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## Factitious disorders and trauma-related diagnoses

BY DANIEL BROWN, PH.D.

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*The recent plethora of lawsuits involving allegations of iatrogenically implanted memories of satanic ritual abuse and other traumas has highlighted the existence of a unique group of psychiatric patients. Although these patients are often successful at deceiving therapists (and sometimes juries), the case studies in this special issue reveal the chronic nature of their propensity to invent traumatic identities and past histories. The core clinical features of affect dysregulation, somatization, and impaired object relations, together with frequent histories of alcohol and substance abuse, parallel the psychiatric co-morbidity frequently found in genuine trauma victims. These case studies also point to early childhood problems in attachment, and sometimes to real childhood trauma, as possible etiologic factors. The current diagnostic system does not adequately capture the full range of these patients' psychopathology, which involves the creation of factitious identities and fictional traumatic personal histories. The particulars of these histories change over time as the patients incorporate, deliberately and/or "unconsciously," details derived from outside sources. Although clearly susceptible to being influenced by authority figures of all kinds, it is evident from these case studies that the core psychopathology at work here is intrinsic to the patients and not the by-product of therapeutic misadventure.*

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The prevalence rates of psychological forms of factitious disorders and the appearance of more complex forms of psychological factitious disorders have increased significantly in the 1980s and 1990s. Case reports of factitious illness in the 1960s and 1970s were mainly limited to the fabrication of physical symptoms, and in the 1970s and 1980s also to the simulation of a single psychiatric illness, such as factitious depression. In the 1980s and 1990s there emerged more complex forms of psychological factitious illness that entail not only the simulation of one or more psychiatric conditions—typically posttraumatic stress disorder and dissociative identity disorder—but also the simulation of elaborately fabricated personal histories and identities, including, at times, highly exaggerated and bizarre histories such as those involving ritual abuse. Even more recently still other new forms have emerged, such as factitious false memory syndrome in the context of malpractice litigation. The current diagnostic nomenclature is inadequate in that it fails to address these complex forms of factitious disorder; thus clinicians and forensic experts do not have the conceptual tools and detection skills to correctly identify complex forms of factitious behavior typically associated with trauma-related diagnoses. This paper was written, as were the rest of the articles in this special issue of *The Journal of Psychiatry & Law*, to fill that void.

## 1. The history of factitious disorders

Factitious disorder first appeared as a diagnosis in the third edition of *Diagnostic and Statistical Manual of Mental Disorders, DSM-III*, published in 1980. A person with a factitious disorder voluntarily feigns symptoms of some illness in order to derive the attention accompanying the “sick role.” Despite attempts to clarify the parameters of this rather new diagnostic entity in the successive versions of *DSM-III-R* and *DSM-IV*, factitious disorder patients remain “a poorly understood group of people.”<sup>1</sup>

Modern study of factitious disorders began in 1934 with Karl Menninger's collection of case histories of patients suffering from "polysurgery addiction."<sup>2</sup> In 1951 Asher coined the term "Munchausen's syndrome," after a German baron well known for telling fantastic tales. Asher defined Munchausen's syndrome as an "acute [fabricated] illness supported by a plausible and dramatic history." He characterized the condition in terms of an "intense desire to deceive everybody as much as possible . . . based [on a] desire to be the centre of interest and attention." According to Asher, the medical report of the Munchausen's patient is "largely made up of falsehoods and fantasy," and the most remarkable feature of the illness is its senselessness.<sup>3</sup> Bursten was the first to attempt an early clinical description of the disorder. Such patients embark on a "life perpetually in search of hospitalization and instrumentation." He described three major features of the condition: (1) a dramatic presentation of one or more medical complaints; (2) pseudologia fantastica, or falsely elaborating symptoms and histories; and (3) "wandering" from clinic to clinic and from doctor to doctor. Bursten emphasized that such patients essentially are "imposters," who defend against a sense of inferiority by avoiding their true identity and by assuming false roles.<sup>4</sup>

Despite these early formulations, factitious illness was rarely diagnosed in the 1960s. Only 12 cases of Munchausen's syndrome were reported in the literature before 1960, and by 1968 the number had risen to only 36. Most of these cases pertained to feigning medical conditions.<sup>5</sup>

In 1968 Spiro reviewed 38 cases of factitious illness. He saw Munchausen's syndrome as a specific type of factitious illness characterized by a chronic, unremitting course over time. Spiro emphasized that despite their fabrication of largely medical symptoms, these patients are best given a primary psychiatric diagnosis.<sup>6</sup> Other clinicians since Spiro have likewise emphasized the psychiatric nature of this condition.<sup>7</sup>

The number of case reports of factitious illness increased in the 1970s and 1980s. Reich and Gottfried described case reports of 41 factitious patients seen at a Boston hospital from between 1970 and 1980.<sup>8</sup> Folks and Freeman reported on 28 cases seen between 1980 and 1985.<sup>9</sup> Prevalence rates for the condition have been estimated at 0.2%–0.8% of patients, with estimates of up to 10% for factitious fever reports.<sup>10</sup>

The types of medical illnesses feigned by factitious disorder patients are as diverse as the disease itself,<sup>11</sup> and it is conceivable that factitious behavior can occur for almost any physiological system in the body.<sup>12</sup> Some attempts have been made to categorize factitious medical manifestations into subtypes, such as self-induced infections, simulated medical illnesses, chronic wounds, and surreptitious self-medication.<sup>13</sup> More recently, factitious cancer<sup>14</sup> and factitious AIDS<sup>15</sup> have become more popular.

Historically, it remains true that the majority of traditional cases of factitious illness pertain to feigning *medical* conditions.<sup>16</sup> However, the past several decades have been characterized by a remarkable increase in factitious *psychiatric* conditions.<sup>17</sup> Here again, the possible psychiatric manifestations of factitious illness are so diverse that they are hard to classify. Common forms of factitious psychiatric illness reported in the literature included factitious depression and grief;<sup>18</sup> factitious psychosis and schizophrenia;<sup>19</sup> factitious neurological conditions, e.g., epilepsy;<sup>20</sup> and feigned alcoholism.<sup>21</sup>

The classification of factitious disorders gets even more complicated due to reports of a co-existence of factitious physical and psychological symptoms<sup>22</sup> and also because of the co-existence of factitious and genuine psychiatric conditions, typically eating disorders and alcoholism, in the same patient.<sup>23</sup> A history of chemical dependency is strongly associated with the subsequent development of a factitious condition.<sup>24</sup>

## 2. Clinical features of factitious disorder

A factitious disorder is best defined as an “artificial production or simulation of a disease [or history].”<sup>25</sup> Like malingering, factitious behavior involves deliberate deception and often intentional self-harm.<sup>26</sup> Symptoms are dramatically presented, and the production of symptoms and/or histories is exaggerated when the patient is being observed. According to Folks and Freeman, the three essential clinical features include pathological lying, recurrent simulated illnesses, and wandering from clinic to clinic assuming a sick role. Supporting evidence includes borderline or antisocial personality traits, childhood deprivation, equivocal results from diverse diagnostic and treatment procedures, evidence of self-induced symptoms, knowledge of the medical field, multiple hospitalizations, multiple scars, a police record, and a dramatic presentation.<sup>27</sup>

Similarly, Ireland et al. described the essential clinical features as simulated dramatic illness; spurious signs of disease produced by self-mutilation or drug abuse; multiple hospitalizations; pathological lying; aggressive, disruptive, or evasive behavior; and premature discharge against medical advice.<sup>28</sup> Multiple patient identities in the same patient over time are quite common,<sup>29</sup> as is a chronic unremitting course.<sup>30</sup>

Some experts have described a continuum of simulating disorders. Cramer et al., for example, see malingering, factitious disorder and somatoform disorder along a continuum.<sup>31</sup> Nadelson, likewise, has described a continuum of simulation, ranging from abnormal illness behavior (malingering and factitious behavior), somatization, conversion disorders, psychogenic pain disorder, hypochondriasis, and patients with “real” illnesses.<sup>32</sup>

Dworkin and Caligor describe a three-dimensional model used to distinguish a factitious disorder from related conditions: symptoms (physical vs. psychological); production of

symptoms (voluntary vs. involuntary); and motivation (conscious vs. unconscious). Unlike malingering, factitious behavior is characterized by unconsciously motivated behavior, and unlike somatization disorder, factitious behavior is characterized by voluntary production of symptoms.<sup>33</sup>

Furthermore, patients engaging in factitious behavior can do so at different “levels of enactment.” At the lower level the patient simply reports false symptoms. At an intermediate level the report is accompanied by simulation behavior. At the higher level of enactment the patient actually creates the illness through self-inflicted, symptom-producing behaviors.<sup>34</sup>

Most experts agree that the basic motivation associated with factitious illness is the compulsive need to assume a sick role in order to get attention or care-taking. In fact, “this goal of obtaining care differentiates factitious illness from other self-destructive behaviors.”<sup>35</sup> However, patients may also engage in factitious behavior to avoid responsibility and to deflect from disappointments in life.<sup>36</sup>

One unresolved issue is the extent to which factitious behavior is voluntary or involuntary. Most experts agree that the simulation of symptoms and/or fabrication of a history is voluntary behavior, while the motivation to adopt a sick role is largely involuntary. While the creation of fabricated symptoms may be voluntary, and the patient is aware of producing false symptoms, the patient actively tries to keep such simulation a secret. However, since factitious behavior essentially is deception, it can entail self-deception in addition to other deception, so that such behavior, although voluntarily produced, nevertheless may not be fully in awareness. Furthermore, it is not always easy to differentiate between conscious and unconscious production and motivation.<sup>37</sup>

### 3. Refining the factitious disorder diagnosis— “hysteria split asunder”

The concept of a factitious disorder diagnosis came from a classic paper titled “Hysteria Split Asunder” published in 1978, just before *DSM-III* replaced the previous *DSM-II*.<sup>38</sup> In that paper Hyler and Spitzer made the point that the *DSM-II* concept of “hysteria,” much like the idea of “insanity,” was over-inclusive, diagnostically imprecise, and difficult to test empirically. They believed that “hysteria” could be divided conceptually into a variety of discrete subgroups, and that well-defined criteria could be established for each of these unique diagnostic entities. In essence, “hysteria” was split into four individual categories and then eliminated as a generic category from *DSM-III*: histrionic personality disorder (Axis II); somatoform disorders (Axis I); dissociative disorders (Axis I); and factitious disorder (Axis I). According to this new classification, conversion disorder became a subtype of the generic somatoform disorders category, and somatoform and dissociative disorders were separated from each other, the former pertaining to physical symptoms and the latter to mental symptoms (with respect to consciousness, identity and memory). Factitious disorders were differentiated from somatoform disorders based on the voluntary production of physical symptoms in the former group as compared with an involuntary report of physical symptoms in the latter group. Like malingering, factitious disorders are voluntarily produced forms of deception. Unlike malingering, factitious disorders are not obviously linked to environmental goals, such as monetary gain.

In this new system, factitious disorder appeared as a genuinely new diagnosis. The basic idea was to delineate the dissimulating feature of hysteria as a separate diagnostic entity in its own right.<sup>39</sup> With this new factitious disorder diagnosis, the idea that certain patients might engage in systematic, planned deception of their doctors, not for monetary gain but for purely psychological reasons, reached a new level of legitimacy.



