Factitious disorder imposed on self (Munchausen syndrome)

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Literature review current through: **Oct 2023.**
This topic last updated: **Mar 27, 2023.**

INTRODUCTION

Factitious disorder imposed on self is characterized by falsified general medical or psychiatric symptoms [1]. Patients deceptively misrepresent, simulate, or cause symptoms of an illness and/or injury in themselves, even in the absence of obvious external rewards such as financial gain, housing, or medications. Factitious disorder imposed on self is distinguished from factitious disorder imposed on another, such as a child or older adult. Early investigation of a possible factitious disorder can prevent patient self-harm as well as iatrogenic complications arising from unnecessary tests and treatments.

Factitious disorder is sometimes referred to as Munchausen syndrome [2]. In some studies, the eponym Munchausen syndrome refers to the subset of severe, chronic, and dramatic cases marked by pathological lying (pseudologia fantastica), peregrination, and use of aliases [3,4].

This topic reviews the epidemiology, pathogenesis, clinical features, assessment, diagnosis, differential diagnosis, and management of factitious disorder imposed on self. Factitious diarrhea, factitious hypoglycemia, dermatitis artefacta, and factitious disorder imposed on a child are discussed in detail separately.

- (See "Factitious diarrhea: Clinical manifestations, diagnosis, and management".)
- (See "Factitious hypoglycemia".)

- (See "Skin picking (excoriation) disorder and related disorders", section on 'Other psychocutaneous syndromes'.)
- (See "Medical child abuse (Munchausen syndrome by proxy)".)

EPIDEMIOLOGY

The prevalence of factitious disorder imposed on self is difficult to estimate because of the secretive nature of the disorder; in addition, patients often deny the illness and seek treatment elsewhere when confronted [5,6].

General population — A community study in Italy estimated that the lifetime prevalence of factitious disorder in the general population was 0.1 percent [7].

Clinical settings — Multiple studies and reviews suggest that in clinical settings, the estimated incidence of factitious disorder is 1 percent [1,8-10]. However, the prevalence ranges widely across different studies. As an example, retrospective studies of inpatients [11] and outpatients [12] each found a rate of approximately 0.01 percent. By contrast, a prospective study of patients with fever of unknown origin found that factitious disorder was present in 9 percent [13], and a study of psychiatric inpatients found that the incidence was 8 percent [14].

The first presentation of factitious disorder is usually in the third or fourth decade of life [6,8,15,16]; however, children have been identified with the disorder [17]. Onset often occurs following a hospitalization for either a general medical condition or mental disorder, and factitious disorder appears to develop gradually [8,16,18].

Risk factors — Factitious disorder may be more likely to occur in [6,8,14,16,19-21]:

- Females
- Unmarried individuals
- Health care workers (past or present)
- Individuals with a psychiatric history
- Individuals who are experiencing family conflict (eg, abuse or parental divorce)

Other risk factors for factitious disorder include age ≤40 years, reported history of trauma, and family psychiatric history [21].

PATHOGENESIS

The etiology and pathogenesis of factitious disorder imposed on self are unknown. The disorder is associated with psychosocial factors, neurocognitive impairment, and neuroimaging abnormalities that may perhaps contribute to pathogenesis.

- **Psychosocial factors** – Factitious disorder imposed on self is commonly associated with psychosocial factors, including early losses via death, sickness, or abandonment; disrupted attachments to others due to neglect, abuse, institutionalization, or other traumas; gratifying (reinforcing) experiences related to the sick role; and a desire for attention [8,20,22,23]. As an example, one study of 93 patients with factitious disorder found a history of physical or sexual abuse in more than 20 percent [6]. The developmental perspective posits that the abnormal illness behaviors begin in childhood as a mechanism for coping with stress.

  It is hypothesized that the sick role behavior associated with factitious disorder is a means of establishing or stabilizing one's identity, maintaining relationships with others, and addressing emotional dysregulation and unmet needs [8,23]. Chronic illness and/or hospitalization may provide patients with benefits that are otherwise unavailable in more conventional social settings such as the workplace; these benefits include a clear role and sense of importance and belonging, and concern and acceptance by others. A study of comments posted by members of online support groups for individuals who self-identified as having factitious disorder found that receiving affection was the most frequently cited motivation for occupying the sick role [22]. Another proposed motivation is that patients may enjoy duping clinicians [20,22].

