Illness deception [revised version]

Christopher Bass
John Radcliffe Hospital
Oxford OX3 9DU
Christopher.bass@obmh.nhs.uk
Barcelona, Feb 2009

Factitious disorder

- A intentional production or feigning of physical or psychological symptoms
- B motivation is to assume the sick role
- C lack of external incentives eg. Financial gain, cf. malingering

DSM-IV, 1997

Criticism of DSM-IV definition

- A cannot accommodate pathological lying (pseudologia fantastica)
- B has no empirical content (a person's motivation is not knowable)
- C external vs internal incentives also not knowable and can change in the same patient

Turner M, Psychsomatics,2006;47:23-32

Examples of Incentives

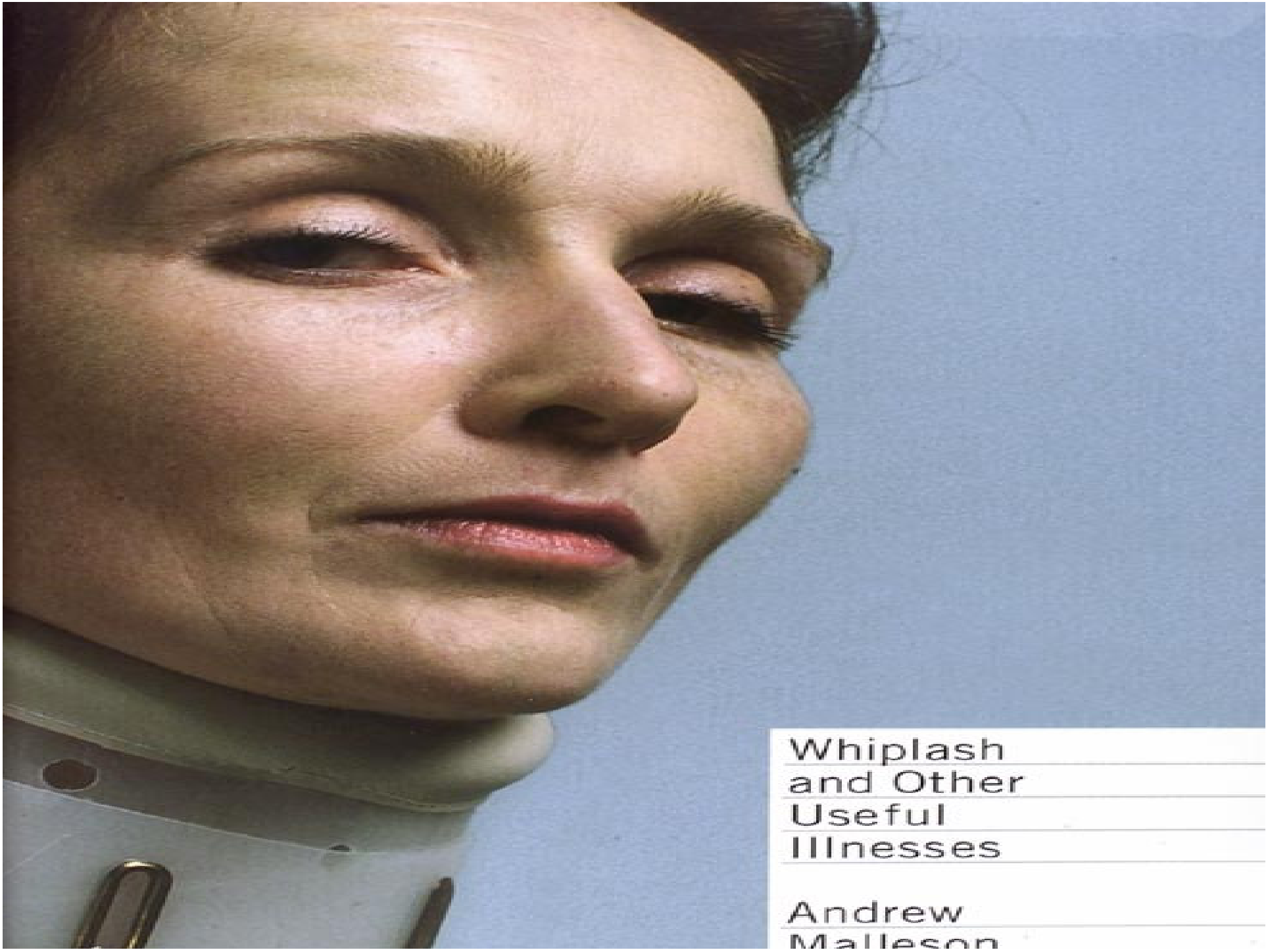
- avoiding work
- obtaining financial compensation
- avoiding military duty
- evading criminal prosecution
- obtaining drugs
- Ensuring early stress free retirement

Intentionality and symptoms

Is the patient generating his useful symptoms intentionally?

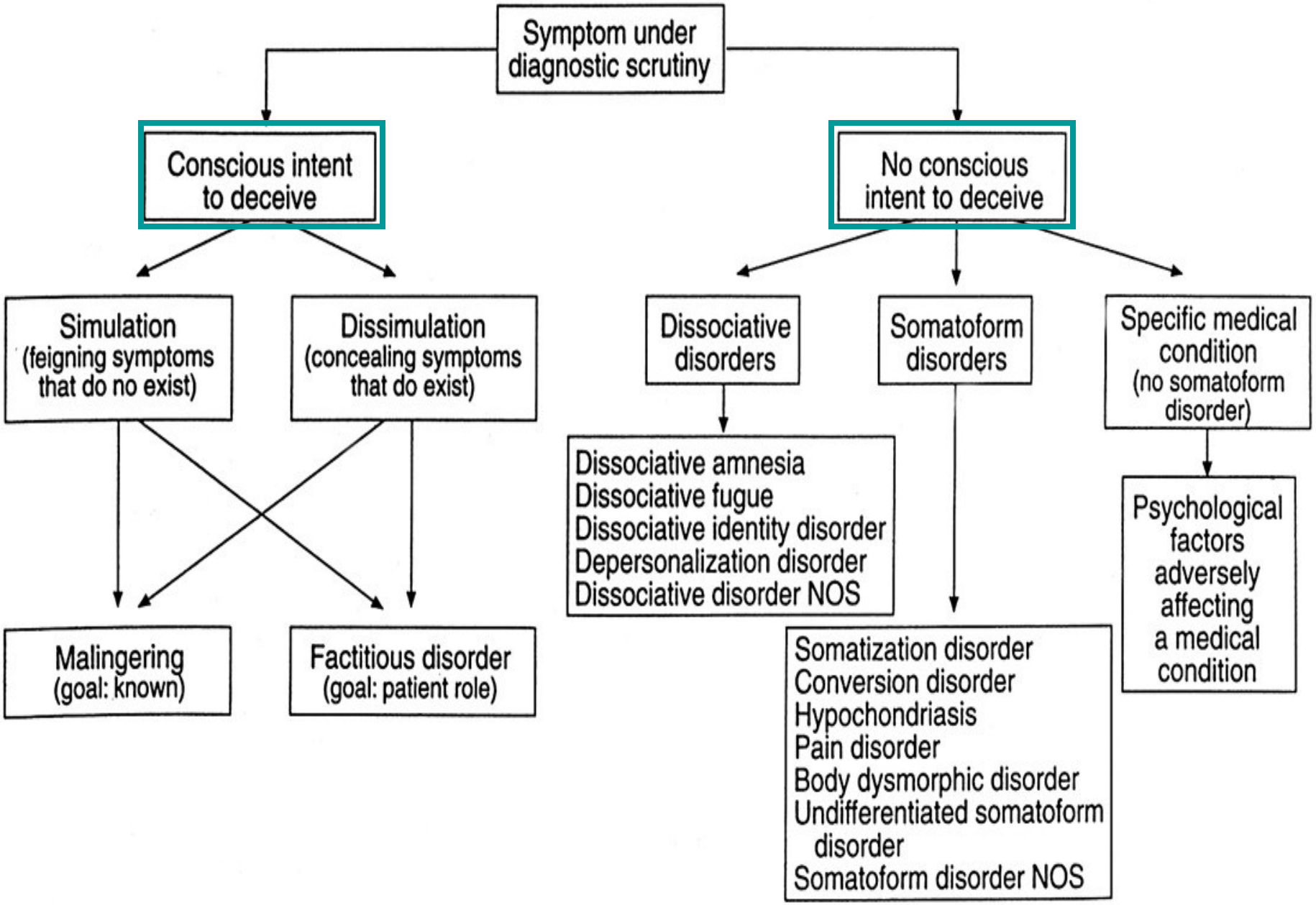
"Many Freudian-minded psychiatrists still hold that both primary and secondary gains are produced unconsciously (unintentionally), though more sceptical psychiatrists wonder how the patient can remain oblivious to his unconsciously motivated behaviour when he so transparently puts his symptoms to such profitable use"

Malleson A (2002; p 286)
Whiplash and other useful illnesses. Magill Univ Press.


