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Feigned Alcohol Abuse
A Unique Case Report

A man presenting with factitious alcohol abuse and its alleged complications is described. It is argued that chronic factitious disorders are more logically viewed as part of that spectrum of conditions where there is abnormal illness behaviour, including somatoform disorders and other related conditions, than as separate nosological or diagnostic entities.

Case description

Presentation

In August 1985, a 41-year-old man, 'L. D.', was admitted for alcohol detoxification. He claimed to have had a 'black-out' for 5 months and therefore had no idea of how he came to be in New Zealand without possessions or identifying documents. He reported that he had resumed very heavy drinking after a 5-year period of sobriety, following his wife's death in a road accident in February that year. He gave a 26-year history of severe and chronic alcohol abuse, claiming at least eight admissions to various hospitals for detoxification, or for alcohol-related disorders, with complications due to alcohol abuse such as an injury to the arm while drunk, haematemesis, pancreatitis, fits, and blackouts. He said he had always been a solitary drinker, consuming a bottle of sherry mixed with a bottle of methylated spirits every day.

Family history

He said he was the youngest of three siblings, with a tragic family history. He came from a well-to-do family, but remembered with resentment that his parents had had little time for him in their active and heavy-drinking social life. In 1972 they had both been killed in a light aircraft crash. His brother had drowned while under the influence of alcohol and his sister had died 20 years previously from cocaine and heroin abuse.

Personal history

He could remember little of his early childhood, but had been expelled from school at the age of 15 years for bringing alcohol to school. He worked for his father as a deck hand for 7 years, and later trained as a chef at the Auckland Technical Institute.

He said he married for the first time at the age of 18 years, and had two daughters, but after 2 years his wife divorced him because of his drinking. She had returned to Canada, taking their children with her. In 1980 he had moved to Sydney, where he met and married his second wife in 1984. He claimed to have lost his job as chef at the Sydney Hilton because of the effects of the heavy drinking which was his response to her death. He denied abusing other drugs, and said that he had not been in trouble with the police, despite his long history of alcohol abuse. He claimed his physical health was not good, as he had been diagnosed as having angina, for which he took sublingual glyceryl trinitrate and oral isosorbide dinitrate.

Examination

He was neatly and relatively cleanly dressed, looked his stated age, and seemed well nourished. He had a tattoo of a kangaroo with 'Australia' written across it on his right forearm. There was a marked tremor of his hands, and he sweated profusely through the first and subsequent interviews, appearing to be anxious, with increased startle reflex. He reported himself to be 'down' but not depressed. He denied suicidal ideation, or any abnormal beliefs or experiences. There was no thought disorder. He appeared to be fully alert and not distractable, yet appeared to struggle with tests of concentration; for example, giving the months of the year backwards inaccurately and slowly, although he had normal digit span. He said he knew the year was 1985, but was anxious to convey his astonishment that it was August already. He had some difficulty remembering past details. He only managed to identify one of three pairs of objects without cueing, and needed a surprising amount of help to recall the others, in view of the fact that he remembered my unusual surname from the outset. On being asked who the Prime Minister was, he gave the name of the Prime Minister of Australia, not New Zealand. A physical examination showed him to be normal. There were none of the stigmata of alcohol abuse that one would expect from heavy and prolonged drinking.

Investigation

The results of blood screening (including mean corpuscular volume (MCV)), liver-function tests (including gamma-glutamyl transpeptidase (GGTP)), and ECG were all normal. EEG showed some minor slow activity without focal features. Psychometric testing revealed an average IQ, with no discrepancy between verbal and performance scores. There was no evidence of an amnesia, nor of frontal lobe impairment. The psychologist noted: " . . . appeared to have hearing difficulty but it was uncertain as to whether or not this was a device to allow him extra time to decide upon how to answer questions . . . L.D. applied only a very modest degree of effort".

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Progress

The patient was observed to settle in quickly on the ward remembering complex details with no apparent difficulty. He was on the whole pleasant and co-operative. His tremor appeared to come and go. He made numerous demands on the intern's time for minor symptoms for which no pathology could be found. He persisted in his claim to have a total 5-month amnesia. Due to the lack of proof from the physical and psychiatric examinations, and the flamboyant and colourful history with the alleged demise of anyone who could identify him, it was suspected that he was lying and that he might not have an alcohol-related disorder.

With L.D.'s permission, we searched unsuccessfully for any records of him, including birth records, records of his parents' fatal aircraft crash, evidence of attendance at the Polytechnic, or employment at either of Sydney's Hilton Hotels. There had indeed been a Mr L. D., who had been on an alcohol-abusers programme at the same time and in the same unit that our patient claimed to have attended, but he was at present living in another city. Again with L. D.'s permission, letters were prepared enclosing two photographs of him, and sent to over 40 hospitals and agencies dealing with alcohol-related problems. There was 16 positive identifications and six negative replies, spanning 10 years, and including 26 pseudonyms, which were usually flamboyant, or otherwise seemingly composed of various counsellors' names. This was at least his 25th admission, the most recent being just 3 weeks previously. He had attended 14 hospitals or alcohol-abuse treatment centres, being admitted up to five times in one unit. Only in the first admission in 1975 was there some additional external evidence (from the police) to collaborate his self-report of alcoholism. Unlike our own experience of him, others had found that challenging his story led to an adversarial response. In all reports, the results of physical examination, liver-function tests and MCV were normal. On four previous occasions, in addition to feigning alcohol abuse, he had feigned bereavement (Snowdon, 1978). The only reliable document concerning relatives was a lawyer's letter recording the dissolution of a very brief marriage that was physically abusive, and never consummated. Five admissions had been documented for physical symptoms. An operation to his knee was apparently for a genuine cause. The more dubious admissions were: once for alcohol-related haematemesis for which no cause was found; twice for chest pain, when normal ECG and effort ECG were recorded (for this he nevertheless continued to receive isorbide dinitrate); and once for 'fits', which were never observed, but for which he received phenytoin for some years. On one of three admissions when claiming amnesia he underwent a computerised tomography scan to exclude a subdural haematoma. On yet another occasion, while in prison for a petty crime, he had complained of visual hallucinations, and had been transferred to hospital.

