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FACTITIOUS DISORDER: A COGNITIVE BEHAVIOURAL PERSPECTIVE

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Abstract. This paper presents a cognitive behavioural perspective on factitious disorder. The DSM-IV definition will be given and aetiological and epidemiological information will be presented, whilst noting the difficulty in collecting data from this group. The difficulty in engaging the patient will be addressed. In assessing the patient, the role of early experiences, the beliefs about their feigning of symptoms, the gains from this behaviour and the reaction of others will be considered. The similarities with somatization and malingering will be discussed. A model of this disorder based on the Beckian approach will be given as will an explanation of why this disorder may become chronic. A treatment strategy will be suggested looking at helping the patient understand their disorder, discussing with them the pros and cons of alerting others to their feigning behaviour, helping them get their needs met in a more appropriate way, looking at the risks involved in the behaviour, and addressing issues of abuse.

Keywords: Factitious disorder, cognitive behavioural approaches.

Introduction

In this paper I will attempt to formulate the problem of factitious disorder with physical symptoms in cognitive behavioural terms. A cognitive behavioural approach has been helpful with other liaison psychiatry problems such as Chronic Fatigue Syndrome (Sharpe et al., 1996), and hypochondriasis (Warwick, Clark, Cobb, & Salkovskis, 1996), and it may therefore be helpful in the case of factitious disorder.

There is, however, a lack of systematic data on these patients, presumably because they are likely to drop out of follow-up, they may be peripatetic and they are unlikely to want to be researched. I will firstly attempt to briefly summarize what is known about these patients. I will then present a CBT model based on literature review, clinical observation and discussion with colleagues. I will not address the issues of factitious disorder with psychological symptoms or factitious disorder by proxy. The model is clearly speculative and I would welcome feedback.

The diagnostic criterion for the disorder, DSM IV (APA, 1995) is:

a. Intentional production or feigning of physical or psychological signs or symptoms.
b. The motivation for the behaviour is to assume the sick role.

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c. External incentives for the behaviour such as economic gain, avoiding legal responsibility or improving physical well-being, as in malingering, are absent.

It can present in a number of ways:

1. A factitious history.
2. A feigned presentation (e.g., complaints of stomach pains or headaches).
3. Self inflicted patho-physiology (as in injecting noxious substances into body tissues to produce swellings) (Hengeveld, Huyuse, Van Der Mast, & Tuinstra, 1988).

The literature is full of dramatic and remarkable case descriptions of such patients and the presentation may be single and short to long standing and repetitive, the latter often being called Munchausen Syndrome. A typical patient described in a recent book on the subject (Feldman & Ford, 1994), called Jenny, walked into work one day and announced she had breast cancer and was terminally ill. She received a considerable amount of care and nurture, despite in actual fact being perfectly healthy. This patient starved herself and shaved her head to mimic the effects of chemotherapy and also became a leading light in the local support group, where her positive attitude was praised. This deception continued for 2 years and when the truth came out, people were very hurt and the patient became ashamed and depressed and was admitted to hospital. The patient had started the deception when her boyfriend split up with her and the initial motivation was to evoke his sympathy.

Epidemiology

Very little is known about the disorder in terms of its prevalence, age of onset, sex ratio and course. Psychiatric liaison services report that factitious disorder is diagnosed in 0.2–1.5% of referrals (Hengeveld et al., 1988; Sutherland & Rodin, 1990). An unpublished study of 8509 psychiatric consultations in the Netherlands reports that the mean age of factitious disorder patients was 34.3 years; women represented 69% of the cases and patients were typically single and unemployed (Ford, 1983). It is clear from many reviews (e.g., Plassman, 1994) that caring professions, such as nurses and health workers, are over represented. This is striking and unexplained; it may be because health workers would be more adept at feigning illness and familiar with how health systems work, so their psychological distress may be channelled in this direction.

Diagnosis and categorization

A phenomenal range of symptoms has been feigned, using ingenious methods, and these symptoms include fever, hypoglycaemia, anaemia, and vomiting. There is commonly a delay before the diagnosis is made, which is unfortunate and may lead to inappropriate intervention, iatrogenic effects and considerable financial costs. For example, in 12 patients with intractable infections it took 6 years to discover that they were infecting themselves (Reich & Gottfried, 1983). Regarding the cost, a patient in San Francisco generated costs of $1,000,000 over one year with feigned aplastic anaemia (Eisendrath, 1996).

Clues to a patient being factitious are that they do not respond to standard treatment, have had a lot of medical care at a young age, have a high degree of medical knowledge, and there is a lack of collaborative information to support their medical history (Eisendrath,

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1996). In diagnostic terms there are two closely related disorders: somataform disorder where physical complaints not attributable to a physical disorder are present, but the symptoms are not intentionally feigned; in malingering there is a clear external incentive for feigning symptoms such as money or ''gaining a bed for the night''.

