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# Munchausen's Syndrome and Other Factitious Disorders in Children—*Case Series and Literature Review*

## ABSTRACT

There has been increasing recognition in the pediatric literature for the past 20 years that illness falsification by caregivers must be included in the differential diagnosis of children presenting with persistent, unexplained symptoms or laboratory findings. However, there is considerably less awareness that pediatric symptoms can also be intentionally falsified by child and adolescent patients, and this unique group has remained virtually invisible. There have been reports that many children with factitious disorders also suffer from other mental disorders, particularly personality disorders. We report an unusual case of Munchausen's syndrome in a 15-year-old patient with sickle cell disease. We also review other reported pediatric factitious disorders in literature. Our purpose is to make clinicians aware of this less known disorder in children and to discuss the similarities and differences these disorders have in children compared to adults with the same disorders.



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## INTRODUCTION

Adult patients who present with symptoms of factitious disease are challenging but children who present with this disorder are at times frustrating. There has been increasing recognition in the pediatric literature for the past 20 years that illness falsification by caregivers must be included in the differential diagnosis of children presenting with persistent, unexplained symptoms or laboratory findings.<sup>1</sup> However, there is considerably less awareness that pediatric symptoms can also be intentionally falsified by child and adolescent patients, and this unique group has remained virtually invisible. Case reports of child and adolescent illness falsification has been described in the US and worldwide. In fact, many of the Munchausen syndrome by proxy mothers describe inducing illness in themselves in their teenage years.<sup>2</sup>

Factitious disorder (FD) is an umbrella category that covers a group of mental disturbances in which patients intentionally act physically or mentally ill without obvious benefits. According to one estimate, the unnecessary tests and waste of other medical resources caused by FD cost the US \$40 million per year. The word *factitious* comes from a Latin word that means “artificial” or “contrived.” The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR)* distinguishes FD from malingering, which is defined as faking illness when the individual has a clear motive—usually to benefit financially or to avoid legal trouble. FD is sometimes referred to as hospital addiction, pathomimia, or polysurgical addiction. Variant names for individuals with FD include hospital vagrants, hospital

hoboes, peregrinating patients, problem patients, and professional patients.

The term *factitious* is derived from a book by an English physician named Gavin, published in 1843, entitled, *On Feigned and Factitious Diseases*.<sup>6</sup> Cases of FD appear in the medical literature as early as Galen, a famous Roman physician of the second century AD. The modern study of FDs, however, began with a 1961 article in *The Lancet* by a British psychiatrist, Richard Asher, who also coined the term *Munchausen's syndrome* to describe a chronic subtype of FD.<sup>3</sup> In 1977, it was Gellenger who first reported a case of FD with primarily psychological symptoms.<sup>4</sup> The term *Munchausen's syndrome* most appropriately refers to the subset of patients who have a chronic variant of FD with predominantly physical signs and symptoms. In practice, however, many still use the term *Munchausen's syndrome* interchangeably with FD.

Munchausen's syndrome was named after Karl Frederick Hieronymus, Frieher von Munchausen, a German Cavalry officer who was well known for exaggerating his adventures. Over time, his stories became more and more expansive and outlandish. Munchausen became somewhat famous after a collection of his tales was published.<sup>5</sup>

Munchausen's syndrome entered the DSM classification for the first time in 1980.<sup>7</sup> Therefore, it is likely that this condition is underdiagnosed.<sup>8</sup> It is thought that people with FD feign illness or injury not to achieve a clear benefit, such as financial gain, but rather to gain the sympathy and special attention often given to people who are truly ill. People with FD are even willing to undergo painful or risky tests and

**TABLE 1. Methods of induction of symptoms in FDs**

- Smothering or suffocating
- Pushing fingers down the throat
- Using laxatives or other drugs
- Swallowing or injecting hazardous substances
- Scratching or deliberately injuring the skin
- Poking with a small or sharp instrument
- Disconnecting drips or IV lines
- Switching patient charts
- Interfering with test samples.

operations in order to obtain special attention from others. Munchausen's syndrome is considered a mental illness because it is associated with severe emotional difficulties. Cases of Munchausen's syndrome often result in expensive and unnecessary medical workup.

The term *Munchausen's syndrome by proxy* was coined in 1977 by an English pediatrician named Roy Meadow.<sup>9</sup> Schuman<sup>10</sup> suggested that Munchausen's syndrome by proxy may be operating in some divorce-related false allegation cases. Ferguson<sup>11</sup> in 1988 gave a fictionalized account of a true, post-divorce case in which the patient was eventually diagnosed as having Munchausen's syndrome by proxy. Forty-two cases of illness falsification by children were identified by Libow.<sup>2</sup> Six cases of FD and malingering in pediatric patients were also described by Peeblo, et al.<sup>12</sup>

## EPIDEMIOLOGY

There are no reliable statistics regarding the number of people in the US who suffer from FDs. Various authors report the following to date:

- In general medicine, there is a 0.5 to 2 percent rate of FD.<sup>13</sup>
- In adolescents with sickle cell,

