M. L. Catalina
V. Gómez Macias
A. de Cos

Prevalence of factitious disorder with psychological symptoms in hospitalized patients

Psychiatry Department
Hospital de Móstoles
Madrid (Spain)

Factitious disorder is characterized by the invention, production or falsification of physical and psychological symptoms that feign a physical or mental illness. Although it is not rare to find symptoms that seem to be factitious among psychiatric patients (both outpatients and inpatients), we have never been able to confirm this suspicion.

Once we had established the suspicion criteria for factitious disorder with psychological symptoms, we discovered that 8% of the patients admitted to an inpatient psychiatric unit had factitious symptoms. The patients were mostly women with a mean age of 36.2 years. The most frequent symptoms were non-consistent response to treatment, worsening of the symptoms when faced with the perspective of a discharge plan, disappearance of the symptoms just after being admitted and intense relationship with other patients or staff during the hospitalization. Although it is not possible to determine the method used in the factitious production of the psychological systems accurately, close observation of the patients helps to infer that 75% of the patients exaggerate the psychological symptoms currently present or those occurring in the past and thus experienced at some time during their lifespan. Invention of psychological symptoms never felt before by the patient and deliberate intervention in the psychiatric treatment to modify the evolution of the illness were less frequent. A total of 25% of the patients with suspicion criteria for factitious disorder with psychological symptoms also had physical symptoms considered to be factitious during the hospitalization and 62% of patients with factitious symptoms developed intense relationships with other patients.

Key words:
Factitious disorder. Psychological symptoms.

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Prevalencia de trastornos facticios con síntomas psicológicos en pacientes hospitalizados

El trastorno facticio se caracteriza por la invención, producción o falsificación de síntomas físicos o psicológicos que simulan una enfermedad física o mental. Entre los pacientes psiquiátricos tanto ingresados como ambulatorios no es infrecuente observar síntomas que se sospecha que son facticios aunque nunca se llegue a confirmar esta sospecha.

Tras establecer unos criterios de sospecha de trastorno facticio con síntomas psicológicos se observó que el 8% de los pacientes ingresados en una unidad de hospitalización psiquiátrica presentaban síntomas facticios. Los pacientes con este diagnóstico eran fundamentalmente mujeres y su media de edad fue de 36,2 años. Los síntomas de sospecha que más se observan son la respuesta poco congruente al tratamiento, el empeoramiento de los síntomas ante la perspectiva del alta, la desaparición de los síntomas rápidamente tras el ingreso y el establecimiento de relaciones intensas con otros pacientes o con el personal durante el ingreso. Aunque no es posible determinar con total exactitud el método utilizado en la producción facticia de los síntomas psicológicos, la estrecha observación de los pacientes permite deducir que el 75% de los pacientes exageran síntomas psicológicos presentes en la actualidad o en el pasado y por tanto experimentados en algún momento de la vida. La invención de síntomas psicológicos aparentemente no experimentados nunca por el paciente y la intervención deliberada con el tratamiento psiquiátrico para afectar la evolución de la enfermedad se observaron con menos frecuencia. El 25% de los pacientes con criterios de sospecha de trastorno facticio con síntomas psicológicos presentaron también síntomas somáticos considerados facticios durante el ingreso. El 62,5% de los pacientes con síntomas facticios establecieron relaciones intensas con otros pacientes.

Palabras clave:
Trastorno facticio. Síntomas psicológicos.

Correspondence:
M.ª Luisa Catalina
Hospital de Móstoles
Río Jucar, s/n
28935 Móstoles (Madrid) (Spain)
E-mail: mlcatalina@eresmas.com

INTRODUCTION

Fictitious disorder is characterized by the invention, production or falsification of physical or psychological symptoms that simulate a physical or mental disease. Both the DSM-IV and ICD-10 consider that the motivation of the behavior is to assume the patient role and that there is no external incentive such as economic benefit that explains the behavior[1,2].

A series of characteristics common to the factitious disorders that facilitate their diagnosis have been described in the medical literature. These may be incongruity of the signs and symptoms with the syndrome, erratic course with improvements and worsenings contingent to admission or to the perspective of discharge, response that does not correspond with the treatment and appearance during admission of new somatic symptoms similar to those of other patients[3,4].

In the factitious disorder and its most severe and chronic form (the Munchausen syndrome) it is frequent to observe the tendency of the patient to lie about his/her life and personal achievements, even exaggerating and dramatizing physical and emotional traumas that that patient reports as involved in his/her disorder[5]. This characteristic is called pseudologia fantastica in the most extreme cases.

No prevalence studies have been made on the factitious disorder in the general population and those existing in the medical population have limited reliability. Prevalence rates ranging from 0.5% to 2% have been described in general medicine6. In some diseases that are difficult to diagnosis such as fever of unknown origin, the prevalence rate may reach up to 10%[7,8]. In chronic diseases such as diabetes, it has been demonstrated that 40% of the poorly-controlled patients deliberately induced the instability of their disease[9]. A total of 20% of the patients with a background of multiple unexplained medical problems met criteria for factitious disorder[10]. Between 20% and 30% of all the medical visits are due to problems that have no objective physical base and some of these problems could be a factitious behavior of disease although without forming a complete factitious disorder[11].

