A STUDY ON TRAITS AND GAINS IN FACTITIOUS DISORDER, AND A NEW SELF-REPORT RATING SCALE

Arumugam Subramanian Senthil Kumar[1], Krishnappa Aranga Ramalingam Praphaukar Raaj[2]

[1]Assistant Professor, Department of Psychiatry, Government Vellore Medical College Hospital, Vellore, Tamil Nadu.
[2]Professor, Department of Psychiatry, Government Vellore Medical College Hospital, Vellore, Tamil Nadu.

ABSTRACT

BACKGROUND

Factitious disorder is a psychiatric diagnosis presenting with feigning of illness, lying in the continuum of somatoform and dissociative disorders through to malingering. Symptoms overlap as traits and gains confound the diagnosis. We wanted to study the pattern of sociodemographic distribution and types of gains between groups of patients with factitious and dissociative disorders, the intensity of factitiousness, masochism and compulsiveness among the two groups, and correlation between the traits**.**

METHODS

A cross-sectional observational study with convenience sampling, with consenting patients with factitious disorder and dissociative disorders, attending the outpatient unit in July 2017 to April 2018 period in the Department of Psychiatry in this tertiary teaching hospital, following institutional ethical committee clearance was undertaken. After case to case matching of patients between the two groups for major types of presenting symptoms, 30 patients in each group were considered for the study. Sociodemographic profile, a self-structured 22 item self-report rating scale for factitious disorder, Yale-Brown Obsessive-Compulsive Scale, and Masochism personality disorder criteria (DSM-III-R) were the tools used. Appropriate descriptive statistics with chi squared and t-tests and correlation coefficients were used.

RESULTS

About 67% and 63% had motor symptoms and 20% and 26.7% had cardiorespiratory symptoms in the two groups. Emotional gains were predominant in two-thirds of patients in both groups. Factitious patients had high scores in a new factitious intensity (FAC22-SR) scale and YBOCS, and mild score in masochism traits.

CONCLUSIONS

Gains have been proved as the driving force in conversion as well as factitious disorder**.** Early diagnosis of factitious disorder is important as misdiagnosis results in a chronic course with costly complications. Addressing obsessive compulsiveness, and masochist behavioural attributes may improve prognosis.

KEYWORDS

Factitious Disorder, Dissociative Disorders, Functional Neurological Symptom Disorder, Compulsion, Masochism, Rating Scale.

HOW TO CITE THIS ARTICLE: Senthil Kumar AS, Praphaukar Raaj KAR. A study on traits and gains in factitious disorder, and a new self-report rating scale. J. Evid. Based Med. Healthc. 2019; 6(21), 1525-1533. DOI: 10.18410/jebmh/2019/308

BACKGROUND

Feigned, fabricated or self-induced physical or psychiatric symptoms or signs amount to factitious disorder. Aggravating pre-existing lesions by self-injury, and forging of records, form other sub-types.[1] Course of illness is usually chronic, and occasionally episodic.[2]

Patients may commonly feign isolated physical symptoms like severe pain, injury, special sensory loss, and motor symptoms including limb weakness or abnormal movements. Rarely they may hide actual symptoms and feign to be normal to avoid demotion, removal from work or retraction of privileges, which is called as 'dissimulation.' They may also either deliberately fabulate exhaustive stories of gallant adventures involving them, or portray themselves as a victim of a series of tragic and catastrophic events, as in Munchhausen's syndrome.

With the advent of the digital informational age, it is expected to be more frequent than ever before.[3] Internet and multimedia ensures perfect simulation, easily deceiving an unsuspecting physician. It is even more deceptive when the patient presents with abstract psychiatric symptoms, as laboratory investigations do not aid in diagnosis even otherwise.

Approximate answers with near misses, *vorbeireden* and clouding of consciousness, are salient features of a hysterical variant called Ganser's syndrome. Previous traumatic experience, and partial dissociative mechanisms, triggered by affective, motivational and psychosocial factors, may be the active components.

