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Factitious disorder comorbid with borderline personality disorder and dysthymia: from medically unexplained physical symptoms to functional neurological disorder

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Summary. Introduction. In this study, we introduce the concept of comorbidity between factitious disorder (FD), borderline personality disorder (BPD), dysthymia (DY), medically unexplained physical symptoms (MUPS) and functional neurological disorder (FND) characterising patients who may tend to exaggerate physical or psychiatric symptoms of presentation to a general or psychiatric hospital with a constellation of signs that do not receive confirmation from further clinical and instrumental assessments. The similarities between these syndromes and the constant presence of borderline personality in the psychopathology make it the possible link between all these syndromes. **Materials and methods**. The authors captured the typical appearance and characterisation of FD-BPD-DY-MUPS-FND (Com-1) syndrome in adult and non-forensic acute psychiatric hospitals in the United Kingdom (UK) and adjacent liaison psychiatric teams through case vignettes. Each case vignette merged similar clinical cases and was cross-analysed using information from various mental health and medical professionals and bridging primary and secondary carers' records. **Results**. The findings suggest striking similarities between the syndromes making borderline personality the bridge pathology for FD, MUPS and FND. The complexity of the diagnosis of these cases is discussed in the study, together with prototypical presentations. **Conclusions.** Improving the management of these often-occurring diseases requires multidisciplinary coordination across psychiatry, general care, neurology and surgery departments.

Key words. Borderline personality disorder, dysthymia, factitious disorders, functional neurological disorder, medically unexplained physical symptoms.

Disturbo fittizio comorbile con disturbo borderline di personalità e distimia: dai sintomi fisici non spiegati dal punto di vista medico al disturbo neurologico funzionale.

Riassunto. Introduzione. In questo studio affrontiamo il concetto di comorbilità tra disturbo fittizio (FD), disturbo borderline di personalità (BPD), distimia (DY), sintomi fisici inspiegabili dal punto di vista medico (MUPS) e disturbo neurologico funzionale (FND) che caratterizzano i pazienti che possono tendere a esagerare i sintomi fisici o psichiatrici della presentazione a un ospedale generale o psichiatrico con una costellazione di segni che non ricevono conferma da ulteriori valutazioni cliniche e strumentali. Le somiglianze tra queste sindromi e la presenza costante di personalità borderline nella psicopatologia rendono possibile il collegamento tra tutte queste sindromi. **Materiali e metodi**. Gli autori hanno colto l'aspetto e la caratterizzazione tipici della sindrome FD-BPD-DY-MUPS-FND (Com-1) negli ospedali per pazienti psichiatrici acuti adulti e non forensi nel Regno Unito (UK) e nelle squadre psichiatriche di collegamento adiacenti attraverso vignette di casi. Ogni vignetta del caso ha unito casi clinici simili ed è stata analizzata in modo incrociato utilizzando informazioni provenienti da vari professionisti della salute mentale e medici e collegando i registri dei caregiver primari e secondari. **Risultati**. I risultati suggeriscono sorprendenti somiglianze tra le sindromi rendendo il disturbo borderline di personalità la patologia ponte per FD, MUPS e FND. La complessità della diagnosi di questi casi è discussa nello studio insieme alle presentazioni prototipiche. **Conclusioni**. Migliorare la gestione di queste malattie che si verificano sempre più di frequente richiede un coordinamento multidisciplinare tra i dipartimenti di psichiatria, assistenza generale, neurologia e chirurgia.

Parole chiave. Distimia, disturbi fittizi, disturbo borderline di personalità, disturbo neurologico funzionale, sintomi fisici inspiegabili dal punto di vista medico.

Introduction

In a study from the authors about the frequency of admission to general adult non-forensic wards, it emerged that female patients with borderline personality disorder (BPD) were the most represented[1]. Another study found that fifty-two percent of BPD persons are high-frequency users of mental health services, with seventy-six percent being females[2]. A review of factitious disorders (FD), including 514 cases, found that 65.4% were females most likely to present to psychiatric services, emergency departments (ED), and medicine units[3]. According to previous research, there may be a link between FD and BPD, as FD may be a sign of BPD or may coexist with it[4-9]. Therefore, treating patients with FD can heavily impact the expenses of the National Health Services

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sustained by providing unnecessary assessments and interventions[10].

Factitious disorders were formerly known as Munchausen syndrome. Rudolph Eric Raspe reported his encounter with the titular Baron Freiherr von Münchhausen, the central personage of "The surprising adventures of Baron Munchausen" (Germany, 1720-1797); this noble gentleman used to entertain bystanders with embellished and unbelievable stories about his campaign in Russia[11]. The World Health Organization's (WHO) International Statistical Classification of Diseases (ICD-10) (officially used in the UK) Code F68.1 and UK National Health Service (NHS) emphasise that the primary goal of persons with FD is to assume a patient role to access public care and to be the center of attention from others with impact on interpersonal interactions with health professionals and other patients[4,12].

In borderline personality disorder (ICD-10 F 60.31), some signs of emotional instability are present, and the patient's own goals, self-perception, and internal preferences are often clouded or disrupted; usually, there are persistent empty emotions[12]. The propensity to enter into passionate and unstable relationships may lead to ongoing emotional crises, excessive attempts to prevent desertion, and suicide threats or self-harming behaviours[12].

Dysthymia (DY), categorised as a persistent mood or affective disorder on the ICD-10-34.1, manifests as periods of days or weeks when people describe themselves as unwell[12]. For most of this time (sometimes for months), they feel worn out and unhappy, as if everything is a struggle and nothing is relished; they ruminate and complain, sleep poorly, are irritable, and feel inadequate, but are typically able to cope with the fundamental demands of everyday life[12].

When two diseases or disorders manifest together in the same individual simultaneously or successively, they are considered comorbid[13,14]. In using multiaxial systems like the Diagnostic Statistical Manual of Mental Disorders (DSM-5) and the ICD-10, healthcare professionals should be urged to record the complete spectrum of diagnoses for each patient to document the complexity of their psychiatric situations[15]. Comorbidity is a frequent finding in mental diseases; it has been described that more than fifty per cent of individuals with a personality disorder diagnosis have comorbid other personality disorders[16,17]. Furthermore, the division of mental illnesses into several categories may impede the comprehensive care of patients and psychiatrists to steer clear of the word comorbidity since it only denotes diverse manifestations of the same psychiatric disorder[18]. However, comorbidity does not clearly distinguish between symptom coincidence collections, such as the appearance of many symptoms in the same illness or other mental disorders with related symptoms[19].

