Why do Iranian patients with factitious disorder choose skin symptoms instead of pain? a literature review of factitious disorder in Iranian patients

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Background: Factitious disorder (FD) is a psychiatric condition in which the affected person deliberately makes up diseases, injuries, or symptoms. Diagnosing this condition is a serious medical challenge. No studies have been conducted in Iran to show these patients' clinical and demographic profiles in an adequate sample size. The present article attempts to extract demographic and clinical details of Iranian FD patients by reviewing the related published articles.

Methods: A search was conducted on this disorder in English and Persian articles published by Iranian researchers between 1960 and 2020 in the MEDLINE, Web of Science, EMBASE, PsychInfo, Google Scholar, and SID databases using factit*, artefacta*, artefactua*, and Munchausen* as keywords in combination with "by proxy" and "imposed upon another". Ultimately, 33 case report articles and 35 cases in total were included in the study, and demographic and clinical details of patients were extracted from the articles.

Results: Of the 35 FD patients, 27 were women. The patients' mean age was 32.5 years. Factors leading physicians to the diagnosis of FD were atypical presentation (n = 18) followed by an unsubstantiated presentation. FD symptoms were mainly physical (n = 31), and reporting unusual and atypical wounds were the most common cause of patients' visits, with a frequency of 25%. Most patients had not undergone a thorough psychiatric examination, and in those who had been evaluated, the most common diagnoses reported were mood disorder and anxiety disorder.

Conclusion: It appears that greater attention is required to teach the diagnosis and assessment of FD.

Keywords: factitious disorders, Munchausen syndrome, cultural psychiatry

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INTRODUCTION

Factitious disorder (FD) is a psychiatric condition in which the affected person deliberately makes up diseases, injuries, and symptoms to be hospitalized and undergo medical interventions with no obvious gain [1]. A prevalence of about 2% has been reported for this disorder [2], although much higher figures have been seen in some studies [3]. The diagnosis of FD is a major medical challenge [4], and a delayed

diagnosis can impose costs and many problems on the patient and medical team [5]. Thus, early diagnosis and avoiding invasive diagnostic and treatment procedures are among the most important measures in dealing with these patients [6]. Furthermore, patients with FD often suffer from several psychiatric disorders requiring specialized attention [7]; thus, psychiatric and psychological assessments and treatments are among the key interventions in this disorder [6]. This disease has attracted the attention of Iranian physicians in recent years; yet, no studies have been conducted in Iran to show the clinical and demographic profiles of FD patients in an adequate sample size. Therefore, there is a gap in knowledge in this area. Consequently, no clinical profile or diagnostic warning signs can be provided to better inform and educate physicians and the treatment team to diagnose the disorder more quickly and avoid unnecessary interventions. Thus, the present article examines Iranian FD patients' demographic and clinical details by reviewing the related published articles.

MATERIALS AND METHODS

First, a search was conducted on this disorder in English and Persian articles published by Iranian researchers between 1960 and 2020 in the MEDLINE, Web of Science, EMBASE, PsychInfo, Google Scholar, and SID databases using factit*, artefacta*, artefactua*, and Munchausen* as keywords in combination with "by proxy" and "imposed upon another". In the initial attempt, 39 articles were retrieved, which were all case reports and of which two were excluded because their full texts were not accessible. Then, full texts of the remaining articles were carefully read; another article was excluded because of irrelevance and three were excluded because of being repetitive. Finally, 33 case report articles remained, of which 31 contained only one case each and two reported two cases each. Thus, a total of 35 cases were included in the study.