A review of the current data on factitious disorder with psychological symptoms establishes its prevalence at 0.14% of the patients admitted to psychiatric units[12].

It is not rare to observe symptoms that are suspicious of being factitious (invented or exaggerated) among both hospitalized and out-patient psychiatric subjects, even if this suspicion is never confirmed.

The objective of this work is to determine the prevalence of them in a psychiatric hospitalization unit, their distribution by genders, the method used in the factitious production of psychological symptoms and the frequency of the coexistence of psychological symptoms and factitious symptoms once suspicion criteria of factitious disorder with psychological symptoms is established.

MATERIAL AND METHOD

After a review of the literature3,4, suspicion criteria were established:

- The symptoms disappear immediately after admission.
- The symptoms worsen when there is perspective of discharge.
- The symptoms are not consistent with the syndrome.
- Response to the treatment is not consistent with them.
- New symptoms appear during the admission similar to those of other patients.
- Physical or emotional trauma is involved but there are no witnesses to collaborate the history.
- Intense relationships are established with other patients or with the staff.
- Lies (pseudologia fantastica) in aspects other than the symptoms are detected.

Between January and June 2006, all of the patients hospitalized in the brief hospitalization unit of the Hospital of Mostoles were evaluated for the presence of suspicion criteria of factitious disorder. Cases were considered to be patients who met three or more criteria. Control was considered to be patients of the same gender who were admitted consecutively to case and with the same diagnosis and who did not met suspicion criteria of factitious disorder.

In each one of the cases, the methods considered to be involved in the invention, production or falsification of both psychiatric and somatic symptoms were determined. The methods considered were:

- Exaggeration of psychological symptoms where there was suspicion that the patient had suffered them at some time in his/her life.
- Invention of psychological symptoms.
- Deliberate intervention on the psychiatric treatment to affect the disease course, for example, suddenly modifying the psychopharmaceutical doses.
- Exaggeration of somatic symptoms.
- Invention of somatic symptoms.
- Deliberate intervention with somatic treatment to affect the disease course.

RESULTS

Eight out of the 100 patients admitted in the period indicated were considered to be cases as they met more than three suspicion criterion. This represents 8% of the total amount of patients admitted to the psychiatric hospitalization unit of the Hospital of Mostoles.

The ages of the cases ranged from 22 to 55 years, with a mean age of 36.12 years and standard deviation of 12.4. Ages of those selected as Control group ranged from 21 to 60 years, with a mean age of 39.87 years and standard deviation of 14.78.

Distribution by gender was identical in both groups. A total of 87.5% were women (seven cases) and 12.5% were men (one case) (fig. 1).

A total of 87.5% of the cases met four or more enrolment criteria. The most frequently detected suspicion criteria in the cases was response inconsistent to treatment present in 100%. Other suspicion indexes detected in more than half of the cases were presence of clinical symptoms inconsistent with the syndrome (87.5%), worsening of the symptoms prior to discharge (75%), disappearance of symptoms immediately after admission (62.5%) and establishment of intense relationship with other patients or with staff during admission (62.5%). Comparison of each one of the suspicion criteria between cases and controls appears in table 1.

Although it is not possible to determine the method used in the factitious production of psychological symptoms with total accuracy, close observation of the patients makes it possible to deduce the suspicion method or methods involved. More than one symptom production method was detected in all the patients. A total of 75% of the patients exaggerate psychotic symptoms present currently or in the past and thus experienced by the patient at some time in his/her life. The invention of psychological symptoms apparently never experienced by the patient occurred in 37.5% of the cases and deliberate intervention with the psychiatric treatment to affect the disease course in 25% (table 2).

Twenty-five percent of the patients with suspicion criteria of factitious disorder with psychological symptoms also had somatic symptoms considered factitious during admission.

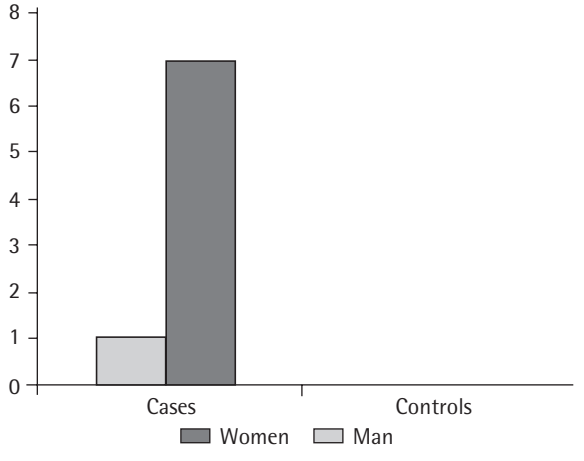

Figure 1 *Distribution by gender.*

Table 1 Suspicion criteria of factitious disorder

	Cases		Controls	
	n	%	n	%
Inconsistent response to treatment	8	100	1	12.5
Inconsistent symptoms	7	87.5	2	25
Worsening of symptoms prior to discharge	6	75	0	0
Disappearance of symptoms immediately after admission	5	62.5	1	12.5
Intense relationship with patients and staff	5	62.5	2	25
Appearance of symptoms similar to those of the other patients	3	37.5	0	0
Lies (pseudologia fantastica)	3	37.5	0	0
Background of non-verified physical or emotional background	1	12.5	1	12.5

