THE EFFECTIVE USE OF CASE MANAGEMENT IN

FACTITIOUS DISORDER

Abstract

Factitious disorder is seldom encountered but the case manager should be aware of this diagnosis. This is a costly disorder. Early identification and involvement by the case manager has the potential to save several thousands of dollars. Empathetic care of the patient may assist him to recover more quickly than if intervention does not occur. This article discusses how a case manager can identify this disorder, and what to do when it happens.

In over twenty years of nurse case management and legal nurse consulting experience, I have encountered factitious disorder approximately three times of which I am aware. Because of the nature of this disorder, it is possible that my path crossed several others with this undiagnosed condition. Case managers and other care providers should be aware of factitious disorder so proper diagnosis may be made.

DEFINITION

Factitious disorder is defined by the DSM-III-R (1987) as the “intentional creation or feigning of physical or psychological signs and symptoms in the absence of external incentives for such behavior.” An essential element of factitious disorder is to get one’s psychologic needs met through the assumption of the sick role. “Factitious disorders, somatoform disorders, and malingering represent various degrees of illness behavior characterized by the process of somatization. Somatization is a process by which an individual consciously or unconsciously uses the body or bodily symptoms for psychological purposes or personal gain.” It is estimated that five to forty per cent of visits to the doctors’ office are due to somatization. Munchausen syndrome applies to the most extreme and intractable 10% of factitious disorder patients.
Baron Karl Freidrich Hieronymus von Munchausen (1720-1791) was known to be a teller of wild tales - dramatic and untruthful. He was a cavalry officer who returned home from war against the Turks and told embellished tales of his adventures. Munchausen syndrome is the best known type of factitious disorder. This disease is characterized by repeated hospitalizations for voluntarily produced false or unreal physical or psychological symptoms associated with fantastic storytelling. The disease is noted in the literature in 1837 (Holmes T. Sir Benjamin Collins Brodie. New York: Longmans, Green, 1898:207) and in 1892 (Charcot JM. Sur un cas d’amnesie retro-anterograde, probablement d’origine hyterique. Rev Med 1892;12:81-96). Current thinking regarding causation concerns the cognitive dissonance theory (individuals avoid inconsistencies in thoughts or beliefs). If one’s self-deception continues, one may alter one’s mental and physiologic states to eliminate cognitive dissonance.

ETIOLOGY
According to Dr. Margaret McCahill, the onset of factitious disorder usually occurs in early adulthood; is more common in women; it may affect persons who have had significant illnesses during childhood and adolescence; it occurs more commonly among health care workers than in other populations; and it may be limited to brief episodes but is usually chronic. Predisposing family characteristics include the following:

1. Growing up in a family of somatizers;
2. Raised by parents who are demanding and unrewarding when the child is well, but caring and loving when the child is ill;
3. Experiencing an environment in which one or both parents suffered illness;
4. Living in an environment in which one or more coping mechanisms for dealing with psychosocial crisis are unavailable;
5. Developing a repertoire of actions used to withdraw from usual life activities or to engage or punish others;
6. Consciously feigning illness to attain something, to avoid punishment or responsibility, or to avoid required duties.
7. Raised by parents who are excluding or rejecting or in broken homes leading to foster home placement or adoption. As adults, people with this disorder often desire to be the center of interest and attention; have a grudge against physicians and hospitals that is somehow satisfied by frustrating and deceiving the staff; have a desire for drugs; and have a desire to escape the police. They frequently have disrupted interpersonal relationships and personality disorders.

**EPIDEMIOLOGY**

Dr. Folks describes five specific motivations for one to maintain the ruse:

1. Manipulation of interpersonal relationships;
2. Privilege of the sick role including sanctioned dependency (One may conclude, then, that this disorder is quite cultural);
3. Financial gain;
4. Communication of ideas or feelings that are somehow blocked from verbal expression;
5. Influence of intrapsychic defense mechanisms.

Because by nature of the disorder few studies have been performed, epidemiology is contradictory. Patients with this disorder often use aliases, wander from hospital or care provider to other hospitals and other care providers, discharge themselves against medical advice, or the disorder is never diagnosed because physicians prefer to trust their patients’ report of symptoms. There appear to be three levels of factitious disorder:

1. The patient describes a history of disease but there are no actual signs of an illness;
2. The patient simulates signs of a disease. For example, the patient may lance his finger to put blood into the urine.
3. The patient may create the disease state. For example, causing wound non-healing by picking at the wound, cutting the skin, contaminating the wound with fecal or salivary contaminants, or reducing blood circulation to the wound by applying a tourniquet.
While it is not in the purview of the nurse case manager to diagnose patients, it is helpful to understand the differential diagnosis with this disorder because we may be in the role of collecting the necessary information which will accurately lead to this diagnosis. A precise diagnosis can go undetected for a long time. Physicians are often seeking other anatomic causes for the physical symptom (such as a non-healing wound). Does the patient have an auto-immune disorder? Is there an infectious agent promoting infection? Is there a tumor?

