CHAPTER 23

FACTITIOUS DISORDER AND MALINGERING

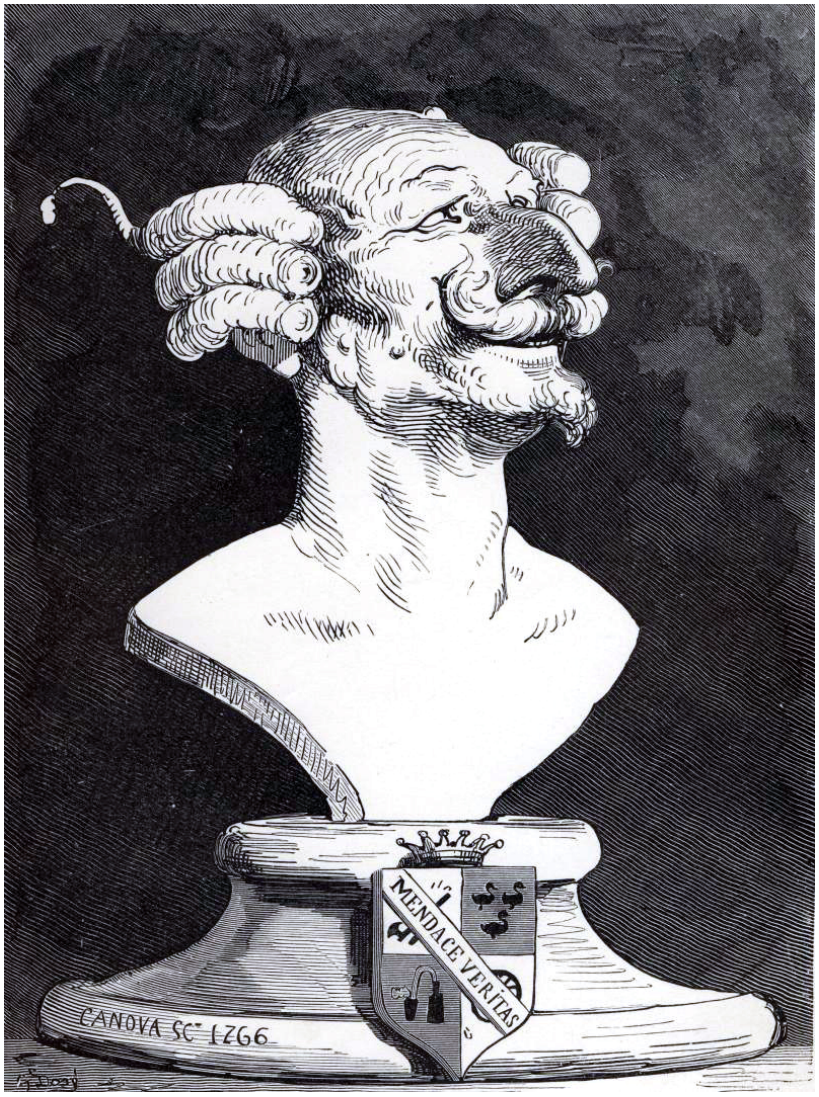

Illustration. Factitious disorder is applied when an individual pretends (fakes) illness. Some forms of factitious disorder are called Munchausen syndrome.

Baron Munchausen (1720-1797) was born in Germany but joined the Russian Army and fought two campaigns against the Turks (1740 and 41). When he returned to his birthplace he became renowned for telling of astounding adventures, including riding on a cannon ball and visiting the moon. In one story he told that he got himself out a swamp by pulling on his bootstraps (loops sewn to the side of boots to assist in getting them on) – this gave rise to the saying “he pulled himself up by the bootstraps”.

The Baron was known as an honest man in business affairs. His tales were considered “witty”. His aim in telling amazing stories was to entertain rather than deceive.

Thus, it is inappropriate to call factious disorder ‘Munchausen Syndrome’, as the Baron never claimed illness, or expected his listeners to believe him.

Introduction

Chapter 22 dealt with the **Somatoform disorders**. These are characterized by "medically unexplained physical symptoms". Two important features of somatoform disorders encourage clinicians to accept 'sufferers' as 'legitimate patients': 1) their symptoms are **not consciously** produced (faked), and 2) they are **not conscious** (aware) of the "motivation" which is driving their symptoms.

In factitious disorder and malingering, however, patients are **conscious** (aware) that they are voluntarily producing the symptoms. These two conditions are different only because of the goal of the behaviour is different.

The goal of the person with factitious disorder is to achieve the sick (patient) role, and clinicians are generally inclined to accept such people as 'legitimate patients'.

