

Factitious Illness (factitious disorders, DSM-IV-TR #300.16, 300.19)

When illness is feigned, one may or may not be able to discern a more or less understandable motive. When one can, for example when someone complains of a “bad back” to escape the draft, such feigning is referred to as “malingering.” When one cannot find a motive—indeed when it appears that the only possible motive could be the desire to be a patient in the hospital—one speaks of a “factitious illness.”

Typically the patient presenting at the emergency room with a factitious illness has a personality disorder with prominent borderline, masochistic, and at times antisocial traits. Often they also have had some exposure to medicine and hospitals, having worked as aides, physical therapists, and the like. The frequency with which hospitalization is sought varies widely. On the one hand, admission may be quite sporadic and occur only at times of great stress. On the other hand, however, there are some whose lives are consumed by these un-needed hospital stays. One variety of this severe pattern is known as “Munchausen’s syndrome,” named after the famous German baron who traveled from city to city, telling fascinating tales about himself. Patients with Munchausen’s syndrome, in addition to wandering and being hospitalized in numerous different cities, often also display what is known as “pseudologia fantastica,” or a capacity for spinning out elaborate tales, at times intermixed with some actual facts, which listeners often find, sometimes despite themselves, intriguing and fascinating.

Typically, the factitious patient presents at the emergency room with an often very convincing history suggestive of a serious disease process. The chief complaint may be of hemoptysis or perhaps of chest pain suggestive of unstable angina. Thermometers may be warmed to simulate a fever, and some have been known to inject themselves with feces to produce a fever. Furosemide may be taken to produce hypokalemia, insulin to produce hypoglycemia, or thyroid hormone to produce hyperthyroidism. Seizures may be reported, and some may bite their tongue to produce a more convincing picture. Once admitted, they may make frequent demands for narcotics, and staff members are often split and played off one against the other. Diagnostic tests are welcomed, even demanded, and as the tests become ever more invasive and dangerous, the patient, seemingly paradoxically, becomes more content. Eventually the physician becomes suspicious. One may see too many old surgical scars; the abdomen may look like a surgical battleground, and evidence of old craniotomies and numerous cutdowns may be seen. Requests to contact family members, friends, or previous physicians are denied, and despite the gravity of the patient’s complaints, no visitors arrive. As more and more tests come back negative, the complaints may change. Chest pain may fail to recur, but severe abdominal pain may take its place. The “fever” may subside as the nursing staff comes to observe the patient throughout the encounter with a thermometer, yet hematuria may unexpectedly appear after the patient pricks his finger and drops blood into the urine sample. Eventually, confronted with the physician’s almost certain conclusion that there is “nothing wrong,” the factitious patient typically becomes

angry, accuses the staff of incompetence, and leaves the hospital against medical advice.

Occasionally, one may also encounter factitious psychiatric illness. Patients may complain of voices and visions or of deep despair and may report severe suicidal ideation. Although such people readily gain admission, the factitious nature of their complaints rarely holds up to the scrutiny of an experienced psychiatrist or psychiatric nurse. The complaints either fail to match any known disorder, or they change in ways that are simply not possible. Confronted with these impressions, the factitious patient also demands discharge; however, at times a wrist may be cut or a noose may be fashioned to convince the physician of the reality of the complaints.

A particularly loathsome variation on factitious illness is the use of a “proxy.” Here, a parent may force anticoagulants, diuretics, or other agents on a child and use the results as a ticket for the child’s admission. Suspicion may be aroused when one notes a certain satisfaction, even contentment, on the parent’s part as the child is subjected to ever more invasive diagnostic procedures.

Factitious patients may be distinguished from those with hypochondriasis, Briquet’s syndrome, or conversion disorder not only by their deliberate simulation of illness but also by their insistence on hospitalization and their ready submission to potentially dangerous procedures. Those with these other disorders, although believing themselves to be ill, do not pursue the proof of that with such blatant disregard for their own safety.

Managing the factitious patient in the hospital is almost impossible. Often the best one can do is to recognize the simulation for what it is as soon as possible and avoid doing any harm with invasive tests. Psychotherapy is generally rejected by the factitious patient, and admission to a psychiatric ward is generally contraindicated because it might serve to increase the patient’s repertoire of symptoms. After discharge the factitious patient typically resumes a peripatetic existence, going from hospital to hospital, ever-changing cities, states, or even countries to avoid becoming known.

BIBLIOGRAPHY

Aduan RP, Fauci AS, Dale DC, et al. Factitious fever and self-induced infection: a report of 32 cases and review of the literature. *Annals of Internal Medicine* 1979;90:230–242.

Asher R. Munchausen’s syndrome. *Lancet* 1951;1:339–341.

Bhugra D. Psychiatric Munchausen’s syndrome. Literature review with case reports. *Acta Psychiatrica Scandinavica* 1988;77:497–503.

Feldman MD, Rosenquist PB, Bond JP. Concurrent factitious

disorder and factitious disorder by proxy. Double Jeopardy. *General Hospital Psychiatry* 1997;19:24–28.

Folks DG. Munchausen's syndrome and other factitious disorders. *Neurologic Clinics* 1995;13:267–281.

Hay GG. Feigned psychosis: a review of the simulation of mental illness. *The British Journal of Psychiatry* 1983;143:8–10.

Pope HG, Jonas JM, Jones B. Factitious psychosis: phenomenology, family history, and long-term outcome of nine patients. *The American Journal of Psychiatry* 1982;139:1480–1483.

Popli AP, Masand PS, Dewan MJ. Factitious disorders with psychological symptoms. *The Journal of Clinical Psychiatry* 1992;53:315–318.

Reich P, Gottfried LA. Factitious disorders in a teaching hospital. *Annals of Internal Medicine* 1983;99:240–247.

Skau K, Mouridsen SE. Munchausen syndrome by proxy: a review. *Acta Paediatrica* 1995;84:977–982.

Wallach J. Laboratory diagnosis of factitious disorders. *Archives of Internal Medicine* 1994;154:1690–1696.