

Review Article

Factitious Disorders in Everyday Clinical Practice

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Summary

Background: The pathological feigning of disease can be seen in all medical disciplines. It is associated with variegated symptom presentations, self-inflicted injuries, forced but unnecessary interventions, unusual and protracted recoveries, and frequent changes of treating physician. Factitious illness is often difficult to distinguish from functional or dissociative disorders on the one hand, and from malingering on the other. Many cases, even fatal ones, probably go unrecognized. The suspicion that a patient's problem may be, at least in part, factitious is subject to a strong taboo and generally rests on supportive rather than conclusive evidence. The danger of misdiagnosis and inappropriate treatment is high.

Methods: On the basis of a selective review of current literature, we summarize the phenomenology of factitious disorders and present concrete strategies for dealing with suspected factitious disorders.

Results: Through the early recognition and assessment of clues and warning signs, the clinician will be able to judge whether a factitious disorder should be considered as a differential diagnosis, as a comorbid disturbance, or as the suspected main diagnosis. A stepwise, supportive confrontation of the patient with the facts, in which continued therapeutic contact is offered and no proofs or confessions are demanded, can help the patient set aside the sick role in favor of more functional objectives, while still saving face. In contrast, a tough confrontation without empathy may provoke even more elaborate manipulations or precipitate the abrupt discontinuation of care-seeking.

Conclusion: Even in the absence of systematic studies, which will probably remain difficult to carry out, it is clearly the case that feigned, falsified, and induced disorders are underappreciated and potentially dangerous differential diagnoses. If the entire treating team successfully maintains an alert, transparent, empathic, and coping-oriented therapeutic approach, the patient will, in the best case, be able to shed the pretense of disease. Above all, the timely recognition of the nature of the problem by the treating team can prevent further iatrogenic harm.

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Feigned disorders are encountered in all disciplines of clinical medicine. Long considered to be primarily malingering, it was not until Freud's concept of the subconscious that they were implicated as having possible characteristics of a disease (1). "Polysurgical addiction" was described in 1923/1934 (2, 3) and "Münchhausen's syndrome" in 1951 (4). The etiopathogenesis of these disorders is ultimately unknown. Today, one mainly

invokes psychodynamic, developmental psychological, and above all trauma psychological models, in which objectification and manipulation of the own body, as well as assuming the sick role are attempts to solve subconscious needs and conflicts (1, 5–9).

The ICD-10 currently defines "factitious disorders" as the "intentional production or feigning of symptoms or disabilities, either physical or psychological" (10). Affected individuals are compelled to feign sickness or cause harm to themselves "repeatedly and for no plausible reason" (10). The motivation for this is described as "obscure": "the aim is presumably to assume the sick role." For "factitious disorder imposed on self/on another," the ICD-11 will, in addition, explicitly require that the deception is not motivated solely by obvious external incentives (10). Subtypes include "Münchhausen's syndrome" ("hospital hopper") and "Münchhausen's syndrome

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TABLE

Factitious disorders, malingering/aggravation, as well as functional, dissociative, and somatoform disorders

Name	Description	Examples
Factitious disorder ICD-10 F68.1	Intentional feigning or production of symptoms to assume the sick role – Can become life-threatening and take on the character of addiction – Sometimes in dissociative states (overlap with dissociative disorders possible)	see Box 1 Repeated admissions with colorful medical histories or self-induced findings
	Self-harm	Significant; often requiring urgent medical intervention
	Production of symptoms	Deliberate, secretive
	Motivation	Unconscious; external incentives are lacking or clearly in the background
	Willingness to change	Low to ambivalent
	Objective findings	Abnormal, sometimes discrepant
	Comorbidity	Significant physical and psychological comorbidity
Malingering/aggravation ICD-10 Z76.5*	Purposeful, intentional feigning or exaggerated presentation, very rarely also involving the production of symptoms – No suffering; subjective experience does not correspond to the symptoms complained of – Usually no longer present outside the examination situation	Transient speech disorders, bandaged limbs, limping, exaggerated expression of pain, small wounds (e.g., when desiring incapacity to work, damages for pain and suffering, pension, deferment of detention)
	Self-harm	None or mild
	Production of symptoms	Deliberate, feigned
	Motivation	Conscious, with clearly recognizable external incentives
	Willingness to change	None or little
	Objective findings	Normal; in the case of aggravation, present to a limited extent
	Comorbidity	Usually low
Functional/dissociative/somatoform/bodily distress disorders ICD-10 F44.-/45.-	Actual suffering and distress due to insufficiently identifiable symptoms – Also present outside the examination situation – Important areas of life are consistently impaired	Dizziness, pain, digestive problems, exhaustion, sensory disturbances, paralysis, seizures (e.g., in stressful or conflict situations or due to anxious, focused self-observation and expectation)
	Self-harm	None or mild
	Production of symptoms	Not deliberate
	Motivation	Unconscious; external incentives are lacking or clearly in the background
	Willingness to change	Predominantly high
	Objective findings	Mostly normal
	Comorbidity	Significant mental and possible physical comorbidity

* Currently not included in the German version ICD-10 GM 2020

by proxy” (fabricating symptoms in another person, usually children or dependents) (10, 11). The current article will not deal with these “by-proxy” constellations, which represent a separate entity and are also ethically and legally complex. Factitious disorders “for proxy” (symptoms that benefit others) and “by Google” or “by internet” (stories of illness disseminated on the internet) have also been described, depending on the purpose or means of deception (1, 12–16).

The current conceptualizations are criticized primarily for the fact that differentiating between func-

tional/dissociative/somatoform disorders, as well as simulation/aggravation, is challenging (1, 16–25). Although these phenomena may clinically resemble one another at first glance, they differ significantly in terms of intention, motive, findings, propensity to self-harm, and willingness to change—which are, in turn, clinically challenging to differentiate (Table). Due to their considerable heterogeneity on the one hand, and their blurred boundaries on the other, factitious disorders ought to be understood as a particularly severe manifestation on a broad spectrum of dysfunctional illness behavior (1, 16–18, 22).

