clinics to amass prescriptions or get definite hospital admissions.
 - There is a slightly higher frequency of FD-BPD in female patients.
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Table 2. Behaviours of FD-BPD

- A tendency of patients with FD-BPD to pilot the therapeutic relationship to achieve personal goals in terms of hospital admissions and access to unlimited psychiatric and medical attention.
 - Patients with FD-BPD might build false allegations against healthcare staff whenever they are challenged and questioned about their symptoms, desired treatment and plan for immediate hospital admission.
 - Patients with BPD-FT are frequently bed blockers and challenging to discharge from the hospital.
 - Mental health professionals treating these patients have a high level of stress and burnout.
 - FD-BPD patients prefer self-referral to the hospital by accessing emergency departments. They can overuse emergency departments, ambulances, Police, and out-of-hour healthcare support.
 - New symptoms and signs are often constructed to delay hospital discharge whenever proposed.
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Unexpected deterioration of symptoms

It is an unexpected deterioration in the patient's condition following early improvement. Patients with FD-BPD are hospitalised for extended periods, often without progress. They may attempt to comment that their existing treatments have resulted only in slight improvement or that diagnostic methods have failed to reveal the real cause of their condition. Therefore, when staff and teams begin to commend these individuals on

their progress, they paradoxically regress in their presentation. They may assert that the improvement was only 'apparent' and that the underlying circumstances have not necessarily improved.

Vignette No. 4

'You say that I am improving. Yesterday, I had an epileptic fit in my room, and no one was there to witness it. I'm also starting to have paralysis, and I cannot walk. It would be best if you did not discharge me from the

hospital without more investigations. I told you the first time that I suffered from epilepsy, but no one seemed to believe me. Now, I cannot walk, and I need a wheelchair.’

Inventiveness

It is the appearance of new or additional symptoms after favourable diagnostic results. Once there is a noticeable improvement in presentation, and hospital personnel are ready to release patients with BPD, paradoxical relapses in their clinical conditions often prevent their release into the community. New symptoms may include neuropsychiatric symptoms, increased pain, convulsions, psychosis, abdominal or chest discomfort, and other symptoms that are difficult to diagnose using standard clinical procedures.

Vignette No. 5

‘I have more pain than when I was admitted. Your doctors did not look into it, and I keep having stomach cramps and feel more demoralised. I still feel suicidal. I had to stop eating to reduce the pain and lost a lot of weight. I believe I need a nasogastric tube for feeding.’

Invasive procedures are not opposed

Patients with FD-BPD may present with distinct diseases that might need sophisticated instrumental examinations for accurate diagnosis or invasive therapy. It is becoming increasingly widespread for young women with FD-BPD to go on a hunger strike and refuse to be fed via a nasogastric tube (NG tube). Other times, patients’ actions, symptoms, and intentional self-harm might escalate to the point where only intravenous and intramuscular drugs would be effective, for example, for quick tranquillisation. Infected wounds (such as refusing antibiotic therapy), extended hunger strikes, or severe self-inflicted wounds necessitating surgical curettage of scars may compel professionals to choose more invasive surgical treatments for these individuals.

Vignette No. 6

‘I swallowed one lithium battery from my mobile phone and three razor blades last night. I need urgent gastric surgery.’

Painkillers are constantly sought

Patients with FD-BPD have a low pain threshold, and their subjective perception of pain may be so intense that they need the most potent painkillers, often opioids. Other times, FD-BPD patients stockpile Paracetamol because they plan to overdose on it and have ready access to emergency facilities. Occasionally, patients admit that painkillers enhance their disposition by breaking the cycle between bodily and psychological discomfort. Healthcare professionals should be cautioned to confirm patients’ claims of severe pain carefully. Exaggerating pain sensations or wrongly reporting them might cause healthcare professionals to overprescribe painkillers and other unnecessary medications. Once a prescription for

a painkiller is written for a patient, it becomes challenging to modify or discontinue that medication since a form of addiction has already developed.

Vignette No. 7

‘I suffer from terrible headaches and diffuse pain. Amitriptyline has little effect, and my family doctor has prescribed Morphine in the past, which was adequate. I can’t sleep at night. I do not understand why you do not continue my prescription for painkillers.’

Frequent neuropathic pain, headaches, backaches, musculoskeletal aches

Patients with FD-BPD may have metabolic syndrome characterised by a morbid Body Mass Index (BMI). As overeating may be used as a means of self-harm or to raise the risk of cardiovascular disease, weight reduction becomes essential for treating FD-BPD. In addition, obesity produces decreased mobility, limitations on physical activity, less personal liberty, and an increase in sick-role behaviour. Additionally, overall physical conditions may be poor. The absence of physical activity and the unconscious restriction of mobility due to many but minor ailments might diminish the chances of enjoying a high quality of life. Diffuse and multi-organ pain might be challenging to assess although there is discrepancy between subjective/reported and objective/observable pain. Currently, the diagnosis of Functional Neurological Disorder is also used in these cases.

Vignette No. 8

‘I suffer from asthma, and I cannot walk. I am stocked on a chair if I do not take regular Paracetamol. I also have back pain and need additional Co-Codamol.’

