

Challenges in Diagnosing Factitious Disorder

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The word factitious comes from the Latin adjective *facticius*, meaning “made by art” or “artificial.” Descriptions of symptoms of what is now referred to as factitious disorder first appeared in the medical literature in the early second century A.D., although the term factitious was coined in 1843 (1). Factitious disorder was first described by Richard Asher, who named the condition Munchausen syndrome (2), and it is defined as the deliberate feigning or exaggeration of injury, impairment, illness, or a psychological condition with the aim of assuming the patient role but no other obvious gain (3). Factitious disorder was initially recognized as a formal diagnostic category in 1980 in DSM-III (4) and was later classified into three major subtypes in DSM-IV-TR (5). Further changes to the criteria for factitious disorder were made in DSM-5 as follows: the disorder is now classified under somatic symptoms and related disorders; description of the disorder has changed from “motivation to assume a sick role” to “deceptive behavior is evident in the absence of external incentives”; and the disorder is now subclassified as “factitious disorder imposed on self” and “factitious disorder imposed on another,” thus removing factitious disorder by proxy from the appendix (3).

The exact prevalence of factitious disorder in hospital settings is currently unknown; however, it may account for 0.6%–3.0% of psychiatric referrals (6). The estimated lifetime prevalence of factitious disorder imposed on self in clinical settings is 1.0%, and in the general population, it is estimated to be approximately 0.1%, with prevalence ranging widely across different studies, from 0.007% to 8.0% (7). According to one estimate, factitious disorder costs the United States \$40 million per year (8), but the financial impact may be much

higher than current estimates in the context of underdiagnosis. The medical literature suggests that the prevalence is higher among females, unmarried individuals, and health care professionals (9). Although the etiology of the disorder or pretense is unclear, there is documented association with psychosocial factors, neurocognitive impairment, and neuroimaging abnormalities.

In the present case report, we highlight the diagnostic challenges clinicians may face in diagnosing and treating patients with factitious disorder.

CASE

“Mr. C” is a 60-year-old man who presented to our facility with a self-reported psychiatric history of bipolar I disorder and borderline personality disorder, a self-reported substance use disorder of alcohol and cocaine use, and a self-reported medical history of chronic obstructive pulmonary disease (steroid dependent with multiple intubations), hypertension, insulin-dependent diabetes mellitus, and hyperlipidemia.

The patient was admitted to our facility endorsing command auditory hallucinations. On evaluation, when asked to explain the circumstances of his admission, he stated, “I am hearing voices telling me to kill myself.” When asked to elaborate, he reported having experienced traumatic events in his life, which affected him severely. He stated that his parents died when he was 7 years old and that he was sexually abused by his stepfather at age 10, which lasted for 3 years. He reported that his wife and one of his daughters died in an accidental house fire in 2007, another daughter died in a car accident in 2013, and his girlfriend died in 2014. Further, he reported having manic symptoms, such as elated mood, rapid and pressured speech, de-

creased need for sleep, racing thoughts, and thoughts of a special connection with God, which lasts for 1 week if left untreated. He was unable to recall when he was last psychiatrically well.

He reported two suicide attempts, both in 2007, first by overdosing on 10 lorazepam tablets, followed by a second attempt in which he tried to hang himself. A review of the patient’s records showed several psychiatric hospitalizations over 10 years, with similar presentation of command auditory hallucinations of self-harm along with affective dysregulation. The records confirmed a positive history of alcohol and cocaine use. His medical admissions were in the context of exacerbation of chronic obstructive pulmonary disease or asthma symptoms after medication noncompliance. The records showed that, on average, the patient was hospitalized more than 300 days per year over the past 5 years (2011–2015). Additionally, the records indicated that multiple psychopharmacological medications, such as antidepressants, antipsychotics, and mood stabilizers, had been prescribed, with inconsistent improvement in symptoms. There was no record of follow-up visits or treatment after his discharges from the hospital.

The patient’s intentional falsification of symptoms and deceptive behavior without any obvious gain led to a diagnosis of factitious disorder. In addition, our treatment team observed splitting behavior (i.e., his initial idealization of his psychiatrist and positive attitude toward the treatment team were reversed when his diagnosis was explained to him). Supportive and trauma-focused psychotherapy were provided but with limited benefit.