**TABLE 2. Factors that raise the possibility that the illness is factitious**

- **Reluctance by the patient to allow healthcare professionals to meet with or talk to family members, friends, and prior healthcare providers**
- **Dramatic or atypical presentation**
- **Vague and inconsistent details, although possibly plausible on the surface**
- **Long medical record with multiple admissions at various hospitals in different cities**
- **Knowledge of textbook descriptions of illness**
- **Admission circumstances that do not conform to an identifiable medical or mental disorder**
- **An unusual grasp of medical terminology**
- **Employment in a medically related field**
- **Pseudologia fantastica**
- **Presentation in the emergency department during times when obtaining old medical records is hampered or when experienced staff are less likely to be present (eg, holidays, late Friday afternoons)**
- **Few visitors despite patient giving a history of holding an important or prestigious job or one that casts the patient in a heroic role**
- **Acceptance, with equanimity, of the discomfort and risk of diagnostic procedures**
- **Acceptance, with equanimity, of the discomfort and risk of surgery**
- **Substance abuse, especially of prescribed analgesics and sedatives**
- **Symptoms or behaviors only present when the patient is being observed**
- **Controlling, hostile, angry, disruptive, or attention-seeking behavior during hospitalization**
- **Fluctuating clinical course, including rapid development of complications or a new pathology if the initial workup findings prove negative**
- **Multiple surgical scars or a gridiron abdomen, indicating the chronic form of FD, or with evidence of self-induced physical signs.**

there is a 0.9 percent rate of FD.<sup>14</sup>

- Pope, et al.,<sup>50</sup> found a prevalence of 4.1 percent in subjects previously diagnosed as psychotic.
- Bhugra found in a retrospective study only 0.5 percent of FD among patients successively admitted in a psychiatric hospital.<sup>6</sup>
- FDs are responsible for 2.2 to 9.3 percent of fevers of unknown origin and 3.5 percent of urinary calculi.<sup>15</sup>
- Of material submitted by patients as kidney stones, 2.6 percent was found to be nonphysiologic and probably fraudulent.<sup>16</sup>
- Of patients referred to the consultation-liaison service of a large teaching hospital in Toronto, 0.8 percent had FD.<sup>16</sup>
- Of infants brought to a clinic in Australia because of serious illness, 1.5 percent were cases of Munchausen syndrome by proxy.<sup>16</sup>

### AGE AND GENDER

People with FD tend to be women aged 20 to 40 years and employed in medical fields, such as nursing or medical technology. Persons with chronic FD (Munchausen's syndrome) tend to be unmarried, middle-aged men who are estranged from their families. Perpetrators of Munchausen's syndrome by proxy are typically mothers who induce illness in their young children; however, sometimes fathers or others are responsible. FDs have been reported in kids as young as eight years.<sup>2</sup>

### PATHPHYSIOLOGY

The causes of FD, whether physical or psychiatric, are difficult to determine because affected patients are often lost to follow-up when they leave the hospital. Magnetic resonance imaging (MRI) has detected

abnormalities in the brain structure of some patients with chronic FD, suggesting that there may be biological or genetic factors in the disorder. The results of EEG (electroencephalography) studies of these patients are nonspecific.<sup>17</sup>

Several different psychodynamic explanations have been proposed for FD. Kaplan, et al.,<sup>18</sup> remarked that patients with FD often present with traumatic events and numerous hospitalizations that occurred during childhood. Eisendrath<sup>15</sup> believed that FD allows patients to feel in control as they never felt in childhood. Tec<sup>19</sup> regarded it as a coping mechanism, learned and reinforced in childhood. A related and very interesting hypothesis is Henderson's conception about "care-eliciting behaviors."<sup>20</sup> This hypothesis has the merit of logically integrating FDs in a large spectrum of normal and pathological behaviors in man and animal. The process of unconscious identification with an important person, who genuinely has the pathology the patient is feigning, is considered important in the choice of symptoms.<sup>4</sup>

Many authors have also underscored the co-occurrence of some pathological personality traits and/or disorders. Identity disturbance, unstable interpersonal relationships, and recurrent suicidal or self-mutilating behaviors are similar to those encountered in borderline personality disorder. Deceitfulness, lack of remorse, reckless disregard for safety of self, repeated failure to sustain constant work behavior, and failure to conform to social norms are common features of FD and antisocial personality disorder.<sup>48</sup>

There is little agreement or evidence as to what causes Munchausen's syndrome or

Munchausen's syndrome by proxy. Some theories suggest that the patient (or caregiver) may have experienced any of the following:

- Abuse or neglect as a child
- Reliving an earlier serious illness over and over again due to difficulty understanding or coping with the experience
- Identifying with a close friend or relative who has had a serious illness
- Very low self-image
- Inflated self-image
- Inability to trust authority figures, such as doctors
- Overwhelming feelings of guilt, thinking they need to be punished for something
- Brain dysfunction, though no genetic links or abnormalities have been found in the brains of people with either syndrome
- Presence of personality disorder, depression, or substance abuse.

