Clinical Note

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The Biography of the Factitious-Disorder Patient

Infantile Confrontation with Illness and Death

The biographies of patients suffering from factitious disorders do not generally exhibit that chaotic juxtaposition of illnesses, object losses, violence and parents with severe personality disorders that characterizes the childhood of the Munchausen patients. The family situation of these patients, in contrast, usually makes a more orderly impression; there is indeed a family, albeit on that is usually under extreme tension.

In the study population of Fras and Coughlin [1], 6 of the 7 patients had a sick father to whom they turned in vain with their childish 'dependency needs'. Instead of strength, these fathers exhibited episodic outbursts of anger, during which, however, they did not physically injure the children. The children lived in a world characterized by 'poor verbal communication'. In this scenario, becoming ill appears to be part of manipulative style of relating, in which wishes and expectation are expressed in physical symptoms instead of in words.

Another aspect was demonstrated in the study population of Pope et al [2]. In 7 out of 8 of their thoroughly investigated cases of factitious psychosis, there was a family history of psychiatric illness: depression, alcoholism, antisocial personality structures, and compulsive syndromes. Nonetheless, there were no productive psychiatric cases. In their feigned psychiatric illnesses, the patients had taken over the symptomatology of family members and, in the hospital, of other patients as well, and turned them into chronic symptoms; 1 patient went so far as to commit suicide. The prognosis is thus significantly poorer than for patients with real psychotic illness. This mechanism, whereby the patient identifies with a primary object via a common illness, is also described by Eckhardt [3] and is interpreted as a form of pathological nonaccomplished mourning work. By identifying with the illness, the patient can avoid giving up and object which he or she has, in reality, already los. Another form of confrontation with illness is the experience of the illness and death of siblings. When the patients attempt to take the place of deceased siblings, they may feel

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that they have been deprived of their own identity. By means of the 'replacement child situation', [3], the parents avoid coming to terms with the death of a child and confronting their real guilt or feelings of guilt. The death of siblings can be experienced by future patients as homicide; these deaths have a massive impact on the person's image of the parents, and especially on the image of the mother.

Object Losses

In 4 out of 6 of their patients, Harnoss et al [4] found early object losses caused by divorce or the death of a parent; this was also true of 44% of the 30 patients studied by Haenel et al. [5] who came from a 'broken home' situation. Carney and Brown [6] state that 61% of their group of 42 patients were 'emotionally deprived in childhood' without describing the exact circumstances; similarly, Sussman and Hyler [7] report that 'the usual history reveals that one or both parents are seen as rejecting figures who are unable to form close relationships' [p. 1244]. Parents of this kind are absent emotionally rather than physically. Their relationship to the child is cool, lacking in tenderness, and often limited to cleanliness training.

In my group of 24 patients, around one third were separated from one or both parents during the first years of life. In several cases, the young children were repeatedly turned over to the care of neighbors or foster families for long periods of time. The result was that every conflict with the mother was associated with the danger of object loss. With remarkable frequency, there was evidence that the parents had an abnormal sex life. Several of the patients' mothers had lived together, at least part of the time, with a rapidly changing succession of partners precisely during the critical first years of their daughters' lives, in some cases even engaging in prostitution. Repeatedly, these patients had a social background marked by wartime poverty and an absent father. The draconian child-rearing practices subsequently employed by these parents can be understood as their projection into the children of their own feelings of moral guilt. In two cases, the child was placed in a foster family or children's home as a result of severe violence on the part of the parents.

The endopsychic consequences of early object losses of this kind are strong persistent dependency wishes, accompanied by fear of dependence because of the danger of being dramatically abandoned again. On of the roots of the clinging to medical institutions and professionals can be found here. In our cultural sphere, these are available at all times almost everywhere; for this reason, they can be fantasized as good maternal primary objects.

In the patient's intolerance of being separated from parents and paternal surrogates, strong feeling of guilt, as well as fear of separation, play an important role. As part of the identification process, the rejection is interpreted as justified aggression which the patient has earned by being bad, malicious and dishonest. In contrast, a separation is never interpreted as the natural creation of zones of freedom.

Pathological Communication Styles in the Patients' Original Families

In severeal cases, the 'schizophrenic communication style' of the patient's original family can be reconstructed. The child's realistic perceptions of him/herself and his/her

environment are ignored, denied, forgotten, modified. This can take place in a rather subtle manner when mothers transform their children into self objects [8] and then 'dictate' to them how they are supposed to feel [9]. The child is expected to place this alien expected reality above his or her own reality. In extreme cases, the conditions are like the ones described by the patients of Miller and Bashkin [11]: 'No one in my family remembers anything. They forget everything they want to forget. Everytime anything happened, the story got so twisted around sometimes it seemed that nothing ever happened at all' [p. 646].

