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Comorbidity between factitious disorder and borderline personality disorder: assessment in medical and psychiatric care

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Abstract
During recent years, there has been a new rise of cases of factitious disorder, mainly linked to comorbidity with Borderline Personality Disorder (BPD). Patients with FD-BPD are of interest and concern for general practitioners, hospital physicians and psychiatrists. Our research is a phenomenological approach for an explanation of this presentation which shows a growing trend. Physical symptoms and factitious medical and psychiatric symptoms can be used by patients with FD and BPD to exercise extra pressure on medical and nursing staff for accessing additional healthcare services, and medical and surgical procedures otherwise not available for minor pathologies. However, the risk is that these patients' elaborated physical and mental symptoms can mislead medical and psychiatric teams to the risk of poly pharmacy, iatrogenic side effects, unnecessary medical and surgical investigations and treatments. The current study develops as a phenomenological approach and assessment tool of FD-BPD in medical and psychiatric care.

Keywords: factitious disorder; borderline personality disorder; phenomenology; assessment; management

Introduction

Several studies report about the comorbidity of Factitious Disorder (FD) with Borderline Personality Disorder (BPD) [1-5]. ICD-10[6] illustrates the presentation of FD and Emotionally Unstable Personality Disorder (in the current study, equivalent to Borderline Personality Disorder) which are characterized by the presence and elaboration of physical and psychological symptoms arising from underlying emotional distress and from the desire to avoid feelings of abandonment. As the National Health Service [5]. and ICD-106 explain, Factitious Disorder is a condition where the patient feigns to be unwell or intentionally constructs signs of disease in themselves. The core purpose of these patients is to adopt a 'sick role' to access nursing and medical support and to be at the core of others' attention by feigning or exaggerating physical or psychological symptoms [6].

In psychiatry, comorbidity refers to the combined manifestation of two or more psychiatric pathologies with physical illnesses [7]. Comorbidity occurs 'When two disorders or illnesses occur in the same person, simultaneously or sequentially.'[8] Furthermore, clinicians should be stimulated to log the full range of diagnoses in every single patient as a way of describing the intricacy of psychiatric cases as comorbidity affects all mental illnesses.[9,10] It is also reported that multiple personality disorders are present in more than fifty per cent of patients when a diagnosis of personality disorder is posed [11]. Moreover, the process of separating psychiatric conditions into many diagnoses may inhibit a holistic treatment of patients, while the term should be avoided as comorbidity refers to various aspects of a specific psychiatric illness [12].

Table 1: Some aspects of Factitious Disorder and Emotionally Unstable Personality Disorder Borderline Type (ICD-10, 1993).

F 68.0 Other disorders of adult personality and behavior
F68.0 Elaboration of physical symptoms for psychological reasons
Physical symptoms originally due to a confirmed physical disorder, disease or disabilty become exaggerated or prolonged in excess of what can be explained by the physical disorder itself.
F68.1 Intentional production or feigning of symptoms or disabilities, either physical or psychological [factitious disorder]
A persistent pattern of intentional production or feigning of symptoms and/or self-infliction of wounds in order to produce symptoms.
F60.31 Emotionally Unstable Personality Disorder Borderline Type
Disturbances in and uncertainty about self-image, aims and internal preferences. Excessive efforts to avoid abandonment. Recurrent threats or acts of self-harm. Chronic feelings of emptiness.
F 60. Personality disorder in general
Evidence that the individual's characteristic and enduring patterns of inner experience and behaviour deviate markedly as a whole from the culturally expected and accepted range (or 'norm'). Such deviation must be manifest in more than one of the following areas, such as control over impulses and need gratification; relating to others and manner of handling interpersonal situations.

