Boundary with other forms of self-injurious behaviour

Individuals who exhibit self-injurious behaviour, often in the context of another mental disorder, may intentionally provide false information to examiners regarding either the self-induced nature of the injuries or the presence of suicidal ideation or intent. The deception in these cases is typically intended to minimize rather than exaggerate the extent to which the individual is viewed as ill, injured or impaired.

6D51 Factitious disorder imposed on another

Essential (required) features

- The presentation is characterized by feigning, falsifying or intentionally inducing medical, psychological or behavioural signs and symptoms or injury in another person – most commonly a child dependent – associated with identified deception. If a pre-existing disorder or disease is present in the other person, the individual intentionally exaggerates or aggravates existing symptoms, or falsifies or induces additional symptoms.
- The individual seeks treatment for the other person or otherwise presents them as ill, injured or impaired based on the feigned, falsified or induced signs, symptoms or injuries.
- The deceptive behaviour is not solely motivated by obvious external rewards or incentives (e.g. obtaining disability payments or avoiding criminal prosecution for child or elder abuse).
- The behaviour is not better accounted for by another mental disorder (e.g. schizophrenia or another primary psychotic disorder).

Note: the diagnosis of factitious disorder imposed on another is assigned to the individual who is feigning, falsifying or inducing the symptoms in another person, not to the person who is presented as having the symptoms. Occasionally, the individual induces or falsifies symptoms in a pet rather than in another person.

Additional clinical features

- The range of behaviours involved in factitious disorder imposed on another is similar to those in factitious disorder imposed on self, and includes reporting episodes of neurological or mental symptoms in the other person; manipulating laboratory tests to falsely indicate an abnormality (e.g. adding sugar to urine); falsifying past or current medical records to indicate an illness; administering a substance (e.g. warfarin) to produce an abnormal laboratory result or illness; and physically injuring or intentionally inducing illness in the other person (e.g. intentional exposure to infectious or toxic agents).
- The simulation or induction of illness or injury in factitious disorder imposed on another may be quite dramatic, resulting in numerous medical investigations and interventions in spite of negative or inconclusive findings.
- The person presented as ill, injured or impaired would in many cases be considered to be a victim of physical or psychological maltreatment (i.e. abuse), which should be classified

separately using the appropriate code from Chapter 23 on external causes of morbidity or mortality.

- There is evidence that a significant proportion of perpetrators of factitious disorder imposed on another have a history of factitious disorder imposed on self.

Boundary with normality (threshold)

- Some individuals whose loved ones have medical conditions may exaggerate the reports of symptoms to medical professionals in order to get their loved one's care prioritized, or to access additional treatments they perceive as necessary or potentially beneficial. Factitious disorder imposed on another should only be considered if there is evidence that the person is feigning, falsifying or intentionally inducing or aggravating the symptoms of the other person.

Sex- and/or gender-related features

- The most common presentation of factitious disorder imposed on another is a mother who fabricates symptoms in one or more of her children.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with motivated deception related to physical abuse

Caregivers who lie about the cause of abuse injuries in their dependents (e.g. claiming that an injury was the result of an "accident" rather than child or elder abuse) solely in order to avoid criminal prosecution or the intervention of child protective services should not be diagnosed with factitious disorder imposed on another. The diagnosis of factitious disorder imposed on another requires a clinical judgement that there are additional motivations for the deceptive behaviour, such as obtaining the attention and admiration of health-care providers.

Boundary with mental disorders with psychotic symptoms

Individuals with other mental disorders (e.g. schizophrenia and other primary psychotic disorders, mood disorders) may sometimes harm others, including their children, in response to a command hallucination or a delusion, or as part of a suicide attempt. In such cases, there is typically no evidence of deception associated with the harmful behaviour other than to avoid criminal prosecution for child abuse or other intervention (e.g. removal of a child by protective services).

6D5Z Factitious disorder, unspecified

Neurocognitive disorders

Neurocognitive disorders are characterized by primary clinical deficits in neurocognitive functioning that are acquired rather than developmental. Neurocognitive functioning specifically refers to neurologically based cognitive skills and abilities believed to be directly related to brain functioning, including but not limited to attention/concentration, memory, language, visual spatial/perceptual skills, processing speed and executive functioning (e.g. problem solving, judgement).

Neurocognitive disorders represent a decline from a previously attained level of functioning. This grouping does not include disorders characterized by deficits in neurocognitive functioning that are present from birth or that typically arise during the developmental period, which are classified in the grouping of neurodevelopmental disorders. Although cognitive deficits are present in many mental disorders (e.g. schizophrenia, bipolar disorders), only disorders whose core features are neurocognitive are included in the neurocognitive disorders grouping.

Neurocognitive disorders include the following:

6D70 Delirium

6D70.0 Delirium due to disease classified elsewhere
6D70.1 Delirium due to psychoactive substances, including medications

Note: The following subcategories are cross-listed from disorders due to substance use:

6C40.5 Alcohol-induced delirium
6C41.5 Cannabis-induced delirium
6C42.5 Synthetic cannabinoid-induced delirium
6C43.5 Opioid-induced delirium
6C44.5 Sedative, hypnotic or anxiolytic-induced delirium
6C45.5 Cocaine-induced delirium
6C46.5 Stimulant-induced delirium, including amfetamines, methamfetamine and methcathinone
6C47.5 Synthetic cathinone-induced delirium
6C49.4 Hallucinogen-induced delirium
6C4B.5 Volatile inhalant-induced delirium
6C4C.5 MDMA or related drug-induced delirium, including MDA
6C4D.4 Dissociative drug-induced delirium, including ketamine and PCP
6C4E.5 Delirium induced by other specified psychoactive substance, including medications
6C4F.5 Delirium induced by multiple specified psychoactive substances, including medications