

FACTITIOUS DISORDER IN SAUDI ARABIA: A REPORT OF TWO CASES

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تتصف الاضطرابات المصطنعة بوجود أعراض عضوية أو نفسية يتظاهر بها الفرد قصداً أو بختلقها دون وجود بواعث جلية سوى رغبته في انتحال الدور المرضي. ولم تدرس هذه الاضطرابات في مرضى سعوديين إلا نادراً. وفي هذه المقالة نعرض حالتين مرضيتين لرجل وامرأة سعوديين مصابين بهذا الاضطراب، وأظهر كل منهما ملامح متلازمة منشوسن. وقد نشد كل منهما - مثلهم مثل كثير من المرضى النفسيين - العلاج عند المعالجين الشعبيين قبل مراجعتهم للمستشفى. وعلى الرغم من اختلاف العوامل الاجتماعية والحضارية فإنه من الواضح أن الوعي والقبول لدى الأطباء بإمكانية حدوث الاضطرابات المصطنعة هو مطلب مهم لتشخيصها.

Factitious disorders are characterized by physical or psychological manifestations that are intentionally produced or feigned with no apparent external incentives in order to assume the sick role. These disorders are rarely reported or may be under-reported in Saudi patients. We describe here two male and female Saudi cases of such disorders. Both presented predominantly with features of Munchausen's syndrome. Like most psychiatric patients both had sought help from traditional healers prior to their reporting to the hospitals. In spite of the socio-cultural factors, it is clear that doctors' awareness and acceptance of the possibility of factitious disorders is a prerequisite to making the diagnosis.

Key Words: *Factitious disorders, cultural factors.*

INTRODUCTION

Socio-cultural factors are important in the epidemiology and psychopathology of various psychiatric disorders^{1,2} including factitious ones. They have an influence on the pathways to seeking medical help.³ In addition, illness behavior has cultural overtones in Arab patients.⁴

Factitious disorders are characterized by physical, and psychological signs or symptoms that are intentionally produced with no external incentives to feign illness.⁵ These disorders have been reported from various cultures.^{6,7}

A distinction should be made between factitious disorders and malingering. In the latter, the patient produces symptoms with an obvious goal. In factitious disorders, the motivation to be a patient is vague and obscure.

Munchausen's syndrome, in its classic description, is an uncommon subtype of factitious disorder which has received great attention.^{7,8} This syndrome is the earliest description of a factitious disorder with predominantly physical signs and symptoms. Although factitious disorders are common among males, recent reviews indicated a

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preponderance of female patients.⁹ The probable judgement that a particular symptom is produced intentionally is made both by direct evidence and with the exclusion of other causes of the symptoms. Almost in all reported cases of factitious disorders with physical symptoms, no obvious major mental disorder has been found. However, many such patients have been described as having underlying masochistic, borderline or dependent personality traits.⁹ Although the prognosis is usually poor, patients who have adequate psychosocial support with less severe personality pathology can do better. In this article, two patients who suffered from such disorders are described.

CASE 1

A 45-year-old, illiterate, Saudi housewife was referred from a medical ward for psychiatric consultation. During her stay in the medical ward, she was investigated for skin lesions distributed mainly on the abdomen and both thighs, but not on her back or other areas of the body inaccessible to the hand. The dermatologist suspected factitious dermatosis (dermatitis artefacta).

Her case history revealed that two years prior to her current psychiatric consultation, she was hospitalized for vague abdominal pain, but all investigations were normal. After discharge from the hospital, she consulted a traditional healer who treated her by cauterization. During the following two years, she presented with recurrent skin lesions on the abdomen, arms and both thighs. Some of the lesions were new, others were exacerbations of old lesions. The lesions were incapacitating and prevented her from performing her usual household chores. Her family background showed that she had four growing children. Her illness had created marital discord but there was no family

history of mental illness. Furthermore, she had no past history of serious physical or mental illness. Her premorbid personality revealed underlying dependent personality traits. The examination of the mental state did not show any major disorder.

During her stay in the psychiatric ward for observation, the lesions were dressed properly. Evidence of intentional production of skin lesions on healed sites and on new areas was reported. When confronted with evidence of their factitious nature, she denied doing herself any harm. Surprisingly, she did not demand discharge.

The judgement that the skin lesions were produced intentionally was made by direct evidence from the staff in the ward and by excluding other causes of these lesions. She was discharged from the psychiatric ward after three months and given a follow-up appointment in the psychiatric clinic but she never showed up.

CASE 2

A 39-year-old, single, illiterate and unemployed Saudi male presented with dramatic severe abdominal pain. He was vague and inconsistent when questioned in detail about the nature of the pain. When all of the investigations proved negative, he started to complain of chest pain. Intentional production of physical symptoms was suspected and he was referred for psychiatric assessment.

His past history showed that he had been admitted to different general hospitals in Saudi Arabia, some of which were far from his hometown. The information received from some of these hospitals showed that repeated medical and surgical consultations, including extensive investigations, did not reveal any physical disorder. In addition, psychiatric assessment showed no evidence of mental disorders either.

During his stay in the psychiatric unit, he presented with acute renal pain, hematuria and evidence of self-induced blood tinged

stool. On confronting the patient about the factitious nature of his complaints after organic causes had been ruled out, he became angry and discharged himself. Two months later, he presented to the hospital in a deaf-mute state but left the hospital when again confronted. Similarly, he did not benefit from traditional healers whom he had visited many times, on the advice of his relatives. He continued to appear in the hospital with different symptoms. Once he simulated the symptoms of acute asthma. We managed him by confronting his symptoms but remaining supportive.

DISCUSSION

One of the essential clinical features of the above two cases is the intentional production of physical symptoms. The first case is that of factitious dermatosis, the second is of chronic physical symptoms associated with multiple hospitalizations. The first case of dermatitis artefacta was preceded by cauterization from a traditional healer which might have acted as a predisposing factor. The second case is similar in presentation to other classic cases of Munchausen's syndrome¹⁰ described in several cultures.

It is important for clinicians to remember that with factitious disorder there could be some real physical illnesses that need appropriate management.¹¹

The behavior of these two patients has cultural dimensions. To travel, females in the Saudi culture need "mahram" (a person whom they cannot legally marry) who might not always be available.¹² This requirement restricts their travel creates an important feature of what was known as wandering type of Munchausen's syndrome.¹³ In females, the type of Munchausen's syndrome that is characterized by less severe psychopathology, a higher functioning level and less frequent facti-

tious behavior is classified as non-prototypical.¹⁴ This classification seems to be justified as revealed in case 1, though it has recently been criticized⁸ because the criteria for classification are not applicable in a good number of factitious disorder cases.

New modern hospitals are common in Saudi Arabia. For submissive female and male patients, falling sick is a means of receiving attention, avoiding responsibility and preserving their integrity. This might be incorporated into the psychopathology of factitious disorders in Saudi culture.

In spite of socio-cultural factors, it is clear that doctors' awareness and acceptance of the possibility of factitious disorders is a prerequisite to making the diagnosis. Once factitious disorder is diagnosed, it is important to confront the patient but remain supportive. Confrontation should be carefully planned. In Saudi culture, it would be inappropriate to inform the relatives that the patient is feigning the symptoms, since this may precipitate psychotic breakdown of the patient.

Interestingly, both patients consulted traditional healers during their factitious behavior. Although consulting traditional healers could be explained partially by the religious background of the Saudi culture, it is interesting that in spite of the modern treatment available in Saudi Arabia, patients including those with factitious disorder, still consult traditional healers with their somatic and psychological symptoms.

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