Factitious Disorder

Code: 300.19 (F68.10)

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Diagnostic Criteria 300.19 (F68.10)

Factitious Disorder Imposed on Self
A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
B. The individual presents himself or herself to others as ill, impaired, or injured.
C. The deceptive behavior is evident even in the absence of obvious external rewards.
D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.
Specify:
Single episode
Recurrent episodes (two or more events of falsification of illness and/or induction of injury)
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Factitious Disorder Imposed on Another
(Previously Factitious Disorder by Proxy)
A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
B. The individual presents another individual (victim) to others as ill, impaired, or injured.
C. The deceptive behavior is evident even in the absence of obvious external rewards.
D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.
Note: The perpetrator, not the victim, receives this diagnosis.
Specify:
Single episode
Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

Recording Procedures

When an individual falsifies illness in another (e.g., children, adults, pets), the diagnosis is factitious disorder imposed on another. The perpetrator, not the victim, is given the diagnosis. The victim may be given an abuse diagnosis (e.g., 995.54 [T74.12X]; see the chapter "Other Conditions That May Be a Focus of Clinical Attention").

Diagnostic Features

The essential feature of factitious disorder is the falsification of medical or psychological signs and symptoms in oneself or others that are associated with the identified deception. Individuals with factitious disorder can also seek treatment for themselves or another following induction of injury or disease. The diagnosis requires demonstrating that the individual is taking surreptitious actions to misrepresent, simulate, or cause signs or symptoms of illness or injury in the absence of obvious external rewards. Methods of illness falsification can include exaggeration, fabrication, simulation, and induction. While a preexisting medical condition may be present, the deceptive behavior or induction of injury associated with deception causes others to view such individuals (or another) as more ill or impaired, and this can lead to excessive clinical intervention. Individuals with factitious disorder might, for example, report feelings of depression and suicidality following the death of a spouse despite the death not being true or the individual's not having a spouse; deceptively report episodes of neurological symptoms (e.g., seizures, dizziness, or blacking out); manipulate a laboratory test (e.g., by adding blood to urine) to falsely indicate an abnormality; falsify medical records to indicate an illness; ingest a substance (e.g., insulin or warfarin) to induce an abnormal laboratory result or illness; or physically injure themselves or induce illness in themselves or another (e.g., by injecting fecal material to produce an abscess or to induce sepsis).

Associated Features Supporting Diagnosis

Individuals with factitious disorder imposed on self or factitious disorder imposed on another are at risk for experiencing great psychological distress or functional impairment by causing harm to themselves and others. Family, friends, and health care professionals are also often adversely affected by their behavior. Factitious disorders have similarities to substance use disorders, eating disorders, impulse-control disorders, pedophilic disorder, and some other established disorders related to both the persistence of the behavior and the intentional efforts to conceal the disordered behavior through deception. Whereas some aspects of factitious disorders might represent criminal behavior (e.g., factitious dis-
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order imposed on another, in which the parent's actions represent abuse and maltreatment of a child), such criminal behavior and mental illness are not mutually exclusive. The diagnosis of factitious disorder emphasizes the objective identification of falsification of signs and symptoms of illness, rather than an inference about intent or possible underlying motivation. Moreover, such behaviors, including the induction of injury or disease, are associated with deception.

Prevalence

The prevalence of factitious disorder is unknown, likely because of the role of deception in this population. Among patients in hospital settings, it is estimated that about 1% of individuals have presentations that meet the criteria for factitious disorder.

Development and Course

The course of factitious disorder is usually one of intermittent episodes. Single episodes and episodes that are characterized as persistent and unremitting are both less common. Onset is usually in early adulthood, often after hospitalization for a medical condition or a mental disorder. When imposed on another, the disorder may begin after hospitalization of the individual's child or other dependent. In individuals with recurrent episodes of falsification of signs and symptoms of illness and/or induction of injury, this pattern of successive deceptive contact with medical personnel, including hospitalizations, may become lifelong.

