Factitious Disorder

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Factitious Disorder

Josephine de Guzman, MD, and Terry Correll, DO

INTRODUCTION

Factitious disorder has been described as “both disease and deception, presenting one of the most challenging (and potentially vexing) variants of psychopathology in medical experience.” Indeed, factitious disorders can be exasperating to the physician and treatment team, as patients with these disorders consume valuable time, resources, and energy. However, a deeper understanding of this disorder reveals that patients are powerfully compelled to appear ill and have little insight into their behaviors.

Individuals who create, amplify, or feign symptoms of illness can be categorized as having either somatoform disorder, factitious disorder, or malingering (Table 1). Patients with somatoform disorders unconsciously produce symptoms for an unconscious psychologic benefit (eg, “paralysis” preventing the patient from acting on an urge to harm another individual). On the other end of the spectrum is malingering, where an individual intentionally produces symptoms for external gain (ie, money, shelter, narcotics, or excuse from duties). Factitious disorders fall somewhere in the middle, where patients consciously create symptoms not for external gain but for the sole purpose of assuming the sick role and the associated “privileges” that result.

There are records of individuals feigning illness as early as biblical times and in ancient Greece. In 1838, Gavin described medical and psychologic ruses put on by soldiers and seamen. Most sought discharge from the military or relief from unpleasant duties, but a small portion seemed driven simply “to excite compassion or interest.” In 1951, Asher brought factitious illness into general medical knowledge and coined the term “Munchausen’s syndrome” after Baron von Munchausen, a retired German cavalry officer known to tell dramatic, exaggerated stories about his travels. Asher described individuals wandering from hospital to hospital subjecting themselves to multiple operations and procedures. Factitious illnesses have evolved with time. Factitious cases of AIDS appeared a few years after the disease was first described, and with the advent of the internet, there are reports of individuals offering false stories of illness to online support groups to garner attention and sympathy.

CASE

A 35-year-old man presents to the emergency department with hypoglycemia. He reports a 13-year history of diabetes and states that he accidentally gave himself 250 U of insulin glargine because he used the wrong syringe. He denies suicidal intent, stating “I didn’t do this on purpose. I don’t want to die. I have a nice life, a nice girlfriend, friends, and a good job.” He states that he currently works as a professional singer but previously worked as a nurse for 3 years and quit because it was “too stressful.” Review of past medical records reveals 12 admissions in the past 7 years to different area hospitals with similar presentations.

On this admission, the patient is found to have an infected central line. The patient claims that the line was placed during a recent hospitalization for long-term intravenous antibiotic treatment of osteomyelitis in his right foot. Magnetic resonance imaging of the foot is performed and reveals no evidence of osteomyelitis. Further psychiatric history reveals a history of emotional and physical abuse by his stepfather and grandfather.

The patient’s blood glucose levels are stabilized, and he is discharged after 5 days with a referral to a psychiatrist for outpatient psychotherapy. Review of subsequent records revealed 2 additional admissions in the next 6 months for repeated self-injection of insulin.

DEFINITION

The DSM-IV-TR diagnostic criteria for factitious disorder are outlined in Table 2.7 Factitious disorder not otherwise specified includes patients with factitious symptoms but who do not meet the criteria for factitious disorder. Included in this category is factitious disorder by proxy, commonly known as Munchausen’s by proxy, in which an individual creates symptoms in another person as a way to assume the sick role (Table 3).
Although it is not an official diagnosis, Munchausen’s syndrome is described in the DSM-IV-TR as the most severe and chronic form of factitious disorder with predominantly physical signs and symptoms. Characteristics of Munchausen’s syndrome include recurrent hospitalization, peregrination (traveling), and pseudo-logia fantastica (pathological lying).

