J. Indian Assoc. Child Adolesc. Ment. Health 2017; 13(3):208-224

Original Article

Clinical presentation and approach to management of Factitious Disorder in adolescents – A case report

Raman Krishnan, Paul Swamidhas Sudhakar Russell

Address for correspondence: Dr Raman Krishnan, Associate Professor, Saveetha Medical College, Chennai. dr_ramkrish@yahoo.com

ABSTRACT

Literature on illness falsification by caregivers is in abundance. There remains an invisible group, where the symptoms can be intentionally feigned by child and adolescent patients. Recognizing this group is essential and a high index of suspicion is necessary to arrive at a diagnosis. In this group, it is not only difficult to identify the mechanism of symptom production but also to delineate if it is feigned by the adolescent or they participate in the fabrication of symptoms along with their perpetrator. Motivation remains another challenging area of debate in this group. As in other pediatric somatic symptom disorders, pediatric factitious disorder also has a better prognosis with a non-confrontational approach, the focus being symptom reduction, uncovering the conflict area, assessing family dynamics and behavioral approaches as and when necessary. Here we present two adolescent patients diagnosed with factitious disorder based on their symptom presentation and family psychopathology. Management principles employed for both the patients are also discussed.

Key words: factitious disorder, clinical presentation, treatment approaches

INTRODUCTION

Illness falsification by caregivers of childrenis a known entity in literature [1,2]. Children and adolescents can fabricate illness themselves or participate in the illness falsification by caregivers.Factitious disorder in adolescents presents with symptom patterns that pose diagnostic dilemma in identifying motivation behind symptom production. In this group, it is difficult to prove conscious motive behind symptom production. The issue of motive remains a major cause of debate [3]. The term 'pediatric condition falsification' is used when the motivation of the behavior is not given importance [4].

Factitious disorders have been reported in children as young as eight years. In adolescents**,** it is more common among females and this is similar to that of adults [2].In literature both physical and psychological symptoms have been described. As in the case of dissociative disorders, attention and care eliciting behaviors appear to be the primary motivation of this group [5]**.** Some evidence is available that children or adolescents may collaborate with caregivers in the production of symptoms.

Literature available on the perpetrators of illness falsification in children has described the mothers of factitious disorder by proxy to have had history of inducing illness in them in their teenage years [6]. High incidence of abnormal illness behavior and somatising disorder are commonly reported among the perpetrating mothers in various studies [7, 8].

In children and adolescents, this group is included under somatic symptom and related disorders as per DSM 5 system of classification. A high index of suspicion is essential to

make a diagnosis of factitious disorder and a better understanding and identification of these children is likely to help prevent the development of more chronic adult factitious disorders. The prognosis is better in adolescents compared to adults and this is similar to the somatoform group. A non-confrontative approach incorporating principles of family systems theory in the management has been reported to be useful in the literature [9]. Here we present atypical symptom presentation of factitious disorder in two adolescents and the therapeutic principles employed in their management.

Patient A

Watery discharge per vagina

Ms J is a 13 year old girl studying in 8th standard born out of 2nd degree consanguineous marriage by LSCS. Her birth and developmental history was unremarkable. She was described to have slow to warm temperament and her scholastic performance was below average. She presented with complaints of watery discharge from vagina for past 1 year. The episodes of wetting used to occur once in a month lasting for 15 minutes to1 hour. There were no specific situations or triggers for such episodes. They have been reported both at home and school setting. Her mother described a typical episode that started with slight wetting of her undergarments followed by heavier clear watery discharge with foul odor that drenched her clothes.