Differential Diagnosis

Caregivers who lie about abuse injuries in dependents solely to protect themselves from liability are not diagnosed with factitious disorder imposed on another because protection from liability is an external reward (Criterion C, the deceptive behavior is evident even in the absence of obvious external rewards). Such caregivers who, upon observation, analysis of medical records, and/or interviews with others, are found to lie more extensively than needed for immediate self-protection are diagnosed with factitious disorder imposed on another.
Somatic symptom disorder. In somatic symptom disorder, there may be excessive attention and treatment seeking for perceived medical concerns, but there is no evidence that the individual is providing false information or behaving deceptively.
Malingering. Malingering is differentiated from factitious disorder by the intentional reporting of symptoms for personal gain (e.g., money, time off work). In contrast, the diagnosis of factitious disorder requires the absence of obvious rewards.
Conversion disorder (functional neurological symptom disorder). Conversion disorder is characterized by neurological symptoms that are inconsistent with neurological pathophysiology. Factitious disorder with neurological symptoms is distinguished from conversion disorder by evidence of deceptive falsification of symptoms.
Borderline personality disorder. Deliberate physical self-harm in the absence of suicidal intent can also occur in association with other mental disorders such as borderline personality disorder. Factitious disorder requires that the induction of injury occur in association with deception.
Medical condition or mental disorder not associated with intentional symptom falsification. Presentation of signs and symptoms of illness that do not conform to an identifiable medical condition or mental disorder increases the likelihood of the presence of a factitious disorder. However, the diagnosis of factitious disorder does not exclude the presence of true medical condition or mental disorder, as comorbid illness often occurs in the individual along with factitious disorder. For example, individuals who might manipulate blood sugar levels to produce symptoms may also have diabetes.
Other Specified Somatic Symptom and Related Disorder 327
Other Specified Somatic Symptom and
Related Disorder
300.89 (F45.8)
This category applies to presentations in which symptoms characteristic of a somatic symptom and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the somatic symptom and related disorders diagnostic class.
Examples of presentations that can be specified using the "other specified" designation include the following:
1. Brief somatic symptom disorder: Duration of symptoms is less than 6 months.
2. Brief illness anxiety disorder: Duration of symptoms is less than 6 months.
3. Illness anxiety disorder without excessive health-related behaviors: Criterion D for illness anxiety disorder is not met.
4. Pseudocyesis: A false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy.
Unspecified Somatic Symptom and
Related Disorder
300.82 (F45.9)
This category applies to presentations in which symptoms characteristic of a somatic symptom and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the somatic symptom and related disorders diagnostic class. The unspecified somatic symptom and related disorder category should not be used unless there are decidedly unusual situations where there is insufficient information to make a more specific diagnosis.
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Feeding and
Eating Disorders
Feeding and eating
disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. Diagnostic criteria are provided for pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder.
The diagnostic criteria for rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder result in a classification scheme that is mutually exclusive, so that during a single episode, only one of these diagnoses can be assigned. The rationale for this approach is that, despite a number of common psychological and behavioral features, the disorders differ substantially in clinical course, outcome, and treatment needs. A diagnosis of pica, however, may be assigned in the presence of any other feeding and eating disorder.
Some individuals with disorders described in this chapter report eating-related symptoms resembling those typically endorsed by individuals with substance use disorders, such as craving and patterns of compulsive use. This resemblance may reflect the involvement of the same neural systems, including those implicated in regulatory self-control and reward, in both groups of disorders. However, the relative contributions of shared and distinct factors in the development and perpetuation of eating and substance use disorders remain insufficiently understood.
Finally, obesity is not included in DSM-5 as a mental disorder. Obesity (excess body fat) results from the long-term excess of energy intake relative to energy expenditure. A range of genetic, physiological, behavioral, and environmental factors that vary across individuals contributes to the development of obesity; thus, obesity is not considered a mental disorder. However, there are robust associations between obesity and a number of mental disorders (e.g., binge-eating disorder, depressive and bipolar disorders, schizophrenia). The side effects of some psychotropic medications contribute importantly to the development of obesity, and obesity may be a risk factor for the development of some mental disorders (e.g., depressive disorders).
Pica
Diagnostic Criteria

A. Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.
B. The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.
C. The eating behavior is not part of a culturally supported or socially normative practice.
D. If the eating behavior occurs in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.
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330 Feeding and Eating Disorders
Coding note: The ICD-9-CM code for pica is 307.52 and is used for children or adults. The ICD-10-CM codes for pica are (F98.3) in children and (F50.8) in adults.
Specify if:
In remission: After full criteria for pica were previously met, the criteria have not been met for a sustained period of time.

Diagnostic Features

The essential feature of pica is the eating of one or more nonnutritive, nonfood substances on a persistent basis over a period of at least 1 month (Criterion A) that is severe enough to warrant clinical attention. Typical substances ingested tend to vary with age and availability and might include paper, soap, cloth, hair, string, wool, soil, chalk, talcum powder, paint, gum, metal, pebbles, charcoal or coal, ash, clay, starch, or ice. The term nonfood is included because the diagnosis of pica does not apply to ingestion of diet products that have minimal nutritional content. There is typically no aversion to food in general. The eating of nonnutritive, nonfood substances must be developmentally inappropriate (Criterion B) and not part of a culturally supported or socially normative practice (Criterion C). A minimum age of 2 years is suggested for a pica diagnosis to exclude developmentally normal mouthing of objects by infants that results in ingestion. The eating of nonnutritive, nonfood substances can be an associated feature of other mental disorders (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia). If the eating behavior occurs exclusively in the context of another mental disorder, a separate diagnosis of pica should be made only if the eating behavior is sufficiently severe to warrant additional clinical attention (Criterion D).

Associated Features Supporting Diagnosis

Although deficiencies in vitamins or minerals (e.g., zinc, iron) have been reported in some instances, often no specific biological abnormalities are found. In some cases, pica comes to clinical attention only following general medical complications (e.g., mechanical bowel problems; intestinal obstruction, such as that resulting from a bezoar; intestinal perforation; infections such as toxoplasmosis and toxocariasis as a result of ingesting feces or dirt; poisoning, such as by ingestion of lead-based paint).

Prevalence

The prevalence of pica is unclear. Among individuals with intellectual disability, the prevalence of pica appears to increase with the severity of the condition.

Development and Course

Onset of pica can occur in childhood, adolescence, or adulthood, although childhood onset is most commonly reported. Pica can occur in otherwise normally developing children, whereas in adults, it appears more likely to occur in the context of intellectual disability or other mental disorders. The eating of nonnutritive, nonfood substances may also manifest in pregnancy, when specific cravings (e.g., chalk or ice) might occur. The diagnosis of pica during pregnancy is only appropriate if such cravings lead to the ingestion of nonnutritive, nonfood substances to the extent that the eating of these substances poses potential medical risks. The course of the disorder can be protracted and can result in medical emergencies (e.g., intestinal obstruction, acute weight loss, poisoning). The disorder can potentially be fatal depending on substances ingested.

Risk and Prognostic Factors

Environmental. Neglect, lack of supervision, and developmental delay can increase the risk for this condition.
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Culture-Related Diagnostic Issues

In some populations, the eating of earth or other seemingly nonnutritive substances is believed to be of spiritual, medicinal, or other social value, or may be a culturally supported or socially normative practice. Such behavior does not warrant a diagnosis of pica (Criterion C).

Gender-Related Diagnostic Issues

Pica occurs in both males and females. It can occur in females during pregnancy; however, little is known about the course of pica in the postpartum period.

Diagnostic Markers

Abdominal flat plate radiography, ultrasound, and other scanning methods may reveal