

Factitious disorder (Munchausen's syndrome)

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ABSTRACT Factitious disorder, often referred to as Munchausen's syndrome, is a condition in which sufferers present to healthcare professionals seeking investigation and treatment for signs and symptoms that they have consciously fabricated for no obvious reason. Factitious presentations have been described all over the world, in every medical specialty and in every age group, yet by its very nature factitious disorder is difficult to study. There is therefore a dearth of evidence in the literature relating to epidemiology, aetiology and therapeutics. The disorder is notoriously difficult to recognise in clinical practice and there are as yet no definitive treatment options available. This article provides a brief overview of the literature before offering guidance on the diagnosis and management of factitious disorder presenting in the general hospital. It also considers fabricated or induced illness, also known as Munchausen's syndrome by proxy.

KEYWORDS Fabricated or induced illness, factitious disorder, malingering, medically unexplained symptoms, Munchausen's syndrome, Munchausen's syndrome by proxy

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INTRODUCTION

Factitious disorder is a condition in which sufferers present to healthcare professionals seeking investigation and treatment for signs and symptoms that they have consciously fabricated. Symptoms may be physical, psychological or both. The word 'factitious' is derived from the Latin *facere* (to make).

In theory factitious disorder is distinct from other disorders characterised by the presence of 'medically unexplained' symptoms such as somatoform disorders (in which the patient's symptoms are presumed not to be deliberately fabricated) and malingering (in which the patient aims to gain some tangible benefit through the production or exaggeration of symptoms). These distinctions are reflected in diagnostic systems such as the International Classification of Diseases 10 (ICD-10), where factitious disorder enjoys its own category (F68.1). However, in clinical practice the boundaries between factitious disorder, somatisation and malingering are often unclear and there is also a strong association with personality disorder.

That patients may purposefully simulate signs and symptoms of disease has been recognised for centuries. In 1843 Hector Gavin coined the term 'factitious disease' to describe illness behaviours he observed in seamen apparently seeking to evoke care and sympathy or to avoid duties. Gavin drew a distinction between patients who engaged in these behaviours for obvious material gain (what we would now call 'malingering') and those for whom no objective external benefit could be identified.

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MUNCHAUSEN'S SYNDROME

In 1951 Richard Asher coined the term 'Munchausen's syndrome' to describe an extreme form of factitious disorder, where the patient presents repeatedly to different hospitals with dramatic but plausible symptoms apparently requiring urgent treatment. In 1977 Roy Meadow used the term 'Munchausen's syndrome by proxy' to describe the intentional false reporting or production of symptoms in another person who is under the individual's care for the purpose of indirectly assuming the sick role. More recently the literature in the UK refers to this type of abuse as 'fabricated or induced illness', appropriately emphasising the effect on the victim (most commonly, but not exclusively, a child).

Munchausen's syndrome, named in honour of the Hanoverian cavalry captain Karl Friedrich Hieronymus Freiherr von Münchhausen, has attracted much interest and comment in the literature, partly as a consequence of its colourful sobriquet, but also as a reflection of the perplexing and serious nature of the condition. This form of factitious disorder describes patients who present with elements of sociopathy, dramatic personal and illness histories and peregrination. They will often try to conceal health history and biographical data in order to prevent detection of similar previous presentations with induced or fabricated symptoms. They may become angry and unco-operative when attempts are made to clarify the picture. This is a chronic form of the disorder, which is generally regarded as being resistant to treatment.

Epidemiology

The deception that defines this disorder undermines attempts to collate accurate epidemiological data. The literature is characterised by reports of single cases and

small case series from specific medical specialties. There are a small number of university hospital-based referral surveys, but estimates of even basic epidemiological variables such as prevalence and sex ratio vary widely.

The single largest case series in the literature was published in 1983 by Reich and Gottfried (see Further Reading). They described 41 cases presenting in a German teaching hospital over a ten-year period. Of those cases, 39 were female. Most had occupations or experience related to medicine. Four clinical clusters were identified: self-induced infections, simulated specific illnesses with no actual disorder, chronic wounds and self-medication.