Medically Unexplained Physical Symptoms (MUPS) is an umbrella term to refer to conditions defined by physical symptoms not better described by another disorder[20,21]. According to estimates, about 20% (15% to 30%) of patients in primary care have chronic symptom disorders or medically unexplained syndromes, such as fibromyalgia or chronic fatigue syndrome[20,21].

Functional neurological disorder (FND) describes a condition with changes in brain network operation rather than brain structure abnormalities[22]. FND is frequently comorbid with depression, posttraumatic stress disorder, anxiety, and cluster B personality disorder, including antisocial, borderline, histrionic, and narcissistic[22]. It thus refers to neurological symptoms which have no organic cause[22]. We have here named the comorbidity FD-BPD-DY-MUPS-FND with "Com-1".

Materials and methods

Patients with comorbidity Com-1 were admitted to the hospital by ED or referred by community psychiatric teams. Others self-refer by calling the Police, crisis team helpline, or paramedic and ambulance services. Nurses and doctors in the psychiatric and medical wards made regular observations and shared electronic records and handovers for scrutiny and follow-up to arrive at a conclusive diagnosis.

This study merges similar clinical cases into typical vignette cases to emphasise essential concepts and support our theories more clearly. One of the authors has experience writing narrative plots and finalising vignettes. Vignettes are often used as prompts for medical education and for assessing the knowledge of medical and nursing students during their psychiatric attachment. For instance, a perfect collection of case vignettes would include descriptions that resembles actual case histories and varied solely by the particular clinical characteristics under investigation[23]. Vignettes aim to provide reports of behaviours that unmistakably mirror practice[23]. However, text vignettes (as used in the current study) are preferred to video or simulated patients because they allow participants to study the material at their own pace without having to fast-forward or remember everything said[24]. Vignettes could also show developmental and phenomenological similarities in their characters[25].

Like other authors, we created vignettes by abstracting information from patient files selected retrospectively[26] or assembling practitioners' self-reflective accounts from similar narratives or facts from separate patients into a logical case vignette, each representing a specific typology of patients. A plot as we constructed it must have a title indicative of the subject matter or primary character (e.g., "woman

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victim of domestic violence"), different co-acting or secondary characters (e.g., "health carers and society"), a location (e.g., "a psychiatric ward") a central behaviour or action (e.g., "factitious behaviour"), consequences or epilogue of the significant action (e.g., "hospital admission"), a writer's commentary (e.g., "distress in the ED departments").

Secondary characters and their interactions with the primary character bring tension to the story[27]. For instance, the vignette method has been used to examine differences in how each health practitioner recognises and handles issues such as depression and other comorbid illnesses[28]. However, opposite to standardised patients or chart abstraction, clinical vignettes are brief, straightforward texts that describe realistic clinical situations so that practitioners can evaluate similar scenarios and help advance their clinical knowledge and practice[28]. Creating a story's universe and stories generally requires developing characters with specific attributes - to explain participation in a past or present storyline, or even as the offspring of other characters - not always characters with predetermined stereotypes[29]. Therefore, this method helped us identify a set of stereotypes that accurately defined a character given a set of trait values employing heuristic techniques and creating a believable story[29]. Furthermore, Patrick Colm Hogan's theory of poetics sustains that narrative elements in stories can map how the emotional system in humans operates in everyday life, from situations that trigger emotions in the reader to actions prompted by our empathic system, which guides our emotional responses[30]. Case vignettes were chosen as a more pedagogical method in qualitative exploratory research on the topic of interest, as they provide a more personal and experiential window into patients' lives without needed ethical approval from local authorities as they do not refer to actual and identifiable patients.

Results

The prototypical cases represented in the vignettes have been summarised in table 1 (as from Callegari et al.)[31].

Table 1. Prototypical cases represented in the vignettes.

	Vignette No 1	Vignette No 2	Vignette No 3	Vignette No 4	Vignette No 5
Gender	F	F	M	M	F
Age	20s	30s	40s	50s	20s
Life events	Separation of parents	History of rape from the previous partner	Alcohol intoxication and fighting outside a pub	Put on fire his house and took an overdose of prescribed medication; unemployment, divorce, alcohol abuse, splitting from his partner	Visit of mother and sister in the ward
Age of somatic symptom's onset	15	25	40	40	15
Age at first psychiatric evaluation	15	20	30	40	15
Hospitalisation in a psychiatric ward	At age 15, in the children and adolescent psychiatric unit	At age 25, in a general adult wards	At age 30s, in a general adult ward	At age 45, in a general adult ward	At age 15, in the children and adolescent ward
Somatic symptoms	Altered blood pressure, low peripheral oxygen saturation, pseudo seizures, paraplegia	Choric pain, intestinal blockage, paralysis, epilepsy, severe pain, dizziness	Claiming ADHD, claiming psychosis and auditory hallucinations, claiming lost prescription of benzodiazepines, antipsychotics, ADHD medication	Insomnia, diffuse pain, forgetfulness, dizziness, vertigo	Pseudo-fits with a rapid resolution, progressive paralysis and use of a wheelchair; double incontinence; refusing to eat and requiring nasogastric tube; subcutaneous pockets where she introduced foreign bodies

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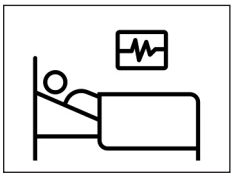
Continue **Table 1.**

