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FACTITIOUS DISORDER: A CASE STUDY OF FICTITIOUS ILLNESS

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SUMMARY

A case of fictitious illness in a young Malaysian Indian male is reported and its relation to the more usual presentation of factitious disorders is discussed. Pathogenesis of this condition and its management are also suggested. Factitious disorders present not uncommonly in this country and it is important for the general duty medical officer and primary care physician to be familiar with this condition.

INTRODUCTION

Factitious disorders are a fascinating group of abnormal behaviours which doctors occasionally encounter and have to manage. For this reason alone, a proper understanding of these behaviours is required by all doctors.

In 1951, Asher[1] described what he called the "Munchausen Syndrome", after the Baron Munchausen whose wanderings and tall-tales resembled some of the behaviours Asher noticed in the three patients he described. However, it appears that the Baron himself never sought the operations which Asher's patients willingly underwent. Many variants of the Munchausen Syndrome are being recognized. Recently Sinanan and Haughton[2] have described what they call an evolution of variants of this Syndrome: "they all attempt to resolve their personal needs by managing the environment and its cultural response to illness by the use and abuse of the available health services . . . because of the creative nature of man, there are many varied presentations of fictitious illness."

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The essential features of chronic factitious disorders with physical symptoms are: plausible presentation of physical illness that is not real, genuine or natural in order to obtain and sustain multiple hospitalizations; voluntary production of symptoms.[3]

Factitious illnesses with psychological symptoms and even factitious psychoses[4,5] have been recognized. Factitious illness by proxy[6] in which "the collaboration or encouragement of persons by other than the patient in simulating a factitious illness" has been described. This situation commonly presents as parents producing the factitious illness in children and has some importance in child abuse.[7]

It is important to make a distinction between factitious disorders and malingering. In malingering the purpose of the symptom and its mode of production are conscious and voluntary. There is a clear purpose to escape a difficulty or responsibility. In factitious disorder, there is a voluntary production of symptoms, but there is no clear purpose except perhaps to adopt the "patient role". The need to adopt the patient role is obscure and appears senseless. No doubt the roots of such behaviour may lie in the unconscious, though such explanations are speculative. In hysterical disorder, the patient is unaware of both the purpose of his symptoms and its mode of production.[8]

The factitious disorder patient once set on his career of abnormal behaviour continues in an ambivalent relationship with hospitals and doctors. In variants of this disorder, the relationship is to a wider target. As Jaspers states "once the game of fancy has started, it frequently leads to self-

deception" and finally a "self-surrender to a fictitious existence."[9]

CASE HISTORY

A ten-year-old Indian male was referred for a psychiatric opinion in May 1985. The chief complaint was that "threads" kept coming out of his right eye. Except for mild inflammation, no abnormality of the eye was found by the ophthalmologist. The "threads" were confirmed to be cotton threads on laboratory examination. The colour of the threads usually matched the colour of his clothing and when the boy was restrained and closely observed for two days, no threads were produced.

The patient on examination was found to be alert, intelligent and verbal. He showed no evidence of psychotic disorder. He strongly denied placing threads in his eyes and his father equally strongly supported his statements. His mother was less sure but went along with the father.

The family had no financial or emotional problems and no evidence of parental discord was found. They had another son who was mentally retarded but all the children were emotionally stable. The patient had no problem going to school. No precipitating event was admitted before the onset of the first episode of his complaint.

The patient appeared to enjoy the attention he was getting. He showed a tendency to conversion and dissociation in that he had a patch of analgesia over the right side of his chest, which did not conform to any somatic pattern of innervation. According to the father, the patient also had the capacity to go into a "trance" during which he could read fluently from any difficult passage in his books, which he could not do normally. These episodes were infrequent and did not occur during my observation. It was thought best not to encourage these tendencies. The patient and his father were very superstitious and strongly believed in the supernatural. The father was inclined to believe that his son was possessed.

A diagnosis of factitious disorder was made and it was concluded that the condition was being maintained by the widespread publicity which had occurred in the local press.

A programme of behaviour modification was planned with the purpose of eliminating attention which was thought to be reinforcing such behaviour.[8] In the beginning, the father appeared to understand the programme and initially was cooperative and he was advised to completely ignore the boy when he produced the threads. The local newspapers agreed to co-operate and kept their silence, at least temporarily. In a few days, the number of threads began to decline but at this point, the father brought in a priest and withdrew his co-operation. Apparently his belief in possession states proved too great and overcame his newly understood principles of learning theory.

The patient stopped coming for further treatment and from press reports (which took up the matter again), it was gathered that a succession of priests, shamans, magicians and others came to treat him. One press report later informed that threads began to appear from the other eye. The last report in the press was one year later, when it was reported that the patient had grown his hair long upon the advice of a priest. However, the threads, though much reduced, occasionally kept coming from his eye.

DISCUSSION

This case is being reported so as to document an unusual case of factitious disorder, which appears to be a variant of the Munchausen Syndrome. What appears to have been a childish prank became a chronic disorder. It is possible that the act of putting threads in his eyes may not have been entirely voluntary, given the patient's tendencies to dissociation. Inner needs of the father also appear to play a part. The undue press publicity was gratifying to the father who continued to produce the reinforcement, which maintained the child's behaviour. The father's belief in demoniacal possession undoubtedly drove him in the unwise direction of reinforc-

ing abnormal behaviour by numerous attempts at exorcism. The father appeared to be committed to a theory of supernatural or organic origin of his son's condition and he could not accept a psychogenic theory of his behaviour.

In 1986, another similar case was reported in the press. On this occasion, it was a little Indian girl who produced small balls of paper from her eyes. Eye examination by hospital doctors revealed no abnormality and laboratory examinations confirmed that the balls were mere paper. The case was dismissed by the hospital authorities as a non-medical matter. What was interesting was the fact that this dismissal was followed by a threat by the girl's father to take the doctors to court for calling it a deliberate hoax.

The fact of contagion[10] should also be mentioned as shown in this second case reported in the press. This case appeared to be almost identical and again the press took it up with great vigour.

CONCLUSION

Factitious disorders are serious disorders in that there is a tendency to chronicity and potentially dangerous behaviour, which may cause serious secondary injuries and even death. They are not diseases but result from the need of some people to simulate diseases. They are disorders of the whole person in his environment and can only be understood from the psycho-social-cultural context. In the case described, it was thought that mere removal of attention would quickly extinguish the behaviour but insurmountable problems appeared in the father's own needs and belief system.

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