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Challenges in the Treatment of Factitious Disorder: A Case Study

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Factitious disorder is difficult to diagnose and effectively treat. It is often met with intense emotion by both the care provider(s) and the client when suspected. However, if missed or untreated, it can become a chronic syndrome that is expensive and potentially dangerous. This article examines barriers to successful treatment of factitious disorder as manifested by a woman who received services from an urban community mental health center over a 7-year period for the management of multiple mental health issues. The unique role of the advanced practice psychiatric nurse is discussed through application of the nursing theory modeling and role modeling.
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WHAT ARE THE benefits of being sick? Some might be time off from work, "TLC" from a loved one, sympathy for enduring pain and suffering, or relief from certain expectations of daily life while not being blamed for laziness. For most people, these benefits are temporary and become less desired as illness improves. However, there does exist a psychological disorder in which an individual purposefully feigns or induces symptoms of illness, either physical or psychological, to assume the sick role and attain the emotional benefits of being cared for by another, usually a medical professional or a team of health care providers (HCPs). The American Psychiatric Association (APA, 2000) refers to this phenomenon as factitious disorder (FD).

FD DEFINED

According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*), the diagnostic criteria for FD are (a) the intentional feigning of physical or psychological signs or symptoms, (b) the motivation for the behavior is to assume the sick role, and (c) external incentives for the behavior (such as economic gain or avoidance of legal responsibility, as in malingering) are absent (APA, 2000). Clinical problems commonly feigned include infection, pain, neurological symptoms (e.g., seizures or dizziness), vomiting, diarrhea, fevers, and symptoms of autoimmune or connective tissue disease (APA, 2000).

Krahn, Li, and O'Connor (2003) defined five levels of FD behavior: fictitious history, simulation, exaggeration, aggravation, and self-induction of disease. Individuals may also eagerly undergo multiple diagnostic examinations and invasive procedures and after extensive medical workups yield negative results they often produce more and/or new factitious symptoms (APA, 2000).

FD is difficult to accurately diagnose and is often met with intense emotion by both the health care team and the client when it is suspected. Common reactions by HCPs include anger, despair, frustration, disgust, and vengeance (Eisendrath & McNiel, 2004; Feldman & Feldman, 1995; Krahn et al., 2003; Stephenson & Price, 2006). In addition, it is a difficult disorder to effectively treat as it requires a vast amount of patience, nonjudgment, and compassion by the treatment team. However, when FD is missed or untreated, it can

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become a chronic syndrome that is expensive and potentially dangerous.

PURPOSE

The purpose of this article is to examine barriers to successful treatment of FD as manifested by a woman who received services from an urban community mental health center over a 7-year period for the management of multiple issues including depression, panic attacks, chemical abuse, somatization, mixed personality disorder, and behaviors consistent with FD. The nursing theory modeling and role modeling (MRM) of Erickson, Tomlin, and Swain (1983) will be applied as an example of how the advanced practice psychiatric nurse (APPN) can approach treatment of FD. Data for the case presentation were obtained through an extensive review of records created by a multidisciplinary team of mental health practitioners, consultation with these providers, and interviews with the client. Privacy is maintained through the use of a pseudonym and exclusion of other identifying information.

REVIEW OF LITERATURE

An abundance of literature over the last several decades describes the myriad facets of FD. Collectively, the research provides an excellent basis for recognizing FD and for primary intervention strategies. Unfortunately, it is a difficult disorder to study in a controlled manner, and the bulk of data is retrospective and primarily composed of individual case studies. Most of the publications were completed by physicians in a variety of medical specialties. There was virtually no literature produced by the nursing profession that addressed FD independent of that "by proxy." In addition, there was no literature found that discussed cases of FD initially diagnosed by a mental health professional within a mental health care setting. Usually, the disorder is first discovered or suspected by a medical professional who then refers the individual for psychiatric assessment.

Epidemiologic studies estimate an incidence rate of 0.8 to 1.3% (Fliege et al., 2007; O'Shea, 2003). O'Shea's study reports a 20% overlap between somatization disorder and FD. This suggests that a significant number of cases involve both unconscious and conscious processes in the illness cycle. Although the main premise of FD is the intentionality of the individual's abnormal illness behavior, he or she may also be unconsciously motivated and reenacting conflicts over dependency and control (Niemark, Caroff, & Stinnett, 2005). Explanations for the low incidence rate include the belief that a large number of cases are missed. According to Feldman and Feldman (1995), individuals with FD respond in a predictable manner in which they deny the allegations, threaten malpractice actions, or simply flee, perhaps to continue the "medical ruse" elsewhere (p. 390). FD may also coexist with actual medical, other mental, and/or chemical health disorders that make it even more challenging to differentiate.

Additional barriers in the recognition of FD are related to lack of knowledge about the disorder, time constraints, and clinician ambivalence about the diagnosis and how it should be managed. The willingness to document FD as a diagnosis varies (Fliege et al., 2007; Krahn et al., 2003; Schlesinger, Daniel, Rabin, & Jack, 1989). Krahn et al. (2003) proposed that HCPs "…are reluctant to consider a factitious process…unless definitive proof is available" (p. 1166). Often, definitive proof is only obtained when the individual is caught in the act of self-injury to produce objective signs of illness or by actual admission of deceit.

Once the treatment team suspects factitious behavior, questions arise about how to intervene and whether or not to confront the individual. Krahn et al. (2003) warned about countertransference that may interfere with the provision of compassionate medical care. Stephenson and Price (2006) noted that HCPs often experience anger or embarrassment when they realize they have been deceived and may react on an impulse to expose the individual's lie and manipulation. However, immediate confrontation is not necessary, and some authors recommend against this approach as it usually does not lead to client acknowledgment but has the potential to cause "irrevocable damage" to the therapeutic alliance (Krahn et al., 2003, p. 1166). Because FD is secondary to another emotional disorder, treatment is aimed at the primary mental illness with the hope that the factitious behaviors will diminish or cease as a result.

Researchers have proposed a number of theories about the pathology underlying FD. O'Shea (2003) provided a psychoanalytic explanation that incorporated a borderline personality construct, often exhibited in FD. O'Shea suggested that the individual receives satisfaction as he or she retaliates

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