### EPIDEMIOLOGY

Because patients with factitious disorder are often secretive and deceptive, it is difficult to obtain accurate epidemiologic data. Therefore, data must be inferred from case reports, a few large series, and referral patterns. The prevalence of factitious disorder appears to vary between 0.3% to 9.3%, depending on the particular patient population and setting. Sutherland and Rodin noted that 10 of 1288 patients (0.8%) referred for psychiatric consultation were diagnosed with factitious disorder. In a prospective study of 1538 patients hospitalized in a Berlin neurology department over 5 years, Bauer and Boegner found 5 (0.3%) cases of factitious disorder. In studies of fever of unknown origin, it is estimated that 2.2% to 9.3% of the fevers were factitious. Herring reported that about 1% of 10,000 renal stone specimens were factitious. Gault and colleagues found that 2.6% of 3300 renal stones were nonphysiologic and thought to be presented by factitious or malingering patients. Data regarding the prevalence of factitious disorder with psychologic signs and symptoms vary as well. In a study of psychiatric inpatients, Bhugra reported 0.5% of admissions were a result of a factitious psychologic condition. In 100 consecutive admissions to an inpatient psychiatric ward, Gregory and Jindal reported a 6% prevalence rate of factitious disorder with psychologic features. Patients with factitious disorder are commonly young women with experience in the health care field. Reich and Gottfried studied 41 patients with factitious disorder, and of these patients, 95% were women, the average age was 33 years, and 68% worked in the medical field. Krahn et al examined 93 patients with factitious disorder and found that 72% were women (mean age, 30.7 years), and 65.7% had experience in health care. Approximately 10% of patients with factitious disorder have Munchausen’s syndrome. These patients tend to be middle-aged, unmarried men who are estranged from their families.

### CLINICAL PRESENTATION

Feigned illnesses occur across every medical specialty, and the spectrum of presentations is broad (Table 5). Some patients with factitious disorder present mainly with physical signs and symptoms. Fabricated histories, falsified clinical and laboratory findings (eg, mimicking a grand mal seizure or adding blood to urine samples),
or induced illnesses (eg, surreptitious medication use, inducing infection, or preventing wound healing) may be a part of the clinical presentation. Feigned illnesses can range from the common urinary tract infection to giving a false history of having AIDS. Patients can present in all settings, from their primary care physician’s office with recurrent headaches to the emergency department with severe hypoglycemia.

Patients with factitious disorder with predominantly psychologic signs and symptoms almost always have real or fabricated physical symptoms as well. Reports of patients with factitious disorder with only psychologic symptoms are rare, but some studies suggest that these patients have a high rate of suicide and a poor prognosis. Popli reported that patients with factitious disorder and psychologic symptoms have some of the characteristics of Munchausen’s syndrome, including itinerancy (wandering), aggressiveness, a lack of intimate or sustained relationships, and falsification of background information. Patients may feign bereavement, presenting with symptoms of depression and suicidal ideation linked to the reported death of a loved one. Collateral information often reveals that the reported dead relative is in fact alive or the death occurred years earlier under much less dramatic circumstances. There are also cases of feigned posttraumatic stress disorder (PTSD). Patients may report PTSD symptoms from combat, rape, or assault that never occurred. These individuals differ from those seeking monetary gain or disability benefits that would be more appropriately diagnosed as malingering.

Other presentations in factitious disorder with predominantly psychologic signs and symptoms include psychosis, dissociative identity disorder, bipolar I disorder, amnesia, substance-related disorders, and eating disorders. Of note, some authors advise particular caution when diagnosing factitious disorders with psychologic symptoms, as some patients eventually manifest true psychotic disorders, such as schizophrenia.

** PATHOGENESIS/ETIOLOGY **

As with many psychiatric illnesses, the etiology of factitious disorder remains largely speculative. It is likely that multiple contributing factors lead to the development of factitious disorder.

** BIOLOGIC FACTORS **

Some researchers have hypothesized that underlying brain dysfunction may contribute to factitious disorder. In a review of 72 factitious patients with pseudologia fantastica (pathological lying), King and Ford found central nervous system abnormalities, including abnormal electroencephalogram findings, head injury, prior infections of the central nervous system, and neurologic abnormalities, in 40% of the patients. Babe et al reported frontal temporal cortical atrophy in 1 case of Munchausen’s syndrome. Pankratz and Lezak observed defects in conceptual organization and processing complex information in 2 of 5 patients with Munchausen’s syndrome. There have also been case reports of abnormalities found on magnetic resonance imaging and single photon emission computed tomography scanning in patients with Munchausen’s syndrome.

