

Factitious Disorder in Children and Adolescents: A Retrospective Study

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Background: *Factitious disorder (FD) presumably manifests at an early age, but epidemiological and clinical data about pediatric FD are still lacking.* **Objective:** *The authors sought to study prevalence data of FD among referrals to a child-and-adolescent consultation–liaison service (CLS).* **Method:** *Authors conducted a retrospective survey of FD on 1,684 patients who were referred to the CLS from 1992 to 2003 (Sample I) and 12,081 patients who were treated in a tertiary-care child health center from 2003 to 2005 (Sample II).* **Results:** *In Sample I, FD occurred in 0.7% and, in Sample II, in 0.03% of the cases.* **Conclusion:** *The prevalence of pediatric FD among referrals to a CLS is similar to those found in studies of adults, and patients share many clinical characteristics.* (Psychosomatics 2008; 49:392–398)

In factitious disorder (FD), patients either intentionally produce or feign signs of medical or psychological disorders, or they misrepresent their histories. The motivation to assume the patient role, rather than to obtain an external reward, distinguishes FD from malingering. Malingering and FD both differ from somatoform disorders (e.g., somatization disorder, hypochondriasis, persistent somatoform pain disorder) and dissociative/conversion disorders in that the former are marked by active dissimulation, whereas the latter are prompted by unconscious conflicts and symptoms that are not intentionally produced.¹ In both diagnostic systems, ICD–10 and DSM–IV, the criteria for FD are nearly identical. Also, the DSM–IV emphasizes that the motivation for the behavior is to assume the patient role.^{2,3} In contrast to deliberate self-harm, FD is indirect

and is not acted-out overtly.⁴ Early and accurate diagnosis of FD protects the patient and may prevent costly and potentially harmful diagnostic and therapeutic procedures.⁵

Factitious illness may have a broad spectrum of presentations. In its milder forms, there may be only an exaggeration of physical symptoms. The most extreme and dramatic form is called Munchausen syndrome, first described by Asher.⁶ In 1951, she wrote:

Here is described a common syndrome, which most doctors have seen, but about which little has been written. Like the famous Baron von Munchausen, the persons affected have always traveled widely (“hospital hoppers”), and their stories, like those attributed to him, are both dramatic and untruthful.⁶

Patients with this syndrome create a complex disease picture, usually with a lengthy history, and visit many doctors and hospitals, undergo multiple dangerous procedures, but often leave suddenly and angrily.⁵

In the pediatrics literature, much attention has been paid to Munchausen syndrome by proxy. In Munchausen syndrome by proxy (MSBP), a perpetrator deliberately

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feigns or induces illness in a child for the purpose of fulfilling *his own* psychological needs. It must be differentiated from pediatric-condition falsification, which is done to effect some secondary gain. Both conditions represent severe forms of child abuse.⁷ However, there is considerably less awareness that medical and psychological symptoms can also be intentionally feigned or falsified by pediatric patients, themselves.

Precise prevalence data on FD are lacking in both the adult and pediatric literature. Patients simulating or feigning disease tend to be secretive and elusive. The histories those patients give are quite unreliable, and they often sign out against medical advice when they are about to be uncovered. Obtaining reliable data for research and prevalence studies has therefore been almost impossible.

Two studies in adult inpatients attempted to investigate the incidence of FD in a general-hospital setting.^{8,9} In the first study, conducted by Sutherland and Rodin, 0.8% of 1,361 patients referred over a 3-year period to a consultation–liaison service (CLS) for psychiatric evaluation in Canada were diagnosed with FD. The second study found a similar incidence, 0.62%, over an 18-year period, using data from 15,000 patients evaluated by a psychiatric consultation service in a German teaching hospital.

Further investigations have come from several subspecialties: At the National Institute of Allergy and Infectious Diseases, the study of 343 patients with prolonged fever of unknown origin found 9% of the cases to have factitious fever and self-induced infections;¹⁰ however, other authors reported lower prevalence rates (2.2% and 3.5%).^{11,12} FDs appearing as neurological syndromes were investigated in a Department of Neurology, yielding a prevalence rate of 0.3%,¹³ and in a Department of Neurosurgery, yielding a prevalence rate of 0.003%.¹⁴ Pope *et al.*¹⁵ identified a cohort of 9 patients (4.1%) with factitious psychotic symptoms from among 219 patients consecutively admitted to a research ward for psychotic disorders,¹⁵ but Bhugra found only 0.5% with factitious psychiatric disorder in a psychiatric hospital.¹⁶ Results of these studies showed that women outnumber men in non-Munchausen types of FD, whereas more adult men than women present with Munchausen syndrome. FD with physical signs and symptoms was more frequent than FD with solely psychological symptoms. The overall prevalence rate of FD in adults treated in hospitals and independent practice was estimated to be 1.3%.¹⁷

Although FD often begins at an early age,^{8,18} to this date, only case studies and one extensive review on the population of children and adolescents have been pub-

lished.¹⁹ The aim of this study was both to determine the prevalence of FD in pediatric patients referred to a Child and Adolescent Psychiatry CLS, and to determine clinical and psychological characteristics of pediatric FD.

METHOD

This study was approved by the hospital's Institutional Review Board.

Two retrospective surveys of FD were conducted on 6- to 18-year-old patients in a large, multidisciplinary tertiary-care child health center that held approximately 265 beds.

Sample I: Referrals to the CLS

Sample I consisted of 1,684 patients who were referred to a Child and Adolescent Psychiatry CLS from 1992 to 2003. The CLS is part of the Department of Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy, which consists of two inpatient units, a daytime clinic, and an interdisciplinary outpatient clinic. Information regarding these patients was obtained from comprehensive database forms that are completed routinely on all patients referred to our department. These forms were completed by Child and Adolescent Psychiatry residents and psychologists after the cases had been reviewed by the attending-physician staff. They have been entered into an electronic database and contain information regarding demographics, patient and family history, psychopathology, somatic and psychiatric diagnoses following ICD–10 criteria, and treatment.²⁰ To increase the sensitivity in this study, we also included six subjects in whom FD was only suspected at the time of treatment. In all identified cases, all available full-length, paper-based hospital charts from all departments of the university hospital were reviewed in order to confirm the diagnosis of FD according to ICD–10 criteria and to retrieve longitudinal information regarding the disease course. Patients were included if their physical and psychological signs or symptoms were judged to be intentionally produced, and their motivation was to assume the “sick role.” If external incentives were present or medical records revealed a plausible medical explanation for the symptoms, patients were excluded. Also, a clinically experienced second rater, blind to the results of the original analysis, independently reviewed all medical records. Intensive chart review gave enough evidence to confirm a diagnosis of FD in all cases but one, in which a diagnosis of FD was originally established or suspected by the con-

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