

Fabrication or Fact? Navigating Ethical and Clinical Challenges in Diagnosing Factitious Disorder

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Abstract

Background: Factitious disorder (FD) is a complex psychiatric condition characterized by deliberate falsification or induction of symptoms to assume the role of a patient, driven by internal psychological needs rather than external rewards. Despite its rarity, FD poses significant diagnostic and ethical challenges in clinical practice.

Methods: This paper explores the nuances of diagnosing and managing FD through two contrasting case studies, underscoring the risks of both overdiagnosis and underdiagnosis.

Results: The first case details a patient with a history of multiple hospitalizations and symptom exaggeration, ultimately revealing a clear pattern of factitious behavior. Despite accumulating evidence, clinicians hesitated to assign the FD diagnosis due to ethical concerns and fear of damaging the therapeutic relationship. This avoidance resulted in repeated iatrogenic harm, violation of ethical principles such as non-maleficence, and delayed psychiatric intervention. In contrast, the second case describes a patient who was prematurely labeled with FD in the absence of sufficient evidence, leading to delayed care for a genuine medical condition and a breakdown in trust with the healthcare system.

Conclusion: These cases highlight the need for a deliberate, evidence-based, and ethically sound approach when considering a diagnosis of FD. Clinicians must balance the imperative to avoid harm with the duty to promote patient well-being through honest communication and appropriate treatment. Non-confrontational approaches, while preserving rapport, may inadvertently reinforce deceptive behaviors or delay psychiatric care for patients with FD. Ultimately, diagnosing FD responsibly requires clear evidence to support clinical suspicion, awareness of unconscious bias, and the use of standardized communication strategies to ensure that patients receive compassionate and appropriate care.

Introduction

Factitious disorder (FD) is an illness where a patient falsifies or induces physical or psychological symptoms to manipulate the care team. These deceptive behaviors are exhibited in attempts to assume the role of a sick person. While the individual is fully aware of their behaviors and intentions to manipulate medical providers, they may or may not be aware of the motive for such behavior, which is to fulfill the need to be taken care of and to reduce the anxiety that results from this unmet need¹. The primary gain of reducing anxiety by assuming the sick role marks factitious disorder as a psychiatric disorder that distinguishes it from other deceptive behaviors, such as malingering.

The prevalence of FD remains uncertain due to underreporting and diagnostic challenges. However, it is recognized as a rare yet clinically significant psychiatric condition that necessitates a nuanced approach. In medical settings, FD imposes diagnostic and management challenges². Unlike many other conditions, providers may hesitate before they confirm the diagnosis, have a transparent conversation with the patient, or navigate providing care for the feigned or induced symptoms. A careful and comprehensive evaluation is needed to avoid iatrogenic consequences stemming from unnecessary tests and therapies yet treat a patient who becomes truly ill because of the factitious behaviors.

While FD can be diagnosed from one care episode if adequate information is available to support the clinical suspicion, the diagnosis is often delayed until a pattern of frequent and usually similar care encounters is noted or discovered in review of medical records^{3,4}. In these encounters, objective findings that contradict subjective reports are common, and the patient may be directly observed engaging in manipulative behaviors or symptom induction. Delay in making the diagnosis of FD may result in consequences of repeated iatrogenic injuries, longer intervals before a patient is referred to psychological interventions that target the factitious psychopathology, and significant waste of human and financial resources for the medical system⁵. On the other hand, making the diagnosis of FD based on unfounded suspicion has its own consequences: a patient may be denied needed interventions or therapies and – as a result – suffer from medical neglect and psychological distress.

Taken together, these challenges underscore the need for a more structured and ethically informed approach to assessing FD. We present two contrasting cases that illustrate the clinical and ethical consequences of both delaying an FD diagnosis and assigning the diagnosis without sufficient evidence. These examples demonstrate how the misapplication or avoidance of a FD diagnosis can result in iatrogenic harm, the erosion of the therapeutic relationship, and missed opportunities for appropriate psychiatric intervention. By comparing these cases, we aim to clarify practical considerations for clinicians and highlight the necessity of ethically proportional, evidence-based decision making when FD is suspected.