- **Neurocognition** – Neuropsychological testing in five patients with factitious disorder revealed deficits in conceptual organization, management of complex information, and judgment, despite intact intelligence and verbal skills [24]. These findings may indicate dysfunction in the right hemisphere of the brain.

- **Neuroimaging** – Although case reports of neuroimaging have described abnormalities in factitious disorder, it is unclear from these cross-sectional studies whether the findings represent etiologic causes, sequelae, neither, or both. Examples of abnormal findings include the following:

  - Magnetic resonance imaging of the brain in one patient detected white matter lesions disseminated bilaterally [25]

  - Computed tomography of the head in one patient showed moderate bilateral frontotemporal cortical atrophy and mild cerebellar atrophy [26]

- Single photon emission computed tomography of the brain in a single patient revealed hyperperfusion of the right thalamus [27]

CLINICAL FEATURES

Signs and symptoms — Factitious disorder imposed on self involves deceptive behaviors that are used to falsify symptoms or induce injuries [1,23]. Patients present themselves as ill or injured, even in the absence of obvious external benefits such as financial gain or avoiding work or criminal prosecution. The disorder is associated with psychological distress and functional impairment, and the severity of illness ranges from mild to severe.

Patients with factitious disorder may feign general medical and/or psychiatric symptoms and illnesses [28]. However, in the large majority of cases reported in the literature, patients present with somatic complaints and assert that they have a general medical illness. Any symptom or disease may be simulated or induced in factitious disorder (table 1); as an example, one study identified several cases of factitious decompression syndrome [29].

The most common falsified symptoms and diseases include [4,16,20,28,30]:

- Abdominal pain
- Arthralgia
- Chest pain
- Coagulopathy
- Diarrhea
- Hematuria
- Hypercortisolism
- Hyperthyroidism
- Hypoglycemia
- Infections
- Seizures
- Skin wounds that do not heal
- Vomiting
- Weakness

The most frequent factitious psychiatric symptoms and illnesses include bereavement, depression, psychosis, and suicidal ideation and behavior [20,28].

Deception is a key feature of factitious disorder [1]. While deceptive behavior itself is not necessarily pathological, the persistent nature of factitious behaviors can lead to significant

morbidity and mortality [8].

Patients may feign symptoms and illnesses by [1,8]:

- Exaggerating or fabricating their symptoms and/or medical history
- Exacerbating or inducing signs, physiologic disturbances, or illnesses (eg, ingesting or injecting medications such as anticoagulants, insulin, laxatives, or thyroid hormone; applying or injecting contaminants such as feces, bacteria, or sputum; delaying wound healing via self-contamination, intentional dehiscence, or self-administered trauma; or swallowing or instilling blood)
- Aggravating genuine, existing illness by not adhering to medical recommendations (eg, triggering seizures by not taking prescribed medication)
- Presenting benign physical findings as pathological (eg, patient with congenitally constricted pupil complaining of head trauma or patient with known ECG abnormality complaining of chest pain)
- Tampering with medical instruments, tests, or laboratory specimens
- Forging medical records
- Coaching others to provide false information to clinicians related to medical history or symptoms

More than one method may be utilized by patients with factitious disorder, even during a single episode of feigned symptoms and/or illness.

When questioned, doubted, or presented with evidence of falsification or tampering, the typical response is denial, often followed by departure against medical advice. Patients may also become disruptive or physically threatening. (See 'Discussing the diagnosis' below.)

Patients with factitious disorder imposed on self use a number of techniques to disrupt the clinician's standard practices. They may exploit the clinician's fear of missing a rare life-threatening disease, play into the clinician's fascination of solving a medical mystery, or convince the clinician that it would be redundant to conduct basic, definitive diagnostic procedures [8].

Multiple clinicians often simultaneously care for a patient with factitious disorder, who may behave in such a way as to "split" the treatment team, pitting different clinicians against each other [20].