The way patients with FD-BPD access regular prescriptions for use in unofficial aims are mainly by presenting to hospitals to have painkillers, claiming Attention Deficit Disorder, reporting having lost the order, having side effects from current medication, going to numerous family doctors and collecting multiple prescriptions, and in extreme cases, faking surgical symptoms to

access surgery and strong (ER) medications [13]. Hence, patients with FD-BPD's presentation could erroneously lead to unnecessary invasive therapeutic investigations and treatments, like intravenous fluid therapy.[1] Besides, patients with FD are regularly challenging; they claim continuous care from health carers to reduce their alleged pain and insist in receiving medications or more medication, complex instrumental examinations, referrals to other specialists, and expensive medical investigations [14]. The authors of the current study found that the increasing incidence of cases with the diagnosis of Borderline Personality Disorder, in some regional areas, might assume an 'epidemic' fashion [15]. hence generating a concomitant increase of FD cases.

FD-BPD can explain an increase of psychotropic medication prescribing in primary care; this is probably due to the raised severity of psychiatric cases diagnosed and comorbidities of diagnoses leading to the increased prescription of antidepressants-antipsychotics prescribing and antipsychotic-sedative-hypnotic recipes.[16] A study in Spain indicated that thirty per cent of patients in primary care present with comorbid depression, anxiety and somatoform illnesses [17].

By observing goals and means of FD-BPD maladaptive behaviours one can assume some similarities with the Dark Triad of Personality; this last is characterised by a combination of Machiavelism (e.g. controlling personality), narcissism (e.g. feeling of privilege) and psychopathy (e.g. highly impetuous, risk-taking behaviours, and low empathy) [18]. The dark triad as applied to FD-BPD is associated to the motivation to control the medical or psychiatric team, to attain some status within other patients, and to influence the decisions of the health carers [19].

The following paragraphs will examine the most common behaviours in patients with FD-BPD and a phenomenological approach for the explanation. Aim of the current study is also to provide a theoretical and phenomenological framing for understanding the responses of patients with FD-BPD.

2. Materials and methods

The current research represents the speculative explanation of behaviours of patients with BPD admitted to a psychiatric intensive care unit in a major hospital in the United Kingdom. The ward has 14 beds, and it serves an adult population with several psychiatric illnesses inclusive of psychoses and personality disorders in their acute stages. The turnover period for each patient is about two to four weeks. Persons with BPD access the wards when they are deemed to be at high risk for self and suicide. The catchment area of the psychiatric hospital comprises 325,837 citizens.

The authors of the current study noticed that most of the patients with BPD diagnosis had a case history of multiple physical ailments; after being admitted to a psychiatric or medical ward, a complex process of assessment was needed to separate what was a real physical concern from the underlying psychiatric condition. Other times, patients were admitted to psychiatric wards from local medical units after extensive diagnostic procedures (resulting negative), and minor surgical operations were suggesting the diagnosis of an underlying FD-BPD.

Patients are referred to our ward both by the Home Treatment Team and by the local hospital and Liaison Team in the case the patient has required medical attention for some reason, for instance, an overdose of paracetamol or serious, deliberate self-harm. The majority of the patients observed with an ICD-10 diagnosis of Emotionally Unstable Personality Disorder, Borderline Type (here designated as Borderline Personality Disorder or BPD) are mostly of female gender with mean age 24 years. Patients with personality disorder usually amount to about 20 to 50% of all psychiatric admissions in our adult psychiatric wards. A phenomenological theoretical approach has been used to explore the narratives and behaviors of patients with FD-BPD. Phenomenology studies how people give meaning to their experiences of the world in which they live [20]. The concept can extend to include people's inner world. Phenomenology also looks into the sense and construction of existential experience and the sustained understanding of such experience.[21] Maladaptive behaviors usually generate from maladaptive cognitions which are a way of reasoning detrimental for the person as they interfere with or hinders that person from making a definitive change from those cognitions while, at the same time, they impede this person's life accomplishments [22]. People often hold maladaptive or groundless beliefs that bring to maladaptive or illogical self-talk which finally produces maladaptive or trivial behaviors.[23] Beliefs and cognition are usually expressed as narratives of patients about their phenomenological world.