### SYMPTOMS OF FD

A patient with FD often presents with the following symptoms:

- A long history of unexplained illness
- A willingness to accept the discomfort and risk associated with medical procedures, including surgery
- A textbook knowledge of the supposed illness and medical practices in general
- Vagueness about the actual

details of his or her condition

- Exaggeration or lying about other aspects of his or her life
- Hostility and antagonistic or overly dramatic behavior
- Problems with his or her nervous system, such as seizures, apnea, and drowsiness
- Gastrointestinal disorders, such as vomiting and diarrhea
- Respiratory difficulties, such as breathlessness and hyperventilation
- Allergic reactions, including rashes, diarrhea, and vomiting
- Unexplained bleeding or discharge from ears, nose, anus, or vagina
- Extensive scarring or loss of body parts, such as fingers
- Anemia or failure to thrive (e.g., malnourishment)
- Abnormal test results, such as blood in urine
- Symptoms of extremely rare or dramatic disorders.

A list of methods patients may use to induce symptoms are listed in Table 1.

### DIAGNOSIS OF FD

The DSM-IV-TR requires that the following three criteria be met for the diagnosis of FD:

1. Intentional production or feigning of physical or psychological signs or symptoms
2. Motivation for the behavior is to assume the sick role
3. Absence of external incentives

**TABLE 3. Differential diagnoses of FDs**

- **Genuine psychiatric pathology**
- **Malingering**
- **Conversion disorders**
- **Real medical illnesses**
- **Overanxious parenting**
- **Normal variability between illnesses**
- **Illnesses resulting from discontinuation of medicines**

for the behavior (e.g., economic gain, avoiding legal responsibility, and improving physical wellbeing, such as in the case of malingering).

Other factors that indicate an illness is factitious are listed in Table 2. Differential diagnoses and essential differentials are listed in Tables 3 and 4.

The DSM-IV recognizes the following types of FD:

- FD with predominantly psychological signs and symptoms
- FD with predominantly physical signs and symptoms
- FD with combined psychological and physical signs and symptoms.
- FD not otherwise specified, which includes those disorders with factitious symptoms that do not meet the criteria for FD. The DSM-IV places FD by proxy (i.e., Munchausen's syndrome by proxy) into this category, defining it as "the intentional

**FACTITIOUS DISORDER (FD)** is an umbrella category that covers a group of mental disturbances in which patients intentionally act physically or mentally ill without obvious benefits. The term *Munchausen's syndrome* most appropriately refers to the subset of patients who have a chronic variant of FD with predominantly physical signs and symptoms.

**TABLE 4. Essential differential of factitious disorder, malingering, and conversion**

Disorder	Production	Motivation
Malingering	Conscious	Conscious
Factitious disorder	Conscious	Unconscious
Conversion	Unconscious	Unconscious

production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care for the purpose of indirectly assuming the sick role.

### MENTAL STATUS EXAMINATION

Patients with FD may vary in their presentation, and no findings have been shown to be pathognomonic. The following findings are possible:

- Appearance may include physical findings as described in previous section
- Attitude may range from cooperative with assessment and treatment to evasive and vague regarding details
- Mood and affect may be brighter than what would be expected given the patient's medical condition
- Perceptual abnormalities, such as hallucinations and disturbances of thought process or thought content, and suicidality and/or homicidality, may be present with FD with predominantly psychological signs and symptoms
- Cognitive functioning may be aberrant if the patient presents with Ganser syndrome.

### CASE REPORT AND LITERATURE REVIEW

**Case report.** A 12-year-old African American boy (Patient A) with history of asthma and sickle cell disease, thalassemia was admitted to the pediatric unit in

January of 2001 with thigh pain. Patient A was stabilized in the hospital with pain killers and IV fluids and was discharged after a week. Apparently, Patient A had a very difficult childhood: He had never seen his father and his mother was in and out of jail. He was currently under the care of his grandmother. Patient A received good care in the hospital, which was something he had not experienced in his life. This started a cycle of repeated admissions to the same hospital. He was admitted nine times during 2001 with complaints that included chest pain, shoulder pain, thigh pain, back pain, bloody sputum, and vomiting. All the workup was negative except for mildly low hemoglobin and hematocrit. Patient A continued to come to our pediatric emergency room in 2002 with the additional complaints of abdominal pain. All gastrointestinal workup was negative. His admissions totaled 13 in 2002 and he spent a total of six months in the hospital. Psychiatric consult was sought when treating physicians did not find any cause of Patient A's presenting complaints and suspicion that he might be intentionally producing or feigning the symptoms was aroused. Patient A was very uncooperative with the psychiatrist. During the initial mental status examination, Patient A appeared alert and oriented to time, place, and

person. He was angry, irritable, and uncooperative, and a full mental evaluation could not be performed due to his refusal to answer questions. Patient A was started on a low-dose antipsychotic and an antidepressant for his impulsive behavior and underlying depression. Patient A continued to seek frequent admission to the hospital in 2003. The patient was admitted to the hospital 19 times in 2003, spending more than six months in the hospital. During this time span, apart from pain presentations, Patient A presented with dizziness, chest pain, abdominal pain, blood in the stool, and other constitutional symptoms. He was seen by gastrointestinal, surgery, and hematology consult services, and complete work ups were performed, which did not reveal anything significant. Patient A continued to come to the pediatric emergency room with the same set of symptoms despite being on an effective pain management regimen. Patient A was admitted 14 times in year 2004. This presented a diagnostic dilemma to the pediatric service as well as consultation and liaison psychiatry. During the course of these hospitalizations, Patient A was found by the staff feigning and producing symptoms in many creative ways. These included but were not limited to the following:

