

Comorbidity of Factitious Disorder and Intellectual Disability: A Case Report

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Individuals with factitious disorder fake illnesses to assume a sick role. They simulate, induce, or aggravate illness, often inflicting painful, deforming, or even life-threatening injury on themselves or those under their care. Factitious disorders are diagnosed in about one percent of patients who are seen in psychiatric consultation in general hospitals. One of the features, that are overrepresented in patients with factitious disorders include: normal or above-average Intelligence Quotient (IQ). Authors describe a rare comorbidity of factitious disorders and intellectual disability.

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Introduction

Patients with factitious disorders present with a broad spectrum of physical and/or psychological symptoms and signs only to obtain a sick role (1,2). This disorder may be challenging, frustrating and troublesome for clinicians, in addition to being easily misdiagnosed (3). The Classic form of factitious disorder, Munchausen's syndrome, is characterized by a chronic course, obscure psychological motives for the behavior, and physical (not psychological) symptoms (4). Although factitious disorder has been reported more frequently in recent literatures, most health care providers are still not sufficiently aware that, this is not a rare disorder (5). Based on physicians' experience and

observations, it is estimated that, 1.3% of patients have factitious disorders (6). One study reported a 9% prevalence of factitious disorder among inpatients (5). Bauer Baegner, diagnosed factitious disorders with neurological symptoms in 3% of 1536 patients on a neurological ward during a one year period (7). In a one-year Psychiatric inpatient sample (n=775), Bhugra, found a rate of 0.5% of patients showing symptoms of Munchausen's syndrome (8). According to some reports disorders related to substance use, somatoform disorders, dysthymia, borderline personality disorder, and sexual disorders are frequently associated with factitious disorders (9,10). Factitious disorders occasionally co-occur with malingering, while co-occurrence with somatoform disorders, are rare. Differentiating these complex presentations and learning the management of factitious disorder can reduce iatrogenic complications, thus avoiding unnecessary health care costs (11). Most of the patients with factitious disorder have been shown to have a high intelligence quotient (IQ) (1,12). In spite of performing a through literature search, authors have managed to find only one case report of co-occurrence of

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factitious disorder and intellectual disability (13). Here we report another patient with this rare co-morbidity.

Case Report

A 15-year-old girl with a chief complaint of genital and anal pain arrived at the emergency department of hospital, reporting that she had been attacked and raped by a gang of youth. In physical examination, however, no sign of injury could be found in genital or anal areas. Since, nobody accompanied her to the hospital and she was a minor. She was admitted for close monitoring. Few hours later a psychiatric consultation was requested following development of a non-organic loss of consciousness in her. During first interview by the psychiatric resident, she was diagnosed to suffer from a dissociative state due to rape and subsequently admitted to the psychiatric ward. During the first psychiatric visit in the ward, she was calmly lying on the bed and though she was mute, she could follow people and objects with her eyes. Her vital signs were normal and physical and neurological examinations revealed no abnormality. However, multiple surgical scars on her abdomen and lower extremities were notified. After a period of four-hour observation and without any especial intervention, she recovered and started complaining of vomiting blood. During the interview, she complained of headache and a burning sensation in her head. Although no tenderness was found in abdominal exam and her vital signs were stable, her saliva was mixed with fresh blood. The examination of the gastric fluid through naso-gastric tube did not indicate any bleeding. She slept well and there was no further complaint during the first night of her stay in hospital. Following day, during the ward round, she mentioned that, she had managed to get her high school diploma and that; her father was a cardiac surgeon. She kept talking about the assault and that; it was done with the cooperation from her maternal Aunt. She also complained of a long lasting depression, which started after her Mother and Siblings were killed in a road traffic accident. Mental state examination was normal except for a low level of general knowledge and

concrete thinking indicative of possibly a below average intelligence. Having suspected a diagnosis of factitious disorder, nursing staff kept a close eye on her. Later that day, she was seen biting her finger and rubbing her lips and inside her mouth with her bleeding finger by a member of staff. When confronted, she confessed the falsification of personal and familial information, she had given and the fact that she had faked her symptoms just to get admitted to hospital. She then provided her real name and address. Her father was subsequently contacted who refuted her account of rape and road traffic accident that she had reported to the team. He mentioned that, she had been unable to finish the primary school due to learning difficulties. He also mentioned that, she had a long and repetitive history of admissions at the medical and surgical wards of different hospitals. She had undergone different diagnostic and invasive procedures like: endoscopy and laparotomy several times in the past. Except for an operation, she had for an osteomyelitis during her childhood, no proofs of any real pathology could be found in her previous medical and surgical discharge notes. Interestingly, her Father reported that, he was working as a health care professional in a hospital. The team did not find any evidence of domestic violence, child abuse or history of sexual abuse at home. An IQ assessment was therefore requested, which confirmed, she was performing at a mild intellectual disability level (overall IQ score=63).

