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CME Objective

After studying this article, you should be able to:

- Employ an understanding of underlying psychological factors that play a role in factitious disorder when diagnosing and managing this condition

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Psychological Aspects of Factitious Disorder

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ABSTRACT

Factitious disorder can present in multiple health care settings, with patients intentionally producing symptoms to assume the sick role. This assumption of the sick role can result in multiple hospitalizations with unnecessary diagnostic workup, as well as invasive diagnostic procedures that can lead to worrisome side effects. Differential diagnoses that should be ruled out include malingering, somatic symptom disorder, and anxiety disorders. For many providers, patients with factitious disorder can be a challenge to treat because the etiology of the disorder remains unclear. There are multiple psychological theories that attempt to explain the motivation and thought process behind the voluntary production of symptoms. Some of these theories have addressed disruptive attachments during childhood, possible intergenerational transfer of the disorder, personal identity conflicts, somatic illness as a form of masochistic activity toward oneself, and intrapsychic conflicts. Confrontation and psychotherapy with a multidisciplinary team has been proposed as a form of treatment. An understanding of the psychological factors associated with factitious disorder can help providers understand the rationale behind the patient's presentation and aid in the formulation of a treatment plan.

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Factitious disorder is currently classified in somatic symptoms and related disorders in the *DSM-5*. Patients with factitious, Latin for *artificial*, disorder present with various symptoms of disease processes that are intentionally produced to assume the role of a sick person. The symptoms are produced voluntarily and consciously with no intention of secondary gain.[1] Patients assume the sick role to receive the associated care and attention from others to cope with their emotional or psychological distress.[2]

Attempts have been made to explain the etiology of factitious disorder via biological and psychological factors; however, the exact cause is not fully understood. Biological factors such as abnormal electroencephalogram findings, head injury, central nervous system infections, and frontotemporal cortical atrophy have been reported.[1] In this article, we focus on providing a psychological explanation for the etiology of factitious disorder.

EPIDEMIOLOGY

The prevalence of factitious disorder is estimated to be 0.8%–1.0% of patients seen for a psychiatric consult.[3] The prevalence of factitious

Clinical Points

- Factitious disorder is more prevalent in females, especially those with health care training, with a mean age at onset of 25 years for both sexes.
- Symptoms may develop in childhood as a desire to receive comfort, attention, and protection from health care providers to compensate for a neglectful or abusive home environment.
- Treatment initiation and maintenance are challenging; however, psychotherapy remains the first-line treatment for patients with factitious disorder.

disorder can be difficult to determine due to many factors including multiple providers involved in the care of these patients, patients with factitious disorder being efficient at hiding their fraudulent behavior, and lack of health care providers trained in making the diagnosis.[4]

It is estimated that up to 5% of all patient and physician encounters may be due to factitious production of symptoms.[5] Studies[2] have examined the rate of various factitious symptoms produced by patients and have reported 2.2%–9.3% of fevers to be self-induced or factitious in those presenting with fever of unknown origin, as well as 2.5% of 3,300 specimens that were submitted as renal stones to be artifacts.

Krahn et al[6] studied 93 hospitalized patients with factitious disorder and reported 72% of the patients to be female, with a mean age of 30.7 years; whereas, the mean age of men was 40 years. The mean age at onset was 25 years for both sexes. Patients with factitious disorder commonly have health care–related jobs. The authors[6] reported health care training was more common in women than men.

CLINICAL FEATURES

The *DSM-5* criteria for factitious disorder include falsification of symptoms, presenting as ill or injured, evidence of deceptive behavior, and signs and symptoms not better explained by another psychiatric diagnosis.[7] The clinical presentation of these patients varies greatly from presenting with seizures or infections to headaches or kidney stones. There are multiple reports[8,9] of factitious disorder in which patients have falsified laboratory tests or exaggerated symptoms. Tseng and Poullos[8] described a patient who presented with Fournier's gangrene and was found to have injected contaminated sewage water in his scrotal veins. Churchill et al[9] reported a prevalence rate of 1.7% over a 5-year period of falsified HIV history and symptoms.

It is not uncommon for patients to present with psychiatric symptoms including dissociative identity disorder, bipolar disorder, depression, and psychosis. In a study[10] of 100 patients sequentially admitted to an inpatient psychiatric unit, a 6% prevalence rate of factitious disorder with psychiatric symptoms was found.