The child's mother attributed the watery discharge to be from the vaginal orifice. She claimed that in an attempt to delineate the cause, she found that it was vagina that was wet and not the urethral orifice after an episode. She was extensively investigated for the above complaints by various gynecologists, surgeons and urologists as reported by the

mother. The child used to become symptom free on the way to hospital and there were no such symptoms documented during the hospital stay or observed by the medical professionals when she was hospitalized for the first time 6 months ago and when re hospitalized 3 months ago. Due to the above symptoms, there was absenteeism from school. She would be asked to take leave by mother on the day of the episode and at least 1- 2 days subsequently till the child becomes asymptomatic. Such episodes resulted in absenteeism almost for 2-3 days in a month. At the time of presentation to us, her mother reported that she had lost all the old reports and investigations that were done to delineate the cause for the child's symptoms. She described that they came by bus to the hospital. When she woke up in the morning, she found that the cover containing all the reports was missing. She was puzzled about the whole event when confronted on the loss of reports in isolation when her clothes and money kept inside the same bag were intact. Feigning of information related to loss of reports was being thought of. There is no history suggestive of urinary urgency or incontinence or diurnal or nocturnal enuresis. There is no history suggestive of seizures or spinal injury. There is no history suggestive of features of anxiety or depression. There is family history of alcohol dependence syndrome in maternal uncle and mental retardation in 3rd degree relative. Child's mother was extensively evaluated during her early adulthood for complains of bullous eruptions in her legs with serosanguinous discharge. She reported that her ailment didn't improve with treatment from any systems of health care and the symptoms dramatically improved following a telephonic conversation with a healer.

The child was evaluated for symptoms of multiple aches and pain 2 years back and for episodes of involuntary jerky movements (on an average of 5-6 episodes in a month) 3-4 years back. She was investigated, by a neurologist and cardiologist for the above complaints and organicity was ruled out. Past diagnoses made at child psychiatry unit were somatoform pain disorder and dissociative convulsions. Possible stressors identified at that time were related to coping with academic difficulties. IQ assessment done during that visit (when her chronological age was 9 years 8 months) showed her to be functioning at mild level of intellectual disability (On BKT, her IQ was 58). Psychological support addressing academic difficulties and mother child interaction were focused during the psychotherapy. However the family did not come for regular follow up.

On General examination there were no stigmata of mental retardation except for short stature. There were no signs of injuries. Genitourinary examination showed underdeveloped secondary sexual characteristics. Other systemic examination was well within normal limits. Complete blood count and urine examination was normal. USG abdomen showed hypo plastic uterus. On mental state examination, child was cooperative, speech was spontaneous and relevant and rapport could be easily established. The child described her symptom in detail and expressed that mother is excessively concerned about her symptoms as well as delay in her menarche. There were no signs of emotional distress or anxiety during the interview.

A provisional diagnosis of factitious disorder with predominantly physical symptoms and signs was made based on the following features; dramatic presentation of symptoms,

multiple investigations, loss of old reports, disappearance of symptoms with hospitalization, possibility of similar illness in mother and past history of vague somatic complaints and dissociative symptoms.

As part of the family assessment, it was found that the boundary between family subsystem and suprasystem was porous. The child's mother would resort to discussing all intra familial issues relating to daily events, daughters education, husbands involvement in family, financial needs with her maternal uncles and her own mother. She was also found to seek help for making important family decisions from her maternal uncle. Financial support for all hospital visits used to be provided by maternal side relatives. She also had expressed concerns that her spouse was disengaged and emotionally unavailable at times of crisis and hence she would seek for emotional support from the extended family members.

The therapy primarily employed family system based approach. During the psychotherapy sessions, mother's anxiety related to the child's symptoms, concerns regarding delayed menstruation, apprehension related to hypo plastic uterus and onset of menarche, related misconceptions were addressed during the initial 2 sessions. Detailed interviews assessing interaction and communication pattern were held. During the subsequent sessions (sessions 3-7), therapeutic sessions focused on mother-daughter interaction and communication pattern with focus on power struggle, decreasing expressed emotions and rewarding for desirable behavior. Mother's ambivalent relationship with the child was explored in detail as it was observed that mother would appear to show excessive concern about the child's overall development but at the same