In our study, we collected narratives and classified behaviors during routine psychiatric interviews and observations while data were stored on an electronic database. Patient's psychiatric history was accessed in the electronic notes and during informal psychiatric assessments. Participant observers were both psychiatrists and mental health nurses. The authors then coded the narratives and behaviors according and summarized the findings into the categories herein reported. Besides, the current study could be interpreted as action research with an attempt to provide recommendations to improve clinical practice [24]. The present research is also nomothetic in the sense that its method of investigation assumes that the behavior of a specific individual is the consequence of rules that are true for the whole population with similar characteristics making the findings of the study empirically generalizable [25].

Phenomenological theories and investigations interpret people's behavior with a focus on subjective 'I' experiences or self-reflective narratives [26]. Besides, as the current study is also a naturalistic observational research, we also classified the observable behaviors of FD-BPD during field studies in our wars comprising routine patient observations. The final stage of the research aimed to create categories for understanding the phenomenology of both narratives and observed behaviors. The results phenomenological categories are reported in the following paragraphs.

2. Results and Discussion

The phenomenological world of FD-BPD is represented by cognitive mindsets that are durable and difficult to challenge without a specific multidisciplinary and psychological intervention to these patients. There are observed impulsiveness, high levels of psychological arousal, personal distress, and little improvement in the face of multiple medical, surgical and psychiatric interventions. All these factors can make FD-BPD clinical presentation a constant challenge and conundrum for any healthcare service with little opportunities to create a robust plan

for targeting the underlying emotional turmoil, these last representing the target of therapeutic actions. The following are the most common cognitive frameworks and behavioral presentation of patients with FD-BPD (Table 2).

Table 2: Presentation of FD-BPD.

Factitious behaviours: claiming to have physical and mental health problem more serious than clinically supported.
Self-inflicted wounds and illnesses, not merely represented by deliberate self-harm.
Constant request for invasive diagnostic and therapeutic interventions.
Exaggeration of pain or painkillers-seeking behaviours.
Medication craving.
Dramatization of symptoms leading to emergency access to hospitals, and to medical or surgical wards.
Constant appeal to staff's attention and support.
Deterioration of physical and psychiatric symptoms when healthcare professionals challenge patients about their symptoms or presenting pathologies.
Claiming multiple allergies to medications to pilot what to have in terms of therapeutic drugs.
Detailed knowledge of organic pathologies, medical procedures, symptoms and hospitals.
Dramatization of presenting symptoms, physical and psychiatric symptoms with a paradoxical complexity.
Paradoxical worsening of presentation once proper medication and treatment have started with initial signs of improvement.
Waves of improvement and deterioration in presentation which cannot be explained by any objective pathology.
Migrating symptoms with shifting of target organs once healthcare professionals communicate that the treated pathology and organ have improved.
Seeking invasive treatment or investigations via dramatization of physical and psychiatric symptoms which do not fit to results of clinical and surgical investigations which result negative.
Pain as a passe-partout to lead clinicians consider a vast array of pain killers and sedative medication.
Neuropathic pains that are difficult to confirm via standard diagnostic and clinical procedures; diffuse pains, musculoskeletal pain, headaches, etc.
Metabolic syndrome with morbid obesity and increased responses to different organic conditions.
Insomnia or alleged insomnia usually due to poor quality of sleep more than reduced time of sleep.
Asthma and inhalers which might represent the respiratory response to an underlying stress.
Emotional focus on symptoms more than on collaborative participation to a therapeutic plan.
Resistance to have any change in the current medication; over-medication and multiple regular prescriptions.
'Experts' in their pathology and detailed descriptions of their conditions as 'from manual' but with personal interpretations of what is needed in terms of diagnosis and Treatement.
Migrant behaviour to diverse hospitals and GP practices to accummulate prescriptions or gain definitive hospital admissions.
Slight prevalence of FD-BPD in the female gender.

