Factitious Disorder: Detection, Diagnosis, and Forensic Implications

April 15, 2007 | Somatoform Disorder [1], Attention Deficit Disorders [2], Munchausen Syndrome [3], Histrionic Personality Disorder [4], Hypochondriasis [5], Addiction [6]
By Allen R. Dyer, MD, PhD [7] and Marc D. Feldman, MD [8]

Few phenomena in medicine are more confounding than the diagnoses involving deception: malingering, Munchausen syndrome, Munchausen by proxy (MBP), and factitious disorder.

factitious adj. 1. Produced artificially rather than by natural process; contrived. 2. Lacking authenticity or genuineness; sham. [Latin facticius, made by art; from facere, to make, do]

Few phenomena in medicine are more confounding than the diagnoses involving deception: malingering, Munchausen syndrome, Munchausen by proxy (MBP), and factitious disorder (Table 1). Physicians rely on patient reports of symptoms as a starting point for evaluation and treatment planning. They expect to be able to trust their patients' reports. When they are misled, deliberately or inadvertently, consciously or unconsciously, physicians are thrown off their game plan. Sometimes they are tempted to call factitious disorder "fictitious disorder"; however, in some cases, the ailments are real but self-induced.

TABLE 1
Factitious disorder and related disorders: some definitions and distinctions

- Factitious disorder: conscious and intentional feigning or production of symptoms, because of a psychological need to assume the sick role to obtain emotional gain
- Malingering: conscious and intentional production or exaggeration of
symptoms for material gain, such as money, lodging, food, drugs, avoidance of military service, or escape from punishment

• Somatization: recurrent and multiple symptoms (eg, pain, GI, sexual, pseudoneurologic al) with no organic basis, believed to be due to unconscious expressions of suppressed emotional conflict or stress; unlike factitious disorders, the symptoms are not created by voluntary, conscious behavior

• Hypochondriasis: obsession with fears that one has a serious, undiagnosed disease, presumably based on misinterpretation of bodily sensations

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Malingering (ie, conscious fabrication of symptoms for external and usually tangible gain) has long been recognized. Its unconscious cousins—what used to be called hysteria and is now more properly called somatoform disorders—have long been studied. The more extreme forms of factitious disorder, Munchausen syndrome (chronic factitious disorder with wanderlust and self-aggrandizement), and MBP, have only recently begun to get systematic attention. In fact, factitious disorder and Munchausen syndrome only entered the diagnostic nomenclature in 1980. In 1995, MBP was included in DSM-IV for the first time as the research diagnosis factitious disorder by proxy (Table 2). However, experts continue to debate whether these 2 terms are truly synonymous (Figure 1). Although more common in the popular imagination, Munchausen syndrome, based on the humorous 18th-century fantasy book, The Adventures of Baron
Munchausen, only accounts for about 10% of the cases of factitious disorder.¹

### TABLE 2

**DSM-IV criteria for factitious disorder**

- Intentional production or feigning of physical or psychological signs or symptoms
- Motivation for the behavior is to assume the sick role
- External incentives for the behavior (such as economic gain, avoiding legal responsibility, or improving physical well-being, as in malingering) are absent

### Serial factitious disorder and MBP

The evaluation involves detailed clinical examination, including extensive history (and collateral history, if the patient will consent), careful physical examination, and relevant laboratory and radiological studies. Sometimes presenting symptoms are not anatomically plausible, such as tunnel blindness or pain or paresis that does not cross the midline. (The fact that psychiatrists and neurologists are both included in similar board certification processes attests to the historical overlap of these symptom clusters.) More often, the patient's presentation of fabricated signs and symptoms is believable.

### CASE VIGNETTE

Over a period of 2 decades, a 44-year-old woman self-induced labor and delivery in 5 consecutive pregnancies by rupturing her own amniotic sac with a fingernail or cervical manipulation or misappropriating and self-administering prostaglandin suppositories from the hospital unit on which she worked as a nurse. Preterm deliveries resulted in fetal demise in 1 case and in neonatal intensive care treatment for 2 of the offspring. One of the surviving children has cerebral palsy attributable to the mother's factitious illness behavior, which represents MBP maltreatment. The patient sought attention and care through the ruses, which were never uncovered by her obstetrical and gynecological caregivers. Indeed, she underwent an unnecessary hysterectomy because of the illusion of heavy menstrual bleeding actually produced by autophlebotomy, with placement of the blood in the vagina. In addition to the MBP, the patient sought—and seeks—misguided medical treatment for herself as part of her self-directed factitious disorder.²