time, would be insensitive to the child's distress. Individual therapy with the child focused on skill deficits in self care and communication, encouraging age appropriate behaviors and verbalizing emotional distress (sessions 8-9). Attempts were made to delineate the method of inducing the symptoms by direct questioning. Mother was elaborating on the symptoms repeatedly and claimed that she wanted to know why the symptoms happen. The child was not able to elaborate on the symptom and subjective distress related to it and hence it was difficult to find out the mechanism of symptom production from her as well. Emotional enmeshment with the suprasystem was identified as one factor which was indirectly reinforcing recurrent medical visits and investigations. It was observed that the mother would resort to elaborately detailing her daughter's minor physical ailments to her family members. Her parents and brothers would reinforce her belief about health related concerns by financially supporting all investigations and hospital visits. Mother was given feedback on this and both were given summary of the overall sessions and their outcomes (session10). During follow up visits, father's involvement in the therapy, health concerns of the child and emotional involvement with family was emphasized. The child was on a monthly follow-up for more than 6 months after discharge and there was no symptom recurrence or onset of new symptoms.

Patient B

Watery discharge per anus

13 years male Mr. MT a student of 9th grade hailing from upper middle socio economic status presented to us with 3 year history of change in bowel habits characterized by pain in left iliac fossa followed by an urge to empty the bowel. Such episodes were found to

be increasingly frequent over days and were found to occur every day after every meal. The stool consistency was watery in nature followed by well formed stool. The child was taken to multiple doctors and he underwent extensive investigations and diagnostic procedures by general physician, gastroenterologist and pediatric surgeon. He was hospitalized thrice in the past and underwent colonoscopies for almost 3-4 times. He also underwent colonic biopsy. He was diagnosed to have irritable bowel syndrome and was given symptomatic treatment. He was advised to follow dietary modification practices and was prescribed ant diarrheal agents. There was no significant improvement in the symptom presentation. There was no change in weight or appetite.

Mother could correlate the onset of symptoms 3 years back with life event of change of residence and tuition centre. The tuition teacher was reportedly punitive and onset of bowel symptoms correlated with the event of being punished by the teacher for not completing his home work. His mother also observed him to be asymptomatic for 2 months during summer vacation and had recurrence of symptom with reopening of the school.

His scholastic performance was below average according to mother's report. She said that he was managing to score above the pass marks in all his subjects. There was no specific difficulty in reading, writing or mathematical ability as per history. Academic records showed careless errors and incompleteness in writing tasks because of poor attention. He had difficulty in sustaining attention both in the class and while doing homework tasks. He would prefer learning in a structured environment with less distraction and teaching done on one to one basis.

There was childhood history of hyperactivity, restlessness, disturbing other children, impulsivity, poor concentration, inability to sustain attention with tasks from 4 years of age but currently inattention was predominant. Difficulties in learning were observed in areas of poor completion of written tasks, careless errors and poor comprehension of the questions. He was also having bed wetting at night since childhood with frequency being thrice a week. According to the mother, he had never been completely dry by night for a continuous period of 6-12 months. There was past history of adjustment difficulties at school setting in his 5th Standard, when he had complaints of school refusal and crying spells following bullying at school. This lasted for a month and following individual sessions with school counselor, he was able to cope well and continue schooling.

His temperamental traits include sensitivity to trivial comments, need for dependency, low adaptability, lower threshold for responsiveness and anxiety in social situations. He preferred to keep to himself and would minimally verbalize his distress. He also had difficulty in initiating and maintaining friendship and preferred lesser age group peers for his company. He enjoyed playing computer games and growing pet animals/birds. The likely possibility of social anxiety features becoming predominant as he is entering into adolescence could explain the overlap of inattention, restlessness along with anxiety in social situations.

