Factitious disorder with self inflicted injuries

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Abstract

A 45 year old Bangladeshi female presented with multiple deep cuts and scratch injuries on her body. It was evident from the detail history and observation that the injuries were done by the patient herself. The absences of any obvious external rewards lead to the diagnosis of the factitious disorder. Deception is a key component in both malingering and factitious disorder but in factitious disorder, getting attention or playing the sick role is the only motive.

Introduction

Factitious disorder is an illness which is challenging for the medical professionals around the globe. The disorder can be defined as the intentional production or feigning of symptoms or induction of injury/disease which can be attributed to a need to assume the sick role.[1] The disorder has two varieties, factitious disorder imposed on self and factitious disorder imposed on another (also called factitious disorder by proxy). The exact prevalence of the factitious disorder is unknown due to the role of deception in this population. The prevalence range between 0.05 and 2.0%, and women are 4-20-fold more likely to be affected than men.[2] Factitious disorder is generally seen more commonly among females, especially in the fourth decade of life.[3] The disorder is more prevalent in women having health care training or jobs.[3] Unlike conversion disorder or malingering, the obvious external reward is absent. The primary motivation is only to receive the medical attention and for this patients may inflict painful, deforming or even life threatening injuries on themselves. Extreme form of factitious disorder is called Munchausen syndrome and estimated to account for around only 10% of factitious population.[3]

Case Report

SB, 45 years old Muslim housewife, residing in a rural area was brought to the Psychiatric outpatient Department on 28th March 2016 with complaints of several cut injuries all over her body and sleep disturbance for 1 month. One month back, she fainted on her way to the toilet and was taken to a nearby health center where it was found that her blood pressure was 200/120 mmHg. After that, the patient was feeling ill and was resting in a bed for most of the time. After a few days, her daughter suddenly noticed a cut mark on her right leg which was bleeding heavily. On query, the patient informed that she accidentally cut herself in a corrugated iron sheet but her family members were surprised as the patient did not go outside. From then, her family members were always accompanying her but on the next day, her daughter left her mother alone only for a few minutes for going to the toilet, came back and saw that another leg was deeply cut and there was a blood stained bled on her side. They quickly took her to a nearby hospital and few stitches were given. When asked about the incidence, she said that she did not remember anything.

In next few days, it was occurring that patient was injuring herself with sharp weapon whenever she had a chance to be alone. Few times, she insisted her care giver to go outside and in the meantime, she injured herself. During this time period, her family members tried their best to keep all the sharp things away from her, but she even went to the kitchen or other rooms to collect sharp objects whereas, for the rest of the day, she was unable to leave bed due to her weakness. After admission, the patient was under observation and it was strongly recommended that no sharp object should be present in the patient's vicinity. Yet, whenever her attendant was asleep or busy, the patient injured herself with nail scratches during the hospital stay. On query, the patient stated that the injuries happened while she had bad dreams during her sleep and she found herself wounded after waking up. But it was evidenced that, none of the injuries happened while patient was asleep.

General examination revealed high blood pressure and several scratch injuries and

stitches over her body (Figure 1). There were three cut injuries on the lateral surface of both legs and scratch injuries on her left fore arm and breast. On mental state examination, the patient was kempt, well groomed, with no odd motor or social behavior. Her mood was depressed but not enough symptoms to meet the criteria for major depressive disorder. There was no abnormality in her speech, thought or perception. Her cognitive function was intact and rapport was established. Surprisingly, the patient was indifferent about the injuries and was not comfortable talking about this topic.

On investigation, all the routine tests (blood count, random blood sugar, creatinine, ECG, lipid profile) were within the normal limit. MRI of brain and EEG were normal.

