

WHEN PATIENTS DECEIVE DOCTORS: A REVIEW OF FACTITIOUS DISORDERS

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Factitious disorders refer to those conditions that individuals willfully create by producing signs and/or symptoms of physical or mental illness. They are distinguished from psychogenic conditions by the complex voluntary behavior involved in creating the symptoms and are separated from malingers who feign or fabricate illness for specific gains. The inability to recognize this condition often leads to inappropriate diagnostic tests, invasive interventions and multiple iatrogenic complications, which makes the condition even more difficult to recognize. This article highlights the history of factitious syndromes as a disorder, reviews the diagnostic criteria and usual clinical presentation, examines diagnostic and therapeutic difficulties associated with suspected cases of factitious disorders, discusses the variations and subtypes of factitious disorders, and suggests treatment approaches for this most elusive disorder.

Factitious disorders refer to those conditions that individuals willfully (i.e., consciously) create by producing signs and/or symptoms of physical or mental illness in order to assume the "sick role" (1). Patients with factitious disorders are involved in complex voluntary conscious behaviors in order to create the factitious symptoms. In contrast, the symptoms of patients suffering from somatoform disorders are mediated by completely unconscious personal motives and are outside of volitional control (2). In a third related diagnosis, malingers feign or fabricate illness to gain specific tangible benefits or secondary gains (e.g., draft evasion, fraudulent compensation, escape punishment).

Unfortunately, throughout the practice of medicine factitious behaviors are not uncommon. Factitious behaviors should be understood within the spectrum of medical and psychiatric health and illness. Across the range from normal adaptive (healthy) functioning to severe disability there may be different shades of abnormal behavior based on the underlying mechanism or goal, including disease magnification, psychosomatic conditions, somatoform disorders, eating disorders, and at the extreme end, malingering.

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Health or illness can also be seen in terms of a range of responses to an underlying process or motivation. There exists a spectrum of unconsciously motivated behavior, ranging from a state of health, to psychosomatic conditions where psychosocial factors affect the course of common disease processes (i.e., asthma), to conscious behaviors motivated by ill perceptions of self (i.e., eating disorders), to unconsciously mediated quasi-medical conditions (i.e., somatoform disorders). Toward the opposite side of the spectrum we find more purely conscious behaviors. The spectrum may range from a state of adequate health to conscious disease magnification to true medical illness. As the level of deceptive behavior and the awareness of it increases, and the underlying motivation moves outward, the deceptive behaviors move from factitious manipulation to pure malingering.

HISTORY OF FACTITIOUS DISORDER

The origin of the term Munchausen's disorder, one of the types of factitious disorder, is as complicated and deceiving as the condition itself (3). Back in the 18th century Baron Karl Friederick Hieronymus von Munchausen (1720-1797) was a German Calvary officer who traveled widely and told fantastic stories of war, which were intended to entertain the public, not to deceive. Different from the modern use of the term, his stories had nothing to do with illness-behavior or the deception of doctors, families, and other health professionals.

In 1838 Gavin reported the first and probably most complete description of why people might knowingly feign, exaggerate, aggravate, or even induce illnesses in themselves (4). He listed a total of eight reasons. The first seven were related to the pursuit of external gains (e.g., to obtain military discharge, financial gain), and thus would fall within the modern day classification of "malingering" (1). The eighth reason, namely "to excite compassion or interest," expresses a motivation to play the "sick role," thus suggesting the underpinning of factitious disorders.

In 1948, Rudolph Erich Raspe, an eighteenth century English courtier and author of children's books, appropriated Munchausen's stories and published them in England under the name "Baron Munchausen's Narrative of his Marvelous Travels and Campaigns in Russia" (5). Again, as in the origi-

nal tales, they were fantastic and exaggerated stories of war, in no way associated with medical deceit or chronic medical problems.

In 1951, Parsons (6) defined the "sick role." According to Parsons, sick individuals are excused from social responsibility, are expected to perceive their condition as undesirable, lack voluntary control of their condition and thus are "not considered at fault" and are expected to seek competent help in curing their condition. Ironically, and in contradiction to Parsons definition of the "ideal patient," that same year Asher (7) applied the term Munchausen's syndrome to identify and describe patients presenting with chronic cases of factitious disorder. Then, as it is now, the term "Munchausen" was associated with extreme, chronic forms of factitious behavior in which extreme and routine lying and purposeful wandering or traveling (also described as peregrination) in order to prevent detection from medical professionals was the norm.

In 1958, Clark and Melnick (8) coined the term "hospital hobos" to describe the repetitive, peregrinative (i.e., purposeful traveling from place to place, or in this case from doctor to doctor, or hospital to hospital) behavior exhibited by Munchausen's patients. In 1969, Pilowsky (9) used the term "abnormal illness behavior" to refer to patients who, without consciously attempting to deceive, exaggerate or create some or all of the presenting symptoms. In 1977, Meadow (10) described in great detail the first case report in the medical literature of Munchausen's-by-proxy with physical symptoms. Nevertheless, the term "Munchausen syndrome-by-proxy" was not formally introduced until 1987, when Rosenberg (11) formally described the syndrome. In 1992, Barsky (12) used the term "somatic amplifiers" to describe patients who may unconsciously exaggerate or create physical or mental symptoms, without obvious secondary gain.

DSM-IV DIAGNOSTIC CRITERIA

The term factitious disorder first appeared in the Diagnostic and Statistical Manual of Mental Disorders (DSM) nomenclature in 1980 with the publication of DSM-III (13). According to modern classification, patients suffering from factitious disorder intentionally produce or feign physical or psychological signs or symptoms. The primary motivation for the fabrication of symptoms (factitious behavior) is to assume the sick role. In cases of facti-

tious disorder, external incentives for the behavior, such as economic gain or avoidance of legal or financial responsibility, are absent (14). Thus, patients with factitious illnesses feign or produce their own disease, are aware of their role in the deception, and keep their simulation of illness a secret.

The DSM-IV recognizes at least five variations or subtypes of Factitious Disorder (1, 3). These include factitious disorder with predominantly psychological signs and symptoms (e.g., factitious psychosis or mourning), with predominantly physical signs and symptoms (e.g., factitious fevers or factitious HIV), and with combined psychological and physical signs and symptoms. In addition, there is the well-recognized Munchausen's Syndrome, discussed later in the article, a term that is poorly understood and often misused by medical professionals. Finally, there is Factitious Disorder-by-proxy (FDP), formerly known as Munchausen's Syndrome-by-Proxy in DSM-III-R.

CHARACTERISTICS AND ASSOCIATED FEATURES

A review of the past personal and medical histories obtained from patients suffering from factitious disorder reveals an unexpectedly large number of childhood illnesses and operations, a childhood record of telling lies, and the creation of a factitious illness when faced with life stressors (e.g., loss). As adults, most patients presenting with a factitious disorder have some association with the health care field (15-17). Within the health care profession, nurses comprise the largest group (54%). Other health professionals include medical technicians (17%), nurses' aides (7%), and student nurses, physicians, hospital administrators, and medical secretaries (4% each).

