Management of factitious disorders: a systematic review

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CRD summary
The authors concluded that there was insufficient evidence to evaluate the effectiveness of any management technique for factitious disorder and further research was required. There were limitations to the methods used to combine studies, but overall the authors’ conclusions reflected the limited evidence from potentially flawed observational studies and were likely to be reliable.

Authors’ objectives
To evaluate the effectiveness of management techniques for factitious disorders (FD).

Searching
MEDLINE, EMBASE, PsycINFO, CINAHL and The Cochrane Library were searched from inception to December 2005 for studies with an English language abstract that were published in peer-reviewed journals. Search terms were reported. In addition, reference lists of retrieved papers were screened.

Study selection
Reviews, randomised controlled trials, controlled trials, case series and case reports that described and evaluated management techniques for adults of either sex (aged over 16 years) FD or Munchausen's syndrome were eligible for inclusion. The diagnosis had to have been confirmed or considered to be the most likely diagnosis. Patients with Munchausen by proxy were excluded.

Included studies were either case reports or case series. The most commonly used management techniques included confrontation with diagnosis (including non-punitive and accusatory approaches), psychotherapy, drug treatment, behavioural therapy and multidisciplinary techniques; treatment duration in case reports ranged from five weeks to eight years, but was not reported for case series. Where reported, participants were predominantly female, ages ranged from 14 to 70 years, psychiatric co-morbidity was common and the duration of factitious illness ranged from two months to 40 years. Duration of follow-up, where reported, ranged from one month to 15 years.

Two reviewers selected studies and resolved disagreements by discussion.

Assessment of study quality
Validity was assessed by considering the adequacy of description of treatment, potential for selection bias, reporting of follow-up for all patients and assessment of outcomes performed independently or using a standardised scale. The authors did not state how the validity assessment was performed.

Data extraction
One reviewer apparently extracted general data onto a standardised form and results were verified by a second reviewer. Since outcomes data were not assessed using standardised measures, the two reviewers independently transformed the reported change in overall condition using an adaptation of the Global Improvement Scale (GIS) from the Clinical Global Impression Scale; disagreements were resolved by discussion. Outcome data were extracted for the last reported follow-up.

Methods of synthesis
Studies were grouped by design (case reports and case series) and combined in a narrative synthesis. For case reports, parametric statistical tests were used to compare mean differences for different treatments; one way ANOVA was used to compare more than two treatments. Differences between studies were considered with respect to confrontational versus non-confrontational techniques, single versus multiple treatments, interventions including psychotherapy versus non-psychotherapy interventions, psychiatric medication versus no medication, longer versus shorter treatments and initial treatment as inpatient versus outpatient.
Results of the review
Thirty-two case reports (n=32) and 13 case series (n=284) were included.

Flaws included potential for reporting bias, lack of control group, lack of diagnostic criteria, lack of independent outcome assessment or use of standardised scale and inadequate follow-up.

Case reports: the mean GIS score was 2.81 out of 7 (range 1 to 7) suggesting a small improvement at follow-up. Seven patients scored 4 or more suggesting no change or a worsening of symptoms; the two patients who scored 7 committed suicide. There was no significant difference in GIS scores between patients treated with confrontation versus non-confrontational techniques, single versus multiple treatments, interventions that included psychotherapy versus non-psychotherapy interventions, psychiatric medication versus no medication, longer versus shorter treatments or initial treatment as inpatient versus outpatient.

Case series: the median GIS score was 0 due to lack of follow-up of most patients. Four patients (3.6 per cent) died. For studies reporting follow-up on more than 80 per cent of patients (seven studies, n=40) median GIS was 2, suggesting improvement.

Authors' conclusions
There was insufficient evidence to evaluate the effectiveness of any management technique for FD and further research was required.

CRD commentary
The review question was clearly stated and inclusion criteria defined for participants. Inclusion criteria for study design and interventions were appropriately broad given the limited evidence identified; no inclusion criteria were defined for outcomes. Several relevant sources were searched, but no attempts were made to minimise publication or language bias. Validity was assessed using specified criteria and results were summarised. Appropriate methods were used to minimise reviewer error and bias during the selection of studies and extraction of data. But it was not clear if similar methods were used for the validity assessment. No details were reported of methods used to assess outcomes in individual studies and it was not clear how valid transforming outcome measures into GIS scores was. In view of the diversity among studies, combining studies in a narrative synthesis was appropriate. But, the usefulness of calculating mean differences in GIS scores between treatment groups in case reports was questionable. There were limitations to the methods used to combine studies, but overall the authors’ conclusions reflected limited evidence from potentially flawed observational studies and were likely to be reliable.

Implications of the review for practice and research
Practice: the authors stated that clinicians should complete a comprehensive psychiatric assessment of patients with FD and assess suicide risk. One person should have primary responsibility of patient management, all members of the multidisciplinary team should be aware of the psychiatric assessment and treatment plan, treatment plans should be individualised, co-morbid illness should be treated appropriately and long-term support provided. If confrontational techniques are used these should be non-punitive and supportive.

Research: the authors stated that there was need to develop a network of interested clinicians and create a central reporting register to routinely collect and analyse standardised patient data.

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