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Factitious Disorder Presented by Haematemesis/Factitious Disorder Imposed on Another (FDIA): A Case Report

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SUMMARY

Factitious disorder imposed on another (FDIA-DSM-5), formerly known as *Munchausen Syndrome by Proxy* (MSP) is a form of child abuse. A case can be recognised by only keeping the relevant diagnoses in mind. There are many cases of FDIA diversified by the contributions of both the caregiver and the child. Most of these cases are complicated by the difficulty of accurately determining the relative roles of the parent and the child and their levels of awareness and motivation. Here, we present the case of an 11-year old girl admitted to our hospital with the complaint of haematemesis 6-8 times a day. A case of factitious disorder was considered following the physical and psychological examinations on the patient. Evaluating the case within this context suggested a case of FDIA by drawing attention to the continuity of the symptoms described in the patient with the those of the caregiver. In approaching cases of FDIA, unravelling the interdependence of the dynamics of different awareness levels of feigning and motivation by the caregiver and the child is very crucial. Considering the variations in the process of FDIA development through interweaving of the motivations of the mother and child, the case presented here is believed to bring a different point of view that will contribute to the understanding of the nature of this disorder.

Keywords: Factitious disorder, parent-child relation, child abuse, haematemesis

INTRODUCTION

Factitious Disorder (FD) is characterized by feigning physical or psychological symptoms or to delude by forming covert intentions, including injury, to induce illness, without any visible reward or benefit (Scher et al. 2014). The diagnostic criteria for Factitious Disorders (FD), formerly named as the Munchausen Syndrome, were altered in the DSM-5 and included under the heading of Somatic Symptoms and Related Disorders and put into 2 categories as the Factitious Disorder Imposed on Self (FDIS) and the Factitious Disorder Imposed on Another (FDIA) (Scher et al. 2014). FD is rarely seen, its nature being based on deception and disguisement. Due to the difficulty involved, not all cases can be diagnosed such that the reported prevalence changes between 0.5% and 2% (Bass and Halligan 2014, Scher et al. 2014). It is reported in the literature that the abnormal behaviours related to somatoform or FD exhibited by the caregiver is transmitted between generations, such as from the caregiver to the child (Bass and Glaser 2014). The course of FDIA involves deliberate production and mimicking of misleading physical or mental symptoms in another who is presented as sick and incapacitated to third parties, where the deceptive behaviour without an external incentive is prominent. It has been reported in the literature that children exposed to this type of abuse get adapted to their mothers as they grow older and develop a factitious disorder by participating in their own harassment. Older children have been observed to share the feigned symptoms in order to meet the expectations of their mothers and to maintain the attention of the mother on them. These children generally are found to have established a way of communticating with their caregivers by accepting the

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fiction created by them (Awadallah 2005, Foto Özdemir et al. 2013a, 2015). The parent who is not the exploiter, generally the father, is distant from the child imposed with the ailment and he is physically and emotionally outside the family system. Some fathers are completely uninformed or they would believe the mother or could not confront the mother despite having suspicions (Morrell and Tilley 2012, Bass and Glaser 2014). Complicated cases with parents indirectly acting in the FDIA and cases contributed both by the caregiver and the child, are rarely discussed in the literature. The difficulty of assessing the relative roles of the caregiver and the child in these mixed cases add to the complications involved (Libow 2002). Often the children, despite appearing to be in agreeable with the clinician, deny any medical desception by persistently displaying the fake symptoms. The parental support given, deliberately or unawares, to the child's sick behaviour causes increased sensitivity in the child to issues of health and the expression of this distress by somatization (Libow 2002).

In the case discussed here, the symptoms attributed to the child have drawn the attention of the clinicians as a part of the FD of the caregiver, since it has been emphasized in the literature that especially children above the age of 6 years join in the presentation of the feigned symptoms and thus support their own exploitation. However, in this particular case, it was found out that the child's artificial and deceptive symptoms had started earlier and were subsequently joined in by the mother who, ignoring her child's deception, exaggerated the symptoms and helped to sustain the FD. The approach to such cases is critical for understanding the dynamics of the differences in the motivations and the level of awareness of the deception by the child and the caregiver. It is therefore believed that presentation of this case could us her a different perspective to understanding the nature of FD.