Material and Methods

This article examines two cases of adult patients hospitalized at the University of Michigan Medical Center (UMMC) whose clinical encounters raised diagnostic questions related to factitious disorder. Case one was selected based on the involvement of inconsistent medical presentations and deceptive behavior prompting consideration of FD, as supported by DSM-5 criteria (1)

identified deception involving falsification of physical symptoms; (2) individual portrays himself as ill or impaired; (3) deception is evident in absence of external rewards; (4) another mental disorder does not better explain the behavior)². Case two was selected based on chart documentation of FD that was inconsistent with patient behavior, and was not supported by documentation of any DSM-5 FD criteria. These cases were identified retrospectively through clinical involvement by the authors and subsequent review of the patients' electronic medical records.

For each case, a comprehensive chart review was performed, including all available inpatient and outpatient documentation across UMMC, as well as outside hospital records when accessible. Data extracted included objective clinical findings, diagnostic testing, documented clinician observations, patterns of healthcare utilization, medication history, and any prior psychiatric or FD-related assessment. Particular attention was paid to discrepancies between reported symptoms and objective findings, the presence or absence of documented deceptive behaviors, and the application or misapplication of DSM-5 criteria for FD. The authors assessed whether documented findings met minimum diagnostic thresholds for FD, and whether alternative diagnoses were adequately explored (including somatic symptom disorder, malingering, and functional neurologic disorder—neither patient met criteria for any of these disorders). The authors then assessed how a diagnosis of FD (or lack thereof) influenced patient care, communication, and clinical outcomes.

Case Presentations

Case 1

MM was a 32-year-old female with a charted history of gastroparesis, postural orthostatic tachycardia syndrome, psychogenic non-epileptic seizures, chronic abdominal pain, and severe malnutrition. Her limited oral intake had previously been managed with total parenteral nutrition (TPN), which had been discontinued due to recurrent deep vein thromboses. She presented to the emergency department with alleged severe abdominal pain and poor oral intake after 16 days of TPN discontinuation. Upon arrival, her vital signs were stable, and her physical examination revealed diffuse abdominal tenderness. Laboratory results were within normal limits without evidence of malnutrition, dehydration, or electrolyte disturbances. MM was admitted for pain control and consideration of nutritional support options, including jejunostomy tube placement. Due to previous gastrostomy tube failures, the team initially advised against further tube placement and recommended outpatient follow-up for abdominal pain and resumption of TPN for nutritional optimization.

Early during her admission, the patient's demands for opioid medications increased, and there was clear evidence of symptom exaggeration and medication-seeking behaviors. For example, MM was noted to immediately start showing pain gestures when approached by nurses or other medical staff, while she had not been in distress before their arrival. When MM was confronted with this clinical suspicion, she exhibited several seizure-like episodes. These behaviors prompted the team to look deeper into her medical records. This revealed a pattern of repeated medical encounters in several health systems with contradicting information and inconsistent findings. Observations concerning deceptive behaviors, such as pulling out gastrostomy tubes, symptom exaggeration, and drug-seeking behaviors, were documented on several occasions. Despite being maintained on opioid medications, records revealed that MM presented to emergency departments every two to three weeks, asking for intravenous (IV) opioid treatment. Furthermore, despite a charted diagnosis of gastroparesis, her gastric emptying scan report was normal, raising concerns about her reported diagnoses. Given that MM's use of opioid medications began after multiple invasive gastroparesis interventions, opioid use disorder (OUD) secondary to FD was suspected. There was insufficient evidence to make an official OUD diagnosis, as chart review did not show any documented use of unprescribed opioids, and MM denied all OUD symptoms. While at times MM appeared to be seeking opioids, this did not seem to be her primary focus. She continued to pursue medical procedures and extending her hospital stay as long as possible, even when the care team set clear limits that her opioid dosages would not be increased, indicating an active factitious psychopathology regardless of the presence or absence of external reward. Despite the evidence and documentation of suspicious factitious behaviors in several care episodes, the psychiatry team preferred to focus on addressing the patient's distress and ultimately refrained from making the FD diagnosis for unclear reasons. Under the threats of leaving against medical advice, MM's opioid doses were increased. Toward the end of her admission, her TPN was restarted, and a follow-up appointment was scheduled to discuss surgical interventions.

