Factitious disorder (FD), sometimes known as Munchausen’s syndrome, is a rare psychiatric disorder that presents with feigned physical and/or psychiatric symptoms. First described by Asher in a classical but rather extreme example, it does present in milder forms, and across a spectrum of severity. Arguments about underdiagnosis notwithstanding, prevalence studies suggest between 0.5 and 2 per cent population prevalence. In my practice as a consultant in liaison psychiatry for over a decade, I have seen two definite cases with a further one referred, who never attended appointments, and most GPs will never see one. Most patients are female and some research suggests an increased representation among healthcare workers.

The focus of this article is FD presenting with signs and symptoms in the adult sufferer; cases in adults and children “by proxy” raise different questions and the interventions and implications of diagnosis are also different. For those interested in this area, further reading is available.

Definitions and disambiguation
WHO’s International Classification of Diseases 10th revision (ICD-10) codes FD as: F68.1 “Intentional production or feigning of symptoms or disabilities, either physical or psychological (factitious disorder)”. It offers the following description, rather than an operationalised definition: “The patient feigns symptoms repeatedly for no obvious reason and may even inflict self-harm in order to produce symptoms or signs. The motivation is obscure and presumably internal with the aim of adopting the sick role. The disorder is often combined with marked disorders of personality and relationships.”

The American Psychiatric Association’s Diagnostic Statistical Manual 5th edition (DSM-5) also includes this disorder, subdividing it into cases in which the person presenting with the symptoms is the patient and cases in which the symptoms are presented by another person.

Figure 1. Procedure for management of suspected factitious disorder

Recognition and management of factitious disorder

Adam Burnel

Factitious disorder is a rare psychiatric disorder characterised by feigned medical symptoms. This article discusses the warning signs and describes a management approach that maximises engagement with the patient while minimising harm.
Factitious disorder

• Seeking treatment/investigations at multiple sites, especially:
  - when repeatedly avoiding primary physician
  - going outside standard/local care arrangements
• Inconsistency in history, signs, previous investigations, especially if:
  - investigations actually contradict history
  - behaviour contradicts history or signs on examination
• Behaviour suggestive of inducing illness/injury, eg:
  - only presenting with abnormal sample when able to do so privately
  - only showing abnormal tests when not in hospital
• Actual evidence of self-induced illness/injury, eg:
  - suspicious shape or distribution of lesions
  - presence of certain organisms in wounds or samples

Table 1. Factitious disorder warning signs

Patients without demonstrable physical disease may present with concerns about an illness or physical symptoms but not have FD. Patients with health anxiety, panic disorder, somatoform and conversion disorders may all present in this fashion, as well as those with certain rare forms of psychosis. The key to differentiation here is the presence or absence of other aspects of the relevant syndrome, and in particular the absence of the presumed intention to receive care. Although it may not always feel like it, a person with somatisation disorder will want to be well; a person with FD will not – although they may say that they do. The other presentation potentially confused with FD is malingering. This is not a disease state and is differentiated from FD through pursuit of the external (often, but not exclusively, pecuniary) rewards associated with being “ill”, as opposed to the intention of receiving care in FD. There is clearly some overlap between these two conditions and the recent article by Bass and Halligen\(^6\) discusses the finer points of differentiation. From the point of view of primary care, the main task is to recognise the possibility of this rare disorder when the clinical presentation suggests it. Further investigation inevitably involves other clinicians.

Diagnosis

As indicated, the process of arriving at a diagnosis in cases of FD will involve more than one clinician and may take some time. When suspicion of this disorder is aroused (see Table 1) there is general agreement about how to proceed (see Figure 1), although there is no robust evidence to support any one approach. An important principle to bear in mind is to attempt to obtain objective evidence and corroboration. For people with FD working in a caring role, the diagnosis may have profound implications but it is still necessary, not least to safeguard the vulnerable. For less experienced practitioners coming into contact with someone they suspect has FD, it is sensible to discuss the case with a more experienced colleague. Once there is evidence of symptoms or signs being feigned, it is time to take matters further.

There is usually more than one practitioner involved by the time this diagnosis is a serious possibility. It is essential that as far as possible all healthcare practitioners currently involved are engaged in the next steps. Given the complex psychiatric nature of FD, it has been suggested\(^6\) that before any diagnostic interview with the patient, there is a discussion with the relevant psychiatrist; most likely working in the local community mental health team when the situation is based in primary care, preferably a liaison psychiatrist when the setting is in secondary care. Liaison psychiatry services will vary in their community presence, but it will be worthwhile contacting the relevant liaison psychiatrist in any event. They may well become involved at a later stage, if they are not already.

Once the relevant professionals have had an opportunity to discuss the case and aftercare arrangements are clarified, a diagnostic interview with the patient is required. Some patients will respond with anger to an attempt to raise the possibility of FD. Depending on circumstances, it may be advisable to seek legal advice and the interview itself should always be conducted with another healthcare professional present. Some patients may respond with other forms of distress, and self-harm following such discussion is not unknown. It is usual, although not essential, for the interview to be led by the psychiatrist.

It is vital that the interview with the patient is approached as a “breaking bad news” exercise. The matters to be raised are likely to be unwelcome, and at least emotive. In keeping with the breaking bad news paradigm, clinicians should allow sufficient time, be prepared for an emotional interaction and make allowance for follow-up appointments.