#### 4. Factitious disorder in the editions of the *DSM*

*DSM-III* (1980) was the first edition of the *DSM* to include the diagnosis of factitious disorder as a new type of dissimulating disorder. According to the *DSM-III*, the following criteria are used for a factitious disorder:

- A. Plausible presentation of physical symptoms that are apparently under the individual's *voluntary control* to such a degree that there are multiple hospitalizations.
- B. The individual's goal is apparently to *assume the "patient" role* and is not otherwise understandable in light of the individual's environmental circumstances.<sup>40</sup>

These criteria emphasize the voluntary production of symptoms, motivated by a desire to assume the sick role. The caveat "not otherwise understandable in light of the individual's environmental circumstances" was meant to underscore the importance of differentiating between malingering and factitious behavior. *DSM-III* also explicitly defines Munchausen's syndrome as a chronic form of a factitious disorder pertaining mainly to physical symptoms.

One of the striking features of these *DSM-III* criteria is that little emphasis is given to factitious *psychological* conditions (or to atypical forms of factitious disorder). Although *DSM-III* sets up a separate category for psychological factitious symptoms, such symptoms are considered quite rare (e.g., Ganser's syndrome).<sup>41</sup>

Several years later the *DSM-III-R* defined the criteria for factitious disorder in the following manner:

- A. Intentional production or feigning of physical [or psychological] symptoms.
- B. A psychological need to assume the sick role, as evidenced by the absence of external incentives for the behavior, such as economic gain, better care, or physical well-being.
- C. Occurrence not exclusively during the course of another Axis I disorder, such as schizophrenia.<sup>42</sup>

Thus several modifications appear in the *DSM-III-R* that are not found in the original 1980 criteria. In the *DSM-III-R*, the meaning of “voluntary control” is more carefully defined as “deliberate and purposeful (intentional),” but not necessarily under the patient’s control. Such control may be deliberate but also “have a compulsive quality.”<sup>43</sup> The *DSM-III-R* also makes more explicit the lack of external incentives operative in factitious behavior, as compared with malingering. A factitious disorder differs from malingering on the basis of an intrapsychic need. Because many more cases of factitious psychological symptoms had been reported in the literature in the early 1980s, *DSM-III-R* also keeps the DSM demarcation between factitious physical and factitious psychological symptoms, but it gives greater definition to the boundaries between each of these categories.<sup>44</sup>

The exclusionary rules of these *DSM-III-R* criteria are very interesting. Generally speaking, a factitious disorder diagnosis is not given if another (real) Axis I psychiatric condition is present (e.g., C. “Occurrence not exclusively during the course of another Axis I disorder, such as schizophrenia.” But see elsewhere, “The presence of factitious physical or psychological symptoms does not preclude the coexistence of true physical or psychological symptoms”).<sup>45</sup> Thus the diagnosis of a factitious disorder is made very conservatively in the presence of a real Axis I psychiatric condition, and *DSM-III-R* clearly downplays the possibility of co-existing factitious behavior and a real Axis I condition. However, a factitious disorder diagnosis is not made exclusive of an Axis II diagnosis or of substance abuse, so that it clearly is possible to have factitious behavior co-existing with a personality disorder diagnosis under *DSM-III-R* definitions.

The *DSM-IV* currently defines a factitious disorder as follows:

- A. *Intentional production* or feigning of physical or psychological signs or symptoms.

- B. The motivation for the behavior is a psychological need to assume the *sick role*.
- C. An absence of external incentives . . . the behavior is *not better accounted for by another Axis I or Axis II disorder* (e.g., not in response to command hallucinations, not a consequence of a suicide attempt).<sup>46</sup>

The distinction between factitious disorders with predominantly physical symptoms and those with predominantly psychological signs and symptoms is preserved from *DSM-III-R*. However, *DSM-III-R* uses separate criteria for factitious disorder with physical symptoms and for factitious disorder with psychological symptoms. *DSM-IV* uses a single generic set of criteria for factitious disorder, and it lists physical, psychological, and mixed factitious forms as subtypes.<sup>47</sup> This represents a conceptual improvement, in that use of the current criteria contains an appreciation that factitiousness can take a variety of forms. *DSM-IV* also contains a “parsimony clause” in that a factitious disorder diagnosis is not recommended if the symptoms can be accounted for by another Axis I or Axis II disorder.<sup>48</sup> Unfortunately this type of thinking, as we will see later, makes it difficult to detect cases in which factitious behavior co-exists with genuine psychiatric illnesses.

Another important change in *DSM-IV* is the recommendation of a new type of factitious disorder not otherwise specified, factitious disorder by proxy, the details of which are included in a list of empirically derived research diagnostic criteria.<sup>49</sup>

In the international diagnostic nomenclature, *ICD-10*, factitious disorders are included under Section F6, Disorders of Adult Personality and Behavior:

FD F68.1 Intentional production or feigning of symptoms or disabilities either physical or psychological (factitious disorder).

- A. A persistent pattern of intentional production or feigning of symptoms and/or self-infliction of wounds in order to produce symptoms in the absence of a confirmed physical or mental disorder.

- B. No evidence can be found for an external motivation (such as financial compensations, escape from danger, more medical care, etc.). If such evidence can be found, category Z (malin-gering) should be used. (World Health Organization, 1990, p. 368)<sup>50</sup>

While *ICD-10* maintains the basic notion of factitiousness as a simulation disorder as found in the *DSM* classifications, it does not include anything about assuming a sick role, and it rejects the idea of an unconscious motivation. Furthermore, factitious disorders as defined by the *ICD-10* are much more closely aligned to personality disorders than in the *DSM* interpretation.

## 5. Diagnostic criticism

While the basic intention of creating a new *DSM* diagnosis of factitious disorder so as to delineate a disease of deliberate deception based on psychological needs is admirable, the enterprise has been somewhat ill conceived. Well-designed systematic field trials of the new diagnosis have not yet been conducted, and most of the published literature on the disorder still consists mainly of case reports.<sup>51</sup> Interrater reliability of the diagnosis (kappa coefficients) remain unacceptably low—lower than most other *DSM* diagnoses.<sup>52</sup> In part, the problem stems from the fact that the conceptual basis for the disorder and its specific diagnostic criteria are not very clearly delineated. According to critics, “the rationale that underlies and informs the diagnostic criteria for factitious disorder is, at present, logically indefensible and empirically unfounded.”<sup>53</sup> A number of problems with the diagnostic category have been identified.

- a. The problem of establishing motivation  
Ultimately the clinician has to make a subjective judgment about whether the deceptive behavior is voluntary or involuntary, and whether or not it is motivated by an unconscious need to assume a sick role. According to Rogers et al.:

Motivation (conscious or unconscious, voluntary or involuntary) is the determining factor in the diagnosis of factitious disorder with psychological symptoms. . . .

Furthermore, the voluntary aspect of its clinical presentation, the pivotal aspect of factitious disorder, remains unresolved and controversial.<sup>54</sup>

Many experts concur that making such a determination is not always easy or always possible.<sup>55</sup> Utilization of countertransference reactions is not a reliable way to make the diagnosis.<sup>56</sup> The problem is further complicated by the fact that simulation behavior in a given factitious disorder patient may arise from very diverse and conflicting motives within the same patient.<sup>57</sup> Based on the unreliability of such subjective judgments, some experts have recommended that the clinician sidestep the determination of motivation entirely and make the diagnosis based on the deceptively produced signs and symptoms alone:

Therefore, an appropriate strategy might be to set aside the slippery question of what is conscious and what is voluntary, and concentrate on the objective features of patients displaying factitious signs or symptoms.<sup>58</sup>

Irrespective of the determination of voluntary/involuntary and conscious/unconscious motivation, the bottom line remains: a systematic pattern of deceptively produced symptoms and/or history.

b. The problem of diagnostic boundaries—exclusion, inclusion, overlap & co-existing conditions

Rogers et al. have criticized the lack of conceptual clarity with respect to exclusion and inclusion criteria in making a factitious disorder diagnosis. They believe this diagnosis “does not appear to satisfy the requirements for a mental disorder of inclusion, exclusion, and outcome criteria.” They further point out that many patients with factitious behavior have concurrent real Axis I psychiatric conditions, and that patients with Axis II diagnoses, notably borderlines, can certainly rival a purely factitious disorder patient in the variability and simulation of symptoms. Furthermore, other

syndromes exist that also entail deliberately produced symptoms such as nail-biting, cuticle-picking, hair-pulling, anorexia or bulimia, and self-mutilation. Some question remains as to how such conditions are and are not similar to a factitious disorder.<sup>59</sup> According to Rogers et al., such overlap with other conditions “calls into question the soundness of diagnosing factitious disorder in the presence of such a disorder [like borderline].”<sup>60</sup>

On the other hand, many experts have avoided the issue of diagnostic overlap altogether; they make the diagnosis of factitious disorder only in the absence of any other real psychiatric condition. Certainly this approach is given support by the passage in the *DSM-III-R* that states that “occurrence not exclusively during the course of another Axis I disorder, such as schizophrenia.”<sup>61</sup> Supporting this view, Sutherland and Rodin emphasize that the diagnosis of factitious disorder “is often a diagnosis of exclusion.”<sup>62</sup>

An additional complication is the variability and heterogeneity within the domain of patients diagnosed with a factitious disorder.<sup>63</sup> For example, *DSM-III-R* and *DSM-IV* arbitrarily divide factitious disorders into three subcategories: physical, psychological, and not otherwise specified. The problem with adopting such categories is that many contemporary factitious disorder patients present with *both* psychological and physical symptoms.<sup>64</sup> Not only has there been a recent remarkable increase in factitious disorder patients with psychological symptoms and mixed physical and psychological symptoms, but there has also been a significant increase in factitiously produced false histories and identities, both associated with, and in the absence of, factitious symptoms. Such complex factitious presentations help us to appreciate the many faces of the disorder, the common core of which entails the need to deceive in some way or another.

Another problem is the diagnostic overlap with other dissimulating and hysteria-related conditions such as malingering,

somatoform disorders, and dissociative conditions. Somatoform conditions can sometimes co-exist with malingering. Sometimes the only clear distinction between a somatoform disorder and factitiousness is the “sociopathic pattern” of deception in the factitious disorder patient.<sup>65</sup> As we will see later in this paper, the co-existence of a factitious disorder and a dissociative disorder is increasingly common.

The factitious disorder patient who has deceived clinicians for years may eventually sue a clinician for malpractice. When such potential monetary gains enter into the equation of systematic deceptive behavior, factitiousness and malingering overlap.

