A patient with the diagnosis of a "factitious disorder": a phenomenological investigation

by

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Submitted in partial fulfilment
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Dedication

To Yvonne

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Abstract

A patient with the diagnosis of a "factitious disorder":
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MAGISTER ARTIUM (CLINICAL PSYCHOLOGY)

In this dissertation, the author provides an account of his therapeutic interaction and experience, as an intern clinical psychologist, in working with a patient in psychotherapy who was eventually diagnosed with a "factitious disorder". This study descriptively addresses how the therapeutic interaction impacted upon the therapist's thinking of the process both diagnostically and in terms of therapeutic goals.

This study consists of a single case, qualitative research design. It concerns the interactions and experiences of the therapist with a specific patient (diagnosed with a factitious disorder) in the context of a multidisciplinary academic hospital setting. The study aims to be predominantly descriptive of this therapy, and as such employs the psychological phenomenological method of Giorgi (1985) in order to provide a *specific description of the situated structure* of the therapy.

As such, this study is able to contribute to the sparse psychological and therapeutic information available on factitious disorders. There are few detailed accounts of

actual therapeutic interactions – specifically from a psychological perspective – for patients diagnosed with factitious disorders. The specific description of the situated structure of the therapy is also compared to the available literature on factitious disorders.

Although the aim of this study was not evaluative in nature, the author does provide some tentative comments on the aetiology and therapeutic considerations for factitious disorders – with regards to this particular case. The author suggests a strong link to personality and character deficits underlying factitious behaviour. The author further suggests the importance of acknowledging the "sick role"; allowing for "face-saving" strategies; providing consistency (on behalf of the therapist); and the setting of rigid, overt, therapeutic boundaries in the psychotherapeutic treatment of factitious disorders.

KEY WORDS:

Factitious disorder
Munchausen syndrome
Sick role
Borderline personality disorder
Somatization
Multidisciplinary team
Psychotherapy
Phenomenology
Psychological phenomenological method
Qualitative research

Samevatting

‘n Pasiënt met die diagnose van ‘n “fiktiewe versteuring”:
‘n fenomenologiese ondersoek

deur

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Voorgelê ter vervulling van ‘n deel van die vereistes vir die graad

MAGISTER ARTIUM (KLINIESE SIELKUNDE)

In hierdie verhandeling, verstrek die skrywer ‘n verslag van sy terapeutiese interaksie en ervaring, as ‘n kliniese sielkundige intern, tydens die behandeling van ‘n pasiënt in psigoterapie wat uiteindelik met ‘n “fiktiewe versteuring” gediagnoseer is. Hierdie studie gee ‘n beskrywing van hoe die terapeut se denkwyse oor die proses verander het in terme van diagnose en terapeutiese doeleindes.

Hierdie studie bestaan uit ‘n enkelgeval kwalitatiewe ontwerp. Dit bestaan uit die interaksie en ervarings van die terapeut met ‘n pasiënt (gediagnoseer met ‘n fiktiewe versteuring) in die konteks van ‘n multidissiplinêre akademiese hospitaal. Hierdie studie voorneem om ‘n hoofsaaklik beskrywend verhaal van die terapie te gee. In hierdie opsig sal die sielkundige fenomenologiese metode van Giorgi (1985) gebruik word ten einde ‘n *spesifieke beskrywing van die geleë samestelling* van die terapie te bied.

Verder, in hierdie opsig, is die huidige studie in staat om ‘n bydrae te lewer tot die beperkte sielkundige en terapeutiese inligting op fiktiewe versteurings. Daar is min gespesifiseerde rekeninge van feitlike terapeutiese interaksies – spesifiek van uit ‘n sielkundige perspektief – vir pasiënte gediagnoseer met fiktiewe versteurings. Gevolglik, in hierdie studie, is die spesifieke beskrywing van die geleë samestelling van die terapie met die bekombaar literatuur van faktiewe versteurings vergelyk.

Alhoewel die doelstelling van hierdie studie nie waardeoordelend van aard is nie, verstel die skrywer ‘n paar voorlopige verklarings oor die etologie en terapeutiese oorwegings van fiktiewe versteurings – met betrekking tot hierdie bepaalde geval. Die skrywer suggereer ‘n sterk verband met persoonlikheid agterstande onderliggend fiktiewe gedrag. Die skrywer suggereer verder die belangrikheid van die erkenning van die “siekterol”, om toelating te neem vir “redding van die skyn”, voorsiening vir vastheid (namens van die terapeut), en die stelling van streng, maar openbare, terapeutiese grense vir die psigoterapeutiese behandeling van fiktiewe versteurings.

