

Frequency of ICD-10 Factitious Disorder: Survey of Senior Hospital Consultants and Physicians in Private Practice

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The authors surveyed physicians for frequency estimates of factitious disorder among their patients. Twenty-six physicians in independent practice and 83 senior hospital consultants in internal medicine, surgery, neurology, and dermatology participated. They completed a questionnaire including the estimated 1-year prevalence of factitious disorder among their patients. Frequency estimates averaged 1.3% (0.0001%–15%). The number of patients treated correlated negatively with frequency estimates. Dermatologists and neurologists gave the highest estimations. One-third of the physicians rated themselves as insufficiently informed. Frequency estimations did not differ by information level. The estimated frequency is substantial and comparable to earlier findings. Authors discuss clinical implications.

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The ICD-10 defines factitious disorder (ICD-10 F68.1) as the intentional producing or feigning of symptoms or disabilities, either physical or psychological, with the goal of being able to assume the role of a patient. This includes Munchausen's syndrome but not malingering. Also, DSM-IV-TR differentiates between factitious disorder and self-mutilation, where the patient does not conceal the real cause of the injury. According to DSM-IV criteria, a person can be diagnosed with factitious disorder on the basis of a single incident of factitious illness behavior.^{1,2}

As a rule, the patients will conceal their contribution to the symptoms. Therefore, they will be unlikely to wish to be studied. This hampers reliable diagnostic identification and makes factitious disorder a very difficult condition to study empirically.^{2,3} The literature on factitious disorder therefore draws largely on case reports and single case studies.⁴ Cases of factitious disorder have been described in almost every medical field, mostly in internal medicine, dermatology, neurology, and surgery.^{5–10} There is ample evidence for the potential severity of the disorder, for example, in the work of Eisendrath and McNeil.¹¹

Epidemiological data are rarely available, because the secretive nature of factitious disorder thwarts traditional epidemiological research.² A literature review by Kocal-event et al.,¹² analyzed 18 studies reporting the figures for overall and relative number of factitious-disorder cases in various clinical samples. The total of patients in those studies amounted to over 52,000. The minimum prevalence of patients diagnosed with factitious disorder was 0.032%; the maximum was 9.36% (weighted mean 0.9%).

This great variation in the results was expected, given

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that the studies differ in their settings, patient clientele, research criteria for factitious disorder, and methods. Another problem is that most studies applied retrospective methods. This was often inspection of chart reviews, which must rely on the completeness and quality of documentation. The willingness to document factitious disorder as a diagnosis may vary considerably.² Finally, there is no research into the number of unknown cases.

There is no general remedy to overcome all these methodological difficulties. As the artificial illness-behavior can hardly be communicated openly with the patient,³ one approach is to ask the responsible physicians. This offers the advantage of using a standardized definition of the disorder by providing the physicians with written information. Furthermore, this gives physicians the opportunity to report suspicious cases that might not be indicated as such in official medical records.

The aims of this study were to investigate physicians' estimates of the prevalence of factitious disorder among their own patient clientele and to investigate differences in the estimations between medical disciplines and between hospital and outpatient settings. We also investigated the associations between physicians' prevalence estimates and their ratings of their state of information about factitious disorder and the relevance of factitious disorder.

METHOD

Participants

In 2003, we approached a nationwide German sample of 241 physicians for their participation. Addresses were obtained from official listings on the Internet. The sample represents physicians in independent practice and senior hospital consultants. It was meant to comprise representatives of the two largest medical fields, internal medicine and surgery, and also dermatology and neurology, where patients with factitious disorder are reported especially often in the literature.^{7,9} Rural, provincial, and urban locations were to be covered, as well as all German states.

A total of 109 physicians participated (45%). Twelve physicians responded but did not participate, six of these because they had not diagnosed any patients with factitious disorder. The sample consisted of 26 practicing physicians (24%) and 83 senior consultants (76%), including 41 dermatologists (38%), 26 neurologists (24%), 24 surgeons (22%), and 18 internists (17%). Within each medical field, all subspecialties were represented. Physicians in independent practice treated a mean of 7,622 outpatients per year

(range: 400–13,000). Senior consultants treated a mean of 4,133 inpatients per year (range: 160–28,350). The total number of patients on whom the estimates are based adds up to about 450,000.