Comorbidity — Factitious disorder imposed on self is frequently observed in individuals with factitious disorder imposed on another. Across multiple studies of those with factitious disorder imposed on another, approximately 55 to 65 percent also had factitious disorder imposed on self [31-33]. These studies also found that among those with both types of factitious disorder, many patients had personality disorders (eg, borderline and histrionic types); our clinical experience is that nearly all patients with factitious disorder imposed on self also have at least one personality disorder. Other common comorbidities in factitious disorder imposed on self include somatic symptom and related disorders, posttraumatic stress disorder, and substance use disorder [31-33]. In addition, two of the studies suggested that approximately half or more of the patients had a history of self-harm [31,32].

Factitious disorder imposed on self can be comorbid with true general medical conditions, including the condition that is feigned [1]. As an example, patients with diabetes may manipulate blood glucose measurements to mislead clinicians and appear more ill than is actually the case.

Course of illness — Information about the course of illness in factitious disorder imposed on self is largely based upon retrospective chart review studies because patients often drop out of care and follow-up [6,8]. The usual course of illness appears to be one of intermittent episodes, although single episodes as well as chronic and unremitting episodes are also reported [1,8,34]. Long-term recovery from factitious disorder may occur, but appears to be rare [5,35,36].

Factitious disorder can lead to diagnostic and therapeutic procedures that result in irreversible morbidity [37,38]. Deaths may also occur because patients underestimate the lethality of their behavior [39]; a case series of 20 patients found that factitious behavior directly led to the death of 20 percent [15]. Suicide can occur as well, but it is not clear how often this occurs [8,36,40].

ASSESSMENT

The evaluation of patients who may have factitious disorder imposed on self includes a general medical and psychiatric history, physical and mental status examination, as well as a detailed chronological analysis of the medical record, which is described below (see 'Medical record analysis' below). In addition, collateral information from family or friends as well as other records can be useful. Although laboratory tests can provide definitive evidence of factitious behavior, there is no specific diagnostic test for factitious disorder, and it is important to consider the reliability and validity of the medical tests that are performed.

The diagnosis of factitious disorder requires the presence of falsified general medical or psychological symptoms. In addition, evidence is required to show that the individual is taking deceptive actions that misrepresent, simulate, or cause symptoms of illness.

Evidence of factitious behavior — Evidence of illness falsification may be gathered from observations during the current hospitalization, medical records from prior episodes of factitious disorder, or family members. In addition, other types of records, other collateral contacts, and the Internet can also help identify evidence of illness falsification. Findings that constitute evidence of factitious disorder include the following [6]:

- Self-induction – The patient is observed (either directly or via video) in the act of inducing illness. Alternatively, suggestive evidence (eg, syringe or medication), which was not left by nursing staff, is found in the patient's room. Permission to conduct room searches is often part of the consent form patients sign before hospital admission. Inconsistent and abnormal clinical findings may cease if the patient is constantly observed by a member of the nursing staff. In addition, serum or urine laboratory results or toxicology screens may reveal unexpected exogenous substances. (See 'Laboratory tests' below.)

- Tampering with records or laboratory specimens – The chain of custody is critical to detect tampering. Was the patient alone with the medical chart? Did the patient bring in previous records rather than sign a release so that records could be obtained directly from previous clinicians? Was the patient alone during a medical test or when a biological fluid was collected?

- Inconsistencies – A pattern of inconsistencies in the patient's presentation suggests volitional falsification. Examples of inconsistencies include:

  - Symptoms do not match objective findings on the physical examination or laboratory tests
  - Reported medical history does not match previous medical records
  - Reported diagnoses do not match objective findings
  - Level of distress does not match symptom report or disease prognosis
  - Medical record names and numbers do not match

- Exaggerated or false statements (eg, psychosocial history is determined to be false)

- Patient admits factitious behavior following feedback from clinicians (see 'Discussing the diagnosis' below)

Medical record analysis — Analyzing records of all clinic visits, emergency department visits, hospitalizations, and home visits can help identify patients with factitious disorder [6,8,23]. Clinicians reviewing a medical record should assess the source of the documented information, review primary data (eg, test results rather than solely the interpretation of test results), evaluate if clinician diagnoses match objective data, consider ways in which objective findings could have been falsified or induced, and assess if the medical record makes sense.