SLEUTELWOORDE:

Fiktiewe versteuring
Munchausen sindroom
Siekterol
Grenspersoonlikheidsafwyking
Psigosomaties
Multidissiplinêr span
Psigoterapie
Fenomenologie
Sielkundige Fenomenologiese Metode
Kwalitatiewe navorsing

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Chapter 1

Overview

1.1 Introduction

In this study, it is the aim of the author to provide an account of his therapeutic interaction and experience with a patient that was eventually diagnosed with a "factitious disorder", and how this impacted on his thinking of the process both diagnostically and in terms of therapeutic goals. The author's therapeutic interaction with this difficult patient is therefore the phenomenon that will be described in this study. The chapters to follow will include an account of his therapy with this particular patient and a phenomenological analysis of the therapy from a psychological perspective with the aim of providing a *specific description of the situated structure* of the therapy (Giorgi, 1985). This will be followed by a literature review focussed on factitious disorders as they are conceptualised from a medical and psychiatric perspective. The study will be concluded with a brief evaluation focussing on the similarities and differences of the phenomenon experienced from a psychological perspective with the available literature from a medical and psychiatric perspective.

During this chapter, emphasis will be given to the subjects involved in the study, the context of this specific case, issues of confidentiality and consent, the phenomenological approach, as well as the aims and contributions of this study. The chapter will be concluded with a brief overview of the chapters to follow. The purpose of the focus on subjects (including aspects investigated and described) and context is firstly to orientate the reader briefly in the specific aspects of this particular case. Secondly, it conforms to the author's theoretical approach (as therapist) of client-centeredness. We will begin with a focus on the subjects of this study.

1.2 Subjects

The primary aspect investigated (or preferably described) will be the therapeutic relationship as was experienced by the author as therapist. This focus suggests that my experiences of the therapeutic relationship will be at the forefront of the study. The author as therapist will therefore be the primary subject in this study. The author will therefore display a dyadic role in this study of both researcher and therapist (i.e. subject). This role will be more fully explicated in Chapter 2. The use of the titles 'author' or 'researcher', and 'therapist' will be used according to the phases of therapy and research to which they apply. They will however refer to the same individual: myself.

This description of the therapy will be punctuated by the patient's entry into individual therapy with the therapist and followed through to termination with the therapist. The patient therefore is also a subject within this study. Reference to the patient's behaviour external to therapy is included only in the sense of where they impacted on the processes within therapy as well as the impact on the therapist's thinking and experiences of the process. Therefore, these are the processes that therapist became aware of.

For the duration of the therapy, the therapist was an intern psychologist at a multidisciplinary academic hospital in the Gauteng region. As such, for the duration of the therapy he also received weekly supervision. The patient entered into therapy with the therapist, following a crisis in the ward, where the internal medicine doctors were treating her. Upon entering into therapy with the patient, psychiatry was not involved, and no diagnosis of a factitious disorder had yet been made. However, through the course of therapy, the psychiatric department became involved, and a diagnosis of a factitious disorder was eventually made.

The diagnosis of a "factitious disorder" will therefore also be an additional area of focus in this study as it impacted the author's experience of the therapy. As is initially evident in the title and up until this point, the author refers to "factitious disorders" in inverted commas. This is as the author, as therapist, does not approach therapy

initially form a primarily diagnostic paradigm. His approach is primarily interpersonal and client-centred. It was however through the observations of various behaviours and interpersonal processes associated with the 'disorder' (I use disorder tentatively as it implies a negative connotation, where my interest was primarily on the interactions and behaviours), that led the author through an experiential process of confusion, denial of the necessity of a diagnosis / label, and towards the benefits afforded by considering the diagnosis. The benefits referred to include his understanding of the processes as well as his modification of therapeutic goals. Therefore, the 'disorder' is central to the study in that it impacted the author's (as therapist) own experience of the therapeutic process. For this reason, the literature review (Chapter 4) will focus primarily on factitious disorders.