- Deliberately dehydrating himself to get sick
- Scratching his IV sites to get infected
- Rubbing dirty chalk into his IV line
- Putting dirt on his IV site
- Cheeking his pain medications
- Self-injecting himself with contaminants
- Taking out his medication port
- Mixing blood in his urine.

Many times, Patient A's room was searched and staff found syringes and pieces of chalk. Patient A was regularly followed

by the psychiatric and became very hostile when confronted with his behavior of feigning symptoms. He craved attention and was very persistent in attempting to be hospitalized. Psychological testing revealed weak coping mechanisms, depression, low frustration tolerance, and a low self esteem. Patient A was tried on antipsychotics, antidepressants, and individual psychotherapy, but nothing seemed to change his behavior of assuming a sick role. Finally, after being confronted for the last time in July of 2004, Patient A never returned to our hospital and reportedly sought admission at another children's hospital that transferred him to an out-of-state facility for patients needing both medical and psychiatric care.

Although Patient A presented

that these disorders can occur in either gender, even in patients with known medical illnesses.

There was no evidence of Munchausen syndrome by proxy in this case as Patient A had no contact with his mother, and the intentional production and feigning of his symptoms occurred while he was hospitalized. Further, while hospitalized, Patient A had no real contact with his grandmother, and he spent the majority of his time in the hospital during these three years.

**Other reported cases in literature.** Other reported cases of Munchausen syndrome in children include the following:

- Peebles, et al.<sup>12</sup> described six cases of factitious disease and malingering in pediatric patients referred to a tertiary care children's hospital.
- Ballas, et al.,<sup>14</sup> described a case

of a nine-year-old girl with recurrent purpura factitia and five-month history of sucking on her skin.

- Yates<sup>26</sup> described the case of an 11-year-old girl with apurpura rash on her chin and lips and six-month history of sucking on pieces of glass.
- Lovejoy, et al.,<sup>27</sup> described cases of a 10-year-old girl and a 14-year old boy with factitious purpura with histories of sucking on pieces of glass.
- Brouhard<sup>28</sup> described cases of a 13-year-old girl and an 11-year-old boy with factitious hypoglycemia and histories of insulin manipulation.
- Libow<sup>29</sup> described the case of an 11-year-old boy with oral bleeding with a four-month history of stabbing himself in the mouth with a ruler.

## FDs HAVE BEEN REPORTED in kids as young as eight years old.

with some of the traits of borderline disorder like impulsivity, low frustration tolerance, self mutilation, low self esteem, and frantic efforts to avoid abandonment, it is difficult to say whether he will develop borderline personality disorder as adult. Patient A was willing to undergo painful or risky tests and operations in order to get sympathy and special attention, with no evidence of any secondary gain. His apparent sole aim was assuming a sick role, which supports the presence of a FD as opposed to malingering. Another important feature of this unique case was that Patient A was a male patient with sickle cell disease, while most cases of FDs reported in literature are in female patients with no known medical illness. This case demonstrates

of a teenager who demanded and received pain medication for her nonexistent sickle cell disease.

- Christopher, et al.,<sup>21</sup> described a case of a teenager with history of factitious asthma who was intubated unnecessarily many times before.
- Sneed and Bell<sup>22</sup> reported the case of a 10-year-old-boy who inserted small stones into his urethra to simulate passage of renal stones.
- Goodwin, Cauthorne, and Rada<sup>23</sup> report on three girls, ages 9 and 10, who exhibited the "Cinderella syndrome," in which they simulated neglect.
- Schade, et al.,<sup>24</sup> described the case of an eight-year-old girl with factitious brittle diabetes who was manipulating insulin.
- White, et al.,<sup>25</sup> described case
- Sheehy<sup>30</sup> described a case of a 12-year-old boy with factitious hypoglycemia with a two-year history of insulin manipulation.
- Abe, et al.,<sup>31</sup> described a case of a 13-year-old girl with factitious hematuria and purpura with a three-year history of tampering with urine.
- Aduan, et al.,<sup>32</sup> described several cases of children of both genders who presented with fevers of unknown origin and histories of thermometer manipulation.
- Herzberg and Wolff<sup>33</sup> described a case of an 11-year-old girl with factitious fever and a history of thermometer manipulation.
- Orr, et al.,<sup>34</sup> described several cases of children of both genders who presented with

## THE CLINICIAN SHOULD secure an enduring and stable patient-physician relationship utilizing a non-confrontational strategy.

recurrent ketoacidosis and histories of insulin manipulation.