Whiplash
and Other
Useful
Illnesses
Andrew

Do the glossaries help?

- Not really


Symptom under diagnostic scrutiny
Conscious intent to deceive
No conscious intent to deceive
Simulation (feigning symptoms that do no exist)
Dissimulation (concealing symptoms that do exist)
Dissociative disorders
Somatoform disorders
Specific medical condition (no somatoform disorder)
Malingering (goal: known)
Factitious disorder (goal: patient role)
Dissociative amnesia
Dissociative fugue
Dissociative identity disorder
Depersonalization disorder
Dissociative disorder NOS
Somatization disorder
Conversion disorder
Hypochondriasis
Pain disorder
Body dysmorphic disorder
Undifferentiated somatoform disorder
Somatoform disorder NOS
Psychological factors adversely affecting a medical condition

Somatoform-Malingering Continuum

Illness	Mechanism	Motivation
Hysteria	U	U
Factitious	C	U
Malingering	C	C

A rock and a hard place

- *The only theoretical difference between malingering, factitious disorder, and the somatoform disorders [including hysteria] is the degree of conscious intentionality involved in the production of symptoms.*

- *The distinction between hysteria and malingering " depends on nothing more infallible than one man's assessment of what is going on in another man's mind"*

Malleson 2003

Construct of volition

- Central to concept of hysteria and malingering as a medical form of illness behaviour is the concept of “free will” (*less controversially* “choice”) -the assumed capacity to deliberate and take responsibility for decisions or actions chosen

Spence S. Cognitive Neuropsychiatry 1999

Free will and responsibility

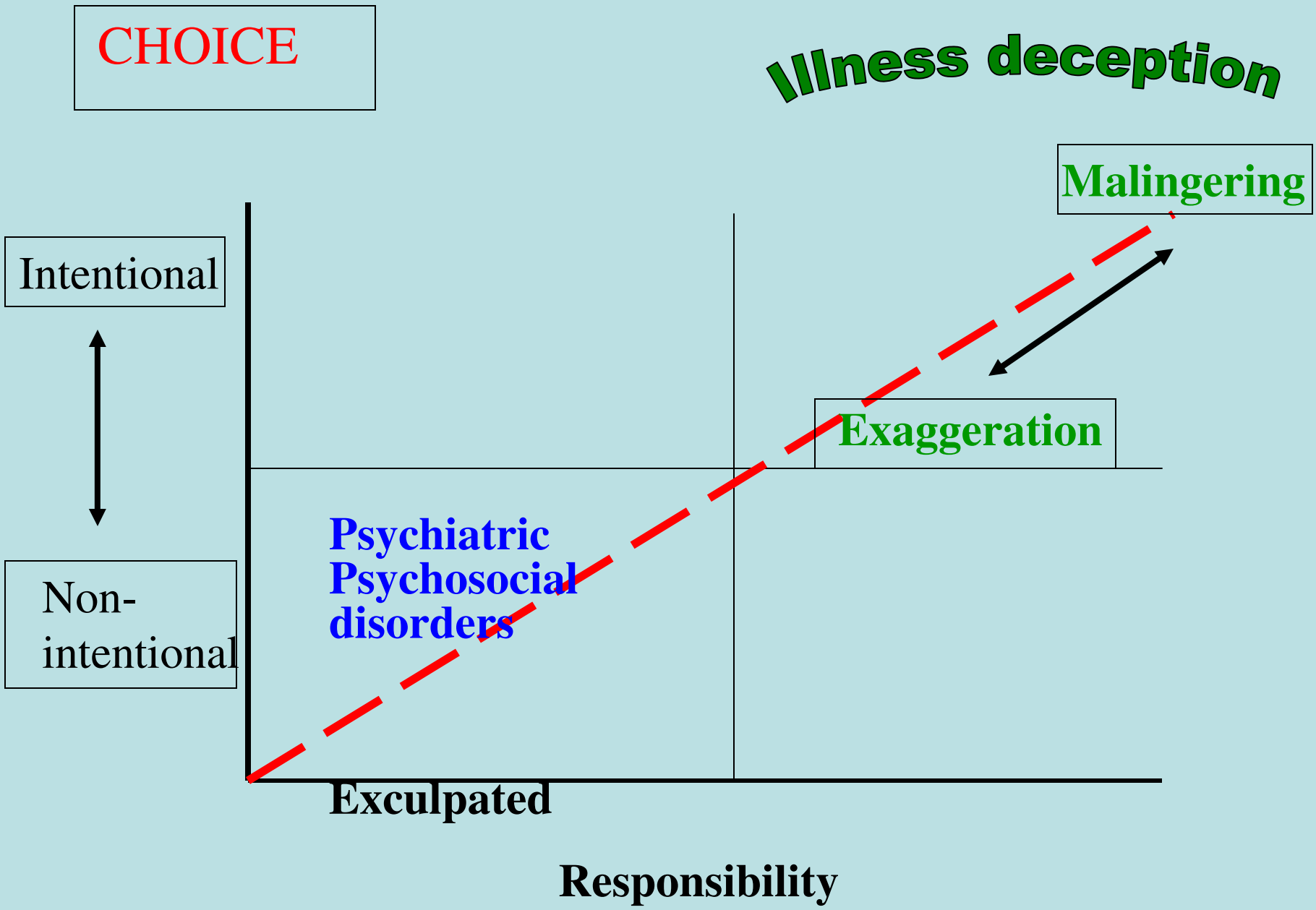
How shall we draw the line between exculpatory pathology of various sorts-

he didn't know, he couldn't control himself-

and people who do evil "of their own free will," knowing what they were doing?

Dennett D. Freedom Evolves. Allen Lane, 2003, p290

Illness behaviour and intentionality



MALINGERING and ILLNESS DECEPTION

PETER W. HALLIGAN | CHRISTOPHER BASS | DAVID A. OAKLEY

OXFORD

From Halligan P, Bass C, Oakley D. OUP (2003)

Base rates of malingering and symptom exaggeration: referral source

Personal injury cases	**29%**
Disability or workers compensation	**30%**
Criminal cases	**19%**
Medical or psychiatric cases	**8%**

Mittenberg W et al. J Clin Exp Neuropsychology 2002;24:1094
(National survey of neuropsychological practices;
Patients referred by defence attorneys/insurers had higher rates)

Base rates of malingering and symptom exaggeration: clinical disorders

Mild head injury	**39%**
Fibromyalgia/ chronic fatigue	**35%**
Chronic pain	**31%**
Neurotoxic injury	**27%**
Electrical injury	**22%**

Mittenberg W et al, 2002

Measurement

- Must carry out neuropsychological tests
- Green's Word Memory Test most useful (a test of memory that looks difficult but is in fact easy-WMT) (1)
- As many as 45-50% of patients show insufficient effort on these tests (2)

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(1) Green P The pervasive influence of effort on neuropsychological tests. Phys Med Rehabil Clin N America 2007;18(1):43-68
(2) Stevens A et al. Psychiatry Research 2008;157:191-200

Legal not medical attribution

- *" The term " malingering" applies to a finding of fact, made by the appropriate tribunal or court, on the basis of all the evidence presented in the course of the proceedings"*

- *As such "there is no basis for the accusation of malingering to be made by any medical expert witness in the guise of a" diagnosis"*

  (Mendelson and Mendelson, 1998)

- ***"Malingering is a social concept, and reflects on the way society encourages certain behaviours, and it is not pathological in the way that for example a major depressive illness is.***

- ***To categorise a patient as a malingerer, which implies fraud, is rightly the province of a judge, and for a medical expert to offer such an opinion could be seen as usurping judicial authority".***

  Trimble 2004

»

Despite this …….