### Table 4. Summary of Studies Evaluating Factitious Disorder with Physical Signs and Symptoms

<table>
<thead>
<tr>
<th>Study</th>
<th>No. of Cases</th>
<th>Women, %</th>
<th>Mean Age, yr</th>
<th>Patients with Experience in Medical Field, %</th>
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</thead>
<tbody>
<tr>
<td>Hawkin et al</td>
<td>19</td>
<td>84</td>
<td>25</td>
<td>73</td>
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<td>Petersdorf and Bennett</td>
<td>16</td>
<td>86</td>
<td>33</td>
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<td>O’Reilly and Aggerle</td>
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<td>Aduan et al</td>
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<tr>
<td>Krahn et al</td>
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<tr>
<td>Sutherland and Rodin</td>
<td>10</td>
<td>70</td>
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PSYCHOSOCIAL FACTORS

Disturbances in childhood development may contribute to factitious disorder. A childhood history of emotional insecurity, unavailable or rejecting parents, and broken homes leading to foster care placement is common. McKane and Anderson identified factitious disorder in a parent and serious childhood illness, especially if the illness was associated with attention and nurturing in an otherwise aloof family, as predisposing factors for factitious disorder.

There are several common psychodynamic motivations for factitious disorder identified in the literature. Dependency needs are usually the most prominent. In the sick role, patients with factitious disorder receive the attention, caring, and nurturing they do not receive elsewhere. Patients also tend to have a poor sense of self, and the sick role may provide them with a well-defined identity. Through pseudologia fantastica associated with Munchausen’s syndrome, patients can even become exciting and important people with extraordinary histories. Patients with a history of abuse create a situation over which they have control, in contrast to the trauma they experienced with absolute vulnerability. Some patients have masochistic tendencies and want to “suffer” at the hands of their physicians. These patients feel they deserve punishment or abuse for “forbidden” feelings or low self-esteem. Reich and Gottfried contend that deeply ingrained hypochondriacal beliefs and fears could motivate some factitious behavior. For example, in their study, some patients were convinced that they had an illness (eg, a tumor or a urogenital tract abnormality) and exhibited factitious behavior in order to undergo elaborate testing in hopes of finding the disease they believed truly existed.

DIAGNOSIS

Factitious disorders are a diagnostic challenge because patients actively attempt to deceive their physicians. In fact, factitious disorder is usually not diagnosed until 5 to 10 years after its onset, generating substantial social and medical costs. Heightened awareness and early diagnosis are key to minimize expenditure of resources. At the same time, diagnostic rigor is essential. Once a treatment team suspects a patient is deliberately fabricating an illness, countertransference issues can hinder compassionate and sound medical care by engendering anger and negative views towards the patient.

Factitious disorders can be diagnosed in a number of ways, depending on the particular case. Some patients are discovered in the act of creating symptoms (eg, tampering with a nonhealing wound) or are found with incriminating paraphernalia (eg, insulin-filled syringes, thyroid medication). Patients with inconsistent or unexplainable signs or symptoms or who fail to respond to appropriate treatment should raise suspicion of factitious illness. Collateral history from family members or other treatment facilities can also assist with the diagnosis. The clinician should be suspicious when the patient refuses to allow contact with family members or with other health care providers. At times, a health care worker may recognize the patient from a previous presentation. In some situations, laboratory tests can facilitate the diagnosis of factitious disorder, as in cases of exogenous thyroid or insulin administration. In a review of 93 cases of factitious disorder, the diagnosis was most often established by inexplicable laboratory results (eg, stool samples from patients with factitious diarrhea consisting entirely of water).

Most of the available literature focuses on factitious disorder with predominantly physical signs and symptoms. Factitious disorder with psychologic signs and symptoms can be especially difficult to diagnose because much of the diagnosis relies on the patient’s own history. Evidence is mixed regarding the utility of neuropsychologic testing. Some authors report that feigned PTSD can be detected using the Minnesota Multiphasic Personality Index, while others were unable to replicate this finding. Rawling reported that the Wechsler Adult Intelligence Scale-Revised and Wechsler Memory Scale were useful and reliable in identifying factitious mental impairment from reported head injury. As in factitious disorder with physical signs and symptoms, careful history taking, close observation, and information obtained from family members or previous health care providers can be extremely useful in making the diagnosis of factitious psychologic disorders.