We suggest chronologically summarizing the medical contacts with a table that includes columns for variables such as contact data (date of contact and location), subjective information (eg, chief complaint, symptoms, and history of present illness), objective information (such as findings on clinical examinations, objective test results, and observations by clinicians), outcome (eg, diagnoses, treatment provided, and efficacy of treatment), and other comments (table 2). Creating a table allows for pattern analysis (eg, health care utilization) and a description of the patient's illness and medical treatment trajectories. Additionally, the table may reveal gaps, contradictions, or evidence of marked evasiveness, which increases the suspicion of a factitious disorder.

Finding evidence or a past diagnosis of factitious disorder in the record may be easier in systems with electronic medical records [20]. Although patients may use aliases for different factitious episodes or medical encounters, if the same date of birth or social security number is used, these can serve as the search term [41]. Such searches are ethically justified if they are conducted for the purpose of sparing patients iatrogenic morbidity.

Insurance records might also provide information about high rates of health care utilization, which are associated with factitious disorder. Other potentially helpful resources include fire department or ambulance company records, dental records, police reports, court documents (depositions, testimony, letters, and other correspondence), disability records, employment records, and school records (eg, attendance, academic performance, and visits to the nursing office). Reviewing these additional records can identify inconsistencies between patient reports and prior records, which can serve as evidence of symptom falsification.

Laboratory tests — The diagnosis of factitious disorder is often established with laboratory data (table 3) [6,42-44].

DIAGNOSIS

Patients are diagnosed with factitious disorder imposed upon self if they present themselves as ill by falsifying physical or psychological symptoms and deceiving clinicians [1]. In the American

Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), factitious disorder is classified as one of the "Somatic symptom and related disorders." (See "Somatic symptom disorder: Assessment and diagnosis", section on 'Terminology and DSM-5'.)

All of the somatic symptom and related disorders are characterized by prominent somatic symptoms that are associated with distress and impairment [45]. However, deception is a key feature that distinguishes factitious disorder from other conditions [1]. (See 'Differential diagnosis' below.)

When to suspect factitious disorder — The presence of factitious disorder imposed on self is suggested by several clues, including [8,20,28]:

- High rates of health care utilization
- Use of multiple health care facilities
- Evasiveness in providing history
- Refusal to grant access to information from external sources such as prior medical records as well as family and friends
- Symptoms are unusual, rare, or do not correspond to a known diagnosis
- Numerous drug allergies
- Inconsistencies in the history, examination, and laboratory tests
  - Inconsistent or misleading history (eg, clinical history changes over time)
  - Intense symptoms that exceed findings from physical examination or laboratory tests (eg, patients complaining of persistent diarrhea and vomiting demonstrate no signs of dehydration)
  - Multiple laboratory results yield discrepant or inexplicable results
- Physical examination suggests an extensive history of illnesses and injuries (eg, numerous surgical scars)
- Tests and procedures, including those that are risky, are eagerly accepted
- Lengthy and extensive clinical evaluation (eg, large number of consultations and tests) that is negative

- Opposition to consulting psychiatry
- Few visitors
- Patient appears more comfortable than warranted by simulated symptoms or disease
- Nonadherence or disruptive behavior
- Course of illness is unusual
  - Resolution of symptoms soon after admission to the hospital
  - New unusual symptoms emerge as presenting symptoms resolve
  - Inconsistent or poor response to standard treatments for the disease in question (eg, wound infections do not respond to appropriate antibiotics or blood sugars remain low despite treatment)
- Ability to predict unusual progress of symptoms or response to treatment
- Exacerbation of symptoms shortly before scheduled discharge from the hospital

Diagnostic criteria — We suggest diagnosing factitious disorder imposed on self according to the criteria in DSM-5-TR, which require each of the following [1]:

- Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception
- The individual presents himself or herself to others as ill, impaired, or injured
- The deceptive behavior is evident even in the absence of obvious external rewards
- The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder

The diagnosis of factitious disorder requires objective identification of illness falsification behaviors and evidence of deception, rather than inference about intent or possible underlying motivation.

DSM-5-TR specifies the course of illness in factitious disorder as follows [1]:

- Single episode
- Recurrent episodes

Factitious disorder imposed on self can also be diagnosed according to the criteria in the World Health Organization's International Classification of Diseases, 11th Revision (ICD-11) [46]. The ICD-11 criteria largely overlap with the DSM-5-TR criteria.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis of factitious disorder imposed on self includes malingering and the following disorders.