RESULTS

Data were collected according to the table proposed in the paper of Yates *et al.* [8]. Based on the reports of the researchers, the following data were obtained:

Demographics

Demographic details, including age, gender, marital status, and occupation. Overall, it was established that attention had been paid to this disorder in Iranian articles mainly since 2001, and the number of cases reported in Iran was more than the mean number of the cases reported in Europe, South America, Asia, Africa, and Australia during the past 50 years and only fewer than those reported in the US and UK [8]. Of the 35 FD patients, 27 were women. The patients' mean age was 32.5 years, with a maximum of 70 and a minimum of 17 years. Specialists had reported all cases but one: 12 cases by psychiatrists, followed by internal medicine specialists (n = 8). Poor relationships and family/marital conflicts were reported as the main stressors and influential factors (n = 21), and according to the articles' authors, FD had mediating and regulating roles in these relationships.

Factors leading to the diagnosis of FD

Factors leading to the diagnosis of FD, that is, the reason physicians suspected diagnosis of FD in the patient. According to previous studies, they were divided into the following four groups [8]:

- Atypical presentation: atypical pattern and course of illness.
- Unsubstantiated presentation: Investigations normal or inconclusive.
- Evidence of fabrication: patient directly witnessed simulating disease.
- Investigations indicating fabrication: Investigations reveal the mechanism of fabrication.

In about 51% (n = 18) of the cases, the factor that led physicians to the diagnosis of FD was an atypical presentation, followed by an unsubstantiated presentation.

Presentation of FD

Presentation of FD or the main presenting symptom and chief complaint of the patient. Most FD symptoms were physical (about 88%; n = 31), and reporting unusual and atypical wounds were the most common cause of patients' visits, with a frequency of 25% (n = 9). Only four cases presented with psychiatric symptoms; two of them were cases

of FD by proxy induced by each patient's mother.

Psychopathology

Psychopathology, that is, the psychiatric diagnosis or underlying psychopathology of the disease. About 45% (n = 16) of the patients had not undergone any psychiatric assessment. The spouse's dissent in two cases and the patient's unwillingness in one were given as the reason for not undergoing a psychiatric assessment. Of the psychiatric assessments conducted, only about 26% (n = 5) were according to the DSM criteria, indicating that most patients had not received a thorough psychiatric evaluation. The most common diagnoses in these patients were depression, reported in about 47% (n = 9) of the cases, followed by anxiety disorders, reported in about 26% (n = 5) of the cases.

DISCUSSION

To some extent, the characteristics of patients with FD in Iranian studies were similar to those in other studies conducted worldwide [8,9]. However, the following issues in Iranian articles made it difficult to compare them with international reports: lack of an accurate psychiatric assessment of patients (in more than 45% of the patients), reporting of unusual wounds as the most common symptom, and the very low number of cases with physical pain as the chief complaint in Iranian articles. Therefore, this discussion focuses on the following two subjects:

Reasons for the lack of accurate psychiatric assessment of FD patients in Iran

The present study showed that only about 54% (n = 19) of FD patients in Iran underwent a thorough psychiatric assessment. Numerous reasons can be cited for this situation, as discussed below:

One reason can be the complex nature of these patients, especially their uncooperative attitude toward the medical team when their symptoms are revealed as fabrications, which leads to their unwillingness to undergo a psychiatric evaluation [10].

The second point is the need for permission from the individual's legal guardian to perform medical assessments. In Iranian society, the patient's legal guardian can decide the type of treatment and its continuation, which can produce challenges in making treatment decisions. In two of the cases, the lack of consent from the patient's guardian prevented psychiatric assessment. This problem is more serious in the case of married women as, usually, medical interventions are not performed on them without the husband's permission [11]. There are many challenges in obtaining informed consent for physical medical interventions in Iran, and there are many deficiencies in this regard [12,13]. However, not even one article was found to have addressed challenges in obtaining informed consent for psychiatric assessments in Iran, which shows the need for greater attention of researchers to this subject. Moreover, it seems that the separation of the psychiatric forensic medicine structure, which is overseen by the judiciary and has no scientific or academic connections to the Ministry of Health and Medical Education [14], and the fact that, despite many attempts, there is unfortunately still no law on mental health in Iran, have compounded the problem.

