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Feigned Bereavement: Twelve Cases

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SUMMARY Twelve patients who feigned bereavement are described. Most appeared depressed on admission, and in over half bereavement was erroneously believed by staff to be an important cause of their depression. This type of behaviour, leading to admission to hospital, may be regarded as abnormal illness behaviour, and reasons are given for considering most of the cases as variants of the Münchausen syndrome. Motivation for these deceptions is discussed, and reference is made to features which might arouse suspicion that bereavement is feigned.

There is no surer way of obtaining sympathy than to be depressed after losing a close relative, and most people can empathize with this condition. However, situations and facts can be falsified in order to obtain sympathy, love, care, attention, and approval. Distortions of reality are common, and often unconsciously contrived.

In this paper we are concerned with patients who report bereavements which in fact has not occurred—at least, not in the manner or on the occasions which the patients describe. We wish to draw attention to the frequency of such feigned bereavement, as well as to discuss its motivation. Six of the cases were referred to one of us (J.S.) from different surgical and medical wards within an 18-month period; other cases were admitted to our psychiatric ward from casualty or had been seen by colleagues in the hospital.

Case Reports

Details concerning 12 such in-patients at a London teaching hospital are summarized in Tables I and II. Six were admitted because of real or reported self-harm, one because of threatened suicide, and 5 for ostensibly non-psychiatric reasons. Brief reports of 3 cases are given; most cases fitted into the pattern illustrated by Cases 1 and 2, whereas Cases 9 and 10 were least typical of the group.

Case 1

A 41-year-old man was admitted to a surgical ward, reporting a ten-minute loss of consciousness after a fall. He appeared depressed and stated that his wife and two children had died two years earlier in a road accident. After transfer to the psychiatric ward discrepancies in his story were noticed. His doctor in Scotland informed us that the patient had never been married; some years previously he had had a series of admissions for physical complaints and was considered to be an example of the Munchausen syndrome. The patient discharged himself suddenly.

Case 2

A 28-year-old man presented to casualty giving a history of an aspirin overdose, but his serum salicylate level was found to be low. He said he had felt severely depressed since witnessing the violent accident in which his mother had died three weeks previously. She had fallen down steps and was impaled through the neck on some railings. The man was angry and defiant but appeared genuinely depressed; he seemed to want help to work through his grief. Next day he attacked a female patient and then discharged himself. Enquiries to verify his story (which included an elaborate and grand personal history) proved negative.

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TABLE I

Twelve patients at Middlesex Hospital who feigned bereavement

Case no.	Age/sex	Marital status	Known to use more than one name	Known no. of previous hospital admissions	Munchausen's syndrome diagnosed or suspected previously	Sudden discharge at least once	Reported recent bereavement
1	41 M	Single	—	Many (= more than 7)	Yes	Yes	Wife, 2 Sons
2	28 M	Single	Yes	6	—	Yes	Mother
3	34 M	Separated	Yes	Many	—	Yes	Wife, Daughter, Brother
4	20 M	Single	Yes	Many	Yes	Yes	Parents, Sister
5	34 M	Uncertain	Yes	Many	Yes	Yes	Wife, 2 Daughters Father
6	62 M	Single	Yes	Uncertain	Yes	—	Fiancee, Father
7	21 M	Single	—	Many	—	Yes	Wife, Father
8	22 M	Single	Yes	Many	Yes	Yes	Wife, Son
9	42 M	Divorced	—	4	—	—	Wife, Daughter
10	40 M	Uncertain	Yes	Many	Yes	Yes	Wife
11	27 M	Single	Yes	Many	—	Yes	Wife, 2 Children
12	50 F	Married	Yes	4	—	—	Husband

Two months later he was admitted to the Maudsley Hospital telling a similar story but using a different surname. Later it became clear that the same man had been in three mental hospitals in 1972, using other names, under similar circumstances.

Case 9

A 42-year-old man was admitted to a surgical ward for endoscopy, which showed distal oesophagitis. He appeared very agitated and stated that his wife and daughter had been killed five days previously. Three weeks later, after commencing treatment with antidepressants and ECT, he wrote out a 'confession' which admitted that his wife and daughter were still alive. He had had two wives and been divorced by both, and he admitted that he was now an alcoholic.

