done but he was managed for depression with several antidepressants with no improvement. He was also diagnosed with dementia and started on donepezil but nothing changed. He is currently psychotropics-free and following a retrospective diagnosis of IRDS and discussion with family, they were relieved that the correct diagnosis of XY's condition has been found.
Results: A physical illness appears to have triggered the regression in both cases. Personality and mood changes especially a manic presentation which is uncommon in people with Down syndrome were also reported. Psychotropic medications were not beneficial in at least the second case. In both cases, the diagnosis of Idiopathic Regression in Down Syndrome was an acceptable explanatory model for the family.
Conclusion: We hope clinicians will make the diagnosis more promptly thus facilitating quick access to adequate treatment.

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Between Intent and Illness: A Look at Malingering vs. Factitious Behaviours

Dr Amy Anyi

Greater Manchester Mental Health Foundation Trust, Manchester, United Kingdom

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Aims: Presented is a 33-year-old gentleman with a diagnosis of emotionally unstable personality disorder (EUPD) well-known to mental health services, including inpatient, community, liaison, and psychological care teams, with a long-standing history of self-harm and suicide attempts, which included deliberately placing himself in high-risk public areas which have at times resulted in detention under mental health legislation.
Methods: Over the past several years, this gentleman has fabricated claims of a cancer diagnosis, terminal prognosis, and multiple surgical procedures – assertions refuted by his medical records – while leveraging these falsehoods on social media and through a crowd sourcing campaign to raise funds by misrepresenting his physical health. Furthermore, he has strategically leveraged medical admissions to access medications, including strong analgesics and for a self-reported diagnosis that remains unverified.

During conducted assessments, he has expressed a desire for psychological therapy and enhanced crisis support yet consistently avoids engaging with the planned, regular support offered by teams who are familiar with his history, including appointments scheduled after episodes of self-harm.

While services have considered a factitious component in his presentation others contest it aligns more strongly with malingering. Consensus with professionals is that given his presentation there are difficulties in developing and maintaining a safe therapeutic relationship due to his disingenuity, threats of complaints, and his active avoidance of any meaningful, structured, recovery-focused work.
Results: Factitious disorder is driven by an internal need to assume the sick role and receive attention or care, with patients intentionally producing symptoms rooted in psychological need rather than for external rewards where the behaviour is characterized by a willingness to undergo invasive tests and treatments, reinforcing their patient identity. Factitious disorder is recognised as a psychiatric diagnosis warranting treatment, whereas malingering is motivated by external incentives and is not considered a mental illness but rather a behavioural strategy. Individuals who malinger tend to avoid procedures that might expose their deception and selectively engage in behaviours that yield tangible benefits.
Conclusion: This case underscores the importance of comprehensive, multidisciplinary assessments in achieving accurate diagnoses by clarifying key differences in motivation, behaviour, and clinical classification. Enhanced diagnostic clarity not only improves patient care, but also safeguards healthcare resources. Despite evident secondary gains in this case, the long-standing emotional instability and interpersonal dysfunction associated with EUPD still necessitate a balanced, empathetic therapeutic approach.

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Unmasking the Mind: A Journey Through Misdiagnosis to the True Identity of Dissociative Identity Disorder

Dr Nadia Amira Ashikin

Hospital Putrajaya, WP Putrajaya, Malaysia

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Aims: Dissociative Identity Disorder (DID) is a complex psychiatric condition that is often misdiagnosed due to its overlapping symptoms with other disorders such as mood and psychotic disorders. The presence of psychotic features, including auditory and visual hallucinations, disorganized behaviour, and memory gaps, can make the diagnosis of DID particularly challenging. This case study highlights a 27-year-old female whose DID diagnosis was delayed due to misinterpretation of her psychotic symptoms, which were initially attributed to other psychiatric disorders.
Methods: A 27-year-old female with a 15-year history of psychiatric care began experiencing symptoms at the age of 13, initially presenting with anxiety and panic attacks. Over time, her symptoms escalated to include episodes of auditory and visual hallucinations, disorganized speech, and erratic behaviour, leading to multiple hospitalizations. During one hospitalization, she displayed regressive behaviours, mutism, aggressive outbursts, hypomania, and dissociative amnesia. Despite extensive workups, including MRI scans and lab tests, no organic causes were found. Her diagnosis fluctuated between psychotic disorders, mood disorders, anxiety disorder, and dissociative disorder. Her mood and psychotic symptoms were initially treated as schizoaffective disorder, but the patient experienced adverse reactions to antipsychotic medications, including galactorrhoea from risperidone and weight gain from amisulpride. These medications were ineffective, prompting a reassessment of her diagnosis. A thorough review of her clinical history, including reports of memory gaps, identity disturbances, and dissociative episodes, led to the reconsideration of DID as the primary diagnosis.
Results: The psychotic features in this patient, such as hallucinations and disorganized behaviour, were secondary to her dissociative episodes, occurring during times of identity disturbance. This case underscores that psychotic symptoms in DID can easily be misinterpreted as part of a mood or psychotic disorder, especially when dissociative episodes are not initially recognized. The prolonged misdiagnosis delayed appropriate treatment, but a more comprehensive understanding of her symptoms led to the correct diagnosis and tailored management.
Conclusion: This case highlights the diagnostic challenges in identifying DID, particularly when psychotic features overlap with other psychiatric conditions. Early recognition of DID, with a thorough longitudinal assessment of both dissociative and psychotic