

Factitious disorders, malingering or maladaptive coping strategies?

Factitious disorder (FD) is the intentional production or feigning of symptoms or disabilities either physical or psychological [1], usually without obvious motivation such as financial compensation or escape from danger. At times the motivation is to receive medical care or to take the sick role [2,3]. Malingering (M) is the intentional production or feigning of either physical or psychological symptoms or disabilities, motivated by external stress or incentives [1,2]. A case of a child subjected to abuse and who presented with pseudo-convulsions prompted us to write this response along with two other cases, to focus on the implications of making these diagnoses [4].

Case 1

A 24-year old single woman was referred from the dermatology unit with a history of multiple skin eruptions for 3 years. She had also been investigated for ear discharge and seizures. She was the seventh of the nine children from a poor family. Her mother left home when she was 9 and the father died when she was 11 years. She had witnessed constant marital conflicts and never had a close relationship with a man. She lived in a hostel and worked as a factory helper. Her earnings were less than an average worker due to frequent absenteeism.

An initial diagnosis of FD was made using ICD-10 [2]. A decision was made to offer psychotherapy and continue exploring her symptoms. Later, an association between pressure from family to marry and a fresh crop of skin eruptions emerged. Sensitive probing revealed that she was subject to repeated incest by her brother from the age of 8. She was reluctant to visit home because there was pressure to marry and memories of past sexual abuse. To escape from the situation, she burnt her body by using hot oil and a liquid detergent. Her diagnosis was reviewed because the underlying cause seemed to be her dislike and fear of marriage. The alternate diagnosis to FD was M, which was even more stigmatising. A decision was made not to use a diagnostic label but to continue to see her and offer supportive therapy. Three years later, she is married, and visits the unit socially.

Case 2

A single woman from an orphanage was referred for assessment of discharge from the ear and nose and

repeated fits for 6 months. These episodes confined her to hospitals for long periods. She was suspected to have a FD.

Further discussion revealed that she was orphaned as a child, when both parents died from a terrorist bomb blast. She was brought up in an orphanage and was now expected to move on and find her own living. There was increasing pressure from members of an armed militant group to join the movement, which she resisted. She felt vulnerable and trapped. She said that she inflicted injuries that caused the discharge or had fits when she felt frightened about her future. In hospitals she found a temporary escape. She improved with psychotherapy and was transferred to another hospital for follow up.

The FDs are characterised by feigned physical or psychological symptoms and signs presented with the aim of receiving medical care [3]. For firm diagnosis of FD, direct evidence of production of these symptoms and exclusion of other causes are necessary. Malingering has to be distinguished from FD. In M there is usually an external motive that is obvious [2]. Malingering is not a diagnosis of a disease, but a behaviour. These differ from somatoform disorders, where the symptoms are medically unexplained but are not deliberately produced [5].

In both our cases the diagnosis changed from FD to M. This illustrates the need to give adequate time before a firm diagnosis is made of such disorders. More importantly, we wish to question the appropriateness of these diagnostic categories in the current ICD classification. Both entities confer culpability on the person who is trying to escape a stressful situation. They are merely cries of desperation of those struggling to survive amidst social cruelty. Furthermore, the label implicitly encourages stigmatisation. Doctors need to avoid taking on the role of detectives searching for diagnostic labels and compound the suffering of those who manifest such symptoms. Instead the focus should be to manage their symptoms, explore their beliefs and show empathy. It is best not to classify them as FD or M but under “factors influencing health status and contact with health services (ICD-10: Z00-Z99)”, as a new entity known as “maladaptive coping strategies to survive”. From the above cases we have tentatively identified the following criteria for inclusion in this category:

- a) The presence of a life-threatening or extremely stressful or unpleasant situation, with no perceptible escape.

- b) The person is trapped by others who are higher in social hierarchy or have more power.
- c) The individuals acquire a potentially serious behavioural pattern to escape when confronted with the situation (in contrast to dissociative disorder where the response is unconscious).
- d) The behavioural pattern disappears after the threat is resolved.

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Protecting markets, excluding competition

It (the UK Commission on Intellectual Property Rights and Development Policy, 2002) stated that intellectual property is of little relevance in stimulating research and development of diseases prevalent in developing countries. It points out that less than 5% of the money spent worldwide on pharmaceutical research and development is for diseases that predominantly affect developing countries. Although expenditure on total pharmaceutical research and development in the private sector doubled to \$44bn in 1990-2000, of the 1395 drugs approved between 1975 and 1999, only 13 were specifically indicated for tropical diseases, including tuberculosis and malaria. Concluding that the research agenda for pharmaceuticals is led by market demands of the developed world rather than the needs of poor people, the commission recommended that intellectual property rules should limit the scope for patenting that serves more to protect markets, and exclude competition, than promote local research and development.

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