Case Report

Factitious Disorder - Patient Pretending to Long Stay at the Hospital

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ABSTRACT

Factitious disorder (FD) is a psychiatric disorder where patients intentionally create false physical or psychological symptoms or exaggerate the already existing ones consciously in the absence of clear external motive. Patients feigned for the sole purpose of assuming the patient's role and to stay lifelong at hospital. Here we present a case of 61 years old Saudi patient presenting with so many various complaints and wasting valuable time and resources of doctors and wants potentially long hospital stays, which affects both the patient and the healthcare system.

Keywords: Factitious Disorder, Long Hospital Stay, Munchausen Syndrome.

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INTRODUCTION

Factitious disorder (FD) is a mental health disorder in which a person acts as if they have a physical or psychological illness; individuals falsify their illness in themselves or in other person, without any external gain or reward. Patient acts as if he has an illness by deliberately producing, feigning, or exaggerating symptoms, purely to attain a patient's role by cheating clinicians in order to take on the sick role and be treated as patients [1]. There is one umbrella term for such disorders factitious disorder imposed on self, also called Munchausen syndrome, it was introduced by Asher [2, 3] and others are Hospital addict, Hospital hobo syndrome, Hospital vagrant. In such disorder there are no objectives for the patients such as economic or monetary gain, days off work, avoidance of legal liability, or desire to live in better conditions. The patient of FD is unaware of the motive of his behaviour [4].

The essential features of chronic FD with physical and psychological symptoms are feasible presentation of illness that is unreal, not genuine or unnatural to get multiple hospitalizations with long stay, and voluntary production of symptoms. It is important to make a difference between factitious disorders and malingering. In malingering the purpose of the symptom and its mode of production are conscious and voluntary. There is a clear purpose to escape a difficulty or responsibility. In factitious disorder, there is a voluntary production of symptoms, but there is no clear purpose except perhaps to adopt the patient role. In hysterical disorder, the patient is unaware of both the purpose of his symptoms and its mode of production [5].

Case Report

A 61- years old, Saudi, single good body-built patient who belongs to lower socioeconomic classes was admitted at our hospital 6 months ago, complaining of chest tightness, low mood, lack of energy and death wishes. Patient has been diagnosed a case of depressive disorder during the first 3 months of his admission period. There were no previous admissions at our hospital documented, but he had three previous

admissions at private hospital one of which extended for more than a year, and he also received treatment from faith healers, but he never reached to baseline. He had pre-morbidity of histrionic personality traits.
As per history from his family there are no stressors in the family, they are highly supportive and caring well about him, and he used to be insisting on being taken to the hospital for admission claiming the above symptoms, he also threatened them by committing suicide if they do not take him to the hospital for admission. When he got admitted for 6 months we tried multiple antidepressant medications, such as escitalopram, fluoxetine, amitriptyline, mirtazapine, but he has never reported that he feels improvement during the interview by the psychiatric team. There was no family history of psychosis, and history of substance abuse was ruled out. We planned work up for electroconvulsive therapy (ECT) such as all routine investigations such as complete blood cell count, liver and kidney function test, serum electrolytes; lipid profile all of which were within normal limit. Radiological parameters and electrocardiogram were done which were normal, detailed medical evaluation including neurological examination was done which revealed no significant findings. After getting fitness from medical specialist, he received 5 sessions of ECT even though he did not report any improvement.
According to the nursing staff report, the patient seems almost normal at all levels, having his meals and sleeps normally. Usually it has been noticed that he is sociable and doesn't complain from any of the above symptoms, except when the medical team is present in the ward. He used to refuse meeting his family whenever they come to visit him. He used to show various unexplained physical symptoms, like pain in the abdomen beside that he claimed depressive symptoms. This case is highly challenging for the medical team for making diagnosis. It has been founded that he is highly familiar how to instigate pain in the abdomen and successfully pretend that he is having symptoms. Staff and doctors were trying not to reinforce him attention seeking behaviour by not paying much attention to his constant physical complaints.
Whenever the treating team informs him more than five times that he is going to be discharged then he starts to exaggerate the same symptoms and used to threatening about committing suicide. On the contrary he feels comfortable to know he is going to stay more in the hospital. We also observed him enjoying the attention he was getting from our medical team. It seems that his complains while in the hospital is a resembling conversional behaviour. Based on this we diagnosed him Factitious Disorder. We decided to refer him for psychotherapy, such as a behaviour modification program was planned with the purpose of eliminating attention which was thought to be reinforcing such type of behavior.