Knowledge

Detailed information about hospitals and medical terms and illnesses. Patients with FD-BPD have a habit of challenging and showing detailed information about their alleged disease, therapy required and medication available. Hence, they appear as 'experts' in the pathology that afflicts them. Consequently, there is an attitude to influence healthcare professionals' decisions in terms of proper diagnosis and required treatment for the 'presenting' illness.

Dramatization

Impressive but unreliable medical history. Reporting ambiguous clinical signs that cannot be objectively falsified by healthcare professionals, such as auditory hallucinations, neurological symptoms, diffuse pains, convulsions, insomnia, gastrointestinal discomfort, respiratory crises, and others.

Vagueness

Blurred signs that are not easily measureable and that become more serious or modify once signs of improvement are reported to patients by health carers. Therefore, patients with FD-BPD tend to show a paradoxical worsening of their symptoms whenever healthcare professionals inform them that their clinical condition shows signs of improvement or that is not as serious as supposed. Hence, a new escalation of symptoms brings a new concern to staff which automatically reacts by increasing the medication, attention and investigations already present in patients' therapeutic plan. Other times, FD-BPD persons might Start to claim that their psychiatric or physical symptoms have become more severe, or that new signs have appeared that were not present at the beginning. There seems to be a migration of targeted organs whenever medics clear one from assumed pathologies.

Unexpected deterioration of symptoms

An unexpected decline in presentation after an initial progress in their illness. Patients with FD-BPD have lengthy admissions into hospitals with little improvement. They might endeavor to show that only small recovery has instead derived from their current therapies or that diagnostic procedures have not highlighted the true nature of their illness. Consequently, when staff and teams start to compliment about their progress, these persons paradoxically relapse in their presentation. They might claim that the improvement was only 'apparent' while the core conditions have not necessarily improved.

Inventiveness

Development of new or supplementary signs after positive diagnostic outcomes. Once there seems an improvement in presentation and staff is happy to discharge patients with BPD from the hospital, they have paradoxical relapses in their clinical conditions which often halt their discharge into the community. New symptoms might be neuropsychiatric symptoms, increased pain, fits, psychosis, abdominal or chest pain, and other symptoms that are not easily cleared by routine clinical diagnostics.

Invasive procedures are not opposed

FD-BPD patients might present with specific pathologies for which complex instrumental investigations for a correct diagnosis or invasive treatment are needed. It is becoming more frequent to find young women with BPD which are Un hunger strike and that do not discard being fed under nasogastric tube (NG tube). Other times, patients' behaviors, symptoms and deliberate self-harming can escalate with the planned consequence that only intravenous and intramuscular medication could help, for instance, for rapid tranquillization. These patients may also behave to lead staff to opt for highly invasive surgical treatments, for example, when keeping wounds infected, after prolonged hunger strikes or following critical self-harm requiring surgical curettage of their scars.

Painkillers are constantly sought

FD-BPD patients have a low threshold for pain while their subjective representation of it might be so dramatic to prompt staff to provide them with the most active pain killers, often opioid-based. Other times, FD-BPD patients accumulate paracetamol because of using it in overdose and getting easy access to accident and emergency departments. Sometimes, patients confess that pain killers improve their mood by interrupting the loop between physical and psychological pain. Healthcare professions should be warned to cautiously scan patients' claim of having 'strong' pain. Exaggeration of pain symptoms can incorrectly lead healthcare personnel to exceed in pain killers and other unnecessary medication. Once a pain killer appears on the patient's prescription, then it becomes difficult to revise or stop it as a sort of addiction has already ensued.