Financial or Other, Competing Interest: None.
Submission 03-05-2019, Peer Review 09-05-2019,
Acceptance 18-05-2019, Published 27-05-2019.
Corresponding Author:
Dr. Praphaukar Raaj K. A. R,
Department of Psychiatry,
Government Vellore Medical College Hospital,
Vellore- 11, Tamil Nadu.
E-mail: prauphaukarkar@gmail.com
DOI: 10.18410/jebmh/2019/308

Incidence rate varies from 0.5% to 5% depending upon the educational, socioeconomic background, urbanization, and previous healthcare field exposure.[4]

It is understood that it is a part of the clinical continuum extending from somatic symptom disorders through to malingering. Even within the focal diagnostic dominion of factitious disorder, many a time we find multivariate causality and psychopathology, and a need for more critically utility oriented subclassification. International Classification of Diseases, 11th edition, ICD11, brings out new disorders with occasional overlapping symptoms, with intentional and incentive unminding facets, similar to factitious disorder (6D50).[5] Body integrity dysphoria (6C21) has a strong desire to become disabled, with preoccupation, pretence and self-harming act. Bodily distress disorder (6C20) has distress, excessive attention and frequent consultations over bodily symptoms with health care providers. Hypochondriasis (6B23) (and Illness anxiety disorder of DSM5) and Body dysmorphic disorder (6B21), parts of obsessive-compulsive spectrum, may share similar preoccupation with a non-existent illness or anomaly, and attention-seeking with professionals. Tic disorders (8A05) and Dissociative neurological disorders (6B60) are differential diagnoses for factitious motor symptoms.

In dissociative disorders (functional neurological symptom disorder, in DSM5), previously conversion disorder, the symptoms are produced unintentionally, though the resulting secondary gains are externally motivated. The symptoms are not substantiated by clinical signs of localizing value. Psychogenic symptoms of almost any kind of physical condition, and factitious disorder, form a third of neurology OPD census, and are frequently confounded with each other in the setting of medically unexplained symptoms.

Though malingering is rare in routine clinical settings, deliberate deception is documented to be around 30% in litigation and disability certification settings. While malingering is not considered as a mental illness as it is purely a goal-directed behaviour, exterior motive of similar intensity is seldom apparent in factitious disorder.[6] Incoherence, inconsistency and discordance in the narration of history and expression of symptoms strongly indicate the need for screening for these disorders.[7]

Pervasive Traits Promoting Gains

Being factitious is a unique trait in itself blooming into a typically deviant behaviour. Though acts are intentional similar to malingering, gains are internally motivated unlike the latter. Also, the patients usually do not have absolute insight about the internal motive that drives him to feigning. Nevertheless, patients find themselves up at legal crossroads many a time. There are even a few descriptions of criminalization of feigning symptoms in ancient literature as in the old Tamil allusion *oḻuṅk-aṟiyā uyir-oḻittōṟku, uyir-oḻittōn oḻuṅku-kariyān aṉṉa-*, and *ākāttiya-kāranukku bramakatti-kāran cāṭci*, meaning "like a sociopath being the character witness for a factitious person."[8]

Masochistic characteristics with repetition compulsion, re-enactment of dependency and idealization, and repetitive drive to beseech care with near obsessive quality in spite of the recurring risk of rejection, abandonment and abuse, are theorized templates for a factitious behaviour.[9,10] The compulsiveness and aggressiveness observed with the deceptive simulation and symptom induction by self-harm may have roots in the traumatic and adverse experiences during childhood in some patients.[2]

Feigning, inducing and aggravating symptoms are made for gains of all psychological reasons and beyond monetary demands.[11] Gains in factitious disorder are primary and subtly secondary, and though apparent from the goal-directed behaviour, the psychopathology remains mysterious mostly. The gratification from resulting attention may be the superficial and theoretically secondary gain. Deep beneath this, the act of feigning and fabricating alone is deemed to relieve specific hidden psychological conflicts, give a narcissistic sense of control and involve compensatory mechanisms, besides the primary defenses like dissociation and depersonalization observed in self-harm ideations. However, the conflicts are seldom revealed or affirmed to, in the clinical setting, confounding the diagnosis with frank malingering or dissociative disorders.

Occasionally, assuming of sick status, may also be an expression of a drive to decontaminate ego from guilt and perceived abandonment, or to justify to the superego with a feigned helplessness, as a reason for having denied a vital help to a significant person in the past. This smokescreen is in turn validated and forged as an authentication with the apparent success and gratification from the make-believe attempts, when treated by others as a sick person. Upon confrontation, they may respond initially by playing a poker's bluff, or digging deep just to justify his stand, until decisively proved otherwise.