Testing and procedures can be repeated unnecessarily by physicians who succumb to the patient's entreaties for additional intervention. Rather than being considered in the differential, factitious disorder is often not considered as a possibility; as a result, it is seriously underdiagnosed. In some
tertiary care settings sensitive to the issue of medical deception, the reported prevalence has been as high as 9.3% among patients with fever of unknown origin.⁴ In a prospective study on a psychiatric unit, the incidence was 6%.⁵ Still, the broader range of somatoform disorders, those mind-body disorders that occur at the intersection of disease and illness, are much more common. In a health care system in which psychological distress is undervalued (and underreimbursed), somatic symptoms become the admission ticket for getting help and assuming the sick role.⁶ Although illnesses (subjectively experienced) often do not have an underlying disease (pathophysiologically understood), medical evaluation and treatment start with the communication of perceived distress by the patient (Table 3).⁶,⁷

### TABLE 3
The role of consciousness

<table>
<thead>
<tr>
<th>Signs and symptoms</th>
<th>Production of symptoms</th>
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<tbody>
<tr>
<td>Diagnoses</td>
<td>Conscious</td>
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<tr>
<td>Malingering</td>
<td>X</td>
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<tr>
<td>Factitious disorder</td>
<td>X</td>
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<tr>
<td>Conversion disorder</td>
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<tr>
<td>Somatization disorder</td>
<td></td>
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<tr>
<td>Hypochondriasis</td>
<td></td>
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<tr>
<td>Pain associated</td>
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</table>
It should be noted that somatoform disorders should be distinguished from psychophysiological disorders in which psychological factors (e.g., stress) produce physiological changes in the body (e.g., elevated blood pressure).

**Etiologic proposals**
There are a number of possible explanations to account for motives in feigning, exaggerating, or inducing illness, and one can draw on various theoretical frameworks for these explanations. Learning theory suggests that behavior learned earlier in life is the best response the person knows. Psychodynamic theories draw on a number of possible tensions or conflicts in the child-parent relationship resulting in the need to be loved or cared for, the need to deceive, the need for revenge, the need to feel in control, the need for mastery over abusive parents, and the need to be punished.
or hurt. Parker\(^8\) suggests that the longing for nurturance and the need for distraction from authentic life stressors are also motivation for deception in the medical setting. Behavioral theories point to exposure to and reinforcement of sick-role activity. The self-enhancement model suggests that individuals covet the specialness of their ailments and their relationships with high-status others (especially doctors). Whatever the conceptualization, such explanations do not excuse the behavior but may make it easier to understand and empathize (Figure 2).

**Detection**

Detection of medical deception must start with a high index of suspicion, perhaps triggered by inconsistencies in the medical presentation. It generally involves careful review of the records of previous treatment. In the case of suspected MBP, it is essential to maintain strict boundaries between the medical staff and the patient and, if need be, the patient's parent who often splits the staff. Detection in the hospital may require covert video surveillance, a somewhat controversial procedure discussed later in this article. Eisendrath and Feder\(^9\) developed the list of red flags presented in Table 4 that can serve as warning signs indicative of possible illness deception, but none is diagnostic in itself.

**Historical examples: lessons to be learned**

Perhaps the best—and most complex—example of a false-positive diagnosis of factitious diagnosis is that of Wendy Scott, a prolific and well-known Munchausen patient who developed a real cancerous tumor that no one would investigate because they thought she was lying. She died prematurely as a result. There is also the case of Joan Nelson, whose endometriosis was misdiagnosed as Munchausen syndrome.\(^10\) False-negatives are much more frequent than false-positives, however. The reason is that doctors routinely overlook the notion of medical deception. They are sure that there is an organic basis to the complaints they can find with "just one more test." The real diagnosis—factitious disorder—eludes them. The patient sometimes goes on to considerable iatrogenic morbidity as a result.

**Forensic implications**

Health care professionals confront a daunting challenge when faced with the medicolegal implications of factitious disorder, and many issues can arise.

The first issue is whether people with factitious disorder even qualify as patients who are entitled to treatment. As Parsons\(^5\) describes in a landmark book, patienthood should accrue only to those who want and attempt to get well, and individuals with factitious disorder do not exhibit this motivation. Conceptualized this way, individuals with factitious disorder may not be entitled to admission and care. Obviously, there may be adverse consequences to the physician from the decision not to treat based exclusively on this diagnosis.