CASE

An 11-year old girl, complained of bloody stools in January 2018, instigating the family to consult the state hospital, when she was diagnosed with an anal fissure and prescribed topical agents for treatment. One month later complaints started of vomiting after meals. Intracranial pressure increase was suspected, but the results of the cranial CT were regarded normal. The patient was referred to a third healthcare center for further examination where Tc-99m pertechnetate scintigraphy test detected a suspect focus of haemorrhage on the ascending colon which was not confimed by colonoscopy that instead suggested focal active colitis in the ascending and the descending colon. Gastroscopic biopsy showed mild helicobacter pylori (HP) positivity. She was started on mesalazine for colitis and lansoprazole, amoxicillin and ciprofloxacin for HP eradication. The patient consulted the Emergency Clinic of Hacettepe University İhsan Doğramacı Children's Hospital in March 2018, with complaints of vomiting "a handful" of fresh blood 6 times in a day. Examination indicated mild tenderness in all quadrants, oral feeding and the treatments for HP and colitis were stopped. In the follow-up, although bloody vomiting at least 4 times daily was reported, this was not detected in the nasogastric tube and a decrease was not seen in the haemoglobin level. The patient was given proton pump inhibitor (pantoprazole) and abdominal examination showed decreased sensitivity. Cranial magnetic resonance imaging (MRI) for the vomiting aetiology was normal. Endoscopic mucosal biopsy for eosinophilic esophagitis, after detection of eosinophilia in the haemogram, was normal. Viral serologic testing result for transaminase elevation was negative. Consultation with the Pediatric Chest Diseases for haemoptysis; pulmonary function test, lung X-ray and chest CT were evaluated as normal. Examination by the otolaryngology unit did not determine a bleeding focus; and the nasopharyngeal and neck MRI for haemoptysis were normal. Hence, all tests required for the bleeding diathesis were normal. The patient described vomiting blood 6-7 times a day without previous eating, swallowing or coughing. During physical examination for vomiting the patient tried to close her lower lip and show the inner part of the lower jaw. Detailed examination showed lacerations thought to be secondary to biting. Since the clinical and laboratuvary evaluations of "A" were not consistent with the ongoing clinical picture, it was decided to consult the Department of Child and Adolescent Psychiatry with a preliminary diagnosis of FD.

Child and Adolescent Psychiatry Assessment: Recurrent interviews were conducted with the patient and her mother for evaluation of FD. It was learned from the mother that the patient "A" lived with her parents and her 18-year old sister, that she was the youngest daughter after 18 and 23 year old sisters, and was brought up without any rules or borderlines, and that the mother was very fond of her. A, while attending the 6th form at a private school, had to be taken to a state school which she could not get used to for at least 1.5 years. Although a successful student who exprienced anxiety about getting low grades, she did not enjoy attending school and studying; and was satisfied not to be at school on grounds of her illness. She found her contemporaries childish and associated with 14-15 year olds. Her elder sister, who had left the family house after getting married, came back on account of hyperemesis in the 5th month of her pregnancy and was given much attention by the family, when the complaints of A started. According to the history taken, initially the complaints consisted of nausea at night and, later turned to vomiting blood after meals, which caused A to come home from school. At meals, she declared having nausea, went to the bathroom, refusing to have any company including her

mother and later claimed having vomited. However, when she was hospitalized, she was seen to go to the bathroom with her mother but vomiting was not observed by the treatment team and her vomit was not analysed.

Psychiatric Assessment of the Child: During the psychiatric interviews, A was observed to be pleased about being in hospital, she was not worried about idiopathic bloody vomiting. The similarity, not only of her physical appearance, but also the expressions and comments in reference to her complaints, as if the child and the mother were using each other's language, were noticed. It was believed that A had a dependence on her mother and did not feel anxiety about illness or prolonged stay in hospital. She was quite defensive in discussions related to her family and school, by insisting that all was well at home and school, and selecting the statements "I am happy with my father", "My father is not a bad guy at all", "I do not have any problems" and "My body is healthy", used in the Beier Sentence Completion Test drew the attention of the interviewers. During these assessments, the patient's emotions were found to be incompatible with her claimed condition. It was, however, learned from her mother that A did not like her father and wanted her parents to get divorced; that most of the time she intervened in the arguments between the parents and that her sister and A were angry with the mother for her acquiescence. The mother claimed that A, who feared arguments, had remarked that "It would have been better without her father". This was thought to underlie the patient's defensiveness.