- Gilarski and Graham<sup>35</sup> described case of a 14-year-old girl with factitious toenail infections and a three-year history of hydrofluoric acid use.
- Kazak, et al.,<sup>36</sup> described a case of 14-year-old girl with factitious lip crusting and a one-year history of self mouth-cutting.
- Witt and Ginsberg-Fellner<sup>37</sup> described a case of a 15-year-old girl with factitious Cushing's syndrome and six-month history of prednisone ingestion.
- Rodriguez-Moreno et al.,<sup>38</sup> described a case of a 15-year-old girl with factitious wrist edema/reflex sympathetic dystrophy and a six-month history of Tourniquet use.
- Tojo, et al.,<sup>39</sup> described a case of a 16-year-old girl with factitious proteinuria and pain and a three-year history of injecting raw eggs into her bladder. **(AUT: ok as edited?)**
- Fonseca and Rubio<sup>40</sup> described a case of a 15-year-old girl with factitious systemic lupus and a history of coloring her face with paint.
- Joseph-Di Caprio and Remafedi<sup>41</sup> described a case of a 17-year-old boy with factitious HIV disease and a two-week history of false symptom-reporting.
- Reich, et al.,<sup>42</sup> described a case of a 15-year-old boy with factitious enterovesicular fistula

and 12-month history of retrograde injection of feces into his bladder.

- Edwards and Butler<sup>43</sup> described a case of a 15-year-old girl with factitious fevers who admitted to using a heating pad to heat her skin.
- Ackerman, et al.,<sup>44</sup> described a case of a 15-year-old girl with factitious panniculitis and a three-month history of milk injections.
- Reich and Gottfried<sup>45</sup> described cases of a 16-year-old girl with self-induced bruises; a 16-year-old girl with fever of unknown origin and three-year history of thermometer manipulation; and a 15-year-old girl with chronic wound infections and a four-month history of wound interference.
- Levin, et al.,<sup>46</sup> described a case of a 16-year-old girl with factitious purpura and ecchymoses with a two-year history of self-beating.
- Karnik, et al.,<sup>47</sup> described a case of an 18-year-old girl with subcutaneous emphysema, tongue ulcers, dermatitis autogenica, and nine-month history of injection of air under her skin.

### FD MANAGEMENT

It is usually very difficult to treat people with FDs because they will go to great lengths to avoid being detected. They may also become hostile and aggressive if confronted, or they may simply move on to another physician or hospital.

In a younger child where FD is strongly suspected,

nonthreatening but direct discussions with the patient can sometimes yield a confession. In cases of older children or adolescents, it is more likely that only tangible evidence (e.g., syringes, witnessed self-bruising) will result in admission of conscious self-harm. A thorough psychosocial history and psychological assessment of the child and family system will help clarify the underlying motives.

The clinician should secure an enduring and stable patient-physician relationship by utilizing a nonconfrontational strategy. An interesting approach is that of "contract conference" proposed by Ritson and Forrest.<sup>48</sup> In this approach, the psychiatrist emphasizes the need for the patient to express him- or herself in the common language of difficult relationships, feelings, and problems, instead of through the factitious language of illness. After that, the patient and physician can focus their efforts on resolving those real problems.

The clinician should also share with other members of the treatment team that the patient's deceitfulness and betrayal of trust is part of his or her illness pattern and is not to abuse the staff. This understanding may help team members avoid negative countertransference and aggressive and ineffective patient management during treatment of the patient with FD.

**Medications.** Medications have not proven helpful in treating FD by itself, although they may be prescribed for symptoms of anxiety or depression if the

individual also meets criteria for an anxiety or mood disorder. Some case reports focus on the use of pharmacological agents in the treatment of FD. Prior and Gordon<sup>49</sup> reported good response to the antipsychotic drug pimozide. Other authors, because of resemblance to OCDs and/or because of the impulsive nature of the disorder, advocate the use of SSRIs.<sup>4</sup>

**Psychotherapy.** Both analytical and cognitive-behavioral approaches have been used to deal with FD, with some benefit, in patients who agreed to engage in such therapies. Approaches are limited by the fact that few people diagnosed with FD remain in long-term treatment. In many cases, however, the FD improves or resolves if the individual receives appropriate therapy for a comorbid psychiatric disorder. Supportive psychotherapy has proved beneficial in some cases.<sup>16</sup> Family therapy is often beneficial in helping family members understand the individual's behavior and his or her need for attention.

**Patient education.** The clinician should convey empathy for the FD patient's distress that has led to the feigning or intentional production of illness. The clinician should inform the patient that his or her distress may improve with treatment. The clinician should point out that without treatment, the patient may again seek hospitalization. The clinician should emphasize to the patient that each episode of producing or feigning illness can result in significant morbidity or

even mortality for the patient through the production of illness or the undergoing of unnecessary tests or treatments.

**Course.** Course and prognosis of FD with psychological signs and symptoms are not fully known because patients are generally lost at follow-up. In cases reported in literature, the course is usually chronic with numerous hospitalizations beginning in adolescence or early adulthood and extending to the late 40s. The rarity of cases older than 45 is an interesting (and intriguing) finding. Possible explanations could be that patients in contact with "genuine" pathology became more skilled in faking those conditions and thus more difficult to diagnose as FD. Also, as the patient ages, it may be that the FD becomes milder, and fewer or no hospitalizations at all are needed (like in the case of antisocial personality). Aging patients also may develop—whether in connection with their FD or not—a genuine pathology that allows them to assume the "patient role" without faking.

