A case of pain, factitious disorder and boundary violations

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Pain Res Manage 2001;6(4):197-200.

Although health professionals are usually familiar with factitious disorders, evaluating such cases may be complicated, particularly in the legal arena. This article describes a patient who presented with pain complaints to numerous doctors. Eventually, a malpractice suit was brought against one of the patient's physicians who had diagnosed her condition as multiple personality disorder (dissociative identity disorder). Factitious disorder and the doctor's prescription of pain medications were issues raised during the trial. In view of the issue of harm, physicians' responsibilities and limitations during ongoing medical care are addressed in this case report.

Key Words: *Boundary violation; Dissociative identity disorder; Factitious disorder; Malpractice suit; Pain*

Douleur, troubles factices et dépassement des limites

RÉSUMÉ : Même si les professionnels de la santé connaissent généralement bien les troubles factices, l'évaluation de ce type de cas peut s'avérer compliquée, surtout du point de vue juridique. Le présent article fait état d'une patiente qui a consulté de nombreux médecins pour des douleurs. Finalement, elle a entamé une poursuite pour faute professionnelle contre l'un de ces médecins, qui avait diagnostiqué une personnalité multiple (trouble dissociatif de l'identité). Durant le procès, il a été question des troubles factices et de la prescription d'analgésiques par le médecin. On traitera donc ici des responsabilités et des limites des médecins en ce qui concerne la prestation de soins médicaux continus, et ce, sous l'angle des lésions.

CASE PRESENTATION

The patient, a 47-year-old woman at the time of the trial, married and a former nurse, gave birth to her first child at the age of 20 years. The following year, she was admitted to hospital with physical symptoms. During the course of the next 16 years, she saw several dozen doctors. Until she became a patient of Dr A, she visited emergency rooms and was admitted to hospital on more than 70 different occasions, including the birth of her second son.

The patient presented with a long history of migraines and cluster headaches starting in her early 20s. Due to the intractability of her pain, she was prescribed narcotic analgesics, managed at times by injection at home. She developed a dependence on meperidine hydrochloride and presented with marked drug-seeking behaviour.

Further, the patient was investigated for difficulties relating to the gastrointestinal, genitourinary, musculoskeletal and central nervous systems, as well as problems with anemia, abscesses and fever. She underwent numerous tests and

Pain is perhaps the most frequent complaint in medical practice (1). In evaluating pain, one must be mindful of physical and psychological problems, but all forms of deceptive behaviours must also be considered. Although they are thought to be rare, factitious disorders involve the intentional production or feigning of physical or psychological signs or symptoms. The motivation for the behaviour is to assume the sick role; ie, it is presumed that the patient gets some type of emotional benefit from being regarded as ill or suffering. External incentives for the behaviour (as in malingering) are absent (2). There are several reports of factitious disorders appearing in civil litigation (3-5). I am unaware of any published cases dealing with a patient presenting with pain complaints diagnosed as factitious disorder, involved in a civil suit claiming damages for boundary violations including rape, misdiagnosis and treatment of multiple personality disorder (MPD) and overprescription of medications. This paper presents such a case. The facts presented here have been made public through the trial process.

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Received and accepted dates to come

invasive procedures. Although she was found to have various ailments, some of them explained by meperidine hydrochloride use and withdrawal, overall, these findings did not correlate with the patient's symptoms. Many test results were found to be negative or normal (6). Of note, a profound and persistent anemia could not be accounted for by many of the doctors who examined her. Eventually, several physicians raised the possibility of a factitious illness, but the patient and her husband completely denied this.

In the course of receiving care, she was also thought to have depression and personality problems. She overdosed on medications on several occasions. About a month before seeing her new family doctor, Dr A, her psychiatrist, noted in his records that her profound anemia was self-induced. In addition, she was having dreams that indicated to her that she had been sexually abused by her father and physically abused by her mother. She also had revelations of sexual interference as a little girl by her father in the form of memories, which she believed to be evidence of sexual abuse.