Exaggeration of the somatic symptoms was considered to occur in 25% of the cases, invention of somatic symptoms in 25% and deliberate intervention with the somatic treatment to affect the disease course in 12.5% (table 2). During admission, 62.5% of the cases established intense relationships with other patients versus 25% of the Controls. The description of other behaviors described by different authors in factitious disorders appears in table 3.

DISCUSSION

None of the patients considered cases were diagnosed on discharge explicitly of factitious disorder even though they met suspicion criteria. Thus we cannot speak of factitious

Table 2 Method of symptom production

	n	%
Exaggeration of psychological symptoms	6	75
Invention of psychological symptoms	3	37.5
Deliberate intervention in psychiatric treatment	2	25
Exaggeration of somatic symptoms	2	25
Invention of somatic symptoms	2	25
Deliberate intervention on somatic treatment	1	12.5

Table 3 Behaviors observed during admission

	Cases		Controls	
	n	%	n	%
Intense relationships with other patients	5	62.5	2	25
Repeated request for medication	3	37.5	2	25
Intense relationships with health care staff	2	25	1	12.5
Behavior of helping health care staff	2	25	1	12.5
Intense relationships with relatives of patients	1	12.5	0	0

disorder but rather factitious behaviors of disease. This fact would explain the high prevalence obtained in this study, that is 8%, versus 0.14% of other authors[12].

The difficulties to diagnose factitious disorder with psychological symptoms are clear. On the one hand, demonstrating that the symptoms are invented, produced or exaggerated by the patient seems almost impossible. On the other hand, the diagnostic classifications themselves hinder the diagnosis as they require, as in the case of ICD-10, that there is no confirmed physical or mental disorder that can explain the symptoms, when in most of the cases of factitious disorder, these may co-exist with a real physical disorder or with a personality disorder. According to the studies published, prevalence of factitious disorder with physical symptoms is greater than that of factitious disorder with psychological symptoms. The difference is probably due to the difficulty to diagnose factitious disorder with psychological symptoms and the fear of the professionals to establish this diagnosis without having objective tests that confirm it.

Distribution by genders is similar to that of other studies, with predominance of women. On the contrary to the Munchausen syndrome in which the proportion of men versus women is 3 to 1, the proportion detected in factitious disorder is 3 to 1 in favor of women[13].

Most of the cases met four or more suspicion criteria so that we consider that the diagnostic reliability is high. The most frequent suspicion criteria and that which differentiate the cases from the controls are clinical criteria related with an infrequent or abnormal course (response to treatment that is inconsistent, worsening of the symptoms before the discharge, disappearance of the symptoms immediately after the admission). Discrepancy between the symptoms that the patient describes and the appearance observed is the greatest suspicion indicator. Another frequent criterion was the tendency of the cases to establish intense relationships with other patients. On the contrary to that described in the literature, pseudologia fantastica, the reporting of invented physical and emotional traumas are not prominent symptoms[14].

There are no studies on the coexistence of factitious disorder with physical symptoms and factitious disorder with psychological symptoms. There may be factitious disorders with pure somatic symptoms, given the stigma that mental disease still supposes for many patients. In fact, these cases coincide with those patients who reject psychiatric admissions after being discovered and when underlying personality disorder is detected. It is possible that the factitious disorders are psychological symptoms that occur with factitious somatic symptoms in greater proportion than in the opposite case.

It is very difficult to determine the method used in the factitious production of psychological symptoms. However, during psychiatric hospitalization, the clinician has the opportunity to closely observe the patient's behavior and to deduce when the patient is exaggerating current or past symptoms, when he/she invents them or when the patient incorporates symptoms that other patients have into their own disease. The most frequently used method was the exaggeration of psychological symptoms suffered at some time of the patient's lifetime.

Patients with factitious disorder with psychological symptoms or factitious behavior of disease that give the impression of being invented or that they are magnifying their symptoms establish intense relationships in the hospital, adapt to the hospital much better than to their setting and it is difficult to discharge them. They seem to find the support, social relationships and safety in the hospital that they do not find in their setting.

The methodological limitations of the present study depend on the already mentioned diagnostic difficulties and on the insufficient number of cases to reach more extensive conclusions.

CONCLUSIONS

The detected prevalence of factitious disorder with psychological symptoms in a psychiatric hospitalization unit was 8%.

Factitious disorder with psychological symptoms was more frequent in women, with a woman-man ratio of 7 to 1. Mean age of the patients was 36.2 years.

The most frequently used method in the production of the disorder was exaggeration of psychological symptoms suffered at any time during the lifespan.

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