A problem with the DSM system is that it slots people into one diagnostic category, whereas it is clear from clinical practice that there is an overlap between somatization, factitious disorder and malingering (Cunnien, 1997). The somatizer is more concerned than the factitious patient with the adverse effect of the symptoms on himself and is less aware of the mechanism that leads to the symptoms. The malingerer has a clear gain in financial or other terms from the symptoms, which will disappear when no longer needed (Hengeveld, 1990). Although the factitious patient's main goal is to be in the sick role there may be significant ''external'' benefits to this, such as avoiding work, gaining insurance payments and so on; they may be very significant for the patient. Also persons may have complex beliefs about the acceptability of lying to meet their ends and it should be noted that deception may be part of the presentation of more routine psychiatric disorders such as substance abuse, eating and personality disorders (Cunnien, 1997). Hopefully, a CBT model would be more useful than a diagnostic model at disentangling the complexities of patients with puzzling symptoms.

Formulation

Earlier formulations of factitious disorder have been psychodynamic. Some of the key components of these explanations are:

1. Achieving control in a life dominated by chaos and abuse (Ford, 1983).
2. Masochism as a response to guilt about angry or sexual feelings. The abuse these patients have suffered is re-enacted in operations and investigations. The patient is believed to feel more in control on these occasions (Plassman, 1994).
3. Rage is directed at physicians who symbolize previous abusers. The rage takes a form of outwitting physicians and family. Many psychodynamic formulations see the symptoms as a defence against further psychological collapse (Plassman, 1994).

Looking at the behavioural literature there are only two reports that describe the treatment of cases; in terms of formulation these reports suggest that symptom production is reinforced by the attention and concern the patient achieves (Klonof, Younger, Moore, & Hershey, 1983; Yassa, 1978). These are more from a behavioural perspective than a CBT one.

A CBT model

A model of the disorder based on the traditional Beckian approach is given here. We know from case series that the factitious patient's early experiences involve some of the following: a particular relationship with a doctor or carer, an experience of hospital, an awareness of illness either suffered themselves or suffered by a close relative or from the media, and finally, an experience of abuse. Certainly, reviews of the disorder emphasize abuse; for example, of a sample of 22 patients, 61% had been abused as children, 24% had been raped, 19% had suffered incest and 28% had experienced a traumatic loss (Plassman, 1994). It is worth saying that their personal histories are likely to be less reliable than usual.

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Looking at the speculated belief structure of factitious patients in terms of other theories of personality such as Jeff Young's model of Early Maladaptive schemas (Young, 1998), it is suggested that their beliefs would be found in the ''disconnection and rejection'' domain where ''the need for security, safety, stability, nurture, empathy, sharing of feelings, acceptance and respect will not be met in a predictable manner''. The typical family of origin for this schema is said to be ''detached, cold, rejecting, withholding, lonely, explosive, unpredictable or abusive''. This upbringing may lead to the formulation of the following core beliefs ''I am vulnerable'' and ''I'll be rejected''. Related dysfunctional assumptions could be ''If I'm in hospital I'll be completely safe'' and ''I will only be accepted and cared for in the medical system'', and possibly ''I can only achieve what I want by lying''.

The beliefs may lie dormant until activated by critical events such as abandonment, boredom or further abuse. This could lead to feigning symptoms and the feigning may simply be presenting a false history of symptoms or may, at a more extreme level, involve behaviours to support the symptoms, such as putting blood in one's urine. At the more extreme end the patient may allow or encourage invasive medical procedures. The choice of a particular illness presentation is likely to depend on a variety of factors:

a. The patient's awareness of how the illness presents in terms of signs and symptoms.
b. The ease of feigning the symptoms.
c. The anticipated effect of presenting the symptoms.

It is certainly puzzling why people have invasive procedures done to them. It may be in some cases a form self-mutilation, a punishment of their own bodies in people who have been badly abused, as a dynamic formulation would hold (Plassman, 1994). However, it may also be necessary for the patient to submit to these procedures to maintain the credibility of the feigned illness presentation; or it may be a mixture of the above, or for other reasons.

Automatic thoughts associated with the feigning behaviour may be ''I'll be safe'' or ''this is working for me'', and accompanying emotional states may be relief, pleasure or excitement. A person may feign symptoms on just one occasion, or it may become a chronic problem. They are more likely to repeat if their goals are achieved, they are undetected, feel satisfied and it is practically easy to repeat. Of course it is likely that factitious disorder is a heterogenous condition. They may be motivated by some need for safety or nurture but may also be driven by anger related to previous real or imagined mistreatment by carers or physicians (Jonas & Pope, 1985).