In their prospective study, Pope, et al.,<sup>50</sup> showed that patients with factitious psychosis had worse outcome than patients with genuine psychosis (e.g., schizophrenia, schizoaffective disorders, or bipolar disorder).

## DISCUSSION

The risk factors for developing FD remain largely unclear. Based on the histories of patients with FD, the following can be projected as characteristics that may predispose an individual to

develop a factitious illness: Presence of other mental disorders or medical conditions in childhood or adolescence that resulted in extensive medical attention; holding a grudge against the medical profession or having had an important relationship with a physician in the past; and the presence of a personality disorder, especially borderline, narcissistic, or antisocial personality disorder.

We know that the mean age of onset of adult FD is most commonly in the patient's early 20s<sup>51</sup> and up to perhaps half the cases may begin in adolescence.<sup>52</sup> One study of adult FD<sup>53</sup> found that all its patients who self-induced infections started this behavior in adolescence, although many were not identified until years later. Reports of illness falsification cases that began in adolescence but were not identified until years later demonstrate that these deceptions can go undetected for years, resulting in serious and permanent damage.<sup>54-57</sup>

Many of the patients show features of borderline personality disorder and often have histories of difficult childhood relationships with the parents. A history of milder degree of abnormal illness may present prior to the development of the syndrome. Subsequent illness behavior reinforced by professionals over the years leads to the escalation of abnormal illness behavior.<sup>58</sup> Many patients report important childhood relationships with physicians or

**NON-THREATENING BUT DIRECT** discussions with the child with FD can sometimes yield a confession.



other parent figures that became selected objects against which love and anger is directed.<sup>59</sup>

Often, a true organic lesion from the past leaves some genuine physical signs upon which the patient elaborates to convey a convincing story.<sup>60</sup> Munchausen's syndrome often begins in early adulthood and may begin after a hospitalization or medical illness, as is the case with Patient A described previously. Many of the patients are medical personnel and are well versed with medical terminology.

Once the diagnosis of Munchausen's syndrome or FD is suspected, failure to obtain a psychiatric consultation places some degree of responsibility upon the clinician for any serious damage the patient may inflict upon himself or herself.

without permission for items used in perpetrating factitious illness violates the patient's privacy unless the search is conducted with the patient's consent. Consent can sometimes be gained by revealing the suspicions of FD to the patient while asking permission to search because patients may insist they have nothing to hide. The use of video cameras to monitor patient behavior, if already in routine use to monitor patients' rooms, does not appear to violate privacy considerations. Covert video surveillance of parents suspected of Munchausen's syndrome by proxy is highly effective (between 56% and 92%) in exposing the fraud. Hospitals can usually satisfy legal concerns by posting signs stating that they use hidden video monitoring.

after the patient turns 40. Munchausen's syndrome by proxy involves considerable risks for the affected person (often a child)—9 to 10 percent of these cases end in the child's death.

A review of the literature on factitious illness in young people indicates that children and adolescents can intentionally falsify illness, although younger children tend to use more obvious, easily identified falsifications and more readily acknowledge their deceptions. Although limited, follow-up data on children who admit to their deceptions suggest there may be less risk of repetition, particularly when the fabrications are confronted at an early stage. Given the risk of these patients developing a chronic pattern of illness falsification and the potential for early intervention, it

**MANY PATIENTS WITH FD** show features of borderline personality disorder and often have histories of difficult childhood relationships with parents.

### **MEDICAL/LEGAL PITFALLS**

In dealing with cases of Munchausen's syndrome by proxy, physicians and hospitals should seek appropriate legal advice. Physicians should keep in mind that the patient with FD is entitled to the same rights to privacy and confidentiality of information as any other patient. Although patients with FD waste valuable resources, notifying other hospitals of patients with FD or circulating a blacklist of such patients probably violates the physician's ethical and legal duties; therefore, this practice should be discouraged. Keep in mind that patients with FD can and do litigate. In a similar vein, searching a patient's belongings

### **CONCLUSION**

The prognosis of FD varies by subcategory. Male patients diagnosed with the psychological subtype of FD are generally considered to have the worst prognosis. Self-mutilation and suicide attempts are common in these individuals. The prognosis for Munchausen's syndrome is also poor. The statistics for recurrent episodes and successful suicides range between 30 and 70 percent. These individuals do not usually respond to psychotherapy. The prognosis for nonchronic FD in women is variable; some of these patients accept treatment and do quite well. This subcategory of FD, however, often resolves itself

is proposed that there is value in differentiating this specific population of children from those with other forms of persistent, undiagnosed medical complaints.