Family assessment: His father was working as a pharmacist and was staying abroad. The child moved to India along with his mother and his 3 siblings 6 months back. His mother reported that he had poor interpersonal relationship with his siblings and would get into frequent conflicts with them on trivial issues because of his preference for

sameness, sensitivity to his belongings being handled by others and impulsivity. His mother had features of anankastic personality traits and she appeared to be critical about his academic performance, personal sense of responsibility and his fights with his siblings. It was found that there was a gross mismatch between her expectations and his skills. She also claimed that her spouse was more permissive in his parenting style. It was also evident from history that 2 of his younger siblings had been investigated for complaints of abdominal pain and loose stools on more than 3 occasions.

General and systemic examinations were within normal limits. His old investigations were reviewed in detail by the pediatric surgeon and no organic causes for his symptoms could be detected.

A provisional diagnosis of factitious disorder, predominantly physical symptoms with Disorder of attention and activity (ADHD), and primary nocturnal enuresis was made. Persisting symptoms in spite of extensive investigations, repeated hospitalizations and rigorous medical evaluations without any diagnosis, symptom disappearance in hospital setting all pointed towards a possible diagnosis of factitious disorder.

Goals of therapy set were:

1. To make him symptom free of the bowel related complaint
2. To reduce the frequency of nocturnal enuresis through behavioural techniques
3. To teach him attention enhancing strategies
4. To encourage mother to use reinforcements and rewards to improve positive behaviours and reduce expressed emotion.
5. To improve mother child interaction

The child was seen as an outpatient once a week for 3 months and subsequently once in a month for almost a year. The initial goal of therapy was to make him symptom free. He was not confronted on the mechanism of symptom production. Detailed interview with him and the mother together revealed mother being critical about his overall behavior. Their interaction pattern was hostile and mother interpreted that most of his skill deficit behaviors related to ADHD were voluntary. The mother thought that his repeated errors in academics, inability to follow instructions and incompleteness in tasks were due to his laziness and was not able to accept that it could be due to developmental issues. Hence she was given adequate information on this and her misconceptions were clarified on a regular basis.

Mother and boy were educated about the results of investigations and feedback about absence of organic causes was given. Therapeutic contract was established and psychological model for the symptom production was explained during the initial 3 sessions. His IQ was assessed on BKT. He scored 87 indicating low average intelligence.

During the subsequent sessions (4-8), both were asked to maintain ABC chart (antecedent, behavior and consequence) for each episode of watery diarrhea. During every session, ABC chart was reviewed and a clear temporal correlation between the symptom onset and exams was established. The episodes were reported most often before the exams or after the exams when exam papers are given. There was a clear association between increased frequency of symptom and mother critical comments on his performance in exams or his behaviors at home.

The child was taught JPMR (Jacobson's Progressive Muscular Relaxation) as it was observed that he had symptoms of muscular tension and sweating due to performance anxiety in exams. He was also encouraged to practice attention improving strategies at home. Mother was educated about the principles of differential reinforcement, rewarding techniques, academic planning, home tutoring and structuring his activities of daily living (sessions 9-12). During the follow up sessions, it was observed that mother had features of adjustment disorder – depressive type. Individual sessions for her were carried out to encourage adaptive coping. She was given feedback on her critical comments and taught ways to positively reinforce his adaptive skill behaviors. It was observed that at the end of 4 months, the frequency of symptoms decreased from 6-8 episodes per month to almost nil.

A behavioral chart for enuresis was also introduced and he was started on Imipramine 12.5mg which was gradually increased to 37.5mg after baseline ECG monitoring. He was under follow up for almost a year and there was no symptom recurrence. The frequency of enuresis decreased substantially from 4-5 in a month to almost 1 or nil. He started showing consistent progress in academic performance.