Almost every physician has been confronted with the “vexing medical puzzles” (1) posed by the possible feigning, falsification, induction, or exacerbation of diseases. What is the background to these disorders, what are typical indicators and difficulties, and what is an appropriate approach?

Methods

This review article presents the phenomenology of, as well as the practical approach to, suspected or proven factitious disorders. It is based on a selective literature search in PubMed using the search terms “Münchhausen”, “Munchhausen”, “Munchausen”, “factitious”, and “factitia”. In particular, current reviews and case series on the subject published since 2000 were taken into account. Recommendations in relevant specialist reference books and from own experience in a supra-regional trauma center were also included.

Results

Epidemiology and clinical presentations

Little is known about the frequency of factitious disorders in their widely varying forms and degrees of severity. Current data from the central Norwegian patient registry showed a prevalence of only 0.0026%; however, careful review revealed that diagnoses were frequently incorrect and far too rarely made (23). A 1-year prevalence of around 1% (to 5%) is usually assumed in clinical populations (1, 5, 16, 19, 26–30). Numbers vary considerably depending on the survey method used and familiarity with the diagnosis, as well as on the specialty (26–30). The (suspected) diagnosis was made in 7.5% of pre-selected patients in a psychosomatic consultation liaison service (28). Systematic reviews of published case studies reported a high proportion of case reports in psychiatry (19%), accident and emergency departments (12%), neurology/neurosurgery (10%), infectiology and dermatology (9% each), endocrinology (13%), as well as cardiology and dermatology (10% each) (29). Between 40 and 64% of cases remain suspected cases (18, 26–28, 30).

Approximately 90% of patients feign sickness by fabricating symptoms in a self-harming manner. These “factitious” disorders in the narrower sense occur primarily in younger females (1, 18, 19, 26–29). Likewise, across medical specialties and clinical presentations, patients with factitious disorders tend to be younger females (1, 29). Merely in neurology and cardiology, as well as in investigations for HIV/sexual dysfunction, the proportion of males appears to be higher, while in dermatology this is the case for older patients (1, 29). Only around 10% of cases correspond to the “Münchhausen” subtype of “evasive hospital hopper with a dramatic medical history.” These cases are predominantly middle-aged males with dissocial personality traits (1, 4, 9, 18, 19). However, the term “Münchhausen’s syndrome” is proposed in some cases in the literature for severe, chronic fabrication of symptoms (23). In clinical routine, the term is often—misleadingly—used in an

differentiated manner for the entire spectrum of factitious disorders.

Clinical manifestations involve all organs and organ systems, are staged secretly and often with considerable skill, and range from inventing medical histories to inducing fatal diseases. Mental and behavioral disorders such as post-traumatic stress disorder or schizophrenia are also feigned (1, 5, 7, 27). Factitious behavior is usually conscious, in contrast to the motives behind it, but may also occur in dissociative (unconscious, trance-like) states (1, 5–7). Individuals in medical (assistant) professions, or who fantasize thereof (“...actually, I wanted to be a doctor”), appear to master this “mimicry of the sick person” (1) particularly well, and 22–66% have medical qualifications (1, 18, 26, 27, 29). Patients that have undergone early or frequent hospitalization or that have sick relatives potentially have a lower inhibition threshold, extensive knowledge, and specific skills with which to feign illness. In addition, the Internet now enables unimpeded access to specialist information as well as anonymous self-presentation to a wide audience (1, 7, 13–15). In the setting of insurance, asylum, and criminal law, occupational medicine as well as the military, malingering due to external incentives predominates, with, however, blurred boundaries to factitious disorders (1, 16–18, 22, 31–33).

Differential diagnoses, comorbidities, and prognosis

Due to the diversity of clinical presentations seen (Box 1), the list of differential diagnoses is virtually endless. Imitation or induction of common infectious, as well as endocrinological, cardiological, dermatological, and neurological disorders, are frequent. Rarer differential diagnoses include, for example, pyoderma gangrenosum, complex regional pain syndrome, and psychogenic purpura/Gardner–Diamond syndrome.

At around 40% (1, 27–29), in some case reviews 58–70% (18, 34), comorbidity with mental and behavioral disorders is high: factitious behavior is primarily seen in personality, addiction, eating, and stress-related disorders. The data vary for somatoform and dissociative disorders, attention deficit/hyperactivity disorders, as well as affective, impulse control, anxiety, and obsessive-compulsive disorders. Body dysmorphic or body integrity identity disorders, including apotemnophilia (ranging from the desire to amputate one or more healthy limbs to erotic fetishism for amputation) sometimes result in self-harm in order to get rid of the supposedly deformed body part. Between 20 and 68% of patients have a somatic comorbidity (1, 19, 27, 28). Pre-existing diseases or injuries often form the organic core, which can be complicated by the patient manipulating findings. And finally, patients with factitious disorders can become ill due to complications or incidentally in the course of their disease.

The scant prognostic data that are available indicate drastic differences in the degree of self-harm and

the resulting degree of disability: approximately 10–30% of factitious acts appear to be isolated and harmless events; one sees mild disease courses and complete remissions. However, episodic or chronic courses with sometimes lasting disabilities appear to be more common (1, 7, 16, 19, 26, 28, 29). Mortality is likely to be increased: causes of death can include complications from (provoked) interventions or suicide (1, 26, 28, 33, 35), while approximately 14% of patients have suicidal thoughts (27, 29). Failure to recognize feigning and symptom fabrication carries the risk of iatrogenic chronification and worsens the prognosis (1, 16, 17, 22, 36).

Dysfunctional motives, behaviors, and contextual factors

Although affected individuals usually credibly convey a desire to get well, they have contrary (“dark”) motives and dysfunctional behaviors (1, 4–9, 16, 17, 19, 22). The lying of these patients, who often have serious problems in many areas of their lives, has been described as “a necessary mechanism to keep greater evils at bay” (8).