Our treatment team made several attempts to contact the patient’s family without success, and thus informa-

tion pertaining to sexual abuse, multiple losses in the family, and suicidal attempts remained nonverifiable. Our team also questioned the accuracy of all self-reported information, since the information was reported inconsistently during different conversations with different team members.

DISCUSSION

In the above case, our differential diagnosis included factitious disorder, malingering, and conversion disorder (see box). Our patient did not appear to have any motivating external gains, such as financial compensation or avoiding jail or prison time, differentiating from malingering. The feigning of illness appeared to be due to an unconscious desire to gain sympathy, as observed in the patient’s records, which showed repeated visits to medical emergency departments at different hospitals.

Because of vague and inconsistent presentation of symptoms, factitious disorder is challenging to diagnose as well as to treat. Symptoms may become worse for no apparent reason and may not improve after standard treatment. To obtain “the sick role,” patients with this disorder may falsify symptoms, fabricate their medical history, and manipulate medical investigations to simulate a condition that requires immediate medical attention. They often attempt to prevent their treatment team from contacting family members and frequently change providers (i.e., doctor shopping) in an effort to hinder continuity of care. They frequently go to different emergency departments at different facilities, which can result in unnecessary laboratory and imaging tests, longer hospital stays, and overutilization of resources (8).

Differentiation from malingering remains challenging, since this may require understanding the concepts of primary and secondary gains. The motivation to receive affection and the desire to undergo medical procedures is often the primal inclination (10). The primary gain is seeking medical attention to receive emotional support. By contrast, in malingering, the patient feigns physical or psychological symptoms for external incentives (secondary gains), such

Differences Between Somatoform Disorder, Factitious Disorder, and Malingering		
Diagnosis	Mechanism of Illness Production	Motivation for Illness Production
Somatoform disorder	Unconscious	Unconscious
Factitious disorder	Conscious	Unconscious
Malingering	Conscious	Conscious

as gaining disability benefits, acquiring leave from work, evading military service, or procuring a justifiable absence from a court of law.

Although often seen by medical doctors in emergency departments, factitious disorder is routinely underrecognized and usually results in unnecessary consultations, investigations, treatments, hospital admissions, and surgical procedures. This may cause iatrogenic harm to the patient (11) and underscores the need for early detection. Additionally, there is evidence that early detection of factitious disorder and identification of comorbid illnesses, along with development of an empathic relationship with the patient, may help in the attenuation of maladaptive behaviors, leading to better outcomes (9, 12).

Management strategies for patients with factitious disorder include exploring the patient’s symptoms in a nonconfrontational manner. Showing disinterest in the fabrication but maintaining interest in the patient conveys to the patient that the provider is concerned. This may improve the therapeutic alliance and prevent the patient from doctor shopping. The medical literature also shows that increasing the number of follow-up visits reduces the frequency of self-injurious behavior.

CONCLUSIONS

Patients with factitious disorder often seek treatment from many providers and

have frequent emergency department visits, some of which lead to inpatient hospitalizations because the treatment team may be manipulated into ordering extensive tests or performing unnecessary medical or surgical procedures. Patients may also inflict self-pain to prolong their hospitalizations and to hide their collateral information. This patient population is typically nonadherent to long-term follow-up, thus limiting improvement in their symptoms. Improving the therapeutic alliance by focusing on the patient’s need for attention may be achieved by scheduling short-interval visits and psychotherapy.

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The authors thank Muhammad A. Tahir, M.D., Research Assistant, SUNY Upstate University, Syracuse, N.Y., and Raheel Memon, M.D., Clinical Observer, Center for Behavioral Health, Florida Hospital, Orlando, Fla., for their assistance with this article.

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KEY POINTS/CLINICAL PEARLS

- The prevalence of factitious disorder imposed on self in clinical settings is approximately 1%.
- In the United States, factitious disorder costs up to \$40 million annually in medical expenses.
- Diagnosis of factitious disorder involves longitudinal review of records rather than focus on cross-sectional current symptoms.

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