



# Factitious disorder in adolescence

To the Editor,

Factitious disorder (FD) is defined as a condition in which a person voluntarily produces symptoms or illness and acts as if they are ill without an external gain (1). In the Psychiatric Disorders Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), it is divided into three types as “Factitious disorders with predominantly psychological signs and symptoms”, “Factitious disorders with predominantly physical signs and symptoms” and “Factitious disorders with combined psychological and physical signs and symptoms”. FD of the caregiver is classified under the title of “unidentified FD” (2).

In the literature, mostly FD of the caregiver is emphasized and it is noted that awareness about the symptoms produced by pediatric patients themselves is low (3-6). In the study of Libow (3), in which pediatric and adolescent patients who produced disease symptoms themselves were reviewed, it was reported that 42 cases were reported in the literature. In our country, there is a small number of pediatric case reports of FD (7, 8).

We wanted to emphasize that FD should be considered in the differential diagnosis in the childhood age group by presenting an adolescent patient with FD who presented with different physical and psychological signs and symptoms in this letter.

A 15-year old male patient was found by police officers in the street and transported to another hospital where he was admitted because of epileptic seizure. Afterwards, he was referred to our hospital and internalized with the prediagnoses of epilepsy, mental retardation and atypical psychosis. On the first interview he stated that he had epilepsy. On the phone call performed with his grandmother, it was learned that he had faintings for 1-2 years, he was referred to many physicians and his faintings continued, although he used his drugs regularly and blood came out of his mouth occasionally. On psychiatric examination, it was found that he had delusions of persecution and delusions of reference that he was being followed and he will be murdered, auditory hallucinations as speaking sounds which said “come here” and visual hallucinations as “soldiers”. Other psychiatric examination findings were found to be normal. Physical and neurological examinations were found to be normal. Detailed laboratory tests were found to be normal. Electroencephalogram and brain magnetic resonance imaging findings were found to be normal. The blood levels of valproic acid were found to be in the efficient range. On the phone call performed with the grandmother, it was learned that he was adopted at the age of 1,5 years, he was sick from his childhood, he was always naughty and escaped from home. The family reported that they could not care for the patient. It was observed that the family did not call for the patient or visited him during his hospitalization. Treatment was started with 20 mg/day olanzapine in addition to 1 000 mg/day valproic acid which was stated to be used previously. Olanzapine was tapered and discontinued on the third day. Risperidon 2 mg/day was added and the patient was followed up with this treatment. During his hospitalization, he had complaints including fainting, cough, blood coming from the mouth, abdominal pain, crying, rocking the head, hitting the head to wall and moving all the time. Finally, he stated that he ingested screw and ate liquid soap. No pathology was found on consultations of urgent medicine, general surgery, pulmonology and neurology performed at different times.

It was notable that the patient generally fainted in the presence of healthcare workers, lay down on the corridor or in front of the nurse's deck, got up from the ground after fainting and lay down on another place. It was observed that the patient tried to draw attention by continuously explaining his complaints to healthcare workers, other patients and their relatives and demanded continuously. It was recognized that he had no distress or concern about his complaints. In contrast, he was very comfortable and willing during recurrent tests performed and was considerably happy to be in the hospital.

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**Received:** 13.10.2013 **Accepted:** 06.01.2014

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DOI:10.5152/tpa.2014.1570

During an interview when these behaviors were discussed, he stated that he intentionally fainted to stay in the hospital, he actually ingested no screw, he bit his cheek so that blood came from his mouth and lied about the sounds he heard. Thereupon, the patient's symptoms, diagnostic and therapeutic process were evaluated and his diagnosis was reviewed. "Factitious disorder" was considered. It was targeted not to perform unnecessary medical investigations and consultations and new therapeutical approaches directed to the psychopathology of the patient were planned.

Approximately one month after his hospitalization, the patient stated again that he ingested screw. On direct abdominal graphy in the standing position taken during urgent surgery consultation, two screws were observed. Colonoscopy was planned, but the patient leaved the hospital without permission and could not be found, although he was looked for around the hospital.

FD which is a chronic disease with a high mortality leads to multiple hospitalizations and medical interventions, self-harming behavior and marked disruption in functionality (1). It has been reported that these symptoms generally start in adolescence, but the diagnosis of FD is made years later (3, 6, 9). Early diagnosis prevents unnecessary investigations and interventions and decreases the risk of self-harm (1, 7). Psychiatric assessment has an important role in the diagnosis (8). In treatment, it has been reported that confrontation does not lead acceptance of the patient that he/she artificially produces symptoms and may cause the patient to discontinue treatment. Therefore, it is recommended that confrontation should be postponed as much as possible, a supportive and emphatic approach should be displayed and the behaviors directed to produce illness should be tried to be changed in time (9, 10).

Conclusively, FD should be considered in patients who have multiple hospital admissions with various physical and psychological symptoms and signs, who display a frequently changing clinical picture, who do not improve despite appropriate treatment and who has incompatibilities in history, examination and laboratory findings. We would also like to remind that considering FD in adolescent patients in the differential diagnosis will provide early diagnosis and treatment and will be beneficial in terms of preventing unnecessary investigations and therapies which may have a risk of harming the patient.

**Informed Consent:** Since the patient was brought by the police and there was no relative, informed consent could not be obtained.

**Peer-review:** Externally peer-reviewed.

**Author Contributions:** Concept - Ü.Ö., V.Ç.; Design - Ü.Ö., V.Ç.; Supervision - G.Ö., A.T.; Funding - Ü.Ö., V.Ç., N.Ö.; Materials - Ü.Ö.; Data Collection and/or Processing - Ü.Ö.; Analysis and/or Interpretation - Ü.Ö., V.Ç., G.Ö.; Literature Review - Ü.Ö., V.Ç., N.Ö.; Writer - Ü.Ö., V.Ç.; Critical Review - G.Ö., A.T.

**Conflict of Interest:** No conflict of interest was declared by the authors.

**Financial Disclosure:** The authors declared that this study has received no financial support.

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