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Factitious disorder

What to do when someone plays sick

These secretive patients intentionally injure themselves or exaggerate physical symptoms, but confronting them may narrow your treatment options.

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An orthopedic surgeon treating a patient, age 29, at a tertiary medical center asks a staff psychiatrist for advice. The patient—who has chronic bilateral knee infections—lives 350 miles away; her treatment-resistant disease has stymied and frustrated her local physicians. Her infections have persisted despite multiple courses of antibiotics and numerous surgical procedures.

Because of damage to the right knee joint, she cannot bear weight or walk. A registered nurse, she has been unable to work or care for her school-aged children for 2 years. The surgeon tells the psychiatrist that the patient denies psychiatric complaints beyond sadness over her inability to fulfill her responsibilities. She expresses a wish to recover and adamantly denies that she manipulates her wound or does anything to interfere with its healing. The medical/surgical team has noticed that while she is away from home receiving orthopedic care, her husband never visits or calls.

Cases such as the one described above are rare, but psychiatrists occasionally

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encounter patients with these baffling characteristics. When the patient's disease fails to respond to treatment as expected—or progresses—members of the medical/psychiatric team need to ask themselves these questions:

- Are we dealing with a drug-resistant infection?
- Is the patient adhering fully with treatment?
- Does the patient do anything to perpetuate this disease process and wish to stay ill?

Asking this last question is difficult but necessary in certain situations. Most of us cannot imagine why a person would wish to remain sick. Why would someone be willing to endure pain and multiple hospital stays, remain isolated from family, and risk a permanent disability? Yet, an unknown number of people strive to appear unwell so that they can receive ongoing medical care.

What are factitious disorders?

Factitious disorders are psychiatric conditions in which patients deliberately portray themselves as ill. They may present with physical or psychological symptoms or both. Their objective is to assume the sick role—not to procure shelter, obtain financial assistance, avoid prison, etc., which would fall into other diagnoses such as malingering.

Table 1

DSM-IV DIAGNOSTIC CRITERIA FOR FACTITIOUS DISORDER

A. Intentional production or feigning of physical or psychological signs or symptoms.

B. The motivation for behaviors is to assume the sick role.

C. External incentives for the behaviors (such as economic gain, avoiding legal responsibility, or improving physical well-being, as in malingering) are absent.

Types

- With predominantly psychological signs and symptoms
- With predominantly physical signs and symptoms
- With combined psychological and physical signs and symptoms

Source: DSM-IV-TR

DSM-IV criteria are straightforward and inclusive (*Table 1*).[1] They do not specify:

- the presence of medical and/or psychiatric disorders, which do not preclude the diagnosis
- reasons why a person may wish to assume the sick role.

The medical literature on factitious disorder includes many compelling case reports. However, the secretive nature of most patients with factitious complaints has made it difficult to conduct carefully designed community-based studies, prospective studies, or controlled randomized trials. Because research is scarce, much is unknown about who gets factitious disorder, what causes it, and how to treat it.

Differential diagnosis

Factitious disorder varies in severity. Among subtypes proposed by Folks et al (*Table 2*),[2] patients in categories 3, 4, and 5—who produce physical illness—can potentially be identified by diagnostic testing.[3] Patients in categories 1 and 2—who exaggerate physical symptoms and provide a false medical history—may be more difficult to detect.

In cases where patients exaggerate symptoms or fabricate histories, little objective information is typically available to the treating physicians. Medical records revealing multiple admissions or emergency room visits may be obtained from other institutions only if the patient gives permission. However, the patient often does not consent or the materials cannot be located.

Third-party payers' pre-authorization procedures and utilization reviews may speak volumes about a patient's search for health care. However, patients who are unemployed or estranged from spouses may lose insurance coverage over time. Government assistance programs such as Medicare and Medicaid provide care to many patients with these chronic problems and do not perform the same degree of utilization review.

Munchausen disorder—a variant of factitious disorder—is not recognized by DSM-IV. The term—while still used primarily by nonpsychiatrists—is generally viewed as outdated. The term is reserved for patients with the most severe and chronic form of factitious disorder.[4] The few studies done of patients with this variant have not adequately examined the specificity and sen-

sitivity of their core symptoms or other characteristics, such as production of a misleading medical condition, travel to multiple medical centers (peregrination), and the telling of tall tales (pseudologia fantastica).