"….. it is interesting to note that the most popular course run by the American Psychiatric Association every year involves the detection of malingered mental illness" (Wessely,1995)

Questions in medical interpretation of exaggeration

Is it deliberate?

- **If so, what is the intent?**
- **Is it with the intent to deceive?**
- **If so, properly a judicial and not a clinical matter;**
- **Is it with the intent to convince?**
  - **More likely with iatrogenic distress/confusion**

Is it "unconscious" (non-deliberate)? If so, what is the evidence?

- **Is it mediated by distress**
- **Is it based on misunderstandings about pain etc**
- **Is it part of a learned behaviour pattern?**

Main C. In: Halligan P, Bass C, Oakley D. (2003)

Factitious physical disorders

Report	Factitious disorders	F/M	av age	medical jobs
Ormsby	dermatoses	30/4	22	-
Hawkins et al	mixed	16/3	25	14 (74%)
Petersdorf et al	fever	12/2	33	5 (36%)
O'Reilly et al	anticoagulation	21/4	38	15 (60%)
Adman et al	fever and infection	25/7	23	16 (70%)
Carney	mixed	26/9	33	17 (49%)
Reich et al	mixed	39/2	33	28 (68%)
Sutherland et al	mixed	7/3	26	2 (20%)
Krahn et al,2003	mixed	67/26	33	26 (28%)

F:M ratio 4:1
Av age 30 yrs
Medical jobs 20-70%
Krahn LE et al. Am J Psychiatry 2003;160:1163

MOST FACTITIOUS PATIENTS

- do not conform to Munchausen subtype
- socially conformist young women
- over 50% are health care workers
- less dramatic symptoms
- geographically stable
- some have established social networks
- may be more amenable to treatment

Reich P & Gottfried L. Ann Intern Med 1983;99:240

Clinical characteristics I

- course of the illness is atypical and does not follow the natural history of the presumed disease

  eg. a wound infection does not respond to appropriate antibiotics (self-induced skin lesions often fall into this category, when "atypical" organisms in the wound may alert the physician)
- physical evidence of a factitious cause may be discovered during treatment eg. a concealed catheter, a ligature applied to a limb to induce oedema
- the patient may eagerly agree to or request invasive medical procedures or surgery
- there is a history of numerous previous admissions with poor outcome or failure to respond to surgery (these patients may overlap with the chronic somatoform patient with "surgery prone behaviour" (DeVaul and Faillance,1978)
- many physicians have been consulted and have been unable to find a relevant cause for the symptoms

Clinical characteristics II

- Additional clues include the patient being socially isolated on the ward and having few visitors [more common in Munchausen variant],
- the patient being prescribed (or obtaining) opiate medication, often pethidine, when this drug is not indicated
- Patient has either worked in or is related to someone who has worked in the health field
- Obtaining collateral information from family members, prior physicians, GP, and hospitals is crucial.

Types of presentation

- Infections that do not heal
- Paradoxical vocal cord adduction simulating asthma [may get into ITU]
- Present with haematuria or bleeding from elsewhere that is unexplained
- Recurrent unexplained dislocations of shoulder
- Feigned seizures [not dissociative]
- Unexplained fever, coma

Systematic approach to assessment: sequence of events

- Read instructions; what are the questions?
- Obtain all notes; GP, medical, personnel
- Dictate relevant notes before conducting interview
- Identify the following from scrutiny of notes:
  - Frequency of attending
  - Frequent change of GP (new registrations)
  - Abnormal/atypical presentations eg.
    - fevers,
    - recurrent dislocations,
    - laryngeal spasm,
    - conversion disorders
    - substance misuse (pethidine)
  - Document investigations and what the patient was told eg. “strongly reassured her that X was normal”

Supportive confrontation: preparation

- Collect firm evidence first eg. Catheter
- Discuss with psychiatrist (or hospital legal team if none available)
- Meet with colleague (psych) and marshall facts; discuss strategy
- CONFRONTATION with patient should be non-judgemental, non-punitive
- Propose ongoing support/ follow up
- If health care worker discuss with MDU, MPS
- Discuss with patient's GP; document in notes

Non confrontational strategies: rationale

- Face saving
- Patient may subsequently explain recovery without admitting problem is psychiatric
- Double bind approaches eg.if lesion does not respond to skin grafting it means that the disorder is factitious in origin

Example

- “We know it’s been difficult for you considering the pain and length of your hospital stay. It's also been difficult for us, trying to work out how best to help you.
- You have been a good patient, putting up with all these tests, and we’ve been good doctors, examining everything we could. In any good relationship the most destructive thing there can be is a conspiracy of silence……

- …We've had too good a relationship to let this conspiracy of silence continue. That's why we are going to tell you what we think.
- We believe you are doing this to yourself (often minimal protest from patient). I don't want this to sound like an accusation, but we must tell you how we feel. We will continue your antibiotics for the infection and the analgesics for your pain. We will continue to see you every day. And we will continue with the physio and follow you up as an out-patient. And we will be back later to see how you are feeling"

Guziek J et al. General Hospital Psychiatry 1994;16:47-53

If the patient is a health care worker

- Phone your hospital legal services for advice
- Telephone the MDU or MPS
- Discuss with patient's GP
- Copy the MDU/MPS into all your written correspondence
- Obligation to inform GMC, UKCC, medical school, registering body etc of the patient

Case vignette

- Tel call from ID consultant
- 21 yr old trainee nurse on bone infection unit
- Found a number of foreign bodies in her L wrist
- Incontrovertible evidence she has self induced illness [ward sister has seen her do it]
- Two hand surgeons and 2 bone infection doctors have also written letters confirming this
- She is surly and denies any emotional problems
- Please can you advise

Management plan

- Discuss history with bone infection doc
- Go to ward and read notes, talk to medical and nursing team
- Tel call to patient's GP for any relevant Pr Med History
- Tel call to hospital legal team
- Tel call to MDU to explain dilemma and possible intervention
- Arrange for supportive confrontation on ward
- Inform patient's GP and registering body of outcome
- Write down all interventions in hospital notes

Guidance for doctors

Good Medical Practice

General Medical Council

Regulating doctors
Ensuring good medical practice

Pathological lying:pseudologia fantastica

- Pathological lying may occur in the absence of another diagnosable psychiatric disorder
- 40% have CNS abnormalities
- Liars show 25% increase in prefrontal white matter and 40% reduction in prefrontal grey/white ratios cf controls*
- Increase in prefrontal white provides people with the cognitive capacity to lie
- 50-60% of perpetrators of FII have evidence of pathological lying from adolescence (CB series)

*Yang Y et al. Br J Psychiatry 2005:187:320-5
Dike C et al. J Am Acad Psychiatry Law 2005;33:342-9

Pathological lying (pseudologia)

- May occur in the absence of another diagnosable major psychiatric disorder
- More often associated with:

➢ Factitious illness

➢ Borderline PD

➢ Antisocial PD

➢ Histrionic and narcissistic PD

Dike C et al. J American Academy of Psychiatry and the Law 2005;33:342-9

Possible functions of deception….

- Lying eases social interaction, by way of compliments and information management.

- Strictly truthful communication at all times would be difficult and perhaps rather brutal (Vrij 2001).

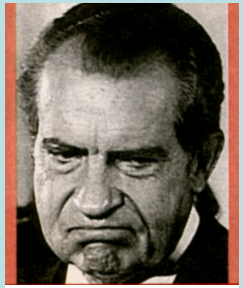
- a vital and strategic skill in the context of conflict, especially between social groups, countries or intelligence agencies.