Malingering — Malingering and factitious disorder are both characterized by deceptive behavior to simulate an illness. However, malingering is defined as illness falsification to obtain obvious external benefits such as money, medications (eg, opioids or benzodiazepines), time off work, child custody, or avoiding criminal prosecution, whereas the deception observed in factitious disorder is not fully accounted for by external rewards. In addition, diagnostic and therapeutic procedures (especially those that are painful or invasive) are avoided in malingering but readily accepted in factitious disorder [4].

If malingering and factitious disorder are comorbid, diagnosing factitious disorder requires clinicians to determine that the patient is taking surreptitious actions to misrepresent, simulate, or cause symptoms beyond what one would expect, in order to obtain external rewards. As an example, drug seeking may be present, but this does not account for the pervasiveness of the abnormal illness behavior.

General medical and mental disorders — Factitious disorder imposed on self is distinguished from true general medical illnesses and mental disorders in that factitious disorder is characterized by evidence of deceptive behavior to simulate symptoms or illnesses. It is useful to consider the prevalence of the various diseases that might be included on the differential diagnosis.

Borderline personality disorder — Borderline personality disorder and factitious disorder can each involve deliberate physical self-harm in the absence of suicidal intent. However, self-induced injury in borderline personality disorder is not associated with deception, whereas patients with factitious disorder use deceptive means when inducing self-injury.

Conversion disorder — Conversion disorder (functional neurologic symptom disorder) and factitious disorder can both involve neurologic symptoms that are inconsistent with neurologic pathophysiology. However, in conversion disorder there is no evidence of deceptive behaviors or falsification of symptoms, whereas factitious disorder is characterized by evidence of deception and falsification. In addition, conversion disorder always involves symptoms related

to the nervous system; factitious disorder can manifest with symptoms involving any organ system.

Delusional disorder, somatic type — Patients with delusional disorder, somatic type, and patients with factitious disorder may both manifest symptoms that are not supported by objective evidence. However, deception is involved in factitious disorder but not delusional disorder.

Somatic symptom disorder — Somatic symptom disorder and factitious disorder can both manifest with excessive preoccupation with somatic symptoms and treatment seeking. However, factitious disorder is characterized by evidence of providing false information or deceiving others about one's illness, whereas patients with somatic symptom disorder do not display these behaviors.

MANAGEMENT

Management of factitious order imposed on self is guided by observational studies.

General approach — Based upon multiple literature reviews, we suggest the following strategies [8,18,28,36]:

- One clinician should oversee patient management
  - Inpatients – Attending of record
  - Outpatients – Primary care clinician; appointments should be regular (eg, every eight weeks) so that medical attention is not dependent upon falsified symptoms or induced illnesses
- Psychiatry should be consulted
- Inform all members of the patient's multidisciplinary team about the diagnosis of factitious disorder and treatment plan
- Assess suicide risk (see "Suicidal ideation and behavior in adults", section on 'Patient evaluation')
- Monitor the patient (eg, place on constant observation) to prevent self-injurious behavior
- Diagnostic and therapeutic interventions should be based upon objective clinical findings

- Procedures should be contingent upon access to past medical records
- Avoid overlooking or ignoring genuine medical disorders
- Discuss the diagnosis of factitious disorder with patients in a supportive manner (see 'Discussing the diagnosis' below)
- Assess and treat comorbid psychiatric disorders (see 'Specific treatment' below)
- Offer ongoing and continued general medical care
- Maintain awareness of countertransference (the clinician's feelings and thoughts about the patient) (see "Unipolar depression in adults: Psychodynamic psychotherapy", section on 'Countertransference')

A study of comments posted by members of online support groups for individuals who self-identified as having factitious disorder (n = 57 members) found that improvement occurred in a few individuals who learned communication skills or positive coping skills, received support from family or friends, or learned to identify and manage factors that triggered their factitious behaviors [22].

It is not clear if treatment setting influences outcomes [47]. A review of single case reports (total n = 32 patients) concluded that improvement was comparable for inpatient and outpatient treatment [36].