The problem of the overlap between a factitious disorder and other Axis I and Axis II conditions has yet to be resolved adequately, and making the factitious disorder diagnosis at the exclusion of real Axis I conditions ignores the clinical observation that factitious behavior frequently is observed in association with other Axis I and Axis II conditions. The co-existence of factitious disorder and bipolar disorder has been documented.<sup>66</sup> The co-existence of factitious behavior and an Axis II personality disorder is extremely well documented across many studies, so much so that some experts have advocated that factitious behavior should be seen as a subset of borderline personality or a mixed personality disorder.<sup>67</sup> The most common types of personality disorders associated with a factitious disorder diagnosis are borderline, narcissistic, histrionic, and antisocial personality disorder.<sup>68</sup> There is also a strong association between factitious behavior and substance abuse and dependency.<sup>69</sup>

The relationship between factitious disorder and major dissociative disorders has not been clarified. While the *DSM-III-R* and the *DSM-IV* at least acknowledged the often clinically observed association between factitious disorder and personality disorder and substance abuse, *DSM-IV* failed to clarify the interrelationship between factitious disorder and dissocia-

tive disorder. As Freyberger and Schneider said, “The phenomenological and etiological relationship between factitious disorder and borderline, acute transient and atypical psychotic disorders, and dissociative states have to be included in the . . . diagnostic systems.”<sup>70</sup>

c. Fusing  
hysteria back  
together  
versus  
diagnosing  
co-morbidity

Hyer and Spitzer’s project of “splitting hysteria asunder” was admirable in its goal of seeking greater conceptual clarity, empirical reliability and validity for each of the four diagnostic entities into which hysteria was split. The problem with this enterprise, however, is that it virtually ignores the natural covariance between each of the four diagnostic entities. Given the increasing number of case reports and empirical studies that show an association between factitious disorder on the one hand and various personality disorders (such as borderline and histrionic personality), somatoform disorders, and dissociative disorders on the other hand, the interrelationship between these conditions, at least for certain patients, cannot be ignored.

Kihlstrom’s radical proposal to return to the archaic diagnosis of hysteria views the attempt to split hysteria asunder as a failure.<sup>71</sup> However, fusing hysteria back together does not adequately address the problems that necessitated the split in the first place. Our more moderate proposal is that these four diagnostic entities remain as discrete entities, but that diagnosticians and clinical researchers more adequately address the degree to which these diagnoses co-vary, at least for certain patients. In other words, the *DSM* criteria should be redrafted to allow explicitly for the fact that a factitious disorder may co-exist with a major dissociative disorder, a somatoform disorder, and a personality disorder, and in at least some patients two, three, or all four of these conditions may occur as multiple co-morbid diagnoses. Multiple co-morbid diagnoses of this nature are not uncommon in clinical reality, and we believe that the *co-morbidity position* is a better solution than Kihlstrom’s *fusion position* or the *DSM*’s



*exclusion position* ("occurrence not exclusively during the course of another Axis I disorder, such as schizophrenia.")<sup>72</sup>

d. Abnormal  
illness  
behavior

Another reasonable solution to the problem of overlap between factitious, personality, somatoform and dissociative disorders is to drop the diagnosis of factitious disorder as a discrete diagnostic entity per se and, instead, to view factitiousness as a type of "abnormal illness behavior" that may co-exist with many types of genuine psychiatric disorders. Pilowsky coined the term *abnormal illness behavior* (AIB), in which the primary motivation is to adopt a sick role. Pilowsky observed that some patients manifest illness behavior in the absence of physical signs of illness or any sense of pain or discomfort. Abnormal illness behavior occurs when the "sick role is not appropriate to the objective pathology observed."<sup>73</sup> Carodoc-Davies stated succinctly: "More logically, these conditions can be viewed as dysfunctional behaviors, not nosological entities."<sup>74</sup> Rogers et al. take a similar position: "Questions remain as to whether factitious disorder with psychological symptoms is more of a symptom/syndrome than a disorder."<sup>75</sup> Other experts have viewed factitiousness not as a discrete diagnostic entity, but as a form of illness behavior strongly associated with a personality disorder.<sup>76</sup>

Our position is that factitious illness behavior is definitely seen in some personality-disordered patients, but is not so limited. Factitious illness behavior can also sometimes be found in association with somatoform and dissociative disorders. One way to handle this interrelationship is to give a diagnosis of a somatoform disorder with factitious features or a dissociative disorder with factitious features. Whether preference is given to making joint co-morbid diagnoses or to an Axis I diagnosis with factitious illness behavior features, in either case the fundamental interrelationship between these hystericalike diagnoses and factitious behavior is preserved. Furthermore, in each case the primary motivation of simulation or embellishment of a genuine Axis I disorder in the service of care-eliciting behavior is emphasized.<sup>77</sup>

## 6. Factitious trauma-related illness behavior

- a. Factitious posttraumatic stress disorder
- As the diagnosis of posttraumatic stress disorder (PTSD) became popularized in the era following the Vietnam War, a new version of factitious behavior emerged in the 1980s: factitious PTSD. Sparr and Pankratz reported five cases of individuals alleging that they had PTSD as a result of combat exposure in Vietnam. Three claimed to have been prisoners of war. All five reported fabricated war stories along with simulated posttraumatic stress symptoms. Eventually their deception was discovered; four of the five patients had never been in Vietnam, and two had never been in the military at all. Sparr and Pankratz concluded, "Factitious posttraumatic stress disorder is yet another variation of the many clinical deceptions that physicians may encounter." Each patient had been "fairly convincing" to the doctors, yet "blatantly misrepresented the facts."<sup>78</sup> Some years later these same authors described three additional cases. They concluded that "factitious PTSD has not disappeared over time."<sup>79</sup> Lynn and Belza similarly reported seven cases of factitious PTSD in the wake of media coverage of PTSD. While the traditional factitious disorder patient with physical symptoms engages in simulation behavior out of a need to adopt a "sick role," Lynn and Belza emphasize that the individual with factitious PTSD does so out of a need to achieve a warrior or hero status. They conclude that factitious PTSD is "not uncommon" as a consequence of the Vietnam conflict. They emphasize that such an individual "had obviously acquired sufficient knowledge of PTSD to develop a tale best suited to his needs. The motives, however, varied in each case."<sup>80</sup> Currently, these findings are not infrequent, and similar cases have appeared in the 1990s.<sup>81</sup> As other international conflicts have received wide media exposure, new versions of factitious PTSD have also been reported, such as the factitious presentation of trauma following a fabricated account of an IRA bombing in Northern Ireland. Once

again the primary motivation was to get attention as a war hero.<sup>82</sup>

An important feature of factitious PTSD is the total fabrication of a fictitious trauma story in addition to the more traditional simulation of psychological symptoms of a trauma-related disorder. Such cases make it clear that simulation behavior is not at all restricted to faking symptoms of a disorder, and that faking a personal history and identity is equally important.

b. Factitious  
victimization:  
fabrication of  
personal  
history

Feldman, Ford and Stone state:

Although patients with factitious disorders typically seek the “patient” role through illness portrayals, some instead portray themselves falsely as “victims.” [Victim status was achieved through fabricated rape reports.] Yet none of the allegations was clearly disproved.<sup>83</sup>

This citation illustrates a growing awareness that some individuals fabricate a personal history of victimization more than they fabricate symptoms, although such reports are often accompanied by simulated rape-related symptoms. Feldman et al. also note that patients most likely to develop false reports of childhood abuse, rape, or other trauma have a “pre-disposition to dissociation.”<sup>84</sup>

Other detailed case accounts of factitious rape have been reported in the literature. One patient with a borderline personality disorder diagnosis alleged two separate incidents of fabricated rape along with the complaint that she could not remember many details of the rapes. She later confessed to fabricating the rape stories while undergoing a polygraph test. In retrospect it became clear that she made up the rapes in order to get attention from her doctor. “[S]he chose to meet her emotional needs by seeking a close therapeutic relationship with a physician who she felt would trust and not question her.”<sup>85</sup>

In a recent case report, a woman made a highly dramatic false allegation of a violent sexual assault. Later it became clear that she had self-inflicted her wounds.<sup>86</sup> Other cases of factitious rape follow a similar trajectory.<sup>87</sup> After presenting four cases of factitious rape, Feldman et al. concluded that each was “prompted by a search for nurturance.”<sup>88</sup>

Factitious victimization is not restricted to rape reports, but covers the entire gamut of trauma and abuse (for example, see the cases described by Marmer in this issue). Fabricated accounts of neglect and physical abuse have been reported.<sup>89</sup>

False allegations of physical assault by a parent<sup>90</sup> and fabricated reports of being an adult survivor of childhood sexual abuse have also appeared in the literature.<sup>91</sup> Sometimes these stories are extensive and bizarre in nature. For example, Stone described a case of a young woman with “unverifiable stories of a horrendous and constantly changing content.”<sup>92</sup> Coons and Grier described a 25-year-old woman with a fabricated history of Satanic ritual abuse.<sup>93</sup> Factitious sexual harassment claims have also been studied. Although no objective evidence existed to verify the harassment charge, these patients nevertheless felt victimized, and they were “motivated to file factitious sexual harassment claims by a need for external validation of their inner experiences.”<sup>94</sup> Factitious bereavement has also been reported—for example, the fabricated loss of a fictitious twin, resulting in hospitalization.<sup>95</sup>

The early literature on factitious behavior primarily pertained to factitious physical symptoms. Only later did mental health professionals come to appreciate the range of factitious psychiatric conditions. Nevertheless, the *DSM* definition clearly places its emphasis on factitious *symptom* production, whether the symptoms are of a physical or a psychological nature. The *DSM* definition does not give proper emphasis to the range of factitious victim reports and personal histories,

irrespective of whether or not they are accompanied by simulated symptoms.

Conceptually, the seeds of understanding factitious victimization are found in Bursten's term "pseudologia fantastica" dating back to the 1950s.<sup>96</sup> Yet *DSM-III* and subsequent editions never picked up on this theme sufficiently to develop a category of factitious personal history in general or of factitious victimization in particular. Therefore most clinicians today have not been provided with the appropriate conceptual tools to detect factitious victim reports unless they are accompanied by increasingly bizarre and inconsistent symptoms over time. The underlying motivation of factitious victimization is less about the adoption of a sick role and more about "the wish to acquire victim status."<sup>97</sup>

We believe the prevalence of factitious victimization is higher than is represented by the few scattered case reports in the literature. For example, textbooks frequently report the well-known phenomenon of false confessions after major crimes have been reported,<sup>98</sup> and the topic is discussed in Schefflin and Brown (this issue). There is increasing evidence that a significant portion of the variance of contemporary "false memory" cases are manifestations of factitious behavior. False-memory recanters typically recover progressively complex and sometimes bizarre abuse and ritual abuse memories in the context of psychotherapy. Sometime later they retract the abuse reports as fabrications and sue the therapist for malpractice. In these lawsuits they allege that the therapist suggestively implanted false abuse memories. High, in this issue, makes the point that the currently dominant explanation for retracted childhood abuse reports previously reported by adults in psychotherapy is the *iatrogenic hypothesis*: that the allegedly false childhood abuse reports were "implanted" through unduly suggestive therapeutic influences. He shows that a plausible alternative explanation for at least a portion of these recanted stories is that both the embellished abuse report to the therapist and the embellished

recanted report to attorneys are a form of factitious behavior. This behavior is motivated by a need for attention—first from the defendant therapist and then from the plaintiff attorney and the court. This thesis has historical support.<sup>99</sup> Marmer (this issue) presents several case studies in which factitious disorder and malingering co-existed within the same patients. He demonstrates that the traditional distinction between factitious disorder and malingering, in terms of primary and secondary gain, isn't that clear-cut, and that some patients fabricate symptoms and trauma stories out of both a need for attention and a wish for financial gain from lawsuits.