Discussion

The symptoms our patient presented with impostership and pseudologia fantastical, were suggestive of a diagnosis of a classic case of factitious disorder (4,12,14). The history of hospital admission during childhood due to a real medical illness (in her case an operation for osteomyelitis) and an intimate knowledge of health care system (her father was a hospital worker) are commonly reported in the literature (12,14). Although, the use of confrontation is controversial in the assessment of people with factitious disorder, patients must be encouraged to face the reality sometime in the course of their admission (14).

This approach can indeed relieve the symptoms, at least temporarily (15). Therefore, such confrontation if used judiciously and with a full consideration of patient's dignity can be a valuable key to the diagnosis. The IQ of the factitious disorder patients is described to be normal or higher than the average (1, 10), though this is not a necessary criterion for diagnosing the condition (4). However, the IQ level seems to determine the complexity and believability of the clinical scenario, a person with factitious disorder presents with, as this was the case in our case report. A broad knowledge of differential diagnoses, thorough history taking and physical examination along with collateral information gathering from previous case files, family and careers are the key factors in successfully assessing patients with a diagnosis of factitious disorder.

References

1. Wise MG, Ford CV. Factitious disorders. *Prim care* 1999; 26: 315-26.
2. Newmark N, Adityanje E, Kay J. Pseudologia fantastica and factitious disorder: review of the literature and case report. *Compr Psychiatry* 1999; 40:89-95.
3. Samaan Z, Hoh E, MacQueen G. Factitious disorder presenting as type 1 diabetes mellitus. *BMJ Case Reports* 2009. Available from: URL: http://casereports.bmj.com/cgi/content/abstract/2009/mar19_1/bcr0720080463.
4. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th ed. Washington, D.C.: American Psychiatric Association; 2000.
5. Sussman N, Joau CB, Joseph A. single case study: Munchausen's syndrome, a reconceptualization of the disorder. *J Nerv Ment Dis* 1992; 175:692-5
6. Fliege H, Grimm A, Eckhardt-Henn A, Gieler U, Martin K, Klapp BF. Frequency of *ICD-10* factitious disorder: survey of senior hospital consultants and physicians in private practice. *Psychosomatics* 2007; 48:60-64.
7. Bauer M, Bogner F. Neurological syndromes in factitious disorder. *J Nerv Ment Dis* 1996; 184:281-8
8. Bhugra D. Psychiatric munchausen's syndrome, literature review with case reports. *Acta Psychiatr Scand* 1988; 77:497-503
9. Sutherland AJ, Rodin GM. Factitious disorder in a general hospital setting: clinical features and a review of literature. *Psychosomatics* 1990; 31:392-9
10. Kapfhamer HP, Rothenhausler HB, Dietrich E, Dobmeier P, Mayer C. [Artificial disorders between deception and self mutilation experiences in consultation psychiatry at a university clinic.] *Nervenarzt* 1998; 69:401-9. German.
11. Drob SL, Meehan KB, Waxman SE. Clinical and conceptual problems in the attribution of malingering in forensic evaluations. *J Am Acad Psychiatry Law* 2009; 37: 98.
12. Feldman MD, Ford CV. Factitious disorders. In: Sadok BJ Sadock V. *Comprehensive text book of psychiatry*. 7th ed. Philadelphia: Lippincott Williams&Willkins; 2000. Vol 2 . p. 1533-43. .
- 13- Heger S. [Factitious disorder in a mentally retarded patient in urology]. *Psychiatr Prax* 1998; 25(4), 206. German.
- 14- Sadok BJ, Sadock V. synopsis of psychiatry behavioral sciences/ clinical psychiatry, editor, Philadelphia: Lippincott Williams&Willkins;2003.
- 15- Reich P, Gottfried LA .(1983). Factitious disorders in a teaching hospital. *Ann Intern Med*, 99(2), 240-247.