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FACTITIOUS DISORDER—A CASE REPORT

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SUMMARY

A case of factitious illness in a young village woman is described. She presented with multiple physical and psychiatric symptoms and had interpersonal and sexual problems. A simple behavioural approach was successful in ameliorating her symptoms.

DSM III (1980) uses the term 'factitious disorder' for illness characterised by physical and/or psychological symptoms that are intentionally produced or feigned for the sole purpose of assuming the patient's role. Chronic factitious illness with physical illness (Munchausen's syndrome) represents the prototype for the factitious disorders. The true prevalence of this disorder is unknown Bhugra (1989). It typically begins in early adulthood and the prognosis in most cases in poor (Sussman and Hyler, 1985). Early deprivation, serious illness requiring extensive medical care in childhood, masochistic, exhibitionistic, psychopathic or obsessional personality traits, dependency and brain damage have been considered as common predisposing factors (Sussman and Hyler, 1985; Bhugra, 1989). Factitious disorder is still rarely diagnosed in India. Presented herewith is a case of factitious illness.

Case Report

A 22 years old, III class pass village woman was hospitalized with multiple complaints—vomiting, fits, swelling of body, stomach ache, weakness, menstrual irregularity, no appetite, anxiety and sleeplessness for 4 years which started after her first marriage. She received treatment from numerous faith healers and had three previous hospitalizations, each precipitated by a major family stress. She did not have sexual relations with first husband. After her second marriage too, family relations were strained. Premorbidly she had histrionic and narcissistic traits. It soon become obvious that she feigned fits only in the presence of doctor. Also, before them she refused to sit, stand or walk on the pretext of being weak. Otherwise she walked for long distances with her husband. The family was over indulgent, carried her to the toilet, bathed and groomed her. Further enquiry elicited that she never really vomited and ate when she wanted. When confronted she and her family members became angry. They insisted that she had a life threatening illness and demanded injections, IV fluids & ECT. X-RAY skull was normal, EEG showed generalized discharges and I.Q. on Bhatia Battery Test was 84.5. Anxiolytics, antidepressants,

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antidiarrhoeals, antiemetics and ECT were ineffective. A seemingly paradoxical procedure was then tried. The patient and her family were informed that she was having a major illness and advised strict bed rest with minimum sensory stimulation. Restriction on amenities and activities were systematically lifted as improvement occurred and reimposed in reverse order when relapse occured. She improved gradually, became symptom free by the 14th day, and was discharged. The duration of stay in the hospital was 2 months.

Comments

Malingering was ruled out as there was no recognizable goal for the production of symptoms. Many common features of Munchausen's syndrome such as extensive travel, impostorship, psychopathy, self-mutilation and interference with diagnostic procedures were not seen in this patient. This may be related to her female sex, poor education and rural background. Although the syndrome has been reported predominantly in wandering, psychopathic males, there are also reports in female nurses who were non-wanderers with conformist personalities (Stafne and Moe, 1951; Carney, 1980). The production of symptoms was deliberate. The present illness served to meet the dependency needs which were otherwise not forthcoming. A simple behavioural approach alongwith a tolerant attitude resulted in improvement. It seems that the prognosis is not always bad. Possible features indicating a favourable prognosis are the presence of minimal antisocial personality attributes and non-wandering.

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