Somatoform disorder. If physicians suspect that a patient's illness is taking an unusual course, they may suspect a somatoform rather than factitious disorder. Patients with somatoform disorder do not intentionally produce their symptoms, whereas patients with factitious disorder deliberately try to appear ill. In both disorders, the underlying cause is unconscious.

Hypochondriasis. Patients with hypochondriasis are obsessed with concerns that they have an illness. Their worries may compel them to seek out examinations and diagnostic tests. Unlike patients with factitious disorder, these patients do not deliberately provide information or manufacture symptoms to create the appearance of a medical disorder.

Malingering. Patients who malinger may engage in deceitful behaviors that can include creating a misleading impression about a medical or psychiatric illness. Being a patient, however, is not their objective. They may be seeking disability payments, insurance settlements, shelter, or food.

Table 2

FIVE PROPOSED SUBTYPES OF FACTITIOUS DISORDER

Characteristic	Examples
May be most difficult to detect	
1. Exaggerates physical symptoms	An epileptic patient has a seizure while EEG is normal
2. Provides a false medical history	Describes a fictitious history of cancer
Can potentially be identified by diagnostic testing	
3. Simulates physical symptoms	Puts gravel into urine sample
4. Modifies physiology to create physical signs	Exerts oneself before vital signs test to elevate blood pressure
5. Induces physical illness	Injects foreign material into a surgical wound to slow healing

Source: Adapted from Folks et al.[2]

Confronted patients may become more guarded and more careful to hide wound tampering

Patient evaluation

Patients suspected of factitious disorder merit a thorough medical and psychiatric evaluation, guided by their presenting symptoms. They commonly have comorbid psychiatric disorders (*Table 3*), which medical/surgical team members and the psychiatrist need to identify before considering a diagnosis of factitious disorder.

Because invasive tests such as angiography, colonoscopy, biopsies, or exploratory surgery are required to exclude some underlying medical processes, the treatment team must take care not to cause harm. The expected benefits of diagnostic testing must be balanced against the risks of an iatrogenic event.

Relatively little is known about how to diagnose a factitious process coexisting with a genuine medical disorder. For example, a patient with well-documented chronic inflammatory disease may easily exaggerate pain and diarrhea to facilitate hospital admission.

To confront or not to confront?

Some patients may relish the patient role for a time—such as while being evaluated for a presumed opportunistic infection—but may not consent to more definitive tests—such as HIV testing. They may demand discharge while they still may be harming themselves, such as by injecting foreign material. The patient may plan to find another health care provider and continue the maladaptive behavior.

If you suspected that our case patient was playing a role in perpetuating her chronic knee infections, would you confront her with the evidence? The answer is unclear, but some

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experts argue against confrontation.[5] Once a patient believes that the medical team suspects a factitious process, he or she may no longer wish to cooperate, even if the diagnostic evaluation is incomplete. Patients often become more guarded about what they reveal after they are confronted. They may become more careful to hide evidence of wound tampering (e.g., syringes) and hesitant to discuss emotional issues (e.g., estranged relationships, feeling overwhelmed by work and home duties).

Case reports suggest that patients who simulate symptoms, modify their physiology, or induce physical illness are at high risk of morbidity and mortality. For example, one report described a patient who underwent two cardiopulmonary resuscitations because of torsades de pointes triggered by hypokalemia related to covert laxative use.[6] Physicians must manage these cases carefully to reduce patient risk. In rare cases where a patient's behavior becomes life-threatening, admission to a psychiatric unit—even involuntarily—may be necessary.

Table 3

DISORDERS KNOWN TO CO-EXIST WITH FACTITIOUS DISORDER

Disorder	Possible issue
Medical	Coexisting medical disease
Delusional	Somatic delusions
Depressive	Somatic complaints, dependency on staff
Chemical dependency	Prescription drug abuse
Eating disorders	Persistent vomiting, weight loss
Obsessive-compulsive disorder	Somatic obsessions
Hypochondriasis	Conviction one is unwell
Pain disorders	Pain complaints
Malingering	Seeking shelter in hospital

Source: Adapted from Folks et al. Somatoform disorders, factitious disorders, and malingering. In: Stoudemire A, Fogel B, Greenberg D, eds. *Psychiatric care of the medical patient (2nd ed)*. New York: Oxford University Press, 2000:458-75.

