



Case Report

Diagnosing and Managing Comorbid Factitious Disorder in a Borderline Personality Disorder: A Case Report

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Abstract

This case demonstrates a comorbid Borderline Personality Disorder and Factitious Disorder situation, uncommon and sparsely described in the literature. Our purpose in sharing it resides as means to augment scientific data and possibly help manage similar situations. This case represents a patient with Borderline Personality Disorder, from an outpatient setting, who was hospitalized due to a mixed state suspicion. She then developed consciousness and behavior changes. Firstly, it resembled a delirium, although there was no obvious explanation for it and besides benzodiazepines in her system, all lab exams were clear. When her consciousness was recovered she was confronted with family information we gathered, and admitted self-injuring (excessive medication) as a means to pretend a stroke, as well forged cancer and chemotherapy symptoms (she cut off all her hair), in order to receive her children's attention. She was later discharged and oriented to a mental rehabilitation institution. Factitious Disorder is an underdiagnosed and confounding condition and possibly correlated to Borderline Personality Disorder. Despite some literature demonstrating a comorbidity relation between Borderline Personality Disorder and Factitious Disorder, there is still controversy among authors, as well as sparse data. This patient showed a clear comorbidity between these two disorders, which corroborates their connection.

Keywords: Factitious Disorder; Borderline Personality Disorder; Self-Imposed; Management; Comorbid

Introduction

Factitious disorder is a psychiatric illness in which some kind of impairment is forged, either fabricated or self-induced in order to receive medical care, although without any obvious external benefits [1-4]. These patients mainly aim at getting attention and feeling accomplished. For some it is their only way to deal with daily stress [5, 6]. Although uncommon (with a prevalence of about 1%) [4], this disorder is most likely underdiagnosed, due to its inherent diagnosing difficulties and confounding symptoms [3]. Factitious disorder is also associated with notable morbidity, mortality, and healthcare expenditure [6-8].

Despite reported comorbidity with other mental disorders, available data is not accurate regarding which psychiatric disorder is more prevalent, or which has a greater risk of comorbidity [9]. Indeed, there is an important and significant lack of evidence-based studies regarding this issue, such that current guidelines and recommendations on managing Factitious disorder are often based on case report feedback, systematic reviews, or expert advice [3]. Nevertheless, some evidence points to a probable correlation between Borderline Personality Disorder [9] and Mood Disturbances [2, 10], also suggesting a poor prognosis and a lack of treatment options for patients [2, 3, 9, 10].

This case reports a unique presentation of both disorders and its inherent approaches and treatment difficulties. We hope it can elucidate and orient future similar cases.

Case Presentation

We hereby present the case of a 55-year-old caucasian female forwarded to our psychiatric outpatient setting due to atypical depressive symptoms and impulsive personality traits. She was on fluoxetine 40mg/day and topiramate 50mg/day.

She had previously been submitted to an appendectomy, cholecystectomy, and an oophorectomy plus hysterectomy. Regarding family history, we were able to acknowledge some issues that may have contributed to the patient's personality construction. Born in Angola, she never met her biological parents, having been adopted at the age of four, and was never able to form a strong connection with her adoptive mother. In fact their relationship was mostly characterized by conflict and bitterness. Her adoptive father, with whom she maintained a more proper relationship, passed away when she was 27 years old. The patient got married and pregnant at the age of 18. She gave birth to a son and later, at the age of 21, a daughter, after which got divorced. By the age of 30 she got married again and birthed a third child. However, six years into her second marriage she once more got a divorce.

At this time, the patient had been retired for 2 years and showed signs of lack of healthy relationships: she had no close friends nor regular contact with her two sons (37 and 25 years old) and daughter (35 years old), and a rather tense and abrasive relationship with her neighbors.

In the first appointment a pattern present since her youth was acknowledged, characterized by: constant unstable humor; impulsive behaviors; feelings of emptiness and anger; low self-esteem; and feelings of insecurity towards relationships. Due to these findings, she was diagnosed with Borderline Personality Disorder [11], even though self-injurious behaviors were not known. As such, despite being on fluoxetine and topiramate, psychology was requested.

Along with psychiatric medication, the patient was also on Montelukaste 20mg/day, Symbicort twice a day, and Aeries 5mg (SOS), due to her asthma condition.

On her second appointment, the patient described feelings of sadness and anxiety due to conflicts with neighbors, resulting in the introduction of clomipramine 50mg/ day, and an increase of topiramate to 100mg/day, while also keeping fluoxetine 40mg/day.

On the third appointment, she described worsened feelings of sadness and emptiness. Clomipramine was augmented to 75mg/day; topiramate 100mg/day and fluoxetine 40mg/day were maintained.

On the fourth appointment, the patient showed visible and notorious reactivity to her neighbors' situation, so another therapeutic change was made: clomipramine was increased to 150mg/day; topiramate was suspended and switched to valproic acid 1000 mg/day; fluoxetine remained.

