SOMATIC SYMPTOM AND RELATED DISORDERS

Factitious Disorder

FD

DSM-5-TR 300.19 | ICD-10-CM F68.10, F68.A

Falsification or induction of illness in oneself or another without external reward, driven by the need to occupy the sick role.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~1% of hospital inpatients	Early adulthood	Female majority in case series	Chronic; multiple institutions

CLINICAL PICTURE

- Illness is manufactured by fabricating history, exaggerating findings, contaminating specimens, injecting insulin or feces, or interfering with wound healing.
- Histories are fluent and textbook-consistent, often supported by real medical knowledge, and details shift when records from other institutions arrive.
- Patients accept painful and invasive procedures readily, and symptoms characteristically escalate as discharge or resolution approaches.
- Care is fragmented across many hospitals and specialists, with reluctance to permit release of records or contact with previous treating clinicians.
- The reward sought is care, attention, and identity as a patient rather than money, medication, or avoided obligation, which separates it from malingering.
- Iatrogenic harm is the leading cause of morbidity, through repeated surgeries, line sepsis, anticoagulation, and cumulative radiation exposure.

DIAGNOSTIC CRITERIA AT A GLANCE

- Physical or psychological signs or symptoms are falsified, or injury or disease is actively induced, in association with identified deception.
- The person presents themselves, or presents another individual, to others as ill, impaired, or injured across medical or psychiatric settings.
- The deceptive behavior is evident even without any obvious external reward, which distinguishes the disorder from malingering rather than from illness.
- The presentation is not better explained by another mental disorder such as delusional disorder or another psychotic disorder held with conviction.
- Specify single episode or recurrent; in the imposed on another variant, the diagnosis belongs to the perpetrator while the victim receives an abuse code.

NEUROBIOLOGY & PHYSIOLOGY

- No biomarker or imaging finding establishes the diagnosis, and reported frontal or white matter abnormalities in case series remain nonspecific.
- Laboratory pattern recognition supplies the objective evidence: high insulin with suppressed C-peptide, undetectable TSH with normal thyroid, or absent drug metabolites.
- Induced disease produces genuine pathology, so hypoglycemia, sepsis, anemia from covert phlebotomy, and surgical complications are real and can be fatal.
- Childhood illness, prolonged hospitalization, abuse, neglect, and early loss are overrepresented, as is employment or training in a healthcare occupation.
- Personality pathology, particularly borderline and narcissistic organization, is the dominant substrate rather than any discrete neurobiological lesion.
- Mortality is meaningful and arises from self-induced disease, complications of unnecessary intervention, and suicide, so this is not a benign condition.

PSYCHOLOGICAL MECHANISMS

- The sick role supplies structure, nurturance, legitimacy, and control that ordinary relationships have not reliably provided for these patients.
- The behavior is intentional while the motivation is largely outside awareness, and holding both facts at once is what makes clinical management possible.
- Attention from caregivers is a powerful reinforcer, so each successful admission increases the likelihood and the intensity of the next presentation.
- Direct confrontation typically produces flight, escalation, complaint, or suicidal crisis rather than confession, and it ends the therapeutic opportunity.
- Countertransference of anger, betrayal, and detective-like scrutiny is the main threat to safe care and should be named explicitly in team discussion.

DIFFERENTIAL & COMORBIDITY

- Somatic symptom disorder and functional neurological disorder involve genuine unfeigned symptoms with no falsification, and carry no deception criterion.
- Malingering is intentional falsification for tangible external gain such as money, opioids, housing, or avoided duty, and is not a mental disorder.
- Delusional disorder somatic type involves fixed false belief rather than knowing fabrication, and responds to antipsychotic rather than behavioral management.
- Borderline personality disorder, depression, substance use disorder, and chronic pain are the usual comorbidities, alongside repeated self-harm.
- Rare genuine disease must be re-excluded periodically, since a factitious diagnosis does not confer immunity from developing real illness later.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication treats falsification itself, so prescribing addresses comorbid depression, anxiety, and affective instability rather than the behavior.
- **SSRIs** are reasonable for comorbid mood and anxiety disorders, with realistic expectations that the presenting behavior may persist unchanged.
- Avoid opioids, benzodiazepines, and any divertible or self-administrable agent, including insulin, anticoagulants, and injectable medications.
- Reconcile the medication list across every institution involved, since polypharmacy accumulated from unnecessary treatment causes its own harm.
- Antipsychotics have no role unless a comorbid psychotic disorder is independently established on its own diagnostic grounds.

PSYCHOTHERAPY

- No randomized trials exist; long-term supportive or **psychodynamic therapy** with one consistent clinician is the best-described approach.
- Face-saving techniques such as inexact interpretation reframe the behavior as a communication of distress and preserve the alliance without demanding confession.
- **DBT**-informed work targets self-harm, emotion dysregulation, and the interpersonal patterns that drive care-seeking through illness.
- Motivational and harm-reduction framing accepts partial engagement, since insistence on full disclosure predicts dropout in nearly every case series.
- Set the treatment goal as reduced medical harm and increased non-illness sources of connection, not as elimination of deception.

ADJUNCT & SUPPORTIVE

- Assign one care coordinator and one medical home, and route all new complaints through that person to prevent parallel workups.
- Consolidate records across health systems, flag the case in the electronic record with ethics and legal input, and document diagnostic thresholds in advance.
- Limit invasive investigation by agreeing beforehand on what findings would justify escalation, which protects the patient more than vigilance does.
- Involve risk management and ethics before covert surveillance, room searches, or specimen testing, since these carry legal and consent implications.
- For factitious disorder imposed on another, report to child protection immediately, review the medical records of all siblings, and involve child abuse pediatrics.

CLINICAL PEARLS

- The act is intentional; the motive is not. Confrontation ends care and rarely ends the behavior.
- One medical home, consolidated records, and pre-agreed testing thresholds beat any prescription.
- Factitious disorder imposed on another is child abuse: report it, and check the siblings.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Bass, C., & Glaser, D. (2014). Early recognition and management of fabricated or induced illness in children. *The Lancet, 383*(9926), 1412-1421. https://doi.org/10.1016/S0140-6736(13)62183-2

Bass, C., & Halligan, P. (2014). Factitious disorders and malingering: Challenges for clinical assessment and management. *The Lancet, 383*(9926), 1422-1432. https://doi.org/10.1016/S0140-6736(13)62186-8

Flaherty, E. G., MacMillan, H. L., & Committee on Child Abuse and Neglect. (2013). Caregiver-fabricated illness in a child: A manifestation of child maltreatment. *Pediatrics, 132*(3), 590-597. https://doi.org/10.1542/peds.2013-2045

Levenson, J. L. (Ed.). (2019). *The American Psychiatric Association Publishing textbook of psychosomatic medicine and consultation-liaison psychiatry* (3rd ed.). American Psychiatric Association Publishing.

Sadock, B. J., Sadock, V. A., & Ruiz, P. (2021). *Kaplan & Sadock's synopsis of psychiatry* (12th ed.). Wolters Kluwer.

Yates, G. P., & Feldman, M. D. (2016). Factitious disorder: A systematic review of 455 cases in the professional literature. *General Hospital Psychiatry, 41*, 20-28. https://doi.org/10.1016/j.genhosppsych.2016.05.002

NOTE

References are formatted in APA 7th edition style with hanging indents. Diagnostic terminology, criteria structure, and coding follow the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; APA, 2022); criteria are paraphrased for instructional use and are not reproduced verbatim. Verify all citations against the original sources before use in academic work, and confirm medication dosing against current prescribing information.