

# Challenges presented by Munchausen syndrome

Munchausen syndrome does not fall into the category of an ordinary somatic, psychological or psychosomatic illness, and its identification, diagnosis and treatment present an unusually great challenge. How can one best help patients?

We would like to focus attention on a condition that we regard as misunderstood, underdiagnosed and incorrectly treated: Munchausen syndrome. We all have many years of experience of treating patients with this syndrome, and want to contribute to increased attention to and understanding of these patients, and how best to help them.

The designation «Munchausen syndrome» was introduced by the English psychiatrist Sir Richard Asher in 1951. He named it after Baron von Münchhausen, an 18th century German nobleman who was known for his fanciful tales (1). In ICD-10, Munchausen syndrome is classified as F68.1: Intentional production or feigning of symptoms or disabilities, either physical or psychological.

## Aetiology and comorbidity

Behaviour in Munchausen syndrome is assumed to reflect an underlying desire for attention, compassion, sympathy and in some cases addictive medicine (assuming that this last is not the primary motive). The urge can be so strong that the patient consents to and in some cases desires invasive examinations and operations, even at the risk of complications, pain and discomfort.

It is possible that curiosity as to how doctors will react to the next hospitalisation, and the power deriving from excitement and a sense of superiority over a non-plussed health personnel may be contributory factors. In some cases, the notion of taking revenge on health workers, prompted by negative experiences in previous hospitalisations, appears to play a part. Many of the patients work within the health service (2), the explanation given being that some individuals in these occupations may feel emotionally drained to the extent that they themselves develop a desire for care (2).

As the patients do not as a rule cooperate with researchers, or in a psychiatric evaluation or treatment, their motivation is usually unknown, and it is very difficult to give a precise description of and to quantify underlying psychological disorders. In the most extensive study so far, an analysis of 455 cases from professional literature, a subsample of 170 patients was assessed for psychiatric disorders (3). Comorbid psychopathology was found in over 80 % of them. A current or earlier diagnosis of depression was recorded considerably more frequently than a personality disorder (41.8 % versus 16.5 %). On the other hand, only one in seven patients in the same subsample was currently suicidal or had a history of suicide attempts. A large percentage of this sub-

sample thus had a diagnosis of depression, in contrast to earlier ideas, where a strong association with personality disorder was seen (2), particularly of the borderline type (4).

In addition to mental illness, there are numerous examples of major and in some cases life-threatening self-induced and/or iatrogenic organic disorders (3). It has also been postulated that there may be relatively

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high mortality attributable to self-inflicted physical harm, complications after invasive procedures and camouflaging of important health information (5). In other words, the patients' suffering is considerable.

## Clinical presentation

Symptom pictures and clinical presentations vary widely. The following are some of the symptoms, induced findings and previous misdiagnoses referred to in the literature (3) or observed in our patients: injection of insulin to cause hypoglycaemia, complaints of retrosternal pain, self-inflicted skin lesions, simulated asthma attacks, self-inflicted corneal lesions, heated thermometer to simulate fever, introduction of blood to urine (either into the urine sample or through a catheter into the bladder), using a pupil-dilating substance to cause anisocoria, taking medicine to produce hypertension or alter blood samples, self-venesection to induce anaemia, induction of vaginal bleeding, false reporting of HIV/AIDS or cancer, the use of a tourniquet to cause swelling of an extremity, self-induced diarrhoea, simulation of epileptic attacks, coma or paralysis, complaints of chronic pain and simulation of deafness or blindness.

In the aforementioned meta-analysis, two of three had a self-induced disorder or injury (3). Patients simulated illness or falsely reported it somewhat less frequently. In our experience, patients seldom admit to simulating. When they realise they are on the verge of being suspected of being mentally ill rather than having a somatic disorder, most of them leave the health institution. Suspicion may be aroused by the

observation of a special behavioural pattern (Box 1) (5).

Patients with Munchausen syndrome often start their behaviour in early adulthood, frequently after hospitalisation for a somatic or mental disorder. There are differing accounts of gender distribution in international literature. A preponderance of men is reported most frequently, but some indicate a preponderance of women (2, 3), which is consistent with our personal experience.

## Differential diagnoses

The syndrome differs from simple simulation, where an external reward is sought, such as avoiding legal problems or achieving financial gain. This is malingering – Z76.5 in ICD-10.

The syndrome must also be distinguished from somatisation disorder, where patients over a long period of time exhibit physical symptoms that are not voluntary and that are experienced as real, without findings of any underlying organic disorder. Similarly, the mental and physical symptoms of dissociative disorders are assumed to take place at the unconscious level, in contrast to those in Munchausen syndrome.