Pseudologia fantastica, a phenomenon characterizing the Munchausen syndrome and occurring occasionally among many patients suffering from factitious disorders, appears to be a reproduction of these early communication styles. The unpleasant perception of realities is masked by the creation of an imaginary reality; like a dream, this reality has a distinct wish-fulfillment function [11, 12].

Infantile Fixation on the Figure of the Physician

Reports on a particularly infantile-acquired attachment to physicians refer mainly to Munchausen patients. In the biographies of this group of patients, physicians appear regularly as important persons who are omnipotent and have the power to make up for deficits of the patient or of his or her entire family. They appear as idealized, albeit sexless, substitute parents ('the physician parents' [13]; as 'primary love objects' [6]).

Patients suffering from factitious disorders exhibit less a full-blown idealization of the figure of the physician than an early interest in treating the body in a medical manner. These patients engage heavily in 'doctor games', develop the desire to become a nurse or other medical professional, and seek out the company of doctors. In this manner, they are able to mitigate their hypochondriacal fear of their own bodies [14]. In this context, the physician appears as a neutral asexual parental figure, one who is also omnipotent, however, with the ability to exert a calming and anxiety-allaying effect. The doctors are 'good parents' [15]. Once the process of factitious illness is underway, doctors and hospitals increasingly become central points of reference for the patients. All non-medical contacts are broken off; only medical personnel now seem to be able to offer reassurance and gratification. At the same time, these patients continuously have to deny the potential danger emanating from this personnel as well as their own progressive dependency. There is good justification for comparing this dependency to an addiction [16].

In my own study population, consisting of 21 women and 3 men, affinities to the medical profession and to doctors are evident mainly in the choice of paramedical professions (see my article on epidemiology). In addition, one woman patient was married – and another engaged – to a physician. The latter woman, who exhibited a tendency toward pseudologia, has also claimed to have had a wide variety of professions, including that of physician, on different occasions. Another patient was the daughter of an optician, whom she experienced as a physician-like figure.

Physical Abuse and Sexual Violence

In both the patient groups engaging in covert self-injury (factitious disease) and in overt self-injury (automanipulation), the question

of whether the patients' reports of having been the victims of violence are based on reality or on their imaginations has been answered mainly in favor of the assumption of real traumata [8, 12].

In the patient group studied by Sachsse [8], the violence was perpetrated mainly by hot-tempered fathers, many of them alcoholics, who used violence to force their standards of performance onto the children. Two thirds of the patients in this group were subjected to violence, which took the form of incest, incest-like situations or rape, during puberty. Eckhardt [3] also describes an 'educationally motivated sadism' which I can confirm from my own studies [17].

The violence inflicted on the child regularly becomes part of vicious cycle: the abused child steps up its efforts to establish a symbiotic relationship and is beaten again for this very reason. With every incidence of abuse, the parents experience increased feelings of guilt, and thus increased aggression against the child as the representation of these feelings. In abusing their children, the mothers are often reproducing their own biographies. When they attack the small child, they are attacking fusional-symbiotic and dominating-violent aspects of their own mothers [see ref. 18].

In my own study population, physical abuse was the most frequently demonstrable form of infantile traumatization, occurring in 54% of the patients' histories. This abuse was committed by fathers, foster parents, close relatives, personnel in children's homes, and mothers. In a large number of cases, the patients were routinely beaten from early childhood straight through to adolescence. The degree of violence inflicted here was always on associated with severe pain and often with physical injury (e.g., bruises) and not, for example, more of a suggestive, symbolic chastisement administrered to underscore the seriousness of a warning. In many cases, the later incidences of automanipulation are analyzable memory equivalents; they reproduce, often in a very concrete and literal manner, the violence suffered by these patients as infants [17]. This appears to apply to sexual abuse, in particular, since this kind of abuse takes place at a later date from a genetic point of view and therefore lends itself to more complex symbolization.

Nevertheless, the literature contains relatively few accounts of sexual violence. Where accounts have been presented, they have come from authors who have been able to conduct and extensive exploration of their patients' histories. The patients of Herzberg and Wolff [15] were the victoms of narcissistic and sexual abuse, an abuse which was subtle to a greater or lesser degree. One mother had, for no reason, 'taken the temperature' of her son rectally every day for years. A father had made fun of his pubertal son's fear of his homosexual attacks; moreover, he had been proud of the son's alleged extreme interest in sex. In patients with factitious hematological disorders, in particular, an incestuous biographical component must be considered. The patients of Agle et al. [19] were molested sexually from the age of 5 onwards; starting at age 12, they were regularly subjected to sexual abuse. Later they exhibited a 'general bleeding tendency'. The patient described by Tucker et al. [20] has suffered from gastrointestinal hemorrhage of indeterminate origin for years. From an early age, this woman had been sexually molested and abused by her stepfather. One of my own patients [17] a woman suffering from severe factitious anemia caused by bloodletting, was the victim of sexual abuse by ther foster father, abuse which probably persisted until well into adulthood. In another case, sexual molestation by a brother proved to be the background for factitious hematuria caused by self-catheterization. Overall 8 out

of my 24 patients were victims of sexual violence; the number of undetected cases is probably high as well.