As author, I wish to also include an open-ended evaluation of the therapy. Open-ended implies that it is difficult to categorically state whether the therapy was either successful or not. The evaluation will rather be on what therapist experienced as the positive aspects of the therapy, as well as those that where either counter-therapeutic or could have been approached differently. However, the evaluation will be linked to the literature available – which is primarily from a medical and psychiatric perspective – with the similarities and differences that the therapist experienced in therapy. The evaluation is thus mainly a subjective experience.

In the termination phase of therapy, the patient did however provide an impromptu and unexpected evaluation of the process of therapy as she experienced it. This evaluation will also be included as it allows for a comparison of the therapists goals with the patient's needs (and subsequent experience). This I believe to be in keeping with the focus on the therapeutic relationship as I experienced it as therapist.

1.3 Context

Having discussed the subjects (and individual aspects) involved in the study, we can now address the context in which this therapeutic relationship was situated. This specific case study took place within the context of a multidisciplinary academic hospital setting. The context of the hospital itself is relevant to a study of factitious

disorders. Kaplan and Sadock (1998) state that in factitious disorders, "patients intentionally produce signs of medical or mental disorders and misrepresent their histories and symptoms. The only apparent objective of the behaviour is to assume the role of a patient without an external incentive" (p. 654). Thus, the importance of this context is threefold. Firstly, it is the context within which the patient entered into psychotherapy. Secondly, the context of a multidisciplinary hospital and health-care facility is central to the disorder. Finally, as an intern psychologist, the therapist was also a member of the multidisciplinary team within the hospital setting, and thus subject to communication with the other involved members, as well as supplying feedback of his own.

As stated above, the patient was initially under the care of the doctors involved with internal medicine. Kaplan and Sadock (1998) state that in cases where the simulation of an illness is suspected that a psychiatrist should usually consulted to confirm the diagnosis of a factitious disorder. The relevance of this is that the therapist entered therapy with the patient in a rather serendipitous manner. Therefore the therapist's initial focus to therapy was not related to a psychiatric diagnosis.

Through the course of therapy, the department of psychiatry did become involved and the diagnosis of a factitious disorder became the primary diagnostic focus of the treatment plan. The treatment on the whole eventually involved a multidisciplinary team, inclusive of doctors, specialists, psychiatrists, social worker, occupational therapists, and psychologists. Another importance of the multidisciplinary team was that there was within the various disciplines a necessitated move towards interdisciplinary communication.

As therapist, I noted various behaviours and interactional patterns of the patient that could later have been assigned to her diagnostic labels, or even provide further motivation for the given diagnoses. These behaviours were noted both within therapy (the patient's interactions with the therapist) and external to therapy (the hospital context in general and the patients interactions with other physicians and hospital staff). This behaviour could however be better monitored and understood when communication amongst the team improved. The focus on the multidisciplinary team

in this study is thus important for additional insight into the processes evident in therapy.

The patient received a diagnosis of factitious disorder with predominantly physical signs and symptoms (refer to Chapter 4). As an intern psychologist, I do have comparatively little medical understanding and knowledge. The presence of communication channels in a multidisciplinary setting thus allowed for me to gain better insight into what where possibly regarded as real illness and feigned illness. The patient's initial focus in therapy itself was predominantly focused on concerns about her physical illness.

1.4 Confidentiality & Consent

Having discussed the subjects involved in the study, and the relevant context, it is important to address the ethical issues of confidentiality and informed consent that are applicable in this particular study. As with all research involving human participants, complete confidentiality regarding any information about the subjects (and in this particular case, context included) must be adhered to (Willig, 2001). The patient, as stated above, is a subject of this study, and thus her consent is needed.

The diagnosis of a factitious disorder carries with it a unique set of ethical problems that add to the necessity of the confidentiality of the participant. Amongst these is the fact that the disorder tends to indicate deceit on behalf of the patient in a medical healthcare context. There is thus an extensive cost to health care facilities that is associated, and therefore an additional concern to confidentiality as the patient can be found to be accountable for these costs. There is the further caution of the possibility of a misdiagnosis, which is even more applicable in the case of factitious disorders (Feldman & Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1996a; Griffith & Griffith, 1994; Kaplan & Sadock, 1998). These ethical issues will be more fully addressed in Chapter 4. Due to the above concerns, the author believes that confidentiality is of utmost importance in this case study.

Every effort has been taken to keep the patient's personal details confidential and unrecognisable to all except involved team members. This has been extended further to take all precautions to keep the multidisciplinary team as well as the medical institution confidential.

