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13.6 Factitious Disorder

motivation to make changes. PROBLEM-SOLVING. The final step is problem-solving, in which patients try to apply the best solution to the problem situation and then review their progress with the therapist. REFERENCES Calvillo-King L, Arnold D, Eubank KJ, Lo M, Yunyongying P, Halm EA. Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review. *J Gen Intern Med.* 2013;28(2):269–282. Creed F. Gastrointestinal disorders. In: Sadock BJ, Sadock VA, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry.* 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:2263. Desan P. Psychosomatic medicine revisited. *Primary Psychiatry.* 2005;12:35. Drossman DA, Toner BB, Whitehead WE, Diamant NE, Dalton CB, Duncan S, Emmott S, Proffitt V, Akman D, Frusciante K, Le T, Meyer K, Bradshaw B, Mikula K, Morris CB, Blackman CJ, Hu Y, Jia H, Li JZ, Koch GG, Bangdiwala SI. Cognitivebehavioral therapy versus education and desipramine versus placebo for moderate to severe functional bowel disorders. *Gastroenterology.* 2003;125:19. Enck P, Bingel U, Schedlowski M, Rief W. The placebo response in medicine: Minimize, maximize or personalize? *Nat Rev Drug Discov.* 2013;12(3):191–204. Guidi J, Rafanelli C, Roncuzzi R, Sirri L, Fava GA. Assessing psychological factors affecting medical conditions: Comparison between different proposals. *Gen Hosp Psychiatry.* 2013;35(2):141–146. Halder SL, Locke GR 3rd, Talley NJ, Fett SL, Zinsmeister AR, Melton LJ 3rd. Impact of functional gastrointestinal disorders on health-related quality of life: A population-based case-control study. *Aliment Pharmacol Ther.* 2004;19:233. Holwerda TJ, Deeg DJ, Beekman AT, van Tilburg TG, Stek ML, Jonker C, Schoevers RA. Feelings of loneliness, but not social isolation, predict dementia onset: results from the Amsterdam Study of the Elderly (AMSTEL). *J Neurol Neurosurg Psychiatry.* 2014;85(2):135–142. Maeda U, Shen BJ, Schwarz ER, Farrell KA, Mallon S. Self-efficacy mediates the associations of social support and depression with treatment adherence in heart failure patients. *Int J Behav Med.* 2013;20(1):88–96. McLean DE, Bowen S, Drezner K, Rowe A, Sherman P, Schroeder S, Redlener K. Asthma among homeless children: Undercounting and undertreating the underserved. *Arch Pediatr Adolesc Med.* 2004;158:244–249. Moran MG. Respiratory disorders. In: Sadock BJ, Sadock VA, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry.* 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:2289. Poricelli P, Affatati V, Bellomo A, De Carne M, Todarello O, Taylor GJ. Alexithymia and psychopathology in patients with psychiatric and functional gastrointestinal disorders. *Psychother Psychosom.* 2004;73:84. Rietveld S, Creer TL. Psychiatric factors in asthma: Implications for diagnosis and therapy. *Am J Respir Med.* 2004;2:1–10. Shapiro PA, Lawson RW. Cardiovascular disorders. In: Sadock BJ, Sadock VA, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry.* 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:2250. Singh JA, Lewallen DG. Medical and psychological comorbidity predicts poor pain outcomes after total knee