Case 2

ZT was a 55-year-old female with a medical history including hypothyroidism, chronic opioid and benzodiazepine use, status-post sleeve gastrectomy complicated by intestinal malabsorption, and subsequent reliance on TPN for nutrition. She was brought to the emergency department by her husband after he found her obtunded at home. She reported a five-day history of fever, diffuse abdominal pain, and intermittent emesis.

In the emergency department, she was febrile to 102.3°F,

normotensive, and mildly tachycardic. She required supplemental oxygen. Her initial laboratory results were largely unremarkable except for a mildly elevated procalcitonin level. A chest X-ray revealed a new right upper lobe consolidation, raising concern for pneumonia. Blood cultures were positive for methicillin-resistant *Staphylococcus epidermidis* (MRSE), and she was started on wide-spectrum antibiotic therapy. Her MRSE bacteremia persisted for four days. An esophagogastroduodenoscopy and transesophageal echocardiogram showed no acute abnormalities. After 11 days, she was discharged on oral antibiotics and resumed TPN.

While hospitalized, ZT revealed that she had been reluctant to seek medical care at symptom onset due to shame and embarrassment surrounding a previous diagnosis of FD that she was assigned in recent admission at an outside hospital. To better understand this diagnosis, the inpatient team undertook an extensive chart review of that admission and several other hospital encounters. However, documentation from the outside medical team showed no clear rationale for an FD diagnosis: there were no unexplained symptoms, no contradictory reports and findings, or observation of symptom induction or deceptive behaviors documented. The absence of documented diagnostic criteria or clinical reasoning made it impossible to substantiate the original diagnosis of FD. Given the lack of supporting evidence, the current inpatient team had a low suspicion for FD and concluded that the previous diagnosis of FD was not supported by any DSM-5 criteria. Accordingly, the diagnosis was removed from her medical history.

Discussion

These cases highlight how both delayed and premature assignment of a FD diagnosis can result in significant clinical and ethical consequences. In MM's case, hesitation to name FD, despite clear and recurrent factitious behaviors, led to escalating iatrogenic harm, inappropriate opioid exposure, and missed opportunities for timely psychiatric intervention. In contrast, ZT's case demonstrates how inaccurately labeling a patient with FD can undermine trust, delay necessary medical care, and compound psychological distress. Together, these cases underscore the importance of minimizing clinical uncertainty and grounding any FD diagnosis in documented DSM-5 criteria, to the best of a provider's ability.

Clinical uncertainty is a critical, objective, or non-personal reason why FD diagnosis is often delayed or not made at all^{6,7}. FD is a clinical diagnosis, and although laboratory findings and other objective data may raise concerns for FD, they do not—on their own—confirm the diagnosis. While hospital-based physicians may encounter cases of FD in their work setting, this exposure is limited

compared to other conditions commonly treated in hospital settings. Limited exposure to FD creates further clinical uncertainty and makes it more challenging for general providers to confirm this diagnosis. With FD progression, patients may develop more sophisticated deceptive skills that can exacerbate clinical ambiguity and result in more hazardous interventions⁸. Some of these behaviors include presenting with vague and unspecific symptoms, using a false identity, falsifying test results and medical records, and changing geographical locations to avoid receiving care within connected health systems. Patients may present with true sickness due to induced symptoms, which further contributes to medical ambiguity, and providers may have a higher threshold for diagnosing FD out of fear of consequences of making a false diagnosis (psychological insult to the patient, stigma, shame, and denying care in the future). This is particularly true when the patient only engages in symptom exaggeration rather than fabrication or induction.