The patient presented by Kafka [21] was, as a small child, the object of an eroticized interest taken in her body by her mother. This led to a mistrusting relationship to her father, a relationship that was also eroticized with sadomasochistic tendencies. From a psychodynamic point of view, it is exactly this constellation of a 'contaminated' relationship to the father which appears to occur very frequently. The relationship to the father does not contain any healing new experience, but rather a reproduction of the traumatic aspects of the relationship to the mother. Among the families of my patients, I was not able to find one father who had effectively protected his child from sadistic or sexual attacks by third parties.

Adolescence

Around one third to one half of the cases of factitious disease begin during adolescence and may be directly related to the experience of puberty, and in girls to the menarche [15; see also my article epidemiology in this volume]. The frequent occurrence of attempted suicide can be interpreted as the expression of a labile emotional situation. In my study population, 8 out of 24 patients had attempted to commit suicide during adolescence. Delinquent behavior of symptomatic (i.e., neurotically determined) character was found in 7 patients, and episodes of addiction had occurred in 13 patients; these were surprisingly high frequencies. It is exactly this symptomatic delinquency which can be a precursor symptom which later develops into the actual factitious disease. In my study population, physical violence was the most frequently reported factor; it included attempted murder, severe bodily injury, several cases of active child abuse in the form of beating, and two cases of arson, both of which led to juvenile psychiatric treatment. This aggressive delinquent activity evolves into the factitious disorder, in which the person's own body becomes the object of destruction [see also ref. 19].

References

1 Fras I, Coughlin BE: The treatment of factitial disease. Psychosomatics 1971;12:117–122.

2 Pope HG Jr, Jonas J, Jones B: Factitious psychosis: Phenomenology, family history, and long-term outcome of nine patients. Am J Psychiatry 1982;139:1480–1483.

3 Eckhardt A: Das Münchhausen-Syndrom: Die chronische Artefaktkrankheit; MD thesis Marburg, 1987.

4 Harnoss CM, Harnoss BM, Lode H, Dissmann T: Münchhausen-Syndrom: Chronisch rezidivierendes Fieber bei sechs Patientinnen. Verh Dtsch Ges Inn Med 1984;90.

5 Haenel T, Rauchfleisch U, Schuppli R, Battegay R: The psychiatric significance of dermatitis artefacta. Eur Arch Psychiatry Neurol Sci 1984;234:38–41.

6 Carney MWP, Brown JP: Clinical features and motives among 42 artifactual illness patients. Br J Med Psychol 1983;56:57–66.

7 Sussmann N, Hyler SE: Factitious disorders; in Kaplan HI, Sadock BJ, (eds): Comprehensive Textbook of Psychiatry IV. Baltimore, Williams & Wilkins, 1985, pp 1242–1247.

8 Sachsse U: Selbstbeschädigung als Selbstfürsorge: Zur intrapersonalen und interpersonellen Psychodynamik schwerer Selbstschädigung der Haut. Forum Psychoanal 1987;3: 51–70.

9 Pao PN: The syndrome of delicate self-cutting. Br J Med Psychol 1969; 42:213–221.

10 Miller F, Bashkin E: Depersonalization and self-mutilation. Psychoanal Q 1974;43:638–649.
11 Plassmann R: Psychoanalyse artifizieller Krankheiten. Habschr Medizinische Hochschule Hannover, 1991.
12 Ford C: The Munchausen syndrome: A report of four new cases and a review of psychodynamic considerations. Psychiatry Med 1973;4: 31–45.
13 Reich P, Gottfried LA: Factitious disorders in a teaching hospital. Ann Intern Med 1983;99:240–247.
14 Herzberg JH, Wolff SM: Chronic factitious fever in puberty and adolescence: A diagnostic challenge to the family physician. Psychiatry Med 1972;13:205–212.
15 Nadelson T: The Munchausen spectrum. Gen Hosp Psychiatry 1979;1: 11–17.
16 Plassmann R: Die heimliche Selbstmisshandlung. Z Psychosom Med Psychoanal 1986;316:336.
17 Paar GH: Selbstzerstörung als Selbsterhaltung. Mater Psychoanal Anal Orient Psychother 1987;1:1–55.
18 Agle DP, Ratnoff OD et al: The anticoagulant malingerer. Ann Intern Med 1970;73:67–72.
19 Tucker LE, Hayes JR et al: Facitial bleeding: Successful management with psychotherapy. Dig Dis Sci 1979;24:570–572.
20 Kafka JS: The body as transitional object: A psychoanalytic study of a self-munilating patient. Br J Med Psychol 1969;42:207–212.
21 Kernberg OF: Borderline-Störungen und pathologischer Narzissmus. Frankfurt, Suhrkamp, 1978.