As in other behaviors that bring short-term gain despite long-term harm, factitious behavior can take on the character of a true addiction (1–9). Those affected put their health at risk. An upward dynamic emerges, involving ever more hazardous deceptions and an increasing number of medical care providers: The more credibly and dramatically the symptoms are presented, the less one initially suspects deception, but rather diagnoses and treats with growing commitment. Physicians become involved in conflicts, are led down the wrong track, and thus—despite their best intentions—are turned into stooges that risk committing malpractice (1, 5, 7, 8, 16–18, 19, 22, 37, *eBox 1*).

Although openly displayed self-harm (for example, in the context of mental illness, rituals, extreme sports, or in the form of body modifications) as well as deception (imposters, “playing hooky”) occur across times and cultures, factitious actions are particularly strongly tabooed. This hampers their early detection and makes them more attractive to those affected (5, 16, 17, 22). Moreover, in societies with highly performing and freely accessible healthcare systems, the sick role is essentially open to all at all times—its obvious advantages are rarely questioned (1, 8, 16, 17, 22).

Management: primum nil nocere!

Factitious disorders threaten the Hippocratic principle “do no harm—nil nocere” insofar as they provoke high-risk interventions. Therefore, their prompt identification is of paramount importance (*Box 2*). Semi-structured basic documentation can be helpful in the clinical assessment (1, 38, 39) (*Figure 1*). Vigilance, face-saving confrontation, and support to stop self-harming are essential in the diagnostic and therapeutic approach (*Figure 2*).

BOX 1

Typical manifestations of factitious disorders (a selection)

- False, exaggerated reports of symptoms, diagnoses, events, or previous diseases (for example, terminal disease involving protracted suffering; deployment in war, rape, survivors of terrorism; presenting other people’s X-rays, chat room lying, fundraising activities on the internet)
- Typical descriptions (for example, of colic, symptoms of appendicitis or myocardial infarction, seizures, or severe constipation)
- Reinterpreting known trivial findings (for example, purported new-onset but congenital nystagmus)
- Feigning signs of disease (for example, manipulating thermometers or electrodes, coloring the skin, spitting red fluid, feigning paralysis, seizures, asthma, or contractions; introducing blood into the trachea or vagina, staging accidents), as well as concealing (dissimulating) disease until it becomes particularly impressive or incurable
- Exacerbating existing diseases and injuries (for example, by interfering with dermatitis, wounds, accesses, plates, fixators, or through fixed poor posture or excessive exercise, over- or underdosing medication)
- Self-bloodletting (auto-phlebotomy), inducing bleeding (for example, nasal, pulmonary, vaginal, rectal)
- Introducing contaminated, poisonous, corrosive substances (for example, water from the toilet, air, feces, urine, blood, alkalis, acids, flower water, petrol, milk, fruit juice, talcum), foreign bodies (nails, glass fragments), or medications (insulin, L-thyroxine, cytostatic drugs, beta-blockers, diuretics, anticholinergic agents, coumarin derivatives) into bodily orifices, larynx, esophagus, stomach, blood stream, muscles, joints, (sensory) organs, frequently the genitalia/uterus
- Physical manipulation of parts of the body (for example, using heat, cold, pressure, rubbing, scratching, blows, forced posture/forced immobilization, strangulation, self-catheterization, inducing premature birth)
- Psychiatric symptoms and diagnoses of all types (post-traumatic stress disorder, depression, anorexia, psychosis/schizophrenia, multiple personalities, amnesia, dementia) with or without use of psychoactive substances

Vigilance in the team

Various warning signs and indicators (*Box 2, eBox 2*) in the findings, context, patient behavior, and not least in the medical professionals’ own actions permit a prompt reaction—ideally before the fatal dynamics of the disorder unfold. Unusual findings and medical histories can be recorded relatively easily and specifically (18, 27, 29, 38–40). The entire team is called upon here: patients sometimes open up in particular to non-medical staff; sometimes non-medical staff in particular observe important details.

Nevertheless, none of these warning signs is evidence of feigned illness (1). They are merely indications that could also be attributed to the primary personality of the patient or to previously overlooked disorders. Most people from difficult backgrounds with problematic relational experiences, abnormal personality traits, or from medical professions do not feign illness. Nor should the responsibility for

BOX 2

Warning signs of factitious disorders*

- Unusual clinical findings (color, wound edges, blisters, strangulation marks, highly variable)
- Implausible or unusual test results (unexplained fever, hyperthermia [43 degrees C], foreign bodies)
- Contradictory laboratory results
- Unusual bacterial spectrum (frequent change in bacteria, fecal bacteria)
- Protracted, inexplicable course of healing, worsening prior to discharge or at home, worsening or improvement predicted by the patient
- Improvement when the primary caregiver is not present
- Eye witnesses that observe the patient manipulating findings
- (Suspected) manipulation of findings in the medical history