Patients with factitious disorder often provide vague histories or symptoms, which are often exaggerated and do not correlate with their physical appearance. Warning signs (Table 1) for health care providers include patients seeking treatment and testing at multiple sites, inconsistent histories, and discrepancies between patient behavior, symptoms, and history.[11] The physical examination may provide clues to self-inflicted injuries such as suspicious shapes or patterns of lesions or cultures that grow certain organisms.[11]

Table 1. Warning Signs for Factitious Disorder

Female sex, health care training
Multiple emergency room visits, hospitalizations, clinic visits, providers
Vague symptoms and history
Lack of objective findings to support history
Suspicious shape and color of lesions on physical examination
Blood, urine, or sputum cultures that grow unexpected organisms

Table 2. Differential Diagnosis of Factitious Disorder

Diagnosis	Symptom Production	Secondary Gain
Factitious disorder	Conscious	No
Malingering	Conscious	Yes
Somatic symptom disorder	Unconscious	No

Many of these patients are very cooperative during their hospital stay and will return back to their normal lives once discharged.[2] However, since assuming the sick role is important to their psychological and emotional well-being, these patients will continue the patterns of feigning symptoms and presenting to various health care providers.[2]

DIFFERENTIAL DIAGNOSIS

The differential diagnosis of factitious disorder includes but is not limited to somatic symptom disorder, malingering, conversion disorder, illness anxiety disorder, and anxiety disorders. Malingering is the conscious production of signs or symptoms for secondary gain, which may include drug seeking, monetary gain, and time off work. Patients with somatoform disorder have unconscious production of physical symptoms, which results in high levels of anxiety and distress in their lives. They have no intention of assuming the sick role or any other secondary gain. In conversion disorder, patients will exhibit genuine physical symptoms, which are the result of psychological distress (eg, seizures in young women at times of high stress during exam week at college).

Patients may present with high levels of anxiety or panic toward a particular symptom but do not meet criteria for factitious disorder. The main difference between any of these disorders and factitious disorder is the unconscious desire to assume the role of being sick (Table 2).[11]

PSYCHOLOGY OF FACTITIOUS DISORDER

It was previously theorized that patients with factitious disorder are aware of intentionally producing their illness but are uncertain of their motivation.[12] Contrary to this previous concept of factitious disorder, it has been suggested that patients with factitious disorder are sometimes aware of

why they choose to falsify a medical condition.[12] However, the psychology behind these motivations remains poorly understood.

This patient group is often reluctant to participate in research studies, and, consequently, the psychology of factitious disorder is not well studied. However, a few factors have been suggested. Among factitious disorder patients, psychological reasons underlying the condition include the thrill of undergoing medical procedures,[12] a need for attention or care,[13] and a sense of control through the deception of health care providers.[13] Other theories that have been proposed include disruption in childhood attachments, intergenerational transfer, masochistic behavior, poor self-identity, and intrapsychic defenses.[14–16]

Disruption in Attachments

Healthy relationships with caregivers are important for child development.[14] If there are problems in these relationships, children may seek to satisfy their innate need for caregiver attention by exhibiting illness behaviors. In this way, children can satisfy their need for comfort and protection through the attention of health care providers who—through completing the duties of their jobs—act as substitute caregivers.[14] These abnormal illness behaviors may extend into adolescence and adulthood. In this way, abnormal illness behaviors may affect the next generation either indirectly—if children model their own behavior after the parent with a history of factitious disorder—or directly if the parent abuses the child by forcing him or her to assume the patient role.[17,18]

Intergenerational Transfer

It is well established that adults who experienced abuse or neglect as children are more likely to become abusers themselves.[19–22] Therefore, individuals who develop factitious disorder in childhood to cope with abuse or neglect may be more likely to become abusers as adults. Through this process of the abused becoming abusers, the offspring of adults who coped with childhood abuse through factitious disorder may be at higher risk of becoming victims of factitious disorder imposed on another (also called Munchausen syndrome by proxy).[14] To simplify, the previously factitious disorder–afflicted parents may fabricate and impose illness on their children.[17,18] No studies have formally examined the possibility that factitious disorder may run in families through children modeling the abnormal illness behaviors of their parents.

Personal Identity

Patients with a diagnosis of factitious disorder commonly have a history of abuse, neglect, and unstable childhood environments. Due to these factors, patients often do not develop a strong sense of self and suffer from low self-esteem. The instability of their childhood results in these patients experiencing a lack of control over their lives. Hence, patients fabricate symptoms and their medical histories, which allows them to feel a sense of control over an aspect of their lives.[1] The role of an ill patient also provides these individuals an identity.[15]

Masochistic Attempts

Undergoing multiple invasive and possibly painful diagnostic tests, procedures, and treatment can be viewed as masochistic attempts.[23] Patients may use these painful measures to punish themselves in order to cope with guilt that may exist as part of their psychiatric comorbidities or history of abuse.[23]