Frequent neuro pathic pain, headaches, backaches, musculo skeletal aches

Patients with FD-BPD utilize a whole array of symptoms which cannot be challenged as these last are 'not under eye inspection.' This way patients with FD-BPD feel they can use pain as a passe-partout for gaining immediate access to medical or psychiatric facilities (like accident and emergency departments), or for getting intense medical or psychiatric attention and intervention beyond their real requirements.

Metabolic syndrome

Patients with FD-BPD might be afflicted by metabolic syndrome with morbid BMI. As excessive eating might be used as a form of self-harm or to increase the likelihood of cardiovascular diseases, loss of weight becomes paramount for the treatment of FD-BPD. Also, obesity causes impaired mobility, restriction of physical activities, reduction in personal autonomy and increase in sick-role behavior. Additionally, physical conditions might be poor in general. The lack of physical activities and the unconscious limitation of movements for multiple but minimal illnesses can reduce the likelihood of a good quality of life.

Insomnia

a way FD-BPD use to access powerful sleep tablets and sedatives is to

Report suffering from sleep problems. Although constant distress and underlying emotional dysthymia can conduct to sleep problems, it is usually not the amount of sleep which is limited but its quality with frequent flashback episodes at sleep induction and early awakening due to a depressive mood. Nonetheless, constant sleep alterations can conduct to chronic fatigue and anhedonia which are subjectively recorded as psychomotor exhaustion, weakness and diffuse pain.

Asthma and inhalers

Chronic Obstructive Pulmonary Disease (COPD), acute respiratory crises with shortness of breath, diagnosis of asthma and the use of inhalers are frequently found in women with FD and BPD. Some of the inhalers which regularly appear in their prescriptions might contain substances which can affect mood (e.g., ephedrine, steroids, etc.) while a psychological addiction to inhalers could be difficult to stop.

Focus on subjective symptoms over collaboration with health carers

Patients with FD-BPD tend to embellish physical symptoms probably from the unconscious drive to control the direction of care and attention from healthcare professionals. Besides, patients with FD-BPD might be trapped in a vicious circle of increasing physical and psychological symptoms whenever they feel frustrated or challenged in their behavior by staff and medics. Therefore, whenever staff applies a logic explanation and challenges patients' symptoms, these last tend to paradoxically worsen. Other times, always after health carers' attempt to rationalize the patient's behaviors they might manage to make formal complaints to the local hospital or team.

Conflicts with medical and nursing staff ensue whenever these patients are challenged on the need of their current medication

Patients with FD-BPD tend to believe that any medication has the power to improve their quality of life and to reduce their emotional distress. Consequently, any attempt from healthcare professionals to reduce the amount of their regular medication is vehemently opposed by FD-BPD patients although multiple medications might not be strictly necessary while their reduction becomes hard to achieve due to patients' opposition.

Hospital migration

It is a behavior where patients with FD-BPD self-refer to different medical or psychiatric services or family doctors who do not know about each other. In some cases, these patients have travelled long distances to access various A&E services until they are finally granted admission to a hospital. It is not infrequent that they report accessing the hospitals that are located along a familiar route of a motorway or train route.

Accruing medications

These patients can accrue different prescriptions from independent medical services and generate a stock of medications which can pose a patient's health at risk. In its extreme cases, such behavior can be considered as a form of self-harm, addiction to prescription, or as a preparation for suicide by overdose.

3. Conclusion

The assessment of FD comorbid with BPD requires coordinated efforts by part of all healthcare professionals involved and

knowledge of the underlying phenomenological processes behind the clinical presentation. A multi-professional team of mental and physical health nurses and doctors should instead create a synchronized team to deliver the same information to these patients to avoid gaps in information and practice. In fact, patients with FD-BPD usually might use discrepancies in the information provided use to split staff or to complain to local healthcare authorities. Instead, the possibility of sharing clinical records via electronic platforms, the coordination of messages provided by all the health carers involved, the endurance to resist pressure from these patient and their families to do more than necessary, a support from hospital managers to deal with risks of allegations and complains can improve the approach to patients with FD-BPD.

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