c. Factitious dissociative identity disorder and other dissociative conditions

Factitious amnesia, often associated with a variety of neurological and physical complaints, has been reported.<sup>100</sup> Factitious presentation of a major dissociative disorder, such as dissociative identity disorder (DID) and dissociative disorder not otherwise specified (DDNOS), has also been discussed recently. Coons was the first to describe cases of factitious DID. In 1978 he observed that some hospitalized psychiatric inpatients who had not been diagnosed with MPD developed MPD-like symptoms after exposure to genuine MPD patients on the unit. He called this phenomenon “pseudomultiplicity.”<sup>101</sup> In 1987 Kluft described six cases of likely simulated MPD associated with criminal proceedings. He compared these with 46 genuine MPD cases according to a set of malingering criteria. He found that all 46 genuine MPD patients shared two or more indicators of malingering with the likely malingered MPD cases, so that traditional indicators of malingering did not adequately discriminate between genuine and malingered MPD. However, clinical criteria could be used to distinguish between the two groups because those with malingered MPD symptoms produced stereotyped, exaggerated, and inconsistent alter behavior over time as compared with genuine MPD patients. The malingered MPD symptoms were not convincing, and such patients showed no prior history of dividedness.<sup>102</sup> In 1991 Chu observed:

With the increasing availability of information concerning MPD in the media, in the scientific literature, and through patient networks and self-help groups, the possibility and incidence of deliberate simulation of MPD is increasing. Although this problem appears to be more frequent in malingering, i.e., in a forensic setting where the motivation is obvious, it is also appearing in the non-forensic clinical setting as a factitious disorder.<sup>103</sup>

He added, "The deliberate and realistic simulation of MPD over a brief period of time is not difficult."<sup>104</sup> However, clinical detection of faked MPD is at times difficult, especially because of the overlap between genuine and simulated MPD on malingering indices. Chu discussed two cases, the first of a "relatively obvious" case of malingered MPD in the context of legal proceedings, and the second of factitious MPD that required "an extended period of evaluation prior to accurate diagnosis [of factitious MPD]."<sup>105</sup> Chu's discussion illustrates two important points: (1) Factitious MPD in the clinical setting is far more difficult to detect than malingered MPD in the legal arena; (2) Between the time of Kluff's 1987 observations and Chu's 1991 observations, "patients with factitious MPD had become considerably more sophisticated in their simulation of MPD symptomatology; thus, the differentiation from genuine MPD was much more difficult and time consuming."<sup>106</sup>

Coons and Milstein<sup>107</sup> conducted the first scientific study comparing genuine and simulated MPD. They reviewed data on 112 patients consecutively admitted to a psychiatric inpatient hospital specializing in the treatment of dissociative disorders. They found that 101 had been diagnosed with genuine MPD and another 11 (10%) were found to have either factitious or malingered MPD. These 11 simulating MPD patients were compared with 50 genuine MPD patients along a number of dimensions such as demographics, response to psychological testing, and clinical features. Although simulating and genuine MPD patients did not differ statistically in most demographic variables or psychological testing, or in the presence of many clinical features typically associated with

MPD (such as the presence of alters, inter-alter dialogues, amnesic barriers, disremembered experiences, changes in handwriting and abilities, and reports of physical and sexual abuse), there were two essential differences. First, with respect to dissociative features, the simulators showed significantly fewer mood alterations and manifested depressed and angry alter personality behavior significantly less than genuine MPD patients. The genuine MPD patients manifested sexual desire disorders significantly more frequently than did the simulators. The simulators also showed more symptoms associated with personality disorders—e.g., substance abuse, self-mutilation, suicidality, and somatization—than did the genuine MPD patients. Co-consciousness between alters was significantly *less* likely in simulated MPD patients as compared with genuine MPD patients. Second, those with factitious or malingered MPD had significantly more features characteristic of simulation disorders than did the genuine MPD patients:

Of the eight symptoms or behaviors characteristic of factitious disorder or malingering which were inquired about in the original study (la belle indifference, exaggeration, persistent lying, pseudologia fantastica, selective amnesia, lack of consistent work history, refusal of collateral interviews, legal problems, and excessively dramatic behavior), all were increased and significantly different from the patients with genuine MPD. . . . Lack of prior dissociation, seeking hospitalization and MPD diagnoses appeared in all of the simulators. Inconsistent symptom presentations and worsening of symptoms while under observation also characterized the simulator group.<sup>108</sup>

It is interesting to note that there were no significant differences between simulating and genuine MPD patients in reports of physical and sexual abuse histories. Qualitatively, these histories were typically much more dramatically presented and exaggerated by the simulators than by the genuine MPD patients, and the simulators were likely to refuse collateral interviews that might have exposed the simulation. Coons and Milstein emphasize that the kind of factitious MPD seen in the early 1990s was much more difficult to



detect than the more obvious reported cases of malingered MPD reported by Kluft in the 1980s:

Although some simulated cases of MPD may be quite obvious, other cases may be extremely difficult to discern, even for an experienced clinician. . . . The clinician must look, rather, for the signs characteristic of factitious disorder or malingering. These include chronic severe disability since late adolescence, lack of a consistent work history, dramatic and exaggerated presentation of symptoms, pseudologia fantastica, demanding and deprecating attitudes towards health care providers, refusal of collateral examinations, selective amnesia, and hospital seeking behavior, and in the case of factitious disorder, a psychological need to assume the sick role.<sup>109</sup>

In an earlier paper, Coons and Grier elaborate on the concept of factitious victimization. Through a single case study they illustrate the factitious presentation of a Satanic ritual abuse history along with simulated MPD symptoms.<sup>110</sup> The patient, a 25-year-old woman, manifested regressive, childlike states for which she claimed amnesia. She was given the diagnosis of PTSD and MPD. Memory processing included frequent attempts at abreaction, to which the patient failed to respond. Then she reported a progressively complex ritual abuse history, including allegations of 15–20 pregnancies. She also reported that Satanic symbols had been carved on her body, but she refused a medical examination that might have corroborated her report. She did not show PTSD symptoms upon careful observation, and a subsequent physical examination failed to reveal the alleged Satanic carvings. When confronted about these inconsistencies, she altered her story to fit the data. A later careful review of her history “revealed lying, stealing, and runaway behavior during her pre-teen years, unproven accusations of paternal incest at age fifteen, and withdrawal from school in the eleventh grade. The accusations of incest began in the late 1970s, when incest became a popular topic. . . . The stories of Satanic abuse did not begin until after she had observed the Geraldo Rivera television special on Satanism.”<sup>111</sup> While Coons and Grier present only a single case study, they note that such cases “will probably become increasingly common as more victims of ritual

abuse present for evaluation.”<sup>112</sup> Indeed, this may have been the case in the 1990s. Because of the rapid proliferation of a professional and popular literature on ritual abuse in the 1980s and early 1990s, it could have been predicted that the prevalence of factitious ritual abuse reports associated with simulated MPD would dramatically increase by the early 1990s. The Coons and Milstein data imply that by the late 1990s one out of every ten patients presenting to a specialty inpatient unit for dissociative disorders and diagnosed as MPD was likely to have simulated MPD. Given this remarkable prevalence rate, it is noteworthy how difficult it has been for clinicians to discriminate between simulated and genuine MPD.

More recently, Ross developed a “four-pathway model” for DID. According to this model, there are four independent pathways contributing to the development of reported/manifested alter personality behavior and the range of clinical features characteristic of DID: (1) iatrogenic (created through therapeutic suggestive influences), (2) factitious (self-generated by the patient motivated by the need to adopt a sick role), (3) created by trauma and abuse, and (4) created by neglect. Ross acknowledges that at least some of the more dramatic and fantastic cases of DID may be factitious disorders masquerading as DID—i.e., the simulation of DID symptoms with no genuine alter behavior present. He observed that such patients have “no history of dissociative symptoms prior to therapy, but there is usually an elaborate medical-surgical history.” He also noted that these patients often “overfake” DID—for example, by getting extremely high scores on the Dissociative Experiences Scale. Furthermore, Ross observed that the presentations of factitious DID may have changed since the mid-1990s. He raised questions about possible factitious false memory syndrome, in which the patient first factitiously alleges that a former therapist(s) suggestively implanted the DID symptoms, and then retracts the abuse history and sues the therapist(s). According to

Ross, the current complex combination of primary and secondary gain derived from factitious false memory syndrome allegations in the context of a lawsuit, and reinforced by the media and by false memory lawyers and their experts, is typically far greater than the simple attention derived from adoption of a sick role with the former defendant clinician(s).<sup>113</sup>

In our own experience with dozens of false memory cases, those DID patients with very flamboyant histories should be scrutinized for possible factitious DID. Draijer and Boon, in this issue, are the first to investigate factitious DID empirically. Using a sensitive diagnostic instrument, the Structured Clinical Interview for Diagnosis–Dissociative Disorders Version (SCID-D), to carefully differentiate between genuine and simulated DID, they developed a list of differential criteria to distinguish between the two presentations. Hopefully, based on sound empirical research of this type in the future, clinicians will be in a better position to differentiate between genuine and factitious DID presentations.

In our opinion, a major limitation of the pioneering work by Coons, Kluft, Chu, Ross, and Draijer and Boon on factitious DID is the either–or assumption inherent in some of this work. These researchers have assumed that observed alter personality behavior and other clinical features associated with DID (e.g., disremembered experiences, time loss, etc.) are either genuine or fabricated. In our view, except for Kluft they have not adequately accounted for the possible co-existence of a genuine major dissociative disorder and a factitious embellishment of this disorder. In our own research, involving careful examination of the medical records of dozens of patients, we have found that the co-existence of a genuine major dissociative disorder (DID or DDNOS) and factitious embellishment of the dissociative condition is not infrequent, at least in the 1990s.

## **7. Complex cases: multiple co-morbidities involving factitious and dissociative combinations**

In an important paper, Toth and Baggaley describe a single case in which a chronic factitious disorder (Munchausen's syndrome) and a genuine dissociative disorder (MPD/DID) co-existed in the same patient.<sup>114</sup> This patient also had a co-morbid borderline personality disorder diagnosis. The authors trace the roots of the three conditions to a life-threatening illness that began when the patient was three years old and later resulted in a 10-month hospitalization, a prolonged recovery time, and an extended period of sexual and physical abuse by a male babysitter and a brother that began around age 5. During the abuse, the patient learned to dissociate into an alter personality who retained the abuse experiences compartmentalized from the host personality. The patient experienced progressive time loss, beginning in the second grade. Into adulthood she experienced an impressive total of 58 medical hospitalizations, mainly for factitious physical symptoms such as fabricated head injuries, fevers, infections, anemia, and urinary tract infections. She had accumulated 13 surgical interventions for fictitious symptoms. Toth and Baggaley believe that the prolonged illness and recovery contributed to the development of the factitious behavior on the one hand, and the childhood abuse contributed to the development of the dissociative disorder on the other hand. They add, "The caring received during the original hospitalization was likely a much-needed respite from the home atmosphere [of abuse] and served to engender a life-long habit of attempting to return to that haven [through feigning illness]."<sup>115</sup> While the authors believe this case represents the co-existence of genuine DID and factitious behavior, they also stipulate that it is not entirely possible to rule out that the DID itself was another factitious creation.<sup>116</sup>

One other case of the possible co-existence of a factitious and a dissociative disorder has been reported in the literature. One of three cases reported by Popli et al. concerned a

patient with voices, memory lapses, and seizures consistent with a dissociative disorder diagnosis and also an uncorroborated, and possibly fabricated, history of childhood sexual and physical abuse, allegedly by a stepfather.<sup>117</sup> Of course, dissociative/factitious combinations can also involve genuine and/or exaggerated suicidal and self-mutilatory behavior. Such patients exaggerate self-destructive reports and behaviors in order to maintain the sick role and prolong hospitalization.<sup>118</sup> Armstrong (this issue) presents a case report of a woman treated for a major dissociative condition (DID) and a self-reported trauma history who subsequently retracted both her dissociative disorder diagnosis and her abuse history and sued her therapists for allegedly implanting them. Armstrong correctly emphasizes the factitious behavior throughout this patient's history, co-existing with her presentation of dissociative symptoms, although Armstrong is skeptical as to whether this patient ever had genuine DID.

