Feigned narratives do not always satisfy needs: the case of factitious disorders

Lilia Gurova
Department of Cognitive Science and Psychology
New Bulgarian University
email: lgurova@nbu.bg

Abstract: When Bradley Lewis announced in 2014 that psychiatry needed to make a "narrative turn", he backed up his appeal as follows: (1) the different explanatory models of mental disorders that are currently competing in psychiatry tell us different stories about mental health; (2) none of these stories has the privilege of being the only true one, and its alternatives the wrong ones; (3) the choice of a model in each case should be made in a dialogue with the patient in order to ensure that the model will be chosen that best meets the patient’s goals and desires and, accordingly, would best support the process of recovery. The latter suggestion however is not easy to follow when the patients’ subjective goals and desires and the goal of returning the patients to a normal way of life diverge, as is the case with the so-called factitious disorders. The problem is worsen by the theory-ladenness of the interpretations of patients’ first-person narratives. This paper argues against a common assumption that biases our understanding of abnormal behavior, in particular the behavior of those who feign stories about illness. This is the assumption that such a behavior satisfies certain, possibly unknown, psychological needs.

Keywords: understanding mental disorders, narrative turn in psychiatry, theory-ladenness of understanding, first-person narratives, factitious disorders, self-engaging behavior

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“We also tell stories just because we cannot stop, because they fascinate and engage us even if we know they are untrue”.

(Boyd 2009, p. 1)

1. **Introduction: the call for a narrative turn in psychiatry and the focus on patients’ first-person narratives**

On April 29, 2013, just weeks before the official release of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), Thomas Insel, who was then director of National Institute of Mental Health (NIMH), expressed in a blog-post the intent of NIHm to “re-orient its research away from DSM categories” (Insel 2013). Admitting the usefulness of DSM (of all of its editions) as “dictionary” ensuring that the same terms are used in the same way by all professionals, Insel at the same time stressed the most serious defect of the DSM categories – their lack of validity due to the fact that these categories refer to “clusters of clinical symptoms, not any objective laboratory measure”. “Patients with mental disorders deserve better”, said Insel, that’s why NIMH had started working on a project which aims to “transform diagnosis by incorporating genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classification system” (Insel 2013). This project, which is known under the name “Research Domain Criteria” (RDoC) is based on several assumption but the most important among them is that “mental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion, or behavior” (Insel 2013). Accordingly, the aim of RDoC is to create a new system of categories, which refer to clusters of “genetic, imaging, physiological, and cognitive data” rather than to clusters of symptoms used to define the DSM categories.

The NIMH’s position, as it was presented by Insel, provoked severe reactions even from those who otherwise shared the concerns about the validity of the DSM categories. One of them, Allen Frances, posted on the website of *Psychiatric Times* the following comment: “NIMH has turned itself almost exclusively into a high power brain research institute that feels almost no responsibility for how patients are treated or mistreated in the here and now” (Frances 2013).
Eventually, the controversy “NIMH vs. DSM 5”, was resolved, at least ostensibly, by a common statement issued on behalf of American Psychiatric Association (APA) and NIMH. The statement contained the declaration that “DSM-5 and RDoC represent complementary, not competing frameworks” for achieving progress in characterizing mental disorders (Insel & Lieberman 2013). This controversy however was recognized by some as a sign for a crisis of the medical model of mental disorders, which both DSM and RDoC endorsed. Accordingly, the recognized crisis was seen as a reason for undertaking a more radical departure from the medical model.

