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DECEPTION IN ILLNESS: CASE SERIES ON FACTITIOUS DISORDER IN THREE YOUNG FEMALES.

Psychiatry

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ABSTRACT

Introduction: Factitious disorder, due to their tendency to have varied presentations, are often well masque in adolescents and young adults. Underlying these presentations typically are psychosocial stresses such as conflicts, interpersonal relationship pressures and scholastic responsibilities, making timely diagnosis and appropriate intervention crucial. Factitious disorders are less prevalent in clinical practice and therefore harder to estimate in general population, especially in uncommon age group and well-adjusted personalities, which make this series unique. **Method:** The subjects in the following clinical assessment are one 22-year-old and two 16-year-old females. A complete clinical interview, psychosocial assessment and an ICD-10-based evaluation was carried out. The psychological intervention consisted of psychoeducation, psychotherapy and family counselling. **Results:** All cases involve significant stressors that influenced symptom fabrication. In one case, significant interpersonal conflict with a family member led to self-inflicted injuries explained as animal bites. In another, academic pressures and bullying manifested as self-induced vomiting. Finally, conflict with father led to self-induced mouth bleeding. Management strategies involve risk reduction, addressing psychological and social dimensions of distress, resulting in symptom resolution and improved coping skills. **Conclusion:** Factitious disorders in youth are uncommon and understudied. This series emphasizes on necessity of early identification and multidisciplinary interventions. Sociocultural milieu needs further exploration to enhance prevention and treatment strategies.

KEYWORDS

Young females, Well-adjusted PMP, Psychosocial stressors.

INTRODUCTION

Factitious disorder imposed on self - Munchausen syndrome - is a syndrome in which patients consciously induce, feign, or exaggerate physical or psychiatric symptoms for the primary motive of assuming the 'sick role' and garnering attention or sympathy from caregivers causing a significant impact on public health and healthcare resources [1]. It is classified under the category "Factitious disorder "[68.1] in ICD-10 and under "Somatic Symptom and Related Disorders" [300.19] in DSM-5. [2,3]The inherent deception in this condition poses a significant challenge for healthcare providers when diagnosing and its prevalence worldwide remains underexplored.[4] However, the exact prevalence of FD in hospital settings is currently unknown,[5,6,7]approximately 1% of referrals to a psychiatric liaison service in a general hospital have factitious disorder.[8] The clinical features remain diverse, but most patients with factitious disorders are adult women with a mean age of 31[9] and most of them have cluster B personality traits[10], however over 1 year only 3 patients presented in tertiary care psychiatry department who met the diagnostic criteria for Factitious disorder imposed on self. FD presenting in young girls with well-adjusted premorbid personality as reported in cases of this series is rare. There is also a paucity of literature which makes this case series unique in guiding how to suspect FD in uncommon circumstances.

RESULTS

Case 1: Ms. P, a 22-Year-Old BA Student

Ms. P, a 22-year-old unmarried first-year BA student residing in 3-generation family of class 2 SES in a rural area., was referred from Dermatology to the Psychiatry department with multiple skin injuries of varying timelines, including some fresh abrasions and others in advanced stages of healing. She claimed these injuries resulted from repeated mongoose bites, asserting that the animal emerged from under her bed specifically to attack her. She even presented a photograph of a mongoose outside her house to support her claims. However, her narrative raised suspicion due to inconsistencies and the absence of corroborative evidence from other family members.

A detailed psychosocial assessment revealed a significant interpersonal conflict with her grandmother. Ms. P described a heated argument a month prior, during which she felt deeply invalidated and neglected. She admitted experiencing feelings of emotional isolation and a desire for care and attention from her family. Physical examination revealed superficial abrasions inconsistent with animal bites and was always after some conflict with family members, further supporting clinical suspicion of factitious behaviour. The diagnosis of factitious disorder (ICD-10: F68.1) was established. Management included psychoeducation to help her understand the consequences of her behaviour, individual psychotherapy to address her emotional distress, and family counselling to improve communication and emotional support within the household. Over time, Ms. P acknowledged fabricating her symptoms to gain attention, and therapeutic interventions focused on helping her develop healthier coping mechanisms.