Hartmann's secondary autonomic ego functions appear during the defenses against 'wrong' drives, such as the rise of care-taking interests as a reaction formation to a previous homicidal wish. A similar rise of care-seeking and symptom-affine interests against the previous masochist and suicidal drives, may also be a plausible mechanism in factitious disorder.[9,12,13] In the anal libidinal phase defenses like reaction formation (similar to obsession-compulsion) are manifested by practice of autonomy as against an earlier drubbing, shame and disgust, and rapprochement against self-doubt, with respect to anal impulses and pleasures.[12]

Late metamorphosed acting out of repressed childhood sexual impulses, goal-directed and overt expression of which may well be a perversed release phenomenon in neuroses with immature adaptive coping defenses.[12]

Neurobiology

Studies have shown increased activity in right hemithalamus, bilateral prefrontal cortex (PFC) – especially ventrolateral PFC, left temporal regions – more specifically hippocampus, and inferior parietal areas, in patients with factitious disorder.[10] Ballmaeier and Schmidt have dealt on the brain imaging attributes of dissociative disorders

including dysfunctional signal communication between PFC and anterior cingulate cortex.[14]

Towards Diagnosis

As patients would deny charges early in the work up, and may retract after initial confession, studies on factitious disorder face basic methodological difficulties, with obvious underestimations in the reported rates of prevalence.[2] Mismatch between the exhibited severity of the symptoms and the recordings of clinical parameters and multidimensional mental status incongruences should raise the suspicion towards factitious behaviour. Meticulous and methodical scrutiny of the collected historical details with chronological medical recordings will reveal psychological instigators, and can guide the treating psychiatrist to comprehend the drives and logistics behind the presenting symptoms.[13] Before psychiatric evaluation all combinations of probable medical conditions, with due consideration for erratic laboratory reports, should be ruled out. In some settings such as neurological and medicolegal, it may be easier to identify voluntary symptom expression in functional weakness, pseudo-seizures/non-epileptic attacks and mixed sensorimotor 'synthetic' symptoms, more so in post-concussional presentations. Constant vigil for inconsistent details, chronic and unrelenting course of illness, surveillance for surreptitious clinical clues and discordant laboratory findings help in the identification of factitious disorder, and in the differentiation from dissociative disorders.[15]

Factitious disorder imposed on others, usually on a child, may have cues including typical behaviour –attention seeking, talkative, aggressive, overly intrusive, at times guarded or threatening replies, inconsistent replies from the child, skipping of assessment dates, hurried, restless or even emotionally explosive behaviour rarely, history of child abuse in mother, child or its siblings, frequent doctor-hopping, objectively overprotective or subtly violating parental behaviour, and apparently somatoform-like, borderline and narcissistic personality characteristics of the attender or family member, rewards from vicarious sick role, and intergenerational transmission of factitious disorders, may be the psychopathology in the fabricating mother.

General physicians too feel the need for a definitive screening tool to rule out factitious disorder quite a few times in day to day consultations. Since the psychopathology in such patients is not beyond voluntary control, and is rather a product of choice,[16] self-report scales are preferred. Questionnaires deceptively devised to milch the deceptive drives, using attractive floaters making them relish their manipulations with a narcissistic hue, and aided by the willingness to divulge or fabricate with their histrionic enthusiasm.

We evaluated the theorized core traits and gains involved in the persistence of illness-claiming behaviour of factitious patients through this study, and suggest a basic screening questionnaire for the disorder imposed on self.

Aim and Objectives

The aim was to estimate and compare the pattern of sociodemographic distribution and different kinds of gains in factitious and dissociative disorders groups, the intensity of factitiousness, masochism and compulsiveness among the two groups, and correlation between these study factors. A utility self-report rating scale for factitious disorder was devised for use in the study.

METHODS

It was a cross-sectional observational study between the two groups viz. factitious and dissociative disorders, with convenience sampling from those attending the outpatient department in the Department of Psychiatry in this tertiary hospital. Institutional ethical committee approval was got from this teaching college both for the scale trial and for the main study, and the study period was from July 2017 to April 2018. About 34 factitious and 72 dissociative disorder patients who gave written informed consent, out of a total of 41 and 75 patients attending the psychiatry department in the said period, were initially registered for the study; 33 and 41 were then selected after matching for the specific major types of presenting symptoms (like motor, sensory, special sensory, musculoskeletal, cardiorespiratory and abdominal). After overall matching for gender, and classes of socioeconomic and residential status, and after three factitious disorder patients withdrawing consent for FACS22-SR scale, thirty cases in each group were proceeded with rating scale administration, and further study and analysis.