Assessment

In epidemiological research, explicit diagnostic criteria are essential.¹³ For this purpose, physicians were provided with a detailed introductory text. The text defined factitious disorder according to ICD-10 criteria. It described signs and symptoms, the assumed motivational background, the secretive nature of the behavior, and frequent psychopathological characteristics, on the basis of available knowledge from the relevant empirical literature. The differences with malingering were highlighted. To enable the physicians to distinguish between factitious disorder and other disorders, the presence of deception was emphasized.¹⁴ Only information on epidemiology was withheld, in order to avoid influencing physicians' estimations.

A survey questionnaire was specifically designed for the purpose of this study. This consisted of five parts: The first was a rating of the physician's state of information about factitious disorder on a 4-point, verbal scale ("never heard or read of," "heard of but not well informed," "informed only along general lines," or "well informed"). The second was an overall rating of the relevance of factitious disorder among the physician's patient practice ("low," "medium," or "high").

The third and crucial part concerns the prevalence estimates. Physicians were first asked whether, during the last year, they had had any patients with factitious disorder among their clientele at all, independently of whether this diagnosis was coded as such. If so, they were asked to estimate how many of their last year's patients presented with factitious disorder, expressed as a percentage. The ratio of suspicious and certain cases should be indicated. On a list of 23 of the most often reported artificial symptoms or illness behaviors (following various overviews^{7,8,12}) the five most frequent forms among their own patients should be marked.

The fourth question asked how, in a case of factitious disorder, the patient would be further treated. The four response options were the following: "by a psychiatric/psychological consultation-liaison service," "by psychiatrically or psychologically trained members of their own staff," "by members of their staff without special training," and "there is no professionally competent further treatment."

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The fifth part gathered information on the respondent's medical discipline and subspecialty and the number of patients treated per year.

RESULTS

A total of 65% of the physicians rated themselves as well-informed about factitious disorder. About one-third of the physicians (28%) stated that they were only informed along general lines; 4% considered themselves not well-informed; and 3% said that they had never heard of this disorder before; 3% of the physicians rated the relevance of factitious disorder as high; 22% rated it as intermediate; and 73% rated it as low.

Physicians who identified themselves as well-informed give higher ratings of relevance than their less well-informed colleagues (Mann-Whitney *U* test: $N=107$, $U=902$, $p\leq 0.001$).

Prevalence estimates are reported in Table 1. Estimations show a wide range, from 0.0001% (or 1 in 10,000) to 15% of patients. The mean estimated prevalence was 1.3%. The most frequently named estimate was 1%. Mean prevalence estimations by well-informed and less well-informed physicians did not differ significantly. Estimations of prevalence and ratings of relevance were slightly correlated (Spearman's $\rho=0.28$; $p=0.004$).

There was a negative correlation between the number of patients treated per year and the estimated number of patients suffering from factitious disorder ($\rho = -0.33$; $p=0.002$). There was no significant difference between those physicians in independent practice and those who were hospital consultants. Differences between members of different medical disciplines were significant only in the hospital setting. Here, surgeons give lower prevalence estimations than did dermatologists (Mann-Whitney *U* test:

$U=95$; $p\leq 0.0001$) and neurologists ($U=114.5$; $p=0.011$).

On average, hospital physicians rated half of the factitious-disorder cases they identified as diagnosed with certainty. Physicians in independent practice only rated 36% of their factitious disorder cases as diagnosed with certainty.

Table 2 reports those factitious signs, symptoms, or illness-behaviors that were reported by at least 10% of the physicians. Manipulations of the skin, demonstrations or statements of pain or other alarming symptoms, and factitious wound healing were the most frequently reported factitious symptoms.

Figure 1 represents the three most frequently reported symptoms within each medical discipline and how the totals were distributed across all four disciplines. In each discipline, there were specific predominant signs, symptoms, or illness-behaviors. Reports by surgeons and dermatologist exhibited marked similarities.