Collaborating with the patient

A comprehensive treatment approach is optimal for patients with factitious disorder. All the patient's objective medical disorders should be addressed in systematically and with empathy. Treating a co-existing medical disorder may help the physician gain the patient's trust, which in turn can help keep treatment options open.

Some patients have been known to exaggerate their physical symptoms because they feel they have a serious, undiagnosed medical problem. They feel that their assessment has been cursory and that they need to compel the physician to do a more thorough evaluation in order to identify the true underlying problem. Although no research supports this observation, these patients may be reassured when their physicians carefully evaluate their medical problems.

Eisendrath[5] recommends that the treatment team take time to get to know the patient and convey that this attention is devoted to the person, not just the medical illness. This approach may increase the likelihood of learning about psychosocial issues the person may be trying to resolve by taking the patient role. Patients also may be more willing to complete the evaluation and adhere to recommended treatment, although these outcomes are not guaranteed.

Case report

For the patient with chronic knee infections, the staff psychiatrist recommended that the orthopedist develop a collaborative relationship with her. Eventually the surgeon told her that she needed psychiatric care, and the patient agreed to psychiatric hospitalization.

In this setting, she was initially observed with a 24-hour monitor and received appropriate wound care. The staff encouraged her to talk about the emotional distress related to having a chronic disease. She never admitted to perpetuating the infections in her knees, although she was suspected of injecting herself with infected material. Psychiatric evaluation revealed a history of multiple strained relationships that suggested a severe personality disorder.

Her wounds slowly began to improve, and she was discharged after 2 weeks. Throughout her stay, she remained reluctant to discuss her relationship with her husband or examine other possible sources of stress in her life. Thus, factitious behav-

ior will probably recur unless she tackles her unconscious motivations for adopting a patient role.

If patients' emotional needs are being met, they may reveal the mechanism of their disease. Unfortunately, experience suggests that very few confess the false nature of their medical illness, fewer accept psychiatric treatment, and even fewer complete the recommended course of treatment.

Comorbid psychiatric disorders provide an opportunity to intervene with selected medications and psychotherapy to reduce patient distress. Chemical dependency treatment in particular can help stabilize a patient with a factitious disorder so that he or she no longer seeks pain medications or sedatives. Patients with an obsessive-compulsive disorder or hypochondriasis may require specifically targeted cognitive-behavioral therapy or pharmacotherapy.

Few references regarding treatment of factitious disorder exist; the only known review of cognitive-behavioral therapy's role in treating this disorder awaits publication.

Bottom Line

Patients with suspected factitious disorder require in-depth medical and psychiatric assessment. Confrontation may make them more secretive and compromise evaluation or treatment. Comorbid psychiatric disorders are common and may provide an opportunity to intervene and reduce patient distress.

Related resources

- Sutherland AJ, Rodin GM. Factitious disorders in a general hospital setting: clinical features and a review of the literature. *Psychosomatics* 1990;31(4):392-9.
- Reich P, Gottfried LA. Factitious disorders in a teaching hospital. *Ann Intern Med* 1983;99(2):240-7.

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2. Folks D, Feldman M, Ford C. Somatoform disorders, factitious disorders, and malingering. In: Stoudemire A, Fogel B, Greenberg D, eds. *Psychiatric care of the medical patient (2nd ed)*. New York: Oxford University Press, 2000:458-75.
3. Wallach J. Laboratory diagnosis of factitious disorders. *Arch Intern Med* 1994;154:1690-6.
4. Asher R. Munchausen's syndrome. *Lancet* 1951; 1:339-41.
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6. Krahn L, Lee J, Martin MJ, Richardson J, O'Connor M. Hypokalemia leading to torsades de pointes: Munchausen's syndrome versus bulimia nervosa. *Gen Hosp Psychiatry* 1997;19:370-7.