Even if inclusion criteria for factitious disorder are met, there is always the possibility that a serious underlying or coexisting medical or psychiatric condition exists. The differential diagnosis for factitious disorder is extensive and includes true physical illness, somatoform disorders, malingering, substance use disorders, eating disorders, and other psychiatric disorders. In addition, personality disorders, especially antisocial and borderline disorder, are frequently comorbid in the factitious disorder population. Physicians must be cautious when suspecting a diagnosis of factitious disorder to ensure legitimate illnesses are not overlooked.
Factitious Disorder

TREATMENT

The main goals in the treatment of patients with factitious disorder are to minimize harm to the patient, help the patient recover from the disorder, and limit unnecessary costs to the health care system. To minimize the patient’s morbidity, unnecessary procedures and tests should be avoided and comorbid medical illnesses should be adequately treated. Assembling a multidisciplinary team that includes the primary providers, a psychiatric consultant, and nursing, social work, and legal staff is ideal. It is essential that the treatment team be cohesive in their approach and educated about the disorder as patients with factitious disorder may use splitting and raise difficult management issues.

Factitious disorders are difficult to cure, and no specific effective treatment exists. Patients with Munchausen’s syndrome generally are considered refractory to treatment, although Yassa reported a case of Munchausen’s syndrome that was successfully treated using intense behavior modification techniques over a 3-year hospitalization. Although most patients with factitious disorder will refuse psychiatric treatment, patients should still be encouraged to pursue treatment. Several reports have described successful treatment using long-term psychotherapy. Plassmann reported a case series where 10 out of 24 patients with factitious disorder accepted and continued long-term psychodynamic psychotherapy; patients “progressed favorably, with a significant or at least marked improvement.” Klonoff et al reported successful treatment of a patient with a variety of neurologic symptoms using psychodynamic and behavioral techniques over a 9-month period.

Some recommend confronting the patient with factitious disorder in a supportive, nonaccusatory manner. However, Eisendrath reported little success with confrontation and instead suggested 3 alternatives: (1) inexact interpretation, (2) therapeutic double bind, or (3) face-saving techniques (ie, symptom relief without exposure or humiliation).

In inexact interpretation, a therapist makes a statement about the patient’s dynamics without specifically identifying the factitious behavior. Eisendrath reported the case of a young woman with a history of episodes of septicemia who expressed feelings of guilt about a sexual relationship to her therapist. The therapist suggested to the patient that she might feel a need to punish herself because of the feelings of guilt. Several sessions later, the patient admitted to producing episodes of septicemia by injecting herself with urine.

The next technique is the therapeutic double bind, in which a physician offers a medical intervention to treat the patient’s illness and also proposes the possibility that the illness may be factitious. If the illness is factitious, medical treatment would not be expected to work. Therefore, the physician provides the patient with the option of either clinically improving with the intervention or admitting that he/she does indeed have a factitious illness. Eisendrath described a 19-year-old woman who presented with a chronic nonhealing wound from a minor ankle surgery performed at age 14 years. A previous plastic surgeon had already confronted her with the diagnosis of factitious disorder, and she sought referral to a different physician. At the new institution, the plastic surgeon and psychiatric consultant presented the patient with a differential diagnosis of an unusual wound-healing problem that should respond to 1 more graft attempt or a diagnosis of factitious disorder. The graft was placed, and there was no recurrence of infection at a 2-year follow-up. The patient’s double bind was to either improve in a face-saving manner with a minor surgical procedure or receive a diagnosis of factitious disorder.