	Vignette No 1	Vignette No 2	Vignette No 3	Vignette No 4	Vignette No 5
Health behaviour	Apnoea Overdose in salt Self-inflicting injuries	Collecting remedies from different hospitals and family physicians, alcohol and illicit substance misuse, including controlled painkillers	Shakes, jerks, altered gait, walking with crutches, "foggy mind", forgetfulness	Self-referral to ED, claiming suicidal ideation and plan, requesting admission to a psychiatric hospital	Refusing to eat by mouth, bedridden, paralysis; refusing antibiotic medication
Psychopathological symptoms	Depressed mood, flat affect, suicidal ideation, visual hallucination, command auditory hallucinations	Complaints and false allegations against staff, suicidal ideation escalating next to discharge, limited anger management and frustration, command and auditory hallucination to kill herself	Frequent ED admissions after calling the Police and saying that he was about jump off the cliff, claiming suicidal ideation and plans, claiming severe depression and hopelessness	Claiming severe depression and suicidal thoughts and intentions, threatening suicide if admission to a psychiatric hospital was not granted	Afraid of losing control of her life, refusing to eat by mouth, mildly depressed, command auditory hallucinations
Surgical or medical site	Arm and leg cuts	Multiple neurological and physical symptoms	Neurological symptoms	Neurological symptoms	Subcutaneous insertion of foreign bodies
Evolution	Remained in a wheelchair and developed double incontinence	Frequent service user, frequent self-referrals to local ED departments after overdosing with prescribed medication, including antidepressants and painkillers	Used to "migrate" to Eds in different towns, reporting the same history and seeking admissions to psychiatric hospitals while escalating in behaviour if the admission was not granted	Short "social" admission to hospital with no objective evidence of severe depression and no action on suicidal ideation. Discharged with some good outcomes to the community mental health team	Constant surgical interventions with a final decision of surgeons not to proceed any further but to act symptomatically

Modified from: Callegari et al.[31].

Nonepileptic seizures and neurological symptoms



Vignette No 1. This vignette describes a prototypical case of a woman in her 20s who reports a history of interactions with Children and Adolescent Mental Health Services (CAMHS). She was prone to self-inflicting severe injuries during her multiple admissions to the mental health wards with deep arm and leg cuts. She also aggravated her vital signs by inducing high or low blood pressure by overdosing with salt, or holding her breath and going into apnoea to cause low peripheral oxygen saturation to alarm nurses and get immediate ED admission. These actions also lead to reduced brain perfusion and triggered pseudo-seizures. She developed paralysis of her lower limbs which did not find neurological causes. After a while, she could no longer move from the bed, although any medical and neurological investigation did not provide an underlying organic cause. A wheelchair was required. Shortly after discharge, she has constantly re-presented at the emergency department ED with a low or flat mood, reporting constant suicidal ideation and a plan to jump in front of a train, visual hallucinations of drops of blood coming from walls or bodies covered by blood and command auditory hallucinations to self-harm. At this point, the team diagnosed possible comorbidity Com-1 and referred her to a chronic rehab psychiatric ward.

Psychogenic epileptic seizures, often known as pseudo-seizures, are a typical presentation in our

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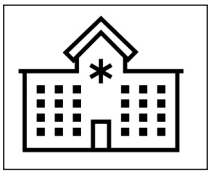
psychiatric wards and the literature of Com-1[32]. These seizures have neither an organic nor a neurological aetiology[10]. An Italian sample of FD patients revealed refractory or psychogenic epilepsy[10]. In psychiatric hospitals, particularly in children and adolescents, psychogenic epilepsy might sometimes take on the characteristics of an "epidemic dissemination" among female patients in the same ward. Patients with no signs of epilepsy should have their anticonvulsant medications withheld while being monitored appropriately[33]. Settings have been found to characterise the typology of the syndrome. For instance, female patients with Com-1 in an adult or adolescent psychiatric ward are usually guided by the alpha patient or patient leader who can recruit more naïve patients and "spread" her current factitious presentation, for example, pseudo-epileptic seizures, dissociative states, or ways of self-harming (e.g., head banging)[9]. These female patients then spend the rest of their time in their hospital bed or restrict their life to a wheelchair as presenting with pseudo-paralysis and might become doubly incontinent despite multiple exams excluding an organic cause of their presentation. To prevent needless surgical therapy for these patients, a firm diagnosis of hysterical paralysis, psychogenic low back pain, and appropriate treatment are clinically crucial[34]. As previously proposed, these presentations might suggest FND for which severe underlying personality disorders have been found in the assessment[35].

Some strategies for diagnosis



Vignette No 2. This vignette is about a prototypical woman in her 30s who often self-referred to EDs or community psychiatric teams with various medical ailments, including chronic pain and insomnia, and multiple remedies from separate prescriptions collected from different family physicians and overdosing on them. She also had a history of polysubstance and alcohol misuse. Symptoms were reported as starting after she claimed being raped by her previous partner, a known drug user in the community. The patient said that she had had several medical assessments, all of which yielded negative findings showing that the numerous illnesses she thought she was suffering could not be confirmed, such as intestinal blockages, paralysis, epilepsy, severe pain and constant dizziness. She had chronic long-term admissions as her behaviors, complaints about staff, physical symptoms, anger, frustration, and psychological distress, including suicidal ideation, appeared to escalate whenever she was informed during ward rounds or at the ED department that the staff was happy to discharge her home. She reported command auditory hallucinations to harm herself by walking in front of cars, which paradoxically intensified when she was informed about her discharge. Her mood was constantly threatening, angry, and making false allegations against staff.

In Com-1 cases, presenting with a fictitious physical or mental illness for admission to EDs is the more frequently recorded way to access a hospital. Assessment should include collateral history from parents or relatives, friends, paramedics, and access to clinical records from family physicians[36]. A former diagnosis of BPD could also direct towards an early diagnostic hypothesis of the Com-1[37]. Female patients are more at risk for Com-1 comorbidity[9].

Disentangling comorbidities

Vignette No 3. This vignette is about a prototypical man in his 40s with a history of polysubstance abuse and antisocial personality disorder. He provided physicians with a falsified list of drugs he was ostensibly taking before admission. Whenever he self-referred to ED, he reported reasons why he should be prescribed benzodiazepines, antipsychotics, anxiolytics, ADHD (attention deficit and hyperactive disorder) medication, and psychotropic medicines. Whenever he was assessed in ED, he used embellished stories about his psychiatric symptoms and psychosis with auditory hallucinations, which did not find confirmation in our records as he was already known to our services as an inpatient with former admissions. On occasions, he would start to shake, have jerks, have altered gait, walk with crutches, reporting foggy mind or forgetfulness. The diagnosis of psychosis was already ruled out during former assessments. He had frequent admissions to ED after he called the Police, mentioning that he was about to jump from the local cliff (high precipices on UK coasts). He reported feeling suicidal and wanting to end his life as being homeless, financially broken, and having no future. His recent admission was triggered after he had a fight out of a pub and was found intoxicated from alcohol. He always resisted being discharged home and became physically threatening when the local liaison team tried to discharge him to the community with crisis team follow-up. Eventually, hospital security was frequently involved in reducing his agitation and aggression and on multiple occasions, it was necessary to use physical restraint and rapid tranquillisation medication (lorazepam and olanzapine).