An year after the onset of NIMH vs. DSM controversy, the high profile scientific journal *Lancet* published a paper appealing for a “narrative turn in psychiatry” (Lewis 2014). The author of the paper, Bradley Lewis, stated there that “taking a narrative turn does not mean abandoning the biological model or any other. A narrative turn says all the models are valuable if used self-reflexively in dialogue with patients and in the service of recovery. Ultimately, it is the patient’s choice which model or combination of models best fits their goals and desires” (Lewis 2014, p. 23). What is the rationale behind this appeal for a narrative turn in psychiatry? According to Lewis, all existing models that explain mental variation (including purely biological models, the biopsychosocial model as well as the psychoanalytic, cognitive and other models) tell us different stories about mental health, using different sets of “root metaphors”. It is wrong however, he said, to assume that just one of these stories is true and the others are wrong. In a sense, all these stories are in the same time true and false but they provide different perspectives on patients’ treatment, and whether the suggested treatment would be successful or not would eventually depend on how the patient would accept the proposed story of his/her health issue. The idea that the explanatory model of particular mental problems should be negotiated between the psychiatrist and the patient had been already made popular at that time. It for example had been advertised by Stanghellini (2013) whose suggestions for focusing the psychiatric interview on the first-person narrative of the patient will be discussed in some detail because Stanghellini’s views demonstrate well the theory-ladenness of understanding patients’ first-per-

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2 This should not be seen as a surprise. An year later the editors of *Lancet* launched an initiative to publish case reports describing “an unusual presentation of a common disease or a rare cause of a common presentation if not something completely novel” motivated by the view that stories like those “form the basis of how we learn, and how we remember” (Berman & Horton 2015, p. 1277).’
son narratives and thus justify the suggestion that the theory-ladenness of understanding patients’ narratives should be given much more attention than it has usually received.

Stanghellini’s dissatisfaction with the domination of the biological model of mental disorders, which he calls “biomedical model” or “biomedical paradigm”, is much more radical than that of Lewis as far as Lewis is only against the domination of this model, not against the model itself. For Stanghellini, the biological model, which assumes that the symptoms of a particular disorder form a cluster because of their common neurobiological cause, in fact works against narration (telling a story about the formation of this cluster) because the formation of a narrative in his perspective requires to order one’s “actions, experiences and beliefs” by establishing the meaningful connections between them, as narratives are based on meaningful connections not on cause-effects relations. Thus the narrative turn in psychiatry for Stanghellini should consist in a radical departure from the biological model and embracing a model that assumes that the symptoms of a given mental disorder form “a meaningful whole” (Stanghellini 2013, p. 343).

He insisted as well that the meaningful relations between the symptoms should be extracted from the first-person narrative of the patient in the course of a dialog (led by a non-structured interview) ensuring that the meaningful connections as they are seen by the patient are grasped correctly. How does that work? Stanghellini tried to illuminate the process on the example of schizophrenia. A common bizarre symptom of schizophrenia is the delusion of external control shared by many of the patients suffering from this severe disorder. According to Stanghellini, however, this otherwise bizarre delusion becomes understandable if one views it as an explanation of the “disturbing changes in bodily experience” (Stanghellini 2013, p. 347).

Stanghellini’s general recommendation is to make sense of the patient’s seemingly absurd or meaningless beliefs and behavior by imagining the kind of world in which these beliefs and behavior would be expectable.

However, the assumption underlying Stanghellini’s “phenomenological” approach, i.e. the assumption that the symptoms of a given disorder form a coherent meaningful whole is a strong theoretical assumption insofar as it does not rest on any direct observations or on inferences from such observations. We need this assumption, as Stanghellini himself has admitted, in order to make understandable for us behavior, thoughts and beliefs, which look bizarre or mean-
ingless to “normal” people. However, if we assume, as Stanghellini does with regard to schizophrenia, that the perceptions of those who suffer from it can be seriously disturbed, why not assume that the semantic connections between perceived events can be just as upset? What if the things are exactly the opposite: the perceptions of those suffering from schizophrenia are intact but the way they bind them in a meaningful whole is flawed?

It’s not only the phenomenological approach to mental disorders that relies on theoretical assumptions in order to make understandable the patients’ first person narratives. It seems as if theoretical (one may call them “philosophical”) assumptions underlie all approaches to mental disorders, including the biological one the proponents of which view it as more objective. Is then Lewis right to insist that none of the stories told by the different approaches is better than its rivals in terms of truthfulness and that the only criterion which one should use for choosing a theoretical perspective on mental health should be its capacity to produce change in the patient’s condition in a given case?