When examined closely, most patients suffering from factitious disorder do not suffer from a long protracted illness process (i.e., lasting years at a time). On the contrary, most patients have intermittent episodes of illness. Usually, these patients initially present to their physicians with a factitiously produced illness process. The doctor's response to their request for help and the type of relationship they are able to develop with their doctors is going to dictate the course of the factitious illness process. If the patient feels understood and supported and his/her needs are met, it is likely that the presenting condition will respond to treatment just to recur later on. Similarly, most

subjects do not wander from hospital to hospital, as is the case in patients with Munchausen's Syndrome. In fact, most patients who are able to develop a trusting relationship with their physicians tend to stay with their physicians as long as their emotional and other unconscious needs are being met by the health care practitioner.

A look at the social system of patients with factitious disorder reveals that most subjects have a rather stable social environment. By far, they frequently are either married and/or have supportive families and for the most part frequently hold responsible jobs, usually in "caring professions."

Factitious disorder patients are usually not very forthcoming with providing a thorough (or truthful) childhood history. When present, family members are usually "unavailable" to medical professionals caring for patients with factitious disorders. Lying is found to be one of the characteristic methods of stress management utilized by individuals suffering from factitious disorders, with stories of a "difficult childhood" embellished to elicit pity or a "caring response" from their caretakers. Unfortunately, true histories of childhood abandonment, object loss, and childhood abuse or neglect are not uncommon. In terms of their past medical histories, most subjects have a history of multiple childhood illnesses and operations. Similarly, these patients' histories reveal that they had a tendency to create factitious illnesses when faced with life stressors (e.g., loss, financial or social problems).

Borderline personality disorder and major depression are among the most common comorbid psychiatric diagnoses (3, 17-19). Also characteristically, most patients have a history of experiencing a long-standing preoccupation with illness and/or hypochondriacal fears, which at times have reached almost delusional proportions. The fact that many patients have medical jobs may be a manifestation of the life-long concern about health and not the cause in and of itself.

Other features associated with factitious disorders differ among the subtypes. Thus, patients with factitious disorder exhibiting primarily psychological signs and symptoms may present with Ganser's syndrome (20-24) or with the use of psychoactive medications (stimulants, hallucinogens, analgesics, hypnotics) as a method of creating the factitious syndromes. On the

other hand, patients with factitious disorder exhibiting primarily physical signs and symptoms may present with a history of substance abuse (analgesics and sedatives), and multiple hospitalizations frequently leading to iatrogenically induced medical conditions. This includes the development of the “Gridiron abdomen” due to multiple surgical scars. Some patients have a poor level of physical functioning, usually leading to chronic physical disability, which is particularly common in cases of Munchausen’s syndrome. See Table 1 for a summary of characteristics and associated features.

Table 1. Characteristic and Associated Features of Factitious Disorders

Most patients:

- Have intermittent episodes of illness
 - Do not wander from hospital to hospital
 - Have a stable social system
 - Frequently have families
 - Frequently hold responsible jobs, usually in “caring professions”
 - A history of:
 - Multiple childhood illness and operations
 - Childhood lying
 - Some association with the health care field
 - The creation of a factitious illness when faced with a life stressors (e.g., loss, financial or social problems)
 - Borderline Personality Disorder
 - Major Depression
 - Life long preoccupation with illness and hypochondriacal fears
 - Quasi-delusional preoccupation with illness
 - In Factitious Disorder with *psychological* signs and symptoms:
 - Ganser’s syndrome
 - Use of psychoactive medications (stimulants, hallucinogens, analgesics, hypnotics)
 - In Factitious Disorder with *physical* signs and symptoms:
 - Substance abuse (analgesics and sedatives)
 - Multiple hospitalizations frequently lead to iatrogenically induced medical conditions
 - “Gridiron abdomen”
 - Poor level of physical functioning usually leading to physical disability
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PRESENTATIONS

The deceptive behavior exhibited by factitious patients can occur at any of three levels (25-27). Patients may provide a factitious history, that is, offer a false history of a diagnosis. There have been documented cases of patients presenting a factitious history of having been diagnosed with cancer (28, 29), seizures (30), sickle cell (31), HIV (32, 33), trauma (34), or PTSD (35-39). Patients may just simply falsely report symptoms such as fever (15, 40-42), convulsions, loss of consciousness, pain (43-45), satanic ritual abuse (46), rape (43, 47, 48), psychosis (48-50), or dissociation (51).

Patients may also simulate a medical illness. They achieve this by contaminating samples (e.g., a patient seeding a urine sample with a drop of blood in order to create a picture of hematuria) (52), tampering with thermometers to simulate fevers (40), and feigning seizures (as opposed to simply describing a history of them as in the example above).

Some patients may actually create a pathophysiological state during which an actual disease process may be clearly diagnosed and identified by physicians. They do this by self-injecting exogenous substances or organisms (e.g., producing abscesses by injecting saliva into the skin, manipulating intravenous catheters with fecal material to cause sepsis), taking exogenous medications or poisons which may create symptoms characteristic of a disease process (e.g., injecting insulin to create episodes of hypoglycemia [53, 54], injecting epinephrine to mimic pheochromocytoma [55] or convulsions, self-administering thyroid hormone to produce a hyperthyroid state, ingesting warfarin or other blood thinners to cause a bleeding disorder, ingesting laxatives to cause diarrheal processes [56]).

Finally, patients may just take advantage of an already existing illness process by interfering with treatment and/or healing of a wound or a fracture, thus perpetuating the abnormal pathophysiology and consequently the sick role. In fact, as suggested above, the most common medical presentations of factitious disorder include sepsis, non-healing wounds, fever and electrolyte disorders. Similarly, the most common methods used to produce factitious symptoms utilized by these patients include the injection or insertion of contaminated substances (29%), the surreptitious use of medications (24%), the manipulation of wounds or fractures, leading to non-healing processes usu-

ally requiring more drastic procedures such as surgery (17%), thermometer manipulation (10%), urinary tract manipulation (7%) (e.g., insertion of fecal material into the urethra) (27, 57-59), and falsification of medical histories (7%).

EPIDEMIOLOGY

Factitious disorders usually develop during the third decade of life. Nevertheless, cases of factitious behavior have been described in a wide range of age groups. It has been reported to occur as early as 4 years of age and as late as 79 years of age. The typical patient with factitious disorder is female. In fact, females outnumber males by as much as 3-20 to 1 (15, 27). Factitious disorder patients are usually socially stable, employed, and conform to the norms of society (15, 60).

Antisocial behavior is rare, but difficulty in establishing stable, heterosexual, long-lasting relationships is not (14). These patients also frequently present a strong personal or family history of "genuine" serious disease. About half of the cases either work in the health professions or have a first-degree relative in medicine or nursing (14, 15, 19, 26, 27, 61). In fact, Nadelson (19) reported that a remarkable 58% of patients suffering from factitious disorder are considered medical or "healing" professionals, including physicians, nurses, nurse assistants, paramedics, physician or clinic office personnel, and emergency medical personnel.

