

**FACTITIOUS DISORDER, FEIGNING ILLNESS,
and ELABORATION OF PHYSICAL SYMPTOMS FOR
PSYCHOLOGICAL REASONS.**

MEDICAL APPENDIX

1. Various attempts have been made to formally classify psychiatric disorders, the two major systems being:
 - 1.1. The **ICD-10 Classification of Mental and Behavioural Disorders** (World Health Organisation, Geneva) is part of the 10th edition of the international Classification of Disease. This Appendix follows the common abbreviation of **ICD-10**. It is the international system used by the majority of clinical psychiatrists in Great Britain.
 - 1.2. The **Diagnostic and Statistical Manual of Mental Disorders (fourth edition)** (American Psychiatric Association Washington DC). References to it in this Appendix follow the common abbreviation of **DSM-IV**. It is a system devised mainly by and for workers in the USA; however, UK psychiatrists were consulted in its formulation.
2. The two systems above have been in existence for many years but only in their current editions have they been closely comparable.
3. This Appendix summarises the generally recognised clinical features and aetiology of factitious disorder (“intentional production or feigning of symptoms or disabilities, either physical or psychological”), feigning illness (“malingering”) and the elaboration of symptoms for psychological reasons (“accident neurosis” or “compensation neurosis”).
4. In this Appendix the ICD-10 codes are provided. The psychiatric disorders are denoted by numbers prefixed with an F. Those codes prefixed with a Z indicate situations where contact may have been made with health services but where no psychiatric disorder is present.

FACTITIOUS DISORDER or MUNCHAUSEN’S SYNDROME

F68.1

(Intentional production or feigning of symptoms or disabilities, either physical or psychological)

5. In this disorder the individual repeatedly and consistently feigns symptoms, for example by cutting themselves, or by producing “sores” by scratching or injecting themselves with toxic substances. The production of symptoms may be so convincing that repeated investigations and operations may be performed at many different hospitals.
6. Common clinical pictures include severe right lower quadrant pain associated with nausea and vomiting, dizziness and blacking out, massive haemoptysis, generalised rash and abscesses, fevers of undetermined origin, bleeding secondary to ingestion of anticoagulants, and “lupus like” syndromes.
7. The individual usually presents the history with great dramatic flair, but is extremely vague and inconsistent when questioned in more detail.

8. There may be uncontrolled pathological lying, in a manner intriguing to the listener, about any aspect of the individual's history or symptomatology (**pseudologia fantastica**).
9. The individual often has extensive knowledge of medical terminology and hospital routines. Once admitted to hospital, she/he may create havoc on the ward by demanding attention from hospital staff and by non-compliance with hospital routines and regulations. After extensive investigation of the initial chief complaints proves negative, there is often complaint of other physical problems and production of more factitious symptoms.
10. Complaints of pain and requests for analgesics are very common. Individuals with this disorder often eagerly undergo multiple invasive procedures and operations. Whilst in the hospital they usually have few visitors.
11. When confronted with evidence of their factitious symptoms, sufferers either deny the allegations or rapidly discharge themselves against medical advice. They will frequently be admitted to another hospital the same day. Their courses of hospitalisation often take them to numerous cities, countries and even different continents.
12. Eventually a point is usually reached at which the individual is "caught" producing factitious symptomatology; she/he is recognised by someone from a previous admission or another hospital, or other hospitals are contacted which confirm multiple prior hospitalisations for factitious symptomatology.
13. The disorder is extremely incapacitating and is incompatible with the maintenance of steady employment, family ties or forming lasting interpersonal relationships.
14. Limited forms of the disorder may be seen which do not require hospitalisation. Examples include **dermatitis artefacta** and **voluntary dislocation of the shoulder**.
15. The aim of the behaviour appears to be to assume the role of a patient, the behaviour being repeated in other locations when the spurious nature of the symptoms is found out. All organ systems are potential targets and the symptoms presented are limited only by the individual's medical knowledge, sophistication and imagination. The acts have a compulsive quality in the sense that the individual is apparently unable to refrain from the behaviour even if the dangers are known.
16. Occasionally a parent will produce symptoms in their child for similar attention, "Munchausen's by proxy": this is excluded from this diagnosis and falls under the ICD coding of child abuse (T 74.8).