Although they seek help, these patients often refuse help. This may be the first indication that the patient has factitious disorder.\(^{15}\) Usually there is a history of many procedures or hospital admissions. Such patients are often aggressive and disrupt the medical office, yet they are quite believable at times. They are often not good historians about their condition.

If the physician suspects the patient is self-harming, recommendations include biopsy of the fresh lesion. This should be presented as “unknown” etiology to the pathologist. The histopathology is often acute inflammation with increased polymorphonuclear leukocytes, scattered erythrocytes, with areas of necrosis with areas of healing with fibrocystic reaction.\(^{16}\) An additional diagnostic indicator is the healing of a wound when the physician can prevent interference by the patient.

Even with suspicions, the MMPI is often not a helpful diagnostic tool. Patients with factitious disorder often express competence in coping with typical life stresses, but may minimize or smooth over their shortcomings or faults. They have few somatic complaints and express little concern about their health. Unusual responses may be given, such as “I have had periods in which I carried on activities without knowing later what I had been doing” and “At times I have fits of laughing and crying I cannot control.”\(^{17}\) Factitious disorder often coexists with personality disorders such as borderline, narcissistic, schizoid, and antisocial.\(^{18}\)
**CASE STUDY**

I first began working with Stan Blaine (not his real name) three months after a right carpal tunnel release because the patient had developed a superficial cellulitis with third-degree burn-like wounds to the volar surface of the right arm. Because of the amount of pain Mr. Blaine described, he was immediately hospitalized. Following review of the medical records, differential diagnoses included factitious disorder, embolus infarct, self-mutilation, fasciitis, and rule/out foreign body inflammatory cell reaction. A psychological referral was made but the patient checked himself out of the hospital against medical advice before this could occur.

Mr. Blaine underwent a full-thickness skin graft on 6/3/97 (three months after referral). The plastic surgeon instructed the patient not to remove the bandages but the patient soaked them off on 6/14/97. The skin graft, consequently, did not “take.” The surgeon continued to treat the wound conservatively until 10/9/97 when a second skin graft procedure was conducted. The surgeon sewed the dressings to the skin at the time of this procedure. The dressing was removed in the physician’s office on 10/21/97 at which time the wound appeared essentially healed. The attending physician released the worker to his normal job of welding.

Two days later Mr. Blaine presented himself in the physician’s office with a separated right shoulder and facial bruising from a fall that he stated was caused by weakness in the leg as a result of the skin graft donor procedure. The attending physician stated the mechanism of injury could not have been as the patient stated. Unfortunately, blisters reoccurred on the right arm which ultimately developed into a 15 X 8 cm. wound for which the attending physician has recommended skin grafting. The payer source has denied authorization for payment, believing the problem to be factitious disorder. The treating physician has opined that there is no logical medical reason for the condition to have recurred and that the patient is, somehow, causing the arm to not heal. The patient, because he is no longer authorized disability payments, returned to work.
Medical History

Mr. Blaine has provided two different birth dates as well as three social security numbers. His medical history reveals an injury to his right hand with a cement mixer in 1965 (when he was either 15 or 19 years old) resulting in compound fractures of the thumb, index, and middle finger metacarpals with gross local deformities. This apparently left him with a useless right thumb. He learned to weld and used his dominant right hand thereafter as a helping hand.

Mr. Blaine sustained a second injury to his right hand in 1980 when he wrapped a drill cable around the hand and had a severe contusion to the wrist. He subsequently underwent fifteen surgical procedures between 1983 and 1992. These included, among others, carpal tunnel release on the right (two times); metacarpal bone fusions; repair of the bone fusion non-unions; nerve transfers; amputation of the right middle finger with transposition of the index finger metacarpal; and extensor tenolysis. Mr. Blaine worked infrequently throughout these years. He was worked up for osteomyelitis on several occasions (he did not have this), and did develop cellulitis more than once during this course.

