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INSTRUCTIVE CASE

Factitious disorder of a 17-year-old female during COVID-19 pandemic

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Case Report

It was a quiet Spring Friday morning when I was asked to examine N, a 17-year-old adolescent female, in the paediatric Emergency Room (ER) after she had tried to infect herself with COVID-19.

The previous evening she had presented alone to the ER of a 1000 bed University affiliated hospital complaining of a pruritic rash. She was examined by a paediatric resident, given loratadine 10 mg and requested to wait for a social worker assessment the following morning.

During the course of the night, N absconded from the paediatric ER and returned after 2 hours claiming that she had tried to infect herself with COVID-19 by reusing a thermometer, which had been used some minutes earlier by a febrile elderly COVID-19 positive patient.

There was no evidence of recent physical illness. She was afebrile, with no cough and good entry in both lungs. Her oxygen saturation was 97% with room air. N's rash had been documented in previous ER presentations and she had been diagnosed as suffering from dermatographism with chronic urticaria.

N explained her behaviour as a way of developing immunity to the COVID-19 assuming that, given her age, she was at low risk of suffering significant manifestations of the illness. She requested to be tested for COVID-19 and if the result was positive she expressed interest in spending her enforced quarantine in a hotel provided by the Israeli Ministry of Health for this purpose. If the result was negative, she agreed to be discharged from hospital and to return to her room. N was being observed in a room in the paediatric ER designated for COVID-19 quarantine with constant observation by a hospital security staff member.

N has presented to the paediatric ER of the same hospital on a number of occasions related to family discord. She was being reviewed by social services with involvement of the family court. Like the rest of the country, she was obliged to remain at home because of the COVID-19 pandemic. She had little contact with her family and was living alone in a room provided to her by social services.

N was studying her second last year of high school from home and had almost no structured daily routine.

She denied use of alcohol, illicit drugs or cigarettes. She also denied a history of trauma, physical or sexual trauma. She denied a history of psychiatric treatment or self-harm.

On examination

N was examined by means of video telephone call as a precaution against COVID-19 infection given that the examining psychiatrist (SJ) was over the age of 60.

The duty social worker (CA) participated in the interview. N at times cooperated throughout the interview. However, she refused to give her parents' contact telephone number. N's affect was euthymic for the most part and at times suspicious. At times, her affect was not appropriate, for example when she was happily describing her motivation in attempting to infect herself with COVID-19.

There was no evidence of delusions, hallucinations or formal thought disorder. N's insight was lacking but formal judgement was preserved. She demonstrated reasonable cognitive ability in trying to justify her behaviour.

There was no evidence on the hospital security camera footage in the ER to verify N's claims.

Contact was made with N's parents and also social services staff who cared for her in the community.

The emerging clinical picture of N was a 17-year-old female with a significant discrepancy between cognitive and emotional abilities in favour of the former with longstanding difficulties in effectively sharing her emotional difficulties. Two years ago, N had demonstrated risk-taking behaviour while crossing the road. She refused to participate in psychiatric or psychological treatment. She was described as being rather solitary with only a few

Key Points

1. Minors with a past psychiatric or complex social history in the paediatric ER should be supervised by designated hospital staff in the absence of parents or legal caretakers.
2. Where factitious disorder is suspected, the physician should show relative disinterest in the fabrication, yet maintain interest in the patient so as to strengthen the therapeutic alliance.
3. The contextual difficulties of the patient managing the COVID-19 social distancing restrictions should be taken into account in the management plan.
4. In order to contain COVID-19 in designated hospital wards, it is important to prevent COVID-19 negative patients from entering these areas using hospital security staff.

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friends. However, there was no evidence of repetitive behaviour in speech or play or difficulties with dealing with change.

When the negative security camera findings were discussed with N, she maintained her claims, rationalising it was the wrong footage.

When the possibility of her discharge was raised, she appeared shocked that she was being permitted to infect others in the community with COVID-19.

Discharge diagnosis

1 Factitious disorder imposed on self.
2 Underlying alexithymia.
3 Parent-child relationship difficulties.

Discharge plan

N was discharged to ongoing social services review with ongoing treatment focusing on alexithymia both on a one to one and also in a group setting. It was recommended that N participate in a supervised exercise program at least 200 min per week.

Discussion

To the best of our knowledge, this is the first report of a COVID-19 related factitious disorder. It is important to address the psychological and social dimensions of this pandemic including the risk of increasing preexisting difficulties with loneliness and isolation. The need to address the unique personal and social context of the patient in order to understand and manage the emerging psychological symptoms has been described.[1]

At the time of N's presentation, there were 765 daily new cases of COVID-19 in Israel, a country with a population of 8 million.[2]

These difficulties are relevant to N who was struggling with the boredom and anxiety of the general quarantine restrictions of COVID-19, which gave rise to her plan to infect herself. It is necessary to take these considerations into account when planning a treatment plan.

Carers of patients suspected of suffering from COVID-19, in particular those at higher risk of serious infection, also need to utilise means for assessment and treatment such as telemedicine[3] to mitigate associated risks as much as possible.

The feigning of illness seen in N's factitious disorder was apparently motivated by an unconscious need for emotional support as a COVID-19 patient. There was no evidence of conscious external secondary gains such as exemption from army service as in malingering or for the unconscious mechanism of illness production seen in somatoform disorder.[3,4] It is important to diagnose this condition early so as to reduce the iatrogenic harm[5] and to optimise the prognosis.[6,7]

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