Psychiatric Assessment of the Mother: It was learned in the interview with the mother that she was raised by her mother after her parents separated when she was very young; she had grown up in an unhappy family atmosphere; that at the age of 16 the mother forced her to arranged marriage claiming lack of means to support her. She explained that as a good student she had wanted to get further education and become a psychologist. Since the start of their marriage, she had experienced problems with her husband who was a shift worker spending time sleeping at home. He had anger control problems, was under therapy for panic attacks and often displeased, criticising and raising arguments when the children tried to intervene, and that she and her children did not love the father. Interviews with the mother revealed that, even though she is not very concerned about A's illness, she is extremely occupied with her vomiting, devalued the previous interviews. Gaps in the history she gave about the disease process; making swift amendments and attempting to orient and undervalue the treatment team when faced with the inconsistencies during interviews; appearance of distinct hostility when confronted and atempting to divide the treatment team by complaints were noted. It was believed that she derived a narcissistic satisfaction from the delay in the diagnosis of her child's illness; being satisfied with taking her to hospitals away from home; and displaying extreme defensiveness and anger by incriminating the hospital team for the previous interventions when discussions on the mental dimension of the patient's condition were attempted. When explained that she should not stay with the child at the hospital since the child's symbiotic relationship with the mother made psychological treatment difficult, she was offended and demanded to be discharged from the hospital, asserting that the child could not do without the mother. After this crisis in the interviews, it became convincing that the behavioral pattern of the child and her mother closely resembled each other, that they amended similarly the gaps in the answers to all purpose oriented questions asked and that the interviews were dominated by pathological manipulation of the interviewers.

Clinical Observations: It was observed during the clinical follow up that there were shared mental processes and a symbiotic relationship between A and her mother, which were more needed by the mother and satisfied by A by acting as her spokesperson. Clinical evaluations revealed their narcissistic personality traits and satisfaction with the prevailing situation. The impression was made that A did not have any worries about leaving the mother and that the mother needed this symbiotic relationship which A satisfied. It was concluded that the mother did not allow A to break up their relationship and act independently; therefore tried to impede the recommendations of the treatment team; ended the positive connection and collaboration with the team when the nature of her child's illness was discovered; and also attempted to prevent the involvement of the father when this was needed. In one-to-one interviews with A on the mental aspect of her illness, explanations such as "My mother doesn't think that my vomiting is psychological", "If it were psychological where was the blood coming from; we would understand if it were in drops, but I used to vomit enough to fill a kidney dish" were some of those indicating the cooperation between them. A also stated that anyhow she did not vomit in the presence of others and that she thought these would not repeat and that therefore she did not want to stay in the hospital. Both A and her mother regarded themselves as informed and competent, and tended to control the evaluation processes. It was observed that A tended to behave older than her age, thinking that she had the natural right to interfere in her parent's marital relationship, that it was natural hierarchy in the household was upside down, herself as a qualified "decision-maker", played her mother's role in order to tolerate her mother's inadequacy. Her mother was aware of A's attitude and she was pleased with it; due to non-age appropriate authority and responsibilities at home, she tried to establish a similar relationship with the treatment team. The symptoms of FD in the case of A were seen to start with the loss of her role and the attention of the family. She

made the primary gains in becoming once again the focus of attention by inventing an illness that could not be explained, which reduced the incidence of arguments between her parents. She also succeded in physically separating her mother from her father in believing that her mother was powerless in taking a decision for divorce. Her secondary gains were believed to be freeing herself from the anxiety of having to share a life with her sister and parents, and escaping the chaotic home environment by prolonged hospital stays for treatment, and also by staying away from school. It was determined that the mother used her child's strength to complete her own inadequacy, that she was satisfied with the attention received through her child's illness and her relationship with the hospital environment and the caring team. Despite being unsuccessful as a wife and mother, she derived satisfaction from controlling any treatment or intervention by believing to be the only caregiver for A who otherwise could not be on her own. She was observed to get satisfaction from the unclarity of the cause of her child's illness, from controlling the treatment process and the healthcare team, presenting her medical opinions on the interventions recommended to continue with this vicious circle and resorting to hostility when confronted.