The issue of informed consent on behalf of the patient (more fully discussed in Chapter 2) is now addressed. The patient has signed a consent form (Appendix B) displaying her willingness to allow her therapy to be used in this study. She was aware of the implications associated; yet tended to display eagerness that her case would be used for academic purposes. This courtesy was extended to both the therapist, as an intern psychologist, and her principle doctor at psychiatry. This displays a general willingness on behalf of the patient for her particular case to be used for research and academic purposes. Consent and participation in this study was only discussed after the therapy had been concluded.

With the issues of participation, confidentiality and consent addressed, the author can now turn to a general outline of the form that this case study will take. As stated in the title, the research takes the form of a phenomenological investigation.

1.5 Phenomenological Study

The research takes the form of a qualitative study. In this study the author refers back to the processes and experiences of therapy, as well as his tentative open-ended evaluation of the therapy, via his ***process notes*** (Bosch, 2002). In addition to this, the author will use feedback – both written and verbal – that was offered by the patient in the termination phase of the therapy. Upon asking for consent to use her as a subject in the case study, the author (as therapist at the time) also requested whether she would reflect upon and formally write up for the author her subjective evaluation of the treatment she received at the hospital. This feedback was requested to be both in general and specific to the therapy, as well as to focus on the positive and negative aspects. This request was further made in light of the fact that therapy had been terminated. The patient was amenable to this suggestion and has subsequently delivered such an essay to the author (Patient, 2002).

The study will be written from a retrospective point of view. The author will first provide a synopsis of the therapy from beginning to conclusion (Appendix A). This is the *naïve description* that is used in the phenomenological study. It includes the therapist's thinking and hypothesising at each stage of therapy as it progressed. The aim of this is to set the background and provide necessary information, and secondly serve as the description for phenomenological analysis. This is essentially the description of the therapeutic process as was experienced by the author (as an intern psychologist). Due to the confidentiality of individual therapy and the ethical considerations suggested above, the actual process notes (Bosch, 2002) cannot be included in the study – nor can the written feedback of the client (Patient, 2002). They will however be kept on record for a minimum duration of 2 years. Therefore, the description of the therapy will be the starting point of the research.

As author, I will make use of the phenomenological research method as set out by Giorgi (1985). For the purposes of conciseness in this chapter, I will provide Kruger's brief summary of the method, which is as follows:

> …the main procedure is to get an effective sense of the whole experience as described, secondly to extract the main themes by first breaking up the material into natural meaning units, thirdly to evaluate each main theme in terms of the total Gestalt, and fourthly, to arrive at a situated, and thereafter an essential structure of experience.
>
> (Kruger, 1986, pg.205)

The description is written from a retrospective view of the psychotherapy and is essentially a descriptive study. It will follow a methodological structure of phenomenological research to be more completely discussed in Chapter 2. The naïve description of the therapy will follow Giorgi's (1985) method to provide a final specific description of the situated structure of the therapy.

The conclusion of the study will focus on the author's own open-ended evaluation of the process and relative success of therapy. This will then be compared with what the patient herself found significant and possibly beneficial within therapy. The two views will then be compared as to whether the goals and experiences where in any light complementary, as well as how they relate in the therapist's mind to the diagnosis of a factitious disorder and the relevant literature.

1.6 Aims & Contributions of Study

In turning to the aims and contributions of the study, the aim of the author is, as stated, to provide a descriptive account of his therapy with a patient who was diagnosed with a factitious disorder. The contribution to the body of psychological knowledge can be evaluated in light of the following quote:

> … In many areas of the so-called "mental health" or "helping" professions (e.g., psychiatry, clinical psychology, counselling, social work), there is often a split between research and practice. … Traditionally after completing training, clinical psychologists are expected to be skilled both in conducting research and in administering direct service, as in clinical treatment. Yet, serious questions have been raised about whether professionals are trained to perform the functions of both scientist and practitioner.
> In clinical psychology, relatively little time among professionals is devoted to research. The primary professional activity consists of direct clinical service … Those who conduct research are rarely engaged in clinical practice. Researchers usually work in academic settings and lack access to the kinds of problems seen in routine clinical and hospital care. Treatment research conducted in academic settings often departs greatly from the conditions that characterize clinical settings such as hospitals or outpatient clinics …
>
> (Kazdin, 1982, p.13)

The description of this particular case can serve to reduce the "split" between research and clinical practice in psychology. As author, I wish to provide an academic research account for a therapy that took place within a natural hospital context. Patients in these contexts often can require multiple treatments to address their various different problems. While research may be interested in finding the *statistical* significance of changes, a clinician may be more interested in *clinically* significant effects. Thus, clinicians are more concerned as to whether the change is significant in the patient's everyday life (Kazdin, 1982). This research, being descriptive in nature will not be concerned with statistical significance. As therapist, the author was himself only concerned with clinically significant effects.