We recently conducted a study of 31 retractors who became plaintiffs in high-profile malpractice suits.<sup>119</sup> Most of these retractors had recovered memories of childhood sexual and/or physical abuse, and then ritual abuse, that they reported to their therapists. Some years after a typically amicable termination with the therapists, where the medical records usually show substantial improvement with regard to the dissociative disorder, these patients retracted the abuse memories and subsequently sued their therapists for malpractice. They alleged that the earlier abuse reports were the product of therapeutic influences that caused false memories of abuse to be suggestively implanted and resulted in a false DID diagnosis. In our study, which we are completing for publication, we found, from an examination of all of the available medical and legal records, that each of these retractors exhibited genuine multiple co-morbid psychiatric diagnoses. Over 70% of the retractors had a minimum of five major co-morbid psychiatric diagnoses, which typically included (1) a major affective illness, (2) PTSD, (3) DID or DDNOS, (4) a mixed personality or borderline personality disorder, and (5) one or more addic-

tive behaviors, such as chemical dependence, an eating disorder, sexual compulsivity, or chronic self-mutilation. Additional diagnoses in some of these retractors included a somatoform disorder and some kind of anxiety diagnosis.

In addition to these genuine multiple co-morbid diagnoses, we also found that an impressive 33% of the sample met the criteria for a factitious disorder co-existing with a major dissociative disorder. These patients over several decades manifested a complex pattern of factitious medical symptoms and syndromes, factitious psychiatric conditions, and factitious victimization reports. A history of chronic lying was usually present. These cases are important in that they show that multiple combinations of genuine co-morbid psychiatric conditions involving trauma-related diagnoses (PTSD and DID or DDNOS) and Axis II personality disorder diagnoses sometimes co-exist with a chronic and progressive pattern of factitious behavior, and later with malingered behavior in the context of malpractice litigation.

The typical course of such *complex* cases is that the PTSD and DID or DDNOS symptoms emerge progressively over time, concurrent with progressively more embellished accounts of abuse, beginning with childhood abuse and neglect, and progressing to bizarre accounts of ritual abuse, human sacrifice and cannibalism. The dramatic nature of these ritual-abuse reports raises the index of suspicion about factitious behavior. This is not to say that genuine childhood abuse may not have been operative in the development of at least some portion of the adult psychopathological symptoms in at least some of these cases. Putting aside the historical truth of abuse, however, these cases definitely show a pattern of factitious distortion and embellishment of the abuse reports. For example, whenever the patient reports being a "high priestess" in a Satanic ritual abuse cult, combined with a long history of highly variable medical and psychiatric complaints, a significant factitious contribution to the overall complex illness pattern must be suspected. In our opinion, the

motivation for these complex symptom presentations, along with the fabricated and/or at least progressively embellished personal abuse histories, is the need for attention from the clinician. The DID patient with a bizarre and sensational cult abuse story, who at one time alleged to be the “high priest” of the cult, is much more likely to command the attention of the therapist and/or the inpatient psychiatric nursing staff than the DID patient with more common childhood abuse recollections.

Such complex cases leave us with the thorny problem of apportioning the relative contribution of genuine multiple comorbid psychiatric diagnoses and factitious symptoms and personal histories in the same patient. These cases illustrate that in contrast to the data of Draijer and Boon reported in this volume, the diagnosis of a major dissociative disorder and a factitious disorder is sometimes not an either–or proposition. Draijer and Boon’s discussion of “flamboyant DID” is their way of acknowledging that such dissociative/factitious disorder combinations also have been observed in their extensive research sample. Armstrong’s case report in this issue also leaves the reader with a question regarding the interrelationship between genuine dissociative symptoms and factitious behavior.

Furthermore, there is a complex relationship between factitiousness and borderline behavior. As we have observed in recanters, as the dissociative disorder is addressed and improves in treatment, additional pressure to maintain the sick role is placed on the factitious disorder and additional pressure to blame others and have others run their lives is placed on borderline disorder. Thus it is sometimes the success of the treatment of the dissociation that invigorates factitiousness and borderline behavior and establishes the preconditions for a malpractice lawsuit.

At the time these patients presented, in the late 1980s and early 1990s, the stories they told about severe abuse, cults,

etc., were reinforced by the media. Therapists were therefore less likely to see the factitious disorder element. Furthermore, the professional literature did not describe factitious aspects of co-morbid diagnoses, and the limited categories in *DSM* for factitious behavior would also have distracted well-meaning healers from understanding these complex cases. The great tragedy is that over the last decade, as therapists have struggled to learn how to treat these cases, the courts have been holding them liable based on a standard of care that did not exist then and is only starting to become clearer now.

## 8. Developmental perspectives: neglect, attachment pathology, and the learned development of factitious behavior

Rogers et al. correctly criticize the *DSM* definition for its lack of concern with the developmental pathology associated with a factitious disorder:

[*DSM-III*] expresses a clear moral condemnation of this kind of deceptive behavior. . . . In *DSM-III*, the diagnosis of deception is totally in the foreground, whereas the patient's disturbed relationship to his or her own body is entirely in the background . . . the objective is to take on the role of patient . . . [what is neglected in *DSM-III* is the] disturbed relationship to his or her own body, as well as the disturbed doctor-patient relationship.<sup>120</sup>

We propose a *three-factor model* for the etiology of a factitious disorder. First, the roots of factitious behavior can be traced to an early pattern of neglect or deprivation, which sensitizes the child to a need for attention. Second, through incidental learning, the developing child and later adult specifically learns that sick-role behavior can be used to elicit care-giving responses from health professionals initially. Third, the socio-cultural context and the type of information available to the factitious disorder patient serve to shape the specific type of factitious behavior, be it simulated physical symptoms, simulated psychological symptoms, false victim-



ization stories, or a combination thereof. We will now more closely examine each of these factors.

a. Neglect, deprivation & loss and pervasive developmental deficits

There is a growing consensus that factitious disorders arise from a “developmental disturbance” and that the relationships factitious disorder patients develop with caregivers is a reenactment of past developmental disturbances.<sup>121</sup> The earliest psychoanalytic descriptions of factitious behavior, originating with Karl Abraham, stressed the “preoedipal deprivation”<sup>122</sup> and “lack of parental affection” in the early childhood backgrounds of these patients.<sup>123</sup> Spiro, for example, wrote:

Early childhood deprivation and difficult relationships with aloof, absent, or sadistic parents may sensitize the latter patients to distorted learning stemming from traumatic early illness or hospitalization. The concept of mastery . . . offers the most useful explanation for the subsequent behavior.<sup>124</sup>

Sometimes early loss, in addition to deprivation, contributes to the development of factitious behavior.<sup>125</sup> Plassmann, for example, sees factitious behavior as an “attempt to cope with the early object losses in a narcissistic manner.” In his sample of 22 factitious disorder patients, 61% had self-reported attachment problems, 24% had rape histories, 19% had incest histories, and 28% had suffered traumatic object loss.<sup>126</sup> According to Nadelson, abnormal illness behavior arises from fundamental problems in “attachment, bonding, and caretaking.”<sup>127</sup> Those adult patients specifically presenting with factitious PTSD “often have childhoods seriously lacking in parental affection.”<sup>128</sup>

These early experiences of neglect, deprivation and/or loss result in pervasive developmental arrests along the lines of relational, self, and affect development. Long-lasting impairments in relational development or attachment pathology (insecure attachment)<sup>129</sup> arise from the neglect and loss. In a study of seven factitious patients, for example, Carlson noted:

Marked defects in interpersonal relationships due to the observed primary illness may help to explain their disorder. . . . It is felt that the major factor contributing to the production of factitious symptoms in these patients was a severe disturbance of interpersonal relationships produced by the patients' primary illnesses. . . . The fabrication of symptoms may serve as a mechanism whereby these individuals can temporarily relate to others, overcome their isolation, obtain caring, have certainty of their needs being met, and possibly act out previous family dynamics.<sup>130</sup>

Nicholson and Roberts have reached a similar conclusion. In their view of the etiology of the factitious disorder:

A general picture emerges in which patients come from disturbed families and reach adulthood with a severely impaired ability to form relationships, lifelong experience of emotional deprivation and diagnosable personality disorder. Fabrication of mental illness may be motivated by a need to seek compensation from sick role benefits and relationships with mental health professionals.<sup>131</sup>

Another developmentally arrested line pertains to the sense of self and the body self. An arrest in body image development sensitizes the child to shifts in bodily states, and over time the child learns to manipulate these states in the service of the emerging factitious behavior:

. . . a pathology affecting the body self as well as a specific pathology in the doctor-patient relationship . . . these patients often have an intimate knowledge of the manner in which their bodies react and are thus able to discover possibilities for manipulation with which the physician is normally unfamiliar . . . good and evil parts of body as representations of negative portions of self.<sup>132</sup>

Arrested self and self-esteem development is a primary feature of factitious behavior. In an important empirical study of 18 factitious disorder patients, Ehlers and Plassmann found that nine had a co-existing borderline personality disorder diagnosis and six had a co-existing narcissistic personality disorder diagnosis. They found that 83% of patients in the sample showed significant evidence for "disorders of self-regulation" and concluded: "The overwhelming majority of patients suffering from factitious disorders therefore demon-

strate a narcissistic pathology.”<sup>133</sup> This failure in self development results in several long-term consequences—an unstable, protean sense of self and a vulnerability to self fragmentation. Such self pathology may serve to explain why the factitious disorder patient can so easily assume very different identities and personal histories over time<sup>134</sup> and why, fundamentally, the factitious disorder patient’s identity is that of an imposter.<sup>135</sup> Some experts have viewed factitious behavior as an adaptive attempt to prevent total fragmentation of an unstable sense of self by asserting and reinforcing false identities.<sup>136</sup>

Affect development is also arrested in the factitious disorder patient. According to Rodin, the factitious disorder patient’s preoccupation with bodily experience arises from a developmental deficit in “emotional awareness.”<sup>137</sup> These patients have considerable difficulty with affective experience and tolerance. According to Spivak et al., they show an “incapacity to appraise what is real . . . can’t experience inner affect states as real . . . can’t perceive emotion and perceptions as real . . . [and have] uncertainty about the validity and continuity of their own subjective experience.”<sup>138</sup>

A related developmental deficit occurs with respect to the development of reality perception and reality testing. Spivak et al. explain:

[The factitious disorder patient] may suffer from underlying disturbances in the sense of reality and in reality testing. These features may be associated with a poorly consolidated sense of self and with difficulty regarding emotional experience as real. Factitious behavior may serve to stabilize the sense of self by concretizing and legitimizing the subjective experience of distress and by evoking responsiveness of a caregiver in a relatively safe, structured context. . . . Two features that may be evident in patients with factitious disorders, but that are not explicitly noted in the *DSM-III-R*, are disturbances in the sense of self and in the sense of reality.<sup>139</sup>

This developmental arrest in reality testing makes it difficult for the factitious disorder patient to determine what is and is not real. Pathological lying, a common symptom in factitious disorder patients, may simply be a reflection of the factitious disorder patient's inability to distinguish what is a subjectively created fabrication and what is objective reality. In this sense, deceiving others may not be the primary intention of the factitious disorder patient, but simply a by-product of a fundamental inner confusion about what is real and what is not. The description of abuse history and its later recantation are similar instances of the inability to know what is real.

