

# Factitious disorder

## Introduction

Factitious disorder involves the intentional production or feigning of symptoms or disabilities. The motivation for this behaviour is not well understood, but is believed to be an unconscious way of having emotional needs met through the sick role.

Because of diagnostic difficulties and the secrecy and itinerant nature of patients with factitious disorder, evidence on which to base treatment guidelines is scarce. This article presents two cases of factitious disorder and discuss the diagnostic difficulties and management approaches to the illness.

## Discussion

Factitious disorder can present with a variety of physical or psychological signs or symptoms (Table 1), the former group being more common. The sociodemographic profile of patients shows a predominance of women between 20 and 40 years of age, often employed in health-related fields. Their presentations are episodic, usually in response to negative life events.

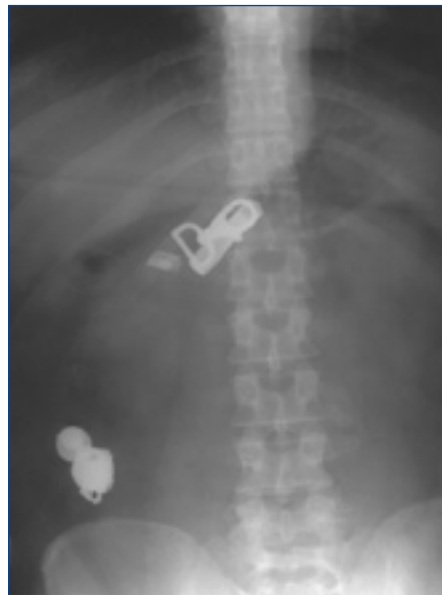


Figure 1. X-ray showing ingested objects in the duodenum and ileocaecum (case report 1).

Case 2 was diagnosed with ‘Munchausen’s syndrome’, a subgroup that represents 10% of cases of factitious disorder (Table 2) (Reich and Gottfried,

Table 1. The commonest feigned physical and psychological signs and symptoms in factitious disorder

Physical	Pain
	Pyrexia of unknown origin
	Infection
	Impaired wound healing
	Hypoglycaemia
	Seizures
	Diarrhoea
	Haematuria
Psychological	Bereavement
	Cognitive impairment
	Depression
	Post-traumatic stress disorder

1983). These patients are commonly socially isolated middle-aged men of low socioeconomic status (Feldman and Ford, 2000).

Making an accurate diagnosis of factitious disorder is hampered by the lack of valid tools to assess motivation and consciousness, and by its high comorbidity with other physical and psychiatric conditions including, as in case 1, self-harming behaviour. Other differential diagnoses include the somatoform and conversion disorders, where physical symptoms are produced unintentionally as a result of an assumed unconscious repression of psychological conflicts.

It may be difficult to distinguish factitious disorder from true illness, particularly considering the comorbidity of genuine illness preceding or occasioned by the condition. Factitious disorder should also be distinguished from malingering, which involves the intentional production or

## Case Report 1

A 38-year-old man presented with a 3-day history of abdominal pain and haematemesis, after swallowing several metal objects: razor blades, a magnet, a battery and keys. He requested surgery to have the objects removed. On physical examination he had generalized abdominal tenderness. The ingested objects were visible on an abdominal X-ray (Figure 1). Following admission the patient discharged himself before a psychiatric assessment could be made. Subsequently it was found that the patient had presented with the same problem to two local hospitals within the previous month.

## Case Report 2

A 53-year-old man presented with a history of loin pain, associated with dysuria and grit in the urine. He reported a past history of prostate cancer, femoral osteosarcoma, and a recent myocardial infarction. He also reported a previous stroke with dysphagia that had necessitated the insertion of a percutaneous endoscopic gastrostomy (PEG) tube. Physical examination showed the PEG in situ and tenderness over the left renal angle. Blood investigations, including prostate-specific antigen, were normal. Urinalysis showed haematuria but a renal ultrasound and intravenous urogram were unremarkable. The patient was admitted and prescribed regular morphine. Five days later he reported severe pain in the left hip, radiating down the leg. A lumbar spine X-ray, bone scan and electromyography were all normal.

After unsuccessful attempts to access previous medical records and contact any informants a psychiatric assessment was requested. The patient’s history contained demonstrably false information, including his assertion that he had been the lead singer of a famous 1970s pop group. When challenged about this and the lack of corroborative information for his past medical history the patient insisted on his version of the facts. However, he agreed to have the PEG removed and all medication discontinued before discharge. He did not accept psychiatric follow-up.