Insomnia

To get access to solid sleep aids and sedatives, FD-BPD would often claim to have sleep issues. Although persistent anxiety and underlying emotional dysthymia may lead to sleep issues, the quality of sleep is often compromised, with recurrent flashback experiences during sleep induction and early waking owing to a sad mood. Consistent sleep disruptions may lead to chronic exhaustion and anhedonia, manifesting as psychomotor depletion, weakness, and widespread discomfort.

Vignette No. 9

‘I cannot sleep at night. I never slept well in my entire life without medication. I get flashbacks in the evening, and I cannot sleep. Lorazepam at 4 mg usually works together with Zopiclone.’

Asthma and inhalers

Women with FD and BPD might present with or inflate Chronic Obstructive Pulmonary Disease (COPD), acute respiratory crises with shortness of breath, asthma

diagnosis, and inhalers' chronic use. Some inhalers that often appear in their prescriptions may include mood-altering chemicals (e.g., ephedrine, steroids, etc.), and psychological dependence on inhalers may be challenging to overcome.

Vignette No. 10

'Without my inhaler, I cannot live. Please do not reduce the dose as I need it constantly.'

Focus on subjective symptoms over collaboration with health carers

Patients with FD-BPD tend to inflate physical symptoms, most likely due to an unconscious desire to steer the direction of treatment and attention from medical personnel. Moreover, individuals with FD-BPD may be locked in a vicious cycle of escalating physical and psychological symptoms anytime they feel irritated or challenged in their conduct by staff or medical professionals. Therefore, if health carers apply a logical explanation and question a patient's symptoms, these symptoms tend to increase paradoxically. On other occasions, after attempting to justify a patient's conduct and to normalise an illness's behaviour, healthcare professionals may find that these patients have instead filed official complaints with the local hospital or team.

Vignette No. 11

'If it is not from the kidney, it must be from the lungs. You say that I look better, but I feel worse. I had pain everywhere yesterday, and I could not breathe or eat. I will complain to the hospital managers that you let me down.'

Conflicts with medical and nursing staff ensure whenever these patients are challenged on the need for their current medication

Patients with FD-BPD assume that any medication may enhance their quality of life and alleviate their emotional suffering. Consequently, FD-BPD patients passionately fight any effort by healthcare providers to lower the number of their prescribed medications, even though many drugs may not be technically essential. Their reduction becomes difficult to accomplish owing to patients' opposition.

Vignette No. 12

'Yesterday, you reduced my Lorazepam after I told you that I could not sleep without it. If you do not reintroduce it, I will file a complaint.'

Hospital migration

It occurs when individuals with FD-BPD self-refer to separate medical or psychiatric services or family physicians, often in different towns, with services being unaware of each other. In other instances, these

patients have travelled extensive distances to visit numerous emergency departments before being admitted to a hospital. FD-BPD individuals frequently describe seeing hospitals along a freeway or rail route they are acquainted with.

Vignette No. 13

'I was in another A&E (Accident and Emergency), and they discharged me, and I still feel suicidal. I re-referred to A&E to this town because I still think of killing myself.'

Accruing medications

These patients may accumulate prescriptions from independent medical providers, resulting in a stockpile of potentially hazardous drugs. In severe circumstances, this conduct might be seen as self-harm, prescription drug addiction, or a precursor to suicide by overdose.

Vignette No. 14

'My family doctors have prescribed me all these medications (a long list). They believe I need them all.'

DISCUSSION

The evaluation of FD-BPD requires coordinated efforts from all relevant healthcare providers and an understanding the phenomenological processes underpinning the clinical presentation. To eliminate knowledge and practice gaps, a multidisciplinary team of mental and physical health nurses and physicians should synchronise its efforts to offer the same information to these patients. In reality, patients with FD-BPD may utilise disparities in the information shared between health carers to split personnel or file complaints with local authorities. Instead, the ability to share clinical records via electronic platforms, the coordination of messages provided by all healthcare providers, the strength to resist pressure from these patients and their families to do more than is necessary, and the support from hospital administrators to deal with allegations and complaints can improve the approach to patients with FD-BPD.

When a patient's assessment of the presenting sickness is questioned or reduced, or the fundamental nature of the illness or symptoms is questioned, the patient may test caregivers and file official complaints against personnel (Steiner & Nowels 2010). Clinical signs at hospital admission may seem severe or exaggerated (Steiner & Nowels 2010). Still, the patient's condition usually returns to normal shortly after entry whenever the necessary clinical or surgical therapy is given, or staff is made aware of the situation (Lazzari et al. 2018a). However, in a medical, surgical, or psychiatric unit, patients' exaggeration or malingering of psychical and mental symptoms can cause mounting concern in unaware staff, which automatically react by increasing the current medication that is already on the

patient's card, beginning new clinical investigations, increasing the level of observation, endorsing patient's desire to immediate referral to the emergency department, or becoming more accommodating to patients' wishes (Lazzari et al. 2018a).