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Patients with factitious disorder simulate, induce, or aggravate illness to receive medical attention, regardless of whether or not they are ill. Thus, they may inflict painful, deforming, or even life-threatening injury on themselves, their children, or other dependents. The primary motivation is not avoidance of duties, financial gain, or anything concrete. The motivation is simply to receive medical care and to partake in the medical system. Factitious disorders can lead to significant morbidity or even mortality. Therefore, even though presenting complaints are falsified, the medical and psychiatric needs of these patients must be taken seriously. For example, an operating room technician, the daughter of a physician, repetitively injected herself with *Pseudomonas*, which caused multiple bouts of sepsis and bilateral renal failure that led to her death. Such deaths are not uncommon. In a 1951 article in *Lancet*, Richard Asher coined the term “Munchausen syndrome” to refer to a syndrome in which patients embellish their personal history, chronically fabricate symptoms to gain hospital admission, and move from hospital to hospital. The syndrome was named after Baron Hieronymus Friedrich Freiherr von Munchausen (1720–1797), a German cavalry officer (Fig. 13.6-1). FIGURE 13.6-1 The Baron Karl Friedrich Hieronymus von Münchhausen (1720–1797). Left: The Baron wears military armor in this 1750 portrait by G. Bruckner. A nobleman who served the Russian army in the war against the Turks, the baron entertained friends with embellished stories of his war adventures in his retirement. His tales gained fame when published by Rudolph E. Raspe. Right: The baron appears as a caricature in this drawing by 19th-century artist Gustave Doré. Like the baron, patients with factitious disorders are real persons deserving of respect, even though they often present themselves as caricatures. (Portrait courtesy of Bernhard Wiebel, <http://www.Muenchhausen.ch>. The actual portrait was lost in World War II. Caricature from Gustave Doré. *The Adventures of Baron Munchausen, One Hundred and Sixty Illustrations* by Gustave Doré. New York: Pantheon Books; 1944.)

EPIDEMIOLOGY No comprehensive epidemiological data on factitious disorder exist. Limited studies indicate that patients with factitious disorder may comprise approximately 0.8 to 1.0 percent of psychiatry consultation patients. Cases of feigned psychological signs and symptoms are reported much less commonly than those of physical signs and symptoms. A data bank of persons who feign illness has been established to alert hospitals about such patients, many of whom travel from place to place, seek admission under different names, or simulate different illnesses. Approximately two thirds of patients with Munchausen syndrome are male. They tend to be white, middle-aged, unemployed, unmarried, and without significant social or family attachments. Patients diagnosed with factitious disorders with physical signs and symptoms are mostly women, who outnumber men 3 to 1. They are usually 20 to 40 years of age with a history of employment or education in nursing or a health care occupation. Factitious physical disorders usually begin for patients in their 20s or 30s, although the literature contains cases ranging from 4 to 79 years of age. Factitious disorder by proxy (called factitious disorder imposed on another in the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders [DSM-5]*) is most commonly perpetrated by mothers against infants or young children. Rare or underrecognized, it accounts for less than 0.04 percent, or 1,000 of 3 million cases of child abuse reported in the United States each year. Good epidemiological data are lacking, however. This disorder is discussed below. **COMORBIDITY** Many persons diagnosed with factitious disorder have comorbid psychiatric diagnoses (e.g., mood

disorders, personality disorders, or substance-related disorders). **ETIOLOGY Psychosocial Factors** The psychodynamic underpinnings of factitious disorders are poorly understood because the patients are difficult to engage in an exploratory psychotherapy process. They may insist that their symptoms are physical and that psychologically oriented treatment is therefore useless. Anecdotal case reports indicate that many of the patients suffered childhood abuse or deprivation, resulting in frequent hospitalizations during early development. In such circumstances, an inpatient stay may have been regarded as an escape from a traumatic home situation, and the patient may have found a series of caretakers (e.g., doctors, nurses, and hospital workers) to be loving and caring. In contrast, the patients' families of origin included a rejecting mother or an absent father. The usual history reveals that the patient perceives one or both parents as rejecting figures who are unable to form close relationships. The facsimile of genuine illness, therefore, is used to re-create the desired positive parent-child bond. The disorders are a