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**Table 2. Features of the Munchausen's syndrome sub-group of factitious disorder**

Core symptoms	Chronic disorder
	Multiple attendances at different hospitals
	Pathological lying
Associated symptoms	Use of aliases
	Dramatic presentation
	Use of medical terminology to intimidate health-care professionals
	Inconsistent and vague history which is difficult to corroborate

From Huffman and Stern (2003)

feigning of symptoms consciously motivated by external incentives, such as financial compensation or escape from incarceration.

Ultimately, factitious disorder is often a diagnosis of exclusion. The consistency of a patient's history should be tested and cor-

roborative information sought. Close observation on a ward may uncover incriminatory objects or behaviour.

In the management of factitious disorder confrontation of the patient by the treating physician and a psychiatrist is most commonly advocated. However, this rarely changes the patient's behaviour as he/she will often discharge him-/herself from hospital and intensify the severity of subsequent presentations elsewhere (Van der Feltz-Cornelis, 2000). Non-confrontational approaches can be more successful. These involve sustaining a therapeutic relationship and contact with the patient, with the aim of identifying and addressing the psychological issues that contribute to the disorder.

The prognosis of factitious disorder is poor because of the patient's reluctance to accept psychiatric treatment and the increased morbidity and mortality, particularly in those with predominantly physical symptoms, and in patients seeking to confirm their illness through litigation (Eisendrath and McNiel, 2004).

## Conclusions

Factitious disorders present a diagnostic and therapeutic challenge. Health-care professionals should maintain a high degree of suspicion in patients with inconsistent and uncorroborated histories. Engaging the patient in a therapeutic relationship is probably the key to changing his/her behaviour. **BJHM**

Table 2 is reproduced from Huffman and Stern (2003) by kind permission of Elsevier.

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## IN THE PUBLIC'S VIEW

# Pouring oil on troubled waters

This government is tired. The media are certainly tired of it. Who knows how much is simply a result of its having been in office for nearly 10 years, and how much is a result of the Iraq effect. I lost confidence in New Labour right from the start, when they could have raised taxes but didn't. From then on it was catch-up all the time, and on some fronts – child poverty and, yes, health – they caught up quite well. But Iraq was terminal. Worse has been the refusal to understand its consequences, with the almost farcical denial that Iraq has fuelled terrorism. Only members of the cabinet seem to deny what is obvious to everyone else. They don't even have the courage to say, 'Well, yes it has; but it is a price we have to pay.' If it was a price worth paying, the public would pay it. But Saddam Hussein was not Hitler. The world is a complicated place. The Bush–Blair doctrine may well be making it less complicated, but to nobody's advantage. Meanwhile, of places without oil or strategic importance – Sudan, Myanmar, Zimbabwe – we take less notice.

Perhaps, if Iraq had not happened, the

media would be less critical of the government, and less sustained in its criticism of some key stories. A current medical story with a good head of steam is Connecting for Health (CfH), the ambitious project for computerizing the NHS. Critic after critic has worried about the delays and the escalating costs; government ministers brush them aside. According to a book that brings tears to the eyes (Craig, 2006), Choose and Book (C&B), one of the trumpeted advantages of CfH, managed just 65 of a planned 200 000 appointments in 2004. Assuming that C&B does finally get off the ground, and that Craig's calculations are correct, its projected costs over the first 10 years would provide every GP's surgery with £10 000 per year to employ a junior clerical assistant. And it would still leave £22 million over each year for front-line services. In the words of one Patricia Hewitt, 'waste and inefficiency in the NHS is intolerable. A penny wasted is a penny stolen from a patient.' – but she was criticizing front-line services when she said it.

Coming too late for Craig's book was the suspension from stock market trading of

iSoft, the company in charge of CfH. The company is suspected of 'highly unusual accounting practices' according to the *Guardian* (23 August 2006, p1), but what is in no doubt is that the three founders of the company gained a cool £80 million between them from share trading. Hewitt, so keen to criticize NHS trusts for inefficiency, seems to have let that one go by.

I am no expert on large computer systems, but Ian Soady, as a former chair of the NHS Information Authority, presumably is. A further story in the *Guardian* prompted him to write a letter accusing the present planners of adopting 'simplistic solutions which were under-researched, had no meaningful clinical input, and were based on naïve solutions... totally inappropriate to the [extremely complicated] NHS'.

Which is, more or less, a good summary of much of New Labour's attempt to 'reform' health care. **BJHM**

Craig D (2006) *Plundering the public sector*. Constable & Robinson, London

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