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Letter to the editors
Carta aos Editores

Factitious Disorder and the Interdisciplinary Team: identification of signs and risk factors

Transtorno Factício e a Equipe Interdisciplinar: identificação de sinais e fatores de risco

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During the last decades, there has been a considerable increase in publications related to the analysis of diagnoses and their impact on the clinic, especially due to the demand to minimize the number of examinations, diagnostic errors, overdiagnosis and unnecessary interventions. Such increase seems to be related to the desire to attenuate the medical community and correlated professions for aspects to be observed during the objective and subjective clinical evaluation of the health of the patient and his situation[1]. The detailing of the problem, as well as the environment in which it emerges, is increasingly seen as crucial to underpin the understanding of diseases, grievances and their management.

In the speech-language and hearing field, this active need to look for details of the clinical history and the environment in which the patient is inserted is not new. It is well known that speech therapists, as well as other health professionals in general, who assume the therapeutic role for themselves, must direct their listening to the problems of the people in their complexities, with an integral approach[2].

Considering that this professional usually has weekly contact, creating a therapeutic and affective bond with his patients, it is extremely important that he seeks to understand the particularities and disorders (including knowing signs, symptoms and risk factors) and to direct, whenever necessary, becoming inclusive a link between the patient and the attending medical professional.

However, there has also been an increase in reported and published cases of disorders and syndromes, often psychiatric, that are similar to cases of patient simulators[3] and conversions. With this, it becomes increasingly clear the importance of professional speech-language pathologists to know about such disorders, signs, symptoms and risk factors that may signal the need for referral and that, when they are found, can positively influence decision making regarding diagnosis and prognosis of these patients. One of the syndromes that walks in this direction and about which it has been spoken is the syndrome of the Factitious Disorder.

Such syndrome is classified as a disorder in which there is the manufacture or induction of signs and symptoms in a conscious and intentional way of a physical, emotional or cognitive disorder, and may even be adulterated by laboratory tests[4,5].

Such fabrications are performed in order to obtain care, medication and / or hospitalizations, however, unlike cases of patients with financial or personal interests in hospitalizations and medicalization, the reported cases of this syndrome seem to present only internal and unconscious motivation in which there are a need to remain under professional care, to receive medical attention and care from health care professionals.

Autoimposive Dysfunction or Münchausen Syndrome, as it was previously known, was first described in 1951 by Richard Asher when analyzing individuals who purposefully invented

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symptoms of certain diseases to seek specialist follow-up[4,5]. This disorder was entitled "Münchausen Syndrome" in honor of Baron Karl Friedrich Hieronymus Freiherr von Münchhausen who, after joining the Russian armed forces, became known for telling fantastical and ghostly stories about the battles he participated against the Ottoman Turks[4,6]. The disorder is also known as "hospital dependency", "professional patient syndrome", "hospital addiction syndrome" and "hospital hopper syndrome".

Later, in 1977, the term was re-meaning, to better describe the cases of children whose parents referred diseases and symptoms that, when analyzed, were found to be made of falsehoods; for this, the nomenclature was created at that moment of "Münchausen syndrome victms by aberrant adult behavior"(Münchausen syndrome by proxy), currently known as" Factitious disorder imposed on another"[7]. Factitious disorder imposed on another is considered a form of psychic abuse in childhood according to the classification proposed by the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM V)[8].

In this case, it is the caregiver who perpetuates the patient's symptomatic condition by adulterating or producing clinical histories, laboratory evidence and/or physical injury leading to unnecessary hospitalizations and medications, therapeutic and surgical procedures, and misdiagnoses[7,9]. Such a perpetuator is commonly identified as the mother, however, there are cases where it is possible to observe the child's symbiotic participation[6,10].

In this context, there are signs mentioned in the literature to which speech-language pathologists must be alert, with the most frequent being frequent reports of food poisoning (intermittent vomiting), diarrhea, seizures, apnea; patients who are frequently observed during central nervous system depression (under the effect of analgesics and sedatives); constant cutaneous lesions, bleeding, pathological behavior present only when there are observers present and who constantly refuse to accept high treatment (creating new demands)[5,6,10]. In addition, it is necessary to be aware of risk factors that can be commonly verified, such as unexplained symptom sets, recurrent hospitalizations, and caregivers who have too much health knowledge, often knowing terminology and detailed procedures of the medical routine.

