Factitious disorder: a case report and literature review of treatment

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Diagnosis of factitious disorder (FD) is frequently difficult and patients may present with physical symptoms only, psychiatric symptoms only or with a combination of both. As long as the nature of the disease is so secretive and large-scale studies are almost impossible, every case report is important. Here, the authors present a case of severe FD and the therapeutic approach taken.

The term ‘Munchausen syndrome’ was introduced in 1951 by Asher for people who purposefully create signs and symptoms of disease and who desire hospital or medical care. The term ‘Munchausen’ is linked to Baron Munchhausen (1720–1797), to whom factitious and unbelievable stories about his life and encounters were credited. At present, regardless of the spread use of the term ‘Munchausen syndrome’ this term is not included in the International Classification of Diseases tenth version (ICD-10). Munchausen syndrome was incorporated into the tenth version of the International Classification of Diseases as Factitious Disorder (FD), which is intentional production or feigning of symptoms or disabilities either physical or psychological – F68.1. The DSM-5 diagnostic criteria for the FD imposed on self are:

a. intentional production or feigning of psychological or physical signs or symptoms
b. assumption of the sick role as motivation for the behaviour
c. absence of external gain, such as avoiding legal responsibility or improving physical wellbeing, as in malingering.

The following subtypes are specified:
a. patients with primarily physical signs and symptoms,
b. patients with primarily psychological signs and symptoms, and
c. mixed subtype.

Patients with FD deceive clinicians in order to assume the sick role and be treated as patients. They may just exaggerate or false report symptoms of a genuine physical illness or they may completely fabricate subjective symptoms, physical examination and/or laboratory results. Fundamentally these patients do not look for any kind of gain such as monetary gain, days off work, etc. They want to be cared for and the factitious behavior is probably a maladaptive coping strategy in order for them to manage their inner emotional distress. This behavior results in needless medical or surgical therapies that pose risks for their health or even their life.

In the following paragraphs we will present an interesting case of severe FD in a young female patient, as well as our therapeutic approach. Our study also reviews the literature about FD treatment. This is a narrative, non-systematic review regarding treatment of FD, which includes selected case reports, series of case reports and reviews indexed in PubMed. We used the following keywords: Munchausen syndrome; factitious disorder, treatment. Our main aim is to provide information on treatment of this disorder whose management may be very challenging.

Case presentation
A 22-year-old female single patient was admitted in our adult psychiatric ward after an unsuccessful serious suicidal attempt, by taking a significant overdose of diazepam. The patient was already diagnosed with Emotionally Unstable Personality Disorder (EUPD) and mild depression. There was history of emotional dysregulation since adolescence and occasionally self-harming behavior by cutting. There were no previous admissions in psychiatric hospitals documented and there was no history of previous overdoses or suicide attempts. She was feeling low in mood for more than a year due to stressors, including her physical health and history of sexual abuse. She was intermittently experiencing auditory pseudo-hallucinations (the voice of the abuser). The patient described the voice as coming from her inner subjective space and lacked the objectivity and sensory realness of a true hallucination.

The patient under investigation was physically unwell since childhood (asthma and epilepsy), which resulted in several hospital admissions during childhood and excessive school absenteeism. She had started studying nursing science but was dropped out of university. The relationship with family members was poor after several incidents of aggression/agitation towards them. During the last year prior to admission in our psychiatric
ward she had several admissions in the local hospitals, in various wards with a variety of physical symptoms (chest pain, seizures, etc). Staff noticed unusual behavior (simulating to be ill) and she was referred for psychiatric assessment six months prior to admission in our ward. The patient at that point was uncooperative in disclosing any information and the psychiatric team concluded that there was insufficient evidence to make the diagnosis of FD.

During the last 6 months prior to psychiatric admission she used to attend A&E departments more frequently, especially during the nights and she got admitted on several wards. She used to present with chest pain, alleged seizures, dizziness, difficulty breathing, abdominal pain, urinary retention, etc. Her mother reported that as the time progressed she was leaving the house only to go to the hospital or to the GP surgery. During her hospitalisation staff noticed again unusual behaviour: she was saying she couldn’t pass urine in order to have a catheter put in. She was repeatedly asking for intramuscular injections and more cannula insertions, even asking for central line insertion. She was putting herself on the floor and saying she had a seizure (one incident was recorded on one of the cameras). She used to phone the respiratory ward roughly twice a week saying she was unwell and needed to be seen urgently. When she went to the ward and doctors said her chest was fine, she would then wish to say a list of other problems unrelated to her respiratory health, such as back pain, tooth ache, etc. A second referral to the psychiatric services had been made, but in the meantime the patient took the overdose that resulted in her admission to our psychiatric ward.