On the rare occasions in which factitious disorder is diagnosed in men, there is usually a poor work record, a disturbed childhood, and a history of substance abuse and recidivism (14). While the Munchausen character usually bristles with psychopathic traits, patients with factitious disorder are typically immature, sensitive, submissive, insecure and dependent. A review of the history of patients suffering from factitious disorder reveals a high incidence of premorbid trauma (3). Around 28% of patients diagnosed with factitious disorder suffered the loss of a parent before the age of one year. Up to 61% of patients have a history of severe childhood abuse. About 24% have a history of rape or sexual assault.

No reliable information is available regarding the prevalence of this disorder. Sutherland and Rodin (62) reported an incidence of factitious disorder of 0.8%, as seen by a psychiatric consultation service. Nevertheless, we

know that 2.2-9.3% of fevers of unknown origin are factitiously simulated (15, 40-42), as are 3.5% of urinary calculi (63). In a prospective study, Bauer and Boegner (64) followed all factitious patients presenting to a neurology clinic during a one-year study period and found that five of 1538 (0.3%) patients were diagnosed as having factitious disorder with feigning of neurological syndromes. Four presented with the classic Munchausen syndrome variant. All patients had a concomitant personality disorder, according to DSM-III-R criteria (13).

Baragwanath and Harding (65) reported on five patients who underwent a total of 36 (range 0-15) operations, of which 60% were performed after the diagnosis of factitious disorder had been suspected. Physicians must remember that the most important role of the surgeon (or physicians in general) is to protect the patient from over-investigation, which includes resisting surgical attempts to cure the condition. Surgical intervention should be reserved for life- or limb-threatening complications of this disorder. Early diagnosis remains essential so that resources are not wasted and, more importantly, the patient is not exposed to unnecessary morbidity.

Factor et al. (66) followed 842 patients with movement disorders seen over a 71-month period at a neurology clinic. They found that 28 patients (3.3%) were diagnosed as having a documented or clinically established psychogenic movement disorder. Tremor was most common (50%), followed by dystonia, myoclonus, and Parkinsonian-like symptoms. On examination, 71% had other psychogenic features, including over 60% with a clear history of a precipitating event and secondary gain. About 50% had a comorbid psychiatric diagnosis (usually depression). Up to 25% of patients presented with combined psychogenic movement disorder and organic movement disorder.

ETIOLOGY AND PATHOGENESIS

There have been various reasons proposed for the etiology of factitious disorders. A number of psychodynamic processes have been proposed. It may be explained as an attempt to achieve control and mastery by the production of symptoms over which they have absolute control; masochism; the displacement of rage toward a symbolic caregiver via symptoms which the caretaker may have to attend to; a defense against loss; or as a substitute for a "lost object," which in cases of factitious disorder is usually from a relatively

early stage of life (i.e., before age one). One behavioral conditioning theory suggests a child's tendency to pathologically amplify or fake a minor symptom or ailment (i.e., belly ache) and feign disease as an attempt to obtain sympathy or attention from a parent or other caregiver. Finally, factitious behaviors may also represent a pathological form of psychological coping similar to what we observe in the somatoform disorders. An association with several severe personality traits, such as borderline personality disorder (BPD) in females and antisocial personality disorder (APD) in males, has also been observed (17, 19).

MUNCHAUSEN'S SYNDROME

Even though many clinicians use the terms factitious disorder and Munchausen's syndrome synonymously, there are significant differences in meaning between the two (See Table 2). Only about 10% of patients with factitious disorder have Munchausen's Syndrome (27). In essence, Munchausen's represents an essentially intractable course of factitious disorder characterized by a pattern of chronic factitious illness production and multiple hospitalizations with associated geographic wandering designed to conceal the deceitful behaviors, sociopathic character, fantastic lies regarding their medical histories, and an exclusion of a personal life aside from their fantasized illness.

Like other factitious patients, those suffering from Munchausen's present a pattern of recurrent feigned or simulated illness. However, patients suffering from Munchausen's usually also display a pattern of pathologic lying (e.g., "pseudologica fantastica"), which dates back to childhood and pervades the patient's entire adult life (67). Different from the usual patient suffering from factitious disorder who has a stable social structure, most patients with Munchausen's present a pattern of peregrination, that is, traveling or geographic wandering to multiple doctors, hospitals, clinics and/or medical centers. Also different from most patients with factitious disorder, Munchausen's patients don't seem to develop close, attached and dependent relationships with their physicians. In fact, they seem determined to fool them and prove them wrong. Once suspected or discovered, a Munchausen's patient becomes angry and dismissive, usually leaving the hospital against

medical advice just to present himself to the next doctor's office or medical center.

Table 2. Characteristic and Associated Features of Munchausen's Syndrome

- Represent about 10% of patients with factitious disorder
 - An essentially intractable course of factitious illness
 - Diagnostic Features:
 - Pathologic lying ("pseudologica fantastica")
 - Peregrination (traveling or geographic wandering)
 - Sociopathic character
 - Recurrent feigned or simulated illness
 - Exclusion of a personal life aside from fabricated illness
 - Epidemiology
 - Male patient (2:1)
 - Between 30-40 y/o
 - Knowledge of a medical field
 - Supportive Features
 - Multiple hospitalizations, usually acute
 - Multiple scars
 - Unusual and/or dramatic presentation
 - Equanimity for diagnostic procedure
 - Equanimity for treatments & surgical procedures
 - New complaints and symptoms emerge when extensive work-up of the initial complaints has proven negative
 - Hospital discharge against medical advice (AMA)
 - Reenactment of the same sequence of events at the next hospital
 - Deprivation or lack of nurturance in childhood
 - Borderline or antisocial personality disorder
 - Police record
 - Drug seeking behavior
 - Evidence of self-induced physical signs
 - Positive room search yielding physical evidence (e.g., medications, syringes)
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While the vast majority of factitious disorder patients are female (15, 27), Munchausen's patients are predominantly male. In fact, about twice those suffering from Munchausen's syndrome are male (2:1). The average age of presentation is between 30-40 years of age, and like other factitious disorder patients, they tend to have either direct or peripheral knowledge of the medical field. Munchausen's patients commonly have a history of multi-

ple hospitalizations, usually for acute problems. Because of the multiple presentations and diagnostic tests they undergo, the physical examination generally reveals multiple bodily scars. Different from factitious disorder patients who present with what appear to be “normal” medical problems, Munchausen’s patients present with unusual and dramatic presentations and histories. Like factitious patients, they offer no resistance or concerns when diagnostic procedures are offered, no matter how invasive they may be.

In most cases of factitious disorder, patients present with a pattern of remitting and relapsing illness. Patients tend to experience acute worsening of the initial presenting complaint leading to delayed hospital discharge or prompt readmission. In cases of Munchausen’s disorder, however, new complaints and symptoms usually emerge once extensive work-up of the initial complaints has proven negative for a medical condition. If at the end of the diagnostic work-up a physician were to confront a Munchausen’s patient, the encounter is likely to end in a discharge against medical advice and likely to be followed with a reenactment of the same sequence of events at the next hospital.