Aetiology

The aetiology of factitious behaviours is not well understood. No common factor or combination of factors has been consistently identified in this group of patients. However, personality factors such as sociopathy, histrionic traits and borderline personality constructs are over-represented and many factitious patients have experienced an emotionally deprived or abusive childhood. Another common theme is experience of illness, either first-hand experience of a significant childhood illness or illness in a caregiver during the patient's childhood. Furthermore, many patients have training or vocational experience in healthcare. Finally, there is some evidence for family history of factitious disorder being a risk factor.

The lack of robust aetiological data has not precluded the development of aetiological theories. In his seminal 1913 text *General psychopathology*, the German psychiatrist and philosopher Karl Jaspers suggested: 'Once the game of fancy is started, it frequently leads to self-deception [and] self-surrender to a fictitious existence which has arisen from an urge to get away from reality.' Asher, in 1951, described 'an intense desire to deceive everybody as much as possible' and lying 'for the sake of lying'. Pilowsky, in 1969, suggested a spectrum of motivation, from totally unconscious needs to allay guilt and become dependent to entirely conscious searching for rewards. The received psychodynamic explanation for the emergence of factitious disorder in the aftermath of childhood physical (or sexual) abuse presumes a split between the 'body-self' and the 'psychic-self' in order to protect the psychic-self from harm. In later life this split is acted out in the interaction between the patient and the medical profession (a form of 'counter-transference identification').

DIAGNOSIS

There are no diagnostic tests for factitious disorder, nor are there any objective clinical methods for distinguishing conscious and wilful deception from unconscious production of signs and symptoms. In essence, the

diagnosis relies upon the doctor functioning as a detective. It is not an easy diagnosis to make and one should be wary of labelling any behaviour as factitious in the absence of unambiguous evidence of deliberate deception. Ideally, the diagnostic process follows the steps below:

1. Identification of presentation inconsistent with objective clinical findings, i.e. not readily explained by the disease model

In cases where the history is changing, vague or contradictory this may serve as a clue that misleading information is being given by the patient either intentionally or unintentionally. In situations where the symptoms fail to improve following appropriate treatments for a particular condition, factitious behaviour might be considered in the differential diagnosis.

2. Exclusion of major differential diagnoses

Has the possibility of a rare illness been ruled out? Or is this an unusual presentation of a common condition?

3. Gathering of (circumstantial) evidence

While factitious patients can present with almost any sign or symptom, certain aspects of their presentation may indicate that their account is misleading:

- Patients may present a dramatic but inconsistent medical history;
- They may be evasive or fractious with the history-taker;
- They may change the biographical information they present (e.g. use aliases, change date of birth by one digit, etc.);
- There may be an unusual number of barriers to obtaining corroborative accounts, e.g. not registered with a general practitioner (GP), uncontactable next of kin, no visitors, etc.;
- There may be a remarkable level of awareness of hospital procedure and illness knowledge and liberal use of medical terminology (note: patients often have healthcare training or occupations);
- The patient may appear eager to have investigations and treatments irrespective of associated adverse effects;
- Symptoms may occur mainly at times when the patient is not being observed;
- There may be multiple normal or inconclusive test results and the development of new symptoms after negative test results;
- The symptoms may change or worsen on commencement of treatment.

4. Identification of at least one piece of unambiguous evidence of deception

In certain cases patients are witnessed tampering with wounds, laboratory specimens or medication: injecting paraphernalia, dyes, cutting implements and so on have all been found concealed by patients for use in the fabrication process. In other cases laboratory or imaging results may provide unambiguous evidence.

5. Confirmation of evidence through second opinion from peers

Once the piece of unambiguous evidence has been identified, the case should be presented to at least one, and ideally several, senior colleagues who should be asked: 'Is there any possible explanation for these findings other than deliberate deception on the part of the patient?' This discussion should be documented in the clinical notes.

6. Exclude somatisation (not deliberate) and malingering (identifiable gain)

Medically unexplained symptoms are very common. Unless there is unambiguous evidence of deliberate deception, it is safest to presume that the symptoms are not consciously fabricated or induced. Where there is clear evidence of deception, it is worth considering what the motive may be (e.g. obtaining money, avoiding work/school or military commission, etc.).