Table 1. DIFFERENCES IN CLINICAL PROFILE AND MANAGAMENT PRINCIPLES BETWEEN PATIENTS A AND B

	PATIENT A	PATIENT B
Age/Gender	13 year old male	13 year old female
Education	9^{th}std	8^{th}std
Presenting symptom	Watery discharge through anus for 3 years	Watery discharge through vagina for 1 year
Typical symptom description by mother of the patients	Pain in the left iliac fossa following a meal with an urge to defecate. There is clear watery discharge in spurts through anus followed by well formed stools. Video recording of episode by mother	Mild wetting of her pants followed by clear watery discharge with fishy odor dribbling down and drenching her entire lower segment of the body. No symptom reported during any hospitalizations
Precipitating factor	House change and change of tuition teacher	None elicited
Past history / comorbidity	Nocturnal enuresis, ADHD	Somatoform pain disorder, dissociative convulsions
Family dynamics	Anankastic traits in mother with high expectations and critical comments, permissive parenting by father, (pharmacist working abroad).Other siblings have frequent GI complaints	Disengaged father, financial and emotional support from suprasystem, ambivalent relationship between mother and child, mother had undiagnosed bullous eruptions in legs that dramatically resolved without treatment
Possible conflict areas/motives identified	Academic coping due to poor attention and mothers expectations/critical remarks	Mothers anxiety related to child's delayed menarche and childs academic difficulties
Organicity ruled out	Multiple specialists met; all investigations including colonic biopsy normal	Visited gynecologist, urologist and surgeon; examination and investigations normal; reportedly old reports lost
Intelligence Quotient as assessed on BKT	Low average intelligence (IQ 87)	Mild level of intellectual disability(IQ 58)
Management principles	ABC for episodes monitored and addressed Mother son interpersonal worked upon Academic support with behavioral techniques for inattention taught Imipramine for enuresis and ADHD	Mothers misconceptions related to menarche delay, Interpersonal relationship between them, emotional enmeshment with suprasystem, adaptive skills training for the child
Follow up	Symptom free for more than a year	Symptom free for more than 6 months

DISCUSSION

Both the case scenarios illustrated atypical presentation of physical symptoms in two adolescents. The fact that the symptoms lacked an organic basis, multiple hospital visits, submissiveness for investigations, and dramatic description of the symptoms, discrepancy between symptoms and investigation results and diagnostic dilemma made us to arrive at a diagnosis of factitious disorder. Pattern of symptom presentation is varied and may involve multiple organ systems. Patients described here had Gastrointestinal and Genitourinary system related complaints [10,11]. A brief summary of both the case scenarios is presented in table 1.

A high index of suspicion of factitious disorder was kept as the symptoms were not observed during hospital stay and repeated investigations were yielding negative results. Psychopathology in the family members of patients with Munchausen syndrome and parent child interaction is well documented in literature**.** Studies have quoted that mothers of victims with factitious disorder report past history of somatisation disorder or factitious disorder young adulthood [12, 13].Both our patients had significant family psychopathology. Emotionally disengaged father with suprasystem enmeshment and history of unexplained medical illness in mother of child A and geographically distant father, anankastic traits in mother child B were observed. In both children, mothers were over involved with almost disengagement from the father in the treatment process as is the case with factitious disorders [14].

In child A, there was past history of somatoform pain disorder and dissociative convulsions which is documented in literature. In child B, there was history of bowel

related complaints in younger siblings possibly identified as modeling for his symptom production. Studies have reported that parents may serve as role models in teaching their children to produce symptoms of their own [1]. Case series on the characteristics of victims of factitious disorder by proxy can provide information on the vulnerable age group, intellectual functioning of children and proposed modes of fabrication of illness.

Both children had deficits intellectual and developmental skills. Child A had mild intellectual disability and child B had low average intelligence with ADHD.

Both children responded favorably to treatment [15]. The treatment approach in case A primarily used principles of family systems theory and in case B, we employed behavioral techniques. We didn't use confrontative techniques to elicit the motive and mechanism of symptom production. Hence it was difficult to comment symptom fabrication by the adolescents themselves or they merely participated in the collusion process with their mothers.

