

# Factitious Disorder manifests as intentional swallowing of foreign objects.

Hannah G. Gersch, Fulton A. Robinson

## \*Corresponding author

Hannah G. Gersch,  
Department of Psychiatry, Quillen College of Medicine, East  
Tennessee State University, TN, USA.

**Received Date :** June 18, 2024

**Accepted Date :** June 20, 2024

**Published Date :** July 20, 2024

## ABSTRACT

**Background:** Factitious disorder (FD) imposed on self refers to the intentional feigning or self-inflicted development of symptoms without external reward.

**instance:** This article discusses a severe instance of self-imposed FD in a 31-year-old individual who routinely presented to various. Over two years, 32 esophagogastroduodenoscopy (EGD) and 28 gastroscopy procedures were performed at regional emergency departments due to purposeful ingestion of foreign particles. The case was compounded by a history of suicide attempts and drug-seeking behavior. The discussion will include the patient's motivations, suicidality in FD, and their current treatment and outcomes.

**Keywords:** Factitious disorders, foreign bodies, suicide, substance-related disorders.

## INTRODUCTION

The term "imposed on self" refers to the intentional fabrication of symptoms or self-injurious behavior in the absence of external reward [1]. The most severe, chronic, or dramatic cases are referred to as "Munchausen". The disorder was previously referred to as a "syndrome". While girls are more likely to be diagnosed with FD, males seem to have the most severe cases [2]. Other risk factors include being single, working in healthcare, having a mental history, and experiencing family conflict or abuse [3-7]. In a retrospective study of 49 patients with FD, over half indicated a history of sexual and violent/physical abuse. 43 percent of the subjects There has also been a history of abuse inside the household [7]. There is limited research on gender variations in the

clinical course of FD and their link with other demographic characteristics. However, there are gender differences in the medical specialties that treat FD patients. A systematic analysis indicated that 77% of FD cases requiring cardiology were in male patients, whereas females were treated by allergy & immunology, infectious disease, and ophthalmology (8). The frequency of FD in the general population is uncertain, with estimates ranging from 0.1 to 8%. However, most research have shown The incidence was found to be approximately 1% [3, 9, 10]. Several ideas for the pathophysiology of FD have been proposed.

Research suggests that these behaviors are a coping method for emotional stress and unfulfilled needs, including attention, care, acceptance, and belonging [3, 11, 12]. One study suggests that the patient's behavior may stem from a need to "establish an identity" (13). FD sometimes overlaps with other psychiatric illnesses. A retrospective assessment revealed that 32.3% of FD patients had other DSM diagnoses, whereas 8.6 to 15.1% had drug dependency.

Depressive disorders are the most common co-occurring mental illnesses in patients with FD [3, 8]. Differential diagnosis for FD includes Somatic symptom disorder, malingering, conversion disorder, and borderline personality disorder are all organic origins of symptomatology (13).

## CASE

The patient, a 31-year-old male, has been presenting to regional healthcare institutions in the Appalachian region for seven years with complaints of purposeful foreign body ingestion.

As self-reported suicide attempts. The patient's mental history included diagnoses of bipolar illness with psychotic characteristics, schizoaffective disorder, major depressive disorder, and generalized anxiety disorder. The patient had a significant social background of homelessness, neglect, and sexual assault during childhood. Foreign bodies that have been ingested include batteries, mechanical nuts, bolts, screws, nails, and razor blade cartridges. Over the past two years, the patient obtained 85 abdomen x-rays (Fig. 1) to track the movement of foreign bodies in the gastrointestinal tract. Additionally, Over the past two years, the patient underwent 32 esophagogastroduodenoscopy (EGD) procedures and 28 gastroscopies to remove foreign materials. Despite frequent foreign body consumption, the patient did not develop

intestinal perforation.

The patient's history of foreign body ingestion and suicide attempts led to voluntary evaluations at multiple inpatient mental health facilities. He had previously been. The patient had psychotherapy and drug trials, including sodium valproate, quetiapine, aripiprazole, sertraline, ziprasidone, citalopram, and escitalopram.

