

# 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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**T**he 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.<sup>1,2</sup>

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.<sup>2,3</sup> The literature on factitious disorder therefore draws largely on case reports and single case studies.<sup>4</sup> Cases of factitious disorder have been described in almost every medical field, mostly in internal medicine, dermatology, neurology, and surgery.<sup>5–10</sup> There is ample evidence for the potential severity of the disorder, for example, in the work of Eisendrath and McNiel.<sup>11</sup>

Epidemiological data are rarely available, because the secretive nature of factitious disorder thwarts traditional epidemiological research.<sup>2</sup> A literature review by Kocal-event et al.,<sup>12</sup> 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.<sup>2</sup> 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,<sup>3</sup> 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.<sup>7,9</sup> 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.<sup>13</sup> 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.<sup>14</sup> 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<sup>7,8,12</sup>) 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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