Half of the physicians (50%) reported that they have their factitious-disorder patients further treated by a psychiatric/psychological consultation-liaison service; 15% reported further treatment by psychiatrically or psychologically trained members of their own staff; 15% reported further treatment by members of the staff without special training; and another 15% reported that there was no competent further treatment at all. There were no differences between medical disciplines with respect to further treatment. Overall, professionally competent further treatment was provided more often to patients in hospital settings than in independent-practice settings ($\chi^2=7.45$; $df: 1$; $p=0.006$).

DISCUSSION

From an epidemiological perspective, the main result is that an estimated 1.3% of patients suffer from factitious

TABLE 1. Estimations of 1-Year Prevalence of Factitious Disorder, Percent

Participating Physicians	N Responding Physicians ^a	Response Rate	Estimated Prevalence			
			Minimum	Maximum	Mean	Standard Deviation
By setting						
Physicians in private practice	24	36%	0.1	5.0	1.0	1.5
Senior consultants	82	53%	0.0001	15.0	1.4	2.2
By medical discipline						
Internal Medicine	16	28%	0.01	2.0	0.7	0.7
Surgery	24	37%	0.0001	5.0	0.7	1.0
Dermatology	40	56%	0.01	15.0	2.0	2.9
Neurology	26	44%	0.006	5.3	1.3	1.4
Overall	106	100%	0.0001	15.0	1.3	2.1

^a 3 missing values.

disorder. This percentage is based on physicians' observation and experience and does not rely on chart reviews. It includes suspicious cases, and this can be viewed as a way of addressing the problem of unrecognized cases. Bearing in mind the severity of the disorder as well as the costs involved, this estimated frequency must be considered substantial.¹⁵

This figure is fairly similar to the averaged values from the literature on the prevalence of factitious disorder.¹² Yet,

for two reasons, we emphasize that the basis for assessment is different from that used in other empirical approaches:

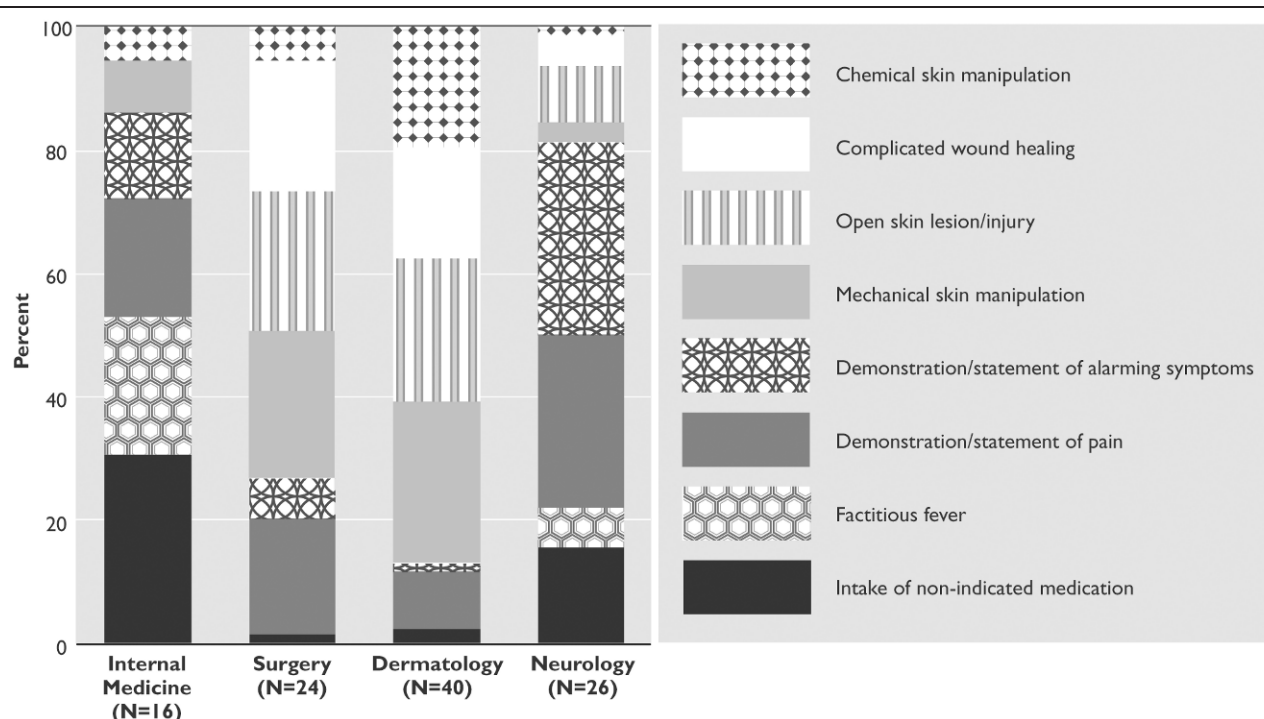
The first reason is that studies reporting the frequency of factitious disorder often investigate selected patient samples that in some cases are more likely to contain patients with factitious disorder.¹² An example is patients with fever of unknown origin.¹⁶ In our study, there was no further selection of patient groups apart from the four investigated medical disciplines.