When presented with the above facts L. D. declared himself mystified. We offered him continued support as an out-patient at the Centre for Alcohol- Related Disabilities provided that he obtained a job as soon as possible. The police had offered to run a computer search using his tattoo as a marker. This identified him under another alias, and resulted in him having to serve a prison term for failing to pay a motel bill.

Discussion

Since Munchausen's Syndrome was first described 25 years ago (Asher, 1951) the literature has contained many case reports and reviews on this subject and the related condition, factitious disorder. This case is a form of Munchausen's syndrome, but is unique in that it is the only one reported where alcohol abuse and its complications were repeatedly feigned. His self-report was usually accepted, not only in regard to his symptoms, but his history. This illustrates the reliance placed on any patient's self-report for diagnosis and consequent management.

His frequent wanderings from hospital to hospital, his use of flamboyant aliases, and the dramatic flair of his presentations support the case for Munchausen's syndrome. He needed more than an excuse for shelter, as is commonly encountered in alcohol-abusing vagrants. He needed the caring concern and involvement of medical professionals in his 'tragic' plight. His 5-month history of total and complete amnesia can be discounted in the face of the above.

As with many cases reported as Munchausen's syndrome, he presented over the course of years both real *and* fictitious symptoms, of a psychological *and* physical nature. If DSM–III (American Psychiatric Association, 1980) criteria are used, the possible diagnoses therefore are:

Axis 1; (a) somatization disorder
(b) factitious disorder with psychological symptoms
(c) factitious disorder with physical symptoms
Axis 2; personality disorder, ? antisocial
Axis 3; ischaemic heart disease (?)
Axis 4; no proven psycho-social stressors
Axis 5; poor adaptive functioning

This list of multiple diagnoses obscures the real condition of this patient and conveys a false sense of mastery to his attendants, by implying complete understanding of this patient's condition. Munchausen's syndrome is included as a factitious disorder in DSM–III terms. In differentiating between factitious and somatoform disorders, a subjective judgement must be made as to whether the symptoms are under voluntary control or not, which may also carry a covert moral judgement. It is presumed that if the symptoms are under voluntary control, the patient can easily stop the behaviour. Further difficulties arise in attempting to separate these above two classes of disorders, where

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the motives are said to be unconscious, from malingering, where the motives are said to be obvious from the environmental situation. This is again a subjective judgement on what is presumed to be happening in the patient's mind, and assumes that 'unconscious' functions are always truly unconscious.

Another cause of confusion for the attending physician is the decision: (1) whether there is genuine illness that can "be explained by a known physical disorder or pathophysiological mechanism" (American Psychiatric Association, 1980); or (2) that the behavioural response to an illness (or to not having an illness) is out of the bounds of normality. Therefore one can have: (a) an illness and behave abnormally, for example a patient with carcinoma and 'functional overlay' (psychological factors affecting physical condition, DSM-III, American Psychiatric Association, 1980) or show pathological denial of ill health, as in anorexia nervosa with cachexia; (b) no diagnosed illness, but behave as if one had an illness, for example in hypochondriasis, somatization disorder, conversion disorder, or psychogenic pain disorder (DSM-III). More logically, these conditions can be viewed as dysfunctional behaviours, not nosological entities, and have been called abnormal illness behaviours (Pilowsky, 1969), together with hypochondriasis, somatoform disorder, conversion disorder, anorexia nervosa, and others. These behaviours can all be seen as a variant of normal human behaviour (Roth, 1962), but because of an underlying psychiatric illness, neurosis, or personality disorder, taken to grotesque extremes, particularly in Munchausen's syndrome. Henderson (1974) wrote of "care-eliciting behaviour" that arises out of the desire for attachment, which is part of normal communal living. However, when this is the only means of interpersonal communication and affective expression, the behaviour is maladaptive, as in somatization disorder. Theoretically, this behaviour is 'extinguished' (in behavioural terms) when the patient learns less injurious ways of obtaining attachment.

In summary, these types of abnormal illness behaviour are subdivided on less than firm criteria. There is still a case to be made for these differentiations, if these divisions can help us to understand pathogenesis or guide management strategies. However, three points must be kept in mind. Firstly, these divisions are tenuous. Secondly, it is types of behaviour that are being observed. Psychopathology may indeed underly these types of behaviour, but a variety of abnormalities might well give rise to similar types of behaviour. Thirdly, these types of behaviour can be observed to a greater or lesser degree in the general population. People with Munchausen's syndrome may well represent the most deviant and damaged in the total population; the most isolated, and those with the most crippled coping skills.

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Fatal Deliberate Self-Harm seen in a Sri Lankan Hospital

A total of 328 patients were admitted for deliberate self harm (DSH) to the General Hospital Jaffna, Sri Lanka, during the year 1984. Twenty-two of these patients succumbed to their injuries. Information about these patients collected before death, and their methods of suicide, are reported.

Method

All patients were seen by the house officers in the medical or surgical wards on admission. They were also seen by the house officer in psychiatry within 24 h of admission; those who survived a longer period were also seen by the author (TG). Sociodemographic data, previous history of physical

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