Second, the physician's responsibility following recognition of factitious disorder may be unclear. Many patients refuse permission for the physician to share confidential but vital information with other health care professionals and family members. A proposed solution is to encourage others to read between the lines by stating, "The patient has forbidden me to comment on whether he has factitious disorder." To our knowledge, this provocative proposal has not been put to the test. A third issue involves possible criminal or civil penalties for patients who mislead others about their illusory ailments. Those caught stealing from department stores are confronted and are likely to be criminally charged. In a parallel way, individuals with factitious disorder steal time and other resources from physicians, hospitals, insurance companies, and others. Yet, perhaps paradoxically, their "disease forgery" is rarely addressed in the court system. An exception occurred in Arizona, where a woman who misappropriated the time and supplies of several doctors was successfully prosecuted for fraud and artifice. Restitution to the doctors was ordered—although at a minimal rate that would require 178 years to complete.\(^11,12\)

Fourth, the potential malpractice liability stemming from factitious disorder is unsettled. Physicians might assume that they could never be held liable for unwarranted interventions in factitious disorder cases, yet such civil cases have arisen. People with factitious disorder have sued physicians for iatrogenic problems caused, at least in part, by their failure to recognize the deceptions. In one such case, fearing an adverse verdict, physicians who treated a woman for cancer that she misrepresented settled for 6 figures.\(^13\) In part, the hesitation to go to court relates to the difficulty judges and juries have in even conceiving of a phenomenon as odd as factitious disorder and Munchausen syndrome, particularly in an individual who appears neatly groomed and entirely appropriate in court.

A fifth issue involves room searches and covert surveillance of patients. Room searches for medical paraphernalia such as syringes and concealed medications are permitted if, as is standard at some hospitals, the patient has consented to them as a condition of admission. The use of covert video
surveillance to monitor patient behavior, or maternal behavior in MBP cases, is even more controversial. The issue usually boils down to the question of a reasonable expectation of privacy in a hospital room. Many courts have ruled that there should be no such expectation, particularly in cases of MBP. Hospitals can avert questions by proactively developing protocols to govern these situations.

The last issue to be discussed involves distributing lists or "black books" of people with factitious disorder to clinics and emergency departments. Although such lists exist in the United Kingdom, this would be unwise in the United States. While some might argue that such registries would dissuade those with factitious disorder from misdirected treatment, they are a violation of patient confidentiality, particularly since the implementation of HIPAA rules that require written permission of the patient to disclose medical information.

**Conclusion**

It may be very difficult to empathize with patients whose life experience has led them to the point where they feel that the best way to get their needs met is to falsify, exaggerate, aggravate, or self-induce symptoms. Although physicians must protect themselves from overt exploitation, keep the dependent person in a proxy situation from being harmed, and may feel the need to guard health resources from misuse, it is important to remember to treat the individual, not the illness.

Table 5 presents a supportive initial approach to patients suspected of factitious disorder.

### Table 5

Principles of a supportive confrontation of patients suspected of factitious disorder

<table>
<thead>
<tr>
<th>Basis for this confrontation approach</th>
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<tbody>
<tr>
<td>• Factitious disorder represents the patient’s attempt to cope with emotional distress (although the patient may not recognize this)</td>
</tr>
<tr>
<td>• The patient is in desperate need of help</td>
</tr>
<tr>
<td>• An understanding and supportive attitude by the staff will make it possible for the patient to cope with and live through the shame and shattered self-image that will result from the confrontation</td>
</tr>
</tbody>
</table>

**Procedure**
Let the patient know what you suspect but without outright accusation.

Support the suspicion with facts.

Provide empathetic and face-saving comments such as, “maybe you took it in your sleep,” “what you did was a cry for help, and we understand,” “we realize you must be in great distress,” and “we want to continue to take care of you.”

Avoid probing to uncover the patient's underlying feelings and motivations so as to minimize disruption of emotional defenses that are essential for functioning.

Assure the patient that only those who need to know will be informed of the suspicion of factitious disorder.

Make sure the staff demonstrate continued acceptance of the patient as a person worthy of their help; the attending physician should continue to show interest and concern.

Encourage psychiatric help.
but if the patient resists, do not force the issue

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