Some male patients with the comorbidity Com-1 might present with complex and embellished reported stories about psychiatric symptoms, psychosis,

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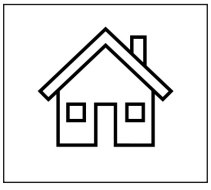
auditory command hallucinations to kill themselves (including threats to or from others), ADHD, epilepsy, and suicidal ideation. Male patients with the Com-1 might also present with pseudologia fantastica[38]. As from the vignettes, patients with comorbidity, especially men, might also have other psychiatric conditions, such as antisocial traits, substance and alcohol misuse, and other personality disorders[39]. Furthermore, individuals with Com-1 are often unwilling to provide personal information during psychiatric assessments and are cautious and inaccurate when disclosing their medical histories, which makes the diagnosis difficult[40]. Therefore, management and therapeutic alliance are constantly at skate in this case.

Moreover, cooperation between medical and psychiatric professionals is required to treat these patients since comorbidity diagnoses must be supported by data from studies and outcomes from practitioners in other medical and mental disciplines who have treated the same patient recently or in the past[41,42]. Furthermore, the symptoms, relationship problems, and therapeutic results are more pronounced when chronic depressive illness and personality disorders coexist[42]. In this case, psychiatric management becomes challenging because unresolved conflicts, unmet long-term social needs, and a history of abuse during childhood might have made it more difficult for Com-1 patients to elicit empathy and attention from others through traditional communication techniques or by downplaying the severity of their mental and physical symptoms[43]. Additionally, individuals with Com-1 might believe that the only way to get support from primary or secondary carers is to self-refer to hospitals by feigning severe sadness and incapacitating physical symptoms to gain the desired attention, treatment, or admission the fastest way[43]. Hence, coordinating different professionals during medical-psychiatric assessment and treatment is essential for a good result and for preventing the misinterpretation of patients' physical and mental symptoms or making diagnostic errors[44]. Furthermore, epochal changes have reduced the social buffers that could eventually address early existential crises in the general population before it, voluntarily or involuntarily, chose to transform its problems and cry for help into factitious disorders to access limited medical, social and financial resources[5].

Factitious psychiatric symptoms



Vignette No 4. The case concerns a prototypical male patient in his 50s who presented with a history of persistent depression and suicidal ideation and plan. He explained to ED a recent episode where he tried to put his flat on fire while on overdose or prescribed medication after splitting from his ex-partner. At the moment of assessment, he was homeless and living in the local hostels. He also had a history of unemployment, divorce, low family contact, reliance on social welfare assistance, alcohol abuse, social isolation, insomnia, diffuse pain, forgetfulness, dizziness, and vertigo. Our services already knew him with a similar presentation. During the assessment by the liaison psychiatric team at the local ED, he regularly claimed to have severe depression with suicidal thoughts and intentions. He requested regular admission to a psychiatric hospital; otherwise, if not granted, he threatened that he would commit suicide. Because of these claims, he was often kept in the ED department for observation, lasting 24 hours, until the liaison psychiatric team agreed on a plan for community support as there were no acute presentations or enduring mental illnesses that could be confirmed, apart from parasuicidal behaviour with maladaptive coping strategies. This person who was repeatedly admitted to our hospital with a series of crises and reported suicidal ideation or psychiatric symptoms has never shown objective, behavioural or clinical signs of depression. Short "social" admissions to psychiatric wards appeared to normalise his presentation with care plans for further community support.

Successfully convincing healthcare providers by faking or exaggerating symptoms might confer benefits on Com-1 patients, including attention; complete care in the hospital; access to controlled medications such as sedatives, painkillers, and antidepressants; a place to stay; invasive surgical procedures; and a chance to engage in low-risk parasuicidal behaviour close to emergency services[5]. Furthermore, we hypothesise that, due to economic hurdles, increased homelessness, difficulty escaping domestic violence, social isolation, and unemployment, some persons might opt to approach a hospital to access shelter, food, restricted medication, and social support by faking symptoms of any kind[5]. The increased cost of housing, homelessness, unexpected unemployment, or recent immigration with no work contract might be social forces for malingering[45]. The benefit of a free hospital bed and roof and access to restricted medications (benzodiazepines, sedative-hypnotics), even for a short period, should be considered as other triggering variables[5].

Psychiatric patients with Com-1 might share their experiences and "skills" on social networks like YouTube and other sites. During hospital investigations, female patients with BPD might also broadcast unauthorised videos of ward staff and premises with derogatory comments about how they are allegedly treated in the hospital. They might use these means

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to diffuse false allegations about staff or the hospital or as an act of revenge that their symptoms were questioned and that their claimed illnesses and requests did not receive full confirmation or satisfaction from ward doctors.

As mentioned before, malingering includes *both* physical and/or psychiatric symptoms. In our experience, feigning psychotic symptoms occurs more frequently among unemployed, middle-aged men with comorbidities, including antisocial behaviour and pseudologia fantastica, who become so entrenched in their pseudo-psychosis that they have become unable to improve their symptoms[38]. The expression "instrumental psychosis" also refers to individuals with an unverified history and unconfirmed diagnosis of prior psychosis who consciously fake psychotic symptoms or obstinately claim it to obtain benefits like housing or living allowances[46,47].