Intrapsychic Defense

A psychodynamic approach to factitious disorder is to view it as an intrapsychic defense, wherein patients feel a sense of importance when receiving close care for their somatic complaints that can counter their low self-esteem.[24] When patients experience anger or aggression toward others, they mobilize somatic complaints as a pathway to obtain their attention. Once help for their somatic complaints is offered by others, these patients are able to decline it, and in this process, also reduce any intrapsychic conflict that was caused by the anger.[24] Being ill is also an effective shield that protects the patient's ego from guilt that may arise from not being able to meet expectations at work, in his or her personal life, or in any other setting.[24]

CLINICAL MANAGEMENT

Similar to diagnosis, treatment of factitious disorder can be difficult and usually requires a multidisciplinary team of a psychiatrist, primary care physician, therapist, social worker, and family members to help the patient develop insight and recover.[1] Patients generally are not receptive to psychiatric care and will often change providers or clinical sites to prevent the pursuit of treatment. There is also a high follow-up dropout rate.[25]

The goal of treatment is to limit the patient's risk of adverse reactions and health care costs of unnecessary treatment and diagnostic tests.[1] Multiple case reports[1] have described the benefit of psychotherapy; however, the evidence behind the use of confrontation remains unclear.

A study[26] of 24 patients with factitious disorder showed only 50% of the patients accepted and pursued psychotherapy. Of those 12 patients, 2 dropped out of treatment and 10 continued therapy for 4 years. The patients are described to have "progressed favorably, with a significant, or at least marked, improvement of the symptomology and the relation capability." [26(p106)]

Bolat and Yalçin[25] recommend using psychoeducation followed by confrontation of the patient's symptoms and disorder. During the psychoeducation phase, they recommend that clinicians (1) provide education regarding factitious disorder, (2) help the patient understand the distinction between factitious disorder and malingering to minimize negative reactions, (3) help the patient understand the symptoms as a request for help, and (4) describe the treatment outcome and help manage the reaction of the

family to the diagnosis of factitious disorder.[25] This phase is to be followed by confrontation of the patient's symptoms. Early intervention and patient acknowledgment of deceit help prevent repetition of the cycle.

Others[27] have recommended avoiding confronting the patient and using techniques such as "inexact interpretation"—the patient is informed that there is a problem; however, it is related to psychological factors. Another technique is to provide the patient with a "face-saving" treatment option to prevent any humiliation by informing the patient that the symptoms or illness may not be responsive to conventional medication treatment. Patients can be offered therapeutic techniques such as hypnosis to help with the healing of the physical and psychological distress.[1]

Psychopharmacologic treatment for factitious disorder and evidence for its efficacy remain lacking, as psychotherapy is considered to be first-line treatment. Treatment of any psychiatric comorbidities such as depression, anxiety, or psychosis can be beneficial for the patient. Selective serotonin reuptake inhibitors (SSRIs) may be used to treat impulsivity in patients for whom it plays a role in the production of feigned symptoms.[3] There is no specific pharmacologic agent approved by the US Food and Drug Administration; however, SSRIs, antipsychotics, mood stabilizers, and antianxiety agents have been used in case reports[28] with variable success.

CONCLUSION

An understanding of the underlying psychological factors that play a role in factitious disorder can assist providers in better understanding the patient's illness. Utilization of this understanding while providing psychotherapy or using confrontation with a patient can be of great benefit in reducing the need for invasive and expensive diagnostic testing, hospital admissions, office visits, and the use of medications.

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For the CME Posttest, see next page.

POSTTEST

To obtain credit, go to http://www.cmeinstitute.com/activities/Pages/PCC.aspx to complete the Posttest and Evaluation.

1. **Patients with factitious disorder have unconscious production of physical symptoms that they utilize for secondary gain, as compared to patients who are malingering.**
   a. True
   b. False

2. **You have a 45-year-old female patient, Ms D, who presented in primary care with symptoms of severe abdominal pain, which are limiting her daily activity. An extensive workup has been performed by the gastroenterology team with no explanation of the symptoms. Ms D denies any anxiety or mood symptoms. You do not believe that she is feigning these symptoms and have no reason to suspect secondary gain. Which statement about evidence-based treatment options should you advise for Ms D at this time?**
   a. Treatment of the patient with a selective serotonin reuptake inhibitor may help improve her quality of life
   b. A multidisciplinary team with the primary care physician, psychiatrist, social worker, and therapist would be the ideal treatment approach
   c. The use of confrontation in these patients is extremely helpful and often a successful treatment option
   d. Refer the patient to surgery for an exploratory laparotomy

3. **Which of the following statements regarding the treatment of factitious disorder is *true*?**
   a. Many agents have been US Food and Drug Administration–approved for treatment of factitious disorder
   b. Once diagnosed correctly, most patients are willing to be involved in treatment, and their symptoms usually remit
   c. The goal of treatment should be to prevent further harm by limiting unnecessary treatment and diagnostic testing