A multidisciplinary evaluation conducted by a Physiatrist, Psychologist, Vocational Counselor, and Occupational Therapist on 5/12/98 indicated the patient’s inconsistent history as compared to medical records, the question of factitious disorder, and the recommendation that he be weaned from his prescription pain medication (Ultram). The psychological exam indicated Mr. Blaine was a “noticeably poor historian” with a somewhat reconstructionist view of past events and actively omitting information and giving misinformation. He was minimizing any emotional difficulties. His MMPI showed a conscious attempt to present himself in a good light while maintaining a facade of adequacy and self-control. He endorsed items reflecting a high degree of somatic focus.
TREATMENT and PROGNOSIS

No specific treatment is considered effective. Some approaches include direct confrontation (literature disagrees on this); blacklisting the patient; modifying the behavior through therapy; prolonged inpatient psychiatric hospitalization; and individual and group psychotherapy. Doctors Antony and Siobhan believe, however, that management of the psychiatric component is controversial and usually unsuccessful.

As can be seen by the case study above, the clinical course is usually chronic and morbidity is very high. Physicians who suspect this disorder are wise to allow the patient to “save face.” Tell the patient the wound has failed to heal despite multiple plastic surgery procedures. Either the patient has the usual wound-healing problems (which should respond to one more graft attempt); or make the diagnosis of factitious disorder if the problem does not respond to the graft attempt. The patient may “save face” by providing an avenue for wound improvement or facing the diagnosis of factitious disorder.

Factitious disorder patients skillfully elude detection and are often not motivated to be involved in sustained treatment. Once these patients are identified it is necessary to set goals. The patient must understand a finite timetable for each stage of treatment, and that treatment will end if he does not cooperate. Surgery must be very limited and only undertaken with proper psychological preparation and careful planning. Counterproductive treatment includes anger from the care provider (perhaps unacknowledged); avoidance; unwarranted accusations of self-harm; undisguised harshness; excessive solicitousness; inattention to concurrent psychiatric and physical conditions; and violation of confidentiality.

Factitious disorder patients predictably deny self-harm. They refuse to be unmasked and often threaten malpractice actions. They frequently flee the care of the attending physician and hospital when such exposure becomes imminent. Studies show only one-third of patients admit self-harm even when confronted with evidence.
All too often, the therapist must accept the simple truth that most factitious disorder patients will not respond as hoped. Even sustained improvement may be followed by a sudden deterioration and resumption of factitious behaviors when stresses intrude....Clearly, many factitious disorder patients will continue to feign or induce illness despite all interventions, reflecting the challenges inherent in the treatment of these patients. In such cases, the therapy is most appropriately viewed as a way to help the patient limit the damage done to his or her body during a discrete period of time.²²

One long-term follow-up study of 43 patients with self-inflicted injury show thirty per cent continued to produce lesions or were disabled with other psychiatric disorders more than twelve years after onset.²³

CASE MANAGEMENT

The case manager, using observation, history taking, and review of medical records, may be the first to suspect factitious disorder. According to Doctors Kasdan and Stutts, “most of these patients will bring another person, relative, or friend into the examining room, whether to confirm the patient’s story or for emotional support. This other person gives the patient a sense of power and personal belief in his or her claim. If the patient’s symptoms are questioned, this individual may become a catalyst for the escalation of emotions, including hostility.” Indeed, whenever possible, Mr. Blaine had either his wife or his nine-year-old daughter present with the physician.

The case manager should build a rapport with the patient while he continues non-invasive treatment. She should reinforce positive health behaviors, encourage the patient to maintain a consistent treatment plan with the attending physician and encourage a multidisciplinary treatment and evaluation approach. Because the case manager has more contact with the patient, his family, and other care providers as well as employer, she is more apt to assist the
physician in understanding the condition. Hence, she may encourage the physician to modify the professional goal and expectation from “curing” to “caring.”

If possible, the case manager should insist on the signing of a Release of Information form. In the case cited above, medical history was obtained expressly because old records were received and reviewed.

**DISCUSSION and SUMMARY**

Factitious disorder is not observed frequently but the case manager should have a healthy suspicion about this possibility when a patient presents as a poor historian, has a medical history of frequent treatment and/or hospitalizations, and there is marked discrepancy between physical findings and current medical data. Both physicians and case managers need to understand that, although most patients are honest and want to be healthy, some have other motives, including litigation.

These patients are considered legally competent; therefore, they are able to make their own healthcare decisions, often costing the healthcare system tens of thousands of dollars. Questions to consider include:

1. Should the patient be held responsible for treatment costs?
2. Should the patient be held liable and prosecuted for fraud?
3. Should there be a central “registry” for such patients?
4. Should patients who leave the hospital against medical advice be reported to such a central “registry?”
5. Should warnings be provided to surrounding hospitals, emergency centers, pharmacies and physicians?

Case managers in all venues (acute care, rehabilitation, workers’ compensation insurance, short- and long-term disability, auto liability, managed care, accident and health insurance,
occupational health, etc.) should keep factitious illness in mind during the course of her daily work.
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