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ABSTRACT
Factitious disorder (FD) is a diagnostic entity in which patients intentionally create false physical or mental symptoms. Although the disorder is rare, having an early diagnosis is critical, because it causes unnecessary health expenditures and tends to become chronic. In this article, a case of delusional disorder who had been monitored for 6 years, then hospitalized due to a pre-diagnosis of drug induced movement disorder, and had a final diagnosis of FD was discussed. Through this case report, it was aimed to emphasize the importance of careful monitoring of the patients for preventing unnecessary investigations and treatments.

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Factitious disorder; movement disorders; delusional disorder; psychological symptoms; factitious motion disorder; antipsychotic medicine

Introduction
Factitious disorder (FD) is a diagnostic entity in which patients consciously present false physical or mental signs and symptoms. Patients do not have available objectives such as economic gain, avoidance of legal liability, or desire to live in better conditions [1]. The patient deliberately fabricates the disease or acts. Primary motivation of these behaviours is known to be the need to receive medical care by assuming the patient role. The patient is unaware of the underlying motive of this behaviour [2].

FD is a disease of which the differential diagnosis is challenging and causes unnecessary health expenditures. It has no definite treatment and usually shows chronicity [3,4].

In this report, a patient hospitalized with pre-diagnosis of movement disorder due to drug side effects was discussed. Written informed consent of the patient was obtained.

Case
The patient was a 61-year-old primary school graduate housewife with two children. She has a sister. In the year her father was put in the prison, she was accepted to a high school, but her family did not allow her to enrol the school. The next time he left prison, her father was nervous and unhappy. When the patient was 16 years old, her father, treated for alcohol dependence and died of liver failure. The mother was a factory worker, constantly complaining of headache. Her parents used to behave in a distant way to each other and their children.

She was married at 26. Because of her husband’s alcohol use and financial difficulties; they had many discussions. She had no friend and family support. She thinks that her husband does not want them because her husband does not work, does not care about her and their children. At that time, she asked her mother for help in the care of the children, but her mother turned down her request for help.

She was described as an individual that had a quick-temper, irritable, constantly fighting with people, feisty, who cared very much about hygiene and cleanliness, along with possible obsessive characteristics, since she was a teenager. She was mentioned about being deceived by her husband in 1999.

The patient, who had been brought to the psychiatry outpatient unit 6 years ago, due to complaints such as talking to herself, jealousy and irritability, had remarks of her husband cheating herself, which were conceptualized as delusions, following the patient being diagnosed with Delusional Disorder. Upon her treatment with antipsychotic medication, her symptoms had totally diminished. During the fourth year of her treatment, her complaints identified as rocking back and forth, moving her eyebrows up and down, clenching her jaw and squeezing her teeth, being unable to stand on her feet without moving have started and became more prominent within the past year. Despite the pharmacological treatment administered, symptoms of the movement disorder did not improve. She was quite unable to do self-care and her daily affairs, even could not get out of the house. Her daughter was living together with the patient. She was the one doing housework at home and distant to her mother.
As she frequently stated that her illness had progressed and wanted to be hospitalized soon, she was hospitalized for clarification of the diagnosis and treatment.

On mental status examination, she entered the interview room in small steps, was talkative and puerile. While sitting, she was shaking back and forth and her eyebrows were moving up and down. Consciousness and orientation was intact. No memory and perceptive problems were detected. Judgment and the reality testing were preserved. In thought content there were themes about the negative effects of her present complaints to her daily life. She had no insight to her complaints which she attributed to drug side effects. Her affect was blunt. The intelligence level was clinically normal. Social and family functioning were impaired. There weren’t any other medical conditions.

The doctor following her in the outpatient clinic told that the patient once called the phone and said, “I’m actually acting.” When this conversation was reminded to her she stated that could not remember that talking.

She was able to adapt easily to the service. At first week, she was constantly shaking while sitting, moved her eyebrows, and avoided to participate in duties. She had more complaints when the health workers were around her, and no complaint while eating or drinking. In the interviews held during the first week, she was giving advocates and inconsistent answers to questions about defining herself and her family. She often talked about not hearing, being forgetful, and not healing. It was observed to avoid doing so by claiming the duties given in the service. At second week, she noted urinary incontinence. She used to complain of urinary incontinence for 3 years but urinary examinations were normal. She had no urinary incontinence during hospitalization period.

Through sessions made with the patient, we have aimed to gain more insight regarding her personality and temperamental characteristics, intra familial dynamics and factors that might possibly cause emergence of symptoms at the time. By taking on a supportive stance and approach, gradual exposure was made, focusing on her ability to express her emotions and problem solving and management skills. When feedback is given that the complaints of the patient may be due to stressful events, not drug side effects; she expressed that she had a difficult life and did not receive support from her family, she was very sorry for her life, never happy in her marriage and had many family conflicts. How this problem was reflected in the behaviour of the patient’s problems and suggestions for solutions were discussed. Taking the positive aspects into consideration, discussions were made on the ability to establish relationships and to exist in life other than being sick.

