

A case of factitious disorder in a 9 year old girl

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Introduction

Factitious disorder is defined as the repeated and consistent feigning of symptoms by an individual without an identifiable physical or mental disorder. This is believed to be a disorder of illness behaviour and the sick role¹. Although intentional feigning of symptoms by caregivers of children is considered by most clinicians when interpreting persistent and unusual symptoms, there is much less awareness that children themselves may falsify symptoms².

Case report

A 9 year old girl was referred to the child psychiatry unit with a history of passage of insects and worms in urine for 2 weeks. She initially complained of lower abdominal pain associated with passing a worm in urine. She was admitted to the local hospital where urine full report (UFR) was normal. At discharge after 24 hours observation, her urine remained clear. Later, she complained of passing cockroaches, spiders and millipedes with urine about four days per week. She showed her urine samples with insects and worms to her parents as evidence and was subsequently brought to the Lady Ridgeway Hospital.

A repeat UFR was normal. She refused to urinate under observation. The mother or grandmother was physically present throughout when the child was hospitalised but her complaints persisted regardless. Nurses observed the child catching a fly, prior to going to the toilet when she returned with a fly in the urine sample. She was catheterised for 24 hours, during which time her urine remained clear.

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She was the youngest of 3 siblings and resided with family. There was no history of repeated hospital admissions and no history of abuse or other recent stressful events. She has engaged in school work and play activities as usual. Assessment revealed a normally developing child with satisfactory academic performance. She willingly engaged in the interview, her speech was relevant and mood was euthymic. She did not express depressive cognitions, delusions or hallucinations. She was eager to discuss her symptoms and drew pictures of insects and worms she passed, upon request. An external motive for feigning symptoms could not be ascertained. She has, however, received extra attention and was excused from daily chores due to her illness.

A diagnosis of factitious disorder was made. The child was confronted in a non-threatening manner and she neither confessed nor denied feigning symptoms. Parents were advised to promote her normal daily routine and to avoid paying attention to her symptoms. The diagnosis was discussed with ward staff and a supportive approach was adopted. Her symptoms improved within the next week.

Discussion

In general medical settings, rates of factitious disorder are estimated to be 0.5–2%². Factitious disorder is usually seen in females, aged 20–40 years². However, it has been reported in children as young as eight years with up to half of adults diagnosed with factitious disorder reporting symptoms since adolescence². Among children, girls are over-represented, especially with increasing age³.

Patients with factitious disorder present with diverse symptoms. In children, common presentations have been fever, ketoacidosis, purpura and infections³. Case reports of falsified proteinuria, post-operative infection, asthma, HIV infection and ‘Cinderella syndrome’ where children falsify neglect, have been documented⁴⁻⁸. Falsifications in younger children tend to be more obvious and easily identified², as with our patient. A review of case reports revealed a mean duration of 16 months of feigned symptoms prior to detection, with a higher risk of being

diagnosed as having somatization contributing to this delay³. However, in this patient, factitious disorder was identified within 2 weeks of presentation, due to the nature of the symptoms. The same review described these children as having a fascination with health care similar to their adult counterparts³.

Genuine physical or mental illness, somatization, malingering and Munchausen syndrome by proxy were considered in the differential diagnosis². Malingering was ruled out due to the absence of external motivation and Munchausen syndrome by proxy was excluded as the symptoms persisted irrespective of who chaperoned her. Somatization was considered unlikely due to the nature of symptoms. Factors that contribute to falsification of illness include history of past medical illnesses requiring hospitalization, psychosocial problems and dysfunction in the family system². However, we could not find such factors in this patient.

Management of children with factitious disorder involves direct discussion in a non-threatening manner. This is more likely to yield a confession from a younger child, although an older child is less likely to confess in the absence of tangible evidence². A good doctor-patient relationship forms the basis for successful management. Ritson and Forrest proposed the 'contract conference' approach for management, where focus is shifted away from illness and towards difficult relationships, feelings and other problems, which the patient is encouraged to resolve⁹. In addition, ward staff should be educated that although patient intentionally feigns symptoms, it is due to the illness rather than deceitfulness². This helps overcome negative counter-transference and provide a supportive environment.

No medication has proven efficacy in treating factitious disorder². Cognitive behavioural and analytical approaches have been tried with limited efficacy, as only few patients remain in long-term treatment². Supportive psychotherapy and family therapy has shown benefit in some cases².

Follow up data of children with factitious disorder is limited. Available data suggest that risk of repetition is less if fabrications are confronted at an early age². Thus, early identification and intervention is likely to help prevent these children from developing a more chronic course leading to adult factitious disorder³.

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