Existing literature supports the patterns observed in these cases. Prior studies have described how delayed recognition of FD can lead to unnecessary diagnostic testing, invasive procedures, prolonged hospitalizations, and increased healthcare utilization^{4,6}. Conversely, the stigma associated with FD has been shown to contribute to diagnostic overshadowing, in which legitimate medical symptoms are discounted or dismissed once the diagnosis is made. The experiences of MM and ZT closely mirror these findings and demonstrate how a FD diagnosis, if inappropriately applied, can lead to patient harm.

The other significant barrier to diagnosing FD is subjective or personal. The ethical principle of beneficence emphasizes the duty of clinicians to promote patient well-being⁹. Acting in line with beneficence would entail disclosing the diagnosis of FD to the patient and providing education, resources, and options for the treatment. While confronting a patient with their FD diagnosis is a necessary step in providing care for their FD, this interaction is often perceived to be difficult for providers, including mental health clinicians¹⁰. This confrontation will likely impose new dynamics in the patient-physician relationship and potentially damage the therapeutic alliance. Providers may refrain from this confrontation to avoid arguing with the patient, who may experience distress, shame, stigma, or anger as a result. For these reasons, it is not uncommon for providers to refrain from making the diagnosis to avoid having this difficult conversation with the patient and their support network. This was likely an important factor for not diagnosing MM with FD in our first case, despite the presence of clear evidence for symptom falsification.

In MM's case, the repeated failures to make the FD diagnosis despite several FD presentations in different health systems led to ongoing unnecessary interventions

such as escalation of opioid use and surgical procedures, causing iatrogenic harm to the patient. The principle of beneficence was violated when physicians refrained from diagnosing MM with FD, and therefore did not provide her with the necessary education and psychotherapy referrals. In addition, by not making the diagnosis of FD, the care team opted to accommodate the patient's requests for opioid use and referred her to unnecessary invasive interventions. This accommodation on the part of the care team subsequently violated the ethical principle of non-maleficence, which states that physicians should not cause undue harm to patients¹¹.

Even when an FD diagnosis is established or strongly suspected, clinicians must remain vigilant not to overlook symptoms that require immediate evaluation, whether these symptoms occurred spontaneously or due to factitious behaviors. In this context, the ethical doctrine of proportionality offers a helpful framework for clinical decision making. Proportionality refers to the idea that the magnitude of a response to a problem should be proportional to the severity and certainty of the problem itself; and that the anticipated benefits of an intervention should outweigh the potential harms.

In MM's case, proportionality would have required naming FD as the diagnosis underlying the presenting symptoms. This would have allowed the conversation with the patient to move forward and focus on the actual matter and not on the secondary issues, such as pain control and oral intake. In the same context, opioids or surgical interventions would have been considered non-proportional responses based on this doctrine. By not providing the diagnosis, MM was deprived of her right to understand that her chronic feigned and induced symptoms are a manifestation of a psychiatric disorder for which she can seek treatment. A patient like MM may leave the hospital thinking that she manipulated providers, succeeded in convincing them of her falsified or induced symptoms, and made them pursue unnecessary testing or pharmacological interventions. She may not have realized that the euphoria experienced in the act of deception is a part of this psychopathology. Without the intervention of a transparent discussion about her behaviors from her care team, the patient may also have learned that these behaviors effectively achieved her goals, potentially encouraging the repetition of similar behaviors or the development of even more sophisticated deceptive behaviors for future care encounters.

In ZT's case, a prior diagnosis of FD without factitious features was a failure of non-maleficence which resulted in a breakdown of the patient-physician therapeutic relationship. The stigma associated with the diagnosis overshadowed her legitimate health concerns, causing a reluctance to seek care for genuine medical needs. This gap in care directly led to patient harm.

