FUNCTIONAL, FACTITIOUS OR FABRICATED?

DR JULANNE FRATER
C/L ADVANCED TRAINEE, MATER IN MIND CLPS
PHD CANDIDATE, QUEENSLAND BRAIN INSTITUTE
MUNCHAUSEN’S, MALIGNING OR MADNESS?

DR JULANNE FRATER
C/L ADVANCED TRAINEE, MATER IN MIND CLPS
PHD CANDIDATE, QUEENSLAND BRAIN INSTITUTE
Idiosyncratic alliteration to illustrate & improve the identification of illusional, imaginary or intentional illness

Dr Julanne Frater
C/L Advanced Trainee, Mater in Mind CLPS
PhD Candidate, Queensland Brain Institute
CASE PRESENTATION

• 23yo female from regional hospital, referred to tertiary centre for neurological investigation of seizures

• Intermittent seizure-like episodes: variable presentation and last for up to an hour

• 18 month history, dramatic increase in intensity/frequency previous 3 months
  – 2-3 episodes per day

• Development of intermittent left arm tremor over past 2 months
NEUROLOGY

- Neuro Examination Normal
- Brain MRI normal
- EEG, including video EEG with capture of events – no seizure activity
- ECG and previous cardiac investigations normal
- Normal bloods: FBC, eLFTs, B12/folate, T4/TSH, antineuronal Abs, inflam markers
- Multiple previous abdominal CT and ultrasounds – normal

Diagnosis Functional Neurological Disorder
(Non-Epileptic Seizures & Functional Tremor)
MENTAL HEALTH HISTORY

• ‘Depression/Anxiety’ for “most of my life”
  – On citalopram
  – Managed by GP
  – Previously attended Headspace, Community MH Acute Care

• Intellectual Impairment

• Occasional Episodes DSH

• Suicide attempt 3 years prior via overdose
SOCIAL & FAMILY HISTORY

• Removed from parents by DoChS 3 years of age
  – no contact with biological parents
• Extensive history CSA – ‘notorious paedophile’ between age 3-7 (uncle)
• Permanent foster care (Aunt) from age 7
• Never worked - on DSP
• Lives with current partner and his Uncle
• Partner has schizophrenia, intellectual impairment and currently in jail for armed robbery - awaiting parole review
• Denied alcohol/drug use history
• Denied personal forensic history
MENTAL STATE AT TIME OF REVIEW

• Mental state unremarkable - nil evidence of pervasive mood or psychotic disorder.

Agree with diagnosis of FND

• Although accepting of diagnosis of FND patient herself could not identify stressors or see correlation of worsening symptoms to psychological stress
• Insightless/unable to describe her emotional state or feelings
COLLATERAL HISTORY

• Extensive psychological, behavioural and conduct issues through school
• Previously diagnosed with:
  – Borderline PD
  – Conduct Disorder
  – Pathological Lying (Pseudologia fantastica)
  – Compulsive Stealing
• Non-compliant with medication use
• Multiple overdoses + frequent suicide threats when perceived needs not met
• Very concrete in thinking: difficulty understanding complex explanations or abstract thinking
• Biological mother had Prader-Wili disease and intellectual impairment (Father ?)
• Regular binge eating behaviour - 6-7 meals in one night
• Has numerous charges for petty theft – was charged with stealing a sleeping bag from a homeless person less than 3 weeks ago
• Aunt believes she ‘makes stuff up all the time’ & ‘attention seeking’
FURTHER COLLATERAL

• Long history of seeking medical services
  – Can call QAS up to 3 times per day
• Frequent admissions for headaches, abdominal pain or seizures
• No diagnosis or cause ever found
• Behaviour escalated +++ since partner went to jail 4 months ago
• Enjoys being in hospital and ‘wants sympathy’:
  – FB/social media posts all about being in hospital – over exaggerates, cancer diagnosis
  – Partner previously used to visit and bring flowers, gifts, extra attention
  – Uses physical symptoms to get people to do things for her and buy her new things
  – Calls carer up to 20 times/day when in hospital – wanting reassurance and lists of chores to be done on her behalf
REVIEW OF MEDICAL RECORDS OVER PRIOR 6 MONTHS

- 82 ED presentations to multiple hospitals
- 8 CT scans (pelvis/abdo)
- 7 Ultrasound scans (pelvis/abdo)
- 20 x-ray series
- 1 x lap cholecystectomy
  - ? Complaints of pain – GB normal on removal/histology
- >250 blood tests
- Plus current neurological investigations
IS FND STILL THE MOST APPROPRIATE DIAGNOSIS?