His depression lessened, he took disulfiram and became a member of Alcoholics Anonymous. But after six weeks he recommenced drinking and discharged himself.

Note that 11 of these cases were men, average age 35, and only two over 42. At least 3 drank excessively; only one appeared of low intelligence (I.Q. 81).

Discussion

Clinical features

These 12 patients were seen in a relatively short period. In over half the cases the supposed bereavement was thought by staff to be a major factor in their depression. What are the indicators that a story of bereavement may be false? One is lack of informants, or geographical difficulty in contacting them. Another is mode

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TABLE II

Behaviour and mood of the 12 patients

Case no.	Ward where first admitted	Reason for admission	Parasuicide before or during admission	Mood on admission	Bereavement thought by staff to be a major factor in causing depression	Later features
1	Surgical	Fall, with reported loss of consciousness	—	Depressed	Yes	
2	Medical	? Overdose	? Overdose	Depressed/ angry	Yes	Admitted to Maudsley, same story
3	Medical	Overdose	Overdose	Depressed	Yes	Twice re-admitted, denying previous admissions
4	Psychiatric	Wrist-cutting	Wrist-cutting	Depressed/ anxious	—	
5	Medical	Asthmatic attack	—	Depressed	Yes	
6	Psychiatric	Depression	(Claims he tried to gas himself)	Depressed	Yes	
7	Medical	Fit	Wrist-cutting	Depressed	Uncertain	Histrionic; pseudo-paraparesis
8	Medical	Overdose	Overdose, wrist-cutting	Depressed	Uncertain	Described hallucinations of little men
9	Surgical	Haematemesis	—	Depressed/ agitated	Yes	Resumed heavy drinking
10	Medical	Pains (various)	—	Normal	—	Imprisoned
11	Psychiatric	Depression	Overdose, jump off bridge	Depressed/ anxious	—	
12	Psychiatric	Depression	—	Depressed/ agitated	Yes	Returned home to husband

of referral, eg from medical and surgical wards where staff have been sympathetic to this type of story. Thirdly, the grief the patients describe (as well as what is observed) may seem unusual; it may be delayed, inhibited, extended, intense—as in some atypical cases of genuine grief described by Parkes (1964). Fourthly, the supposed death is dramatic, and the dead person is usually a child or young adult. This type of bereavement is particularly associated with atypical grief reactions (Parkes, 1972). Most of the patients described violent deaths of relatives, two gave details of suicides of relatives, and one said there was 'blood everywhere' when his wife died. Nursing staff sometimes became suspicious when patients who denied much previous medical contact seemed well aware of hospital routines. However, among all staff

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there was also a notable reluctance to accuse bereaved people of falsehood; this could lead to controversy.

There is at least an overlap between the presentation and progress of these patients and that of the Münchausen syndrome. Indeed six of them had previously been diagnosed as being examples of the syndrome. Most had used more than one name (Table I); the majority had been in-patients many times in spite of relative youth, and others *may* have been, but gave details that could not be checked; searching other hospitals' records would not necessarily have been productive since they might have used different names. At least six had been seen independently at both the Middlesex and the Maudsley Hospitals. Nine of the 12 patients left hospital abruptly (though not every time) when details of their deceptions were becoming clearer. Much of the histories given by patients had a fantastic quality, so that the description 'pseudologia phantastica' would seem apt.

However, a notable feature distinguishing 11 of our series from most previously described cases of the Münchausen syndrome was their observed depression. Asher (1951) did not refer to a psychiatric presentation of the Munchausen syndrome in his original description, but it seems appropriate to include in this category those cases in which persons repeatedly seek medical attention by simulating psychiatric symptoms. Persons who repeatedly crave hospital attention through overdoses or other self-harm are not usually considered to be feigning illness; but when this behaviour is associated with fabricated stories (eg Cases 2, 3, 4, and 8) there is justification for regarding it as a form of hospital addiction. A number of patients in our series simulated physical symptoms; some at least simulated mental symptoms; they all fabricated stories of bereavement, but this does not necessarily mean that all their observed symptoms (eg depression) were feigned.