On her fifth appointment, conversive symptoms were addressed and a psychotherapeutic approach was made for insomnia. Valproic acid was increased to 2000 mg/day, clomipramine was reduced to 100mg/day, and levomepromazine 75mg/day was initiated; fluoxetine was maintained.

On the sixth appointment, conflicts with neighbors were the main complaint, along with extreme fear. Levomepromazine was increased to 150mg/day; the other medication remained.

On the patient's seventh appointment, clomipramine was reduced to 50mg/day due to nocturia complaints; the remaining medication was maintained. In the next appointment, the patient showed aggravated insomnia, irritability, anxiety, and fear, partly due to pandemic financial problems, although conflicts with neighbors were better. So, she started on olanzapine 10 to 20mg/day and clonazepam 1mg SOS if anxiety.

The following appointment was urgently requested: the patient had the same symptoms as before and was taking clonazepam 4mg/day, with no mention to olanzapine. So, clonazepam was suspended and switched to lorazepam 2,5 to 5 mg/day.

Ten days after the latter outpatient consultation, she was admitted to our institution's psychiatric emergency department, due to a car accident.

On admission, she was calm, colaborant, and had no alterations in orientation, attention, memory, perception or judgment. However, the patient presented dysphoric-toned humor, structured suicidal ideation (by exploding a container of propane gas), paranoid overrated ideas, and total insomnia. At the time the patient reported to be on fluoxetine 40mg/day, trazodone 100mg/day, clomipramine 150 mg/day, valproic acid 1500 mg/day, olanzapine 10 mg/day, levomepromazine 25mg/day and lorazepam 2.5mg/day, even though trazodone was not prescribed in the previous outpatient appointment. She did not explain who prescribed it or why it was prescribed. She was also incapable of explaining how her medication had been taken.

Therefore, suspecting an inaugural mixed episode versus Borderline Disorder acute crisis, the patient was admitted to our psychiatric ward for the first time. Since there was no way to confirm her adherence to medication and due to insomnia complaints, it was placed according to the last consultation, except for olanzapine which was increased to 20mg/day.

During the first days, despite normal blood work, she showed an altered state of consciousness which resembled an acute confusional syndrome. This confusion was maintained even though she was on olanzapine 20 mg, the only medication she had accepted. Therefore, her eldest son was contacted in order to gather more clinical information. According to him, the patient had been telling she had a series of strokes and cardiac arrests and had cut her own hair to fake a cancer disease. Two weeks before admission she was driving over-medicated, apparently on purpose in order to cause car accidents, but on admission, she maintained the stroke story to her son.

Due to this information, we started to suspect this altered consciousness was related with auto inflicted overdosing, and hypnotic or sedative medications were reviewed: clomipramine, olanzapine, and levomepromazine were suspended; fluoxetine, valproic acid, and lorazepam were reduced. One week after her consciousness began to improve.

On day 16 the patient was discharged with the following diagnostics: Borderline Personality Disorder as primary diagnosis and Factitious Disorder as secondary diagnosis.

Medication was substantially reduced to fluoxetine 20mg/day, valproic acid 500mg/day, and lorazepam 1mg/day. The patient was referred to a mental rehabilitation institution and maintained her outpatient follow-up.

Discussion

Despite some literature demonstrating a comorbidity relationship between Borderline Personality Disorder and Factitious Disorder, there is still controversy among authors, as well as a sparsity of data. This patient showed a clear comorbidity between these two disorders, which corroborates their connection.

According to DSM-V criteria for Factitious Disorder, it is clear the deception identification, as well as physical symptoms falsification (cutting hair to resemble cancer treatments) as injury induction (overmedication). It is also clear that the patient presents herself to others as substantially ill (strokes, cardiac arrests), and there are no obvious secondary benefits. Although it is rare for Factitious Disorder patients to admit their deceptive behavior is done intentionally to gain internal benefits [4], contrary to Borderline Personality Disorder patients who easily admit it, this patient was considered to have both conditions.

There was no previous history of self-injury to ameliorate her pain or emptiness feelings as seen so many times in Borderline Personality Disorder but rather a recent deception and forged situations in order to obtain attention [1].

This case was challenging and mainly difficult to manage due to Delirium confounding symptoms. Fortunately, the patient confessed later what she did, otherwise, it would be very hard to reach the final diagnosis, as expected from a Factitious Disorder.

Even though the comorbidity between Factitious Disorder and Borderline Personality Disorder rationally suggests a more difficult diagnosis and a worse prognostic, we have to consider her Borderline Personality Disorder as the core reason for our diagnosis.

Conclusion

In summary, recognizing and managing comorbid Factitious Disorder and Borderline Personality Disorder are quite challenging and may be confounding even to experienced professionals.

We hope this Borderline and Factitious Disorder overlapping case report will add information to pre-existing literature, in order to facilitate recognition and therefore direct treatment, both pharmacological and psychotherapeutic.

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Ethical Considerations: Informed consent was obtained from the patient.

Conflicts of Interest: The authors have no funding or conflicts of interest to disclose.

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