These cases suggest several practical recommendations for clinicians. When FD is suspected, providers should conduct comprehensive chart reviews across healthcare systems, document objective observations rather than speculative interpretations, and ensure that DSM-5 criteria guide diagnostic decisions. Early psychiatric consultation is essential, though it should complement and not replace clear medical documentation and communication. Transparent, compassionate discussions with patients regarding safety concerns and treatment rationale are critical, even when such conversations are challenging. In the inpatient setting, consistent multidisciplinary care plans, the avoidance of unnecessary procedures, and clear boundaries around interventions may reduce harm. Unfortunately, existing research on FD offers limited guidance on the most effective strategies for approaching this diagnosis with patients.

Many clinicians believe that confronting patients with the care team's belief that they are falsifying or inducing their symptoms is necessary². However, following such confrontation of the FD diagnosis, the rates of patients acknowledging the falsity of their symptoms ranged from 22% to as low as 0%^{3,12}. Other researchers advocate for non-confrontational strategies¹³, citing that patients are more likely to accept the diagnosis of FD if they felt psychologically safe and that patients are less likely to engage in psychotherapy if they feel humiliated. However, these strategies are challenging to maintain over time, as the patient may feel that the care team is weak, naïve, or easy to manipulate. While a confrontational approach may place the patient-physician relationship at risk and lead some patients to terminate care, the alternative is to proceed with unnecessary interventions or to present vague reasons to the patient to avoid such interventions. A confrontation with patients about their FD diagnosis, on the other hand, sets the stage for moving the treatment course forward. It provides clear reasons to justify specific therapeutic interventions, such as keeping the hospitalized patient under close monitoring to prevent harmful induction of symptoms, providing education about FD and resources for treatment, documenting FD as a diagnosis in the medical record, declining unnecessary interventions, or even initiating a "therapeutic discharge"¹⁴.

While encountering behaviors concerning for FD, it is important that providers be aware of unconscious biases that may impact assessment and management plans to ensure that decisions are made equitably and fairly. If the collected information does not fit the clinical picture of FD, a diagnosis should not be made, as the stigma associated with FD may impact future care utilization for the patient and decision making for the clinician.

Further research is needed to identify evidence-based communication strategies, evaluate the outcomes of

proportional intervention models, and develop structured clinical guidelines for FD assessment and management. Longitudinal studies examining patient outcomes after diagnosis, as well as interventions aimed at reducing stigma, would be particularly valuable.

Conclusion

While often distressing to a patient and challenging to a clinician, establishing a diagnosis of FD and documenting it in the medical records is essential to protect patients from undue harm in the form of unnecessary medical interventions. However, clinicians should be aware of the potential adverse effects that an incorrect FD diagnosis can have on the patient's future care utilization, as well as future providers' potential denial of care. While diagnosing FD will likely significantly impact the therapeutic relationship, this should not supersede the obligation for clinicians to communicate honestly with their patients. In fact, treatment cannot move forward in the patient's best interest unless the FD diagnosis is fully disclosed. Diagnosing FD remains complex and challenging, and awareness of possible biases is crucial in the process of evaluating the diagnosis.

Declarations

Ethical Publication Statement

The research reported has adhered to guidelines set forth by the University of Michigan ethics committee, and is in line with guidelines set forth by the Office of Human Research Protection.

Declaration of Helsinki STROBE Reporting Guideline

This study adhered to the Helsinki Declaration. The Strengthening the Reporting of Observational studies in Epidemiology (STROBE) reporting guideline was followed.

Data Availability

No data were generated from the study

Author Contributions

Conceptualization, SF and AS; Writing—Original Draft Preparation, SF, CJ, EB; Writing—Review and Editing, EB, CJ and AS; Supervision, AS; Administration: SF, AS.

Conflict of Interest

The authors report no proprietary or commercial interest in any product mentioned or concept discussed in this article. No funding was obtained for this manuscript.

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