TABLE 2. Frequency of Physicians' Reports of Different Kinds of Factitious Signs, Symptoms, or Illness-Behaviors (109 physicians, 459 reports)^a

Signs/symptoms/behaviors	Frequency	Percent
Mechanical manipulation of the skin	59	57
Open lesions or injuries of the skin	57	54
Demonstration or statement of pain	52	49
Complication of wound healing	44	42
Chemical manipulation of the skin	32	30
Demonstration or statement of other alarming symptoms	32	30
Pulling out hair	30	28
Symptoms or laboratory results affected by not taking indicated medication or substances	29	27
Symptoms or laboratory results affected by taking medication or substances not indicated	25	24
Factitious edema or hematoma	19	18
Factitious abscess	16	15
Factitious fever	12	11

^a Up to five kinds could be reported.

FIGURE 1. Most Frequently Reported Signs, Symptoms, or Illness-Behaviors for Each Medical Specialty



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The second reason is that any estimation is a cognitive-judgment process. The figure that was specified most frequently by the physicians was 1%. According to cognitive theory, judgments of frequency and probability implicitly make use of a cognitive heuristic known as “availability.”¹⁷ Here, the number “1” is the smallest whole number of the decimal system and thus a more “available” cognitive datum than, for instance, “3” or “0.68.” Therefore, in an uncertain situation, it is more likely to serve as estimate.¹⁷

We should also emphasize that the physicians’ estimations vary greatly. This could either reflect true differences in number or the tentative character of the estimates. Taking all of this into account, we do not conclude that our results represent the “true prevalence.” We prefer to regard the physicians’ estimate as a specific piece of information on the subject.

Also, our results help identify several problems. The willingness to participate was particularly high in dermatologists compared with members of the other medical disciplines. For patients with skin diseases, a high prevalence of psychiatric morbidity has previously been documented.¹⁸ Furthermore, in dermatology, factitious disorders seem to adopt more conspicuous manifestations, and

only in dermatology does the ICD-10 offers an additional diagnostic code for factitious disorder (factitious dermatitis: L98.1). This underscores the need for a greater awareness of factitious disorder in medical fields other than dermatology.

One-third of the participating physicians acknowledge that they were not well-informed about factitious disorder. It was assumed that the physicians who participated in the study would be better informed than those who did not participate. Furthermore, presenting oneself as being uninformed is socially undesirable. Therefore, the true number of uninformed physicians might be even higher.

In conclusion, we assert that there is a need for better professional training in the recognition of this disorder. This need seems particularly salient in independent-practice settings, where physicians were more uncertain in their diagnosis of factitious disorder and reported a less favorable situation for the further treatment of their factitious-disorder patients. Also, in view of the high frequency of unexplained signs and symptoms in many other medical areas, for example, nonphysiological kidney stones¹⁹ or vaginal bleeding,²⁰ future studies should examine factitious-disorder estimations of physicians from other specific specialties, such as urology or gynecology and obstetrics.

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