Pathogenesis and motivation

This leads us to consider why the patients behaved in the way they did. Pilowsky (1969) describes a spectrum of motivation for such behaviour, from totally unconscious needs to allay guilt and become dependent, to entirely conscious searching for rewards, eg financially. A desire for financial gain appears to have been the prime motivation for the story of bereavement in Case 10. Social security officers have uncovered a number of cases where allowances have been fraudulently claimed for non-existent families. In Case 11 the man was imprisoned for fraud, though not directly because of his story of bereavement.

Apart from Case 10, all patients appeared depressed and/or showed self-destructive behaviour at some stage. In Case 1 the story was so convincing in detail and presentation that it seemed possible that the patient had at least partially convinced himself. In a number of cases there was obvious mental anguish even after gaining admission and attention, and it is probable that other losses or deprivations underlay their reactions. In Case 9 the patient was so deeply depressed that ECT was considered appropriate. Genuine reactions accounted for by feigned bereavement might be regarded as pseudo-malingering (Schneck, 1970); false stories provided reasons, excuses, for behaving in a depressed way.

It may be difficult to separate reality from fantasy, elaboration or invention, and conscious from unconscious motivation. Jaspers (1913–46) commented that 'once the game of fancy has started, it frequently leads to self-deception', and spoke of transformations from fantasy to hysterical realizations and pseudologia, the construction of delusion-like worlds, and 'self-surrender to a fictitious existence, which has arisen from an urge to get away from reality'.

In cases of the Münchausen syndrome Asher (1951) described an 'intense desire to deceive everybody as much as possible. Many of the subjects' falsehoods seem to have little point. They lie for the sake of lying.' In our own series, the elaborateness of some of the patients' fabrications suggests a similar predilection for falsehood, but varying in intensity, and maybe resulting in excitement but no recognizable pleasure. In some cases it seemed as though the patients were seeking a new life (with a new name) to get away from themselves and their problems.

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Our patients sought sympathy. When in due course deceptions were revealed, the staff (if previously sympathetic) were often left witn a sense of betrayal, of being 'taken in' (Vaisrub, 1974) on realizing that the foundation for the whole relationship was based on a deliberate deceit; this applied particularly to nurses who cared for those on medical and surgical wards. It applied most obviously, perhaps, when the bereavement was most credible and most convincingly the cause of suffering (Case 1); and it applied with particular force to a member of staff who had genuinely suffered bereavement similar to that described by the patient.

Management and implications

In half the cases, psychiatric treatment of their abnormal behaviour was prevented by sudden self-discharge. In others, attempts were made to understand why the stories were being told, with the aim of helping patients to understand themselves and eventually to develop alternative ways of attaining self-esteem. In most cases it was considered that medication would not be beneficial.

Management of cases of feigned bereavement was helped by discussion among staff, particularly of the feelings aroused. Reluctance to accuse can be replaced by determination to punish: staff should have opportunities to express their reactions, in order to develop insight into their own responses.

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References

ASHER, R. (1951) Münchausen's syndrome. *Lancet*, **260**, 339–41.

—— (1959) Malingering. *Medical Society of London's Transactions*, 75 (reprinted in *Talking Sense*, 1972. London: Pitman Medical).

JASPERS, K. (1913–46) *General Psychopathology*. English translation 1963 by Hoenig, J. and Hamilton, M. W. Manchester University Press.

PARKES, C. M. (1964) The effects of bereavement on physical and mental health. *British Medical Journal*, *ii*, 274.

—— (1972) *Bereavement*. London: Tavistock.

PILOWSKY, I. (1969) Abnormal illness behaviour. *British Journal of Medical Psychology*, **42**, 347–51.

SCHNECK, J. M. (1970) Pseudo-malingering and Leonid Andreyev's 'The Dilemma'. *Psychiatric Quarterly*, **44**, 49–54.

VAISRUB, S. (1974) The immortal baron. *Journal of the American Medical Association*, **230**, 90–1.

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