Patients with Munchausen’s disorder commonly have a history of antisocial behavior, a police record for criminal offenses, and a history of drug seeking behavior (68). In fact, the most common comorbid psychiatric diagnoses are borderline and antisocial personality disorders (3, 17, 19). Not surprisingly, a review of their early life reveals a history of deprivation or lack of nurturance during childhood. To complete the picture, some patients have been known to grow up to develop Munchausen’s Syndrome themselves or to believe that they are truly disabled after having been victims of by-proxy illness during childhood.

In retrospect, the exam or history may reveal evidence of self-induced physical signs and, when done, room searches usually yield physical evidence of self-induced injurious behavior (e.g., medications, syringes).

DIAGNOSIS

Factitious disorders are extremely difficult to diagnose and even more difficult to confirm than most psychiatric conditions. In fact, the average length of time between the initial presentation and diagnosis varies from a

few months to 6 years. Reasons for diagnostic delay include lack of suspicion from medical personnel, as well as the complexity and veracity of the symptoms presented by the patient.

There is an unwritten, unspoken contract between patients and doctors. It is the patient's responsibility to accurately report symptoms in a timely fashion to his physician. As physicians, we are used to taking patient's complaints, histories of illness, and signs and symptoms at face value. It is then the doctor's responsibility to accurately interpret the signs and symptoms presented by patients and to diagnose and prescribe appropriate treatments. In exchange, patients are expected to faithfully follow the doctor's instructions and to take prescribed medications and carry out instructions (e.g., diet, exercise, or restrictions) as directed by their physician. This principle dogma, the unwritten contract, is violated by factitious patients who deceive their physician and who only follow treatment recommendations to a point, in order to create or maintain a degree of sickness and dependency on the care and affection of his/her unwitting physician.

The deceitfulness of their actions usually baffles physicians who will continue to develop a differential diagnosis and an increasingly complex treatment plan, either blaming themselves for being unable to accurately diagnose or treat the presenting symptoms, or blaming a "virulent or unusual variant" of a known disease process. Unfortunately, this delay in diagnosis does more than deceive doctors. It often leads to inappropriate diagnostic tests, invasive interventions and iatrogenic complications. Furthermore, it may lead to enormous financial drains on the health care system.

In an attempt to recognize patients who may be factitiously causing their illness, physicians may want to look for a number of clues that can help identify factitious disorder patients. Clues include a medical condition that does not respond to seemingly correct medical treatment, a history of working in the health care profession (e.g., nurse, paramedic, physician, spouse or relative of physician), a remarkably large number of medical interventions in order to diagnose a given (or related) condition to no avail, and an excessive eagerness to undergo diagnostic and therapeutic interventions. Factitious disorder patients also appear to have a keen and accurate ability to predict the waxing and waning of the signs and symptoms. This usually precedes a phy-

sician's attempt to discharge a patient from the hospital after a relatively extensive hospital stay characterized by multiple remissions and relapses. Despite the fact that most factitious disorder patients appear to have relatively stable environments (e.g., a spouse and job) they often appear to be rather isolated, having very few hospital visitors despite prolonged hospital stays and multiple hospitalizations.

In the end, there are only three "fool-proof" or definitive ways of diagnosing a factitious disorder. The patient is "caught in the act" of injuring him/herself (e.g., nurse or doctor walks in, or surveillance system records, while patient is in the process of injecting the medication or contaminant in order to produce the symptoms.), or the patient "confesses" to inflicting self-harm after being confronted with evidence acquired from previous physicians, medical records, or a room search turns out evidence of self-injurious behavior. The third and most likely way of making a diagnosis of factitious disorder is by consensus of the multiple consultants commonly involved in the puzzling picture created by factitious patients. Usually, the presence or absence of scientific proof for a given presentation or the presence of bizarre evidence ends up being the decisive factor. This is what I call "the preponderance of the clinical/scientific evidence" method. In my clinical experience, this is the method most likely to accurately diagnose factitious disorder.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis of factitious disorder must include a true general medical condition which may escape modern diagnostic skills or which doesn't follow a classic course or presentation (69). That is, at times physicians may displace their frustration regarding diagnostic or treatment failure onto the patient. In my experience, this is more commonly the case if the patient happens to suffer from a personality disorder. In the case of factitious disorder with psychological symptoms, a true mental disorder should be considered. Certainly, it is also possible to have a patient who suffers from a real medical and/or psychiatric problem, who presents with factitiously created symptoms (70).

Given the nature of the underlying problem, that is, excessive preoccupation with health, bodily functioning and illness, the somatoform disorders

(e.g., hypochondriasis, conversion disorder, pain disorder, and somatization disorder) should be considered. Along with these, a delusional disorder with somatic preoccupation must be ruled out. Given the high incidence of major depression in patients with factitious disorder, the possibility that the presenting symptoms represent self-mutilation or a suicide attempt should be explored. Finally, clinicians must consider the possibility of malingering.

SOMATOFORM DISORDERS

According to DSM-IV (1), the common feature of all somatoform disorders is the presence of physical symptoms that suggest a general medical condition but are not fully explained by a diagnosable physical illness, substance abuse, or another mental disorder. Different from cases of factitious disorder and malingering, these conditions are created via unconscious mechanisms and as such are not under voluntary control.

DSM-IV (1) recognizes five types of somatoform disorders, including somatization disorder, hypochondriasis, conversion disorder, pain disorder, body dysmorphic disorder and undifferentiated somatoform disorder. They all must be considered in the differential diagnosis of factitious disorder. Closer attention will be paid to conversion disorder as it is another condition in which the mind deceives the body, and because of its diagnostic connection with factitious disorder.

MALINGERING

Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, which is motivated purely by external incentives (e.g., avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs). Even though under a limited number of circumstances it may represent adaptive behavior (e.g., feigning illness while captive of the enemy during wartime), malingering is neither a medical nor a psychiatric diagnosis and is usually considered criminal or sociopathic behavior.

As in the case of factitious disorders, malingering may present with a rather complex picture and may pose a difficult differential diagnosis. The condition should be suspected when a number of factors are noted. These

include a medico-legal context to the presentation (e.g., symptoms presenting after an accident where there is a pending legal case), a marked discrepancy between the person's claimed stress or disability and objective findings, a lack of cooperation with either the diagnostic evaluation or poor compliance with the prescribed treatment regimen. Finally, as in cases of factitious disorder, antisocial personality disorder is commonly found in cases of malingering.

Often times it is rather difficult to differentiate factitious disorder (including Munchausen's) from malingering. Because the mechanism of symptom formation is conscious in both presentations, the clinician or the medical staff may witness similar phenomena such as various acts of fabrication, laboratory results which contradict observable signs or reported symptoms or histories, and lack of expected response to seemingly appropriate medical treatment. As in cases of factitious disorder, room searches may lead to physical evidence (e.g., medications, syringes, infectious material), which may explain the observable phenomena.

