

Ask Dr. Stern about factitious illness.
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Factitious illness: A 3-step consultation-liaison approach



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Make the diagnosis when it is present, and rule it out when it is not

Ms. J, age 33, arrives at the emergency department (ED) complaining of chest pain and shortness of breath—symptoms she says are similar to those she had during episodes of pulmonary embolism (PE). Routine laboratory workup, including chest CT and ultrasound of the lower extremities, indicate a very low likelihood of PE, but she insists that she be admitted.

On the medical floor, nursing staff note that Ms. J appears short of breath only when directly observed. Medical records reveal multiple visits to other hospitals with repeated requests for admission. When gently confronted, she maintains she will die if she is not treated.

Has your hospital's medical staff ever been puzzled by a patient's inconsistent presentation or unsettled by a concern that he or she was not being straightforward with them? Have they suspected that a patient such as Ms. J may be voluntarily producing his or her symptoms?

This article suggests a 3-step approach by which the consultation-liaison psychiatrist can help medical staff identify and manage patients with factitious illness.

Cardinal features

In factitious illness, the patient's symptoms are:

- under voluntary control and consciously produced
- not a direct result of a medical or psychiatric condition

- produced to assume the sick role (not to accrue secondary gain—a core feature of malingering).

Patients with factitious illness tend to present with realistic scenarios that suggest a physical or psychological disorder.

CASE

Self-inflicted injury

Ms. H, age 50, surprises even the most seasoned clinicians when she presents to the ED with brain parenchyma herniating from an open wound in her skull. She denies having picked at her scalp and does not endorse a history of obsessive-compulsive disorder or trichotillomania.

On the medical floor, however, she is seen picking at the wound, which leaves blood on her protective mittens. Surgical repair is repeatedly attempted, and her case is complicated by chronic infections and a nonhealing wound.

Clinical presentation

Factitious disorder presents 3 diagnostic and treatment challenges for a hospital’s medical staff:

- To recognize and treat (even self-inflicted) serious medical conditions that can be life-threatening.
- To orchestrate appropriate diagnostic evaluation. (Remember that factitious illness is a diagnosis of exclusion.)
- To handle countertransference reactions to patients that can be intense; physicians may experience anger, frustration, resignation, and hatred.

You can help medical staff manage these patients’ behaviors and minimize barriers to care by explaining the disorder as a manifestation of psychiatric suffering.

CASE

‘Suicidal’ but not depressed

Mr. B, age 48, presents to the ED with thoughts of suicide and profoundly depressed mood. On examination, however, he does not appear depressed. He repeatedly requests food, cigarettes, and assistance in finding shelter, which lead to concern that his main goal is secondary gain. However, because Mr. B has a history of serious suicide attempts—including some

Table 1

Medical clues to a patient with factitious illness

Vague symptom history that frays upon examination
Irritability and evasiveness with continued questioning
Familiarity with hospital procedures and protocols (some patients have received medical training)
Multiple scars as evidence of past procedures and hospitalizations
Acceptance of painful medical procedures without complaint
Itinerant lives devoid of close personal relationships
Failure to accurately identify themselves
Lack of a verifiable history
Source: Reference 1

while an inpatient—the ED physician is reluctant to dismiss his complaints and unsure about how to proceed.

3-step diagnostic approach

Treating factitious illness is predicated upon making the correct diagnosis, which requires the medical team to investigate and gather data from collateral sources, such as outside hospital medical records and other providers. The diagnostic process can be summarized in 3 steps:

- ▶ **Step 1.** Determine whether the patient has an identifiable medical or psychiatric problem that could explain the symptoms.
- ▶ **Step 2.** Determine whether the symptoms are consciously or unconsciously produced. Somatoform disorders—such as conversion disorder and somatization disorder, for example—are thought to result from processes outside the patient’s control.
- ▶ **Step 3.** Distinguish if the motivation is to obtain the sick role (consider factitious illness) or if material benefits are the goal (consider malingering). Both motivations may be operative in a given patient.

Medical evaluation. Certain aspects of the patient’s medical presentation can steer the physician to making a diagnosis of factitious illness (*Table 1*).¹ For patients

Clinical Point
Minimize barriers to care by explaining to medical staff that the disorder is a manifestation of psychiatric suffering



Factitious disorder

Clinical Point

The emergency department often is these patients' gateway; they arrive in the evening or on weekends when less experienced staff are on call

with physical symptoms, staff should order standard evaluations based on clinical judgment (such as ECG and cardiac markers to evaluate chest discomfort). Sometimes somatized symptoms are superimposed on an identifiable physical problem, and effective management includes treating both the medical illness and its created counterpart.²

Psychiatric evaluation. Physicians should think of factitious psychiatric illness when:

- a patient's behavior is notably different when he believes he is being directly observed and when he believes he is alone³
- psychiatric symptoms do not readily fit into diagnostic categories (such as a vague mix of memory loss, suicidal thoughts, and psychosis)
- the patient is suggestible or provides a diffusely positive review of systems (for example, he may report additional symptoms after having observed other patients).

When evaluating a patient with suspected factitious psychiatric symptoms, perform a comprehensive psychiatric evaluation to identify an Axis I or II disorder. Rule out possibilities such as dementia associated with complaints of memory loss, psychosis associated with reports of hallucinations, or affective symptoms or Axis II pathology associated with thoughts of suicide. Patients with factitious disorder often have an underlying psychiatric illness such as a personality disorder, but the Axis II disorder does not fully explain the presenting complaint.