On the other hand, most frequently falsified is the presence or intensity of suicidal ideation and plans, probably because their declared existence mainly warrants admissions to a psychiatric hospital for further assessment or delays a discharge from ED. However, any idea or plan of suicide should not simply be based on a patient's self-report with statements like "I'm feeling suicidal"[47]. Suicide attempts can be described with varying degrees of confidence as objectively demonstrated or subjectively disclosed but contradictory with chart check or collateral history[48]. Practitioners who assess these patients, who frequently present to the ED[48], might find it challenging to discharge them once suicidal ideation is reported to the assessment team; the risk of professional investigations is too high to take the risk. Cases of more commonly reported statements like "I'm feeling suicidal" might instead suggest dysthymia accompanying social triggers for female BPD crises, such as a recent relationship split, conflict with primary and secondary carers, and holiday break of primary care coordinators[49]. Sometimes, in the case of those women with BPD who also have a history of polysubstance misuse, we might discover more subtle plans by proxy from a male partner to "get some Lorazepam to take home from the ED" hence instigating their partner to feign severe and anxiety which, allegedly, "in the past benefitted from anxiolytic medications"[49]. The frequently reported statement after self-referral in ED is, "I'm feeling suicidal, and I'll kill myself if you discharge me", might conceal recent crises or strong emotions, such as anger, fear, despair, paranoia or anxiety that the patient feels unable to cope with should s/he be left alone or at home[49]. On the other hand, triggers for FD in males with the syndrome might be recent economic hurdles, problems with the Police, or homelessness, which might incite them to try the "madness pathway" to avoid persecution or a night sleeping rough; at presentation they frequently claim to be "psychotic" or "paranoid" or "I hear a voice telling me to kill myself" although no objective evidence is found after constant clinical and interprofessional assessment, nurses' observations and exchange of data between health carers[49,50].

A frequent self-reported comorbidity among female patients with BPD is "bipolar disorder" or "I'm bipolar"; however, the reported symptoms are likely caused by cyclothymia, which is categorised by prolonged turmoil of mood with recurrent periods of mild depression and mild elation. These mood swings start early in adulthood and have a chronic course, but they are typically not associated with significant events in the person's life[4]. Nonetheless, according to comprehensive research, around 20% of BPD patients also have bipolar disorder; 20% of people with bipolar II are diagnosed with BPD, and 10% of people with bipolar disorder are diagnosed with BPD[51].

Factitious physical symptoms

Vignette No 5. A prototypical female patient in her 20s with a history of psychiatric admissions in regular adult wards. She was diagnosed with pseudo-seizures when in the ward, as all neurological investigations resulted negative for true epilepsy. She had a comorbid diagnosis of autistic spectrum condition and attention deficit and hyperactive disorder. We explored possible environmental factors which could trigger the fits finding that these were more frequent during idle time when no one engaged her in occupational activities. We constantly referred her for specialist investigations, resulting in negative results for any pathology. She was presenting with symptoms of what we felt was an extended FND, and after a few weeks of apparent well-being, she developed paralysis of her legs, which could not find a neurological cause. Relapses usually occurred after the visit of her mother and sister in the ward. The sister was referred to by her mother as "successful and not problematic", and this comment appeared to trigger her episodes. She remained bedridden and became doubly incontinent. The support plan increased, and two nurses were allocated for continuous observation arm reach twenty-four hours daily. Her affect was flat, and her mood was mildly depressed; she did not display signs of aggression, reported auditory hallucinations commanding her not to eat, and was afraid of losing control of her life. Eventually, she stopped eating and requested to be on an NG (nasogastric) tube. In addition, she developed subcutaneous pockets where she regularly inserted pens and metallic objects and refused antibiotic medication to reduce the recurring infections.

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Factitious gastrointestinal disorders occur primarily in female patients with the syndrome who are willing to be on NG tubes because preferring this procedure without being diagnosed with an eating disorder. They are often discharged home with NG tubes and can live uneventfully. Also, the literature confirms the volunteer aim in this direction. There is a case description of a young lady who purposefully refused to eat and insisted on having a feeding tube installed[52]. Other fabricated intestinal pathologies, such as gastrointestinal bleeding brought on by the wilful and futile consumption of hazardous chemicals, lithium batteries, sharp objects or razor blades, might result in internal bleeding and even death. Although lengthy examinations and gastrointestinal endoscopy or nasogastric tubes may be the covert secondary gain of many female patients in adolescent and adult psychiatric facilities, fictitious gastrointestinal bleeding may not have immediate benefits from surgery[53]. The solution might be using cognitive-behavioural approaches with positive and negative reinforcements, token economy, and milieu therapy[54].

Factitious dermatological disorders occur when patients with the syndrome have self-inflicted skin wounds that result in infection. Patients often refuse antibiotic therapy, which risks sepsis and acute hospital admission. Often, patients with Com-1 create subcutaneous pouches where they constantly insert foreign bodies requiring constant surgical attention. The use of genitalia cavities is another route for inserting foreign bodies. The clinical picture comprises artefactual skin illnesses caused by intentional or unconscious self-mutilation by cutting, rubbing, scratching or para-artefactual manipulations of pre-existing dermatoses; the skin is a BPD target organ[55] (tables 2 and 3).

Table 2. Prototypical behaviours of FD-BPD-DY[a] syndrome in primary and secondary care.

Behaviour	Characteristics and consequences
Factitious behaviours	Claiming to have severe physical and mental health problems while they might be more moderate than the disclosed severity, e.g., "severe pain, severe depression, severe suicidal ideation".
Self-inflicted wounds and illnesses	Raising concerns to healthcare professionals that result in successful self-referral to emergency departments.
Presenting with unexplainable medical and surgical symptoms	The unexplainable medical and surgical symptoms might warrant long and complex invasive investigations.
Claiming a history of "rare and undiagnosed diseases"	Reporting a history of a rare illness that, as they claim, has never received full attention from medics and which warrants further and complex diagnostic investigations or invasive procedures (e.g., gastroscopy, colonoscopy, nasogastric tube).
Claiming constant and intense pain	The consequence is the indiscriminate use of prescribed painkillers. There is a discrepancy between subjective (disclosed pain) and objective (pain behaviour) presentations. They are affected mainly by painkiller addiction.
Medication shopping	They might access different healthcare services or family physicians, each unaware of the others, resulting in multiple prescriptions of restricted medications.
Frequent emergency departments attendees	Recurrent admissions to hospital emergency departments in short periods. They tend to sabotage routine referrals by bypassing family physicians' or community health carers' referrals. Self-referral is expected, as well as police referral if found in public places while displaying hazardous behaviours, e.g., on a bridge with the "alleged intention" to jump, at the train station with the "intention to jump in front of a train," "on the beach intending to jump from the pier," and "wandering and walking amid the road traffic or on motorway edges."
Escalation of factitious behaviours when the attention of the staff is lifted	Displaying behaviours that need increased attention from staff in general or psychiatric wards as presumably at risk for self and others. The default response from professionals is to allocate constant visual checks and close physical supervision from two or more staff members (e.g., "one-to-one supervision").
Making false allegations towards staff when thwarted or when their behaviour or symptoms are challenged	Apparent escalation of psychical and psychiatric symptoms, including declared suicidal ideation when staff challenges their presentation or attempts to establish a therapeutic alliance to these patients or promote their responsibilities.
Claiming multiple allergies to proposed medications	Aim to exert control over the prescribed medication to drive health carers to prescribe what they desire; for example, sleep medicine, potent sedatives and benzodiazepines, and high dosage of antidepressants.