Magnification of symptoms or lack of effort on neurological or neuropsychological tests can have several underlying causes (71), especially when associated with or found within the context of civil or criminal litigation. The differential diagnosis in these cases must include malingering, factitious and somatoform disorders. But it is important to remember that the detection of exaggeration during the reporting or examination of symptoms does not automatically indicate that the individual is malingering.

In the end, the main difference between factitious behavior and malingering hinges on the motivation for symptom production. Malingers fake their symptoms in order to obtain tangible secondary gains, while in cases of factitious disorder the main goal of the production of symptoms is to be in the sick role. That is, to derive sympathy from a caring medical professional so as to reenact a failed object relation, or to reestablish a similar relationship in the present. As in cases of true medical illness, there may be an associated secondary gain in the factitious presentation, but that is usually an incidental by-product rather than the primary motivation.

FACTITIOUS DISORDER: CLINICAL MANAGEMENT

The first step in the treatment of factitious disorder is the recognition of the syndrome, or at least to have an appropriate index of suspicion. If factitious disorder is suspected, a psychiatric consultation should be obtained. One of the most important steps includes a thorough review of the patient's medical record and improved communication among members of the treating and consulting teams. Despite a suspicion or even a certainty of the diagnosis, a team approach should be directed at altering the delivery of medical care in a physiologically acceptable way, which addresses any potential or ongoing problems, but minimizes iatrogenic problems. In order to protect the patient, the primary team should avoid unnecessary and potentially dangerous diagnostic or operative procedures.

From a pharmacological point of view, treatment options are limited. There are no controlled studies demonstrating the effectiveness of any pharmacological agent in the treatment of factitious behaviors. Even though depressive and OCD-like qualities have been described in patients suffering from factitious disorder, there are no controlled studies demonstrating the effectiveness of antidepressant agents (SSRI's included) in the diminution of factitious symptoms or behavior. Furthermore, most patients are usually unwilling to accept any psychiatric intervention, including the use of psychotropic agents.

The use of confrontational approaches has been advocated, and in my clinical experience, it is the most effective approach. In fact, confrontation is usually the foundation of effective management. When this approach is used, the confrontation should be done by the patient's primary care physician (PCP) or whomever the patient identifies as his/her doctor. The psychiatric consultant usually designs the treatment plan after consultation with all members of the treatment team. The psychiatrist should be present (along with a representative of each consulting team involved) and remain in the room after the confrontation has finished. The approach during and after confrontation should be non-punitive and supportive. It is imperative that the PCP stresses the need for continuity of care and that he/she recognize the patient as a sick person and the need for further treatment. Along these lines, all members of the treatment team, primarily the psychiatric consultant, must

interpret the fabrication of symptoms as a cry for help. Clinical experience suggests that the patient-doctor relationship often improves after confrontation. It also suggests that most patients require a combined medical and psychiatric approach, which should be utilized by the PCP as part of the ongoing, comprehensive medical treatment plan.

There are a number of non-confrontational approaches, which are to be carried out by all members of the treatment team as adjuvant to, rather than in lieu of, the above-mentioned approach. These include the building and maintenance of rapport between doctor and patient while continuing any necessary non-invasive medical treatment.

Behavior modification techniques have been advocated (72-75). These suggest the reward of socially acceptable behavior while discouraging self-destructive or factitious behavior. The use of "face-saving techniques" may be useful. This advocates the use of maneuvers such as self-hypnosis that provide the patient with an ego-acceptable rationale, which explains the patient's recovery while reinforcing acceptable behavior. The "therapeutic double-bind" technique emphasizes that the patient has two choices: he/she can prove that the disorder is not factitious by responding to relatively minor and benign medical intervention; on the other hand, the patient may prove that the disorder is in fact factitious by failing to respond to the suggested treatment (76). Finally, there is the "inexact interpretations" technique in which the therapist gives the patient an interpretation that is partially correct but incomplete, stopping short of overtly identifying the factitious origin (77).

Ultimately, the goal of treatment is usually not to cure, but to prevent further morbidity and surgery (thus minimizing iatrogenic injury), to prevent further hospitalizations, to promote more socially acceptable and mature ways to express distress, and to have their need to be cared for met. In order to achieve these goals, physicians must consistently express their interest in the patient's well being, while maintaining concrete and firm treatment rules designed to promote healthy behavior. Physicians must maintain consistent and clear communication among all members of the management team and with the patient, both in the inpatient and outpatient settings. The best way to minimize confusion and breakdown of communication, while minimizing

team splitting, is for a single physician (preferably the PCP) to be "the identified care giver" whose responsibility it is to coordinate and approve any needed specialist consultation and any diagnostic test and/or treatment suggested by members of the consulting team.

In order to minimize or avoid the patient's feelings of abandonment, regular medical visits are recommended. Physicians are advised to not wait for crises to occur. Prophylaxis is always the best treatment. The immediate goal is to diminish the positive reinforcement of acute illness, while promoting acceptable expressions of distress. Patients should be allowed and encouraged to receive nurturance and support from the PCP and members of the consulting team, when exhibiting healthy behaviors. Despite improvement in symptoms and diminishment of self-injurious behavior, patients should be provided with reassurance that they will not be abandoned. It is imperative to continue to monitor for the possibility of real organic illness. Remember that even patients with factitious disorder do eventually get sick.

The ultimate aim of treatment is to replace maladaptive (factitious) behaviors with healthier ones. Even when treatment appears successful, be aware that relapses may occur. When they do, they should be used as opportunities to learn more about the motivations behind the factitious behavior.

DISEASE COURSE

The course of factitious disorders is rather variable. The condition, although usually chronic, is characterized by a remitting and relapsing course. Nevertheless, in rare occasions, the condition may be limited to one or more brief episodes. Often, the onset takes place after patients have been hospitalized for a "true" medical condition or mental illness.

In fact, by the very nature of the illness, the patient's goal is to be in the "sick role." If we remember Parsons' definitions of the sick role (above), sick individuals are excused from social responsibility, are expected to perceive their condition as undesirable, lack voluntary control over their condition and thus are not considered at fault and are expected to seek competent help in curing their condition. In turn, physicians are expected to expertly listen to and elicit diagnostic clues from their patients, accurately diagnose the condition, and prescribe the necessary treatments to deal with the condi-

tion. In return, patients are expected to follow the doctors' recommendations and get better.

As such, factitious patients will present with a factitious complaint or illness, which will elicit a diagnosis and treatment recommendations from his/her physician. Because the primary goal of factitious patients is to be in the sick role and to be taken care of by an "object figure," they will initially seek help and diligently follow the recommendations and treatments. This often results in improvement, which elicits a sense of pride and well being from their care-taking physician. Unfortunately, as the conditions improve, the physician's level of interest understandably fades away. So instead of asking the patient to return to the clinic every other day, he/she is asked to return in a week or a month. Patients perceive this "lack of interest" on the part of the physician as a sign of abandonment and/or become jealous of other patients. This then elicits a "worsening" of symptoms, either by non-compliance with the medical regimen, manipulation of the initial disease process, or the creation of a new problem, usually of greater seriousness or impact, in an attempt to recapture the physician's interest. By far, most patients remain loyal to their physicians from whom they desire attention and care. Similarly, most factitious patients are liked, at least initially, by their physicians who diligently attend to their patient's problems. Different from cases of Munchausen's syndrome, most factitious patients do not wander in search of new doctors but remain loyal to their primary physician.