The third technique is to provide patients with a way to relinquish their symptoms without exposure or humiliation. For example, Klonoff et al developed a biofeedback program that allowed a patient with factitious seizures to give up the seizures without an explicit confrontation. Hypnosis has also been used. Eisendrath described a 25-year-old woman with a nonhealing abdominal wound despite 15 operations over a 10-year period. The patient had a history of abuse by her alcoholic father and was also a heavy smoker. She was offered self-hypnosis as a way to stop smoking, increase tissue oxygenation, and improve blood flow to the wound, thereby facilitating healing. The psychiatric consultant also used inexact interpretation to suggest that anger about her father’s abuse might make it difficult for her to benefit from paternalistic figures and that she might want to defeat her surgeons as a means of expressing the anger. The patient responded to these suggestions and began using self-hypnosis regularly. The patient allowed her wound to heal and remained well at a 6-month follow-up.

There are no clear data addressing the effectiveness of pharmacotherapy to treat factitious disorders. Patients with factitious disorder and comorbid depression have shown improvement with antidepressant therapy in addition to psychotherapy. Medications should be used as appropriate to treat comorbid Axis I diagnoses; however, patients should be carefully monitored given their self-destructive tendencies.
PROGNOSIS

There is general consensus that factitious disorders cause significant morbidity. Patients can undergo multiple tests, procedures, and treatments, each with their own risks. These may include medication trials, angiography, biopsy, laparotomy, lumbar puncture, and amputation. Fatalities directly linked to factitious disorder may be less common but do occur. Reich and Gottfried reported 1 death out of 41 cases. Eisendrath and McNiel describe 4 fatal cases out of 20 factitious disorder patients who were involved in civil litigation. Causes of death included myocardial infarction caused by self-administered epinephrine and septicaemia from self-injected bacteria.

The diagnosis of factitious disorder generally carries a poor prognosis. However, there is wide variability over the course of the illness. Grunberger et al followed 10 patients with factitious hypoglycemia due to surreptitious insulin injections for an average of 5 years; 3 patients successfully transitioned into productive life, while 2 patients eventually committed suicide. Patients with especially poor prognoses include those with Munchausen’s syndrome, antisocial or borderline personalities, and chronic medical conditions.

FACTITIOUS DISORDER BY PROXY

CLINICAL PRESENTATION

In factitious disorder by proxy (also known as Munchausen’s by proxy), an individual indirectly assumes the sick role by creating illness in another person, usually a young child. The most commonly induced or falsified symptoms include bleeding, seizures, impaired consciousness, apnea, diarrhea, vomiting, fever, and rash. The perpetrator is typically the mother, although a small number of fathers have been described as the perpetrators. Mothers are commonly in their early 20s, married, from middle-class backgrounds, and tend to have personality disorders, somatizing behaviors, and considerable family dysfunction. When observed, the mothers appear quite attentive and concerned; however, when they are unaware of being observed, they appear indifferent to the child.

EPIEMIOLOGY

As in factitious disorder, precise epidemiologic data regarding factitious disorder by proxy is unavailable, and estimates vary. Studies in the United Kingdom, Ireland, and New Zealand estimated the annual incidence of factitious disorder by proxy (with victims aged < 16 years) to be 0.5 to 2.0 per 100,000 population. In a study of 115 children with fever of unknown origin, 3.5% were found to be factitious. A large study of 20,090 children who presented with apnea revealed that 0.27% were the victims of factitious disorder by proxy. The victims appear to be equally male and female and are typically aged younger than 4 years. Average time from onset of symptoms to diagnosis is 15 to 20 months.

Although factitious disorder by proxy appears to be less common than factitious disorder, morbidity and mortality rates are much higher. Rosenberg surveyed 117 cases of factitious disorder by proxy and reported acute morbidity in all cases, permanent disfigurement and disability in 73% of cases, and a mortality rate of 9%, mostly from apnea and poisoning. One literature review of 451 cases revealed a mortality rate of 6%.

DIAGNOSIS AND MANAGEMENT

Diagnosis of factitious disorder by proxy can be difficult and is often accidental. The mother may be observed actively inducing symptoms (e.g., smothering her child with a pillow to induce apneic episodes). Laboratory studies may indicate the surreptitious administration of medication, such as sulfonylureas, laxatives, or thyroid replacement. Covert video surveillance has been used to make the diagnosis but is controversial, as it raises issues of invasion of privacy. The diagnosis can be supported if a child’s symptoms abate during a trial separation of mother and child.