Management issues

Regarding the issue of how one engages the patient, models of non-punitive confrontation have been developed. The confrontation is frequently followed by a period of in-patient dynamic psychotherapy. In terms of the CBT model presented, confrontation will presumably activate thoughts such as ''I won't have my needs met. I won't be looked after. I will be thrown back into an intolerable situation'', with associated anxiety. There will also be shame and embarrassment associated with being found out. It is therefore understandable why these patients often flee.

Non-confrontational strategies have also been used, often with a ''face saving'' element. Klonoff et al. (1983) applied behavioural treatment to a patient with factitious non-epileptic seizures. This involved positively reinforcing improvement by using biofeedback as a sup-

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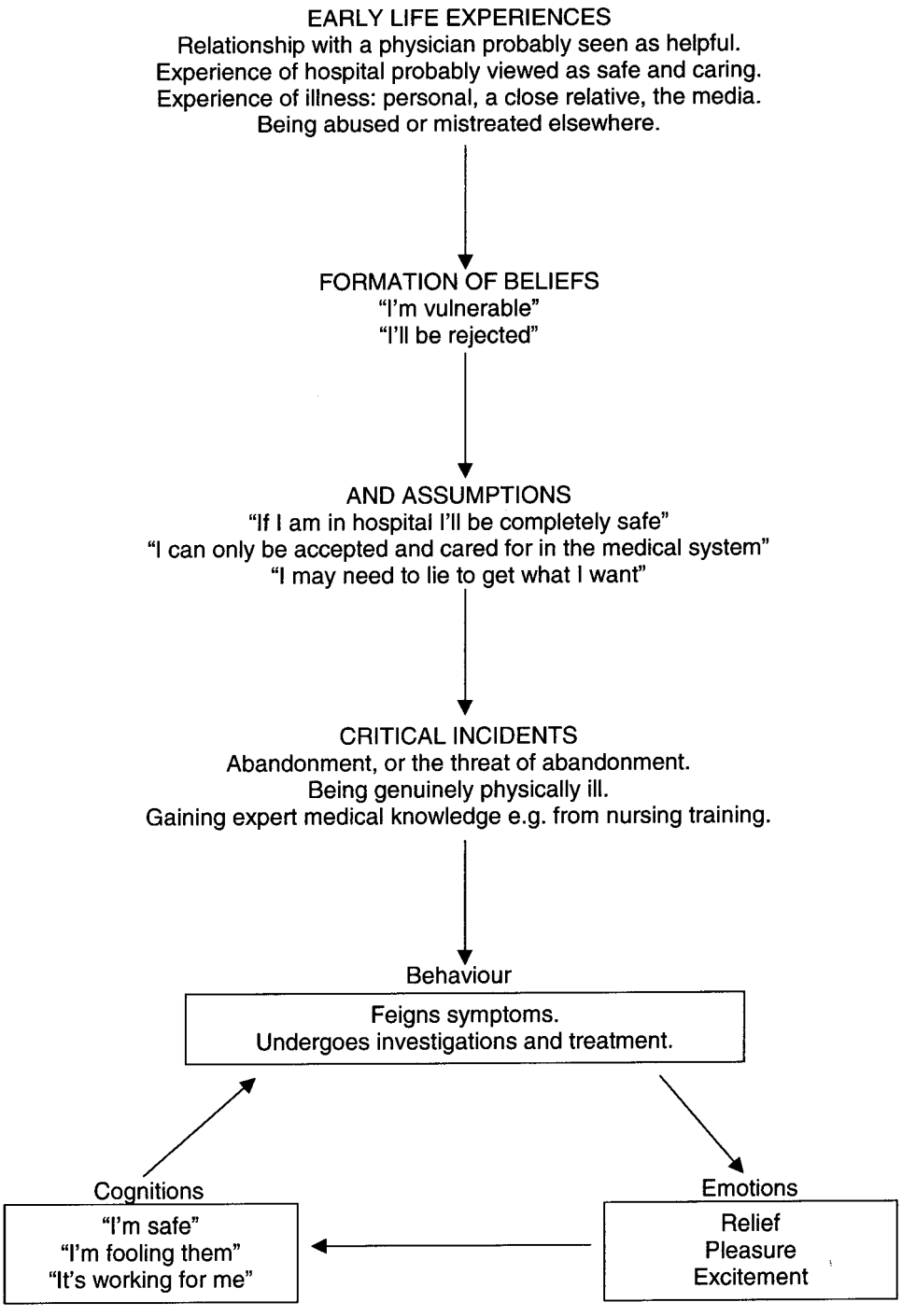


Figure 1. Diagram of Model

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posed ''curative'' agent. Schwartz and colleagues (1993), successfully treated a patient with factitious cellulitis. Their intervention included paradoxical free access to hospital, wound care, holistic help and rehabilitation, limited tests, weekly psychotherapy and amitryptiline. Eisendrath (1996) put emphasis on using ''face saving'' techniques and has developed a ''therapeutic double blind''. In this, the patient is challenged to: 1) Prove that the disorder is not factitious by responding to a benign medical treatment or 2) Prove that the disorder is factitious by not responding. Teasell and Shapiro (1994) used a double blind approach with rehabilitation patients who had ''factitious motor disorder''. Their symptoms were interpreted as due to a physical cause, but amenable to full recovery. They were told that if they recovered fully, it would indicate organic pathology, but less than complete recovery would suggest a psychiatric cause. The patient was given a course of physical therapy with ''remarkable success''. Plainly, these face-saving approaches require very consistent multidisciplinary working.