The comorbidity of FD-BPD might be linked to an underlying mood disorder and emotional dysregulation where patients with BPD might tend to exaggerate their symptoms to control increase awareness in the hospital staff, gain admission to hospitals when unnecessary, or sabotage therapeutic plans to assume the role of chronic patients making it difficult to discharge them from the hospital (Lazzari et al. 2017).

Moreover, the choice of using factitious disorders or inflating subjective feelings and symptoms can reflect the option of many persons with BPD to use hospital admission and long-term stay as a way of escaping from difficult family conditions, social isolation, interpersonal conflicts or abuses, and fear of being unable to regulate emotional dysregulation in time of crises (Lazzari et al. 2017). Neither is it easy to challenge BPD who present with FD as they are prone and used to make false allegations against staff members who are also at high risk of losing their professional registration because of these frequent allegations (Lazzari et al. 2018b). The ultimate (and patient's hoped) reaction is likely to be an unlimited allocation of medical and human resources to persons who might use constructed physical and psychological symptoms to possibly attract more severe diagnoses, more intense care, more prolonged admissions, and less rejection from healthcare organisations.

Management and interprofessional practice

We found that several actions could direct the management of patients with comorbid BPD and FD. Any challenge about the truthfulness of what patients declare should be avoided as it can trigger complaints and a breach of professional trust. Healthcare practitioners need to be aware that once a patient reports a possible FD problem, staff should start a standard battery of assessments to rule out that the reported symptoms have indeed an actual organic basis which was never investigated before.

The therapeutic alliance is maintained as long as the interactions between staff and FD-BPD patients does not dispute the degree of truthfulness of the patient's claims. Furthermore, interprofessional discussions and collaboration from multiple medical and surgical disciplines should arrive at a final and conclusive diagnosis and management plan (Lazzari et al. 2017). It is not unusual for these patients to become heavy service users and make official complaints to the hospital management. For these reasons, corporate and clinical governance, also involving the chief executive officers, should lead to multidisciplinary discussions and integrate care plans when ward management or community support becomes too complicated (Lazzari et al. 2021). One major com-

ponent in corroborating a diagnosis of FD-BPD is constant behavioural and clinical assessment for patients in medical or psychiatric wards and sharing of information among all the agencies involved.

For example, pseudo-seizures can be triggered by environmental factors in the wards and community and are more frequent in female patients with BPD. In the wards, other female patients with BPD can copy the pseudo-seizures of others and learn FD skills. A 24-hour EEG will clear the diagnosis. Patients can be managed with reassurance and *Pro Re Nata* sedative medication. In the worst case of factitious paralysis and incontinence, a clearance from neurologists might suggest intensifying psychological assessment of undisclosed needs. Ward doctors can regularly conduct routine phlebotomy and blood exams to rule out tardive dyskinesia or neuroleptic malignant syndrome. Iatrogenic side effects from medications can mimic FD. When patients seek invasive surgical procedures – e.g. nasogastric tube feeding without having a confirmed diagnosis of an eating disorder – health psychologists should assess if patients agree to alternative care plans for their eating habits.

When severe pain is disclosed, nurses should have a behavioural assessment of degrees and should not accept personal accounts. The unresponsiveness of pain to ordinary painkillers (including low dosage of Amitriptyline for patients not at risk of suicide) should confirm the diagnosis of FD pain. In no circumstances should FD-BPD patients be prescribed oral medications if having a history of overdoses and when unsupervised at home. The secretion of Paracetamol requested in the wards to combat pain can instead result in accumulation and fatal overdoses. In other cases, voluntary and sublethal overdoses of Paracetamol, without suicidal intent and plan, can be used by FD-BPD persons to rapidly access hospitals' emergency departments and receive total care. All inpatients with FD-BPD should thus be monitored face-to-face when provided with oral medication to avoid that they hide them with the intent to pile them. Finally, interdisciplinary meetings involving professionals from multiple specialities are needed to effectively manage BPD and generate efficient care plans by involving corporate management in the decisions (Lazzari & Shoka 2016). At some point, the responsible psychiatry consultant might decide to reduce and stop further medical or surgical assessments of the cared FD-BPD patient.

Different pharmacological treatments have been tried to modulate mood dysregulation. Several studies suggest the combination of an antipsychotic with an antidepressant such as Fluoxetine and Olanzapine (Jariani et al. 2010). Furthermore, many persons with BPD acquire additional information from online communities for personal support. In fact, internet blogging may have important implications in care; online communities offer an additional venue for learning about the disorder and resources for treatment, and can be significant support in the form of hopeful messages,

resources, educational material, and sharing of personal stories and experiences with BPD, as well as a “safe space” for sharing these experiences (Gamlin et al. 2019).

CONCLUSION

The current research sheds light on one of the significant and constant issues in public and psychiatric hospitals in healthcare scenarios. The ability of medical and psychiatric personnel to disentangle complex presentations and medically unexplainable conditions is a growing need to detect and address the comorbidity of FD-BPD. From the authors’ experience, this novel pathology is about to assume an ever-increasing impact on healthcare. It appears that more and more patients are privileging this way to present to hospitals to address their multiple needs and have their voices heard.

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