Case Study

CASE STUDY: LATE DETECTION OF FACTITIOUS DISORDER-MUNCHAUSSEN'S SYNDROME WITH FEIGNED SCHIZOPHRENIA

Vie Cheong Thong[#], Deshvin Kaur Amanjit Singh[**], Sze Hung Chua[***]*

[*]Department of Medicine and Health Sciences, Universiti Malaysia Sabah, Kota Kinabalu, Malaysia;

[**]Department of Medicine and Health Sciences, Hospital Mesra Bukit Padang, Kota Kinabalu, Sabah;

[***]Department of Psychiatry and Mental Health, Hospital Lahad Datu, Lahad Datu, Sabah

Abstract

The Authors present a case illustrating factitious disorder, who was previously diagnosed as schizophrenia for 2 years, with a comorbidity of depressive disorder (unspecified) and obsessive-compulsive disorder. The factitious presentation involved exaggeration of symptoms, demanding and challenging behavior towards medical personnel, prolonging of sick role by refusing necessary intervention. Diagnosis of schizophrenia complicated patient's condition when poly-pharmacy was introduced. The element of deception too provided difficulty in clinician to identify other comorbid psychiatric issue of depression and Obsessive Compulsive Disorder (OCD), with the suspicion of Borderline Personality Disorder. We emphasize the importance of recognizing possible signs of deception through looking at the atypical presentation throughout the treatment course and consequences following the misdiagnosis. ASEAN Journal of Psychiatry, Vol. 25 (1) January, 2024; 1-6.

Keywords: Factitious Disorder, Munchaussen's Syndrome, Poly-pharmacy, Schizophrenia, Borderline Personality Disorder

Introduction

Factitous Disorder (FD) is a diagnosis of exclusion, hence posing a significant challenge to clinician to diagnose one. Extensive investigation might be done to search for a valid diagnosis, but due to the nature of the disorder, which often involves deception by the patient, investigations would often be unfruitful. The prevalence of the illness is unknown, possibly due to the deceptive nature, as well as under-reported cases, where clinicians are found to not record the diagnosis, according to Diagnosis and Statistical Manual of Mental Disorders, 5th Edition, Text Revision (DSM-V-TR).

Two types of FD are mentioned in the diagnosis criteria: Imposed on self or imposed on another (previously termed by proxy). The core features of factitious disorder are the falsification of symptoms, either medical or psychological, through identified deception including exaggeration, fabrication, simulation, or induction. Diagnostically, the need to ascertain the motivation behind the deceptive behavior is to differentiate between typical FD and maligering: While malingering involves a clear secondary gain, FD on the other hand emphasizes more in identifying the falsification acts (Table 1). Still, there is lack of clear evidence of difference between them, and clinicians are still struggling to be certain in their diagnosis [1]. The lack of documented cases is because of only 50% of patients received psychiatric evaluation [2]. There were also reported difficulty in reaching the diagnosis due to many unnecessary interventions, further complicating the clinical picture and causing more harm to the patient [3].

The presented case will further discuss the relationship between FD, depression, and poly-pharmacy.

Case Presentation

Ms Volga was a 25-year-old local ethnic lady, single and unemployed. She first presented to our psychiatry outpatient clinic in June 2020, following a referral from private sector.

Miss Volga started having abdominal pain since her adolescent years. It mostly happened during the period of menses. She described it as burning, faint and colicky in nature, with a pain score of 9/10. It gradually worsened until 5 years ago she decided to seek medical help, and she was told to have Salmonella infection. Since then, she was often preoccupied with the worry of contamination, having intrusive thoughts, and was having repetitive hand washing up to sixteen times a day. She would feel relieved for a short while after the compulsive handwashing, but the intrusive thoughts would still recur afterwards.

1 year later, Ms Volga's abdominal pain worsened and became intolerable, especially during her menses. She was brought to a clinic and treated for dysmenorrhea and endometriosis. She was started on hormonal therapy of oestradiol. She finds the treatment ineffective, and started having depressed mood, with occasional crying spells, reduced energy most of the time, and difficulty in concentrating in daily tasks. She was having suicidal ideation due to intolerable pain. She got admitted to general hospital after an episode of overdosing on paracetamol and flu medication in 2019. It was then she was referred to our psychiatry outpatient clinic, for continuation of care.

Upon our initial assessment, Ms Volga complained of her depression symptoms, and revealed that she heard voices talking to her especially when she was depressed, commanding and insulting her. She feels worried and finds herself checking for information on her illness online. She was diagnosed Major Depressive Disorder (MDD) and Obsessive-Compulsive Disorder (OCD), and started on combination of antidepressant, antipsychotic, and benzodiazepine.

After some time, we noted that Ms Volga would frequently visit the clinic before her appointment date, usually 1-2 days after a change in her prescription by her clinician. She would request for change of prescription again, at the same time provided her list of medications she wished to try or discontinue. If her wish were not complied, she would return with physical complaints which resembled the side effects of prescribed medications. She also had occasions of visiting other clinics to request for specific treatment declined by us and brought their referral letters back to us as proof. However, if her request were granted, she showed rapid improvement, even total resolution of her symptoms, which would last for few weeks before she came to our clinic and had new requests again.