Inclusion Criteria

Inclusion criteria in the first and second groups included patients of age 12 years and above, fulfilling the ICD-11 MMS diagnostic criteria of Factitious disorder imposed on self (FD) and Dissociative disorders (DDs), respectively.

Exclusion Criteria

Exclusion criteria included patients with primary mood and psychotic diagnoses, those with history and diagnosis of comorbid or primary organic brain lesions, those in paediatric age group, comorbid diagnoses of peripheral neuropathy, diabetes mellitus, hypertension and any neurological condition.

Materials Used

A sociodemographic profile including age, gender, occupation, and residential and socioeconomic status was included, and most of these variables were considered for initial matching and appropriate study cases to be arrived.

A semi-structured self-report rating scale by name 'Facsimile Assuming Convincer 22 –Self Report, ' FAC22-SR, based on the diagnostic criteria for factitious disorder, was devised for in-study administration to the patients, having 22 items, in yes/no pattern with a point for affirmative responses. A score of 9-14 may suggest a possible factitious disorder, and 15 or more may suggest probable factitious disorder. After formal and independent translations by the two authors (SK and PR) into local vernacular (Tamil) version, an optimal consensus was arrived at a definite final

translated version, which was then back translated by a linguistic professional. The back-translated version was compared with the original for final adjustments. Inter-rater variability was found to be minimal. Then the translated instrument was also administered to a small sample of chronic factitious disorder patients (n=7, independent of study sample), for assessing scale comprehensibility and making finer adjustments. Chronic factitious disorder patients were defined as those with more than six months of feigning symptoms.

Masochism (Self-defeating) personality disorder criteria of DSM-III-R (MPD DSMIIIR) was administered to assess the masochism traits, with a point for each fulfilled criteria and a total score range of zero to eight, with five as the cutoff.[17,18]

Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) was administered to quantify the obsessive trait of the motive to produce/complain (factitious) symptoms, and the compulsion for the same. With five items each in the obsession and compulsion subscales and each item having a score from zero to four, the score range is between zero to 20 for each subscales.[19]

Each rating scale including the newly devised one was administered wholly by the same author for all sixty patients to avoid rater bias, FACS22-SR and MPD-DSMIIIR by PR and YBOCS by SK.

Appropriate descriptive statistical tests were administered using SPSS 20.0 package, with Chi squared test for frequency study, Student's t-test for study of differences in means, and Pearson's correlation coefficient test for association between variables.

RESULTS

About 83% and 63% were female in both the factitious disorder and dissociative disorders groups. About 60% and 67% were from rural domicile in both groups. The peak age of FD was 25 to 34 years, while DDs peaked in the 15 to 19 and again in the 25 to 29 age groups. This different pattern was statistically significant.

About 73% and 66% in both groups belonged to middle socioeconomic class, predominantly to upper middle subclass. Patients were predominantly unemployed (63%) and self-employed (43%) in the FD and DDs groups respectively, the numbers being statistically significant.

About 67% and 63% were predominantly exhibiting motor symptoms in both the groups, while sensory symptoms were the least in both groups. Cardiorespiratory symptoms appeared in 20% and 26.7% patients in the two groups respectively. Mean scores in the new factitious disorder self-report scale FAC22-SR, were 16.9 in the factitious disorder group and less than half of it (8.25) and well below (<15) the disorder level, in the dissociative disorders group, and the results were statistically significant too. Mean masochism scores were minimal and are only up to trait level (4.28) in factitious patients, but was at disorder-level (5.83, over the cut-off of 5/8) in patients with dissociative disorders. Obsessiveness was predominantly moderate to severe in factitious patients (in 86.6% of patients), but only subclinical to mild in most of the dissociative disorders patients (73.3%); mean scores were 12.7 (severe) and 5.1 (mild) respectively. Compulsiveness was predominantly moderate to extreme in factitious patients (76.6%), but only subclinical in most of the dissociative disorders patients (86.7%); mean scores were 13.0 (severe) and 1.93 (subclinical) respectively.