The goal of the person who is malingering is acquisition of external goods, such as money, or escape punishment/responsibilities, and such people are generally not considered to be 'legitimate patients'.

Factitious disorders (DSM-IV)

A. Intentional production or feigning of physical or psychological signs or symptoms.
B. The motivation for the behaviour is assumed the sick role
C. External incentives for the behaviour (such as economic gain, avoiding legal responsibility, or improving physical well-being, as in Malingering) are absent.

Factitious disorder was first introduced as a diagnostic category in 1980 (DSM-III).

It is included in the main body of the DSM-IV (along with schizophrenia and bipolar disorder). It is characterized by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role (a role in which one gets many advantages, including care, consideration and support from professional people, as well as being relieved of the responsibility to go to work and caring for others).

People with factitious disorder are accepted as legitimate patients; it is argued that they have emotional needs (as we all do), but lack understanding of their own emotional life, and the ability to satisfy their emotional needs in more appropriate/adaptive ways.

Three types have been described:

1. Common factitious disorder, is probably the most prevalent and is primarily among women (72%) most frequently (66%) working in health related areas (Krahn et al, 2003). Typically, these women do not travel to present at different treatment centres, and have a history of emotional deprivation and current sexual and/or relationship problems. The term "factitious nurses" has been applied (Kanaan & Wessely, 2010).

2. Munchausen syndrome (first described in 1951, Asher) more often features a single male in his 40's who has an antisocial or other Cluster B personality disorder. He frequently travels from one treatment centre, often from one city to another and presents at different treatment facilities (these travels are usually in the aftermath of being challenged or excluded by treatment authorities). The symptoms and their aetiology are usually described in dramatic terms. The 'patient' may offer extraordinary reasons why past records cannot be obtained, from the last doctor's surgery and all his/her records being burnt in a fire, to him/her being struck off the Medical Register for mismanaging the case, even to the patient confessing that he is a secret agent and not being allowed to reveal the names he has used in the past. There are usually also self-aggrandizing lies (pseudologia fantastica) – which led to the condition being named for Baron Munchausen.
3. Munchausen by proxy is applied when the "patient" claims a person who is dependent on them (usually a child) is sick. The "patient" may be damaging the dependent person to generate the symptoms, such as by administering a toxin. This is a distinct problem and will be dealt with under a separate heading.

Factitious disorder most commonly presents with physical complaints. The prevalence is difficult to estimate, however, attempts include that 0.5-2% of general hospital presentations (Eckhardt-Henn, 1999) and 10% of fever of unknown origin (Rumans & Vosti, 1978).

The prevalence probably varies with speciality, with up to 15% of presentations to neurologists and dermatologists involving factitious symptoms (McCullumsmith & Ford, 2011).

The prevalence of factitious disorder among psychiatric patients is unclear. "It is frequently difficult to adequately diagnose this disorder, above all, when the faked symptoms are those of a psychological or psychiatric disorder" (Catalina et al, 2009).

Catalina et al (2008) set out not to identify factitious disorder, but factitious behaviour in psychiatric inpatients. They developed an 8 criteria suspicion of factitious disorder test, with an identification threshold of 3 positive criteria responses. Using this tool they found 8% of psychiatric inpatients demonstrated factitious behaviour.

Suspicion criteria of factitious disorder

1. Inconsistent response to treatment
2. Inconsistent symptoms (with respect to presenting syndrome)
3. Worsening of symptoms prior to discharge
4. Disappearance of symptoms immediately after admission
5. Intense relationships with patients and staff
6. Appearance of symptoms similar to those of other patients
7. Lies (pseudologia fantastica)
8. Claimed background of non-verified physical or emotional disorders

While people with factitious disorder want to be patients, they do not (usually) want to be the patients of psychiatrists. This may be because psychiatry is a low status

speciality or does not provide the preferred type of care. Other factors may be that being referred to psychiatry suggests that the doctors believe there is no pressing organic problem. And, psychiatry deals with emotions, being aware of and managing them – this can be threatening stuff for people with factitious disorder who are attempting to deny such issues.

When people with factitious disorder are confronted with irrefutable evidence of feigning, they usually angrily refute the irrefutable, or cry and flee the scene (Hamilton et al, 2009) to represent at another hospital, or the same one using a different name.

The treatment of people with factitious disorder is difficult and there is little evidence (yet) to guide the clinician. Eastwood and Bisson (2008) reviewed all available case studies and case series. They found there was no difference in outcome whether or not 1) patients were confronted with true nature of their behavior, 2) psychotherapy was provided, or 3) psychiatric medication was provided.