Note:
[a]Factitious Disorder-Borderline Personality Disorder-Dysthymia.
[b]Biographical data omitted for confidentiality.

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Table 3. Factitious and real symptoms of FD-BPD-DY patients, according to the authors' experience.

Symptoms	Real or presumably real	Factitious, exaggerated or prototypical symptoms of FD-BPD-DY
Auditory hallucinations	Egosynthonic, linked to underlying dysthymia.	Egodystonic, not related to the declared mood.
	Outside the head or room. Hearing people gossip about themselves.	Inside the head or on its side, near the ears.
	Male or female talking or commenting about the patient (third person). Patients might shout at the voices to silence them.	Second person, usually a command telling the person to "kill herself" and that "she should be dead". Most often, female BPD patients attribute male voices to the person who raped them when they were adolescents.
	Difficult to disclose as the patient forms an alliance with the voice which instructs the patient not to reveal as this would attract negative consequences for self and others.	Eager to disclose what the voice says.
	Simple words, mumbling, whispering, unclear content.	Complex and articulated phrases, long sentences attributed to the voice. Commanding second-person auditory hallucinations suggesting self-harm.
	For a few seconds or minutes per day. Can be reduced by listening to music with headphones.	Constant, "24/7".
Visual hallucinations	Simple, shapeless, not fully formed, triggering an emotional response. Seen in front, in the direct visual field.	Complex, linked to mood, sometimes scary, such as seeing blood, seeing mutilated bodies, seeing bleeding people. Shadows are seen from the corners of the eyes.
Tactile hallucinations	They might be linked to organic causes. Feeling touched on the shoulder.	When present, they have a sexual reference and are a flashback of former sexual abuses.
Sense of presence	Linked to epilepsy or organic causes. Normal bereavement reaction.	Feeling the presence of the past perpetuator/s of violence. Feeling that he is still around and exerting influence.
Olfactory hallucinations	They might be from organic causes (e.g., burned tire or toast).	They are linked to a history of abuse, e.g., the smell of male aftershave.
Ideas of reference	Believing that people might be ready to attack and harm them.	Believing that people gossip and criticize them because of their appearance (e.g., being fat, being slim).
Depression	It is not directly reported. Feeling "down"; appearing flat or objectively depressed, tearful, dispirited, subdued. Limited physical activity, poor sleep, and poor appetite.	Subjectively high but inconsistent with ward/nurse behavioral observation, which reports patients are having a conversation with others, are smiling, are active and focused and have good sleep and appetite. At times, factitious eating disorder to access long-term nasogastric tube.
Diurnal variations	Not present.	Worse in the late afternoon and evening, with sundowning syndrome and flashbacks; in the wards during nurse shifts and decreased staff presence.
Weekly variations	No link.	Worse during the weekend, Fridays, Saturdays and Sundays evenings, with admission to ED.
Setting variations	Worse during interpersonal interactions, paranoia, living isolated and adrift from the community, not being interested in others.	They might live in their flat, with social withdrawal from all activities, spending most of their time "doing nothing," "watching TV," and missing educational and interpersonal engagement.
Interpersonal variations	Become suspicious, alert, guarded, or irritated during interviews.	Report feeling relaxed from the interview and having a considerate practitioner looking into their case.
General hospital or psychiatric admission	Resisted.	Welcomed or sought.

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Continue **Table 3.**

Symptoms	Real or presumably real	Factitious, exaggerated or prototypical symptoms of FD-BPD-DY
Capacity and insight	Denies mental illness.	Accept the diagnosis of depression or bipolar disorder but might resist the diagnosis of personality disorder.
Behavioral involvement	Might accept to be involved in activities.	Resist any attempt to be involved in any activity; disengaged.
Reaction to diagnosis	Accept more benign diagnoses or diagnoses of mild degree of their pathology.	Challenge more benign diagnoses or mild degree of their pathology.
Reaction to mental health compulsory section	They are grateful when the mental health section for mandatory admission and treatment is lifted or not proposed.	Presentation deteriorates as soon as a mental health section is rescinded; would escalate in behavior to suggest that mental health section is the "only" way to keep them safe.
Paranoia	Refers to the belief that there are people who are after the patient to harm him, kill him, or steal important information from him (e.g., by implanting microchips in the brain).	Commonly refers to the belief that people gossip about them or that laugh because of them or their appearance.
Interpersonal disclosure	Usually truthful and guarded.	Usually lying; constructing false allegations against staff.
Stable sexual relationships	Usually absent; not in a stable relationship; social drift.	In conflicting relationships from which they feel they cannot escape; violent partners involuntarily sought as a form of self-harm or repetition of a lethal life script of ancient abuses.
Reaction to psychotropic medication	Resisted, rejecting initiation, change or increased dosages. Prefer oral medication.	Sought, desiring new and more medication, antidepressants, mood stabilizers and increased dosages. Would falsely escalate in aggressive or self-harming behavior in a psychiatric ward to "access" (?) intramuscular rapid tranquillization (e.g., Lorazepam).
Interaction with primary carers	Distrustful, paranoid, avoidance; disengaging from community mental health services.	"Attract-Attack" behavior by deceitfully forming a strong link with a carer to make false sexual or physical abuse allegations against him or her thereafter. Raising serious complaints. Making false allegations, recording conversations between doctors and nurses without notification, frequent use of helplines, and having limitless and stressful interactions with care providers during frequent crises.
Use of social media	Sometimes quarrelsome paranoia with multiple letters of complaints to national and international agencies. They might post videos of themselves on YouTube. Believe that they have unique and famous friends.	They might take photos and short videos of the inside of the wards and post them on social media with inflammatory and non-factual remarks towards psychiatric personnel. Recording conversations between doctors and nurses without notification. Falsifying events to achieve secondary gains. "Frequent complainers".
Behavior inside wards	Socially isolated, reduced social interactions, flat affect, violence as a sign of paranoia, disorganized, isolated in their rooms.	Female patients with BPD form cohesive groups with an alpha leader who is the most experienced; gamma patients are usually newly admitted or less experienced. The alpha directs "ways of behaving in the ward, ways of group self-harm" and provides instructions about when nurses' shifts allow more undisturbed self-harming behaviour.
Referral to a general or psychiatric hospital	Referred by police, referred by GP or by community teams.	Self-referral or transferred by ambulance or police if found wandering along roads, bridges, or overdosing.