- b. Learning Most experts concur that the developing pattern of factitious behavior begins as a learned adaptive strategy to cope with deprivation, loss, and the subsequent arrests across developmental lines. Early on in the process they learn to discern and attempt to gain some control over internally shifting self-states, shifting bodily and affective states, and over the vicissitudes of their connections to others and their reality sense. Experience with childhood illnesses, especially if prolonged, also contributes to the developing pattern. Factitious disorder patients have been known to have an "early preoccupation with health and illness."<sup>140</sup> Relations with health care providers in childhood are a critical factor in the developing pattern, in that these patients learn that health care providers readily give the kind of caring and nurturance that otherwise are lacking. Cramer et al. say that "a central factor was the relationship with physicians who had been important figures in childhood." They add that it is perhaps no accident that a good number of factitious disorder patients at one time or another worked in the health field. As the direct recipients of care-giving from health care providers or through observations of others who receive such care, those who eventually develop a factitious pattern have learned to associate health care providers with receiving the kind of nurturance and attention they desire.<sup>141</sup>

In later childhood and adulthood, typically through contact with the health care system, they learn that simulated behavior consistently elicits care-giving responses from health care providers. Once this association is firmly established through incidental learning, they embark upon a progressively learned, and ultimately compulsive, pattern of deceit and simulated behavior targeted specifically at health care providers. The fundamental motivation is based upon a “longing for nurturance”<sup>142</sup> and a “desire to be at the center of interest and attention.”<sup>143</sup> On account of their failure in reality testing, factitious disorder patients usually show evidence of a long history of pathological lying and/or antisocial behavior by late childhood and adolescence.<sup>144</sup>

Similar to addictive behaviors, such as alcoholism and drug addiction, the learned factitious pattern eventually takes on a life of its own—with progressive encroachment on the various areas of everyday life functioning, and the development of a set of rationalizations to justify a pattern of simulated behavior that is, at this point, compulsive. Now the factitious disorder patient must continue the cycle of deceit even in the face of greater disruption of daily life and greater potential risks.

c. The  
sociocultural  
context

Nadelson said: “All [factitious disorder patients] have learned such behavior in a culture.”<sup>145</sup> In this culture, assuming a “sick role” is a legitimate way to exempt oneself of daily responsibilities and still be lovingly cared for.<sup>146</sup> Factitious disorder patients learn that sick-role behavior directly gratifies their longings for secure attachment. However, the ever-changing forms of factitious behavior also shift as popular culture shifts. Popular culture in the 1960s and 1970s placed the medical profession in high esteem, and it is perhaps no accident that most of the case reports of that era were factitious disorder with physical symptoms. Popular culture and media exposure in the 1980s concerned themselves with post-traumatic stress disorder following the Vietnam War and with the discovery of the prevalence and long-term effects of

childhood abuse. Again, it is perhaps no accident that relatively new forms of factitious illness were increasingly reported in this era, such as factitious PTSD, factitious MPD, and factitious victimization. The popular culture of the late 1980s and early 1990s detailed gruesome accounts of severe forms of abuse, such as extreme sadistic abuse and ritual abuse. In this era, more complex forms of factitious illness appeared, such as factitious DID and the co-existence of multiple co-morbid real psychiatric conditions involving combinations of DID or DDNOS, a personality disorder, and factitious embellishment of an alleged severe abuse history. The popular culture of the mid-1990s spread the idea of therapeutically implanted false memories, and with that, factitious retractor behavior increasingly found its way into the courtroom. Based on these shifting socio-cultural trends, Feldman and Ford recommend that clinicians “take social climates and world events into consideration” when evaluating factitious presentations.<sup>147</sup>

## 9. Summary

- The core feature of factitious illness is a systematic pattern of deceit and simulated behavior motivated by attempts to adapt to developmental failures.
- The *DSM* assumptions about exclusionary criteria, especially with respect to genuine Axis I diagnoses, are inadequate. The *DSM* fails to address with sufficient specificity the co-existence of genuine psychiatric disorders and factitious behavior. Its criteria should explicitly allow for the co-existence of a factitious disorder diagnosis with other genuine psychiatric conditions, or at least use the category of factitious behavior in association with genuine psychiatric conditions.
- By splitting hysteria asunder in *DSM-III*, the complex interrelationship between dissociation disorders and facti-

tious disorders was lost. The current *DSM* definition fails to account for cases in which genuine DID or DDNOS co-exists with factitious behavior, and it fails to address with necessary precision the issue of totally factitious DID.

- The *DSM* conceptualization fails to show an appreciation for the pervasive developmental deficits in attachment, self, body-self, affect, and reality testing characteristic of factitious behavior. These developmental deficits serve as a plausible explanation for shifting self presentations, manipulation and self-inflicted injury of the body, fabricated histories, and abuse reports that are impossible to verify as true or false, and all these deficits are for the sake of eliciting care-giving from health providers by means of elaborate deceptions.
- The forms of factitious disorder shift as the socio-cultural context changes. In the 1960s factitious illness was observed with predominantly physical symptoms. In the 1980s factitious illness with psychological symptoms became increasingly prevalent. In the late 1980s and 1990s factitious victimization and personal histories, as well as complex forms of factitious conditions combining factitious physical and psychiatric symptoms with factitious personal histories and identities, with or within the co-existence of genuine psychiatric conditions such as a major dissociative disorder and a personality disorder, were increasingly prevalent. The data that 10% of all inpatients diagnosed with DID may be simulating DID, and that 33% of patients diagnosed with genuine DID or DDNOS may have significant factitious embellishment of their symptoms and histories, are impressive, and such data make a strong argument that both clinicians and legal experts need to improve their skills for detecting simulated DID.<sup>148</sup>

- Diagnostic nomenclature must account for the increasing prevalence of factitious personal histories and identities, not just factitious symptoms.
- The interaction between popular culture exposure to, and reports of, claims of extreme trauma and false memories have given rise to complex factitious cases and factitious retraction cases.
- More recently, factitious false memory syndrome and factitious retractor behavior, either co-existing or not co-existing with genuine DID or DDNOS, is becoming increasingly prevalent. Factitious behavior is a more plausible alternate explanation for plaintiff false memory retraction lawsuits than the iatrogenesis explanation, especially given the data that one out of ten inpatients diagnosed with DID is simulating and one out of three patients with genuine DID or DDNOS also has a significant factitious symptom and fabricated/embellished personal history presentation. These complex and factitious retraction cases increasingly are making their way into the courts, where the great need for attention is compounded by potential external monetary incentives. Here factitious behavior and malingering may overlap. The courts have been as ill-equipped to detect factitious behavior as the clinics have been.
- All experts concur that factitious behavior, especially in its psychological forms, is very difficult to detect.<sup>149</sup> Clinicians are not, and should not be, trained to be detectives,<sup>150</sup> and they rarely receive training in the highly specialized areas of detecting malingering and deceit. The entire foundation of the doctor–patient relationship is based on the patient telling the truth about his or her symptoms. The doctor’s duty to provide care is most effective when matched by the patient’s duty to act in good faith in accurately presenting symptoms and a history.



- Factitious behavior is a pattern of systematic deception that arises within the patient. The courts must develop an increased sensitivity to the contribution that factitious and borderline mental disorders, coupled with post-therapeutic suggestive influences, have played in the filing of false memory complaints against healers. The courts must now determine the relative responsibility and duty the doctor owes to the deceptive patient who enters the legal system essentially saying "You are liable because you believed me."

## Notes

1. A.A. Nanji & J.F. Denegri, "Factitious Illness and Syndromes à la Munchausen," *Annals RCPSC*, 16:33-36, 1983, p. 36.
2. K. Menninger, "Polysurgery and Polysurgical Addiction," *Psychoanal. Quart.*, 3:173-199, 1934.
3. R. Asher, "Munchausen's Syndrome," *Lancet*, 1:339-343, 1951, p. 339.
4. B. Bursten, "On Munchausen's Syndrome," *Arch. Gen. Psychiatry*, 13:261-268, 1965, pp. 261-263; see also J.C. Barker, "The Syndrome of Hospital Addiction (Munchausen Syndrome): A Report on the Investigation of Seven Cases," *J. Ment. Sci.*, 108:167-182, 1962.
5. M.M. Robertson & J.A. Cervilla, "Munchausen's Syndrome," *Brit. J. Hosp. Med.*, 30:308-312, 1998.
6. H.R. Spiro, "Chronic Factitious Illness," *Arch. Gen. Psychiatry*, 18:569-579, 1968; cf. also P. Fink & J. Jensen, "Clinical Characteristics of the Munchausen Syndrome: A Review and 3 New Case Histories," *Psychother. Psych.*, 52:164-171, 1989.
7. B. Blackwell, "On Munchausen's Syndrome," *Brit. J. Hosp. Med.*, 1:98-102, 1968.
8. P. Reich & L.A. Gottfried, "Factitious Disorders in a Teaching Hospital," *Annals Int. Med.*, 99:240-247, 1983.
9. D.G. Folks & A.M. Freeman, "Munchausen's Syndrome and Other Factitious Illness," *Psychiat. Clin. N. Am.*, 8:263-278, 1985.
10. According to Reich and Gottfried, *supra* note 8, factitious illness is "far from rare" (p. 245). In other studies the prevalence rates are 0.2%–0.8%: (0.2% of cases in emergency service of a psychiatric hospital, Carlson, 1985; 0.5%, Bhugra, 1988; 0.8%, Sutherland