When it is suspected of self-imposed Factitious Disorder and/or Factitious disorder imposed on another, this must be reported to the entire attending team and the monitoring of the patient and those who live with him, especially children, must be very close and of an interventionist nature, seen that the prognosis is reserved.

The Factitious Disorder has no known prevalence, however, it is estimated that about 1% of hospitalized patients meet the diagnostic criteria[8]. This disorder, even of low occurrence, has a high impact on the life of the affected subject and the people around him, as well as high costs for the systems that serve him, since these patients usually migrate between services[7,9].

Such a cost increase is generated mainly due to unnecessary and inconclusive exams and procedures, treatment of under diagnostics and erroneous diagnoses that may arise during the period of interaction with this population, prolonged stay in professional follow-up because there is no concrete diagnosis and development rapid "complications" in patients starting the investigation, but there is no confirmed diagnostic hypothesis.

The diagnosis of Factoid Disorder is based on the combination of evaluation and observation of different professionals, including in diverse moments and situations, which highlights the importance and necessity of interconsultations and an interdisciplinary action in order to complement the integral understanding of the case. However, such a diagnosis must also be extremely considered, since once it has been identified, described and accepted (or not) by the family, irremediable consequences may arise.

Thus, it is evident the relevance and importance of speech-language therapists to be aware of the existence of this syndrome and how to proceed when encountering such patients. In addition, the role of this specialist, whether in evaluations, re-evaluations or consultancies, as well as that of other professionals with a therapeutic link, is increasingly seen as essential for a precise and differentiated diagnosis, since it provides an interesting exchange of information and between professionals.

REFERENCES

1. Graber ML. The incidence of diagnostic error in medicine. BMJ Qual Saf. 2013;22(Suppl 2):ii21-7. http://dx.doi.org/10.1136/bmjqs-2012-001615. PMid:23771902.
2. Mesquita A, Carvalho E. A Escuta Terapêutica como estratégia de intervenção em saúde: uma revisão integrativa. Rev Esc Enferm USP. 2014;48(6):1127-36. http://dx.doi.org/10.1590/S0080-623420140000700022. PMid:25626514.
3. Rodrigues DB, Freitas GA, Farias AEM, Amorim-Gaudêncio C. Simulação de sintomas e transtornos mentais: Uma revisão crítica do fenômeno para a psicologia. Estudos de Psicologia (Natal). 2016;21(2):134-45.
4. Sousa D Fo, Kanomata EY, Feldman RJ, Maluf A No. Munchausen syndrome and Munchausen syndrome by proxy: a narrative review. Einstein (Sao Paulo). 2017;15(4):516-21. http://dx.doi.org/10.1590/s1679-45082017md3746. PMid:29364370.
5. Oner E, Unlu M, Solgun B, Kocyigit H, Cimen P. A case of factitious bleeding: munchausen s syndrome. Journal of Evolution of Medical and Dental Sciences. 2015;4(48), 8416-19. http://dx.doi.org/10.14260/jemds/2015/1219.
6. Mehl AL, Coble L, Johnson S. Munchausen syndrome by proxy: a family affair. Child Abuse Negl. 1990;14(4):577-85. http://dx.doi.org/10.1016/0145-2134(90)90105-3. PMid:2289187.
7. Rosenberg DA. Web of deceit: a literature review of Munchausen syndrome by proxy. Child Abuse Negl. 1987;11(4):547-63. http://dx.doi.org/10.1016/0145-2134(87)90081-0. PMid:3322516.
8. APA: American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-V). 5th ed. Arlington: APA; 2013.
9. Wittkowski H, Hinze C, Häfner-Harms S, Oji V, Masjosthusmann K, Monninger M, et al. Munchausen by proxy syndrome mimicking systemic autoinflammatory disease: case report and review of the literature. Pediatric Rheumatology. 2017;15(1):19. http://dx.doi.org/10.1186/s12969-017-0152-6. PMid:28381287.
10. Lacey SR, Cooper C, Runyan DK, Azizkhan RG. Munchausen syndrome by proxy: patterns of presentation to pediatric surgeons. J Pediatr Surg. 1993;28(6):827-32. http://dx.doi.org/10.1016/0022-3468(93)90337-K. PMid:8331513.

Author contributions

AVP, CGMB, MRG and BNGG idealized the letter to the editor, discussed, analyzed and drafted the letter. All authors reviewed and approved the final version of the letter.