It is recommended that pediatricians include illness falsification by the child patient in the differential diagnosis of a persistent and unexplained medical condition, along with somatization, malingering, and Munchausen's by proxy abuse. Conditions that always begin when the child is alone or unobserved (e.g., hematemesis only seen after the child emerges alone from the bathroom, or bruises that always appear when the child is unobserved) should arouse suspicion, as should lesions

and rashes that only occur on accessible parts of the body.

A detailed examination of the child's early medical history indicating frequent, unexplained medical problems may provide clues to the possibility of the patient's earlier experiences of intentional illness exaggeration or falsification by a caregiver. The parent's affect and degree of concern and cooperation should be carefully observed when presented with the physician's suspicions or evidence of deception, because this may yield clues to possible coaching or collusion. Young children may even be willing to reveal specifics of parental coaching or collaboration if directly questioned.

## REFERENCES

- Rosenberg D. Munchausen's syndrome by proxy: Currency in counterfeit illness. In: Helfer MD, Kempe RS, Krugman RD (eds). *The Battered Child, Fifth Edition*. Chicago, IL: University of Chicago Press, 1997:413-30.
- Libow JA. Child and adolescent illness falsification. *Pediatrics* 2000;105:336-42.
- Asher R. Munchausen's syndrome. *Lancet* 1951;1(6):339-41.
- Andrei SZOKE, MD, 2000. Available at: [http://andreisz.club.fr/Munchausen\\_genpres.html](http://andreisz.club.fr/Munchausen_genpres.html). Access date: March, 2006.
- Jones JG, Butler HL, Hamilton B, et al. Munchausen's syndrome by proxy. *Child Abuse Negl* 1986;October;33:403.
- Bhugra D. Psychiatric Munchausen's syndrome: Literature review with case reports. *Acta Psychiatr Scand* 1988;77:497-503.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*. Washington, DC: American Psychiatric Press, Inc., 1980.
- Pope HG, Jones JM, Jonas B. Factitious psychosis: Phenomenology, family history and long-term outcome of patients. *Am J Psychiatry* 1982;139:1480-3.
- Meadow R. Munchausen syndrome by proxy. *Arch Dis Child* 1982;57(2):92-8.
- Schuman DC. False accusations of physical and sexual abuse. *Bulletin of the American Academy of Psychiatry and the Law* 1986;14(1):5-21.
- Ferguson D. *Bad Moon Rising: A True Story*. Nashville, TN: Winston-Derek, Inc., 1988.
- Peebles R FD and malingering in adolescent girls: Case series and literature review. *Clin Pediatr* 2005;44(3):237-43.
- Ballas SK. Factitious sickle cell acute painful episode—Secondary type of Munchausen Syndrome. *Am J Haemtol* 1996;53(4):54-8.
- Eisendrath SJ, Feder A. Management of factitious disorder. Feldman MD, Eisendrath SJ (eds). *The Spectrum of Factitious Disorders*. Washington, DC: American Psychiatric Press, 1996.
- Todd S, Iqbal A. Factitious Disorders—eMedicine. Available at: [www.emedicine.com/med/topic3125.htm](http://www.emedicine.com/med/topic3125.htm). Access date: March 2006.
- Factitious disorder. In: Thackeray E (ed). *Encyclopedia of Mental Disorders*. Thomson Gale, 2003. eNotes.com. 2006. Feb, 2006 <http://health.enotes.com/mental-disorders-encyclopedia/factitious-disorder>
- Kaplan H., Sadock BJ, Grebb JA. Factitious disorders. In: *Kaplan and Sadock's Synopsis of Psychiatry, Seventh Edition*. Williams and Wilkins, 1996.
- Tec L. Precursors of Munchausen's syndrome in childhood. *Am J Psychiatry* 1975;132:757.
- Henderson S. Care eliciting behavior in man. *J Nerv Ment. Dis* 1974;159:172-81.
- Eckendart-Henn et al. Factitious Disorders and Munchausen's—State of research. *Psychother Psychosom Med Psychol* 1999;49(3-4):75-89.
- Christopher KL, Wood RPII, Eckert RC, et al. Vocal cord dysfunction presenting as asthma. *N Engl J Med* 1983;308:1566-70.
- Sneed RC, Bell RF. The Dauphin of Munchausen's: Factitious passage of renal stones in a child. *Pediatrics* 1976;58(1):127-30.
- Goodwin J, Cauthorne CG, Rada RT. Cinderella syndrome: Children who simulate neglect. *Am J Psychiatry* 1980;137:1223-5.
- Schade DS, Drum DA, Duckworth WC, Eaton RP. The etiology of incapacitating, brittle diabetes. *Diabetes Care* 1985;8:12-20.
- White JG, Pearson HA, Coddington RD. Purpura factitia: Attracting attention by self-inflicted lesions. *Clin Pediatr* 1966;5:157-60.