When the patient was 37 years old, Dr A became her family physician for 22 months. During this time, the patient visited emergency rooms or was admitted to hospitals approximately 50 times for both physical and psychiatric symptoms. She also saw numerous other doctors. Dr A's first note of psychiatric matters revealed in particular depressive symptoms, a history of abuse, borderline personality disorder and multiple personalities.

Several months later, the patient described four different personalities to him for the first time and manifested three of these during an office visit. Shortly thereafter, he diagnosed MPD. He applied the principles of psychotherapy as described by Putnam (7), Ross (8) and Braun (9), including the use of intravenous amobarbital sodium (Amytal; Lilly, Canada) during interviews. She brought out fantastic memories of satanic ritual abuse. By the time their relationship ended, there were 12 different alters.

As the therapy proceeded, she overdosed several times. She also developed a love transference toward Dr A. He started to overstep his boundaries. He held sessions outside the office. He engaged in hugs with the patient. He prescribed meperidine hydrochloride in larger amounts without developing and implementing a withdrawal plan (6). Finally, the patient felt rejected by the doctor when he refused to go on a date with her. Shortly thereafter, she discontinued her treatment with him.

In the following seven years leading up to the trial, she complained to the College of Physicians and Surgeons. After making her original complaint, the patient made a further allegation of rape. In the intervening years, the patient attended a psychologist who diagnosed "post-traumatic stress disorder, major depression rule out borderline traits". The focus of many sessions related to the patient's perceived victimization by Dr A (6).

At the disciplinary hearing of the College, the physician was found to have failed to maintain the standard of practice because he had prescribed meperidine hydrochloride and other pharmaceuticals in circumstances in which he knew or

should have known that the patient was abusing or misusing them. Dr A failed to set and maintain appropriate boundaries in the psychotherapeutic relationship. The rape allegation was withdrawn (10).

In the subsequent lawsuit, the patient alleged that the doctor was negligent in the diagnosis and treatment of a psychiatric condition, and that he planted or induced her frightening memories and multiple personalities through a damaging form of psychotherapy and highly inappropriate prescribing practices. She claimed that Dr A intentionally exploited his position as her physician by overmedicating her, and that he 'raped' her during one of their therapeutic sessions. She claimed to be totally disabled and unable to function in any meaningful way. The patient argued that the doctor was a predatory, exploitative physician who planted false memories of abuse, drugged her and treated her for his own self-serving reasons (6).

The defence position was that the doctor was victimized by a clever patient who deliberately engaged in deception to obtain drugs and maintain the sick role, used vast amounts of resources in the health care system and was now doing the same in the legal system (6).

The patient's medical records were reviewed for the trial by several psychiatric experts. They all agreed that the patient suffered from substance dependence before seeing Dr A. However, there were differing views on other psychiatric diagnoses. Several experts, including the author, questioned the validity of the diagnosis of MPD, and thought rather that she had a borderline personality disorder and factitious disorder. During testimony, one of the patient's psychiatrists testified that she had told him how she had accomplished the drops in her hemoglobin. The patient also acknowledged reading books about sexual abuse and incest survivors.

The judge concluded that it was the patient who first told the doctor that she had MPD, and rejected the patient's contention that the doctor created the alters. The judge also rejected the argument that the doctor 'planted' or 'induced' her memories of abuse through therapy because these were present before she saw the doctor. The judge was satisfied that the ritual and satanic abuse memories were not induced by the doctor. These may have been induced by her reading (6).

The judge also found that the overall picture emerging from the evidence was more consistent with self-induced disease than undiagnosed medical conditions. The plaintiff's testimony about the alleged rape was found to be unreliable. The defendant established that the plaintiff had serious underlying conditions, including factitious disorder, that had seriously interfered with her life before she ever saw Dr A. His acts or omissions did not materially contribute to her condition. The judge accepted that the patient was vulnerable, but found that the doctor did not take advantage of her (6).