MANAGEMENT

After making a difficult (and often late) diagnosis, the clinical team is faced with unfamiliar moral and, in some cases, legal challenges. Specific management decisions will vary from case to case; however, the author would recommend pursuing the following steps:

1. Collate information

Pull together all of the information available from case notes and corroborative accounts (where it has been possible to obtain these). Include a detailed description of the unambiguous evidence of deception together with the record of the meeting with colleagues confirming that 'the only possible explanation for these findings is deliberate deception on the part of the patient'.

2. Discuss with liaison psychiatry (or general psychiatry if your hospital does not have a dedicated liaison service)

The psychiatrist may be able to help with diagnosis and offer advice on ongoing management. Furthermore, psychiatrists are likely to be more familiar with the moral, legal and interpersonal issues that such cases raise.

3. Confront the patient

The responsible consultant should meet with the patient in the presence of a witness/chaperone and present them with the evidence. Obviously this meeting needs to be thoughtfully planned (as with any 'breaking bad news' meeting) and a detailed record must be kept. The consultant must choose his or her words carefully – the author would suggest something along the lines of: 'We have gathered the following information... after discussion with senior colleagues we have concluded that the only possible explanation is that you have deliberately deceived us.' Then offer the patient an opportunity to 'come clean', for example: 'We appreciate that sometimes when people are under stress they behave in a way that they would not normally behave.

Do you think that might have happened here?' If the patient does not take this opportunity a more confrontational approach is required: 'We are offering you the opportunity to explain what has happened. Unless you provide an explanation, we will have to presume that you are deliberately lying to us.'

4. Renegotiate the doctor/patient relationship

Occasionally the patient will confess and apologise. Under these circumstances it may be possible to draw a line under the previous factitious behaviours and negotiate a new doctor/patient relationship (either with the current consultant or with a colleague). Before doing so it would be prudent to discuss the case with a psychiatrist. In some cases there may be a role for psychiatric or psychological treatment (e.g. dialectical behavioural therapy).

However, often patients will deny that they have sought to deceive and will either offer no explanation or claim they have been 'set up'. Consultants can choose how they respond to this, but the author would recommend the following statement: 'The doctor/patient relationship has to be based upon trust. I believe that you have broken that trust by deliberately seeking to deceive me. I can therefore no longer be your doctor.'

5. Minimise future medical involvement

Before recommending any medical or surgical intervention, a doctor balances the potential benefits against the potential risks to the patient. The presence of factitious disorder fundamentally alters this balance. Patients with factitious disorder are likely to sabotage treatment, thereby negating any potential benefit from the intervention and ensuring that the risk almost always outweighs the benefit (the only exception being treatment that is immediately required to prevent death). Following the principle of 'do no harm', medical involvement should be kept to an absolute minimum in patients with factitious disorder.

6. Disseminate information

Once the diagnosis of factitious disorder has been made and the patient has rejected the opportunity to tell the truth, a clearly worded letter should be prepared highlighting the diagnosis and describing the nature of the deceit. This letter should contain a physical description of the patient and a list of all the aliases, addresses and dates of birth that the patient is known to use. It should also summarise the patient's known *modus operandi* (the factitious histories and behaviours that he or she has presented with). The letter should then be sent to all doctors who are likely to come into contact with the patient, e.g. accident and emergency departments, out-of-hours GP services, etc.

7. Consider the safety of others

While there is no literature on the relationship between factitious disorder and factitious disorder by proxy, it is

good clinical practice to consider the potential risk to children and other dependents of patients with factitious disorder and to make a child protection or vulnerable adult referral where appropriate. Furthermore, these patients often work in healthcare or social care settings where patients or clients may be placed at risk. Again, it is good clinical practice to inform the patient's employer and/or professional regulator of their presentation.

DIAGNOSIS AND MANAGEMENT OF FABRICATED OR INDUCED ILLNESS (MUNCHAUSEN'S SYNDROME BY PROXY)

The principles of diagnosis outlined above are broadly applicable to suspected 'by proxy' cases (more detailed advice can be found in the National Institute for Health and Clinical Health clinical guideline 89 – see Further Reading below). The principles of management described above are also applicable, although in 'by proxy' cases the first step must always be to ensure the safety of the suspected or potential victim. This is usually achieved through physical separation from the suspected perpetrator (which characteristically results in a resolution of the symptoms).