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Discussion

Undiagnosed Com-1 can result in lengthy or unnecessary admissions, medical and surgical investigations, and legal complications that affect practitioners and the whole healthcare system. As this phenomenon is expanding and verified in other countries, detailed knowledge of its character will likely help different healthcare sector sectors.

Regarding the causes, a correlation study found a link between FD, early childhood abuse and drug use[3]. According to our former studies, a problematic population might employ fake symptoms to assume the patient's role and gain hospital admission as a temporary escape from economic and social hardships, homelessness, loneliness, recent crises, and social conflicts[56]. Com-1 patients might seek access to potent analgesics, opioid-based drugs, and higher dosages of antidepressants, sleep aids, and psychotropic drugs; they also seek long-term admission to a general or psychiatric hospital by exaggerating their physical and psychological symptoms[13]. Patients with FD may use various strategies to obtain medications, including fabricating surgical signs to receive surgery and more potent (or higher dosage) medications[57]. Other times, the aim is to access restricted medications or higher dosages of the prescribed ones, such as antidepressants, anxiolytics and benzodiazepines[58]. Other times, patients with comorbidity may approach doctors trying to deal with other untreated psychiatric illnesses or to anaesthetise mental or emotional distress[59].

The comorbidity has increased the load of admissions into psychiatric and general hospitals in some areas corresponding to meaningful decreases in the socioeconomic conditions of the adjacent population, with self-referral to hospitals reported as an emotional response to social isolation, emargination, depression, unemployment, and other conditions[5].

Compared to patients without MUPS, patients with MUPS might spend up to twice as much on healthcare each year, which results in extensive diagnostic testing, hospital stays, unnecessary opioid prescriptions, and treatment that is not patient-centred[20]. According to the most significant research on comorbidity rates, persons with MUPS are more likely to have affective disorders, such as depression or personality disorders (50.6%), in later life[22]. There is also an association between MUPS, panic disorder and substance abuse; nonetheless, these patients are seen by a psychiatrist very late in their history of illness[60]. Psychological and social risk factors for MUPS are a history of violence or child abuse; furthermore, men frequently report paraesthesia (17.3%) and epileptic crisis (15.2%), while women headache (30%), paresthesia (16.2%), epileptic crisis (10%), and vertigo (8%)[60]. Another study discovered a prevalence of married, female, and working patients and personality disorders in MUPS patients[61]. Internal medicine, neurology, and the short-stay unit are the most often used units in MUPS, and the most frequently reported symptoms are headache, pain, syncope, and vertigo[61]. Some authors suggest the comorbidity or similarity between MUPS and factitious disorder in a case where malingering pain leads to a high dosage of painkillers prescribed[62]. Literature reports a case of hallucinosis not responding to medication, the willingness to accept psychiatric admission, and increased intensity when the patient was near discharge[63].

There is also a 60-80% prevalence of female patients with FND with seizures that have an onset in the late 20s, while FND movement disorders prevail in the late 30s in the male gender, including tremors, jerks, myoclonus, gait imbalance, limb weakness, and generic motor dysfunction[22]. FND is classified as "conversion disorder/functional neurological symptom disorder" in the chapter "Somatic Symptom and Related disorders, code F44.X" in the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5)[64]. Criterion A of the DSM-5 requires "One or more symptoms of altered voluntary motor or sensory function", this means that patients present with neurological symptoms, and when these concern motor function (F44.4), they can be divided into two broad categories: negative symptoms (lack of movement, weakness) or positive symptoms (abnormal movements such as tremor, jerks, dystonia, and others); symptoms can also occur in brief episodes and resemble an epileptic seizure, encompassing the functional seizure (F44.5) diagnosis[64].

FND symptoms range in type and include abnormal sensation, abnormal control of movement (such as weakness, tremor, or dystonic posturing), episodes of altered awareness that resemble epileptic seizures (functional/dissociative seizures), and cognitive difficulties[65]. In people with FND, pain – including chronic migraine – fatigue and the subjective experience of "cognitive fog" are pretty standard[65]. It is possible and frequent the occurrence of functional and organic neurological disorders in the same patient simultaneously or at different times of life; comorbid neurological conditions occur in approximately 20% of cases of functional disorders; about 2/3 to 3/4 of patients with FND have psychiatric comorbidity[66]. Major depression has been reported in 32% to 43% of cases of FND, an anxiety disorder in 62% to 79%, posttraumatic stress disorder (PTSD) in 23%, dissociative state in 47%, somatisation disorders in 27%, personality disorder in 45% to 74%, borderline personality disorder in 34%[35]. Several studies pointed out that childhood trauma, specifically physical or sexual violence, emotional or physical abandonment, and a more significant number of stressful life events

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and traumatic episodes are present in patients with FND[66]. Patients with FND often return to the Emergency Department (ED). Their symptoms have historically been seen as challenging to treat in the ED; they may appear abruptly with symptoms comparable to epileptic seizures, strokes, or other neurological diseases[67]. In our sample, we found female inpatients in inpatient psychiatric or medical wards diagnosed with BPD, cases of acute paralysis (paraplegia), and doubly incontinence, leading to difficult-to-treat complete dependence of these patients on the physical support from staff[68].