Discussing the diagnosis — Discussions with patients about the diagnosis of factitious disorder imposed on self are sometimes referred to as confrontation [36]. However, we suggest that clinicians think of these discussions as meetings for informing patients about their diagnosis, and that clinicians provide compassionate feedback regarding clinical findings and recommendations [3,8,18,28]:

- Emphasize that the patient needs help
- Avoid expressing anger, acting judgmental, and taking punitive or retaliatory actions
- Provide assurances that general medical care and support is available
- Minimize humiliation and help the patient "save face":
  - Confession is not required for initial management and treatment.
  - Discuss the entire differential diagnosis, not just factitious disorder.

- Offer interventions that are unlikely to cause harm (eg, progressive relaxation or self-hypnosis) and that allow the patient to discontinue the factitious symptoms without acknowledging the disorder. The interventions can be framed as a means of augmenting ongoing general medical care.

- Focus more upon stressors that the patient faces and less upon the deception and illness simulation – Explain that complex and puzzling general medical illnesses are stressful and that stress can adversely affect one's health. Psychiatric treatment can be offered as a means of addressing stress in a setting that is associated with less morbidity and mortality.

Patients who are presented with the diagnosis of factitious disorder often respond with denial. As an example, a retrospective study of patients (n = 71) who were given this diagnosis found that only 23 percent acknowledged simulating or inducing their illness [6].

In addition, many patients who are given the diagnosis of factitious disorder respond by lodging complaints, becoming disruptive, leaving against medical advice, or seeking care elsewhere [8]. Patients may also threaten lawsuits. (See 'Litigation' below.)

Specific treatment — Psychotherapy is standard treatment for factitious disorder imposed on self, based upon reviews of low-quality studies such as case reports [3,8,36]. The therapeutic approach is comparable to that for personality disorders [20]. In the absence of high-quality studies that have compared different psychotherapies, supportive psychotherapy [20] or cognitive-behavioral therapy [18] is often suggested. The ACCEPTS (**AC**knowledgment, **C**oping, **E**mpathy, **P**arenting, **T**aking charge, and Support) treatment model for factitious disorder imposed on another may be helpful, particularly when both factitious disorders are present [48].

However, several studies suggest that it is difficult to engage patients in treatment. A review of 13 observational studies (total n = 284 patients) found that more than 60 percent either refused or did not follow up with psychiatric treatment [36].

A review of observational studies (eg, case reports) concluded that medications, such as antidepressants and/or antipsychotics, were not beneficial for factitious disorder [36].

Patients with factitious disorder plus comorbid anxiety disorders, depressive disorders, psychotic disorders, or personality disorders may respond to standard treatment for these comorbidities (eg, antidepressants for anxiety and depressive disorders, antipsychotics for psychosis, and dialectical behavior therapy for borderline personality disorder) [20,28,49]. In

addition, patients with factitious disorder and a history of trauma may respond to evidence-based treatments for trauma (such as trauma-focused cognitive behavioral therapy).

PROGNOSIS

The prognosis for factitious disorder imposed on self is poor [4]; recovery appears to be infrequent, especially among patients who are identified later in their course [8]. Patients with comorbid anxiety disorder, depressive disorder, or substance use disorder may have a better prognosis, whereas patients with personality disorders are more refractory [28,50].

Litigation — Patients with factitious disorder imposed on self may respond to discussions about the diagnosis by initiating malpractice lawsuits. Motivations for doing so include [3]:

- Financial gain – If money is the primary issue, the diagnosis should be changed to malingering (see 'Malingering' above)
- Anger and humiliation
- Simulating the illness in a courtroom rather than the hospital

In addition, clinicians may become defendants in litigation that is initiated by family members of patients who die as a result of factitious disorder [15].

Cases may arise in which clinicians request medical records from other clinicians or hospitals despite patient refusal to provide consent. Although releasing such records may be justified to prevent iatrogenic injuries, hospital legal departments (risk management) should be consulted before acting on such requests [8].

FACTITIOUS DISORDER IMPOSED ON ANOTHER

Factitious disorder can be imposed on another, such as a child, adult (eg, older adult parent) or a pet, and is a form of abuse [51,52]. National clinical and case management practice guidelines, endorsed by American Professional Society on the Abuse of Children, are available (see 'Society guideline links' below). The diagnostic criteria for factitious disorder imposed on another, according to the DSM-5-TR, are as follows [1]:

- “Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception
- The individual presents another individual (victim) to others as ill, impaired, or injured

- The deceptive behavior is evident even in the absence of obvious external rewards
- The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder"

The diagnosis of factitious disorder imposed on another is applied to the perpetrator rather than the victim. DSM-5-TR emphasizes objective identification of illness falsification behaviors, rather than inference about intent or possible underlying motivation.