The above pattern of illness creation, intense clinical interest from the clinician, and symptom improvement with decline in clinical interest produces the waxing and waning of factitious symptoms. The above pattern explains why factitious disorder patients suffer intermittent episodes of illness and do not wander from hospital to hospital. Most patients have a rather stable social system. Most patients have families, are married or in a committed relationship, and many hold responsible jobs. Unfortunately, these jobs are usually within what are known as the "caring professions," which may explain why it is that these presentations are so difficult to spot as factitious when initially presenting.

Factitious disorders, including Munchausen's syndrome, rarely result in mortality. Nevertheless, mortality is an unfortunate frequent occurrence in cases of Munchausen's by proxy (11, 78).

PROGNOSIS

The overall prognosis for all forms of factitious disorder is poor. The prognosis is particularly bad for patients suffering from Munchausen's Syndrome. The patient's prognosis is further complicated by the potential presence of co-existent physical disease or intermittent medical illness. Another layer of complication is the potential development of iatrogenic complications often resulting from the multiple diagnostic tests these patients undergo in the pursuit of a final diagnosis. Once certain procedures are performed, it may be impossible to ever rule out organic disease. Take for example the case of a patient abusing anti-diarrheal agents leading to factitious intestinal obstruction who undergoes abdominal surgery in order to rule out intestinal obstruction or ischemia. Once surgery has been performed, even if there was no resection, the differential diagnosis for further episodes of abdominal pain must include the possibility of iatrogenic adhesions as a consequence of prior surgery. Many patients also present with co-existent psychiatric disorders. The most common of these disorders are major depression and personality disorders (3, 17-19).

LEGAL AND ETHICAL ISSUES

What should a physician do if he/she suspects factitious disorder? Can the physician refuse to continue to treat? Is there any responsibility to report the patient? Once the patient leaves his institution, should the physician alert other doctors or medical centers regarding the patient's behavior? Should others be warned even when there is no absolute or definitive evidence of factitious behavior?

These are all very difficult questions and there is no easy answer to any of them. In theory, a physician could terminate treatment of a patient if the patient does not follow a reasonable rule, that is, lacks compliance with recommended treatment. Using the argument of poor compliance and interference with adequate treatment, a physician could terminate treatment after providing the patient with notice of intent to terminate, along with appropri-

ate notice regarding timing and, usually, a list of facilities or individual practitioners. Others suggest that no physician should be placed in the position of referring a factitious patient to a colleague without providing adequate disclosure. This has raised the issue of doctor-patient confidentiality versus a sense of responsibility toward the next caregiver.

The issue of privacy in factitious disorder is delicate. There is the instant tendency, once there is suspicion of factitious behavior, to either throw the patient out of the hospital or to devise some plan to "catch the patient in the act." Nevertheless, the principle of privacy prevents us from "spying" on patients. There may be a number of very limited exceptions to this principle (i.e., cases of factitious disorder-by-proxy, where the health and safety of a third party, such as a dependent children or elderly adult, may be at stake) which should not be exercised without consulting your institution's counsel or the local authorities (79, 80).

Otherwise, the principle of patient's privacy suggests that patients retain the rights of informed consent and informed refusal for any and all procedures or treatments to be performed on or given to them. Therefore, no procedure should be initiated without the patient's knowledge and consent. In general, regardless of the level of suspicion, laboratory or other investigations without the full consent of a patient are unethical and should be avoided. The performance of searches is advocated when there is a high index of suspicion. On the other hand, one should inform the institution's counsel office of what you intend to do and why. The patient should then be informed of the suspicion and the wish to search the room for the reasons already discussed. At that time, the patient should provide consent. The only exceptions to this rule include situations in which the safety of the patient or others is in question, or when a patient exhibits mental status changes presumed to be due to the voluntary ingestion or injection of a substance and the patient's mental status impedes him/her from providing consent.

Patients suffering from factitious disorder may cause considerable damage to themselves due to the self-injurious behaviors in which they engage. Due to the risk of self-destructive behavior, usually based on past history of actual behavior, some courts have mandated treatment or placement for protection of self. This process is generally difficult and time-consuming, usu-

ally requiring the assistance of the patient's parents or spouse, and the primary care physician. Outpatient guardianship to limit and manage the abuse of medical facilities and procedures has been described.

Another problem encountered when dealing with cases of factitious disorder is how to maintain the patient's confidentiality and freedom in a situation that may well prove harmful to the patient. Proponents of the utilitarian approach believe that physicians should act in a way that produces the greater good for the greatest number of people. Based on this approach, a violation of confidentiality in cases of factitious disorder may be justified.

In contrast, those who support the sanctity of the patient-doctor relationship hold that no situation should violate the principle of patient-doctor confidentiality. In fact, the World Medical Association, in the Declaration of Geneva, stated that "there are no legitimate reasons to violate doctor-patient confidentiality" (81). Nevertheless, others suggest that by their deceitful acts, people suffering from factitious disorder do not fulfill their part of the patient-doctor contract and therefore no real doctor-patient relationship exists. If we are to subscribe to this principle we should assume that doctors in this situation are not bound by their code of professional ethics (82).

In the end, it may be better to honor the doctor-patient confidentiality principle except in the clear-cut situations in which adherence to this policy would be harmful specifically to the patient or to another person (due to the possibility of danger to self or danger to others). This certainly does not apply to cases of factitious disorder-by-proxy in which most jurisdictions would require immediate reporting to the appropriate authorities (i.e., child or adult protective services).

Because it usually takes so long to appropriately diagnose cases of factitious disorder, the net result is an immense drain on the medical system. Time, money, and other resources are unnecessarily spent in the diagnostic investigation and treatment of these cases. Some states have enacted legislation against the fraudulent acquisition of medical services. Thus, factitious patients may be seen as wasting or stealing the time and expertise of health care professionals and as abusing and stealing medical and private and federal financial resources (83).

In October 2000, a Florida circuit court jury found Kathy Bush (42 years old) guilty of aggravated child abuse and Medicaid fraud after a three month trial. She had been charged with fabricating illnesses in her 12-year-old daughter, Jennifer, in an attempt to gain attention and sympathy for herself. Because of the deceitful behavior Mrs. Bush used to create her daughter's symptoms, the victim had been hospitalized 200 times and had undergone about 40 operations, including removal of her gall bladder, appendix and a portion of her intestines. The state of Florida had become involved in the case years earlier and had removed Jennifer from the custody of her mother in April 1996. Since her custody had been taken over by the state, Jennifer had not been hospitalized. Yorker (84) provides an excellent summary of other pertinent legal cases of factitious disorder by proxy and their outcomes.