DISCUSSION

This case is being reported an unusual and rare psychiatric condition that may be difficult to be recognized, because patient is being feigned with depressive complaints. Even though we didn't observe improvement in his symptoms after getting multiple antidepressant medications, and received 5 sessions of ECT. Our patient wanted long term hospital stay because whenever we decided to discharge him he is restarting same complaints, and threatening to do suicide with attention seeking histrionic traits.
There are many factors predisposing the FD such as physical and psychological problems, existence of personality disorder, repeated hospitalization [6]. In our patient sometime he is pretending pain in abdomen to get attention then pretending depressive features. He has history of multiple admissions at private hospital. The patient who is suffering from FD has no clear gain, and in our patient in spite of good family support there is no clear gain. In malingering there is always an external gain. In conversion disorder there is alteration in voluntary sensory and motor function. Patients belonging to lower socioeconomic classes with a previous history of social maladjustment are frequently affected by this disorder, [7] and our patient is also from lower socioeconomic status.
The pattern of clinical presentation may be helpful in identifying FD, during interviewing patient would either complained of self-inflicted injuries, falsely report symptoms, or feign a disease or injury with a dramatic appearance, but had inconsistent medical history [8]. Many patients suffering from FD presenting with somatic complaints and they are reluctant to see a psychiatrist, and may abscond before being interviewed. The subtype of FD is predominantly psychological signs and symptoms, which is uncommonly reported, because of the subjective nature of the symptoms [9]. In our patient he is sometime complaining abdominal pain to gain an attention of doctors and later depressive features with suicidal threats.

In our patient, his motivation for pretending to be sick was the assumption of the sick role and there was no connection to any kind of external gains, and therefore he fulfilled the criteria for the diagnosis of FD. We excluded the possibility of malingering, as his behaviour was not appropriately adapted to a clear-cut long-term goal. FD often has comorbid psychiatric conditions. The most common of which are depression and personality [10], in our patient he is pretending as depressive features, and he has histrionic trait.

FD is difficult to diagnose with high index of suspicion to be considered which is necessary in recognizing it. So, highlight the awareness not only within psychiatrists, but also within physicians in different medical specialties, and health care professionals. As well as prevent unnecessary diagnostic investigations and treatment expenditures.

REFERENCES

1. American Psychiatric Association: Diagnostic and statistical manual of mental disorders. American Psychiatric Association, Arlington, VA; 2013.
2. Baylin RIS. The deceivers. BMJ 1984;288:583-4.
3. Asher R. Munchausen's syndrome. Lancet 1951;1:339-41.
4. Rothchild E. Fictitious twins, factitious illness. Psychiatry 1994;57:326–32.
5. Carney MW. Artefactual illness to attract medical attention. Br J Psychiatry 1980;136:542-7.
6. Burton M, Warren M, Lapid M. Munchausen syndrome by adult proxy: a review of the literature. J Hosp Med 2015;10:32–5.
7. Goldman HH. Review of General Psychiatry 3d Edition. California: Appleton and Lange. 1988;40470–6.
8. Tatu L, Aybek S, Bogousslavsky J. Munchausen syndrome and the wide spectrum of factitious disorders. Front Neurol Neurosci 2018;42:81-6.
9. Catalina M, Gomez V, de Cos A. Prevalence of factitious disorder with psychological symptoms in hospitalized patients. Actas Esp Psiquiatr 2008;36:345-9.
10. Yates GP, Feldman MD. Factitious disorder: a systematic review of 455 cases in the professional literature. Gen Hosp Psychiatry 2016;41:20-8.

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