Occasionally, it is possible to encourage these patients into a therapeutic relationship to address the difficulties of their psychological lives. They have usually suffered emotionally deprived early lives, often coming from homes where illness has been a prominent feature. Often, relatives have also presented with factitious disorder. The aim of treatment is for the patient to gain insight into their emotional lives and learn more adaptive methods of communicating their emotional needs and dealing with their distress. This calls for a long-term commitment by both the patient and the treating clinicians. Psychotherapy of most forms (in spite of the findings of Eastwood and Bisson (2008) would) has much to offer. The important component is a trusted therapist (family physician, mental health professional) with whom the patient can explore events of their lives as they present.

As with the treatment of conversion disorder (Chapter 22), it can be helpful to offer a treatment strategy which will allow the patient to discard the factitious symptoms without loss of face. In conversion this may be graded exercise, in factitious disorder biofeedback or hypnosis may be useful (McCullumsmith & Ford, 2011).

Munchausen by proxy is a special case as the “patient” is causing harm to a dependent other (usually a child) to attract care. Accordingly, legal authorities must be alerted when a case is suspected/detected.

Debate continues as to whether this condition is over or under diagnosed. However, suggested figures are alarming. An Australian study found Munchausen by proxy present in 1.5% of infants brought to a hospital with apparent life-threatening episodes (Rahilly, 1991).

The responsible people are generally mothers (75%). The children are generally less than 5 years of age. The time from first presentation to diagnosis in around 22 months – by which time, 6% of the children are dead. The majority of the children’s siblings (61%) have had similar illnesses, and 25% of them are dead (Sheridan, 2003).

Munchhausen by internet is a new phenomenon: the individual fakes a recognized illness in virtual environments, and may attach themselves online support groups (Pulman and Taylor, 2012). It is possible that on occasions this is with malicious intent, but this method also allow the individual to gain a sense of belonging and support.

M**alingering (DSM-IV)**

The essential features of malingering are the intentional production of false or grossly exaggerated physical of psychological symptoms, motivated by external incentives such as avoiding military duty or work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.

Malingering does not appear in the main body of the DSM-IV. It is listed at the end of that manual under the heading: “Other conditions that may be a focus of clinical attention”, along with other conditions such as “Bereavement” and “Religious or spiritual problem”.

Up to 30 (Mittenbert et al, 2001) or 40% (Larrabee et al, 2008) of those seeking disability, workers compensation and other form of damages are probably malingering.

Mental health professionals with special interest and training are employed to help with the **detection of malingering** in the legal rather than the clinical setting. This is usually in response to claims for compensation following a claimed accident; often the claims involve decreased cognitive ability. A large number of neuropsychological tests have been designed to detect malingering. Many depend on the fact that if patients are guessing, they must get the right answer 50% of the time; malingerers produce statistically significantly more wrong answers than they could by chance (Vitacco et al, 2006).

The 15 Item memory test (Lezak, 1976) is a simple example of a mechanism which has been used when individuals are claiming memory difficulties. The individual is shown the 15 items (depicted below) for 10 seconds, along with the advice that there are “15 items” and that this is “a very difficult test”. The individual is then asked to write down all figures he/she can remember. In fact, this is an easy test, and all but the most impaired individual can remember the vast majority. The trick is that if the individual can remember one item in a row (across), then he/she should be able to remember all items in that row. The malingerer may remember “nothing” or an occasional figure, but not complete rows. For example, suspicion is justified if the individual remembers 1 and 2, but not 3, or 1 and 3, but not 2.

A B C
1 2 3
○ □ △
a b c
I II III

Illustration. The 15 item memory test (Lezak, 1976). May be used in the detection of malingering of memory disorder. See text above for explanation.

The neuropsychology of malingering detection has evolved into highly specialized field (far beyond The 15 item memory test). Often called symptom validity testing (SVT), a wide variety of validated, objective, reliable tests are available.

There are also special tests for special circumstances/conditions, such as those designed to distinguish genuine symptoms of PTSD form faked symptoms of PTSD (Gray et al, 2010).

Neurophysiology of legitimate and fake symptoms

Theoretically, symptoms which are unconsciously produced (as in conversion disorder or physical disorder; 'legitimate') and symptoms which are consciously produced (as in factitious disorder and malingering; 'fake') would be underpinned by activity in different brain regions.

Although not directly supporting this notion, it is of interest that different parts of the brain are activated when the individual speaks the truth or lies. Deception is associated with increased activity in prefrontal cortex and anterior cingulate cortex (Ganis et al, 2003), which are areas involved in executive functions.