Some patients with factitious disorder and factitious disorder by proxy initiate lawsuits (85, 86). There are several scenarios associated with malpractice liability. The first of these scenarios includes denial of factitious behavior and subsequent suing of the physician, accusing him/her of factitious behavior, for defamation. The second scenario involves the issue of negligence, that is, the physician's inability or failure to consider and/or identify the factitious behavior as part of the differential diagnosis. Thus, the claim would be that unneeded procedures should have been avoided by an astute clinician. Usually, these follow complications associated with unnecessary diagnostic tests or procedures.

CONCLUSION

As noted throughout the article, patients suffering from factitious disorders are a diagnostic challenge and a therapeutic nightmare. The difficulty in diagnosis and treatment seems to be associated with the elaborate schemes devised by the patients to fool their physicians. A complicating factor is the fact the factitious behavior violates the unspoken contract between patient and doctor, in which the former accurately reports symptoms so the latter can make an adequate diagnosis. The inability to recognize the deceitful behaviors often leads to inappropriate diagnostic tests, invasive interventions and multiple iatrogenic complications, which makes the condition even more difficult to recognize and usually places the physician in the role of co-conspirator in the patient's plans. Only after recognizing and directly ad-

addressing the factitious behavior, usually after confrontation and a supportive, but structured treatment plan, can these patients ever improve. Unfortunately, once the deceit is discovered, it is difficult for physicians to develop the trusting nonjudgmental relationship necessary for an adequate patient-doctor relationship.

REFERENCES

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, American Psychiatric Association, 1994
2. Maldonado JR, Spiegel D: Conversion Disorder. Review of Psychiatry, Volume 20. Washington, D.C. American Psychiatric Press, 2000
3. Feldman MD, Ford CV: Patient or Pretender: Inside the Strange World of Factitious Disorders. New York, John Wiley and Sons, 1993
4. Gavin H: On Feigned and Factitious Diseases. Edinburgh, University Press, 1838
5. Raspe RE: The Singular Travels, Campaigns, and Adventures of Baron Munchausen. London, Cresset Press, 1948
6. Parsons T: The Social System. Glencoe, Free Press, 1951
7. Asher R: Munchausen's Syndrome. Lancet 1951; 1:339-341
8. Clark E, Melnick S: The Munchausen Syndrome or problem of hospital hobos. Am J Med 1958; 25:6-12
9. Pilowsky I: Abnormal illness behavior. Br J Med Psychol 1969; 42:347-351
10. Meadow R: Munchausen's syndrome by proxy: the hinterland of child abuse. Lancet 1977; 2:343-345
11. Rosenberg DA: Web of deceit: a literature review of Munchausen syndrome by proxy. Child Abuse and Neglect 1987; 11:547-563
12. Barsky A: Amplification, somatization, and the somatoform disorders. Psychosomatics 1992; 33:28-34
13. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington, D.C., American Psychiatric Association, 1987
14. Carney MWP: Artefactual illness to attract medical attention. Br J Psychiatry; 136: 542-547, 1980.

15. Aduan RP, Fauci AS, Dale DC, Herzberg JH, Wolff SM: Factitious fever and self-induced infection: a report of 32 cases and review of the literature. *Ann Intern Med* 1979; 90:230-242
16. Craemer B, Gershberg MR, Stern M: Munchausen syndrome: its relationship to malingering, hysteria and the physician-patient relationship. *Arch Gen Psychiatry* 1971; 24:573-578
17. Freyberger H, Nordmeyer JP, Freyberger H et al.: Patients suffering from factitious disorders in the clinico-psychosomatic consultation liaison service: psychodynamic processes, psychotherapeutic initial care and clinicointerdisciplinary cooperation. *Psychother Psychosom* 1994; 62:108-122
18. Earle JR, Folks DG: Factitious disorder and coexisting depression: a report of successful psychiatric consultation and case management. *Gen Hosp Psychiatry* 1986; 8:448-450
19. Nadelson T: The Munchausen spectrum: borderline character features. *Gen Hospital Psychiatry* 1979; 1:11-17
20. Bhugra D: Psychiatric Munchausen's syndrome. *Acta Psychiatrica Scand* 77:497-503, 1988
21. Cheng L, Hummel L: The Munchausen syndrome as a psychiatric condition. *Br J Psychiatry* 1978; 133:20-21
22. Cocores JA, Santa WG, Patel MD: The Ganser syndrome: evidence suggesting its classification as a dissociative disorder. *International J Psychiatry Med* 1984; 14:47-56
23. Miller P, Bramble D, Buxton N: Case study: Ganser's syndrome in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry* 1997; 36:1:112-115
24. Weiner H, Braiman A: The Ganser syndrome. *Am J Psychiatry* 1955; 111:767-773
25. Eisendrath SJ: Factitious illness: a clarification. *Psychosomatics* 1984; 25:110-117
26. Ford CV: Factitious illness, in *The Somatizing Disorders: Illness as a Way of Life*. Edited by Ford CV. New York, Elsevier Biomedical, 1983; 135-154
27. Reich PJ, Gottfried LA: Factitious disorders in a teaching hospital. *Ann Intern Med* 1983; 99:240-247
28. Feldman MD, Escalona R: The longing for nurturance: a case of factitious cancer. *Psychosomatics* 1991; 32:226-227
29. Songer DA: Factitious AIDS: a case report and literature review. *Psychosomatics* 1995; 36:406-411

30. Jones JR, Horrocks FA: Fictitious epilepsy associated with amnesia. *Br J Psychiatry* 1987; 150:257-258
31. Ballas SK: Munchausen sickle cell painful crisis. *Annals of Clinical and Laboratory Science* 1992; 22:226-228
32. Churchill DR, De Cock KM, Miller JE et al.: Feigned HIV infection/AIDS: malingering and Munchausen's syndrome. *Genitourin Med* 1994; 70:314-316
33. Nickoloff SE, Neppe VM, Ries RK: Factitious AIDS. *Psychosomatics* 1989; 30:342-345
34. Davis D, Barone, JE, Blackwood MM: Munchausen syndrome presenting as trauma. *Journal of Trauma-Injury Infection and Critical Care* 1997; 42:6:1179-1181
35. Lynn EJ, Belza M: Factitious posttraumatic stress disorder: the veteran who never got to Vietnam. *Hospital Community Psychiatry* 1984; 35:697-701
36. Neal LA, Rose MC: Factitious posttraumatic stress disorder: a case report. *Med Sci Law* 1995; 35:546-549
37. Resnick PJ: Malingering of posttraumatic disorders, in *Clinical Assessment of Malingering and Deception*. Edited by Rogers R. New York, Guilford, 1988; 84-103
38. Sparr L, Pankratz LD: Factitious posttraumatic stress disorder. *Am J Psychiatry* 1983; 140:1016-1019
39. Sparr LF: Factitious posttraumatic stress disorder: does it exist? *Neurol Clin* 1995; 13:413-429
40. Herzberg JH, Wolff SM: Chronic factitious fever in puberty and adolescence. A diagnostic challenge to the family physician. *Psychiatr Med* 1972; 3:205-211
41. Knockaert DC, Vanneste LJ, Vanneste SB, et al.: Fever of unknown origin in the 1980s. An update of the diagnostic spectrum. *Arch Internal Medicine* 1992; 152:51-55
42. Rumans LW, Vosti KL: Factitious and fraudulent fever. *Am J Med* 1978; 65:745-755
43. Feldman MD, Ford CV, Stone T: Deceiving others/deceiving oneself: four cases of factitious rape. *South Med J* 1994; 87:736-738
44. Fishbain DA, Goldberg M, Rosomoff RS, et al.: Munchausen syndrome presenting with chronic pain: case report. *Pain* 1988; 35:91-94
45. Oldham L: Facial pain as a presentation in von Munchausen's syndrome: a case report. *Br J Oral Maxillofacial Surgery* 1974; 12:68-90