form of repetitional compulsion, repeating the basic conflict of needing and seeking acceptance and love while expecting that they will not be forthcoming. Hence, the patient transforms the physicians and staff members into rejecting parents. Patients who seek out painful procedures, such as surgical operations and invasive diagnostic tests, may have a masochistic personality makeup in which pain serves as punishment for past sins, imagined or real. Some patients may attempt to master the past and the early trauma of serious medical illness or hospitalization by assuming the role of the patient and reliving the painful and frightening experience over and over again through multiple hospitalizations. Patients who feign psychiatric illness may have had a relative who was hospitalized with the illness they are simulating. Through identification, patients hope to reunite with the relative in a magical way. Many patients have the poor identity formation and disturbed self-image that is characteristic of someone with borderline personality disorder. Some patients are as-if personalities who have assumed the identities of those around them. If these patients are health professionals, they are often unable to differentiate themselves from the patients with whom they come in contact. The cooperation or encouragement of other persons in simulating a factitious illness occurs in a rare variant of the disorder. Although most patients act alone, friends or relatives participate in fabricating the illness in some instances. Significant defense mechanisms are repression, identification with the aggressor, regression, and symbolization. **Biological Factors** Some researchers have proposed that brain dysfunction may be a factor in factitious disorders. It has been hypothesized that impaired information processing contributes to the pseudologia fantastica and aberrant behavior of patients with Munchausen disorder; however, no genetic patterns have been established, and electroencephalographic (EEG) studies noted no specific abnormalities in patients with factitious disorders. **DIAGNOSIS AND CLINICAL FEATURES** Factitious disorder is the faking of physical or psychological signs and symptoms. Clues that should trigger suspicion of the disorder are given in Table 13.6-1. The psychiatric examination should emphasize securing information from any available friends, relatives, or other informants, because interviews with reliable outside sources often reveal the false nature of the patient's illness. Although time-consuming and tedious, verifying all the facts presented by the patient about previous hospitalizations and medical care is essential. **Table 13.6-1 Clues that Should Trigger Suspicion of Factitious Disorder**

Psychiatric evaluation is requested on a consultation basis in about 50 percent of cases, usually after a simulated illness is suspected. The psychiatrist is often asked to confirm the diagnosis of factitious disorder. Under these circumstances, it is necessary to avoid pointed or accusatory

questioning that may provoke truculence, evasion, or flight from the hospital. A danger may exist of provoking frank psychosis if vigorous confrontation is used; in some instances, the feigned illness serves an adaptive function and is a desperate attempt to ward off further disintegration. Factitious disorder has been divided into two groups depending on the types of signs or symptoms feigned. There is one disorder marked by psychological symptoms and another marked by physical symptoms. Both may occur together. In DSM-5, no distinction is made between the two and the disorder is divided into that “imposed on self” and that “imposed on another” (factitious disorder by proxy). In the discussion that follows, the clinical picture of either psychological symptoms or physical symptoms is considered separately. Factitious Disorder with Predominantly Psychological Signs and Symptoms Some patients show psychiatric symptoms judged to be feigned. This determination can be difficult and is often made only after a prolonged investigation. The feigned symptoms frequently include depression, hallucinations, dissociative and conversion symptoms, and bizarre behavior. Because the patient’s condition does not improve after routine therapeutic measures are administered, he or she may receive large doses of psychoactive drugs and may undergo electroconvulsive therapy. Factitious psychological symptoms resemble the phenomenon of pseudomalingering, conceptualized as satisfying the need to maintain an intact self-image, which would be

marred by admitting psychological problems that are beyond the person’s capacity to master through conscious effort. In this case, deception is a transient ego-supporting device. Recent findings indicate that factitious psychotic symptoms are more common than had previously been suspected. The presence of simulated psychosis as a feature of other disorders, such as mood disorders, indicates a poor overall prognosis. Inpatients who are psychotic and found to have factitious disorder with predominantly psychological signs and symptoms—that is, exclusively simulated psychotic symptoms—generally have a concurrent diagnosis of borderline personality disorder. In these cases, the outcome appears to be worse than that of bipolar I disorder or schizoaffective disorder. Patients may appear depressed and may explain their depression by offering a false history of the recent death of a significant friend or relative. Elements of the history that may suggest factitious bereavement include a violent or bloody death, a death under dramatic circumstances, and the dead person being a child or a young adult. Other patients may describe either recent and remote memory loss or both auditory and visual hallucinations. Some patients may use psychoactive substances for the purpose of producing symptoms, such as stimulants to produce restlessness or insomnia, or hallucinogens to produce distortions of reality. Combinations of psychoactive substances can produce very unusual presentations. Other symptoms, which also appear in the physical type of factitious disorder, include pseudologia fantastica and impostorship. In pseudologia fantastica, limited factual material is mixed with extensive and colorful fantasies. The listener’s interest pleases the patient and, thus, reinforces the symptom. The history or the symptoms are not the only distortions of truth. Patients often give false and conflicting accounts about other areas of their lives (e.g., they may claim the death of a parent, to play on the sympathy of others). Imposture is commonly related to lying in these cases. Many patients assume the identity of a prestigious person. Men, for example, report being war heroes and attribute their surgical scars to wounds received during battle or in other dramatic and dangerous exploits. Similarly, they may say that they have ties to accomplished or renowned figures. Table 13.6-2 lists various syndromes feigned by patients who want to be seen as having a mental illness. Table 13.6-2 Presentations in Factitious Disorder with Predominantly Psychological Signs and Symptoms