There appears to be a true physiological difference in brain activity when conversion disorder is compared to the brain activity when subjects are pretending (faking) weakness (Stone et al, 2007; Garcia-Campayo et al, 2009). fMRI studies show conversion disorder is characterized by activation of bilateral putamen and lingual gyri, left inferior frontal gyrus, and left insula and deactivation of the right middle frontal and orbitofrontal cortices. Experimental subjects who faked weakness where characterized by activation of the contralateral supplemental motor area only.

Also, electrophysiological testing could theoretically differentiate conversion disorder from factitious disorder or malingering (Gupta & Lang, 2009; Hallett, 2010).

The distinction between factitious disorder and malingering

Current diagnostic practice is to treat these conditions as different on account of the different goals: factitious disorder generated by the desire for the sick role, and malingering generated by the desire for external matters such as cash, release from goal or the avoidance of military service or other work.

It should be pointed out that some experts do not accept this as a satisfactory distinction (Turner, 1999; Catalina et al, 2009). Bass & Halligan (2007) opine that whenever there is "deceptive behaviour" (as in factitious disorder) the appropriate diagnosis is malingering. We look forward to see what DSM-V has to offer.

It is not uncommon to read the opinion that in both factitious disorder and malingering, the patient is "lying" (Hallett, 2010).

A case

Ms X, a 42 year old woman who had been living with a younger man for some years was brought to a general hospital by police, who requested a psychiatric assessment. The police had been alerted by Ms X's partner. He had found that Ms X had cuts to her left thigh, upper arm and abdomen and that their flat and the adjoining flat had been "trashed" (property had been broken and strewn over the floor).

Ms X claimed that while her partner was absent a man had entered her flat, taken a butcher's knife from the kitchen and cut her in these three places. She said she believed the intruder had come to the wrong address, and had been intending to do violence to the man who lived next door, who had been receiving "hate mail".

The police were hoping to obtain a psychiatric explanation (to make this a medical rather than a police matter). The police did not believe the account of an intruder, which meant that Ms X should face the charge of making a false claim to police. They also believed that Ms X was responsible for the "hate mail" (also a chargeable offence of harassment/assault). The advantage for the police of a psychiatric explanation would be that they would be free of the obligation to charge a person towards whom they were sympathetic.

On medical examination Ms X showed clusters of scratches on her left upper thigh and arm, and abdomen, which were inconsistent with a butcher's knife attack. There were many scratches in each site rather than a single deep slash. It is inconceivable that Ms X would have remained stationary to allow an assailant to deliver narrow bands of scratches, and those on her upper thigh and abdomen were in sites ordinarily covered by clothing (which meant an assailant would have had to lift her clothing to perform the task).

On psychiatric examination Ms X was a reluctant historian, and provided no further useful information. She did not wish to stay in hospital and intended to leave when her partner arrived.

Ms X's partner hurried to the hospital when he learned of her whereabouts. He told that he had decided (and had informed) Ms X that he intended to leave the relationship and go off to another city with his male friend who lived in the next flat.

The differential diagnosis in this case includes the following:

1. Factitious disorder. Here, although the signs were generated by the individual, the aim of factitious disorder (being taken care of by the health professionals) was lacking. Ms X did not bring herself to the hospital, she was brought by police. It is true that the signs she generated caused her partner to express concern for her, but there was no evidence that this had been her motivation.
2. Malingering. These signs were generated by the individual as occurs in malingering. However, the gaining of release from prison or financial compensation, which are the common motivators of malingering, were absent.
3. A two level explanation. This would appear to be the best explanation. The partner was in the process of leaving to go to another city with his friend. It is likely that Ms X was angry and wrote "hate male" to this man. Ms X was being abandoned by her partner. It is likely that she was angry and inflicted self injury as a means of releasing her distress (as occurs in borderline personality disorder), and "trashed" both flats. Then, to explain the scratches and household damage she knowingly invented the story of the intruder. Thus, the probable explanation is no psychiatric disorder other than possible borderline personality traits, with frustration leading to superficial scratching and property damage, which was then denied and the denial supported by the invention of the story of an intruder.

Comparing somatoform disorder, factitious disorder and malingering

	Symptom production	Motivation
Somatoform disorders	Unconscious	unconscious
Factitious disorder	Conscious	unconscious
Malingering	Conscious	conscious

The DSM-IV is atheoretical: it avoids aetiological theories and mechanism which are believed to underpin disorders, restricting attention to description. Accordingly, it does not raise the issue of consciousness or unconsciousness of symptom production, instead, pointing out that some symptoms are intentionally produced (conscious).