Jeffrey Archer

Not only did Baron Archer of Weston-super-Mare perjure himself: he asked a good friend to lie under oath too, to give himself an alibi in his 1987 libel trial

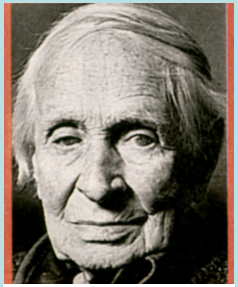
Shirley Porter

Asked to pay £42m to settle the homes-for-votes scandal, the former council leader said she only had assets of £300,000. Eventually the dame was relieved of £12m



Richard Nixon

'There can be no whitewash at the White House,' said President Nixon in 1973, shortly before several coats of Watergate whitewash were discovered



Van Der Post

Sir Laurens van der Post embellished his experiences for his books, and posed as a lieutenant colonel when he was an acting captain in the second world war

Martha Stewart

America's best-loved homemaker turned out to be a myth-maker as well, when she fibbed about a suspicious sale of biotech shares and was sent to prison

Bill Clinton

He lied about Monica Lewinsky — but he has also lied for world peace. During Middle East negotiations, Clinton told each side that the other side was ready to do a deal

Koko the Gorilla

After ripping a steel sink from its moorings, the ape — famous for using sign language — signed to claim that her tiny pet kitten had done the damage

Deception -part and parcel of “normal development”

“... despite apparent emphasis upon honesty in human discourse there are emerging evolutionary, developmental and neuro-developmental-psychopathological literatures which suggest that deception (in animals and humans) and lying (specifically in humans, utilizing language) are consistently increased among organisms with more sophisticated nervous systems (Giannetti 2000)”.

Spence S et al., 2003

Summary

- **Some patients exaggerate/ fabricate symptoms for reasons that are not always knowable**

- **This is more common than we think but we lack the tools to detect it**

- **Try to identify evidence of pathological lying [this is a relatively objective marker of deception]**

- **The "medicalisation of distress" and iatrogenic factors [doctors as "excluders"] play a major role, but the patient is the "driver" of the investigations**

- **Patients can and do exercise choices and determine their actions ie. they have "free will"**

- **supportive confrontation is the preferred approach to management, but the evidence suggests that only 1 in 6 acknowledge their deceptions**

Factitious or induced illness [2002]

- Munchausen syndrome by proxy
- 451 papers/reports on children [Sheridan M, 2003]
- One on the mothers

Doctor charged with misconduct over murder claim

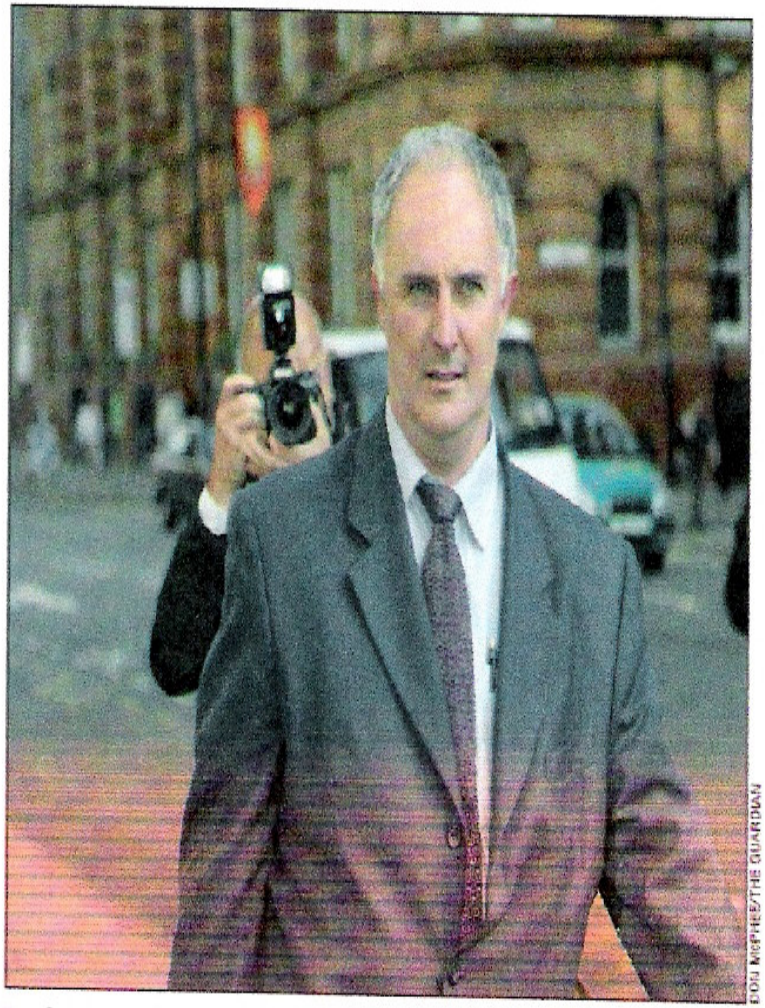
Owen Dyer *London*

Professor David Southall, one of Britain's best known paediatricians, was this week charged with serious professional misconduct by the General Medical Council.

The case against him centres on the allegation that he accused a father of murdering his child on the basis of only having seen the father interviewed in a television documentary.

As the *BMJ* went to press on Tuesday, the case against Professor Southall had been spelt out, but Professor Southall's lawyer had not yet presented his defence.

The GMC said that Professor Southall had accused Steve Clark, the husband of Sally Clark, who was then in prison for the murder of two of her children, of killing his son after he had seen Channel 4's documentary *Dispatches* in April 2000. In the interview, Mr Clark



BOB MCPHEE/THE GUARDIAN

Professor David Southall admits he acted on limited information

on the basis of watching a programme on TV."

After his accusation, Professor Southall was interviewed by Detective Inspector John Gardner of Cheshire Constabulary. But the detective concluded there was no case, writing in his report: "It illustrates how a well-meaning but scantily informed person can theorise about what actually happened."

Mr Gardner told the GMC that Professor Southall "thought Steve Clark came over as insincere and an attention seeker." He said that Professor Southall had been "adamant" that a nose bleed was concurrent with an attack. Under questioning from Kieran Coonan, representing Professor Southall, Mr Gardner acknowledged that the paediatrician had told him of his suspension and that Professor Southall had been open about the fact that he had

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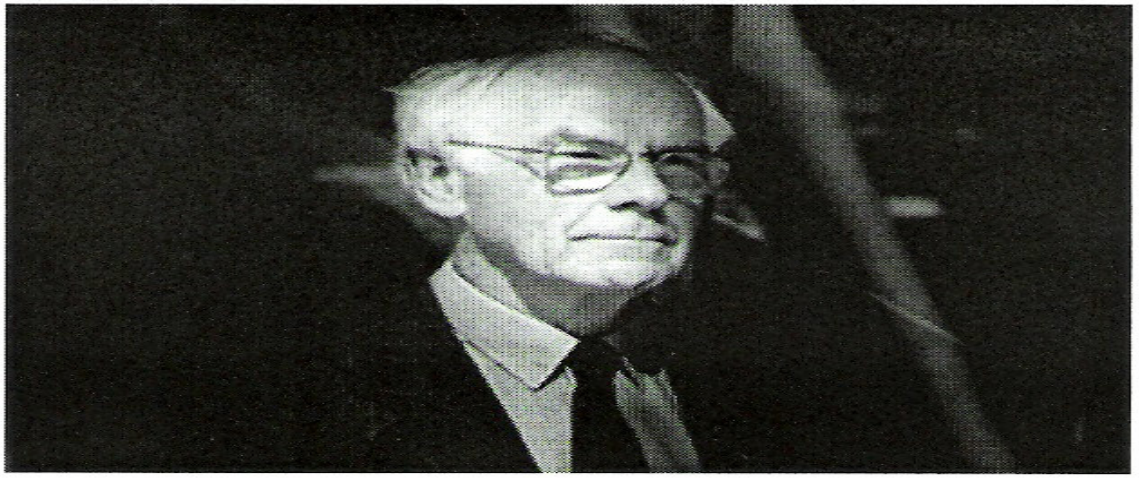
Britain

July 15, 2005



Professor Sir Roy Meadow, 72 (Chris Young/PA)

Professor Sir Roy Meadow struck off

BY SAM KNIGHT, TIMES ONLINE

Professor Sir Roy Meadow, once Britain's most

Stop this pillory of paediatricians

The current bias in favour of accused mothers is putting babies' lives at risk, writes **Yvonne Roberts**

HIGHER AND HIGHER pile the faggots of apparently devastating criticism, forming what increasingly looks like the funeral pyre for the reputation of retired paediatrician Professor Sir Roy Meadow.

have come forward and confessed. In 1992, for instance, in the US, Waneta Hoyt admitted that, two decades earlier, she'd suffocated her five babies, all recorded as 'cot deaths'.