- & Rodin, 1990; 0.3% with neurological symptoms, Eisendrath, 1984). D. Bhugra, "Psychiatric Munchausen's Syndrome: Literature Review with Case Reports," *Acta Psychiatr. Scand.*, 77:497-503, 1988; R.J. Carlson, "Factitious Psychiatric Disorders: Diagnostic and Etiological Considerations," *Psychiatric Med.*, 2:383-388, 1985; S.J. Eisendrath, "Factitious Illness: A Clarification," *Psychosom.*, 25:110-117, 1984; A.J. Sutherland & G.M. Rodin, "Factitious Disorders in a General Hospital Setting: Clinical Features and a Review of the Literature," *Psychosom.*, 31:392-399, 1990.
11. Sutherland & Rodin, *supra* note 10, p. 392.
  12. Eisendrath, *supra* note 10.
  13. Reich & Gottfried, *supra* note 10.
  14. M.D. Feldman and R. Escalona, "The Longing for Nurture: A Case of Factitious Cancer," *Psychosom.*, 32:226-228, 1991.
  15. S.E. Nickoloff, V.M. Neppe & R.K. Ries, "Factitious AIDS," *Psychosom.*, 30:342-345, 1989.
  16. Robertson & Cervilla, *supra* note 5; A.P. Popli, P.S. Masand & M.J. Dewan, "Factitious Disorders with Psychological Symptoms," *J. Clin. Psychiatry*, 53:315-318, 1992.
  17. *Id.*
  18. Carlson, *supra* note 10; J.R. Earle & D.G. Folks, "Factitious Disorder and Coexisting Depression: A Report of Successful Psychiatric Consultation and Case Management," *Gen. Hosp. Psychiatry*, 8:448-450, 1986; E.L. Merrin, C. Van Dyke, S. Cohen & D.J. Tusel, "Dual Factitious Disorder," *Gen. Hosp. Psychiatry*, 8:246-250, 1986; J. Snowden, R. Solomon & H. Druce, "Feigned Bereavement: Twelve Cases," *Brit. J. Psychiatry*, 133:15-19, 1978.
  19. Carlson, *supra* note 10; H.G. Pope, J.M. Jonas & B. Jones, "Factitious Psychosis: Phenomenology, Family History, and Long-Term Outcome of Nine Patients," *Am. J. Psychiatry*, 139:1480-1483, 1982.
  20. A. Eckhardt, "Factitious Disorders in the Field of Neurology and Psychiatry," *Psychother. Psychosom.*, 62:56-62, 1994; J.R. Jones & F.A. Horrocks, "Factitious Epilepsy Associated with Amnesia," *Brit. J. Psychiatry*, 150:257-258, 1987.
  21. G. Caradoc-Davies, "Feigned Alcohol Abuse: A Unique Case Report," *Brit. J. Psychiatry*, 152:418-420, 1988.
  22. Jones & Horrocks, *supra* note 20; Merrin et al., *supra* note 18.

23. Co-morbidity of a factitious disorder with an eating disorder can be found in C.M. Bulik, P.F. Sullivan, J.L. Fear & A. Pickering, "A Case of Co-morbid Anorexia Nervosa, Bulimia Nervosa, and Munchausen's Syndrome," *Int. J. Eating Dis.*, 20:215-218, 1996; cf. also C. Burge & J. Lacey, "A Case of Munchausen's Syndrome in Anorexia Nervosa," *Int. J. Eating Dis.*, 14:379-381, 1993.
24. For the coexistence of alcoholism and factitiousness see, for example, a case in Jones & Horrocks, *supra* note 20.
25. Folks & Freeman, *supra* note 9, p. 2741; see also R.M. Jones, "Factitious Disorders," in H.I. Freedman and B.J. Kaplan (eds.), *Comprehensive Textbook of Psychiatry*, 6th ed., Baltimore: Williams & Wilkins, 1995, pp. 1271-1279.
26. H. Spivak, G. Rodin & A. Sutherland, "The Psychology of Factitious Disorders," *Psychosom.*, 35:25-34, 1994.
27. *Id.*
28. P. Ireland, J.D. Sapira & B. Templeton, "Munchausen's Syndrome: Review and Report of an Additional Case," *Am. J. Med.*, 43:579-592, 1967.
29. M.R. Phillips, N.G. Ward & R.K. Ries, "Factitious Mourning: Painless Patienthood," *Am. J. Psychiat.*, 140:420-425, 1983.
30. R. Rogers, R.M. Bagby & N. Rector, "Diagnostic Legitimacy of Factitious Disorder with Psychological Symptoms," *Am. J. Psychiatry*, 146:1312-1314, 1989.
31. B. Cramer, M.R. Gershberg & M. Stern, "Munchausen Syndrome: Its Relationship to Malingering, Hysteria, and the Physician-Patient Relationship," *Arch. Gen. Psychiatry*, 24:573-578, 1971.
32. T. Nadelson, "False Patients/Real Patients: A Spectrum of Disease Presentation," *Psychother. Psychosom.*, 44:175-184, 1985.
33. The three-dimensional model consists of symptoms (physical vs. psychological), production of symptoms (voluntary, involuntary), and motivation (conscious vs. unconscious). A factitious disorder is defined in terms of unconscious motivation and voluntary production of both physical and psychological symptoms. R.H. Dworkin & E. Caligor, "Psychiatric Diagnosis and Chronic Pain: DSM-III-R and Beyond," *J. Pain Sym. Management*, 3:87-98, 1988.
34. Eisendrath, *supra* note 10.
35. *Id.*
36. Phillips et al., *supra* note 29.

37. Rogers et al., *supra* note 30.
38. S.E. Hyler & R.L. Spitzer, "Hysteria Split Asunder," *Am J. Psychiatry*, 135:1500-1504, 1978; cf. also E.R. Bishop & E.M. Torch, "Dividing 'Hysteria': A Preliminary Investigation of Conversion Disorder and Psychalgia," *J. Nervous and Mental Disease*, 167:348-356; S.E. Hyler & N. Sussman, "Somatoform Disorders: Before and After *DSM-III*," *Hosp. Comm. Psychiat.*, 35:469-478, 1984; S.E. Hyler & N. Sussman, "Chronic Factitious Disorder with Physical Symptoms (the Munchausen Syndrome)," *Psychiatr. Clin. North Am.*, 4:365-377, 1984; for a critique of the rationale to split "hysteria" asunder, see J.F. Kihlstrom, "One Hundred Years of Hysteria," in S.J. Lynn and J.W. Rhue (eds.), *Dissociation: Clinical and Theoretical Perspectives*. New York: Guilford, 1994, pp. 365-394.
39. Hyler & Spitzer, *supra* note 38.
40. American Psychiatric Association, Committee on Nomenclature and Statistics, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* (ed. 3). Washington, DC: American Psychiatric Association, 1980, p. 209.
41. Merrin et al., *supra* note 18.
42. American Psychiatric Association, Committee on Nomenclature and Statistics, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)* (ed. 3, revised). Washington, DC: American Psychiatric Association, 1987, pp. 318-319.
43. *Id.*, p. 315.
44. S. Taylor and S.E. Hyler, "Update on Factitious Disorders," *Internat. J. Psychiat. Med.*, 23:81-94, 1993.
45. American Psychiatric Association, Committee on Nomenclature and Statistics, *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (ed. 4). Washington, DC: American Psychiatric Association, 1994, pp. 318, 315.
46. *Id.*
47. Jones, *supra* note 25, p. 1271.
48. *Id.*; Taylor and Hyler, *supra* note 44.
49. *Id.*; for additional works on Munchausen's by proxy see R. Meadow, "Munchausen Syndrome by Proxy: The Hinterland of Child Abuse," *Lancet*, 2:343-345, 1977; D.A. Rosenberg, "Web of Deceit: A Literature Review of Munchausen Syndrome by Proxy," *Child Abuse & Neglect*, 2:547-563, 1987; H.A. Schreier, "The Perversion of

- Mothering: Munchausen Syndrome by Proxy," *Bull. Menninger Clin.*, 56:421-437, 1992.
50. Cited in R. Plassmann, "Munchausen Syndrome and Factitious Diseases," *Psychother. Psychosom.*, 62:7-26, 1994.
  51. Taylor & Hyler, *supra* note 44.
  52. Rogers et al., *supra* note 30.
  53. R. Rogers & R.M. Bagby, "Reply to B.F. Hoffman's 'Legitimacy of Factitious Disorder Diagnosis' ", *Am. J. Psychiatry*, 147:680-681, 1990, p. 681.
  54. Rogers et al., *supra* note 30, pp. 1312-1313.
  55. Motivation may not be possible to ascertain. See Taylor & Hyler, *supra* note 44; M.D. Feldman & J.M. Feldman, "Tangled in the Web: Counter-transference in the Therapy of Factitious Disorders," *Int. J. Psychiatry Med.*, 25:389-399, 1995; J. Kalivas, "Malingering Versus Factitious Disorder," *Am. J. Psychiatry*, 153:1108, 1996.
  56. H. Willenberg, "Counter-transference in Factitious Disorder," *Psychother. Psychosom.*, 62:129-134, 1994.
  57. Rogers et al., *supra* note 30.
  58. J.M. Jonas & H.G. Pope, "The Dissimulating Disorders: A Single Diagnostic Entity," *Comprehen. Psychiatry*, 26:58-62, 1985, p. 60.
  59. M. Hirsch, "Syndromes Related to Factitious Diseases," *Psychother. Psychosom.*, 62:63-68, 1994.
  60. Rogers et al., *supra* note 30, p. 1313.
  61. *DSM-III-R*, *supra* note 42.
  62. Sutherland and Rodin, *supra* note 10, p. 395.
  63. Factitious disorder constitutes a heterogeneous group of patients according to Sutherland & Rodin, *supra* note 10; cf. also Fink & Jensen, *supra* note 6.
  64. "The DSM-III classification of factitious disorders encourages artificial separation into disorders with physical and those with psychological symptoms." Merrin et al., *supra* note 18, p. 246.
  65. The boundaries between hysteria, factitious illness, and malingering are ill defined." Spiro, *supra* note 6, p. 575, emphasized the "sociopathic pattern of factitious illness." Mutually exclusive categorization fails to consider the overlap of somatoform conditions and malingering.

66. A. Lazarus, "Factitious Disorder in a Manic Patient: Case Report and Treatment Considerations," *Int. J. Psychiatry Med.*, 15:365-369, 1985-1986.
67. T. Nadelson, "The Munchausen Spectrum," *Gen. Hosp. Psychiat.*, 1:11-17, 1979, views factitiousness as a subgroup of borderline character pathology. He says, "Munchausen's Syndrome is, in short, one of a number of directions that can be taken by people with borderline pathology" (p. 14).
68. Carlson, *supra* note 10, emphasizes the frequent link with major personality disorders (antisocial, schizoid, borderline), schizophrenia, hysteria, and brain damage. The many other authors who have stressed the affinity between factitious disorders and personality disorders include: R.P. Aduan, A.S. Fauci, D.C. Dale, J.H. Herzberg & S.M. Wolff, "Factitious Fever and Self-induced Infection: A Report of 32 Cases and Review of the Literature," *Annals Int. Med.*, 90:230-242, 1979; M. Bauer & F. Boegner, "Neurological Syndromes in Factitious Disorder," *J. Nerv. Ment. Dis.*, 184:281-288, 1996; Carlson, *supra* note 10; H.H. Dohn, "Factitious Rape: A Case Report," *Hillside J. Clin. Psychiatry*, 8:224-231, 1986; Earle & Folks, *supra* note 18; D.G. Folks, "Munchausen's Syndrome and Other Factitious Disorders," *Neurol. Clin.*, 13:267-281, 1995; Folks and Freeman, *supra* note 9; T.D. Geraciotti, C. Van Dyke, J. Mueller & E. Merrin, "The Onset of Munchausen's Syndrome," *Gen. Hosp. Psychiatry*, 9:405-409, 1987; Lazarus, *supra* note 66; T. Nadelson, "The Munchausen Spectrum: Borderline Character Features," *Gen. Hosp. Psychiatry*, 10:11-17, 1979; Nadelson, *supra* note 32; R. Ries, "DSM-III Differential Diagnosis of Munchausen's Syndrome," *J. Nerv. Mental Dis.*, 168:629-632, 1980; M.H. Stone, "Factitious Illness: Psychological Findings and Treatment Recommendations," *Bull. Menninger Clin.*, 41:239-254, 1977.
69. "Associated psychiatric disturbances includes substance abuse, psychogenic pain disorder, malingering, dysthymic disorder, and borderline personality disorder." Sutherland & Rodin, *supra* note 10, p. 392.
70. H.J. Freyberger & W. Schneider, "Diagnosis and Classification of Factitious Disorder with Operational Diagnostic Systems," *Psychother. Psychosom.*, 62:27-29, 1994.
71. Kihlstrom, *supra* note 38.
72. *DSM-III-R*, *supra* note 42.
73. I. Pilowsky, "A General Classification of Abnormal Illness Behaviors," *Brit. J. Med. Psychol.*, 51:131-137, 1978.