Looking at the pros and cons of confrontation in terms of the CBT model described here, it is suggested that patients who are in the process of being uncovered are likely to have one of the following beliefs:

a. ''I can't stop'' or ''I won't stop''.
b. ''I need to stop, but I cannot admit I have deceived''.
c. ''I need to stop, admit it and get help''.

The patient who will not stop is the biggest challenge; if he is confronted, he is likely to bolt and go to another hospital. These problems present considerable management problems for both health systems and society that are beyond the scope of this paper. A non-confrontational approach may work for a while, but if the benign medical treatment does not work and the patient is given a factitious diagnosis directly, he is likely to depart at this point.

The second type of patient who wants to change, but is scared to admit deception, may respond to the ''double blind''. This may best be presented to the patient in the following way: ''You have a condition, which may be physical or psychological. We know that treatment X is effective in this condition and we would ask you to have it. If the treatment does not work then this means that your condition is psychological''. It is possible to have ethical concerns about this because of the element of deceit; it probably can be justified in terms of the medical treatment being benign and the procedure being in the patient's best interest. I suspect that the determined factitious patient would not have difficulty in undermining or outwitting the ''double blind''.

The detailed therapy with the third group will be described next. The CBT therapist would have to be aware of transference issues. The hot cognitions in the initial meeting will be ''I need to be looked after'', ''I am ashamed of myself''. These need to be quickly addressed in the therapeutic relationship. The therapist needs to adopt a nonjudgmental, accepting attitude to limit the patient's potential shame. It is likely that the patient will want to be looked after by the therapist. A therapy protocol could be assessment, formulation, behavioural and negative thought change and finally schema work. The assessment would look particularly at triggers for factitious behaviours, gains and losses, alternative coping strategies, and detailed assessment of recent episodes. In this mental state examination it would be important to detect co-morbidity, for example, depression or substance abuse. Personal history would help the therapist understand schema development.

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The therapy should first help the patient understand why he is acting in this way; the face-saving issue should be addressed next, and the pros and cons of alerting family and professionals should also be dealt with; for example, coming clean to everyone may be a deterrent to continuing the behaviour. The immediate trigger should be addressed and the problem solved as much as possible. In the same way as one would deal with anorexics, the physical dangers of repeated medical procedures should be emphasized. Discussions should take place on how the person's needs can be met in a more appropriate way in terms of pleasurable gratifying activities; activity scheduling may be used here. Emphasis may need to be put on balancing out the benefits of the behaviour against the costs in terms of relationships and health in the longer term. The patient's unhelpful schemas need to be accessed and addressed.

The main problem with therapy will be engagement, particularly as the patient may swing between wishing to change and thinking that the factitious behaviour is the best way to get his needs met.

Beck et al. (1990) have various suggestions for dealing with potentially dependent patients. It may be necessary to allow some initial dependency, but the therapist needs to work to wean the patient away from this as soon as possible. To encourage independence patients should be allowed to set behavioural targets from an early stage and take increasing responsibility for the therapy. Regarding termination issues, Beck and associates suggest sessions should be faded out and the patient could be given control of this. The patient could be offered almost indefinite booster sessions.

A patient I treated fitted fairly well into the model. She had been sexually abused by her grandfather and had started a career of admissions to hospital to escape his attentions. In adult life she had many admissions to psychiatric hospitals with dramatic psychotic and depressive symptoms. Many of these were to escape abusive relationships. She had recently begun a caring relationship but when her partner worked away or there were problems, she would feign asthma and gynaecological symptoms. Her beliefs were ''I cannot cope by myself'', ''I'm helpless'' and she got relief from tension by being admitted, which gave her partner a powerful message. However, she was seeking to stop this behaviour. We agreed a clear formulation, examined her triggers and discussed ways of dealing with them more constructively, such as developing a wider social network and seeking non-medical help. Unfortunately, she dropped out after a few sessions; she was ashamed of the problem and did not like information being recorded in her psychiatric notes. It may therefore be important to discuss the issue of confidentiality at the start of therapy.

Further research is clearly needed to test the validity of this model and to address the nature of early beliefs, the role and nature of activating events, and why the disorder can become chronic.

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