Since the mother and A did not cooperate with the treatment team, the father had to be reached before the discharge of the patient from the hospital and was informed about the nature of his child's condition. He was told that current disease did not entail an organic aetiology, but the child had to be followed up by a psychiatrist with child and adolescent mental health expertise in their city who had been contacted and informed of the case by our clinic.

DISCUSSION

Given that vomiting blood took place only when the patient was alone in the bathroom and the considerably well being of the patient after continuation of this complaint despite the voluminous blood loss reported, normality of the physical examination and laboratory investigation results, not finding a focal point of the reported haemorrhage after imaging investigations, the calmness and acceptance of the mother and child during the multiple interventions within the hospital departments, seemingly not worrying about the unclarity of the cause of the complaint and even appearing satisfied with it, the presence of serious inconsistencies and gaps in the disease history they gave, their attempts to control the treatment procedure and the hostility shown to the the treatment team when confronted, confirmed the diagnosis of this case to be FD in agreement with the relevant literature (Yonge and Haase 2004). Unfortunately, children realize the attention they receive from their mothers when they feign symptoms in front of the treatment team and try to sustain this attention. Diagnosis of FDIA in the case of A was suggested by taking into account that at the initial stages of the illness nobody was allowed in the bathroom while she vomited blood, and that when hospitalized she was seen to go to the bathroom with the mother in the evening hours without the presence of any member of the treatment team and also noting the contradictions in the mother's account of the disease process before admission to hospital, immediately in fabricating amendments when faced with these and the gaps in the given history, denigration of the earlier treatments, attempts to orient the treatment team, frequent change of hospitals, expressions of hostility to the medical service personnel and requesting to be discharged when the deception was recognized. Interestingly, mothers seem to partake and coach the children in FD when children are suspected to simulate the disease. Also, collaboration of the mother in the deception underlies the immediately of request for discharge when the child's deception is exposed (Libow 2002).

In cases of FDIA, when distortions of a child's health is supported by the mother, the child feels uneasy and anxious with increased preoccupation with health and may become confused about state of health. Also, repetitive examinations to detect the underlying reason and giving treatment might prompt the mother and child to a silent consent to the artificial behavior and deception and may cause the child to maintain the scam or develop a somatoform disorder or FD (Bass and Glaser 2014). In the case of A, the use of a shared speech with the mother, and interpreting the disease with the explanations of the mother were noteworthy. It was thought that although not started by the mother, her later support for the deception planned by the child for her own purposes, impaired the child's perception of reality, and her ability to distinguish reality.

The aetiology of artificial behaviours in FD have not been well understood and the existence of a common aetiological factor has not been reliably defined. The themes most common to these cases are that the disease has been rehearsed previously and any resultant attention has been noted. Considering the symptoms and timing in the case of A in the simplest terms, the feigning of illness was started after experiencing the extreme family sympathy manifested for her sister's hyperemesis due to pregnancy. Mental disorders comorbid with FD have not generally been diagnosed, but psychodynamically attachment disorders and B cluster personality traits have been frequently mentioned. Narcissistic personality traits, as observed in both the child and the mother in the case of A, or otherwise antisocial, paranoid personality traits, sociopathic/psychopathic tendencies, hysterical, anxious/dependent personality characteristics and borderline personality traits are frequently reported in the literature (Bass and Jones 2011, Bass and Glaser 2014, Foto Özdemir et al. 2015). Also, many patients diagnosed with FD have exprienced abuse or emotional deprivation at early