- Yates VM Factitious purpura. *Clin Exp Dermatol* 1992;17:238-9.
- Lovejoy FH, Marcuse EK, Landrigan PJ. Two examples of purpura factitia. *Clin Pediatr* 1971;10:183-4.
- Brouhard BH. Surreptitious insulin administration. *Am J Dis Child* 1987;141:28-9.
- Libow JA. Multigenerational issues in Munchausen's by proxy. Childhood factitious disorders. Presented at the NIH-sponsored International Research Conference on Munchausen's by Proxy; August 1998; Stockholm, Sweden.
- Sheehy TW. Case report: Factitious hypoglycemia in diabetic patients. *Am J Med Sci* 1992;304:298-302.
- Abe K, Shinozima K, Okuno A, et al. Munchausen's syndrome in children: Bizarre clinical and laboratory features. *Acta Paediatrica [Japan]* 1984;26:539-43.
- Aduan RP, Fauci AS, Dale DC, et al. Factitious fever and self-induced infection. *Ann Intern Med* 1979;90:230-42.
- Herrzberg JH, Wolff SM Chronic factitious fever in puberty and adolescence: A diagnostic challenge to the family physician. *Psychol Med* 1972; 3:205-12.
- Orr PO, Eccles T, Lawlor R, Golden M. Surreptitious insulin administration in adolescents with insulin-dependent diabetes mellitus. *J Am Med Assoc* 1986;256:3227-30.
- Gilarski CK, Graham JL. Factitious illness following toenail surgery. *J Foot Ankle Surg* 1995;34:228-33.
- Kazak AE, Westervelt VD, Bracikowski A, Hassler C. A systems-oriented treatment of an adolescent with factitious lip crusting. *J Adolesc Health Care*. 1988;9:337-9.
- Witt ME, Ginsberg-Fellner F. Prednisone-induced Munchausen's syndrome. *Am J Dis Child* 1981;135:852-3.
- Rodriguez-Moreno J, Ruiz-Martin JM, Mateo-Soria L, et al. Munchausen's syndrome simulating reflex sympathetic dystrophy. *Ann Rheum Dis* 1990;49:1010-12.
- Tojo A, Narba S, Kimura K. Factitious proteinuria in a young girl. *Clin Nephrol* 1990; 33:299-302.
- Fonseca E, Rubio G. Factitious systemic lupus erythematosus. *Lupus* 1993;2:195-7.
- Joseph-Di-Caprio J, Remafedi GJ. Adolescents with factitious HIV disease. *J Adolesc Health* 1997;21:102-6.
- Reich P, Lazarus JM, Kelly MJ, Rogers MP. Factitious feculent urine in an adolescent boy. *J Am Med Assoc* 1977;238:420-1.
- Edwards ME, Butler KM. Hyperthermia of trickery in an adolescent. *Pediatr Infect Dis J* 1987;6:411-4.
- Ackerman AB, Mosher DT, Schwamm HA. *Factitial Weber-Christian syndrome*. *J Am Med Assoc* 1966;198:155-60.
- Reich P, Gottfried LA. Factitious disorders in a teaching hospital. *Ann Intern Med* 1983;99:240-7.
- Levin RM, Chodosh R, Sherman JD. Factitious purpura simulating autoerythrocyte sensitization. *Ann Intern Med* 1969;70:1201-6.
- Karnik AM, Farah S, Khadadah M, et al. A unique case of Munchausen's syndrome. *Br J Clin Pract* 1990;44:699-701.
- Ritson B, Forrest A. The simulation of psychosis: A contemporary presentation. *Br J Med Psychol* 1970;43:31-7.
- Prior TI, Gordon A. Treatment of factitious disorder with pimozone. *Can J Psychiatry* 1997;42(5):532.
- Pope HG, Jones JM, Jones B. Factitious psychosis: Phenomenology, family history, and long-term outcome of nine patients. *Am J Psychiatry* 1982;139:1480-3.
- Reich P, Gottfried LA. Factitious disorders in a teaching hospital. *Ann Intern Med* 1983;99:240-7.
- Raymond CA. Munchausen's may occur in younger persons. *J Am Med Assoc* 1987;257:3332.
- Plassman R The biography of the factitious-disorder patient. *Psychother Psychosom* 1994;62:123-8.
- Bliss EL. Self-induced abscesses: A diagnostic and treatment enigma. *Int J Psychol Med* 1974;5:275-82.
- Sale I, Kalucy R. An observation on the genesis of Munchausen's syndrome: A case report. *Aust N Z J Psychiatry* 1980;14:61-4.
- Paperny D, Hicks R, Hammar SL. Munchausen's syndrome. *Am J Dis Child* 1980;134:794-5.
- Sussmen N, Hyler SE. Factitious disorder. In: Kaplan HI, Sadock BJ. *Comprehensive Textbook of Psychiatry, Fourth Edition*. Baltimore, MD: Williams and Wilkins, 1985:1242-7.
- Sale I, Kalvey R. An observation on the genesis of Munchausen's syndrome. A case report. *Aus NZ J Psychiatry* 1980;14:61-4.
- Cramer B, Gershberg MR, Stern MR. Munchausen's syndrome: Its relationship to malingering hysteria and the physician-patient relationship. *Arch Gen Psychiatry* 1971;24:573-8.
- Myall, RWT, Collins FJU, Ross A, et al. Chronic factitious illness: Recognition and management of deception. *J Oral Maxillofac Surg* 1984;42:97-100.