*See eBox 2 for other possible but less specific indications

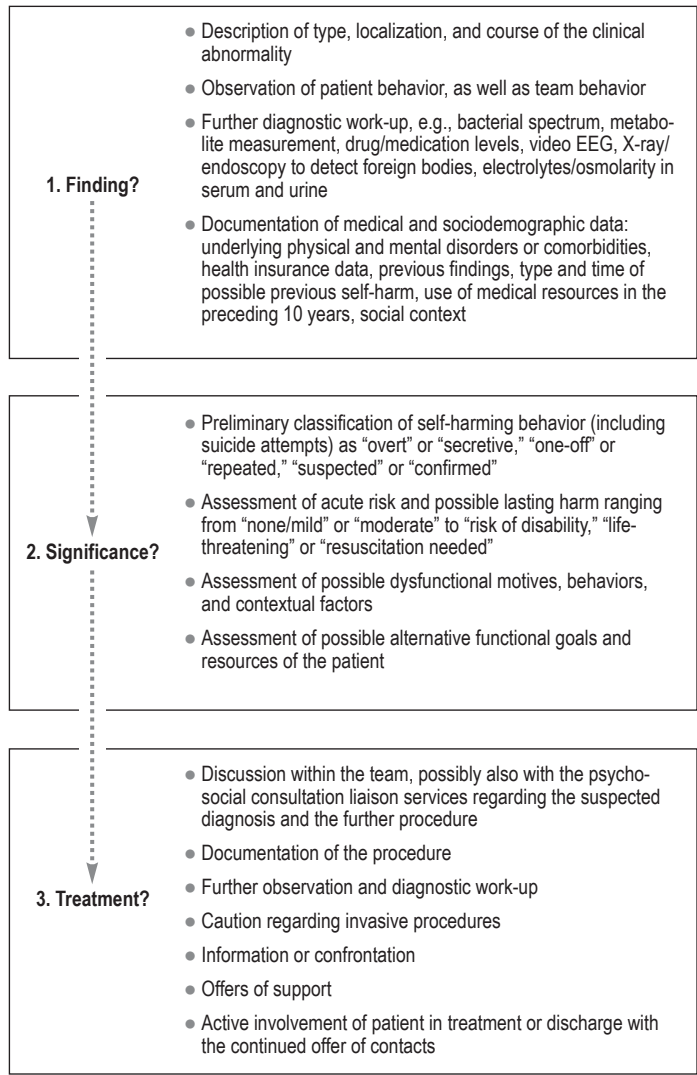
treatment failures be prematurely apportioned to patients as putative saboteurs. Having said that, patients can hide for a long time behind operational blindness and taboos. Precisely the staged drama of suffering, then the injustice, and finally disillusionment are typical of the disorder (1, 5–9, 19). Ongoing denial shared with the patient and aimed at avoiding conflict or ensuring profitable further treatment is to be avoided at all costs (1, 5–9, 16, 17, 19, 22, 34).

If there are warning signs, factitious disorder is a legitimate differential diagnosis. If the suspicion is substantiated, it becomes a suspected diagnosis. Suspected feigned illness should be discussed within the entire team to establish team consensus and to make sure that no member of the team behaves in a dysfunctionally over-involved, openly mistrusting, or outraged manner. Instead, the “ill-health dramatics” should be met with an attitude of routine professionalism and empathy, as well as a consistent and broadly consented treatment strategy (1, 7, 16, 17, 22, 34).

Information and confrontation

If there are sufficient indicators, a recommended approach is to inform patients of the differential diagnosis of self-infliction and, where appropriate, confront the patient with the suspected diagnosis in a stepwise, constructive, and supportive approach (indirect confrontational approach) (1, 5–9, 16, 17, 19, 22, 26, 24, 34). Part of this approach includes not insisting on exposure, evidence, or confessions. Patients should feel secure in the knowledge that they will continue to receive active treatment and that other differential diagnoses are being considered.

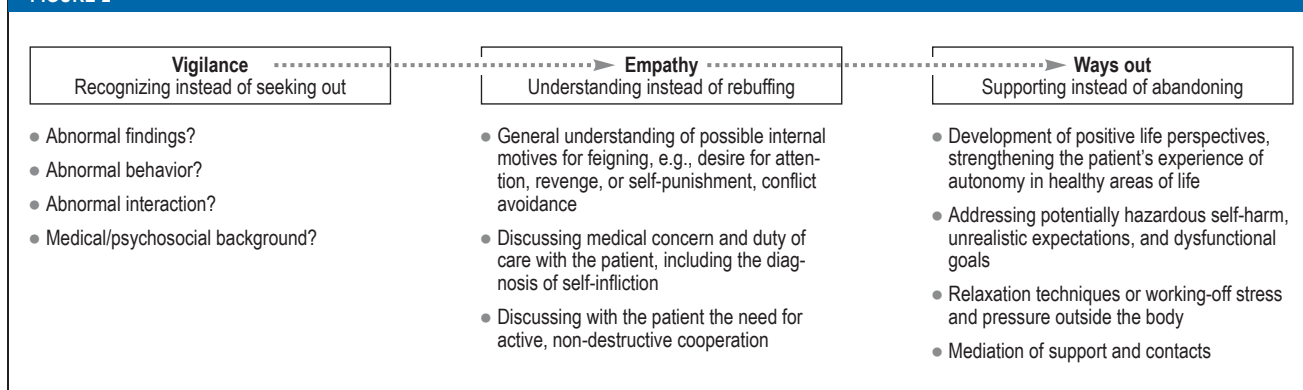
FIGURE 1



Semi-structured basic documentation for suspected or confirmed self-harm (modified from [39])

Confrontation can bring considerable relief for patients, since their deception is associated with privation and pain. Many of them have wanted to abandon the sick role, and the web of lies it involves, on several occasions (1, 5–9, 19). A supportive confrontation can also be used to openly explain the opportunities of psychotherapy. Some patients take this offer—even if initially only in order to improve their abilities to relax or cope with stress or pain. On the other hand, for many patients, admitting that their illness is feigned means loss of face and costs them enormous effort. Many deny feigning illness for this reason, but desist after a confrontation. Thus, they are subsequently better able to explain the incipient improvement in their status and still avoid the diagnosis of an artificial disorder (1, 5–9, 26, 34).

FIGURE 2



Dealing with factitious disorders

Harsh, indignant, or sarcastic, not to mention sardonic, condemnation is advised against (1, 5–7, 9, 26, 34). This leads one into the (relational) trap set by patients and is likely to result in patients “going underground” and continuing their deception in a more differentiated manner in other institutions. In a retrospective study, 80 of 93 patients underwent psychiatric consultation, and 71 were confronted with the suspected diagnosis; only 16 admitted feigning illness (26). Only 19 of 93 patients agreed to psychiatric treatment, while 18 left the hospital against medical advice (26). In a review of 32 case reports, 17 patients were confronted with the suspicion of self-infliction, 14 of these with a non-punitive approach, but without a discernible correlation to the outcome (34).