We know from covert

Rigorous tests are executed. Eventually, a case conference is called to decide what action to take.

A joint working party of paediatricians and pathologists will report on this experiment in March, and it is to be hoped it will make recommendations to ensure that such thorough investigations become the norm.

We should also end the vow of silence on paediatricians who, when a case is

Beverly Allitt with a young patient. She killed four children and attacked nine others to attract attention

The horrific scale of Münchhausen deceit

MAD or BAD?

The convicted serial child killer Beverley Allitt is said to suffer from Munchhausen's Syndrome. ERIC BAILEY hears how experts make the link between illness and evil

SOME sufferers from Munchhausen's Syndrome, says Dr David Enoch, a specialist in rare

there not a danger that, in a desperate need to somehow rationalise the awfulness of the acts, we miss the obvious conclusion: that Bever-

Killer's 40 visits to casualty with mystery ailments

DT 19-5-93

BEVERLEY ALLITT visited the casualty department of Grantham and Kesteven general hospital more than 40 times between 1985 and being detained in September, 1991, according to her medical history.

This was in addition to visits to other hospitals and her own family doctor.

She had gone to hospital more than 20 times before she was accepted for training as a nurse in 1988.

Between Feb 23 and April 22, 1991, when she attacked the 13 children, she stopped her visits to the casualty department. The visits resumed while she was on police bail after her first arrest in May, 1991.

At the end of her trial the court was told three specialists had agreed that Allitt, 24, suffered from Münchausen's Syndrome, a condition in which a person produces false stories and invented symptoms to receive needless medical attention, and Münchausen's syndrome by proxy, in which she deliberately made children ill to

graph has seen a copy of her medical history from 1985. It reads:

Sept 30, 1985: Injury from kicking door. Little toe X-rayed.

Feb 24, 1986: Injury to finger.

July 9: Consults GP after missing two periods. Referred to obstetrician to confirm she is not pregnant.

Aug 2: Injury to toe from kicking door.

October: Three appointments to complain of abdominal pain. Admitted to hospital. No sign of ulcer. She produces green vomit, but no one sees her being sick. Staff conclude she is making herself vomit.

Dec 1: Injury to right hand, no fracture found.

December: Complains of problems eating fat. Doctor writes: "My feeling is that the symptoms are psychosomatic reflecting stress in her family circumstances."

March 27, 1987: Haematoma (blood-filled swelling) to right hand.

May 5: Hand is moving freely after physiotherapy, but three days later she com-

Beverley Allitt now and, right, before the trial

June 4: Another haematoma to right hand.

June 10: Tender bruise to right hand, said to have been caused in fight.

July 24: Injury to left hand, said to have been caused by falling off bike.

Aug 5: Further exploration of haematoma on top of right hand. Doctors recommend no more X-rays of hand injuries.

Nov 8: Complains of four injuries to left hand and categorically denies hitting hand.

Nov 12: Says she has treated

thumb in car door. Doctors suspect that hand injuries may be self-inflicted.

December: Doctor writes: "I don't know why she gets all these haematomas. She seems a sensible girl."

July 7, 1988: Goes to Great Yarmouth hospital complaining of possible fracture of scaffoid bone in wrist. Nothing found.

September: Starts nurse training. Soon complains of muscle strain after lifting patient. Returns three days

Jan 20, 1989: Complains of head injury and double vision.

March 14: Referred to consultant with back strain.

March 16: Headache and blurred vision.

March: Reports blood in urine although none is seen by doctor.

Aug 8: Reports injury to right foot after stepping on glass, although no glass found.

August: Dropped weight on right foot.

Oct 8: Complains again of glass in right foot.

Jan 14, 1990: Goes to Pilgrim hospital, Boston, complaining of injury to right hand.

Jan 28: Reports hand injury again to Grantham hospital.

May: Admitted to hospital for five days for tests on possible urine retention.

July 7: Complains of severe colic pains.

July: Doctor at City hospital, Nottingham, notes "hysterical symptoms" concerning her regular use of pethadine.

Oct 3: Complains of stomach pains. Complains of blood in urine, but urine clear. Appendectomy, but appen-

Oct 10: Appendectomy wound oozing and bleeding in way which suggests tampering with wound.

Nov 22: Complains of cystic lump in right hip.

May 13, 1991: Another urinary infection complaint although tests reveal nothing. Doctor writes: "Pattern of symptoms extremely odd and gruesome vicissitudes of self-treatment."

May 15: Small cuts on left foot.

July: Complains of acute retention of urine with a temperature of 41 degrees which falls to normal within 30 seconds. Doctors suspect thermometer was warmed. One writes: "A very strange lady."

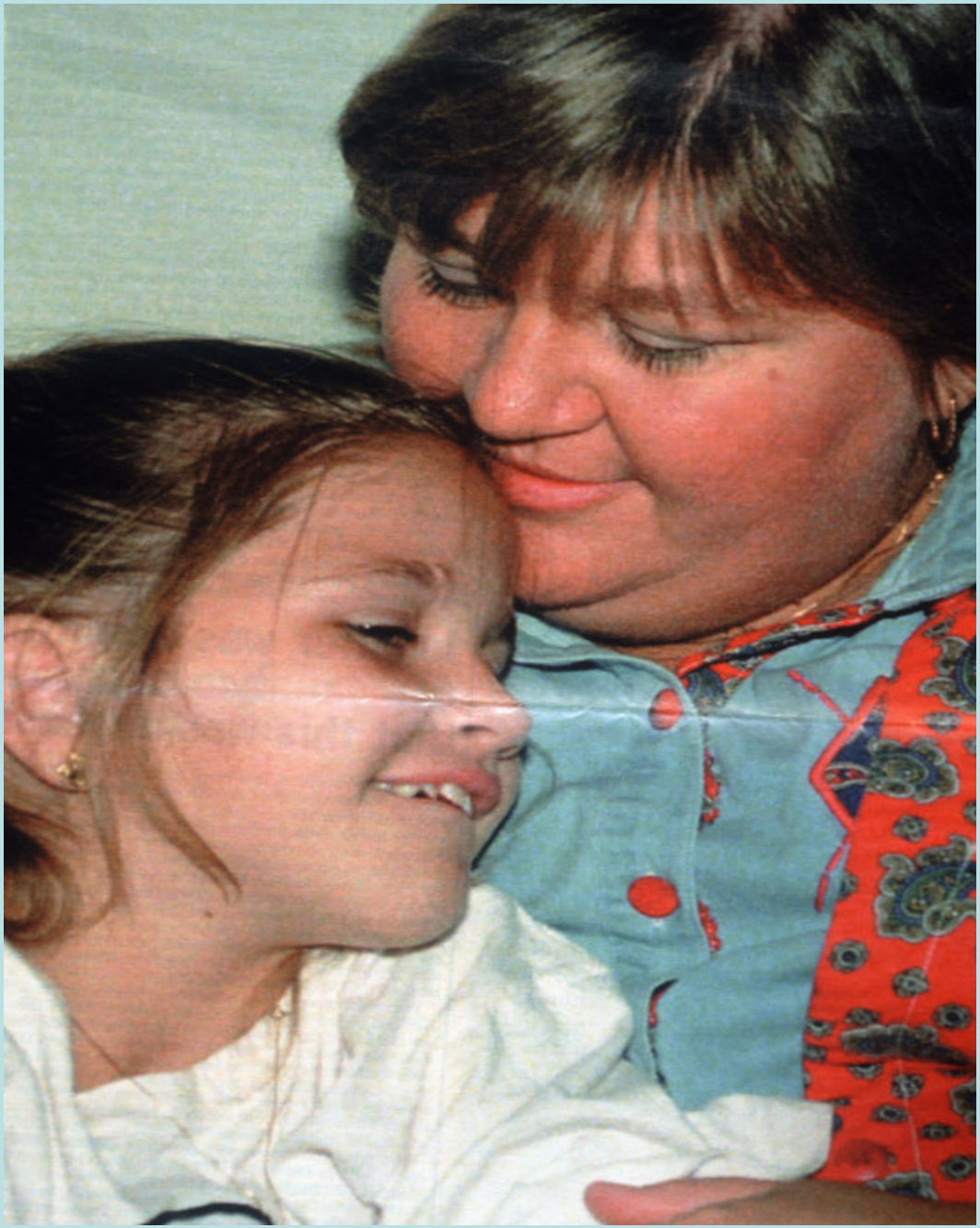
July: Right breast swollen after three spot-like puncture marks found, suggesting she has injected liquid into the breast.