In search for an answer of this question I’ll discuss in the next section the peculiar story of the recognition and the following attempts to define, explain and treat the so-called factitious disorders (FD). This case study will reveal how the different attempts to make understandable the feigned narratives of the patients with FD rest on different assumptions as well as on one common assumption – that these narratives and the behavior, which they support satisfy a particular psychological need. The latter however is a theoretical assumption, which does not rest on any direct evidence. On the contrary, this assumption directly confronts the first-person narratives of many patients with FD. At the same time, patients' stories cannot be taken as a basis for an explanatory model either, due to their serious discrepancy with reality, but mainly because they serve purposes that hinder the recovery process. The suggestion I will try to defend is that the behavior of patients suffering from FD should not be interpreted as aimed at satisfying certain unclear (or disputed) psychological needs, but should be seen instead as self-supporting, or as an end in itself. This model of explanation, which does not directly confront the understanding demonstrated by the patients themselves, may be a more successful basis for discussing strategies to deal with the pathological symptoms, because it suggests to focus on the available
pathways to involvement in alternative activities rather than on the justification of such involvement by stressing any unclear and contested needs.

2. **A short reconstruction of the story of factitious disorders**

In ICD-10 factitious disorders (FD) are associated with “intentional producing or feigning of symptoms or disabilities, either physical or psychological”, in the absence of external incentives and rewards, and of “confirmed physical or mental disorder” (WHO 1992, F68.1). FD are described in a similar way in DSM-5 (APA 2013, p. 324) although there they are presented as a subcategory of “somatic symptom and related disorders” rather than to “disorders of adult personality and behavior” as in ICD-10. Notice that although FD are associated with *Intentional* lying, the goals or causes behind the intentional process are not specified. They are only negatively defined by excluding from their class any external gains or rewords. This omission, as we will see, is not accidental, and it is not motivated solely by the ideology of DSM and ISD to offer definitions based on observable symptoms only. This omission is also due to disagreements about the alleged goals and causes behind the simulation or fabrication of symptoms typical of patients with FD. Some of these disagreements, as we’ll see, stem from deeper theoretical divergences.

The phenomenon of intentional lying without obvious incentives has been probably known for ages but it was first referred by the term “factitious disorder” by Hector Gasin in 1838 (Kanaan & Wessely 2010). Since then until the middle of the 20th century this term had been only sporadically used. However, the situation changed in 1951, when Richard Asher gave the first more elaborated description of the phenomenon and called it “Munchausen’s syndrome”. Factitious disorders entered officially the 3rd edition of APA’s classification of mental disorders - DSM-III (APA 1980) but one of their sub-species, the factitious disorders imposed to another, was not officially recognized until 2013 when the 5th edition of DSM was published.

Since their official recognition, factitious disorders have been a subject of persistent controversies. To understand them we should first shed light on some aspects of the context in which the disorder was recognized as such by the psychiatrists.
In his 1951 paper Richard Asher described the typical patient showing the Munchausen’s syndrome in the following way: he “is admitted to hospital with apparent acute illness supported by a plausible and dramatic history. Usually his story is largely made up of falsehoods; he is found to have attended, and deceived, an astonishing number of other hospitals; and he nearly always discharges himself against advise, often quarrelling violently with both doctors and nurses.” (Asher 1951, p. 339)

This general account of the typical manifestations of the Munchausen’s syndrome is supported by three more detailed descriptions of real cases. Asher did not propose a definite procedure for diagnosing the syndrome, he only offered some “useful pointers” that might help to recognize the condition. He, however, made an important remark, which must be kept in mind. It is that the feigned stories of the Munchausen patients always contain some truth: “it must be recognized that these patients are often quite ill, although their illness is shrouded by duplicity and distortion” (Asher 1951, p. 339).

Asher ended his paper with two conclusions. The first is about the practical importance of finding a way to recognize Munchausen patients as they “waste an enormous amount of time and trouble in hospitals” (Asher 1951, p. 341). The second conclusion is about the need to find an explanation of this condition “which might lead to a cure of the psychological kink3 which produces the disease” (Asher 1951, p. 341).