Ms. MA was 24 years of age when she first presented in 1973 after an overdose. She gave a history of recurrent overdoses and wrist-slashing attempts since 1969, and, on admission, she stated that she was controlled by her dead sister who kept telling her to take her own life. Her family history was negative. She was found to be carrying a list of Schneiderian first-rank symptoms in her handbag; she behaved bizarrely, picking imaginary objects out of the wastepaper basket and opening imaginary doors in the waiting room. She admitted to visual hallucinations and offered four of the first-rank symptoms on her list, but her mental state reverted to normal after 2 days. When she was presented at a case conference, the consensus view was that she had been simulating schizophrenia but had a gross personality disorder; however, the consultant in charge dissented from that general view, feeling that she was genuinely psychotic. On follow-up, this turned out to be the case. She was readmitted in 1975 and was mute, catatonic, grossly thought disordered, and the diagnosis was changed to that of a schizophrenic illness. She has been followed up regularly since and now presents the picture of a mild schizophrenic defect state; she takes regular depot medication but still complains of auditory hallucinations, hearing her dead sister's voice. She is a day patient. (Courtesy of Dora Wang, M.D., Deepa N. Nadiga, M.D., and James J. Jenson, M.D.)

Chronic Factitious Disorder with Predominantly Physical Signs and Symptoms Factitious disorder with predominantly physical signs and symptoms is the best-known type of Munchausen syndrome. The disorder has also been called hospital addiction, polysurgical addiction—producing the so-called washboard abdomen—and professional patient syndrome, among other names. The essential feature of patients with the disorder is their ability to present physical symptoms so well that they can gain admission to, and stay in, a hospital. To support their history, these patients may feign symptoms suggesting a disorder involving any organ system. They are familiar with the diagnoses of most disorders that usually require hospital admission or medication and can give excellent histories capable of

deceiving even experienced clinicians. Clinical presentations are myriad and include hematoma, hemoptysis, abdominal pain, fever, hypoglycemia, lupus-like syndromes, nausea, vomiting, dizziness, and seizures. Urine is contaminated with blood or feces; anticoagulants are taken to simulate bleeding disorders; insulin is used to produce hypoglycemia; and so on. Such patients often insist on surgery and claim adhesions from previous surgical procedures. They may acquire a “gridiron” or washboard-like abdomen from multiple procedures. Complaints of pain, especially that simulating renal colic, are common, with the patients wanting narcotics. In about half the reported cases, these patients demand treatment with specific medications, usually analgesics. Once in the hospital, they continue to be demanding and difficult. As each test is returned with a negative result, they may accuse doctors of incompetence, threaten litigation, and become generally abusive. Some may sign out abruptly shortly before they believe they are going to be confronted with their factitious behavior. They then go to another hospital in the same or another city and begin the cycle again. Specific predisposing factors are true physical disorders during childhood leading to extensive medical treatment, a grudge against the medical profession, employment as a medical paraprofessional, and an important relationship with a physician in the past. See Color Plate 13.6-2 for factitious skin disease.