August: Complaints of undisclosed injuries at Peterborough General Hospital. Doctor writes: "I am not sure whether we are dealing with Münchausen's."

Aug 12: Says she has brain

THE ALLITT INQUIRY

Independent inquiry
relating to
deaths and injuries
on the children's ward at
Grantham and Kesteven
General Hospital
during the period
February to April
1991



Florida woman accused of sickening child for 8 years

July 20, 1999
Web posted at: 11:17 p.m. EDT (0317 GMT)

From Correspondent Susan Candiotti

FORT LAUDERDALE, Florida (CNN) -- A Florida mother intentionally made her daughter sick to draw attention to herself by contaminating the child's blood, tampering with her feeding pump and sickening her with unprescribed medication, prosecutors said Tuesday.

By age 8, Jennifer Bush underwent some 40 surgeries and spent 640 days in hospitals.

"The cause of her illness was her mother Kathy Bush," Assistant State Attorney Dennis Nicewander told jurors during opening statements.

VIDEO
CNN's Susan Candiotti reviews the case
Windows Media 28K 80K

Kathy Bush, 41, is charged with aggravated child abuse and Medicaid fraud. She faces up to 45 years in prison if convicted on both charges.

INCREDIBLY CARING

Fabricated or Induced Illness in a Child by a Carer

A READER

Christopher Bools

department for
education and skills

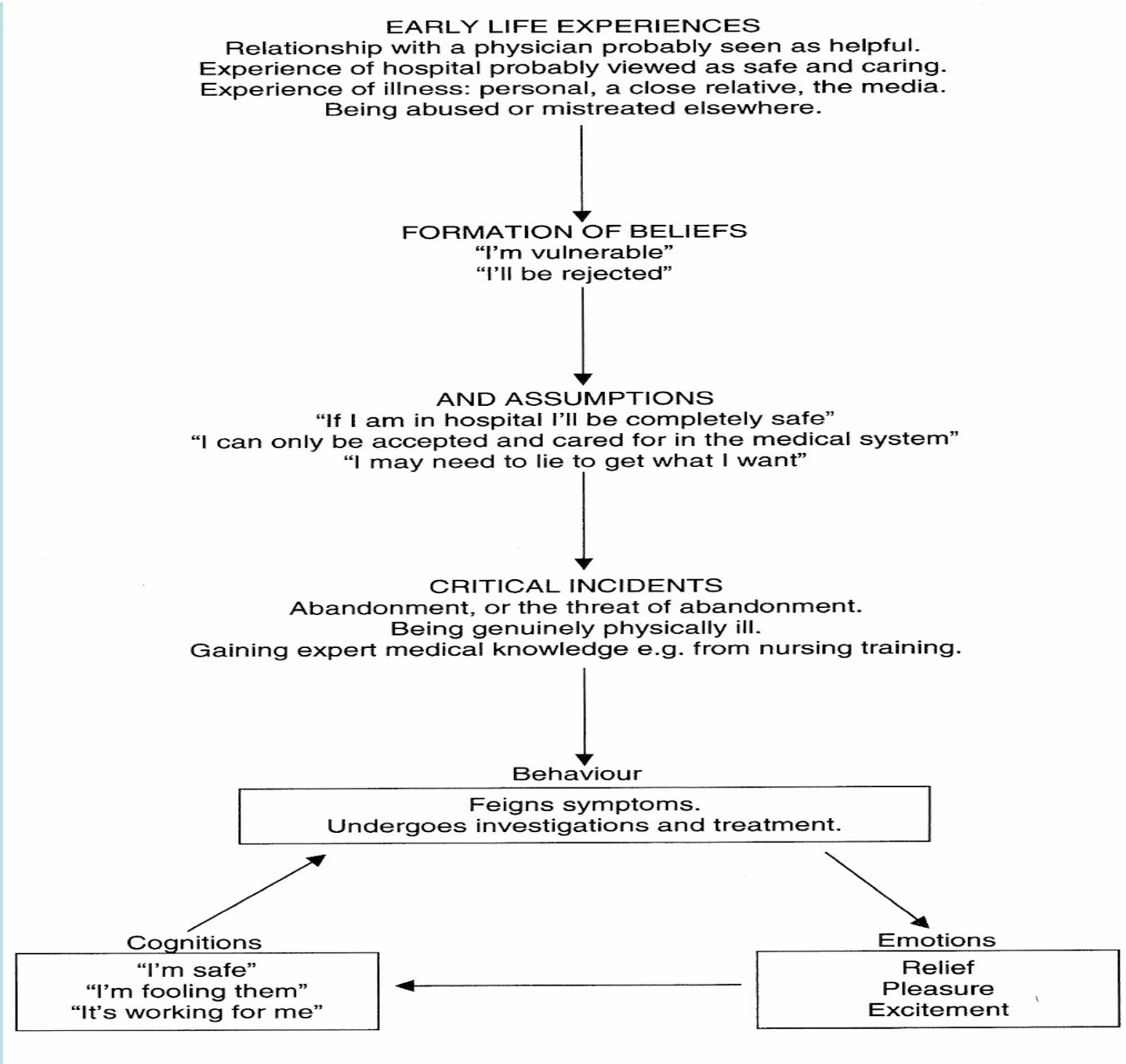
Assessment of the child's mother: Preparation

1. **Medical records of the child's mother**
   - **Hospital**
   - **GP (hand written and typed)**
2. **Medical records of child(ren)**
3. **Social work records/reports**
4. **Police records/videos**
5. **Legal documents**
   - **statements of mother and father**
   - **report of child's guardian**
6. **Interview mother and partner [*audiotaped, with consent*]**
7. **Interview grandparents**
8. **Telephone interview with GP, social worker, paediatrician, and guardian**

Disturbance of attachment representations

- FII as a function of disturbed mother-child attachment bond [1]
- Early attachment style has a direct effect on later parenting of one's own children
- Fearful attachment fully mediates link between childhood trauma and somatisation [2]

[1] Adshead G and Bluglass K. Br J psychiatry 2005;187:328-33.
[2] Waldinger R et al. Psychosomatic Medicine 2006;68:129-35.



Kinsella P. Behav Cog Psychotherapy 2001;29:195-202

Assessment of child's mother: interview

Interview: what am I looking for?

Explore, in a non-provocative fashion, the inconsistencies:

Eg. "*I see from the medical notes that when you were discharged from hospital on 22.4.1996 you were given a diagnosis of irritable bowel syndrome by Dr Brown; when you saw your GP Dr White the next week on the 26th you told him that you had bowel cancer. Can you clarify that?*"

"In Katie's GP notes on 6.3.2002 it says that you told the GP that Katie had bladder cancer; but Mr Black, who carried out the cystoscopy on 12.2.02 wrote to your GP on 16.2.02 to say that the cystoscopy was normal and that he could not find a cause for the blood in the urine. Can you clarify that?"

Interview: aknowledgement

Eg. *"The evidence from the records I have read suggests that you gave the anticonvulsants to Jerome on 3.5.04 and that the A and E notes from St Elsewhere Hospital document this on 5.9.04. Is that the case?"*

Attempt to establish whether acknowledgement is absent, partial, or full.