On second week, movement abnormality was not observed any more even when the health workers were around. The patient’s relatives were informed and drug treatment was terminated. The patient did not report any problems other than complaints during the period when she did not take antipsychotic medication. The task list was made and the patient was sent home on weekends. It was realized that she was doing her task on her return home, her doctor was trying to earn her appreciation and liking, her need to express her feelings.

No clinical depression or anxiety disorder was considered. The Minnesota Multiphasic Personality Inventory test was rated “invalid.” In the Beier Sentence Completion test, loneliness theme was predominant. Bender-Gestalt test was used to video the physical movements of the patient during the interview. The patient did not swing while she was drawing. The interview records were watched with the patient. Upon the psychiatric diagnosis clarified as FD, she was discharged from the inpatient unit, with a plan to continue her treatment with individual sessions at the outpatient unit. Her complaints that comprised rocking back and forth as well as sudden cessation of movement as she was walking, just during the times her relatives and close social circle paid her visits as well as just before the time of discharge reappeared. After discharge, she could do self-care and daily work, had better relationships and no shaking behaviour. However, new somatic complaints occurred.

**Discussion**

FD is an exclusionary diagnosis [3]. Firstly, other medical conditions that may cause the indication should be excluded. In the differential diagnosis, firstly the movement disorder due to drug side effects was evaluated. Walking with small steps, slowness in motion and decreased facial expression are typical findings of “parkinsonism.” “Akathisia” must be considered if the patient is not able to stand still without moving, and finally the act of moving the eyebrows up and down and swinging motion suggest the differential diagnosis of “tardive dyskinesia,” although they are not typical [5]. If the symptoms do not improve despite appropriate treatment approaches, if the neurological examination is normal, and the improvement of symptoms is observed on follow-up interviews or when the patient is alone; then the diagnosis of Parkinson disease, akathisia and dyskinesia should be ruled out.

During the interview with the patient and her relatives; the diagnosis of delusional disorder was excluded, because her complaints were periodic rather than permanent [6], rapid recovery of symptoms, thoughts on deception were not so intense, and it was understood that domestic problems had originated from financial issues rather than the patient’s thoughts. It was thought
that the diagnosis of delusional disorder put on the patient 6 years ago might be wrong.

Simulation should also be evaluated in the differential diagnosis of FD. There is always an obvious goal in simulation and the person can stop producing signs and symptoms when he/she gets the desired earnings [7]. We excluded simulation because our patient did not have any significant desire for a gain.

One of the psychiatric diagnoses one needs to bear in mind for the differential diagnosis of FD has been identified as borderline personality disorder (BPD). Although symptoms such as instability observed in relationships, frequent lying are common entities in both disorders, it is well known that frequent applications to health facilities and demands on further and more detailed tests and procedures are not prominent in the course of BPD. Instability in relationships, repetitive suicidal ideation and behaviour, mood swings and significant impulsivity have not been observed among our case’s reported symptoms [1,8].

The diagnosis of FD was established because all the test results were normal, she was willing to talk about her symptoms, being examined and having tests and insisted on inpatient treatment and once mentioned that she was acting in the outpatient clinic, the complaints aggravated after family conflicts, the presented findings changed from time to time, nobody had observed her urinary incontinence which she had been complaining for a long time and she had no symptoms when there was no health worker around her during hospitalization period.

It is suggested that patients with FD have frequently refusing parents who do not establish close relationships, history of abandonment, neglect and abuse. Traumatic experiences of early life lead to low self-esteem and unmet needs of being approved, securely attachment and trust [7,9]. Since the patient was forced to drop out the school and do the housework after her father died, lost her father with whom she had a closer attachment and trust [7,9]. Since the patient was forced to drop out the school and do the housework after her father died, lost her father with whom she had a closer attachment and trust.

The patient’s mother’s constant headache complaints, the increase in complaints due to negative life events; the presence of depressive symptoms in the father; being tried to suppress the feeling of guilt by taking alcohol have indicated that her parents did not have suitable coping skills. It was also determined that the patient could not adequately express her problems and did not have appropriate coping skills too. Her high motivation to be adopted a patient role can be attributed to mentioning continuously of her symptoms and the possibility of not being recovered, reminding that frequently, having frequent polyclinic visits, and calling her doctor to get a service.

Behavioural explanations asserted that FD is the result of social learning, positive and negative reinforcement. By means of faking symptoms of being sick, getting attention, taking more support, gaining others sympathy and compassion serve as positive reinforcements in continuing her illness. Getting rid of duties and responsibilities is a negative reinforcement of faking symptoms of being sick [10]. Although the patient was grumpy and incompetent person in the case, it was learned that after her complaints had started, she became a more compatible person and earned the sympathies of her relatives; her children feel sorry for her instead of feeling angry; she could not fulfill many tasks including her own self-care needs; because of that her daughter undertook household affairs; and it was tried not to reflect the negative events in the family to the patient. It was claimed that all those changes in her life play a positive and negative reinforcement for faking symptoms of being sick.

We conclude that careful monitoring of the patients with ambiguous and changing symptoms, eagerness to have diagnosis, treatment and hospitalization is important to diagnose FD and to prevent unnecessary diagnostic investigations and treatment expenditures.

**Disclosure statement**

No potential conflict of interest was reported by the authors.

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