Figures 1 and 2 provide a stepwise approach, while eBox 3 lists concrete examples for use in informative and confrontational interviews. Where possible, these should take place in the presence of a team member familiar to the patient, not held in passing or in the heat of the moment, and should be documented (1, 5–9, 16, 17, 22, 34).

Tasks and ways out

Ongoing offers of contact with permanent contact persons, as well as concrete treatment arrangements, can build bridges and open (back)doors (1, 5–9, 16, 17, 22, 34) (Figures 1 and 2, eBox 3). By providing security, social contacts, autonomy, and an identity beyond the sick role (for example, professional prospects), the often remarkably intricate deception is, in the best case, no longer necessary and patients are able to stop or at least reduce the behavior (1, 5–9, 16, 17, 22, 34).

As a precondition for further treatment, patients should agree to contribute in an active and motivated manner (5–9, 16, 17, 22, 34). Examples include acceptance of wound closure measures, alcohol/nicotine abstinence, cessation of opioid use, home physiotherapy exercises, participation in stress-management programs, or initial psychotherapy interviews. For general health-promoting measures of this kind, factitious behavior does not need to be proven.

Treatment contracts in the narrower sense can be counterproductive. In cases of severe disorder, they can lead to even more sophisticated deceptive behavior (7). In addition, stipulated conditions (ending tampering and inappropriate behavior) and sanctions (confinement to the unit, discharge) are difficult to implement. Patients should be informed in a dispassionate manner that, according to experience, self-discharge or discharge due to non-cooperation occur more commonly in patients with feigned or malingered disorders and are documented in the discharge papers.

Early assessment by a psychiatric, psychosomatic, or psychological consultant supports specialist diagnostic confirmation, including an assessment of the risk patients pose to themselves or others and the initiation of further contacts. It would seem that consultations are now offered in 50–86% of suspected cases (26, 27, 30, 34). However, many patients dismiss consultations as unnecessary, which is mooted as an indication of factitious behavior (1, 16, 17, 22, 26, 27). If initial consultations do take place, patients often present themselves as particularly competent, capable of suffering, and with an almost ideal setting (“the psychologist thinks I’m completely normal and very brave”) (19). However, experienced practitioners will not let themselves be deflected in this way, but instead suggest at least short consultations in order to build a relationship of trust (1, 5–9, 19, 34). This primary caregiver should be alert to (early, adverse) experiences, but avoid probing for causes—the focus is always on the situation in the present. The patient should be able to entrust the caregiver with their personal information, but also be made aware that information relevant to their treatment will be shared with the team—otherwise the relationship becomes unilaterally collaborative or even conspiratorial.

Psychotherapy is then provided in a two-track approach (1, 26, 34):

- Low-threshold psychological counseling as in all severe and chronic disorders, with a focus on coping, acceptance, developing positive life

Key messages

- Factitious disorders are important differential diagnoses that should not be a taboo subject either within the treating team or towards the patient.
- They can accompany physical and mental disorders. The absence of clear external incentives and a strong propensity to self-harm distinguish them from malingering. However, there are overlaps and mixed presentations.
- If a factitious disorder is suspected, a vigilant and considered approach is crucial, involving particularly careful team coordination and clear indications.
- Communication with the patient should be as empathetic as possible. The medical duty of care in relation to hazardous developments and unnecessary measures should be clearly referred to.
- Both concrete psychosocial support and a transferral of responsibility for treatment to the patient are important steps on the path to developing autonomy and perspectives beyond the sick role.

perspectives, as well as monitoring anxiety and depressive and suicidal symptoms

- Open discussion regarding factitious behavior relevant at least from a differential diagnostic perspective, achieving an understanding for protective measures (for example, negative wound pressure therapy, protective cast), improving motivation to change and self-regulation, for instance using relaxation techniques, reducing self-harming behavior also in the sense of “recovering from past wounds” (1), developing healthier goals (Figure 2).

Consulting psychological counseling as well as in- and outpatient psychotherapy can by all means be successful (5–7, 9). However, according to an overview of 45 case reports and case series using widely heterogeneous interventions, neither confrontation nor psychopharmacological drugs or psychotherapy affect outcomes. Only a trend towards a more positive course in the case of long-term versus shorter treatment was seen (34).

Summary

Feigning and self-induction of diseases likely occur more frequently than generally assumed and display highly differing degrees of severity and course. Since these behaviors are conflict-laden and potentially hazardous, they require fundamental vigilance in terms of medical due diligence. The physician’s first and foremost duty is to protect affected individuals from themselves, as well as from unnecessary procedures and treatments.

Recommendations on how to deal with these patients are primarily based on accumulated clinical experience and case studies; there is a significant lack of systematic studies. There are no guidelines to date and these would be virtually impossible to formulate. The topic will remain clinically and scientifically difficult since:

- Due to the nature of the disorder, patient cooperation is poor
- The feigning and its background often remain undetected or treatment is discontinued
- The terminology is unclear and the distinction from similar phenomena, including malingering, is blurred
- One sees numerous mixed clinical presentations involving organic and mental disorders.

In the case of a high-risk constellation, both team and patient should be promptly informed. If clues increase in number, a differential diagnosis becomes a suspected diagnosis. This requires a fundamental understanding of the often powerful motives for feigning. Taking an actionist approach should be avoided. A constructive treatment plan coordinated by the whole team should not focus on medical interventions and exposure, but rather on offering ongoing contact, psychosocial support, and on the patient assuming responsibility for their treatment. In this way, improper treatment can be avoided, the autonomy of the patient preserved, and, ideally, the factitious behavior abandoned for more functional goals.

Conflict of interest statement

The authors state that no conflicts of interest exist.