AETIOLOGY

17. The motivation for this behaviour is almost always obscure, the condition being best described as a disorder of illness behaviour and the sick role. It is usually associated with personality disorders of various types.
18. The onset is usually in early adult life, often following hospitalisation for true physical illness.

19. Other predisposing factors include employment as a nurse, technician or other paramedical professional; underlying dependent, exploitative or masochistic personality traits; or an important relationship with a physician in the past. Some appear to hold a grudge against the medical profession.
20. Factitious disorder is almost always superimposed on a severe personality disorder, which is a predisposing factor.

FEIGNING ILLNESS (malingering)

Z76.5

21. This is the conscious simulation of symptoms for certain advantages. It has been defined as “the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives such as avoiding work, obtaining illicit drugs, obtaining financial compensation, avoiding military conscription or evading criminal prosecution”. It may be difficult to differentiate from a compensation neurosis or a dissociative disorder, the decision resting on the following:
 - 21.1. detailed observation reveals a discrepancy between the claimed disability and the objective findings on examination and investigation
 - 21.2. personality factors
 - 21.3. the circumstances surrounding the disorder, especially if there is a medico-legal context
 - 21.4. the consequences of recovery versus continued disability, in particular the benefits which would pertain if the symptoms were maintained
 - 21.5. lack of co-operation with the diagnostic evaluation and prescribed treatment regime.
22. Malingering is therefore differentiated from conversion and other somatoform disorders (which are due to unconscious mechanisms) by:
 - 22.1. the **conscious and voluntary** production of symptoms
 - 22.2. and by the presence of a recognisable goal, although the goal may not be obvious.

ELABORATION OF PHYSICAL SYMPTOMS FOR PSYCHOLOGICAL REASONS (includes accident and compensation neurosis) F68.0

23. This is characterised by physical symptoms, which are initially compatible with, and originally due to, a confirmed illness or disability, but which become exaggerated or prolonged for psychological reasons. These reasons may be clearly financially motivated (“compensation neurosis”) but, in some cases, the motivating factors may include more psychological considerations, such as dissatisfaction with the result of treatment or investigations or disappointment with the amount of personal attention received from the medical profession. While minor and transient exaggeration of symptoms in certain situations for various reasons is probably common, the full syndrome of persistent excessive symptoms motivated solely by hopes of financial gain is rare.

AETIOLOGY

24. Formerly, the concept of compensation neurosis was clear and mainly based on work by Miller in the 1960s. This showed that men seeking compensation after head injury had more prolonged complaints than those with more serious injuries who were not seeking compensation. Miller also found that recovery followed payment of compensation. However, the notion has become more obscured as other studies have emerged showing that complete recovery does not necessarily occur even after successful settlement.
25. Several explanations for this have been postulated, one study showing that the more the family believed the physical basis for the complaints, the less likely was recovery. Other sociologically-based theories offer interpretations based on the concept of the sick role and illness behaviour (see below).
26. Other social and familial factors may be involved in that the person may find it difficult to abandon the symptoms without compromising his or her integrity. Furthermore, the individual may have become dependent on the new role as an invalid which confers a status which he previously did not have, this being in addition to the more obvious benefits of the sick role.

CONCLUSION

27. **Factitious disorder** is a condition in which there are psychological or physical symptoms without diagnosis or explanation other than a need to assume the role of being a patient. There are often associated abnormal personality traits or a frank personality disorder.
28. Factitious disorder contrasts with **malinger** in that, in the former, there is no apparent goal other than to assume the patient role. In malingering, the motivation is entirely conscious and motivated towards perceptible gain.
29. In “**accident (compensation) neurosis**” there is always a history of injury or disability, most commonly trivial; however, the symptoms are more prolonged or more severe than the degree of tissue damage would suggest, the motivating factors being complex, as described above.

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