Case 2: Ms. R, a 16-Year-Old High School Student

Ms. R, a 16-year-old high school student residing in joint family of LMSES in urban area, referred from Medicine Department to Psychiatry with recurrent complaints of severe abdominal pain and persistent vomiting episodes. Despite undergoing extensive medical evaluations, including imaging studies and endoscopies, no organic pathology was identified. Nevertheless, she insisted on the severity of her symptoms and frequently requested additional investigations.

Further exploration revealed significant academic stress and recent bullying incidents at her school, both of which she had concealed from her family. Her mother reported discovering empty medication packets hidden in Ms. R's room, raising concerns about self-induced symptoms. Subsequent discussions revealed that Ms. R had been ingesting small amounts of household cleaning agents to provoke vomiting episodes, driven by a need for validation and attention from her family and these instances occur more frequently during exams.

A diagnosis of factitious disorder (ICD-10: F68.1) was made. Treatment involved a multidisciplinary approach, including psychoeducation for both Ms. R and her family to address the underlying issues. Cognitive-behavioral therapy (CBT) was introduced to help her develop adaptive coping strategies, while school-based interventions were implemented to address the bullying. Over time, Ms. R's symptoms subsided, and she began to demonstrate improved emotional resilience and self-esteem.

Case 3: Ms A, a 16-years-old senior secondary student

Ms. A, a 16-year-old senior secondary student residing in joint family of class 2 SES in rural area, Case Series referred from ENT Department, presented with complaints of bleeding from the mouth and nose. Despite undergoing oral examination, endoscopy, imaging studies, and hematology work, no organic pathology was identified. Her symptoms persisted.

During the clinical interview, Ms. A expressed She further added that she was forced to comply with family norms she disliked and was Physically assault by her father led to bleeding from her mouth, which provided her with attention and relief from her studies and the

obligation to follow strict family rules. Subsequent discussions revealed the patient was collecting blood in her mouth by repetitive coughing and injuring enlarged tonsils with nails.

A diagnosis of factitious disorder (ICD-10 F68.1) was made. Treatment involved psychoeducation for both the patient and family to address the underlying issues. CBT was introduced to develop coping strategies, and the family was advised to reduce secondary gains. Ms. A's symptoms subsided, and she showed improvement with no instance of bleeding in the past month.

DISCUSSION

Factitious disorder in adolescents and young adults poses unique diagnostic and therapeutic challenges due to its deceptive nature and uncommon presenting group. Patient consciously fabricate, exaggerate, or induce symptoms to assume “sick role" often leading to unnecessary medical interventions and resource utilization. The three cases presented here illustrate the complex interplay between psychological distress, cultural influences, and the desire for attention or care or freedom from strict rules. In Ms. P's case, her fabricated narrative of mongoose bites reflected her feelings of neglect and unresolved conflict with her grandmother. Similarly, Ms. R's self-induced vomiting was an expression of her emotional distress stemming from academic pressures and bullying. Similarly, Ms. A's self-induced bleeding reflecting her need for attention and to follow unfulfilled desire for some freedom.

A common pattern observed in all three cases is presence of significant psychological stressors, including family conflict, academic stress, and a need for attention or validation.

Cultural and familial dynamics play a significant role in shaping symptomatology. In South Asian societies, where mental health issues often carry stigma, somatic complaints may be more socially acceptable than emotional expressions of distress. This cultural context likely influenced both patients' presentations, as they used physical symptoms to communicate their unmet psychological needs.

So far, there are no established treatments backed by strong research, and no official diagnostic criteria have been defined [11].

Improvement in these cases show importance of a multidisciplinary approach that addresses the psychological, social, and familial dimensions in management of this condition. Early recognition is crucial to prevent unnecessary medical interventions and associated healthcare costs. Psychoeducation, psychotherapy, and family counselling were instrumental in resolving symptoms and promoting healthier coping mechanisms for all patients. Moreover, addressing underlying stressors, such as interpersonal conflicts and academic pressures, is essential to achieving long-term improvement.

Notably all three patients shown improvement following structured psychological interventions, signifying multidisciplinary approach in FD management.

CONCLUSION

This case series highlight the complexity of diagnosing and managing FD, particularly in young individuals facing psychological stressors.

Given the rarity of such cases, further research is needed to explore the sociocultural determinants and psychological underpinnings of factitious disorder in diverse populations. Integrating mental health education into community health programs and fostering open conversations about psychological well-being can play a pivotal role in reducing stigma and promoting early intervention.

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