Another important reason could be the attitude of non-psychiatrist physicians toward psychiatric services since, in most cases lacking a psychiatric assessment, the patient's physician had not requested psychiatric consultation. This seems to be an important and challenging subject that requires special attention, particularly because once the symptoms are found to be fabricated, these patients may provoke strong negative emotions in the medical team [15,16], which can affect their treatment decisions. Numerous studies have been conducted on physicians' attitudes toward psychiatric issues, revealing that physicians poorly accept responsibility for psychiatric problems even in countries where attitudes toward these issues are positive [17]. Other reasons for not requesting psychiatric consultation include factors related to the physician's specialty. For instance, it has been shown that internal medicine specialists are more comfortable requesting psychiatric consultation regarding their patients than other specialists [18]. Overall, this field appears to require further studies.

Most common symptoms of patients diagnosed with FD

As mentioned, presenting with unusual and atypical wounds was the most common cause of

FD patients' visits with a frequency of 25% (n = 9). In studies conducted in other countries, too, most patients diagnosed with FD presented with physical symptoms, among which dermatological problems, especially wounds, were the main causes of the patients' visits [8]. However, the main difference was in the frequency of visits with the complaint of pain, which was reported to be very low in Iranian studies, but is among the most common complaints of FD patients in studies conducted in other countries [8,9]. This inconsistency requires a more accurate explanation. One probable explanation of this phenomenon might be in the acceptance of pain as an important medical symptom in Iranian culture. Even if the exact cause of pain is not identified, the suspicion of FD hardly comes to the physician's mind [19,20]. In Iranian culture, it is very common to express one's feelings through physical symptoms, especially pain. The reason for this situation is probably because, in this way, individuals can express their problems metaphorically and, at the same time, distance themselves from personal problems and avoid taking responsibility for them, and moderate and manipulate social relationships to some extent using these symptoms. In Iranian culture, the body is considered to be very much affected by environmental factors such as the warm or cold temperament of foods, humidity, and climate, and imbalances among these factors are assumed to result in physical manifestations, especially in the form of pain [21]. Thus, attributing these physical symptoms to environmental and social factors is, to a large extent, socially acceptable and is sympathized with and accepted by relatives. This is probably the reason that pain is less suspected of being fabricated despite a long duration and lack of improvement. However, such acceptance in Iranian culture does not apply to wounds in various parts of the body. In Iranian culture, a wound is indicative of a lack of balance and accumulation of toxins in the body and causes much concern in those around, and therefore, the first suggestion for its treatment in Iranian traditional medicine is detoxification [22,23]. Thus, it appears that there is low tolerance and acceptance of a wound in the subconscious of Iranians and Iranian physicians, and its long duration and lack of improvement are less acceptable and come under scrutiny, meaning that its fake nature is quickly realized. However, this cultural formulation to explain this inconsistency in the clinical presentations of FD patients in Iran requires further and more sensitive studies on cultural factors affecting diseases.

CONCLUSION

Overall, it appears that physicians have been noticing factitious disorder (FD) in Iran more in recent years relative to most other countries. Still, most patients have not received a thorough psychiatric assessment, and greater attention to the teaching of the diagnosis and assessment of this condition seems to be required. In addition, perhaps researchers can use the approach of cultural psychiatry in conceptualizing its epidemiology and etiology – a practice that has been neglected. Our review provides the clinical recommendations that follow below, which can be somewhat helpful in guiding diagnosis, treatment, and future studies in this field.

Clinical recommendations

- Iranian Clinicians should be particularly vigilant for FD in patients who are female, early middle-aged, with a history of working in the healthcare system, with atypical clinical manifestations, and living in a conflicted family or marital relationship.
- Although patients with FD may appear in any specialist setting, it is expected that in Iran, psychiatrists, internal medicine specialists, orthopedists, and dermatologists will encounter more cases, especially since the most common symptoms of these patients in Iran are skin symptoms and atypical wounds.
- Given the high prevalence of psychopathology in these patients, paying attention to psychiatric assessments and seeking counseling in the early stages of treatment may be helpful.

Conflic of Interest: None declared.

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