Factitiousness in the FD patients was mildly correlated with masochism (r=0.270) and moderately with obsessiveness (r=0.666); it had significantly strong positive correlation with compulsiveness (r=0.889). Their masochism was moderately associated with both the obsessiveness (r=0.521) and compulsiveness (r=0.454). The compulsive behaviour showed moderately positive correlation with obsessiveness (r=0.541).

Factitiousness in the DDs patients was mildly negatively correlated with masochism (r=-0.136); it had almost no correlation with obsessiveness (r=0.06) and compulsiveness (r=0.03). Their masochism was mildly positively associated with both the obsessiveness (r=0.187) and compulsiveness (r=0.191). Compulsiveness was minimally associated with obsessiveness (r=0.254), and therefore appears less secondary to the latter.

Gains/incentives were emotional (attention seeking, reprieve from conflicts like deprivation, insecurity, loneliness, bereavement, guilt, abuse, humiliation and disrespect, vindication, thrill-seeking, reduplication of past events for relishing or rectification, reaction formation, condoning by others of his or her personality issues, and others) in 66.7% of factitious patients, financial (6.7%), sexual (10%), other marital (13.3%) and social (cultural) (3.3%). This pattern was comparable to dissociative disorders where again emotional gains were predominant in 53.3%.

6D50 Factitious Disorder Imposed on Self
Factitious disorder imposed on self is characterized by feigning, falsifying, or inducing medical, psychological, or behavioural signs and symptoms or injury associated with identified deception. If a pre-existing disorder or disease is present, the individual intentionally aggravates existing symptoms or falsifies or induces additional symptoms. The individual seeks treatment or otherwise presents himself or herself as ill, injured, or impaired based on the feigned, falsified, or self-induced signs, symptoms, or injuries. The deceptive behaviour is not solely motivated by obvious external rewards or incentives (e.g., obtaining disability payments or evading criminal prosecution). This is in contrast to Malingering, in which obvious external rewards or incentives motivate the behaviour. Inclusions: Münchhausen syndrome Exclusions: Excoriation disorder (6B25.1) Malingering (QC30)

Table 1. ICD-11 MMS, International Classification of Diseases-11th Edition, Morbidity and Mortality Statistics

	Factitious Disorder n (%)	Dissociative Disorders n (%)	χ^2 (p)
Age in years			
<15	0 (0)	3 (10)	17.545 (0.0036)**
15-19	3 (10)	9 (30)	
20-24	7 (23.3)	4 (13.3)	
25-29	9 (30)	13 (43.3)	
30-34	10 (33.3)	0 (0)	
>=35	1 (3.3)	1 (3.3)	
Sex			
Male	5 (16.7)	11 (36.7)	3.068 (0.798)
Female	25 (83.3)	19 (63.3)	
Residence			
Rural	12 (40)	10 (33.3)	0.287 (0.592)
Urban	18 (60)	20 (66.7)	

Table 2. Socio-Demographics Between Factitious and Dissociative Disorders Groups. **p<0.01

	Factitious Disorder n (%)	Dissociative Disorders n (%)	χ^2 (p)
Occupation			
Unemployed/Student	19 (63.3)	5 (16.6)	16.833 (0.002)**
Unskilled	5 (16.6)	4 (13.3)	
Semiskilled	0 (0)	1 (3.3)	
Healthcare related	2 (6.6)	6 (20)	
Business/Shop owner	4 (13.3)	14 (46.6)	
Socioeconomic status (by avg. monthly family income)			
Low <INR 20,000	4 (13.3)	4 (13.3)	3.393 (0.494)
Lower middle 20,000-60,000	9 (30)	7 (23.3)	
Upper Middle 60,000-100,000	13 (43.3)	13 (43.3)	
High >100,000-140,000	4 (13.3)	6 (20)	

Table 3. Sociodemographic Differences Between Factitious and Dissociative Disorders Groups, Occupation and Economics. **p<0.01