The patient had been suffering from asthma since childhood (poorly controlled when young), epilepsy, gastro-oesophageal reflux disease, irritable bowel syndrome, spinal epidural lipomatosis and osteoporosis. On admission, she was on 33 different medications from various medical specialties, including inhalers, painkillers, etc. She had been taking cimetidine, ranitidine and omeprazole simultaneously. She had also been taking paracetamol, oxycodone, gabapentin, amitriptyline, fentanyl patches and, when required, oramorph for neuropathic pain. The only psychotropic medication was diazepam 5mg twice a day. We considered that amount of medication as a significant substance misuse and we tried, with the assistance of the respiratory and medical team, to reduce her medication from 33 to 19 drugs. Initially, she was very aggressive towards staff and was constantly asking for her initial medication to be prescribed again.

During her admission she used to simulate all kind of physical symptoms on a daily basis and several times during the day. She was very well informed about various medical conditions to the extent that all the on-call doctors used to find the interaction with her really challenging. She knew how to instigate an asthmatic crisis or how to successfully pretend she was having a seizure. Staff and doctors were trying not to reinforce her attention seeking behavior by not paying much attention to her constant physical complaints, but they were very stressed because this patient has already serious physical health problems and staff and doctors were afraid of being accused of negligence. There is one incident documented, when she had a genuine asthmatic crisis and she was ignored by staff members. There were also a few incidents of head banging, as well as some self-strangulation attempts.

Interestingly, she accepted the diagnosis of EUPD, but she was explicitly denying the diagnosis of FD, despite plenty of evidence showing her pretending to be ill. She used to become very aggressive and hostile towards the consultant in charge of treatment once she was confronted with the diagnosis of FD and she used to keep saying that it was a false diagnosis and that she was only physically unwell.

In terms of treatment she had weekly hourly appointments with the ward psychologist for stabilisation with a view to starting psychotherapy in the future. Initially she did not engage well with the stabilisation therapy and she missed lots of sessions. In our Trust when patients have a history of complex trauma, psychoeducation around the diagnosis and stabilisation skills are offered as a first phase of psychological treatment. The intervention enables clients to understand their diagnosis and develop skills to help regulate their emotional intensity. Stabilisation is a structured psychological intervention. The number of sessions provided depend on the patients level of understanding and ability to adopt new skills. All clients with complex trauma have this intervention prior to receiving either EMDR or psychotherapy. We started her initially on quetiapine 200mg three times a day and sertraline 150mg in the morning, to help her with impulsive behavior and low mood, but she experienced excessive drowsiness with quetiapine and we had to discontinue it. She was subsequently started on zuclopenthixol decanoate 200mg weekly injection. After less than a month of receiving the injection, she showed significant improvement in terms of pretending less symptoms and engaging in far less impulsive behaviors.

At the end she became more receptive towards the diagnosis of FD and she accepted to be transferred to a specialised unit for patients with personality disorders for long-term rehabilitation. Surprisingly, before her transfer, she
also acknowledged that sometimes she was over-exaggerating about her symptoms.

Discussion and review of literature

Several factors can predispose for FD such as the presence of other mental health problems (eg depression), health conditions in childhood or in adolescence that result in continuous treatments or repeated hospitalisations, bitterness against doctors and existence of a personality disorder.\(^6\)

Very often, patients suffering from FD have experienced abandonment and/or abuse (emotional, physical, etc) in childhood.\(^7\) Plenty of patients who have FD have features compatible with EUPD.\(^8\) Based on MRI findings that showed brain abnormalities in some patients with FD, a hypothesis was formulated indicating that congenital or acquired anatomical alteration of the central nervous system could be correlated with the appearance of self-induced FD.\(^9\)

FD sometimes must be differentially diagnosed from other psychiatric disorders, such as hypochondriasis, conversion disorder, somatisation disorders and malingering. The patient who suffers from FD has no clear gain. In malingering there is always an external gain. In conversion disorder there is alteration in voluntary motor or sensory function.\(^4\) The exact incidence of FD cannot be estimated with accuracy. Men who belong to lower socioeconomic classes with a previous history of social maladjustment are frequently affected by this disorder.\(^10\)