Factitious Disorder with Combined Psychological and Physical Signs and Symptoms In combined forms of factitious disorder, both psychological and physical signs and symptoms are present. In one representative report, a patient alternated between feigned dementia, bereavement, rape, and seizures. Table 13.6-3 provides a comprehensive overview of a variety of signs and symptoms that may be faked and mistaken for genuine illness. The table also includes the means of simulation and possible methods of detection.

Table 13.6-3 Presentations of Factitious Disorder with Predominantly Physical Signs and Symptoms with Means of Simulation and Possible Methods of Detection

Factitious Disorder by Proxy In this diagnosis, a person intentionally produces physical signs or symptoms in another person who is under the first person's care, hence the DSM-5 diagnosis of "Factitious Disorder Imposed on Another." One apparent purpose of the behavior is for the caretaker to indirectly assume the sick role; another is to be relieved of the caretaking role by having the child hospitalized. The most common case of factitious disorder by proxy involves a mother who deceives medical personnel into believing that her child is ill. The deception may involve a false medical history, contamination of laboratory samples, alteration of records, or induction of injury and illness in the child. BC, a 1-month-old girl, was admitted for the evaluation of fever. Psychiatric consultation was requested due to inconsistencies in the mother's reporting of medical information despite her presentation as a knowledgeable and caring mother who worked as an emergency medical technician. BC's mother reported her own diagnosis of ovarian cancer when she was 3 months pregnant with BC. She reported undergoing a hysterectomy during her cesarean section, and that she had been getting radiation therapy at a local hospital since BC's birth. The pediatrician called the local hospital with the mother's permission and learned that she had a corpus luteum cyst removed at 3 months' gestation and mild hydronephrosis but no cancer or hysterectomy. BC's mother, when confronted with this, stated only that she might need a kidney transplant for the hydronephrosis. On further exploration, it was discovered that the mother had brought her children to multiple emergency rooms, giving inaccurate histories that prompted excessive testing. At one visit, she told clinicians that her 2-year-old son had lupus and hypergammaglobulinemia, and at another visit, that he had asthma and seizures. She also pursued a minor cosmetic surgical procedure for him against his pediatrician's recommendation. Clinicians suspected that BC's mother intentionally fabricated symptoms, such as by

warming BC's thermometer, and that she did not actively induce symptoms in her children. She was faithful in keeping medical appointments, and her children appeared healthy and well cared for, despite her factitious behavior. The mother denied a psychiatric history but gave permission for clinicians to contact the local psychiatric hospital, which revealed her history of depression, anorexia, panic disorder, and a suicide attempt resulting in a psychiatric hospitalization.

Subsequently, she received psychotherapy and psychopharmacotherapy, which she stopped a few months prior to this presentation. During BC's admission for fever, her mother agreed to resume psychiatric treatment. A social services referral was made, and the pediatrician decided to schedule regular follow-up visits for the children. **PATHOLOGY AND LABORATORY EXAMINATION** Psychological testing may reveal underlying pathology in individual patients. Features that are overrepresented in patients with factitious disorder include normal or aboveaverage intelligence quotient, absence of a formal thought disorder, poor sense of identity, including confusion over sexual identity, poor sexual adjustment, poor frustration tolerance, strong dependence needs, and narcissism. An invalid test profile and elevations of all clinical scales on the Minnesota Multiphasic Personality Inventory² (MMPI-2) indicate an attempt to appear more disturbed than is the case ("fake bad"). No laboratory or pathology tests are diagnostic of factitious disorders, although they may help to confirm the diagnosis by demonstrating deception. Certain tests (e.g., drug screening), however, may help confirm or rule out specific mental or medical disorders. **DIFFERENTIAL DIAGNOSIS** Any disorder in which physical signs and symptoms are prominent should be considered in the differential diagnosis, and the possibility of authentic or concomitant physical