Symptoms with Absent Clinical/Lab Findings	Factitious Disorder Group n (%)	Dissociative Disorders Group n (%)	χ^2 (p value)
Motor Symptoms			0.577 (0.989)
Convulsion-like and Dyskinesia- like movements	7 (23.3)	7 (23.3)	
Dystonia-like posturing of limbs/face & neck	6 (20.0)	5 (16.6)	
Limb/extremities weakness	7 (23.3)	7 (23.3)	
Respiratory discomfort and/or chest pain	6 (20.0)	8 (26.7)	
Pain (abdomen, limbs headache, diffuse backache)	3 (10.0)	2 (6.7)	
Visual impairment/Loss of vision	1 (3.3)	1 (3.3)	

Table 4. Frequency Tables for Individual Symptoms for Both Groups

Traits	Factitious Disorder	Dissociative Disorders	Statistic (p Value)
FAC22-SR, m (sd)	16.9 (6.75)	8.25 (4.05)	t, 6.004 (<0.001)**
Masochism, m (sd)	4.28 (2.26)	5.83 (2.43)	t, 4.723 (<0.001)**
Obsessiveness n (%)			χ^2 (P)
Subclinical	2 (6.7)	12 (40.0)	25.972 (<0.001)**
mild	1 (3.3)	10 (33.3)	
moderate	10 (33.3)	4 (13.3)	
severe	16 (53.3)	3 (10.0)	
extreme	1 (3.3)	1 (3.3)	
mean (sd)	12.73 (5.61)	5.13 (2.33)	
Compulsiveness, n (%)			χ^2 (P)
Subclinical	2 (6.7)	26 (86.7)	39.792 (<0.001)**
mild	5 (16.7)	2 (6.7)	

moderate	6 (20.0)	1 (3.3)	
severe	10 (33.3)	1 (3.3)	
extreme	7 (23.3)	0 (0.0)	
mean (sd)	13.0 (4.52)	1.93 (0.69)	

Table 5. Comparison of Factitiousness, Masochism, Obsessiveness and Compulsiveness Traits in Both Groups. **p<0.01

6a: Correlation r in FD group	**FAC22-SR**	**Masochism trait**	**Obsessiveness**	**Compulsiveness**
FAC22-SR	-	0.270 (<0.001)	0.666 (0.102)	0.889 (<0.001)**
Masochism trait	0.270 (<0.001)	-	0.521 (0.079)	0.454 (0.044)*
Obsessiveness	0.666 (0.102)	0.521 (0.079)	-	0.541 (0.048)*
Compulsiveness	0.889 (<0.001)	0.454 (0.044)	0.541 (0.048)	-
6b: Correlation r in DDs group	FAC22-SR	Masochism trait	Obsessiveness	Compulsiveness
FAC22-SR	-	-0.136 (0.046)	0.063 (0.925)	0.031 (0.449)
Masochism trait	-0.136 (0.046)	-	0.187 (0.034)	0.191 (0.590)
Obsessiveness	0.063 (0.925)	0.187 (0.034)	-	0.254 (0.055)
Compulsiveness	0.031 (0.449)	0.191 (0.590)	0.254 (0.055)	-

Tables 6a & 6b. Correlation Tables for Individual Traits for Both Groups. *p<0.05, **p<0.01

Facsimile Assuming Convincer 22 –Self-Report scale Senthil & Praphaukar, 2019, FAC22-SR	Yes /No
1. With my physical symptoms, I affirm being referred for psychiatric counselling today. 2. I do agree that others find my symptoms atypical and unusually recurring. 3. I do think that because my symptoms are so mild/trivial, physicians often miss their significance and seriousness. 4. I would be happy if I can suddenly find myself sprightly healthy and strong. 5. I would be anxious if I find my family members had left for their work as/if I appear healthy to them. 6. It is just chance that people fail to notice or weren't around, every time when I experienced these symptoms. 7. I would pull myself up to help (with errands or earning) a family member more sick than me. 8. (If I had to play in a video game or a stage play) I would prefer portraying an injured warrior dying in bed, than one left unattended in battle. 9. I usually feel timid and offended when a stranger offers to help me. 10. I am eager and brave enough to undergo painful bodily investigations. 11. I would prefer crying or lamenting to a close friend, than crying alone. 12. I feel giddy or immobilised often when I get emotional when alone. 13. I would feel ashamed if people find about my physical illness. 14. I often get gloomy, unsatisfied or irritable on the day of my discharge from hospital.	
15. I might not have accessed the physician but for the erratic concern shown by my family members/friend(s). 16. I find my clinical tests and lab investigations done too casually to get any positive result. 17. I feel unsatisfied and deprived when the health professionals show lesser than usual interest in talking with me. 18. I understand that people with my symptoms may or may not be hearing voices when alone, either transiently or regularly. I hear such voices too. 19. I understand that people with my symptoms may or may not have visual loss, either momentarily or regularly. I have had visual loss too. 20. I understand that people with my symptoms may or may not have weakness/abnormal movements of one or more limbs, either momentarily or continuously. I have had such weakness/abnormal movements too. 21. I have encountered interesting adventures that had been brilliant and wonderful, and/or a series of heart-breaking tragic events including multiple personal crises -many times victimizing me. 22. Wherever I go, many a time I have had the pleasure of playing a hero/heroine of those circumstances and had been wondered at and hailed as a saviour by the people there.	

