Simulated Illness: The Factitious Disorders and Malingering

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KEYWORDS

- Factitious disorder • Malingering • Simulated illness
- Munchausen syndrome

INTRODUCTION

Consciously simulated illnesses fall into two diagnostic categories: factitious disorders and malingering, differentiated by both motivation for behavior and consciousness of that motivation. Factitious disorder behaviors are motivated by an unconscious need to assume the sick role, while malingering behaviors are driven consciously to achieve external secondary gains. Thus, factitious disorders are psychiatric disorders in the Diagnostic and Statistical Manual-IV text revision (DSM –IV TR), whereas malingering is listed as a condition not attributable to a mental illness. Diagnosis of factitious disorder depends first on detection of the conscious production of symptoms and then on delineation of the motivation behind the deception. This review will focus on the commonalities in detection of consciously simulated illnesses generally and on the difficulties in distinction between factitious disorder and malingering. The background and clinical presentations of factitious disorder and malingering have been extensively reviewed,[1–4] and will not be extensively covered in this review. This review will discuss current controversies in diagnosis and recent research providing further insights into the detection of simulated illnesses, and end with a discussion of ethical and legal issues associated with factitious disorder diagnoses.

Diagnosis

Factitious disorder diagnosis

Factitious disorder was introduced as a psychiatric diagnostic category in DSM-III in 1980, as a mid-way point between malingering and the somatization disorders,[5] characterized by "physical or psychological symptoms that are voluntarily initiated by

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Box 1
Diagnostic criteria, existing and proposed, for factitious disorder

A: DSM-IV TR Criteria for Factitious Disorder

A. Intentional production or feigning of physical or psychological signs or symptoms.
B. The motivation for the behavior is to assume the sick role.
C. External incentives for the behavior (such as economic gain, avoiding legal responsibility, or improving physical wellbeing, as in Malingering) are absent.

Code based on type:

300.19 With Predominantly Psychological Signs and Symptoms: if psychological signs and symptoms predominate in the clinical presentation

300.19 With Predominantly Physical Signs and Symptoms: if physical signs and symptoms predominate in the clinical presentation

300.19 With Combined Psychological and Physical Signs and Symptoms: if both psychological and physical signs and symptoms are present but neither predominates in the clinical presentation

300.19 Factitious Disorder Not Otherwise Specified.

B. Proposed DSM-V Criteria for Factitious Disorder

1. A pattern of falsification of physical or psychological signs or symptoms, associated with identified deception.
2. A pattern of presenting oneself to others as ill or impaired.
3. The behavior is evident even in the absence of obvious external rewards.
4. The behavior is not better accounted for by another mental disorder such as delusional belief system or acute psychosis.

C. Rosenberg criteria for Munchausen by proxy (Rosenberg and Marino[124])

- Illness in a child which is simulated (faked) and/or produced by a parent or someone who is *in loco parentis*;
- Presentation of the child for medical assessment and care, usually persistently, often resulting in multiple medical procedures;
- Denial of knowledge by the perpetrator as to the etiology of the child's illness [at least before the deception is discovered]; and
- Acute symptoms and signs of the child abate when the child is separated from the perpetrator.

Excludes physical abuse only, sexual abuse only, and nonorganic failure to thrive only

the patient . . . (with) no apparent goal other than to assume the role of a patient.[6]" DSM-IV TR criteria for factitious disorder recognizes four sub-types differentiated by the type of symptom simulated (**Box 1,** A). Factitious disorder NOS largely consists of Munchausen by proxy, where one person, usually an adult caregiver, simulates or produces illness in someone else (proposed criteria in **Box 1,** C).

Since DSM-III, the diagnostic validity and appropriate classification of factitious disorder has been debated. Concerns have arisen over the difficulties inherent in objectively determining motivation for behavior in distinguishing between the sick role and secondary gain and in detecting production of psychological symptoms, as well as the lack of specific inclusion, exclusion criteria and outcomes data.[7] Some have argued that any deceptive behavior, including the conscious production of symptoms, should be categorized as malingering regardless of the motivation.[8,9] They argue that since individual patients use choice in their decision to deceive, giving