Is this now FND, Factitious Disorder or Malingering (Fictitious Disorder)?
# Key Features of Somatic Symptom & Related Disorders (1)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Somatic Symptom Disorder</strong></td>
<td>Excessive anxiety &amp; preoccupation with one or more unexplained symptoms &gt; 6 months</td>
</tr>
<tr>
<td><strong>Illness Anxiety Disorder (Hypochondriasis)</strong></td>
<td>Fear of having a serious undiagnosed illness despite few or no symptoms &amp; consistently negative evaluations</td>
</tr>
<tr>
<td><strong>Functional Neurological Disorder</strong></td>
<td>Neurologic symptoms incompatible with any known neurologic disease; often acute onset associated with stress</td>
</tr>
<tr>
<td><strong>Factitious Disorder (Munchausen’s)</strong></td>
<td>Intentional falsification or inducement of symptoms with goal to assume the sick role (no external incentive)</td>
</tr>
<tr>
<td><strong>Malingering</strong></td>
<td>Falsification or exaggeration of symptoms to obtain external incentives (secondary gain)</td>
</tr>
</tbody>
</table>
### Key Features of Somatic Symptom & Related Disorders (2)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Symptoms Intentionally Produced</th>
<th>Conscious Reason for Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatic Symptom Disorder</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Illness Anxiety Disorder (Hypochondriasis)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Functional Neurological Disorder (Conversion Disorder)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Factitious Disorder</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Malingering</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Factitious Disorder (sick AND not sick)

Functional Neurological Disorder (double sick)

Malingering (not sick)

People who genuinely have a problem, but exploit it (sick, but a jerk about it)

Symptoms Intentionally Produced ('Fake')

Symptoms Involuntary ('Real')

Motivated by Compulsion (Need for Sympathy)

Motivated by Secondary Gain (Money or Time)
FACTITIOUS DISORDER: RISK FACTORS

• Childhood trauma, such as emotional, physical or sexual abuse
• A serious illness during childhood
• Loss of a loved one through death, illness or abandonment
• Past experiences during a time of sickness and the attention it brought
• A poor sense of identity or self-esteem
• Personality disorders
• Depression
• Desire to be associated with doctors or medical centers
• Work in the health care field
• Pseudologia fantastica
FACTITIOUS DISORDER SIGNS AND SYMPTOMS

- Clever and convincing medical or psychological problems
- Extensive knowledge of medical terms and diseases
- Vague or inconsistent symptoms
- Conditions that get worse for no apparent reason
- Conditions that don't respond as expected to standard therapies
- Seeking treatment from many different doctors or hospitals, which may include using a fake name
- Reluctance to allow doctors to talk to family or friends or to other health care professionals
- Frequent stays in the hospital
- Eagerness to have frequent testing or risky operations
- Many surgical scars or evidence of numerous procedures
- Having few visitors when hospitalised
- Arguing with doctors and staff
- Manifestations that appear worse when the patient is undergoing active examination than when he or she is casually interacting with staff members or other patients
POTENTIAL RISKS/COMPLICATIONS

• Injury or death from self-inflicted medical conditions
• **Severe health problems from infections, self-inflicted injuries or unnecessary surgery or procedures**
• Not receiving treatment for ‘real’ illness
  – ‘boy who cried wolf’ syndrome
• **Alcohol or other substance abuse**
• Significant problems in daily life, relationships and work, loss of supports
• **Abuse when behavior is inflicted on another (Munchausen’s-by-proxy)**
• Costs to medical system due to repeated tests, unnecessary investigations
TREATMENT

• **Having a primary care doctor**
  
  – Using one doctor or gatekeeper to oversee medical care can help manage needed care and the treatment plan and reduce or eliminate visits to numerous doctors, specialists and surgeons.

• **Psychotherapy** and behavior therapy may help control stress and develop coping skills. If possible, family therapy also may be suggested.

• **Medication** - depression or anxiety, co-morbid mental health conditions

• **Hospitalisation** - In severe cases, psychiatric admission may be necessary for safety and treatment.

---

Treatment may not be accepted or may not be helpful, especially for people with severe factitious disorder. In these cases, the goal may be to avoid further invasive or risky treatments.