Total (Score 1 each for Yes to items 5, 8, 10, 11, 14-22, and No to items 1-4, 6, 7, 9, 12 and 13. A score of 9-14: possible factitious disorder; 15 or more: probable factitious disorder)	

Table 7. FAC22-SR Scale for Factitious Disorder

Gains (Predominant)	Factitious Disorder n (%)	Dissociative Disorders n (%)	Statistic χ2 (p Value)
Emotional	20 (66.7)	16 (53.3)	4.44 (0.349)
Financial	2 (6.7)	0 (0)	
Social/cultural	1 (3.3)	1 (3.3)	
Sexual	3 (10)	7 (23.3)	
Marital	4(13.3)	6 (20)	

Table 8. Frequency of Types of Gains in FD Group

DISCUSSION

In this study 86.6% factitious patients were mid-adults (25-34 years of age), similar to 82% in the study by Jimenez et al.[20] This is contrary to the studies by Krahn et al, and Yates and Feldman, where a staggering 49.2 to 50.4% patients were over 40 years of age. The FD group here had predominantly females similar to 90% in Jimenez et al, 72% in Krahn et al, and 66.2% in Yates and Feldman.[21,22] The same study showed 16.1% being unemployed, against 63.3% in this study. In contrast to 27% seen in Yates and Feldman, and 44% in Krahn et al, only 6.6% were occupied in healthcare related areas in this study.

Here neurological motor symptoms were more frequent, in contrast to studies like Yates and Feldman where 13% presented with endocrine, 9.7% each with cardiac and dermatological symptoms.

In this study, over three-fourths showed moderate to severe scores both in obsessiveness and compulsiveness. This was similar to the intense compulsiveness (77.8%) in the study by Yates and Feldman, but contrary to the classical study by Carney and Brown where 26% had nil to subclinical (unacknowledged) repetitive thoughts, 12% were predominantly obsessive with acknowledged psychological motives, and 32% were predominantly and compulsively attention seeking.[23] The obsessiveness was about 17.2% and repetitive compulsive healthcare seeking in 30.1% of factitiously ill patients in the study by Krahn et al. This study showed disorder level masochism in 37.5% FD patients, comparable to Krahn et al which showed self-harming masochist behaviour in at least 30.3% of patients, but lesser than 58.7% seen in Yates and Feldman.

Emotional (67%) and spousal (23%) were common gains, similar to a study by Jimenez et al which showed both kinds of gains in about 100% and 13% of patients.[20] Krahn et al showed emotional gains in 69.9% (including 22.6% abuse history) and gains in immature relationship issues in 20.4% of patients.[21]

Factitious disorder may be refractory to treatment as the patient usually exhibits persistence and compulsiveness in the voluntary behaviour. The deliberateness and repetitiveness are driven by any or all of the following: desiring circumvention of or relief from an incompletely dissolved, corroding and intrusively obsessive guilt, craving to be understood and served under, enforcing care and relishing the resultant gratification, exhibiting masochism as a quencher of intrapsychic conflicts,[9,13] acquiring an emotional solace following loss of a family member or job, recreating childhood symptoms of illness or abuse –to forge a sense of control of situations, and occasionally a subconsciously driven vendetta against an acquaintance from the past, condensating in the present against similar-behaving caregivers or family members, especially those reminiscent of childhood abuser.[24] Perpetrators include early disruptive attachments, possible parental modelling, and identity conflicts.[13] Most of these scenarios indulge defenses like displacement, reaction formation and acting out, among others.