DSM-5-TR specifies the course of illness in factitious disorder imposed on another as follows [1]:

- Single episode
- Recurrent episodes

The clinical features, assessment, diagnosis, and management of factitious disorder imposed on a child are discussed separately. (See "Medical child abuse (Munchausen syndrome by proxy)".)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Medical child abuse (Munchausen by proxy)".)

SUMMARY AND RECOMMENDATIONS

- **Overview** – Factitious disorder (Munchausen syndrome) is characterized by falsified general medical or psychiatric symptoms. Factitious disorder imposed on self is distinguished from factitious disorder imposed on another (by proxy). (See 'Introduction' above.)
- **Epidemiology** – The estimated lifetime prevalence of factitious disorder imposed on self in the general population is 0.1 percent, and in clinical settings the estimated incidence is 1 percent. (See 'Epidemiology' above.)
- **Clinical features** – Factitious disorder imposed on self involves deceptive behaviors that are used to falsify symptoms or induce injuries. The most common falsified symptoms and diseases include abdominal pain, arthralgia, chest pain, coagulopathy, diarrhea, hematuria, hyperthyroidism, hypercortisolism, hypoglycemia, infections, seizures, skin

wounds that do not heal, vomiting, and weakness. Patients may feign symptoms and illnesses by fabricating symptoms; inducing illnesses; aggravating genuine, existing illness by not adhering to medical recommendations; tampering with medical instruments, tests, or laboratory specimens; and forging medical records. The usual course of illness appears to be one of intermittent episodes, and long-term recovery is rare. (See 'Clinical features' above and "Factitious diarrhea: Clinical manifestations, diagnosis, and management" and "Factitious hypoglycemia".)

- **Assessment** – The evaluation of patients who may have factitious disorder imposed on self includes a general medical and psychiatric history, physical and mental status examination, and analysis of the medical record. In addition, collateral information from family or friends as well as other records can be useful. In analyzing past medical records, it is helpful to summarize the medical contacts with a table (table 2). Also, the diagnosis of factitious disorder is often established with laboratory data (table 3). (See 'Assessment' above.)

- **When to suspect the disorder** – The presence of factitious disorder imposed on self is suggested by several clues, including high rates of health care utilization; evasiveness in providing history; refusal to grant access to prior medical records; inconsistencies in the history, examination, and laboratory tests; lengthy and extensive clinical evaluation that is negative; and poor response to standard treatments for the disease in question. (See 'When to suspect factitious disorder' above.)

- **Diagnosis** – The diagnosis of factitious disorder imposed on self requires each of the following:

  - "Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception
  - The individual presents himself or herself to others as ill, impaired, or injured
  - The deceptive behavior is evident even in the absence of obvious external rewards
  - The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder"

(See 'Diagnostic criteria' above.)

- **Differential diagnosis** – The differential diagnosis of factitious disorder includes malingering, general medical and mental disorders, borderline personality disorder,

conversion disorder, delusional disorder, and somatic symptom disorder. (See 'Differential diagnosis' above.)

- **Discussing the diagnosis** – The diagnosis of factitious disorder imposed on self is presented to patients by providing accurate and compassionate feedback about the clinical findings. (See 'Discussing the diagnosis' above.)
- **Treatment** – For patients with factitious disorder imposed on self, we suggest psychotherapy as first-line treatment, rather than pharmacotherapy or no treatment (**Grade 2C**). (See 'Specific treatment' above.)
- **Prognosis** – The prognosis for factitious disorder imposed on self is poor. (See 'Prognosis' above.)
- **Factitious disorder imposed on another** – Factitious disorder imposed on another, such as a child or older adult, is a form of abuse. (See 'Factitious disorder imposed on another' above and "Medical child abuse (Munchausen syndrome by proxy)".)

ACKNOWLEDGMENT

The UpToDate editorial staff acknowledges Don Lipsitt, MD, who contributed to an earlier version of this topic review.

Topic 7765 Version 21.0

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