The judge also found that Dr A's conduct fell below the standards of the profession, but it was not predatory or exploitative. He did not breach his fiduciary obligations.

The judge did not find it necessary to address the claim for damages (6) because it was not thought that Dr A had caused any significant damage to the plaintiff. Her problems were long standing and existed before she ever saw him.

DISCUSSION

Toth and Baggaley (11) presented a case report of a woman with factitious disorder. The patient had had 58 hospital admissions to nonpsychiatric wards over a 12-year period. There were 13 surgical interventions, but the diagnosis of factitious disorder appeared only twice in the patient's records. There were extensive attempts at psychotherapy before recognition of MPD. The diagnosis that had most commonly been given had been that of borderline personality disorder. With treatment for MPD, the patient's factitious symptoms, as well as talking about being a 'multiple' subsided. The authors postulated two explanations: first, that this might be a sign of emerging health as an understanding of the pathogenesis of the personality/personalities appeared. The fact that so much fruitless psychotherapy had been attempted before the diagnosis of MPD indicated that the recognition and acceptance of this disorder were necessary for therapy to begin. An alternative explanation for the patient's manifestation was that the MPD was just one more form of factitious disorder created by the patient, perhaps prompted by the recent increase in awareness of this condition (MPD) in the lay and scientific press.

According to Cunniën (12), any disorder can be feigned, and highly subjective states such as dissociative identity disorder are particularly prone to simulation. Merskey et al (13) argued that MPD is either a factitious or a fictitious diagnosis. They do not reject the concept of dissociative disorders, but the artifactual generation of MPD should not make sense to a critical medical profession (13).

In the present case, I postulated that the patient who first presented with physical complaints, including pain, came to adopt the self-definition (14) of 'MPD', a self-definition that was also adopted by the doctor who then pursued it with rigour. However, the patient eventually rejected this diagnosis, possibly as in the Toth and Baggaley (11) case. Although the patient abandoned the psychological symptoms of dissociation that she had created, she eventually took on the victim role. It could be argued that the patient shifted from a factitious motivation to a malingered one, anticipating a litigation-related monetary award.

Eisendrath et al (5) raised the hypothesis that the sick or patient role may be interchangeable with 'aggrieved' or 'victim' role for some people. There appears to be a continuum for individuals with factitious behaviour. Some limit their behaviour to the medical arena, while others appear primarily to portray a societal 'victim' role. Most cases appear to represent a point on the continuum that combines some elements of both the patient and victim roles (5).

The judge found that the plaintiff no longer presented evidence of factitious disorder with mainly physical symptoms. However, the issue was raised that it was possible that her unconscious need was presently being met in the litigation.

The judge also found that she appeared to be functioning better in several important areas of her life (6).

Although the issue of factitious illness had been brought up on a few occasions in the more than 20 years of this patient receiving care, it took a civil suit for this patient's pathology to be revealed in details. As stated by Eisendrath (4), a busy clinician would simply not have the time to review and interpret an individual's complete set of medical records.

Boundary violations have been described in the literature as having the potential to be harmful. The differences in impact may depend on whether clinical judgement has been used to make the decision, whether adequate discussion and exploration have taken place and whether documentation adequately records the details (15). Dr A was found negligent in this aspect of his care. However, the judge ascribed no damages (6).

Feldman et al (16) reviewed four cases of women who claimed to have been the victims of rape. The allegations were ultimately disproved. These authors advocated thorough investigations of rape claims, even when patients have known histories of deceptive behaviour (16). In the present case, the rape allegation was not proven (6).

The case discussed in the present report represents the complex problems facing physicians in treating patients with very intricate histories. This patient presented with complaints of pain, but subsequently, a whole range of other issues had to be dealt with by doctors, including diagnosing and treating symptoms that were true, false and exaggerated. In conclusion, the onus is always on the physician to do no harm, but in the final analysis, two individuals are involved in the doctor-patient relationship. The interaction needs to be always evaluated when issues of damage surface.

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