Quite infrequently, mere narcissistic needs of assigning oneself with a sense of role, identity and purpose in life, especially when having an anomic background, may be the only delineated cause. Positive reinforcement with care and nurturing by health system, coupled with neglect or victimization by family members during the neurodevelopmental period, may also etch a stronger attention-seeking behaviour later. Very rarely fabricating may be a part of proving to others and assuring himself or herself of being sick or as a victim of abuse, in hypochondriasis and delusional disorders respectively.[10]

Secondary gains included momentary evasion from punishment – utilizing the sympathy, and allowance or leniency in the continual of same devious behaviour under the pretext of being sick or from an inertial or wishful unwillingness to change to a more disciplined person. Masochism here fall along the lines of borderline personality traits, especially enacted in parasuicidal/intentional self-harm behaviour, and compulsiveness mimics the salience of alcohol dependence in some facets. The diagnosis of factitious disorder metamorphoses into malingering once the patient starts to have frank inclinations to monetary or material gains.

Compulsiveness and subjective gratification from feigning or fabricating symptoms may be considered parallel to that experienced in patients with kleptomania and paraphilia.

Just as some quantum of factitiousness may creep after months and years in patients with physical illnesses with functional overlay and in dissociative disorders,[25]

malingering may be an endpoint in at least one subtype of fastidious patients.

Management

Fatalities from factitious self-harming behaviour approximate up to ten percent.[26] Only a third accept the charges of fabrication, and one in ten consent to psychological treatment.[27] Revelation of factitious disorder may bring in intense denial in the patient, and expressed emotions from the caregivers, besides amplifying the subterranean hostility shared with the treating physician and psychiatrist.[1] Immature defenses, overt sensitivity to narcissistic injury, and personality disorders, make successful therapeutic alliance and long-term therapy with mental health professionals essential for a good prognosis. Hence non-confrontational strategies including face-saving approaches like symptom legitimization with double-bind, self-hypnosis and inexact interpretations, focussing on the feeling of control over recovery.[28] Initial decriminalization strategies like projecting the behaviour as a manifestation of great, unsatisfied emotional needs, and focussing on his or her genuine needs, would both deescalate the apprehension of the sting of humiliation and address the psychological conflicts at once.

Minimizing harm can early diagnosis and avoiding invasive procedures, attendance in interdisciplinary meetings, treating mood and personality disorders, fixing a 'gatekeeper' primary caregiver, and initiating prosecution for fraudulent behaviour as a disincentive.[10] Long term psychological follow-up, and more stable relationships and social networks are important for a better prognosis. Factitious disorder imposed on others, just like paedophilia, narcotic abuse and outward physical aggression, carry a need to be criminalized, in view of expectant harming behaviour.

CONCLUSIONS

Gains have been proved as the driving force in conversion as well as factitious disorder, a mixture of primary and subtle secondary gains in factitious disorder acting as psychological feeders to quench the hidden narcissistic cravings.

The need for early pick-up of the diagnosis of factitious disorder is that misdiagnosis may result in a chronic course with costly and unwanted surgeries or medications which may result in permanent physical disabilities in the patient and physical and psychological strain in caregivers.[24]

Correlation of factitiousness with compulsiveness and inflexibility as forms of persistence, and overt acting out, implies deployment of level III defenses including reaction formation.[29]

Modeling, improvement of self-esteem, stigmatizing adoption of sick role, can deter from feigning, besides appropriate psychoeducation on social complications including risk of abandonment by caregivers and family members upon revelation of the patient's true intentions. Evaluation, and medical and behavioural treatment of comorbid borderline or other cluster B personality disorders, depression or PTSD (in past abuse), and addressing coping skills, would prove useful in chronic and refractory cases.[30] Treating obsessive compulsiveness and self-harming/self-defeating behavioural attributes may help in positive outcomes.

Limitations

Munchhausen by proxy has not been considered in the proposed new factitious disorder tool. Other factors like borderline, narcissistic, histrionic and dependent personality traits, guilt, gratification, institutionalization, mothering and altruism, could not be included in the study, which would have been a comprehensive consideration of the relevant variables. A larger sample size and these inclusions in future studies would be more useful.

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