In what follows the attempts to solve the second tasks will be traced in order to make explicit the diverse theoretical assumptions behind these attempts to find the unknown “psychological kink” and the ways these assumptions interfered with the interpretations of feigned first-person narratives produced by patients with FD. It should be mentioned meanwhile that since the introduction of FD in DSM (first in DSM-III), the term “Munchausen’s syndrome” has been reserved for a specific sub-type of FD characterized by a severe and chronic course of FD, associated with feigning or fabrication of mostly physical symptoms. The discussion from now on will be focused on the attempts to explain the disorders belonging to the more general category of FD, as it is described in the modern editions of DSM and ICD.

In a review chapter published in 2001, Feldman, Hamilton and Deemer reported that at least four hypotheses explaining FD had been raised until the end of the last century. The behavioral

3 The italic is added by me, LG.
explanation of FD viewed them as a result of “past social learning reinforced by current positive or negative stimuli” (Feldman, Hamilton & Deemer 2001, p. 149). The cognitive explanations referred to flaws in the cognitive processing. The psychodynamic explanations, which focused on early traumatic experiences, weakened ego and superego deficits generally saw FD as a non-adaptive intra-psychic defense. Feldman, Hamilton and Deemer themselves argued for the forth explanation of FD based on what they called “the self-enhancement model”, which builds on the hypothesis that FD enhance or protect self-esteem.

As Feldman, Hamilton and Deemer (2001) themselves acknowledge, although each of the available explanations broadens our understanding of FD to some extent, none of them offers a sufficiently complete understanding of the processes that lead FD sufferers to simulate and fabricate symptoms of disease without visible benefit from this. Schwartz et al. (1994), for example, have shown that social learning is, at best, only an insignificant part of these processes, because in many cases, when the necessary conditions for social learning of the sick role are present, those placed in these conditions do not assume this role and thus do not develop FD. Moreover, it is often observed that the alleged “attention seeking behavior” persists despite the doctors trying to not reinforce it (Mousailidis 2019). Certain deficits in cognitive processing explain relatively well the cases of hypochondria, in which distorted perceptions of normally functioning bodily processes lead to the formation of beliefs about an underlying disease. However, in the patients with FD, there is a deliberate simulation or fabrication of symptoms rather than a misperception of normal functions as pathological. The psychoanalytic explanations, although different from the explanations referring to social learning, encounter similar problems: traumatic events or circumstances that are thought to trigger FD do not lead to FD in the majority of people.

It is important to stress here that the different explanations of FD not only lead to different understandings of the processes associated with these disorders, but also influence the way psychiatrists perceive and describe the stories of their patients. The latter was recognized as a significant obstacle to the adoption of standardized protocols for writing case reports, which made difficult to compare and consolidate the available case reports in systematic and narrative reviews. However, attempts at such reviews were made as we shall see soon.
In 2004, Marc Feldman, one of the authors of the review chapter (Feldman, Hamilton & Deemer 2001), reduced “the ultimate puzzle” of FD to the question about “the psychological benefits of playing “the sick roles”” (Feldman 2004, p. xvii). He added also that it is “important to understand why so little progress has been made toward the scientific understanding of this particular psychological problem” (Feldman 2004, p. xviii). Apparently, Feldman was not inclined to accept that the lack of progress might be connected to the biased formulation of the “ultimate puzzle”, suggesting that the intentional simulation or fabrication of symptoms brings some psychological benefits.

What is the present understanding of FD? In one of the few systematic reviews summarizing the findings of 455 case reports, Yates and Feldman (2016) confess that the motivation of FD patients is “almost always obscure” but in the same time speculate that it might include desire to receive “affection and care”, “adrenaline rush”, “sense of control over those who are deceived”. The assumption behind these tentative explanations is that intentional behavior should be driven by explicit (conscious) goals or desires transcending the immediate (proximate) ends of this behavior. But is it necessarily so? In the next section, I will point out several important advantages of considering the behavior of patients with FD as self-engaging and an end in itself, and not as determined by (still unclear) psychological “kinks” or motives, as the currently discussed explanations of this behavior suggest.