Interactions with primary and secondary carers

If ignited by FD, even the most common manifestation of deliberate self-harm (DSH) might harbour a glimpse of malingering behaviour, intensifying worries and attention from hospital staff. This condition can generate, at times, a cascade of unnecessary diagnostic tests or treatments, such as intramuscular medicine for quick tranquillisation or an inappropriate increase in antidepressant or sedative prescriptions[69].

In general, corporate or local management of the comorbidity is challenging, and areas of unclear information about the patient's condition might hinder the care plan. Patients might not collaborate to disclose what former doctors diagnosed about their case or might give conflicting information about their current family doctor[70]. Patients with Com-1 are demanding inpatient management as they might require constant assessment and complex diagnostic decisions from health professionals to evaluate ongoing symptoms, alleviate their alleged pain, or screen the need for further medical treatment[70]. The degree of physical and emotional symptoms are challenging to assess in persons with the comorbidity as also reported suicidal ideation or severity in depressive symptoms were sometimes found, after a second analysis, being driven not entirely from genuine accounts, especially during acute admissions to hospital or ED[71]. In primary care as well, there are also cases of FD and comorbidity of depression, anxiety and somatoform disorder in up to forty per cent of cases[72].

Hence, due to the complexity of diagnosis and treatment, it is advocated that health carers in primary and secondary care could conduct unobtrusive behavioral observations or long-term assessments to disentangle the difference, for example, between subjective and objective depression, anxiety or pain with inpatient settings being the most adequate for this valuation[73].

The management of persons with Com-1 requires agreed-upon and tailored plans and constant interprofessional handover among all primary and secondary practitioners involved in patient's care, as complying with medical and surgical investigations solely based on patient's accounts might impact evidence-based practice; hence, the need for effective communication between patients and their doctors is critical[73]. If not correctly identified, the risk of missing the diagnosis could be overprescribing drugs guided by the "subjective" accounts of these patients who approach mental health and ED facilities, believing that if they convey intense psychological symptoms, they can get help[74]. But EDs are also where mental health professionals work to extract from patients' multiple and dramatic accounts the underlying diagnosis and filter, whenever possible, any intention of malingering, which, in any respect, is still a sign of distress[75]. Therefore, persons with Com-1 are more likely to seek frequent hospital admissions, increase their use of all psychotropic medications, report incorrect paracetamol overdoses, and self-refer to EDs to deal with ongoing emotional, social, and financial crises that cannot be resolved at home or autonomously[76].

For therapy to be completed successfully and to support a successful discharge into the community, there must be a therapeutic alliance with patients with FD[73]. However, there is a risk that individuals with Com-1 may leverage the therapeutic alliance to obtain unnecessary diagnoses, treatments and hospital beds that are unnecessary[73]. The authors, who practice liaison and general adult psychiatry, discovered that any medical or psychological symptoms might be fabricated, including pain, epilepsy, gastrointestinal obstructions, severe depression, suicidal thoughts and plans, psychosis, and adverse drug reactions[76]. One study found that fifty per cent of adolescent FD patients had been reared in foster care; the same survey also discovered that forty-two per cent of the adolescents with FD had histories of documented sexual or physical child abuse[77]. Managing patients with these illnesses is challenging due to fragmented treatment; a good treatment is far less probable without trust, sufficient explanation, and comprehension[78].

The diagnosis of MUPS has recently been used to address similar presentations[79]. When physical complaints persist for over a few weeks, and a doctor cannot identify a physical issue with the body that may be the cause, they are sometimes referred to as MUPS; these complaints are common and include persistent pain and dizziness[80]. The reported frequency is for up to twenty percent of presentations in primary care; also listed five factors that contribute to maintaining MUPS: (1) physiological (autonomic dysregulation, central sensitisation, dysfunction of the hypothalamic-pituitary-adrenal (HPA) axis, and sleep disruption; (2) social (loss of role, medical uncertainty); (3) cognitive (catastrophic misinterpretation of symptoms, symptom

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focusing, and intolerance of uncertainty); and (4) behavioural (avoidance behaviour)[81]. Additionally, FND used to describe the same phenomenon, has been applied to refer to medically mysterious neurological symptoms that seem to be brought on by nervous system issues but are unrelated to any one illness or physical condition[82]. A person with FND may have headaches, migraines, or dizziness as well as troubles in moving, such as difficulty walking or controlling arms and legs, balance issues and tingling or twitching throughout the body; visual alterations, such as blurred vision; discomfort that is often difficult to pinpoint and exhaustion[82].

We hypothesise that FD, DY, MUPS and FND might coexist, represent the same picture, have the same underlying psychopathology or suggest a common denominator and phenomenological trigger, which we assume is linked to BPD.

Limitations of the study

Vignette-based clinical cases can carry a clinical bias[83] and reduce clinicians' likelihood of basing their decisions on non-transferable medical circumstances. Furthermore, there is no published advice or assessment of this approach despite the potential influence of vignette-based utilities on medical decision-making[84]. It is common practice to evaluate judgements and decision-making processes using vignette-based methods, particularly clinical decisions made by healthcare practitioners[85]. Yet, the validity of the findings and conclusions of this research has sometimes been questioned due to concerns that vignettes may not fully represent "real world" occurrences[85].

Conclusions

The current study aimed to highlight a pathology that is becoming more frequently found in ED and liaison psychiatry worldwide. Speculations have been attempted to explain the increase in these presentations, suggesting possible epochal changes in how the general population approaches any aspect linked to its health and the idea of care and caring. We have proposed some explanations and theories to provide practical examples and guidelines for recognising and eventually approaching patients with comorbidity Com-1.

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Ethical aspects: all cases were anonymised, and biographical data were changed into vignettes, ensuring anonymity. After altering personally identifiable data, ethical approval from the hospital committee was waived. The accounts are retrospective, and identities and locations are concealed or altered for privacy.

Conflict of interests: the authors have no conflict of interests to declare.

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