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► **Supplementary material**

eBoxes:

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Supplementary material to:

Factitious Disorders in Everyday Clinical Practice

by Constanze Hausteiner-Wiehle and Sven Hungerer

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eBOX 1**Selected ethical and legal aspects of artificial disorders**

In 1986, Don Lipsitt reported the case of a 34-year-old female patient with factitious disorder of many years' standing (feigned end-stage metastatic stomach cancer) (37). She had developed stomach pain during a stay in Europe as a medical student, obtained an unindicated gastrectomy following her return, and repeatedly presented to a variety of hospitals where she reported that her stomach had been removed due to cancer. Further exploratory surgical procedures followed. After her boyfriend, also a medical student, ended their relationship, she returned to her family in an emaciated and weakened state and received the diagnosis of "end-stage stomach cancer" from a general practitioner, who referred her once again to hospital for a search for metastasis. During a regimen of chemotherapy, she recovered so astonishingly fast that the diagnosis was reviewed once again—without findings. She sought legal advice. A law student, whom she later married, advised her to sue 35 physicians involved in her treatment for 14 million dollars in damages and compensation. She claimed that she had made a complete recovery, that she admired physicians as almost "godlike," and that she wanted to finish her studies and open a clinic with the awarded money. An agreement was quickly reached in court, since the lawyers argued that the patient had repeatedly falsified her story; on the other hand, they also feared a lengthy and expensive trial due to her long-overlooked psychological diagnosis. The patient was awarded 315 000 dollars.

Physicians should be aware that, although a patient can sue for incorrect (suspected) diagnosis of "factitious disorder," in such cases generally only assumptions regarding cause as well as failure to take measures were wrong (1, 7, 37). On the other hand, undetected factitious disorder represents a potentially life-threatening mental disorder in which active incorrect actions/treatment have already taken place (1, 7, 37). Therefore, high-risk constellations, differential diagnoses, and individual treatment courses should be documented in a careful and transparent manner (1, 17, 22).

According to German law, patients with factitious disorders are not liable to prosecution in accordance with the right to self-determination; self-harm, like suicide, are not criminal offenses. In the case of imminent danger, when minors are involved, and to protect third parties (although this relates primarily to by-proxy constellations), a relaxation of medical confidentiality is justifiable on the grounds of beneficence and non-maleficence, and even required in the case of acute risk of harm to self or others (1, 7). If there is concrete suspicion of tampering, Kapfhammer (1) and Feldman (7) recommend informing the hospital director and legal advisor—as well as the police in isolated cases involving the use of hazardous objects or substances, and particularly if a risk of harm to others is suspected.

The idea of a register for suspected cases of factitious disorders to facilitate communication between all treatment providers is regularly considered; Asher spoke of “hospital black lists” (4). However, this carries the risk that other diseases in listed people would be underestimated and they would encounter problems with insurance cover (7). In only few countries to date, there is an obligation to report by-proxy syndrome (7). In the past, a number of case studies that were just slightly modified to protect patient identity were published in order to sensitize colleagues to the phenomenon; this would be virtually impossible today. As long as legislation governing the relaxation of confidentiality does not extend to falsification of information, as well as the feigning and induction of diseases, physicians remain bound by it (7).

Also important to note:

- In Germany, searches of private property and video surveillance are not permitted outside psychiatric units. Even searching garbage cans is problematic. Some medical centers solve this problem by including such measures (as a matter of routine or in individual justified cases) in the admission agreement or in the house rules, with the rationale that hospital rooms, by their very nature, offer less privacy than do, for instance, hotel rooms (7). In the US, there is often talk of lowering the legal hurdles to video surveillance in patient rooms; this is already possible in some cases if by-proxy syndrome is suspected and a child is at risk (7).
- The usual duty to inform the patient and obtain consent also applies to diagnostic tests aimed at proving tampering.
- Patient confinement (for medical reasons, usually on closed intensive care units with psychiatric staff) should be avoided wherever possible. This represents a significant encroachment on personal rights and is reserved for cases of self-endangerment. Due to the generally strict interpretation of the right of self-determination today, patients are (quite rightly) usually discharged after a few days anyway. It is only in rare cases that patients accept confinement as an opportunity; but more often, they see it as an act of violence and respond with further feigning behavior. However, in the case of severe and chronic disease, there is the option to arrange official care, which is barely capable of preventing tampering and also represents legal incapacitation, but provides patients with a contact person as well as concrete help with their lives, and thus possibly also more functional life plans.
- The question of responsibility for treatment costs has not arisen in Germany as yet, given that a mental disorder is assumed to be present. In the US, it would appear that health insurances have already sought redress from patients with factitious disorders (1, 7). Malingering can be prosecuted as insurance fraud.

eBOX 2

Possible, primarily unspecific indicators of factitious disorders

Finding

- Unusual appearance of findings (color, wound edges, blisters, strangulation marks, highly variable)*
- Unusual or conflicting laboratory results (widely fluctuating anemia, immunosuppression, hormone or drug levels, electrolytes)*
- Unusual bacterial spectrum (frequent change in bacteria, fecal bacteria)*
- Unusual, implausible, or impossible test results (fever of unknown origin, hyperthermia [43 degrees C], foreign bodies)*
- Unusual paraphernalia (medical equipment, elastic bands, bags of color, vials/ampules), unusual course of wound healing, worsening shortly before discharge, regular worsening at home, improvement when the primary caregiver is not present*
- Localization within reach of the patient's own hands, systemic or multiple
- Unusual general physical findings (for example, a strikingly high number of [surgical] scars), inconsistent limping, absence of vegetative signs when pain is reported, countertension/antagonistic innervation in muscle function tests
- Particularly stubborn symptoms ("treatment failures")
- Discrepancy between symptoms and findings