Women who have received medically-related training in the past have also been known to be affected.\(^11\) Some authors report equivalent incidence between male and female patients. FD is characterised as secretive in nature and there are not many epidemiological studies about this disorder. It has been estimated that around 6–8% of total psychiatric admissions and 1–2% of hospital admissions could be manifestations of FD.\(^12\)

Treatment of patients who have been suffering from FD is difficult. In cases where their deceitfulness is revealed, patients often become angry and they often discharge themselves from doctors’ care. They may seek for medical services in a different hospital (peregrination). Most of these patients lack insight into their mental health illness and they infrequently engage in long-term psychotherapy or cognitive behavioural therapy, which seem to play an important role in treatment according to some authors.\(^13\)

Unfortunately our review has shown that there are not large cohorts or long-term follow up studies of patients suffering from FD in the psychiatric literature. Furthermore, we have found that there are not any controlled and randomised studies regarding treatment of FD. There are not any comparative studies published among the different types of therapeutic strategies.

We believe that the absence of reliable epidemiologic research or clinical trials regarding FD is explained by the fact that the patients frequently do not agree with the diagnosis and deny any kind of treatment and they may seek for medical services in other hospitals and clinics.\(^14\)

A study claims that these patients are resistive towards psychiatric therapy either openly or with covert passivity and negativism. The same study claims that the patient’s family members should be involved in treatment and the responsible clinician must try to discover as many supportive factors as possible.\(^15\) What is surprising with these patients is that despite the fact they may reject any effort for psychiatric treatment, they are ready to undergo massive investigations or even treatment of factitious illness.\(^16\)

It has been also noted that after successful diagnosis and confrontation, some patients will display some reduction in factitious behavior, even though they may continue denying that they fabricate the symptoms and avoid psychiatric intervention.\(^17\) Another study denotes that confrontation is beneficial on the way to recovery but it should be done only in an inpatient setting with close monitoring, as the confrontation is considered risky.\(^18\) On the other hand, other studies assert that the risks of confrontation outweigh the benefits and should therefore be avoided.\(^19\) Plenty of case reports regarding FD emphasise the importance of a robust therapist-patient alliance.\(^20\) According to them the first step towards treatment and management is a tolerant attitude.\(^21\) The psychiatrist should also make attempts to stop the self-discharge and subsequent peregrination.\(^22\)

There is a report of a successfully treated patient over a period of 3 years, by using a dynamic behavior modification program. The authors used a system that reinforced positive attributes by rewarding acceptable behaviour with praise and approval and a list of unwanted symptoms such as pain, epileptic fits, aggression, etc, were negatively reinforced by denying privileges. Behavioral explanations assert that FD is the result of social learning, positive and negative reinforcement.\(^23\)

In 2008 a systematic review on FD was published. This review consisted of 13 case series and 32 case reports and concluded that there is not sufficient data to assess the efficacy of any treatment strategy for FD, including medication treatment, psychotherapy, behavioral therapy and multidisciplinary approaches (confrontational or not) and the superiority of one treatment compared to another.\(^24\)

Prognosis of these patients is in general poor and depends on factors
such as early diagnosis of the disorder, psychiatric assessment and the co-existence of personality disorder or depression. The psychiatrist can then focus on either psychological and/or pharmacological treatment depending on the underlying mental health condition. One case study reported that the treatment of underlying depression, regular outpatient appointments accompanied by psychotherapy resulted in an excellent prognosis for the patient. Mayo and Haggerty observed 22 patients with FD who underwent psychotherapy and 10 of them were improved. Patients with FD can be refractory to psychotherapy.

The majority of patients suffering from FD present with somatic complaints: are reluctant to see a psychiatrist and may abscond before being interviewed. The subtype of predominantly psychological signs and symptoms, is uncommonly reported, likely due to the subjective nature of the symptoms. There are large series of case reports which have no psychiatric complaints documented. Bursten reported a case of FD presented as schizophrenia; the patient received a course of electroconvulsive therapy (ECT) during repeated hospitalisations.

It has been suggested that FD with psychiatric presentation may be more common than generally recognised. A review has shown that there is a possibility of underestimation of the number of factitious patients who exhibit psychiatric symptoms. One Spanish study found an 8% rate of factitious symptoms in an inpatient psychiatric population.