Somatoform disorder symptoms are not legitimate symptoms, in so far as they suggest dysfunction of a bodily organ which is healthy. However, they are certainly legitimate symptoms in that they are a cause of suffering and disability for the patient. The symptom is unconsciously produced by the patient for unconscious reasons. Most clinicians accept that people with somatoform disorder are legitimate patients, but management is difficult and most avoid them.

In factitious disorder, symptoms are feigned. An example is the pricking of a finger to produce apparent haematuria. The patient is unaware of the motivation, and when confronted, cannot give an explanation for their actions. The motivation of these actions is unconscious.

In malingering the individual also produces the symptoms intentionally, but here the goal that is obviously recognizable when the circumstances are known.

The distinction between somatoform disorders, factitious disorders and malingering is blurred. For example, if a person in a terrifying situation (war) has a conversion disorder she/he is accepted as a bona fide (legitimate) patient. Some would accept the person in the terrifying situation who has factitious disorder as a bona fide patient also, but not the malingerer. Both the patient with factitious disorder and the malingerer are scared, the distinction is that one is more aware of her/his mental processes than the other. It is important for people working in health not to wander into the minefield of morality.

In practice the distinction between somatoform disorders and factitious disorders is more difficult to make than between these two and malingering.

Attitude to people with medically unexplained physical symptoms

The general public and to some extent the health professionals regard people with medically unexplained physical symptoms with suspicion. Students of human behaviour may be interested to look at this negative attitude (Pridmore et al, 2004).

As mentioned in an earlier chapter, the sick role carries obligations and privileges. The obligations include that the patient 1) accepts that the sick role is undesirable, 2) co-operates with others so as to achieve health, and 3) utilize the services that society regards as competent in the diagnosis of treatment. Clinical experience is that some people with medically unexplained physical symptoms, a) appear to enjoy the sick role (rather than regarding it as undesirable), b) do not appear to be co-operating or trying hard to regain heath, and c) appear to over-use or under-use professional services.

The privileges of the sick role include that the person is 1) regarded as not responsible for his/her state, and is not regarded as producing this state by an act of will, 2) accepted as someone who requires care, and 3) entitled to exemptions from normal obligations, such as going to work. These are valuable privileges. They translate to free access to emotional, physical and financial support, benefits which ordinarily must be earned through the expenditure of energy.

The first privilege (not being regarded as responsible to her/his state) can be recast as a primary obligation. Once the doctor and the community accept that the ‘candidate’ sick person has not purposefully produced his/her state by an act of will, the other privileges follow.

Patients with somatoform disorders are not wilfully producing their symptoms. This is hard to accept by those who do not understand these disorders. Those who are

malingering are consciously faking their symptoms and are fully aware of their goals. They do not 'deserve' the privileges of the sick role. Most difficulty arises in relation to patients with factitious disorder. These patients do pretend to have symptoms, but they do so because of emotional need. When viewing from this perspective, many would concede that patients with factitious disorder 'deserve' the sick role. But, many would not. This is a topic which requires further work.

The problem of whether patients with factitious disorder 'deserve' the sick role only arises in the West, where we see people as being composed of two parts: body and mind. This is Cartesian dualism, a philosophy developed by Rene Descartes (French; 1596-1650). This complex matter is beyond the scope of the DOP. However, Eastern philosophy does not make this division (Lee, 1999). Monists believe that the body and soul are the same. People, not bodies or minds, develop illnesses (Kendell, 2001). Many Westerners currently believe dualism is "very probably wrong" (Shermer, 2004).

Faking injury is known in sub-human species. A bird will feign a damaged wing to draw predators away from a nest; a predator will fake weakness to draw scavengers into striking distance.

So, why do people respond so strongly if they think someone has gained something unfairly? Part of the answer may be that our sense of justice is one of the high points of human civilization, which somehow translates into a strong reaction when this sense is offended. However, there may be deeper roots as well. Current evolutionary theory holds that there is selection advantage conferred by "reciprocal altruism". The larger the flock or herd, the greater the chances of the survival of the species, and if an injured or weakened individual can be assisted without excessive cost to the helper, then help will be provided. This comes down to a balance between the benefit to the helper of having another surviving member, and the cost in energy to the helper of providing help (Trivers, 1971). Individuals who unduly waste the energy of the helper are excluded from further help (Tooby & Cosmides, 1996). Thus, annoyance with fakers may be of several origins.

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