Factitious disorder by proxy is regarded as a form of child abuse, and perpetrators often face criminal charges. Health care providers who suspect or diagnose factitious disorder by proxy must contact children’s protective services authorities. The immediate protection of the child is of utmost importance and usually requires removal of the child from the home, at least temporarily. The child should be treated medically as necessary and should also receive psychiatric evaluation and therapy. The perpetrator should also be offered psychotherapy, as there are some cases of successful treatment.

CONCLUSION

Patients with factitious disorders consciously produce, amplify, or feign physical and/or psychologic symptoms of illness in order to assume the sick role. Although
assumed to be relatively rare, factitious disorders cause significant morbidity and present many diagnostic and treatment challenges. The clinical presentations of persons with factitious disorder are varied and impact every area of medicine. There are likely multiple biologic and psychosocial factors that play an etiologic role. The main treatment goals for these pernicious disorders are to minimize harm to the patient and drain on health care resources. Factitious disorder by proxy is a particularly disturbing variant of the disorder in which typically a young mother indirectly assumes the sick role by creating illness in her child. Clinicians should be especially vigilant as factitious disorder by proxy carries even greater morbidity and mortality and should be regarded as a form of child abuse.

SUMMARY POINTS

- Patients with somatoform disorders unconsciously produce symptoms for an unconscious psychologic benefit.
- Malingering patients intentionally produce symptoms for external gain.
- Patients with factitious disorder consciously create symptoms for the sole purpose of assuming the sick role and the associated “privileges” that result.
- Patients with factitious disorders are powerfully compelled to appear ill and have little insight into their behaviors.
- Feigned illnesses occur across every medical specialty, and the spectrum of presentations is broad.
- The prevalence of factitious disorder appears to vary between 0.3% to 9.3%, depending on the patient population and setting.
- There are 2 common profiles of the patient with factitious disorder: the young woman with experience in the health care field (most common) and the middle-aged, unmarried man estranged from his family (Munchausen’s syndrome; about 10% of patients with factitious disorder).
- Munchausen’s syndrome is the most severe and chronic form of factitious disorder with predominantly physical signs and symptoms.
- Characteristics of Munchausen’s syndrome include recurrent hospitalization, peregrination (traveling), and pseudologia fantastica (pathological lying).
- Reports of patients with factitious disorder with only psychologic symptoms are rare, but some studies suggest that these patients have a high rate of suicide and a poor prognosis.
- Some authors advise particular caution when diagnosing factitious disorders with psychologic symptoms, as some patients eventually manifest true psychotic disorders, such as schizophrenia.
- Factitious disorders are a diagnostic challenge because patients actively attempt to deceive their physicians.
- Factitious disorder is usually not diagnosed until 5 to 10 years after its onset.
- Some patients are discovered in the act of creating symptoms or are found with incriminating paraphernalia.
- Patients with inconsistent or unexplainable signs or symptoms or who fail to respond to appropriate treatment should raise suspicion of factitious illness.
- Collateral history from family members or other treatment facilities can assist with the diagnosis.
- Laboratory tests can often facilitate the diagnosis of factitious disorder.
- Physicians must be cautious when suspecting a diagnosis of factitious disorder to ensure that legitimate illnesses are not overlooked.
- The main goals in the treatment of patients with factitious disorder are to minimize harm to the patient, help the patient recover from the disorder, and limit unnecessary costs to the health care system.
- Factitious disorders are difficult to cure, and no specific effective treatment exists.
- Countertransference issues can hinder compassionate and sound medical care.
- There are no clear data addressing the effectiveness of pharmacotherapy to treat factitious disorders.
- Medications should be used as appropriate to treat comorbid Axis I diagnoses, and patients should be closely monitored.
- Factitious disorders cause significant morbidity and even some mortality.
- The diagnosis of factitious disorder generally carries a poor prognosis.
- In factitious disorder by proxy, commonly known as Munchausen’s by proxy, the perpetrator is typically the mother of the young child.
- Factitious disorder by proxy is regarded as a form of child abuse, and perpetrators often face criminal charges.
- Health care providers who suspect or diagnose factitious disorder by proxy must contact children’s protective services authorities.

ACKNOWLEDGMENTS

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