Regarding our patient, her motivation for pretending to be sick was the assumption of the sick role and there was no connection to any kind of external gains and therefore she fulfilled the criteria for the diagnosis of FD. We excluded the possibility of malingering, as her behavior was not appropriately adapted to a clear-cut long-term goal. Possible predisposing factors were the sexual abuse and the serious health problems she encountered as a child. We believe that she had been suffering from long-standing maladjustment difficulties and the simulation of physical signs and symptoms may probably represent a type of psychological defense mechanism. The simulation of illness was done consciously but behind these actions was an unconscious and underlying need for attention and care. Like many others, our patient had a link to the health care professions. She mainly used to simulate physical symptoms, however, we cannot absolutely exclude the possibility that some or even all of her psychiatric symptoms were manifestations of the FD.

There is one case report indexed in Pubmed, which has similarities to our report. This report describes improvement of FD after the use of pimozide, which is an old typical antipsychotic medication. In this study the patient suffered from FD and comorbid depression and showed great improvement of factitious behavior after receiving paroxetine 20mg daily and pimozide 2mg daily. Paroxetine is an antidepressant medication belonging to the SSRI group (selective serotonin reuptake inhibitor). The patient displayed deterioration in her mental state with reappearance of illness simulation behavior, after she stopped taking her medication. When she was given pimozide again, she displayed improvement again. This study does not specify if the patient received paroxetine the second time, apart from pimozide.

Our study indicates as well that the use of a typical antipsychotic medication, such as zuclopenthixol or probably the combination of an antipsychotic with an SSRI, such as sertraline may have a role to play in alleviating the factitious symptoms, so that the patient can engage more willingly to the subsequent psychological intervention, such as psychotherapy. Typical antipsychotics may be useful in treating the delusional thoughts, associated with FD. In the study of improvement of FD with pimozide, the patient received simultaneously pimozide and paroxetine, so it is rather unclear whether pimozide or paroxetine was more useful, whereas in our study the patient had already been taking sertraline for a few months and the great improvement happened after the introduction of zuclopenthixol into her treatment regime and therefore there is better indication that the typical antipsychotics may have a therapeutic role to play, at least in a number of patients.

In literature there are documented cases of monosymptomatic hypochondriacal psychosis (MHP) successfully treated with pimozide. This is an illness characterised by a single delusional system with hypochondriacal content. Within the delusional system, the patient shows marked illogicality insisting, against all evidence, on a physical aetiology, going to many physicians, and initiating strange cures of their own. Our patient used to simulate various physical symptoms in various systems and her presentation does not favor MHP.

Of course, our study has limitations. The fact that our study was conducted in a hospital setting with a few months of treatment may constitute an important bias. There is also a possibility that the zuclopenthixol effect was not pharmacological, but was either a placebo effect and/or part of the transference relationship with the clinicians. It is also possible that by giving her an intramuscular injection weekly, we actually fulfilled her unconscious need for attention and care. The patient might have thought that we were taking her very seriously and cared a lot about her by giving her a potent injectable medication.
There are also other factors apart from zuclopenthixol that may have contributed to her improvement. The fact that she had weekly hourly sessions with the psychologist (even if it was not psychotherapy) may had a role to play as well. The direct confrontation by the psychiatrist in charge of her treatment may have contributed in her recovery as well.

Conclusions

We suggest that doctors of all specialties and especially psychiatrists should report more cases of FD. As long as the nature of the disease is so secretive and large-scale studies are almost impossible, every case report is important. More research is also required in this field to comprehend the social and psychological characteristics of FD and to discover which treatment system can be most helpful for these patients.

Diagnosis of FD is frequently difficult and the authors want to spread awareness not only within psychiatrists, but within all medical specialties and health care professionals, even among the general population. Patients with FD may present with physical symptoms only, psychiatric symptoms only or with a combination of both. A high index of suspicion is considered necessary in recognising FD. Also, when suspecting the diagnosis, clinicians should keep in mind that FD may co-exist with actual physical disease, as happened with our patient, and that significant harm or even death could be the outcome of the patient’s efforts to simulate illness.

It is also important in case of patients who suffer from FD and other mental health comorbidities, the psychiatrists diagnose early and treat the underlying disorders. Despite the fact that prognosis is poor, we believe that every patient deserves a chance for treatment, as the literature does not contain some significant recovery outcomes and the best treatment method is still under debate.

The authors strongly believe that FD is profoundly under-diagnosed by doctors from all specialties, including psychiatrists. We believe that our patient improved as a consequence of confrontation, stabilisation therapy and use of zuclopenthixol decanoate injection.

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Declaration of interests

No conflicts of interest were declared.

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