46. Coons PM, Grier F: Factitious disorder (Munchausen type) involving ritual satanic abuse. *Dissociation* 1990; 3:177-178
47. Dohn HH: Factitious rape: a case report. *Hillside J Clin Psychiatry* 1986; 8:224-231
48. Gelenberg AJ: Munchausen's syndrome with a psychiatric presentation. *Dis Nerv Syst* 1977; 38:378-380
48. Kanin EJ: False rape allegations. *Arch Sex Behav* 1994; 23:1-6
49. Pope HG, Jonas JM, Jones B: Factitious psychosis: phenomenology, family history and long-term outcome in nine patients. *Am J Psychiatry* 1982; 139:1480-1483
50. Popli AP, Masand PS, Dewan MJ: Factitious disorders with psychological symptoms. *J Clin Psychiatry* 1992; 53:315-318
51. Coons PM, Milstein V: Factitious or malingered multiple personality disorder—eleven cases. *Dissociation* 1994; 7:81-85
52. Wallach J: Laboratory diagnosis of factitious disorders. *Arch Intern Med* 1994; 154:1690-1696
53. Berkowitz S, Parrish JE, Field JB: Factitious hypoglycemia: why not diagnose before laparotomy. *Am J Med* 1971; 51:669-674
54. Waickus CM, de Bustros A, Shakil A: Recognizing factitious hypoglycemia in the family practice setting. *Journal of the American Board of Family Practice* 1999; 12:2:133-136
55. Keiser HR: Surreptitious self-administration of epinephrine resulting in "pheochromocytoma." *JAMA* 1991; 266:1553-1555
56. Topazian M, Binder HJ: Brief Report: Factitious diarrhea detected by measurement of stool osmolality. *New England Journal of Medicine* 1994; 330:20:1418-1419
57. Grunert BK, Sanger JR, Matloub HS, Yousif NJ: Classification system for factitious syndromes in the hand with implications for treatment. *J Hand Surg* 1991; 16:1027-1030
58. Masterton G: Factitious disorders and the surgeon. *British Journal of Surgery* 1995; 82:12:1588-1589
59. Mendez-Fernandez MA: The factitious wound: plastic surgeon beware. *Ann Plastic Surg* 1995; 34:187-190
60. Bayliss RIS: The deceivers. *BMJ* 1984; 288:583-584
61. Guziec J, Lazarus A, Harding JJ: Case of a 29-year-old nurse with factitious disorder. *Gen Hosp Psychiatry* 1994; 16:47-53

62. Sutherland AJ, Rodin GM: Factitious disorders in a general hospital setting: clinical features and a review of the literature. *Psychosomatics* 1990; 31:392-399
63. Gault MH, Campbell NR, Aksu AE: Spurious stones. *Nephron* 1988; 48:274-279
64. Bauer M, Boegner F: Neurological syndromes in factitious disorder. *Journal of Nervous and Mental Disease* 1996; 184:5:281-288
65. Baragwanath P, Harding KG: Factitious disorders and the surgeon. *British Journal of Surgery* 1996; 83:5:711-712
66. Factor SA: Psychogenic movement disorders: frequency, clinical profile, and characteristics. *Journal of Neurology, Neurosurgery and Psychiatry* 1995; 59:4:406-412
67. Ford CV, King BH, Hollender MH: Lies and liars: psychiatric aspects of prevarication. *Am J Psychiatry* 1988; 145:554-562
68. Folks DG, Freeman AM: Munchausen's syndrome and other factitious illnesses. *Psychiatr Clin North America* 1985; 8:263-278
69. Vaughan BL, Knight JR: Self-induced vomiting as a presentation of abdominal mass. *Pediatrics* 1997; 99:5:731-733
70. Kwan PB, Lynch S, Davy A: Munchausen's syndrome with concurrent neurological and psychiatric presentations. *Journal of the Royal Society of Medicine* 1997; 90:2:83-85
71. Iverson GL, Binder LM: Detecting exaggeration and malingering in neuropsychological assessment. *Journal of Head Trauma Rehabilitation* 2000; 15:2:829-858
72. Eisendrath SJ: Factitious physical disorders. *West J Med* 1994; 160:177-179
73. Eisendrath SJ: Factitious disorders and malingering, in *Treatments of Psychiatric Disorders*, 2nd edition. Edited by Gabbard GO. Washington, D.C., American Psychiatric Press, 1995
74. Klonoff EA, Youngner SJ, Moore DT et al.: Chronic factitious illness: a behavioral approach. *Int J Psychiatry Med* 1983-1984; 13:73-83
75. Yassa R: Munchausen's syndrome: a successfully treated case. *Psychosomatics* 1978; 12:242-243
76. Eisendrath SJ, Feder A: Management of factitious disorders, in *The Spectrum of Factitious Disorders*. Edited by Feldman MD, Eisendrath SJ. Washington, D.C., American Psychiatric Press, 1996; 195-213

77. Eisendrath SJ: Factitious physical disorders: treatment without confrontation. *Psychosomatics* 1989; 30:383-387
78. Meadow R: Letter to editor. *Child Abuse Negl* 1990; 14:289
79. Feldman MD: Spying on mothers. *Lancet* 1994; 344:132
80. Foreman DM, Farsides C: Ethical use of covert videoing techniques in detecting Munchausen syndrome by proxy. *BMJ* 1993; 307:611-61
81. World Medical Association: Declaration of Geneva, reprinted in *Ethics in Medicine: Historical Perspectives and Contemporary Concerns*. Edited by Reiser SJ, Dyck AJ, Curran WL. Cambridge, MA, MIT Press, 1977
82. Ford CV, Zaner RM: Response to the article "Ethical and management considerations in factitious illness: one and the same" by Sadler JZ. *Gen Hosp Psychiatry* 1987; 9:37-39
83. Powell R, Boast N: The million dollar man: resource implications for chronic Munchausen's syndrome. *Br J Psychiatry* 1993; 162:253-256
84. Yorker BC: Legal issues in factitious disorder by proxy, in *The Spectrum of Factitious Disorders*. Edited by Feldman MD, Eisendrath SJ. Washington, D.C., American Psychiatric Press, 1996; 135-156
85. Feldman MD, Ford CV: Liejacking. *JAMA* 1994; 271:20:1574
86. Lipsitt DR: The factitious patient who sues. *Am J Psychiatry* 1986; 143:1482

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