Perspective

Looking Toward DSM–V: Should Factitious Disorder Become a Subtype of Somatoform Disorder?

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Background: *Factitious and somatoform-disorder patients are alike in that they both organize their lives around seeking medical services in spite of having primarily a psychiatric condition. In DSM–IV, the key difference is that factitious-disorder patients feign illness, and somatoform-disorder patients actually believe they are ill. Although patients may not be conscious of their motivation or even their behaviors, deliberately embellishing history or inducing symptoms exemplifies behaviors designed to enhance a self-concept of being ill.* **Conclusion:** *For DSM–V, we propose reclassifying factitious disorder as a subtype within the somatoform-spectrum disorders or the proposed physical-symptom disorder, premised on our belief that deliberate deceptions serve primarily to portray to treaters the sense of being ill.* (Psychosomatics 2008; 49:277–282)

By placing factitious disorder with physical symptoms in a separate category, DSM–IV asserts that it is truly distinct from other psychiatric disorders. This diagnostic partitioning is problematic because it implies that factitious disorder with physical symptoms has a distinct etiology, symptoms, and treatment. The current criteria specify that patients must intentionally produce an appearance of illness and have no apparent motivation for their deception other than a desire to receive medical care. Thus, DSM–IV separates factitious disorder from somatoform disorders by emphasizing that factitious patients "fake" their symptoms, even as they, in most other respects, resemble somatoform-disorder patients. Both patient types express emotional distress in somatic or physical terms, and the physical symptoms of factitious disorder are frequently comorbid with psychological symptoms.[1] Both disorders feature medically unexplained physical symptoms, and it is widely agreed that both are organized around trying to meet emotional needs in maladaptive ways. Psychiatric comorbidity commonly occurs with both. Kroenke has recently proposed a new DSM–V category of physical symptom disorder that could potentially encompass both groups of patients.[2]

Somatization Versus Deception: The Challenges of Assessing Beliefs and Motivation

Factitious patients present themselves as being sick and needing care. The fact that they are manufacturing their ill appearance has supported the mainstream contention that they are not actually somatizing, but are frankly lying. However, the line between lying and embellishment or deliberate enhancement to make physically manifest what is emotionally experienced is not easy to draw.

Deception is hardly unique to factitious disorder. For example, reported base rates of "symptom exaggeration" are 39% in mild head injury, 35% in fibromyalgia and chronic fatigue syndrome, 31% in chronic pain, 15% in depressive disorders, and 11% in dissociative disorders.[3] Moreover, the motivation for deception is virtually impos-

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sible for the clinician to determine accurately.[4] Indeed, the task of determining whether the actions the patient takes in feigning illness are intentional, voluntary, conscious, or unconscious, is problematic in that these behaviors represent an "untestable diagnostic hypothesis for many cases."[5] Finally, some authors have found the current DSM–IV diagnostic category for factitious disorder conceptually flawed because of its emphasis on deception, rather than on underlying psychopathology. Thus, given the vagaries of the factitious-disorder diagnosis construct and its similarities with somatoform disorders, which can be challenging to demonstrate objectively, we propose the creation of a factitious-disorder subtype within the somatization-spectrum disorders.

Factitious disorders are traditionally viewed as distinct from both somatoform disorders and malingering (Table 1). Patients with somatoform disorders have medically unexplained symptoms into which they are said to lack insight because they reject medical opinions that their complaints are without an organic basis. Even as they complain insistently of their pain, they do not consciously induce symptoms or exacerbate signs.[6]

Malingering patients, on the other hand, feign medical illness and manipulate the medical setting in order to pursue specific conscious goals. They do not view themselves as ill and do not seek the sick role for its own sake, but, rather, "act sick" only to achieve obvious manifest personal benefit. Although these distinctions appear relatively straightforward, they are frequently not clear-cut. Establishing the factitious-disorder diagnosis with a high degree of diagnostic certainty remains one of the more challenging tasks within psychiatry.

Data from patients' interviews are bolstered as much as possible by testimony from collateral sources, including family members or friends and involved medical and surgical services, laboratory tests, and outside records. Medical explanations for the signs and symptoms must be excluded. When the patient's medical presentation is atypical, with suspicious inconsistencies, the primary-care physician or team may question whether the patient has a psychiatric condition. A psychiatric consultation is requested to probe the patient's emotional functioning and offer insight into psychological difficulties, illness-behavior, and motivation. Efforts are made to detect lying or exaggeration. Highly subjective, the diagnosis hinges on the psychiatrist's impression of the patient's beliefs and behaviors; although experienced psychiatrists can develop proficiency in assessing these areas of functioning, the reality is that few do. Most psychiatrists see few of these patients and are thus insufficiently informed to make and document a factitious-disorder diagnosis.[1,7]

Turner has called for creating a specific DSM–V category for patients with "lying or deliberate autobiographical falsification."[8] Such a category would combine malingering and factitious disorders, as well as the phenomenon of *pseudologia fantastica*. Turner does not, however, define *pseudologia fantastica* or pathological lying in terms usable by either clinicians or researchers. In previous research, we have found it difficult to define the boundaries between misapprehending, distorting, and lying, let alone standardizing the definition of a lie.[1] Medical teams often lack collateral data to determine whether a patient is misrepresenting facts.

Another conundrum also emerges: who defines a lie as a lie? A patient's subjective, narrative truth may bear little resemblance to the "objective" medical truth perceived by her physicians. Furthermore, even "honest" patients are known to have difficulty accurately and consistently repeating their medical histories because of time, state, or personality factors.[9] Physicians themselves are not immune from inadvertently putting distortions into the medical record. Certainly, when patients report apparent false memories or exaggerations of past traumas, it is often difficult to ascertain whether they are doing so deliberately or mistakenly, whether because of unconscious processes or the natural evolution of the story as it is told and retold

TABLE 1. DSM–IV Diagnostic Categories: Somatoform, Factitious, and Malingering

	Somatoform Disorders	Factitious Disorders	Malingering
Insight that physical symptoms are related to psychological factors	None; unconscious process	None; unconscious process	Not applicable; conscious process
Illness behaviors	Feels ill; unconscious process	Feels ill; conscious process	Does not feel ill; to look ill and/or have needs met, conscious process involved
Motivation	Primary gain of sick role	Primary gain of sick role	Secondary gains, including retreat from responsibilities, acquiring controlled substances, food, shelter, compensation