Biography, context, and medical history

- (Suspected) Manipulation of findings in the medical history*
- Works in a healthcare profession
- Long list of symptoms, numerous (exotic, severe) previous diagnoses, accidents, surgical procedures
- Involved in malpractice/compensation litigation
- History of being a "victim," "unlucky," a "con artist," "storyteller"
- Previous risky or self-harming behavior (alcohol, drugs, high-risk sports, scars, tattoos, piercings, imprisonment)
- Developmental abnormalities, relating in particular to affect regulation and body experience (eating disorders, obsessive-compulsive behavior, self-harming)
- Reporting unusual experiences (survivors of terrorism, natural catastrophes)
- Conflict situations with relief offered by the sick role (unemployment/homelessness, divorce, legal disputes, threat of imprisonment, deportation notice)
- Traumatic experiences in the medical system or negative models (long hospital stays, deaths among family or friends due to "malpractice," chronically sick or self-harming relatives); occasional exacerbation on relevant anniversaries
- Early experiences of loss, violence, neglect, trauma, recent losses
- History of mental illness or comorbidity

Behavior and personality

- Abnormal insistence on hospital admission, invasive investigations, or treatments

- Frequent change of physician, sudden self-discharge, incomplete, unrealistic, or possibly falsified medical reports, findings are forgotten or not disclosed
- Relatives and GP not available
- Frequent change of address or job
- Annoyance at normal findings, invalidation of previous treatment providers
- Unusually broad medical knowledge and vocabulary
- Abnormal non-verbal behavior while presenting symptoms, during bandage changes, crisis-like escalations, etc.: coming across not as concerned, but rather as enthusiastic, excited, or indifferent ("*la belle indifférence*"), abnormally high pain threshold, avoidance of eye contact, semblance of dissociation ("being out of it")
- Constantly present (particularly mothers in Münchhausen's syndrome by proxy), long periods spent in the bathroom, or never in room
- Conspicuous personality/affect:
 - Dazzling, successful, talented, grandiose, self-aggrandizing, with a tendency to lie (*pseudologia phantastica*)
 - Touching, self-sacrificing, especially brave, abandoned by the whole world
 - Unusually cooperative, confident, competent, or defiant or evasive
- Conspicuously unfeeling or depressed, hopeless or aggressive, hostile

Interaction

- Eye witnesses observe unusual behavior or manipulation of findings*
- Patient predicts worsening or improvement
- Expresses or implies need for action via urgency, despair, admiration ("you're my salvation/last hope; something has to happen")
- Expresses or implies desire for revenge or retribution against physicians/medical system
- No, abnormally close, or even promiscuous contact with fellow patients or staff
- Conspicuously few or many visitors
- Refusal to talk to psychologists/psychiatrists/ psychosomatic specialists
- Refusal to allow a third-party medical history, usually with specious excuses
- Divided sympathies within the team
 - The "good guys" (believe the patient, want to help, empathize greatly)
 - The "bad guys" (mistrustful, want to expose the patient, feel used or betrayed)
- Unusual physician engagement
 - Feels flattered, also invalidates previous treatment providers
 - Not averse to taking patient cases home in their thoughts
 - Extensive reading-up, particularly exotic differential diagnoses
 - Particularly extensive, uncritical diagnostic work-up/treatment, referral to prominent experts
- Prescription of non-indicated drugs, for example, with addiction potential or re-sale value (opiates, benzodiazepines)

* Specific red flags

eBOX 3

Supportive information and confrontation

Sample formulations

- “The important thing is that you cooperate constructively. There are lots of ways you can do this...”
- “You are an important treatment partner—we need you on board. The first step is for you to stop smoking—only then can we continue your treatment in a meaningful way.”
- “The first and most important goal is to stabilize your hemoglobin level at XY. Are you on board with this?”
- “It is important that we first of all agree that our joint goal is to enable the anemia resolve.”
- “The surgery you request is not indicated from a medical perspective—not even if local findings should continue to worsen.”
- “We are not permitted or willing to perform investigations or procedures that we consider harmful.”
- “We are doing what needs to be done in a case such as this—no less, but also no more, in order to protect you very specifically from risks and adverse events. ‘Less’ is often ‘more’ in medicine.”
- “We have many years’ experience with this disease and its broad differential diagnosis, including rare organic and mental disorders.”
- “When people have worries, they often get sick or make a poorer recovery. So we also have to look for solutions to these worries. As a first step, I recommend that you talk with our social services.”
- “This disease course is very protracted and burdensome. We’re worried about your psychological stability, not least with regard to depression and lack of interest in life. We propose that a psychiatric colleague has a talk with you.”
- “I can imagine that you sometimes feel lonely without work/family, etc., and in hospital you at least have people around you. But hospitals are not a good place to combat loneliness.”
- “When diseases are very stubborn, one always has to consider whether there is something that is preventing recovery. Strange as it may sound, sickness does also have its benefits.”
- “We have noticed that your self-determination is very important to you, and that is as it should be. On the other hand, a lot is dictated to you in hospital; that’s also how it has to be. One can feel under a lot of pressure.”
- “Time and again, we see patients who—often not at all intentionally—work against the healing process, for example, heavy smokers, patients who do not stick to their diabetes diet, or who take their medication incorrectly. It is important that you and us both recognize and modify harmful behaviors of this kind.”
- “We quite often see patients who, on the one hand, want to get better, but who, on the other, prevent this for a variety of reasons and by various means. We always take a two-track approach in the case of complex findings: good surgical treatment and psychological support.”
- “We see patients time and again who consciously or unconsciously, sometimes even while they’re asleep, scratch or contaminate their wound in some other way. That is why, as a general precautionary measure, we will dress it in such a way that no external contamination is possible.”
- “This wound has a couple of characteristics that indicate to us that it will only heal if you help with the treatment. This includes stopping smoking and also

negative wound pressure therapy generating an alarm if the wound dressing becomes loose.”