illness must always be explored. Additionally, a history of many surgeries in patients with factitious disorder may predispose such patients to complications or actual diseases, necessitating even further surgery. Factitious disorder is on a continuum between somatoform disorders and malingering, the goal being to assume the sick role. On the one hand, it is unconscious and nonvolitional, and on the other hand, it is conscious and willful (malingering). Conversion Disorders A factitious disorder is differentiated from conversion disorder by the voluntary production of factitious symptoms, the extreme course of multiple hospitalizations, and the seeming willingness of patients with a factitious disorder to undergo an extraordinary number of mutilating procedures. Patients with conversion disorder are not usually conversant with medical terminology and hospital routines, and their symptoms have a direct temporal relation or symbolic reference to specific emotional

conflicts. Hypochondriasis or illness anxiety disorder differs from factitious disorder in that the hypochondriacal patient does not voluntarily initiate the production of symptoms, and hypochondriasis typically has a later age of onset. As with conversion disorder, patients with hypochondriasis do not usually submit to potentially mutilating procedures. Personality Disorders Because of their pathological lying, lack of close relationships with others, hostile and manipulative manner, and associated substance abuse and criminal history, patients with factitious disorder are often classified as having antisocial personality disorder. Antisocial persons, however, do not usually volunteer for invasive procedures or resort to a way of life marked by repeated or long-term hospitalization. Because of attention seeking and an occasional flair for the dramatic, patients with factitious disorder may be classified as having histrionic personality disorder. But not all such patients have a dramatic flair; many are withdrawn and bland. Consideration of the patient's chaotic lifestyle, history of disturbed interpersonal relationships, identity crisis, substance abuse, self-damaging acts, and manipulative tactics may lead to the diagnosis of borderline personality disorder. Persons with factitious disorder usually do not have the eccentricities of dress, thought, or communication that characterize schizotypal personality disorder patients. Schizophrenia The diagnosis of schizophrenia is often based on patients' admittedly bizarre lifestyles, but patients with factitious disorder do not usually meet the diagnostic criteria for schizophrenia unless they have the fixed delusion that they are actually ill and act on this belief by seeking hospitalization. Such a practice seems to be the exception; few patients with factitious disorder show evidence of a severe thought disorder or bizarre delusions. Malingering Factitious disorders must be distinguished from malingering. Malingerers have an obvious, recognizable environmental goal in producing signs and symptoms. They may seek hospitalization to secure financial compensation, evade the police, avoid work, or merely obtain free bed and board for the night, but they always have some apparent end for their behavior. Moreover, these patients can usually stop producing their signs and symptoms when they are no longer considered profitable or when the risk becomes too great. Substance Abuse Although patients with factitious disorders may have a complicating history of substance abuse, they should be considered not merely as substance abusers but as having

coexisting diagnoses. Ganser's Syndrome Ganser's syndrome, a controversial condition most typically associated with prison inmates, is characterized by the use of approximate answers. Persons with the syndrome respond to simple questions with astonishingly incorrect answers. For example, when asked about the color of a blue car, the person answers "red" or answers "2 plus 2 equals 5." Ganser's syndrome may be a variant of malingering, in that the patients avoid

punishment or responsibility for their actions. Ganser's syndrome can be classified in DSM-5 as a type of dissociative disorder and in International Statistical Classification of Diseases and Related Health Problems, 10th edition (ICD-10), it is classified under other dissociative or conversion disorders. In contrast, patients with factitious disorder with predominantly psychological signs and symptoms may intentionally give approximate answers. COURSE AND PROGNOSIS Factitious disorders typically begin in early adulthood, although they can appear during childhood or adolescence. The onset of the disorder or of discrete episodes of seeking treatment may follow real illness, loss, rejection, or abandonment. Usually, the patient or a close relative had a hospitalization in childhood or early adolescence for a genuine physical illness. Thereafter, a long pattern of successive hospitalizations begins insidiously and evolves. As the disorder progresses, the patient becomes knowledgeable about medicine and hospitals. The onset of the disorder in patients who had early hospitalizations for actual illness is earlier than generally reported. Factitious disorders are incapacitating to the patient and often produce severe trauma or untoward reactions related to treatment. A course of repeated or long-term hospitalization is obviously incompatible with meaningful vocational work and sustained interpersonal relationships. The prognosis in most cases is poor. A few patients occasionally spend time in jail, usually for minor crimes, such as burglary, vagrancy, and disorderly conduct. Patients may also have a history of intermittent psychiatric hospitalization. Although no adequate data are available about the ultimate outcome for the patients, a few of them probably die as a result of needless medication, instrumentation, or surgery. In view of the patients' often expert simulation and the risks that they take, some may die without the disorder being suspected. Possible features that indicate a favorable prognosis are (1) the presence of a depressive-masochistic personality; (2) functioning at a borderline, not a continuously psychotic, level; and (3) the attributes of an antisocial personality disorder with minimal symptoms. TREATMENT No specific psychiatric therapy has been effective in treating factitious disorders. It is a