Clear-cut cases where there is unambiguous evidence of deliberate deception resulting in actual or potential harm to a vulnerable third party are a criminal matter and consultants should contact the police and their defence union. Cases where factitious acts are suspected but without unambiguous evidence present a far more difficult challenge: fail to act on the circumstantial

evidence and you risk being criticised for not preventing subsequent harm; yet make a premature or false allegation and you risk damaging the therapeutic relationship and may even invite professional and/or legal challenge. Most clinicians deal with these cases by admitting the suspected victim to an acute ward 'for observation and investigation' in order to buy more time for information gathering and discussion with colleagues and other agencies. The overarching priority is always the safety of the suspected or potential victim and, with this in mind, a child protection or vulnerable adult case conference is often indicated.

KEY POINTS

- Factitious disorder is the deliberate feigning of symptoms and/or signs of illness without any apparent gain.
- Medically unexplained presentations are very common, so it is unwise to presume that a patient is deliberately faking their condition unless one has unambiguous evidence of deception.
- In order to diagnose factitious disorder, the clinician must function as a detective, gathering evidence of deception.
- If evidence of deception is found, this should be confirmed through peer discussion before challenging the patient.
- In patients with established factitious disorder, medical and surgical interventions should be limited to treatments immediately required to prevent death.

FURTHER READING

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SELF-ASSESSMENT QUESTIONS

1. **A seven-year-old girl complains of stomach ache early on Monday morning. She has no other symptoms or signs of illness and her temperature is normal. Her mother is due to attend an appointment at her local community mental health resource office later that morning. Which ONE of the following is the girl most likely to be experiencing?**
 - A. Acute appendicitis.
 - B. Factitious disorder by proxy.
 - C. Mesenteric adenitis.
 - D. Personality disorder.
 - E. Separation anxiety.

2. **Which ONE of the following is not suggestive of factitious disorder?**
 - A. Condition repeatedly deteriorates when patient is left unattended.
 - B. Cotton-bud ends found in poorly healing wound.
 - C. Dramatic account of medical history.
 - D. Large numbers of visitors.
 - E. +++glucose on urine dipstick with random blood glucose of 4.2 mmol/l.

3. **Which ONE of the following distinguishes a patient who is 'malingering' from one with factitious disorder?**
 - A. Clear motive for deception.
 - B. Multiple normal or inconclusive test results and development of new symptoms after negative test results.
 - C. Patient evasive when questioned.
 - D. Symptoms not readily explicable by medical (disease) model.
 - E. Unambiguous evidence of deliberate attempt to deceive doctors.

4. **A patient known to suffer from factitious disorder, with a documented history of falsely claiming to suffer from diabetes mellitus and repeated presentations with hypoglycaemia presumed to be caused by self-administration of insulin, is brought to the accident and emergency department (A&E) with a Glasgow Coma Scale (GCS) score of 6. During her previous admission she had denied injecting herself with insulin. A blood sample taken at that time has subsequently been found to contain recombinant insulin. Which ONE of the following actions would not be appropriate?**
 - A. Administer intravenous dextrose.
 - B. Admit the patient to a medical ward for inpatient glucose tolerance testing.
 - C. Call a psychiatrist.
 - D. Check her blood glucose.
 - E. Confront her with the blood result that proves that her hypoglycaemic attacks are caused by injected insulin.

5. **An elderly woman suffering from multi-infarct dementia lives with her granddaughter, who is a trainee nurse. The woman has a bulbar palsy and is fed via a percutaneous endoscopic gastrostomy (PEG) tube. On two occasions in the past three weeks her granddaughter has brought her to the A&E in a poor physical state. On both occasions she has been found to be profoundly hypernatraemic but has improved rapidly with simple intravenous fluids. Thorough physical investigation has provided no organic explanation. She arrives at A&E in a blue-light ambulance with a GCS score of 4. Which ONE of the following would not be appropriate?**
 - A. Confront the granddaughter with the fact that she is poisoning her grandmother with salt.
 - B. Consider a diagnosis of factitious disorder by proxy.
 - C. Ensure that a member of staff is present whenever the granddaughter is in the same room as the patient.
 - D. Rehydrate the patient, then admit her to a medical bed pending further investigations.
 - E. Take a sample from the PEG tube on admission and analyse for osmolality.

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