The patient was diagnosed as a case of factitious disorder imposed on self–single episode. The treatment plan was mostly non-pharmacological. We had four sessions of counseling with the patient holding a firm but empathetic approach. The patient was confronted with evidence that the injuries were self-induced. In the first two sessions, the patient denied but later she agreed to the fact. Her family members were also included in the last session and they were advised not to blame or scold the patient for her act. We could not find any possible external gain from her behavior instead of getting attention. She also had the relaxation training session. She was prescribed with antidepressant mirtazapine (15 mg daily) and sedative (clonazepam, 1 mg daily). She was discharged on 13th April 2016 with the above-mentioned drugs with a tapering course. She was taking indapamide (1.5 mg/day) and bisoprolol (5 mg/day) for the treatment of hypertension.

After 3 weeks, the patient came for follow-up, and there were no more incidents and her depressive mood subsided.

Discussion

Patients with factitious disorder may mimic medical symptoms, interfere with diagnostic investigations, exaggerate or lie about a medical condition or even directly self-induce illness or injury.[4] The motivations of the patient with factitious disorder are 'almost always obscure' and may include a desire to receive affection and care unlike malingerer, who fabricates medical need for reason of clear external reward (such as evading military service or gaining disability benefits).[5]

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition[1] requires that the following three criteria be met for the diagnosis of factitious disorder imposed on self: (A) Falsification of physical or psychological sign or symptoms, or induction of injury or disease, associated with identified deception; (B) The individual presents