## DISCUSSION

Although there are numerous case reports and case series in the literature describing FD, limited case reports of FD specifically involving It is possible to intentionally swallow alien items. This instance highlights severe FD, which can lead to intentional eating of non-nutritional objects and suicide. Attempts made through pharmaceutical consumption. The discussion will include the patient's motivations, suicidality in FD, therapeutic options, and current outcomes. The primary criterion for FD in the DSM-V is the absence of external rewards or motivators for the patient. Self-inflicted symptoms, whether reported or true. However, the patient's behavior may have been motivated by drug-seeking. The patient's frequent intake of foreign objects necessitated numerous EGDs, each requiring sedation. This patient may have had a physical or chemical dependence on opioids or other sedative medications. Due to his concomitant substance use disorder (SUD), he may have eaten things to obtain the necessary anesthetics for EGDs. However, the patient was not clinically evaluated for SUD, and a study of the chart did not reveal if the diagnosis requirements were met. Furthermore, most people have Individuals with SUD or chemical dependency on analgesic and anesthetic medicines may obtain them illegally or through a medical prescription. They do not purposely swallow foreign things to gain sedative or analgesic substances. Although the patient's symptoms were consistent with FD, recent hospitalizations have shown increased aggressive behavior, including requesting IV pain medication, fighting with staff, and necessitating restraints during stays.

The patient's new conduct may indicate a psychiatric diagnosis other than SUD or FD, such as bipolar illness with psychotic characteristics. was previously diagnosed. The patient's violent conduct may be attributed to metabolic or toxicologic abnormalities, particularly given their history of intentional overdoses. This instance highlights the importance of addressing co-occurring suicidal ideation with FD. The patient had a long history of serious depression disorder and suicide thoughts. After being discharged from inpatient mental health care, a patient returned to the emergency room and claimed to have consumed an entire bottle of

aspirin. Serial salicylate level tests over 48 hours demonstrated that the patient's blood salicylate level did not exceed 30 mg/dL (normal range: 15-30 mg/dL). During another presentation, the patient claimed to have consumed 80 citalopram pills. After consulting with poison control, the patient was admitted for observation due to their questionable history and recurring complaints.

## CONCLUSION

This case describes a factitious disorder characterized by intentional ingesting of non-nutritious foreign materials, with repeated claimed suicide attempts through medicine ingestion. Drug-seeking may be the motivation for this behavior. The patient's actions and suicide thoughts continue to complicate the situation. This patient's unsatisfactory psychiatric treatment is consistent with other accounts of treatment failures for FD. Insufficient research is hindering effective treatment and management of FD. More study on FD could help clinicians better manage this complicated and challenging condition.

## REFERENCES

1. Munro S, Thomas KL, Abu-Shaar M. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, Arlington, VA 2013. Nature. 1993.
2. McCullumsmith CB, Ford CV. Simulated illness: The factitious disorders and malingering. Vol. 34, Psychiatric Clinics of North America. 2011.
3. Bass C, Halligan P. Factitious disorders and malingering: Challenges for clinical assessment and management. Vol. 383, The Lancet. 2014.
4. Krahn LE, Li H, O'Connor MK. Patients who strive to be ill: Factitious disorder with physical symptoms. American Journal of Psychiatry. 2003;160(6).
5. Catalina ML, Gómez Macías V, de Cos A. Prevalence of factitious disorder with psychological symptoms in hospitalized patients. Actas Españolas de Psiquiatría. 2008;36(6).
6. Reich P, Gottfried LA. Factitious disorders in a teaching hospital. Annals of Internal Medicine. 1983;99(2).
7. Jimenez XF, Nkanginieme N, Dhand N, Karafa M, Salerno K. Clinical, demographic, psychological, and behavioral features of factitious disorder: A retrospective analysis. General Hospital Psychiatry. 2020;62.