3. **The advantages of understanding behavior of patients with factitious disorder as self-engaging and an end in itself rather than as directed to the satisfaction of certain presumed psychological needs**

Let’s go back to Asher’s 1951 article, which first described Munchausen's syndrome. Asher noted there the extreme incooperativeness of patients with this syndrome and their fierce resistance to any attempt to be told that they were not suffering from what they were trying to convince the others that they are suffering. Almost all case reports published in the following years confirmed Asher's observations. If the patients with FD sought the sick role to attract attention, love and care, why did they refuse the attention and care offered to them, but at the cost of acknowledging that they need them and not the treatment of the diseases or disabilities
they have deliberately fabricated? A hint leading to the answer of this question can be found in the confession of a former patient diagnosed with FD, who shares the following: “I was 9 1/2 when my little sister was born. That day, my life changed forever. Not just because I was no longer the baby, but because my sister was born two months early and was diagnosed with Cerebral Palsy. She needed a lot of care and attention than the typical bay and that’s when I became the invisible girl. I was emotionally abandoned by my mom and emotionally and verbally abused by my father. A couple years after her birth, I began faking things to get the attention I was missing out on. It was something that went deeper than just getting attention. It was something deeper.”

Of course, one cannot expect a patient to account for her thoughts, feelings and beliefs in scientific terms. As already noted, understanding of first-person narratives is always associated with interpretation, or translation in terms of a known theory, or theoretical framework. But do we have a theory that explains human behavior with something other than external causes and internal psychological needs? It turns out that there are such theories.

Boyd, a quote from the book of whom is used as the motto of this paper, offers an original evolutionary explanation of what we can define as self-engaging behavior. We often do things deliberately, not to achieve something else, not to achieve a certain effect, but for their own sake. And we keep doing these things even when they are no longer so desirable, simply because we can't stop or because we don’t see a compelling enough alternative. The prototype of self-engaging behavior is playing. Animals also play, Boyd notes, “but pretend play appears to be an almost exclusively human activity” (Boyd 2009, p. 181). The explanation of pretending behavior as self-engaging is compatible with what we find documented in many case reports. Often, for instance, patients with PD are women who lead a monotonous life that does not offer any engaging activities (Feldman, Hamilton & Deemer 2001). For such women, playing the sick role turns out to be much more engaging than anything else in their daily life. Compatible with this explanation are also the descriptions of cases of spontaneous recovery of FD patients after being involved in a new engaging activity, for example, after making a commitment to take care of a pet (Feldman, Hamilton & Deemer 2001).

4 This is an excerpt from a patient’s narrative posted by Marc Feldman on April, 2017, 2020, at Important treatment advice from a woman who recovered from Munchausen by Internet | Dr. Marc Feldman. The italic is mine - LG.
If the hypothesis stating that playing the sick role is a form of self-engaging behavior gets confirmed, this will open up new opportunities to help FD sufferers, which opportunities might be seen as meaningful alternatives to what is currently offered within the medical model.

4. Conclusions
The narrative turn in psychiatry could not lead to success without taking into account the theory-ladenness of understanding patients’ first-person narratives. This general conclusion is supported by the analysis of the so-called factitious disorders. It has been generally accepted that the patients with FD strive to play the sick role in order to satisfy some psychological needs. As plausible as this assumption may sound, it is not necessarily true because we do not have enough evidence to support it. On the contrary, the resistance of patients with PD to accept this assumption is a good reason to question it. This paper highlights the advantages of an alternative theoretical assumption, according to which the behavior of those assuming the sick role is self-engaging and not determined by external causes or internal psychological needs. First, the idea of self-engaging behavior is consistent with the first-person stories of patients diagnosed with FD who have successfully overcome their condition. This idea explains as well the typical social profile of the FD patients. An important advantage is also that the prevalence of self-engaging behavior has an evolutionary explanation. And last but not least, the idea of self-engaging behavior explains the recovery of patients with FD after a successful switch to another completely different engaging activity.

References