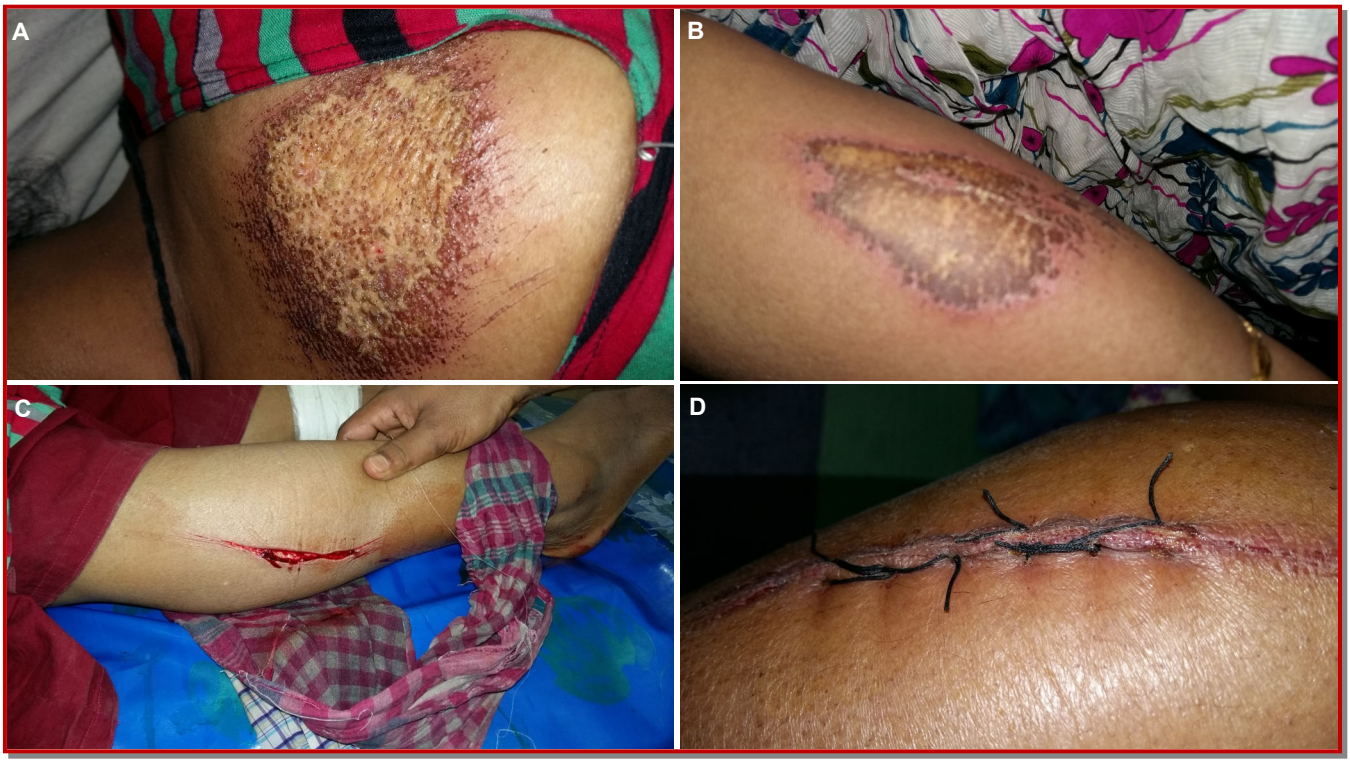

Figure 1: The nail scratch injury over the left breast (A) and on the left forearm (B). Deep cut on lateral surface of right leg (Just after the cut) (C) and after stitching (D)

himself or herself to others as ill, impaired or injured; (C) The deceptive behavior is evident even in the absence of obvious external rewards; (D) The behavior is not better explained by another mental disorder. The diagnosis has two specifiers: Single episode and recurrent episodes.

SB's history and presentation met the diagnostic criteria of factitious disorder, imposed on self. She acknowledged that she did the injuries by herself and her motivation for such behavior was to assume the sick role and to get the attention of her children. Her son studies in Dhaka and her daughter has recently been married. After knowing about their mother's illness, both of them came home and were taking care of her. The reason behind using blade or fingernails for injuring herself was the availability within her surroundings.

Malingering was an important differential diagnosis for this case but the possibility was excluded as there was no evidence of any personal gain. Conversion disorder was excluded as there was no alteration in voluntary motor or sensory function.

In a systematic review of 455 cases of factitious disorders, it was found that most of the patients (66.2%) were female and the mean age at presentation was 34.2 years which is in concordance with our case.[6] Patients elected to self-induce illness or injury more (58.7%) than simulate or falsely report it. Among the psychiatric morbidities, current or past diagnosis of depression was described more frequently than personality disorder (41.8% versus 16.5%).

In this case, the patient also had depressive symptoms for which medications were given. We used non-confrontational technique for management and it turned out to be effective as there was the rapid improvement and no relapse of symptoms in last 1 year. Many different management techniques have been reported, primarily focusing on confrontational versus non-confrontational approach. But results of a systematic review found no significant difference between outcomes of confrontational and non-confrontational approaches.[7]

An early diagnosis of the factitious disorder can be obtained by clinical clues, incompatible findings especially discordant laboratory results and new sophisticated laboratory assays.[8] Though in this case, there was a little role of laboratory test in general, laboratory can play a key role in the detection and diagnosis. If the investigation of the factitious disease is requested, then the clinician must provide as much information to the laboratory as possible in terms of clinical signs and symptoms, so that appropriate tests can be advised.[9]

Worldwide, there have been reports of recurrent deep ulcers resembling rare cancers,[10] multiple soft tissue injuries[11] and numerous reports of dermatitis artefacta. It is a condition (also called factitious dermatitis) where skin lesions are solely produced or inflicted by the patient's own actions without any rational motive for this behavior.[12] Common presentations of dermatitis artefacta are excoriations, ulcers, blisters, eczematous lesion and bruises.[13] Both single case report and case series of dermatitis artefacta have been published in India. [14, 15] The nail scratch injuries, in this case, resemble dermatitis artefacta but the deep cuts cannot be explained by it.

We did not find any report of factitious disorder in Bangladesh on web search but a case series of bloody tears was reported from the Sylhet where an important differential was factitious disorder.[16]

Conclusion

Factitious disorder is uncommon but important. A good knowledge of factitious disorder by health personnel will help in early identification of the diagnosis and, therefore, allow for a better treatment and prognosis.

Conflict of interest

There is no conflict of interest.

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