The purpose of the diagnostic interview is to explore the possibility of the diagnosis from the point of view that the patient is suffering from an unpleasant disorder that requires sympathy and a focus on what might actually help. Because of the scope of this article, it is not possible to go into detail with regard to typical lines of questioning or phrases. However, by the end of this process, if successful, there will be agreement about the problems and what to do about them.

Treatment

The treatment of FD itself is nonpharmacological (see Table 2). However, where there are co-morbid psychiatric or physical health disorders, these clearly require treatment, and this can become a sensitive and difficult issue to manage. A guiding principle in managing FD is to clearly agree any interventions required in advance, and to have a mechanism for keeping any ongoing or new interventions proactively under review. Communication between all those who come into contact with the patient is vital. There have been recommendations for a national database including aliases, but so far this has not happened. However, it may be that there are local systems in place to facilitate communication about people with FD and it may be worthwhile to explore this with colleagues or more senior health managers.

The nonpharmacological management of FD can be regarded as falling into two broad camps. Firstly there are direct attempts to help the sufferer with the disorder itself. There is currently no evidence base for guidance, but generally some form of psychotherapeutic intervention is merited. It is reasonable to expect that there may be a number of attempts at such interventions. It may also be useful to consider more than one modality of treatment. There are no reliable figures in terms of prognosis. Clinical experience suggests that a significant proportion of patients go on to have chronic courses of variable severity.

The second strand of nonpharmacological treatment is the wider management of FD sufferers’ medical needs. As suggested
above, there is a need to maintain a twin posture of sympathetic therapeutic endeavour with robust control of access to healthcare interventions, in an effort to limit harm. The GP will be at the centre of this endeavour as they are likely to be the healthcare practitioner with the widest angle on the patient’s contacts with other practitioners and services. Although matters are improving, healthcare record systems are notoriously fragmentary. This is true even before considering the possibility that people with FD may present using a false name, date of birth and fabricated histories. Although it is extremely difficult, all those who come into contact with an FD sufferer must be meticulous in documenting their contact and share this with as many other healthcare practitioners as possible who are currently, or likely to become, involved, in the individual’s care. As a bare minimum, there should always be communication with the GP.

There is always tension associated with proceeding with medical interventions when there is prior knowledge of feigned symptoms. Clinicians can feel on the horns of a dilemma: if one overinvestigates/treats, one may be guilty of facilitating iatrogenic harm and squandering scarce resources. On the other hand, people with FD can and do become unwell the same as anyone without a history of FD. In my view, the helpful rule of thumb that applies to medically unexplained symptoms also applies in the management of FD, although with a significant caveat. If a person presents with a new set of symptoms or signs, or if a previously noted set of symptoms and signs changes significantly, then this should merit further investigation. The caveat that applies in the case of a person with known FD is that it is important to try to be sure there is a good level of clinical consistency in the history and examination findings before proceeding. Another colleague’s opinion may be useful. Clinicians should progress with further investigations or interventions only on a clearly agreed basis and avoid escalating potential harm as far as possible.

Further management

The management of a person suffering from FD is likely to extend over a considerable period of time. For any clinician who is going to remain involved, it will be important to make supportive resources available across that period. Many primary care sites now operate systems to help cope with patients with FD and other demanding problems. Continuity of care is helpful, but must be sustainable. Agreed, regular contact is one way to keep abreast of problems, but agreement may be difficult to obtain. This article has so far described accepted practice in relation to patients presenting with FD for the first time without serious health concerns. The other form of presentation is that of a patient with an acute medical problem who also has FD, but this is unknown to the clinician involved. This scenario arises most commonly within accident and emergency departments and out-of-hours services, but can also occur within GP practices. Here, the patient will typically be from outside the area and medical records will contain no useful information. Such presentations will usually progress down the standard journey of care until the inconsistency between complaints and evidence of underlying pathology becomes clear. Such patients may manage to receive highly invasive investigations and even treatment before the nature of their complaint comes to light. In this scenario, the procedure described above is a reasonable template to follow; however, the timescales will need to be compressed, as the likelihood of iatrogenic harm is higher. An additional suggestion in such circumstances is to enquire of colleagues and managers as to whether there is any form of database held locally that might be helpful in identifying the individual. It may be worthwhile contacting the local liaison psychiatry service, which may also have experience of the patient. In my clinical practice, I have found that while people with FD will create new names, dates of birth, community health index numbers (CHIs), life stories and, of course, presentations, there is a general tendency for these to be “recycled”. A patient presenting on multiple occasions to various services will tend to use only a few different names and details. There is often a tendency for the presenting complaint to be even less variable. It is therefore sometimes possible to heighten suspicion just by finding out whether there have been similar presentations in the area or in other services nearby. Again, once clinical suspi-

Table 2. Principles of factitious disorder management

<table>
<thead>
<tr>
<th>Principle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain attempts to engage therapeutically</td>
</tr>
<tr>
<td>Make clear and mutually agreed plans where possible</td>
</tr>
<tr>
<td>Maintain contact with all those involved in care</td>
</tr>
<tr>
<td>Always consider relevant data sharing</td>
</tr>
<tr>
<td>Provide opportunity for regular contact, but allow for “burn out”</td>
</tr>
</tbody>
</table>

Conclusion

FD is a rare psychiatric disorder that many practitioners will never come into contact with. Because of its rarity and difficulty in engagement, there is very little evidence on which to base practice. However, maintaining a sympathetic yet clear approach with a view to the long-term outcome will help to ensure the twin aims of engagement while minimising harm.

References


Declaration of interests

None to declare.

Dr Burnel is a consultant in liaison psychiatry at Glasgow Liaison Psychiatry Service