- “Your laboratory results show a vitamin D deficiency. We’re going to correct that with a vitamin D supplement. If that does not get the healing process going, the only other possibility is tampering by you, however strange that may sound.”
- “We like to talk to patients as early on as possible about the differential diagnosis of self-infliction, because we don’t see that as rarely as one would think.”
- “As long as an injury heals well, we don’t look for rarer causes. But in your case, the bacterial colonization is so unusual that we need to think in broader terms, even about the possibility of self-infliction. It’s part of our medical duty of care and due diligence.”
- “Combined with the unusual constellation of laboratory results, we have to think about self-infliction—it is not that uncommon. Unfortunately, medical personnel are at particular risk of this. Assuming you agree, we’re going to apply a closed dressing and provide you with psychological support during your treatment.”
- “We will continue treatment if we see an improvement in the healing process in the next few days. Otherwise, it might make more sense for you to be discharged.”
- “If evidence comes to light showing that your anemia has been caused by you either through negligence or by intent, we are obliged to mention this in your medical report.”
- “If your medical records show that you tampered with the wounds yourself, your insurance might not automatically pay for the treatment and potentially even suspect insurance fraud.”
- “All the findings indicate that this fracture was caused by human interference. We take this very seriously and, of course, we will continue to offer you surgical treatment as well as support from our psychiatrist.”
- “You do indeed have a serious medical problem, which, however, is associated with a lot of shame for most of those affected by it. We’re concerned that you—for reasons that are likely important to you, or perhaps unconscious but medically hazardous—are introducing foreign objects into your wound/digestive tract/bladder, etc.”
- “Your laboratory results are contradictory and can really only be explained by external influences.”
- “The bacteria that we found in your wound point to them having been put there. We interpret this as a cry for help. You will remain our patient, but please speak to our psychiatrist.”
- “The nurse came into the bathroom today while you had a cannula in your hand. We have been concerned for quite a while now that there are serious hurdles to your healing process. We would like to help you get over these hurdles.”

Questions on the article in issue 26/2020:

cme plus+

Factitious Disorders in Everyday Clinical Practice

The submission deadline is 25 June 2021. Only one answer is possible per question. Please select the answer that is most appropriate.

Question 1

What should the physician do when a patient is suspected of feigning, falsifying, inducing, or exacerbating disease?

- a) Initially hold back with treatment and instead wait for the patient to make active contact
- b) Confront the patient with their suspicion and, where necessary, demand a confession and evidence
- c) Not inform the treating team about the suspected diagnosis, since this might provoke the patient
- d) Remain alert to other possible indications and confront the patient with the possibility of feigning in a stepwise and supportive approach
- e) Contact as many people as possible in the patient's personal sphere and question them about the suspicion

Question 2

In which group do factitious disorders predominantly occur in the form of secret manipulation or self-induction of diseases in their own body?

- a) Older men
- b) Children
- c) Older women
- d) Younger men
- e) Younger women

Question 3

How does the ICD-10 define factitious disorder?

- a) As "intentional production or feigning of symptoms or disabilities either physical or psychological"
- b) As "a disorder in which anxiety is caused exclusively or predominantly by clearly defined situations that are in actual fact unhazardous"
- c) As "recurring compulsive thoughts and actions"
- d) As "partial or complete loss of normal integration of memories of the past"
- e) As "chronic hallucinatory psychosis"

Question 4

What percentage of patients with factitious disorders report suicidal thoughts?

- a) Around 14%
- b) Around 60%
- c) Around 2%
- d) Around 0%
- e) Around 25%

Question 5

Which warning sign might point to a factitious disorder?

- a) Very rapid and stable bone healing
- b) Widely fluctuating, sometimes contradictory laboratory parameters
- c) White coat hypertension
- d) Morning hyperglycemia
- e) Wound colonization by an MRSA bacterium

Question 6

What should the further treatment be for a patient with poorly healing wounds who is suspected of tampering with their wounds?

- a) They should be transferred for close surveillance to a room that is easily visible to the staff.
- b) They should sign a binding treatment contract that contains clear sanctions (treatment discontinuation, ward arrest) in the case of continued tampering.
- c) They should be discharged home, since further treatment in hospital has no prospect of success.
- d) The differential diagnosis of self-infliction, as well as joint treatment goals and protective measures (for example, protective cast, negative wound pressure therapy), should be discussed with them in an empathetic manner.
- e) They should receive as little attention as possible from the treating team, since attention leads to further tampering.

Question 7

What distinguishes factitious disorders from functional, somatoform, and dissociative disorders?

- a) The propensity to self-harm is high in functional, somatoform, and dissociative disorders.
- b) Patients with factitious disorders carry out the tampering unconsciously, usually in a trance.
- c) Factitious acts are usually carried out consciously, but the motives for them are predominantly unconscious and dysfunctional.
- d) Patients with factitious disorders suffer greatly from their symptoms and exhibit a strong propensity to change.
- e) Functional, somatoform, and dissociative disorders usually involve abnormal and often hazardous objective findings.

Question 8

What distinguishes factitious disorders from malingering?

- a) The propensity to self-harm is high in malingering.
- b) The motives for malingering are predominantly unconscious.
- c) For factitious disorders, there are usually clearly recognizable, mainly financial incentives.
- d) There is usually a high level of physical and psychological comorbidity in malingering.
- e) The findings in patients with factitious disorders generally continue to be present outside the examination situation, can take on the character of an addiction, and lead to hazardous complications.

Question 9

Which themes should initially take the foreground at the beginning of psychotherapeutic counseling and support?

- a) Experiences of sadism in early childhood
- b) The earliest recollection of parent–child conflict
- c) Patient and family psychiatric history
- d) How, exactly, the tampering was carried out from a technical point of view
- e) The current situation and ways of coping with it

Question 10

What often characterizes patients with factitious disorders?

- a) A stable familial, professional, and financial situation
- b) Good medical knowledge, often as a result of working in the medical sector themselves
- c) Avoidance of the sick role
- d) Good cooperation in and openness to psychotherapy
- e) A low number of previous and concomitant diseases