Case Report

A Case Report of 5 yr Old Boy with Malingering in Wesley Guild Hospital, Ilesa, Nigeria

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Abstract

There are few reported cases of malingering in children in developed countries, but none has been reported among Nigerian children. This could be because of missed diagnosis, thus creating the impression that malingering is rare in children. Ability to clearly establish that a client has a primary motive behind feigning the illness is a major to look for in malingering. We present a case of a 5-year-old boy with a history of recurrent abnormal body movement and shaking of his body which on detailed evaluation revealed the intention behind his presentation.

Keywords: Behavior problem, health problem, mental health

Introduction

Malingering is described as the intentional exhibition of false or grossly exaggerated physical or psychological problems. Malingering may occur in circumstances where the person wishes to avoid responsibilities or obtain compensation in situations where benefits might be given.[1] Motives of malingering in children vary from amusement, avoidance of physical and psychological discomfort, and material gain.[2-4] These clinical manifestations also often lead to a diagnostic dilemma as it is usually confused with factitious or dissociative disorders.[5] Malingering can also be confused with pseudoseizures, in which there are some involuntary movements, though often occur in patients who also have previous history convulsive episodes. Psychological issues or stress may be a trigger with secondary gain or for attention.[5,6] Pseudoseizures and malingering are two distinct entities. Malingering is completely voluntary and conscious, while there is often an involuntary component to pseudoseizures.[5,6] A high index of suspicion of malingering is made in clinical settings where the complaint is subjective and not accompanied by objectively demonstrable organic disorders.[2] A wrong diagnosis of malingering may unjustly stigmatize a client and deny him needed care, so proper and detailed evaluation is necessary. Psychiatric illnesses are attractive to malingers over their perception that such illnesses are easy to duplicate.[2-4]

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A 5-year-old male was brought by his grandmother with a history of recurrent abnormal body movement and shaking of his body. It was initially misconstrued as seizure or dystonic reaction without the loss of consciousness for 3 days. It was of abrupt onset and a fluctuating pattern. The client had no history of drugs usage such as antipsychotic or antiemetic that could cause abnormal body movement or dystonia. There were intervals of normal movement and behavior. He was said to be having 4–5 episodes of abnormal body movements per day. There was no history of muscle spasm, tongue thrusting, stridor, or dysphonia. There was no history of seizure at any time. There was no history of use of anticonvulsant at any time and electroencephalogram done was normal. The physical and neurological examination done on him was normal. His cognitive functions and psychometric evaluation done withdraw a person test was normal. Laboratory results, including a full blood count, blood film for malaria parasite, and blood chemistry (serum calcium, sodium, potassium, and bicarbonate), were essentially normal. He was sleeping

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well and was fully interactive and energetic in the ward. The child was initially managed as a case of dystonia; even though, no history of the use of drug that can cause dystonia. He was placed on iv fluid and diazepam 2.5 mg twice daily for 2 days. On the 3rd day, repeated abnormal body movement persisted even while walking without any fall. There was curiosity to look at malingering as a diagnosis in the child despite his age because of abnormal movement and gyration while walking without any fall which is not consistent with features of seizure disorder, pseudoseizure, or dystonia. The need to consider interaction with the child was encouraged to explore a positive outcome. The child was then instructed to display that movement voluntarily, and to our amazement, he was able to display the movement repeatedly and was able to abort the movement voluntarily. He was able to repeat this symptom and abort severally when instructed. Further history at this point revealed that child and grandmother had frequented kind of syncretic churches where worshippers fall into a state of religious trance, during which they gyrate their bodies rhythmically while delivering "spiritual" messages. On close discussion with the child, he revealed his perceived passion for the body movement learnt from the spirit-filled worshiper in the church and the attention he gets from the grandmother when displaying such movement. Adopting a nonjudgmental approach and gentle persuasion, the client was encouraged to tell the full story, and he expressed the passion he has for such movement and dance. He enjoyed mimicking the abnormal body movement because of the attention he gets from the grandmother any time he displayed it.

Discussion

There are was no recognized protocol to manage malingering if suspected. Each case is unique and will require an approach peculiar for the specific symptomatology, educational, and cultural background of the client and the secondary gain associated.[2,3] Malingering must be differentiated from factitious and dissociative disorders as well as pseudoseizure. In malingering, the client is aware of the primary motive behind the feigned symptoms.[2,3] While in factitious disorders, the client intends to adopt a sick role rather than achieve any other gain. In dissociative disorders, on the other hand, the person is not aware of the unreal nature of the symptoms but truly believes that they have the reported ailments.[2-4,7] A clear documentation and proper evaluation will promote a safe and supportive relationship to assist in eliciting possible underlying motivations.[8,9] The client's knowledge of psychotic symptoms must be explored. The nature of the secondary gain that is being sought must be unveiled. The client should not be accused directly of feigning illness or lying as this may jeopardize the doctor–client relationship.[10,11]

Conclusion

It is believed that malingering is difficult to diagnose in childhood and a high index of suspicion is needed to unravel the condition. This reported case has made us to realize that conditions such as malingering have not received due attention and diagnosis might probably be missed, thus creating the impression that the condition is rare in children. Malingering is also a diagnosis of exclusion. A detailed history must be taken, the client must be thoroughly evaluated, examined, and relevant laboratory investigations and psychometric evaluations must be done. Clinicians should be tactful, neutral, and nonjudgmental when managing a malingerer. The symptom inconsistencies must be presented to the client in a nonjudgmental manner and possible remedy offered. Clinicians should act in the best interest of the client in an ethical, legal, and professional manner.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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