74. Caradoc-Davies, *supra* note 21, p. 420.
75. Rogers et al., *supra* note 30.
76. "Simulation does not appear to constitute a separate disorder but is rather a symptom of a more fundamental problem such as personality disorder." S.D. Nicholson & G.A. Roberts, "Patients Who (Need to) Tell Stories," *Brit. J. Hosp. Med.*, 51:546-549, 1994, p. 546.
77. Phillips, Ward & Ries, *supra* note 29.
78. L. Sparr & L.D. Pankratz, "Factitious Posttraumatic Stress Disorder," *Am. J. Psychiatry*, 140:1016-1019, 1983, p. 1018.
79. L. Pankratz, "Continued Appearance of Factitious Posttraumatic Stress Disorder," *Am. J. Psychiatry*, 147:812, 1990, p. 812.
80. E.J. Lynn & M. Belza, "Factitious Posttraumatic Stress Disorder: The Veteran Who Never Got to Vietnam," *Hosp. Comm. Psychiatry*, 35:697-701, 1984, p. 701.
81. Factitious (Vietnam) PTSD is discussed in one of the three cases in Popli et al., *supra* note 16, and in one of the three cases in Merrin et al., *supra* note 18.
82. See L.A. Neal & M.C. Rose, "Factitious Post Traumatic Stress Disorder: A Case Report," *Med. Sci. Law*, 35:352-354, 1995, for a single case of a 24-year-old man who claimed to be a victim of an IRA bombing in Northern Ireland. A later review of the military and medical records revealed that he couldn't possibly have been present at the bombing incident, although he had been in the military at the time. His behavior was explained in terms of motivation to adopt a sick role and be admired as a war hero.
83. M.D. Feldman, C.V. Ford & T. Stone, "Deceiving Others/Deceiving Oneself: Four Cases of Factitious Rape," *South. Med. J.*, 87:736-738, 1994, p. 736.
84. *Id.*
85. Dohn, *supra* note 68, discusses a single case of a 26-year-old woman with factitious rape. She described two incidents but complained that she couldn't remember much. She had superficial scratches on her body, had a history of lying, and confessed to falsification under a polygraph test. She had a borderline personality disorder diagnosis.
86. K.L. Gibbon, "Munchausen's Syndrome Presenting as an Acute Sexual Assault," *Med. Sci. Law*, 38:202-205, 1998.
87. See one of three cases about factitious rape in Merrin et al., *supra* note 18.

88. Feldman et al., *supra* note 83, present cases of four women with factitious rape (p. 736)
89. Falsified accounts of physical abuse and neglect found in J. Goodwin, C.G. Cauthorne & R.T. Rada, "Cinderella Syndrome: Children Who Simulate Neglect," *Am. J. Psychiatry*, 137:1223-1225, 1980.
90. False accusation of assault by parents found in A. Feinstein & A. Hattersley, "Ganser Symptoms, Dissociation, and Dysprosody," *J. Nerv. Ment. Dis.*, 176:692-693, 1988.
91. For a single case report on false sexual abuse, see M. Matas & A. Marriott, "The Girl Who Cried Wolf: Pseudologia Phantastica and Sexual Abuse," *Can. J. Psychiatry*, 32:305-309, 1987.
92. M.H. Stone, "Factitious Illness: Psychological Findings and Treatment Recommendations," *Bull. Menninger Clinic*, 41:239-254, 1977, p. 244.
93. P.M. Coons and F. Grier, Factitious Disorder (Munchausen Type) Involving Allegations of Ritual Satanic Abuse: A Case Report," *Dissociation*, 3:177-178, 1990.
94. S. Feldman-Schorrig, "Factitious Sexual Harassment," *Bull. Am. Acad. Psychiatry Law*, 24:387-392, 1996, p. 388.
95. E. Rothchild, "Fictitious Twins, Factitious Illness," *Psychiatry*, 57:326-332, 1994, describes five cases of patients hospitalized with factitious disorder who described the fantasized loss of a fictional twin.
96. Implied in Bursten's term "pseudologia fantastica," *supra* note 4.
97. Feldman-Schorrig, *supra* note 94.
98. G.H. Gudjonsson, *The Psychology of Interrogations, Confessions and Testimony*. New York: Wiley, 1992.
99. M.L. Erickson, "Negation or Reversal of Legal Testimony," *Arch. Neurol. Psychiat.*, 40:548-553, (September) 1938.
100. For example, factitious disorder with neurological symptoms includes fainting, seizures, amnesia, headache, pain, tremor, and hemiparesis (Bauer and Boegner, *supra* note 68); factitious epilepsy associated with amnesia is reported in Jones & Horrocks, *supra* note 20. For additional discussion see J. Goodwin, "Munchausen Syndrome as a Dissociative Disorder," *Dissociation*, 1:54-60, 1988.
101. P.M. Coons, "Examples of Pseudomultiplicity," *Memos on Multiplicity*, 2:4-5, 1978.



102. R.P. Klufft, "The Simulation and Dissimulation of Multiple Personality Disorder," *Am. J. of Clinical Hypnosis*, 30:104-118, 1987.
103. J.A. Chu, "On the Misdiagnosis of Multiple Personality Disorder," *Dissociation*, 4:200-204, 1991, p. 202.
104. *Id.*
105. *Id.*
106. P.M. Coons and V. Milstein, "Factitious or Malingered Multiple Personality Disorder: Eleven Cases," *Dissociation*, 7:81-85, 1994.
107. *Id.*
108. *Id.*
109. *Id.*
110. Coons and Grier, *supra* note 93.
111. *Id.*, p. 178.
112. *Id.*
113. C.A. Ross, *Dissociative Identity Disorder: Diagnosis, Clinical Features, and Treatment of Multiple Personality*. New York: Wiley, 1997, p. 68.
114. E.L. Toth, "Factitious Hypoglycemia and the Multiple Personality Disorder," *Annals Int. Med.*, 112:76, 1982; E.L. Toth & A. Baggaley, "Coexistence of Munchausen Syndrome and Multiple Personality Disorder: Detailed Report of a Case and Theoretical Discussion," *Psychiatry*, 54:176-183, 1991.
115. *Id.*, p. 179.
116. "An alternative explanation of our patients' manifestations would be that the MPD is just one more form of factitious disorder created by the patient, prompted perhaps by the recent increasing awareness of this condition (MPD) in the lay and scientific press." *Id.*, p. 181.
117. One of three cases discussed in Popli et al., *supra* note 16.
118. For discussions of suicidality in factitious patients, see Bhugra, *supra* note 10; A. Cremona-Barbaro, "The Munchausen Syndrome and Its Symbolic Significance: An In-depth Case Analysis," *Brit. J. Psychiat.*, 151:76-79, 1987; Eckhardt, *supra* note 20.
119. D. Brown, A.W. Schefflin and D.C. Hammond, "False Memory Lawsuits: The Weight of the Scientific and Legal Evidence,"

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120. Rogers et al., *supra* note 30.
121. D.G. Folks, "Munchausen's Syndrome and Other Factitious Disorders," *Neurol. Clin.*, 13:267-281, 1995.
122. K. Abraham, "The History of an Imposter in the Light of Psychoanalytic Knowledge," *Psychoanal. Quart.*, 4:570-587, 1935.
123. Also emphasized by Bursten, *supra* note 4, and Spiro, *supra* note 6.
124. Spiro, *supra* note 6, p. 578.
125. Geraciotti et al., *supra* note 68.
126. Plassmann, *supra* note 50, p. 9.
127. Nadelson, *supra* note 32, p. 182.
128. Lynn & Belza, *supra* note 80, p. 701.
129. M.D.S. Ainsworth, M.C. Blehar, E. Waters & S. Wall, *Patterns of Attachment: A Psychological Study of the Strange Situation*. Hillsdale, NJ: Erlbaum, 1978.
130. Carlson, *supra* note 10, pp. 383, 387.
131. Nicholson & Roberts, *supra* note 76.
132. Plassmann, *supra* note 50, p. 9.
133. W. Ehlers & R. Plassmann, "Diagnosis of Narcissistic Self-Esteem Regulation in Patients with Factitious Illness (Munchausen)," *Psychother. Psychosom.*, 62:69-77, 1994.
134. M.W.P. Carney & J.P. Brown, "Clinical Features and Motives Among 42 Artifactual Illness Patients," *Brit. J. Med. Psychol.*, 56:57-76, 1983.
135. Cramer et al., *supra* note 31.
136. *Id*; Geraciotti et al., *supra* note 68.
137. For a discussion of somatization as "a disturbance in the cohesion of the self," see G.M. Rodin, "Somatization: A Perspective From Self Psychology," *J. Am. Acad. Psychoanal.*, 19:367-384, 1991, p. 381.
138. Spivak et al., *supra* note 26, p. 27.
139. *Id.*, pp. 25-27.

140. Reich & Gottfried, *supra* note 8.
141. Cramer et al., *supra* note 31.
142. Feldman & Escalona describe a case of factitious cancer based on a “longing for nurturance,” *supra* note 14, p. 226.
143. Folks & Freeman, *supra* note 9, p. 270.
144. Geraciotti, *supra* note 68.
145. Nadelson, *supra* note 32, p. 183.
146. T. Parsons, *The Social System*. New York: Free Press, 1951.
147. M.D. Feldman and C.V. Ford, *Patient or Pretender: Inside the Strange World of Factitious Disorders*. New York: John Wiley, 1994, p. 142.
148. Coons and Milstein, *supra* note 106; Brown et al., *supra* note 119.
149. For example, Popli et al., *supra* note 16, p. 317, say, “Not one of our three patients was ever diagnosed as having factitious disorder with psychological symptoms despite repeated psychiatric hospitalizations and outpatient care.”
150. A.W. Schefflin, “Narrative Truth, Historical Truth and Forensic Truth,” in L. Lifson and R.I. Simon, *The Mental Health Practitioner and the Law: A Comprehensive Handbook*. Cambridge, MA: Harvard University Press, 1998, pp. 299-328.