## General observations

There are no good studies of incidence or prevalence in the general population in international literature. There are clearly high unreported figures (6) and almost insuperable methodological challenges.

Most doctors are reluctant to suspect patients of simulation. We are used to fraud and lies occurring not infrequently in everyday life, but as a doctor one is trained to trust the patient almost unreservedly. When suspicion is in fact aroused, doctors often fail to go further in that direction for fear of overlooking an organic diagnosis, with ensuing negative reactions from the patient and potential liability for damages.

A possibly even greater obstacle is the trouble and work involved in widening the investigation and reviewing previous diagnoses, especially when these have been made at other hospitals. In most cases, doctors feel they may avoid further problems by discharging the patient as quickly as possible, hoping that they will not return. The result is enormous abuse and overuse of health services and, not least, the risk of irreversible harm to patients as a result of unnecessary invasive examinations and repeated operations. In some cases, the injuries the patients incur as a result

## BOX 1

**Main observations that point towards malingering and factitious disorders (from Cruz-Portelles et al. (5) by permission).**

Atypical, dramatic, vague and inconsistent presentation of symptoms although apparently plausible

Sometimes technical medical words slip out

Inconsistency between medical history and objective findings

Perfect descriptions that resemble a medical textbook

Large number of admissions into different hospitals with a long medical history

Employed or trained in a branch of medicine

Visits to the emergency department when the most experienced staff is not available (holidays, in the evenings and weekends)

Indifferent acceptance of risky and invasive procedures

Emergence of symptoms only when the patient is being observed

Abuse of drugs, especially prescription painkillers or sedatives

Hostile, controlling patients, particularly when they are not heard or when questioned about their background or medical history, or when they are asked documentation as proof of illness

Apparent development of complications or change in the initial clinical symptoms when the suggested disease has been ruled out

of medical treatment are greater than the injuries they inflict on themselves (2, 7, 8).

In our experience, the resources spent on these patients may be greater than on patients with real organic conditions. Treatment of patients with Munchausen syndrome often leads to conflict in a department. This takes time that could otherwise have been spent on other patients. We cautiously estimate that the costs for each of our patients have averaged over NOK 1 million. This includes stays in intensive care departments and disbursements from the Norwegian System of Patient Injury Compensation. These costs can be compared with those calculated for the USA (2).

The Internet and social media provide new platforms for seeking attention and sympathy, giving vent to anger and control of others (9). It is alarming to see how easily these frauds can be carried out, how difficult it is to discover the perpetrator and how extensively some victims may be harmed (10).

It is important to bear in mind that also

patients with Munchausen syndrome may have an organic disease, like anybody else. Consequently, every patient with known Munchausen syndrome who presents with a significantly altered symptom picture has the right to a thorough diagnostic evaluation. This can only be reduced if it can be documented once again that the findings are factitious. The plethora of induced symptoms and findings makes this a major challenge, of course.

The clinician can now find support in 190 relevant publications. On the basis of these, a relatively long list has been prepared of laboratory and technical aids in 13 medical areas (11). Of course, the list can never be quite complete, and the most important tool continues to be the doctor's common sense.

## Treatment options

Treating patients with Munchausen syndrome is difficult, as most of them avoid a psychiatric evaluation. In the few cases where there is communication with the patient, the treatment must target the underlying mental problems.

If there is a previously described mental illness, for example a severe depression, for which there is a specific treatment, and the pathological behaviour may be secondary to this, the primary disorder can be treated with the hope of getting the patient to stop simulating illness at the same time. However, it is rare for psychiatric or possibly medicinal treatment alone to motivate patients to stop their self-harming behaviour and thereby put a stop to the suffering the persons concerned inflict on themselves and on others.

In Norway, all inhabitants have a personal identity number. This provides a good possibility of identification and relatively high transparency when a comprehensive discharge summary with the diagnosis F68.1 is sent to other involved health institutions. We have followed our patients for several years (in one case for 15 years) and have been able to show that sending a detailed discharge summary, not only to the primary doctor and referring doctor or health institution, but to all health enterprises that the patient has been in contact with according to their own verified information, has resulted in the person concerned either stopping their behaviour or having their activity considerably reduced.

In our experience, the distribution of discharge summaries with the diagnosis F68.1 is seldom used by other doctors. The reason seems to be that many are uncomfortable about this approach, feeling that they stigmatise the patient. However, in our view, attempting to protect the patient against serious self-inflicted and iatrogenic injuries, which sometimes put their lives at risk, is an ethically higher objective than passively accepting that the patient continues in his or her behaviour.

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