Unlike adults, Factitious disorder in adolescents have a very good prognosis as is evident in both the cases. A non confrontative approach with established therapeutic alliance with the child and primary care givers would facilitate early recovery [16].

CONCLUSION

It is essential to consider factitious disorder in the differential diagnosis when we come across symptoms which presentation in children and adolescents [17]. Systematic non confrontative approach, delineation of unconscious motives both in the patient and primary care giver, involving other significant family members when appropriate are some of the core strategies that helps in faster improvement and better prognosis.

REFERENCES

1. Ehrilich S, Pfeiffer E, Salbach H, Lehmkuhl U: Factitious Disorder in Children and Adolescents: A Retrospective Study. Psychosomatics 2008, 49:392–398.
2. Jaghab K, Skodnek KB, Padder TA:Munchausen's Syndrome and Other Factitious Disorders inChildren—Case Series andLiterature Review. Psychiatry 2006, 3(3):46-55.
3. Bass C, Adshead G: Fabrication and induction of illness in children: the psychopathology of abuse. Advances in Psychiatric Treatment 2007, 13:169–177.
4. Shaw RJ, Daval S, Hartman JK, DeMaso DR: Factitious disorder by proxy: pediatric condition falsification. Harv Rev Psychiatry 2008, 16(4):215-24.
5. Libow JA: Child and adolescent illness falsification. Pediatrics2000, 105:336–342.
6. Savino AC and Fordtran JS:Factitious disease: clinical lessons from case studiesat Baylor University Medical Center. Proc (BaylUniv Med Cent) 2006, 19(3):195–208.
7. Meadow R: The Dangerousness of Parents Who Have Abnormal Illness Behavior. Child Abuse Rev 2000, 9:62-67.
8. Bools C, Neale B, Meadow R: Munchausen Syndrome By Proxy: A Study Of Psychopathology. Child Abuse Negl 1994, 18(9):773-788.
9. Griffith JL: The Family Systems of Munchasen Syndrome by Proxy. Fam Process 1988, 27:423-437.
10. Peeble R, Sabella C, Franco K, Goldfarb J: Factitious Disorder and Malingering in Adolescent Girls: Case Series and Literature Review. ClinPediatr. 2005, 44:237-243.

11. Khan SA, Davey CA, Khan SA, Trigwell PJ, Chintapatla S: Munchausen's syndrome presenting as rectal foreign body insertion: a case report. Cases J2008, 1:243:1-5.
12. Marcus A, Ammeermann C, Klein M, Schmidt M: Munchasen syndrome by proxy and factitious illness: Symptomatology, parent-child interaction and Psychopathology of parents.Eur Child Adolesc Psychiatry 1995, 4(4):229-236.
13. Ishak WW, Rasyidi E, Saah T, Vasa M, Ettekal A:Factitious Disorder Case Series with Variations of Psychological and Physical Symptoms. Prim psychiatry2010, 17(9):40-43.
14. Maldonado JR: When parents deceive their childrens' doctors: a review of factitious disorder by proxy. Am J Forensic Psychiatry 2002, 23(2):29-58.
15. Clarke C and Skokauskas N: Pediatric symptom falsification (Munchasen syndrome by Proxy) – Psychiatric manifestations. BJMP 2010, 3(4):a344.
16. Eisendrath SJ: Factitious physical disorders: treatment without confrontation. Psychosomatics 1989. 30:383–387.
17. Howe GL, Jordan HW, Lockert EW, Walton M: Munchasen's syndrome or chronic factitious illness: A review and case presentation. J Natl Med Assoc.1983, 75(2):175 - 181.

Raman Krishnan ,Associate Professor, Saveetha Medical College, Chennai ; Paul Swamidhas Sudhakar Russell- Professor and Head, Child and Adolescent Psychiatry, Christian Medical College, Vellore.