childhood, as in the case of A (Adshead and Bluglass 2005, Sheridan 2003, Bass and Jones 2011). Feigning a somatic illness helped A cope with her internal conflicts with the shift of her attention to preoccupation with body problems. The feigned illness not only kept A away from the conflicted and loveless relationship of her parents, but also from the emotional role burdened by her mother's inadequacies and the feeling of guilt towards her father by siding with her mother. Psychodynamically, the motivations in FD can be the impulse to become free from the reality, to resolve family conflicts, to be rewarded for fake illness, the intense desire to deceive everyone as much as possible or the feeling of guilt over subconscious needs. One of the important explanations given in this respect was the motive to protect the psychic self from the traumatic experiences with the parents, creating a somatic illness representing the adverse experiences of early life by splitting the "body self" and the "psychic self" and thus to protect the psychic self from effects of the emotions of hostility, hate, fear and pain (Scher et al. 2014, Rogers 2004). Some researchers have reported that the nature of the human mind is prone to deception, and that deception is predictable in the very early stages of life. From the perspective of developmental psychopathology, development of attachment strategies, including deception, when adapting to complicated disorders such as FD is not surprising (Bass and Halligan 2014). Early developmental disruptions and maltreatment cause disorganisation in the stress response systems of the body, problems of emotion regulation and insecure/disorganised or obsessive/fearful attachment relationships (Kozlowska 2014, Adshead and Bluglass 2005, Bass and Jones 2011, Bass and Glaser 2014). Individuals who are deprived of constructive contributions in early life may exhibit inappropriate behaviours by developing a pathological adaptation to their emotional needs. These emotional strategies that turn into behaviour often involve hypocrisy and deception (Kozlowska 2014, Bass and Halligan 2014); and may lead to personality disorders, somatic symptoms or factitious disorders (Kozlowska 2014, Sheridan 2003). In FDIA, the consensus is that "mothers have pathogenic early period relationships that could not be solved with their own parents in their own childhood" (Schreier and Libow 1993, Adshead and Bluglass 2005). In the case of A, we determined risk elements in her mother's past such as early childhood exposure to neglect in a chaotic family environment, conflict and divorce between parents, growing up with a single parent and being forced into arranged marriage at adolescence for being a burden to her mother. These adverse experiences have impeded the development of her parenting capacity. Having repudiating parents, incompetent in building close relationships, abandonment, unfulfilled need for dependence and self-esteem, undeveloped emotional affirmation have resulted in using her children to compensate for her inabilities, such as by giving A the roles of a parent and spokesperson. It is thought that the mother prevented separation with A both physically and emotionally by nourishing the relationship addiction with her child's illness, thereby attemtping to boost her incompetent caregiving, unsatisfied dependence and narcissistic needs through the mediation of FD. It has been described that the desire of these mothers to get close to the hospital personnel and the medical profession with the motivation to appear as attentive, ideal parents in compensation for the neglect and abandonment experienced in childhood (Schreier and Libow 1993). The caregiver, by making herself or the child a victim, tries, on the one hand, to attract the attention of the healthcare staff while challenging and denigrating them, on the other (Scher et al. 2014, Sheridan 2003, Yonge and Haase 2004). Pathological lying (psuedologia fantastica), hypocrisy, fraud, and sadomasochistic elements in FD, have frequently been reported (Bass and Jones 2011, Schreier and Libow 1993). In the case of A, it was thought, in accordance with the literature, that both the mother and child tended to pathological lying in continuing the child's desceptive plan and that the corner stone of their relationship with the treatment team and each other were hypocrisy and dishonesty. In this very case it was seen that the mother had joined in the deception created by the child, and her ascriptions to the story had made the child unable to discriminate between lies and reality which also contributed to resisting the treatment team. In order to meet her own narcisistic demands, it had been necessary for A to continue as the center of the symbiotic relationship imposed by her mother. Denial, isolation and insensitivity and secondary gains played important roles in continuing with her story. In conclusion, it is believed that the cycle feeding the psychopathology in the parent-child relationship in the presented case has the intertwined and mutually supportive properties of the clinical features of FD, the development of the particular psychopathology and its psychodynamic characteristics and shows that deception in interpersonal relationships is transmitted between generations. Although this case of FD appears to have presented with the deception planned by A, it can be seen that the superficial relationships, deprivation in interpersonal relationships, lack of openness, denials, isolation, animosities, hypocrisy and deception in this family are all in the pattern of the relationships transmitted from the mother to the child. It was observed that A from very early years of life had to bear the mission of acting as a parent for her mother, experienced a strong love-hate relationship with the mother and conflicting emotions about the harmfulness of the mother she very much needed. Hence, in this disorder wherein the relationship with the caregiver is central, the most significant mechanisms for the development of the psychopathology appear to underlie the pathological dependence of the child on the mother which produces illness through extreme attachment and thereby gains a posessive control over the body of the child (Foto Özdemir et al. 2013b,

2015). FD in children sometimes represents the development of an autonomy by the child against the abusive parent by creating a medical deception (Libow 2002). Therefore, in-depth clinical data on children with FD can be of great value in the elucidation of the dynamics in the development of inappropriate behaviours.

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