"*Is it possible that someone could have done this to Jerome without them being aware that they had done it?*"

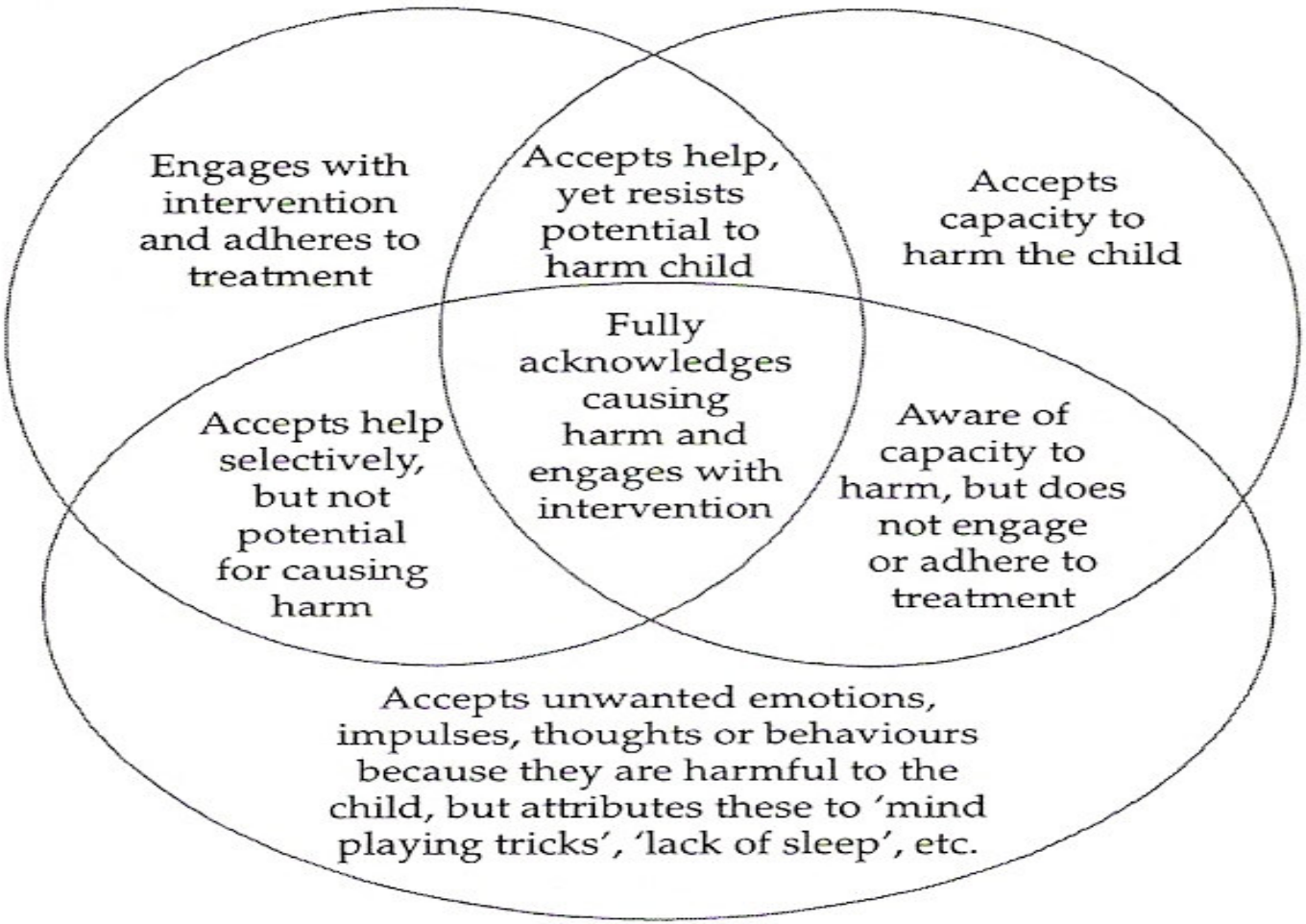


Fig. 1 The main components of acknowledgement. (Adapted by D. Jones from David, 1990.)

Psychopathology of mothers

N=47 (19 interviewed)

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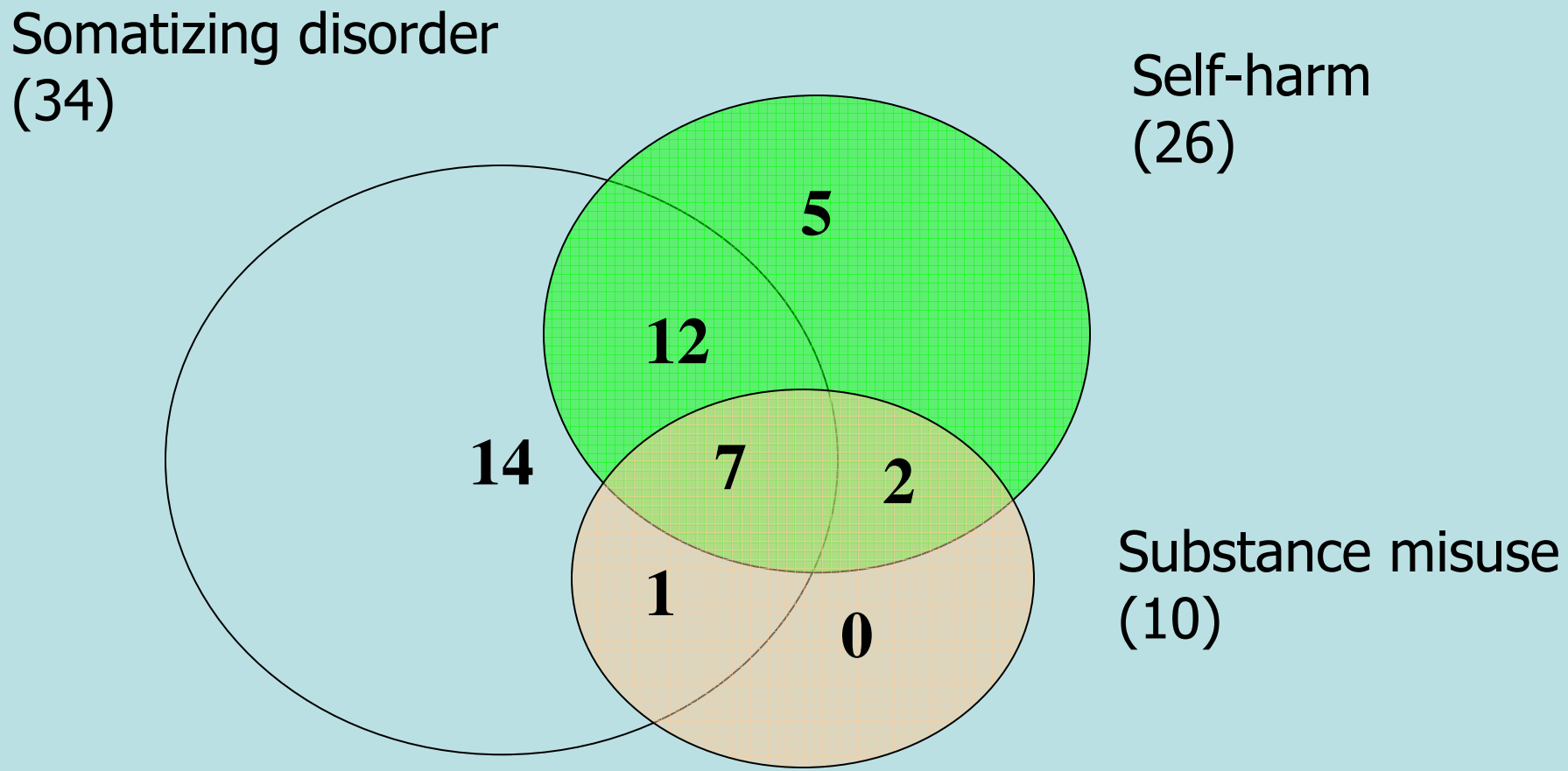
34 (72%) somatoform disorders
26 (55%) self-harm
10 (21%) alcohol/drug misuse

