Chapter 114 – Factitious Disorders and Malingering

Episode overview

Core questions:

1. What is a factitious disorder? What is malingering?
2. List DSM-5 criteria for the diagnosis of Factitious Disorder Imposed on Self (FDIS)
3. List DSM-5 criteria for the dx of Factitious Disorder Imposed on Another
4. List 4 characteristics of malingering

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[1] What is a factitious disorder? What is malingering?

These are disorders that occur in patients who are simulation experts! They simulate or intentionally produce symptoms. Factitious disorders are characterized by symptoms or signs that are intentionally produced or feigned by the patient in the absence of apparent external incentives. Common examples of simulated symptoms include a fever of unknown origin or seizure disorders.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) classifies factitious disorders into two types:

1. **Factitious disorder imposed on self (FDIS)**
2. **Factitious disorder imposed on another (FDIA)**

FDIS is also known as…

- Munchausen syndrome
- “Hospital hobo syndrome” (patients wander from hospital to hospital seeking admission)
- Peregrinating (wandering) problem patients
- Hospital addict
- Polysurgical addiction
- Hospital vagrant.

One approach to handling a patient with a factitious disorder is therapeutic double bind or contingency management. It involves informing the patient that a factitious disorder may exist. The patient is further told that failure to respond fully to medical care would constitute conclusive evidence that the patient’s problem is not organic but rather psychiatric. The problem is therefore reframed or redefined in such a way that, (1) symptoms and their resolution are both legitimized, and (2) the patient has little choice but to accept and respond to a proposed course of action or seek care elsewhere.

Malingering: the simulation of disease by the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives**,** such as avoidance of military conscription or duty, avoidance of work, obtainment of financial compensation, evasion of criminal prosecution, obtainment of drugs, gaining of hospital

admission (for the purpose of obtaining free room and board), or securing of better living conditions.

Malingerers, on the other hand, do not want to be treated. Because they are "gaming the system" for personal advantage, the last thing they want is an accurate identification of their behaviour and appropriate intervention. The emergency clinician should maintain clinical neutrality, offering the reassurance that the symptoms and examination are not consistent with any serious disease.

[2] List DSM-5 criteria for the diagnosis of Factitious Disorder Imposed on Self (FDIS)

See box 104.1 in Rosen's 9th Edition for the DSM-5 Criteria for the Diagnosis of Factitious Disorder Imposed on Self

DSM-5 Criteria for the Diagnosis of Factitious Disorder Imposed on Self

1. Falsification of psychological or physical signs or symptoms, or induction of disease or injury associated with identified deception
2. The individual presents to others as injured, ill, or impaired
3. The deceptive behaviour is apparent even in the absence of external incentives
4. The behaviour is not better explained by another mental disorder

With a factitious disorder, the production of symptoms and signs is compulsive; the patient is unable to refrain from the behaviour even when its risks are known. **The behaviour is voluntary only in the sense that it is deliberate and purposeful (intentional) but not in the sense that the acts can be fully controlled. The underlying motivation for producing these deceptions, securing the sick role, is primarily unconscious.**

Individuals who readily admit that they have produced their own injuries (e.g., self-mutilation) are not included in the category of factitious disorders.

These patients are willing to undergo incredible hardship, limb amputation, organ loss, and even death to perpetuate the masquerade. Although multiple hospitalizations often lead to iatrogenic physical conditions, such as postoperative pain syndromes and drug addictions, patients continue to crave hospitalization for its own sake.

They typically have a fragile and fragmented self-image and are susceptible to psychotic and even suicidal episodes.

Identification of a factitious disorder is usually made in one of four ways:

1. The patient is accidentally discovered in the act,
2. Incriminating items are found,
3. Laboratory values suggest nonorganic etiology, OR
4. The diagnosis is made by exclusion.

[3] List DSM-5 criteria for the diagnosis of Factitious Disorder Imposed on Another

FDIA is an especially pernicious variant that involves the simulation or production of factitious disease in children by a parent or caregiver.

This is different from child abuse… the key discriminator is motive: e.g., the mother is making the child ill so that she can vicariously assume the sick role with all its benefits.

The condition excludes straightforward physical abuse or neglect and simple failure to thrive; mere lying to cover up physical abuse is not FDIA.

Previously known as Munchausen syndrome by proxy.

See Box 104.2 in Rosen's 9th Edition for DSM-5 criteria for the diagnosis of Factitious Disorder Imposed on Another

DSM-5 Criteria for the Diagnosis of Factitious Disorder Imposed on Another

1. Falsification of psychological or physical signs or symptoms, or induction of disease or injury in another, associated with identified deception
2. The individual presents another individual (victim) to others as injured, ill, or impaired
3. The deceptive behaviour is apparent even in the absence of external incentives
4. The behaviour is not better explained by another mental disorder

Victim children often have a legitimate illness. Mean age at diagnosis is 40 months. Most have a history of failure to thrive and multiple hospitalizations. The perpetrator receives some personal fulfillment from the care and attention of the hospital staff, which is often admiration for her persistence, willingness to sacrifice, and patience, and she is typically pleasant, medically savvy, and socially skilled. Invasive procedures on the child are often welcomed. Although psychosis is very unusual in the parent, depression, anxiety, and somatization are typical in the perpetrator.

In 20% of reported deaths, the parents had been confronted and the child sent home to them, subsequently to die.

So get help!

[4] List 4 characteristics of malingering

Malingering is frequently found in association with antisocial personality disorder.

In some "patients," such as those seeking drugs, homeless persons seeking hospital admission on a cold night, or prisoners wanting a holiday from incarceration, the secondary gain may be clear. In other persons, the external incentive may be obscure.

In contrast to the person with factitious disorders, the malingerer prefers counterfeit mental illness, because it is objectively difficult to verify or to disprove. Amnesia is the most common psychological presentation, followed by paranoia, morbid depression, suicidal ideation, and psychosis.

See Box 104.3 in Rosen's 9th Edition for Characteristics of Malingering

Characteristics of Malingering

1. Medicolegal context of the presentation (e.g., the patient was referred by his or her attorney)
2. Marked discrepancy between the person's claimed stress or disability and objective findings
3. Poor cooperation during the diagnostic evaluation or poor compliance with previously prescribed treatment regimens
4. The person exhibits or has a history of antisocial behaviour

Let's try to wrap this up!

Patients with factitious disorders are distinguished from malingerers because their desired hospitalization or surgery seems to offer no secondary gain other than to play the sick role.

The chronicity of malingering is usually less than that associated with factitious disorder, and malingerers are more reluctant to accept expensive, possibly painful, or dangerous tests or surgery.

Key points:

- Two big categories for patients... with consciously synthesized symptoms/signs:
  - They want something - secondary gain - malingering
  - Motivated to achieve the sick role - factitious disorders
- Despite suspicions of the patient fabricating disease:
  - You should still be caring, non-judgmental and SEARCH for objective clinical evidence of treatable medical or psychiatric disease
  - Get collateral / chart / family history
- Unnecessary tests, medications, and hospitalizations should be avoided in the absence of objective evidence of a medical or psychiatric disease, and patients should be referred for ongoing primary care.
- In cases of suspected FDIA involving children or elders, protection of the victim takes first priority.