Table 1. Differences between Factitious Disorder and Malingering.

Factitious Disorder (F68.10/F68.A)		Malingering (Z76.5)
Classification (DSM-5-TR)	Somatic symptoms and related disorders	Other conditions that may be a focus of clinical attention
Mental Disorder (Bass et al., 2019)	A mental disorder	Not a mental disorder
Gender Prevalence (Udoetuk et al., 2020)	Women>men	Men>women
Behaviour (DSM-5-TR)	Falsifying symptoms about themselves or others	Falsifying symptoms about themselves
External incentives (Van Impelen et al., 2017)	Lack of external incentive (assuming sick role/internal incentive)	Presence of external incentive (personal gain)
Motivation (Lipson, 2013)	Unconscious	Conscious
Cooperativeness in treatment (Lipson, 2013)	Cooperative for procedure	Less cooperative for procedure
Associated Personality Disorder (Lipson, 2013)	Borderline Personality Disorder	Antisocial Personality Disorder.

Her condition often fluctuated, with sometimes varying complaints of psychotic-like symptoms such as seeing vivid bizarre images, hearing voices, and having the feels of everyone is talking about her. She also had anger outburst with self-harming behaviour, with repeated overdosing, drinking poisons and cutting her forearms. For those, she was sent to the emergency department for acute treatment. Due to the increased severity and bizarre nature of her illness, she was diagnosed schizophrenia 5 months into her follow-up treatment.

As Ms Volga repeatedly come to the clinic with multiple complaints, her medications got revised repeatedly, often resulted in the increment of number and dosage of medications. Merely after 3 years in our care, she had tried on most antipsychotics, antidepressants, and mood stabilizers. Her regime at one time consisted of a combination of high dose oral Sertraline, lithium, Asenapine, Intramuscular Paliperidone Palmitate and regular Clonazepam. Despite such adjustments, her condition still worsened, with mixture of depressive, Obsessive Compulsive Disorder (OCD) and psychotic symptoms. She also suffered from medications side effect such as weight gain, hyperprolactinemia, and tachycardia, requiring addition of Propranolol. Psychological intervention was unfruitful as she was not cooperative to the therapy.

Results and Discussion

The difficulty of the managing the above case was due to lack of cooperation from the patient's main caregiver-the mother. Patient's mother would help her to get the treatment she requested, pleading to the treating doctors and refusing for any treatment that may cause discomfort to them. When Ms Volga's condition worsened, the team has multiple times advised for admission for monitoring, but it was strongly refused. With many occasions of difficult communications, eventually there was no longer trust from both sides.

Her challenging behavior towards the clinicians resembled of those with Borderline Personality Disorder (BPD): Evident threats, anger outburst, and irrational demands [4]. Despite having strong suspicion, we failed to elicit any diagnostically essential criteria which should be evident from early adolescent, such as the affective instability, interpersonal relationships, impulsivity, or identity disturbances. Based on history provided by multiple sources, most of her changes happened in her late adolescent, with none of usual predictive factors such as childhood traumatic experience, temperamental issue, and difficult parent relationship [5].

There are many literatures that discuss the resemblance between FD and Borderline Personality Disorder (BPD). Goldstein wrote an analysis report in 1998 based on twenty-nine cases found over 10-year period in 1998. It was found consistently that FD affects woman more than man, with ratio of 2:1. There is more single than married or divorced patients, which supports the notion that they are doing poorly in interpersonal relationships, pointing to the possible association with Axis II diagnosis, especially BPD. Of nineteen reported. 53% had a past or present diagnosis of BPD. It was also reported that BPD shares similar traits of self-destructive behavior with factitious disorder [6]. Nadelson has proposed that adoption of sick role in Munchausen's Syndrome is behavior of patients with BPD [7]. Based on all these information, the team is still monitoring Ms Volga for the possibility of the diagnosis.

The suspicion of Factitious Disorder arose, when, as seen in the case [3]:

- **Lack of response/improper response is noted during treatment:** Ms Volga's condition has not improved since she was under treatment for 4 years, despite frequent visits to the hospital. As we went through her clinical notes, we noticed a pattern: Her condition often fluctuates following certain 'triggers' in her life. For example, after a switch in her medication, if it is her request being granted, her psychosis and depression symptoms would resolve rapidly in just 3 days after the changes made or, if it is her request denied, her condition will continue to worsen, resulting in anger outburst and self-harming episodes at home. Of note, based on a trial by Gallego et al., the response is only evident between 8 to 16 weeks since the start of treatment for patients with first episode psychosis. Ms Volga's rapid resolution of symptoms is therefore unusual [8].