17/19 (89%) personality disorder

Bools C et al. Child Abuse & Neglect 1994;18:773

Relationship between somatizing disorder, self harm, and substance misuse for 41 mothers



Assessment of personality in 19 mothers

Types of personality disturbance (PAS; Tyrer 1989)

Antisocial	11
Histrionic	10
Borderline	10
Avoidant	10
Narcissistic	9
Schizotypal	8
Dependent	7
Paranoid	7

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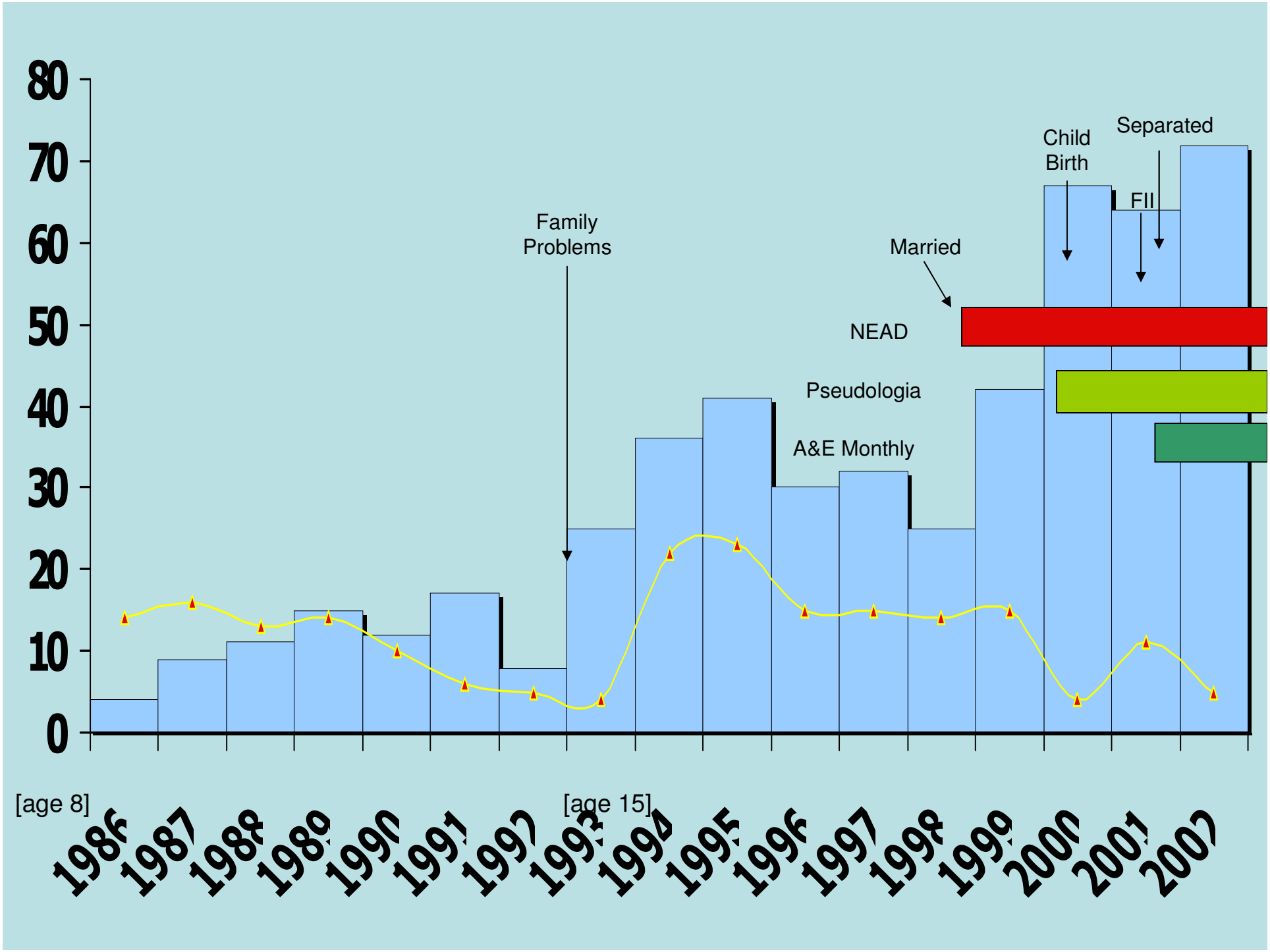
14 of 19 mothers scored >4 across 5 or more items on the PAS


80
70
60
50
40
30
20
10
0
Child Birth
Separated
FII
Family Problems
Married
NEAD
Pseudologia
A&E Monthly
[age 8]
[age 15]
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002

Hospital departments consulted 8/2001-4/2003

Symptoms	Departments attended
Blackouts and "seizures"	Neurology x 3
Neck spasm	Orthopaedic
Haemoptysis	Chest physician
Blurred vision	Ophthalmic surgeon
Hair loss	Dermatology
?pseudoseizures	Psychiatrist x 2
Bleeding PV	Obs and Gynae
Neck sprain;Injured knees; *Chest pain;Injured R leg* *Collapse;Allergic reaction* *Trauma at home;Pain R shoulder*	} A and E 20 visits in 18mths

Psychopathology of mothers (n=28)

Biographical data	**Mean age**	**28years**
	married	**15 (53%)**
Developmental data	**CSA/physical abuse**	**19 (68%)**
	Time in foster care	**11 (40%)**
Medical/Psych history	**MUPS/Fact illness**	**23 (82%)**
	Pseudoseizures (PNES)	**9 (32%)**
	?Epilepsy/skull fracture	**6 (21%)**
	Pseudocyesis	**6 (21%)**
	Pseudologia fantastica	**16 (57%)**
	Psych in-patient	**9 (32%)**
	Psych out-patient	**21 (75%)**
	DSH	**16 (57%)**
	Forensic history	**10(6 sh/lifg)**
Psychiatric diagnoses	**Somatoform/fact disorder**	**23 (82%)**
	Personality disorder	**20 (71%)**

FD and FII may be inter-related

- 75% of mothers of children have history of factitious or somatoform disorder
- 70-90% of mothers have axis II disorders (antisocial, histrionic, borderline, i.e. Cluster B)
- FD and FII can co-occur, so finding one should trigger search for the other**
- Pre-existing FD in mother can be abandoned after birth of child and extended to next generation through FII [Allitt]

**Feldman M et al, Gen Hosp Psychiatry 1997

Motives

- Often complex and not knowable
- ?mothers form disturbed relationships with health care professionals which replicate disturbed past relationships with carers
- History of deception going back to adolescence (pseudologia fantastica)

People makes things up in order to distance themselves from what is happening to them

16.8.2004

Overview of case management

- **Conclusion that condition is factitious**
- **Multi-disciplinary planning for the child's protection**
- **Separation of child and carer**
- **Psychosocial assessment**
- **Potential for re-unification?**
- **If yes, assessment & intervention**
- **Formulation of a care plan**
- **Long term follow up**

How are perpetrators managed?

- Psychological strengths/weaknesses
- Acknowledgement of abuse
- Motivation
- Whether convicted in court vs finding of fact (family court)

- If charged with assault –prison , or
  --probation order plus condition of treatment
- If not, then as for treatment of severe BPD

If family reunification not possible how should mother be treated?

- **Depends on key psychopathological findings**
- **Long term (3-5 yrs) individual treatment with experienced clinical psychologist (ev-based therapy)**

How do you measure outcome?

- **Acknowledgement of abuse**
- **Compliance /engagement**
- **Appropriate engagement with services (A &E;GP and hosp services; social services)**
- **Reduce alcohol/substance misuse**
- **Reduce DSH**
- **Reduce prescribed substance misuse**
- **Stop lying**

Summary

- **Wide range of psychopathology in fabricators**
- **Severe effects on children**
- **Links between FD and FII**
- **Perpetrator needs comprehensive assessment**
- **Interprofessional liaison essential**
- **Effective reunification possible for selected cases**
- **Long term follow up needed for mothers**
- **Effective management of PD in mothers**

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