The psychiatric presentations of Munchausen syndrome can be especially complicated, as they are usually associated with less objective evidence than are medical presentations (*Box*).⁴⁻¹⁰ Clarity of the history and diagnosis may be in the eye of the beholder.

Admission characteristics

Somatic complaints. Chaos often surrounds the hospitalized patient with factitious illness. The ED commonly is their gateway, and they tend to arrive in the evening or on weekends when less experienced staff are on call.¹¹

Box

Factitious disorder: Presentation severity ranges up to Munchausen syndrome

Munchausen syndrome—a particularly severe factitious illness—is characterized by peregrination, recurrent presentations, and *pseudologia fantastica* (stories that seem outrageously exaggerated).⁴ In 1951, Asher named this syndrome for Baron von Munchausen, an 18th century Prussian officer who wandered from city to city creating tall tales about his life.⁵

Munchausen by proxy, in which a parent is responsible for producing illness in a child, may lead to extensive medical evaluations and treatment.

After more than 50 years, factitious illness continues to draw scientific and clinical attention. A search of PubMed over the last 10 years found nearly 500 citations. Presentations included:

- symptomatic bradycardia caused by beta-blocker ingestion⁶
- refractory hypoglycemia caused by surreptitious insulin injections⁷
- false reports of aortic dissection⁸
- recurrent episodes of self-harm including bilateral blindness from ocular trauma⁹
- fabricated sweat chloride test results in a patient claiming to have cystic fibrosis.¹⁰

Because the patients' somatic complaints predominate, the ED physician must complete a full evaluation, even if aspects of the history are inconsistent. Patients tend to appeal to physicians' nurturing qualities in an attempt to have them provide care and attention.¹²

Escalating demands. During the hospital stay, patients with factitious illness may make repeated requests for care, which may escalate into demands if their needs are not met.¹³ At this point, staff often start to experience negative countertransference reactions. As medical tests reveal little to no evidence of an organic basis for their symptoms and no cohesive psychiatric diagnosis is reached, patients may complain of misdiagnosis and mistreatment.¹³

Patients usually leave before psychiatric consultation can be obtained, and the underlying suffering that led to their factitious complaints remains unaddressed. Typically, patients are lost to follow-up until the next presentation at another hospital, where the process begins again.

What motivates patients?

The motivation behind factitious presentations can be bewildering. Asher's paper on Munchausen syndrome described several possible reasons for patients' behavior, such as desire to be the center of attention, holding a grudge against the medical profession, drug seeking, looking for shelter, and running from police.⁵ This list, however, includes correlates of secondary gain, which with today's psychiatric nomenclature would lead to a diagnosis of malingering.

Psychological factors. Some clinicians have tried to address underlying psychiatric factors, but data on evaluation and management are limited because these patients usually eschew psychiatric examination. Although the patient is voluntarily producing the symptoms, unconscious psychological factors are at play and are an essential part of the picture.¹⁴

When assessed, patients appear to have lived rootless lives with few attachments, which may have been the result of sadistic and unsatisfying relationships with authority figures of their youth.^{15,16} Their grandiosity and distortion of the truth suggest a narcissistic need to overcome feelings of incompetence or impotence.¹⁷ Their ambivalent relationship to hospitals and physicians may reflect a need for caretaking, arising from early relationships and past caretakers.

Lastly, there is a component of masochism; this makes some individuals (erroneously) believe that if you don't inflict pain you don't care about them.¹³

Treatment challenges

Because patients with factitious disorder are not easily studied, no particular treat-

Table 2

Recommended care for a patient with factitious illness

Fully investigate all medical and psychiatric complaints, especially if physical safety is threatened

Maintain a healthy skepticism about unusual or illogical presentations while attempting to preserve an empathic connection with the patient

Be aware of countertransference reactions, as they may provide valuable insight about the underlying cause of the patient's symptoms

Realize that psychiatric symptoms and medical presentations fall on a continuum from conscious to unconscious; at times there may be a mix of motivations

Report all findings nonjudgmentally, both to the patient and in medical documentation

ment is well-supported in the literature. Approaches that have been reported include preventing patients from being re-admitted to medical facilities, admitting patients for psychiatric treatment, and providing outpatient therapies such as individual psychodynamic psychotherapy, behavioral modification, and group psychotherapy.¹⁸

Other management strategies suggested in the literature include:

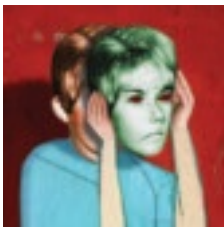
- reframing cognitive distortions
- drawing up a set of realistic hospitalization goals (with a written contract)
- maximizing the therapeutic alliance
- avoiding team splitting
- minimizing iatrogenic harm.¹⁹

Whatever the treatment, educate the medical staff about this complex disorder (Table 2), including the hazards of premature and unsubstantiated interventions or painful procedures. Also help them manage countertransference reactions. Provide an outlet for the staff's intense emotions, and help them place such emotions into a therapeutic context.

Confront patients? The efficacy and style of confronting patients with factitious illness have been hotly debated. Although no consensus has emerged, an empathic, nonthreatening confrontation may help

Bottom Line

Factitious illness is a diagnosis of exclusion. Avoid premature and unsubstantiated interventions or painful procedures. A 3-step approach can help staff conduct an appropriate diagnostic evaluation and handle countertransference reactions.



Factitious disorder

the patient accept much-needed psychiatric care.¹³

Nevertheless, prepare the physician for the patient to respond to confrontation with denial and resistance because he or she feels exposed and humiliated. If the physician makes it clear that ongoing medical care will still be available—even if the symptoms are fabricated—the patient may be more willing to accept psychiatric treatment.¹³

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Related Resources

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