clinical paradox that patients with the disorders simulate serious illness and seek and submit to unnecessary treatment while they deny to themselves and others their true illness and thus avoid possible treatment for it. Ultimately, the patients elude meaningful therapy by abruptly leaving the hospital or failing to keep follow-up appointments. Treatment, thus, is best focused on management rather than on cure. Guidelines for the treatment and management of factitious disorder are given in Table 13.6-4. The three major goals in the treatment and management of factitious disorders are (1) to reduce the risk of morbidity and mortality, (2) to address the underlying emotional needs or psychiatric diagnosis underlying factitious illness behavior, and (3) to be mindful of legal and ethical issues. Perhaps the single most important factor in successful management is a physician's early recognition of the disorder. In this way, physicians can forestall a multitude of painful and potentially dangerous diagnostic procedures for these patients. Good liaison between psychiatrists and the medical or surgical staff is strongly advised. Although a few cases of individual psychotherapy have been reported in the literature, no consensus exists about the best approach. In general, working in concert with the patient's primary care physician is more effective than working with the patient in isolation. Table 13.6-4 Guidelines for Management and Treatment of Factitious Disorder The personal reactions of physicians and staff members are of great significance in

treating and establishing a working alliance with these patients, who invariably evoke feelings of futility, bewilderment, betrayal, hostility, and even contempt. In essence, staff members are forced

to abandon a basic element of their relationship with patients —accepting the truthfulness of the patients' statements. One appropriate psychiatric intervention is to suggest to the staff ways of remaining aware that even though the patient's illness is factitious, the patient is ill. Physicians should try not to feel resentment when patients humiliate their diagnostic prowess, and they should avoid any unmasking ceremony that sets up the patients as adversaries and precipitates their flight from the hospital. The staff should not perform unnecessary procedures or discharge patients abruptly, both of which are manifestations of anger. Clinicians who find themselves involved with patients with factitious disorders may become angry at the patients for lying and deceiving them. Hence, therapists must be mindful of countertransference whenever they suspect factitious disorder. Often, the diagnosis is unclear because a definitive physical cause cannot be entirely ruled out. Although the use of confrontation is controversial, at some point in the treatment, patients must be made to face reality. Most patients simply leave treatment when their methods of gaining attention are identified and exposed. In some cases, clinicians should reframe the factitious disorder as a cry for help, so that patients do not view the clinicians' responses as punitive. A major role for psychiatrists working with patients with factitious disorder is to help other staff members in the hospital deal with their own sense of outrage at having been duped. Education about the disorder and some attempt to understand the patient's motivations may help staff members maintain their professional conduct in the face of extreme frustration. In cases of factitious disorder by proxy, legal intervention has been obtained in several instances, particularly with children. The senselessness of the disorder and the denial of false action by parents are obstacles to successful court action and often make conclusive proof unobtainable. In such cases, the child welfare services should be notified, and arrangements made for ongoing monitoring of the children's health (see Table 13.6-5 for interventions for pediatric factitious disorder by proxy).

Table 13.6-5 Interventions for Pediatric Factitious Disorder by Proxy

Pharmacotherapy of factitious disorders is of limited use. Major mental disorders such as schizophrenia will respond to antipsychotic medication; however, in all cases, medication should be administered carefully because of the potential for abuse. Selective serotonin reuptake inhibitors (SSRIs) may be useful in decreasing impulsive behavior when that is a major component in acting-out factitious behavior.

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