- **Wax-and-waning of symptoms, vague or unspecific complaints:** There were times that the team found Ms Volga to be highly suggestible when reporting her symptoms. During assessment, Ms Volga would answer yes to most close ended questions about

presence of psychopathology, but there were inconsistencies noted between her claims. The context of her hallucination changed frequently, with too much or too little detail of her experiences. She couldn't talk specifically about what were the sequences of events, such as her anger outbursts, her mood swings, and the intrusive thoughts that she has experienced for past 4 years. She also came with somatic complaints, often resembled side effects of her medications, and requested doctors to make altercation to them. Still, she could not specify the details. Even if she did, they did not fit into the usual presentation of those complaints.

- **Refusal of a formal assessment:** Patients with FD are often found to be refusing formal assessment. This may because of the fear of going through a formal assessment, knowing that their deception effort could be exposed. For Ms Volga, she requested for financial aid in the past, but refused to be assessed by Occupational Therapists despite the need, and she refused to provide any reason to her refusal.

- **Gain:** Although we found no evidence of secondary gain which suggests malingering, Ms Volga did receive much attention from her mother since she fell 'ill'. We suspect the presence of primary gain, which was the attention given during her sick role. Thus, bringing the suspicion of Factitious disorder.

The diagnosis is further supported by an assessment of MMPI-2-RF, conducted by clinical psychologist. It was reported as there are multiple domains with score invalid in their validity scales, suggestive of over reporting. In a recent meta-analysis, it is found that MMPI-2-RF is highly effective in detecting feigning of mental disorders. The Fp-r in newly revised MMPI-2-RF maintains its effectiveness in capturing feigned psychopathology with very high specificity.

Another aspect that needs addressing in this case is poly-pharmacy, which is a common phenomenon observed in psychiatric treatment. Based on a recent cohort by Stassen, it is known to be associated with 60% of treatment in patients in schizophrenia as well as depressive disorders. For Ms Volga, poly-pharmacy is one of the main consequences, stemming from repeated visits to different clinicians with differing point of view. She was prescribed four different classes of psychotropic at a time, with most of them are on high or maximum doses. Based on National Association of State Mental Health Programme Directors (NASMHPD) (NASMHPD Technical Report, 2001), poly-pharmacy is divided into five groups [9]:

- **Same-class poly-pharmacy:** Use of more than one medication of the same class (e.g., use of two antipsychotics in patients with schizophrenia).

- **Multi-class poly-pharmacy:** It is the use of full therapeutic doses of more than one medication from different classes for the same symptom cluster (e.g., use of lithium and second generation antipsychotic, such as olanzapine, for treatment of bipolar disorder).

- **Adjunctive poly-pharmacy:** Use of one medication to treat side effects caused by another medication of a different class (e.g. usage of trihexyphenidyl to treat extrapyramidal syndromes caused by antipsychotics).

- **Augmentation poly-pharmacy:** It refers to the use of one medication at a lower than normal dose along with another medication from a different class in full therapeutic dose for the same symptom cluster (e.g. addition of low dose haloperidol in a patient responding partially to risperidone); or the addition of a medication that would not be used alone for the same symptom cluster (e.g. augmentation of antidepressants with lithium or thyroid hormone).

- **Total poly-pharmacy:** It is the total count of medications used in a patient, or total drug load.

The usage of multiple medications has known to alter the nature of the medicines, including the therapeutic effects, side effect profiles as well as the dosage requirements [10]. Despite the known side effects, psychiatrists still highly adopt poly-pharmacy. The reasons are mostly associated with the lack of response to mono-therapy despite multiple switching attempts, to compensate for the side effect of an existing drug, or as preference based on experience of the treating clinician [10,11].

It is important to remind ourselves that although many literatures do not advocate for poly-

pharmacy, it does have supporting evidence of effectiveness in combination of certain drugs but none of them are proved superior to another. There is also a lack of conclusive evidence of the superiority of poly-pharmacy than mono-therapy [12-14].

In Miss Volga's situation, we are concerned of her medication regime as she was showing physiological and psychological changes since the addition of her medicines [15-17]. As we look back on her clinical notes, her depression symptoms worsened with increment of her medication, along with the presence of emotional and cognition dampening. These can be a side effect of psychotropic, especially antipsychotics [18]. Through a recent systemic review by Sirinoot, poly-pharmacy is associated with increased drug-related problems and risk of depression. However, it is often difficult to ascertain the diagnosis of major depressive disorder due to the possibility of patient exaggerating or simulating the symptoms to prolong the sick role [19-22].

Conclusion

The diagnosis of Factitious Disorder should be based on continuous observation, inconsistencies of reported symptoms, with evidence from multiple agencies such as psychiatrist, clinical psychologist, and occupational therapist. Poly-pharmacy may be a direct consequence to patient with FD, but more research is needed in terms of their relationship. We also emphasize the weight of a diagnosis of great disability such as schizophrenia would imply an opportunity of sick role adaptation for FD patients.

Notes on patient consent

Patient and her mother have given consent for the team to produce this case report.

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Declaration of Interest

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Corresponding author: Vie Cheong Thong, Department of Medicine and Health Sciences, Universiti Malaysia Sabah, Kota Kinabalu, Malaysia

E-mail: *winstonthong@gmail.com*

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