Addressing this particular case more specifically, all of the literature the author has consulted to date tends to refer to factitious disorders predominantly from a medical and psychiatric perspective, focussed on diagnosis, clinical presentation, and

management. Similarly, most of the references to psychology tend to be focused on the hypothesised aetiologies of the disorder (Barlow & Durand, 1999; DSM-IV, 1994; Eckhardt, 1994; Ehlers & Plassmann, 1994; Eisendrath, 1996; Eisendrath & Feder, 1996; Eisendrath, Rand & Feldman, 1996; Feldman & Ford, 1994; Feldman & Smith, 1996; Ford, 1984; Ford, 1996a; Ford, 1996b; Freyberger et. al., 1994; Freyberger & Schneider, 1994; Gieler, 1994; Griffith & Griffith, 1994; Hirsch, 1994; ICD-10, 1992; Kaplan & Sadock, 1998; Lipsitt, 1996; Maxmen & Ward, 1995; Meyer, 1989; Meyer & Salmon, 1984; Nadelson, 1996; Nordmeyer, 1994; Paar, 1994; Parker, 1996; Plassmann, 1994a; Plassmann, 1994b; Plassmann, 1994c; Sachsse, 1994; Stoudemire & Fogel, 1993; Wedel, 1995; Willenberg, 1994). The author has found very few references to actual therapeutic interactions from a psychological perspective for patients diagnosed with factitious disorders. Thus, the literature refers rather to the behavioural style of such patients within a medical milieu and their management. There is as suggested by the following quotes, a poor prognosis for treatment:

> No specific psychiatric therapy has been effective in treating factitious disorders. It is a clinical paradox that patients with the disorders simulate serious illness while they deny to themselves and others their true illness and thus avoid possible treatment for it. Ultimately, the patients elude meaningful therapy by abruptly leaving the hospital or failing to keep follow-up appointments.
>
> (Kaplan & Sadock, 1998, p.658)

Maxmen and Ward (1995) state, "Wilhelm Kaiser claimed the only requirement for successful therapy is that two people be in a room. And since patients with factitious disorders don't stay in the room, the only thing that's clear about treating them is that nothing is known to work" (p. 309). What this study offers is the account of a therapist who was able to conduct therapy with a patient who was diagnosed with a factitious disorder for a contracted period of time. While the effectiveness of therapy will remain an open-ended debate, this account does suggest that therapy with such patients is at least possible. The effectiveness of the therapy is not the priority of this study – only the description of it.

Feldman and Smith (1996) additionally state that "[v]ery little has been written about the personal and interpersonal consequences of factitious disorders. Reports in the literature usually focus on the objective medical consequences of disease portrayals"

(p. 175). This descriptive study will hopefully also serve the purpose of adding to the limited descriptions of personal and interpersonal consequences and interactions evident in factitious disorders. This study is less concerned with the specifics of the disease portrayals of the patient. It is more concerned with the psychological descriptions of the patient's behaviour and interpersonal interactions.

Further, because of the enormous financial drains on the health care systems (rarely restricted to any particular disciplines), it is generally in "everyone's interest to identify and appropriately treat factitious physical disorder patients as quickly as possible" (Eisendrath, 1996, p. 28). For both the patients' and hospitals' benefit, it can be seen as necessary to as quickly as possible spare the patient the risks of extended hospitalisations, and unnecessary, potentially dangerous and disfiguring procedures (Ford, 1984; Kaplan & Sadock, 1998). The same can be suggested for those patients with factitious disorders that present with psychological signs and symptoms, and the psychiatric care they abuse.

The author would therefore like to describe his experience as intern psychologist who was able to 'sit' (even if serendipitously) with the patient in therapy up to an agreed upon date for termination. This descriptive experience could serve to assist the reader in addressing and viewing factitious disorders from a different perspective to the general medical or psychiatric models. It views the disorder from a psychological perspective. Whether the therapy 'worked' will be addressed in an open-ended discussion by the author in Chapter 5, but will probably remain a topic for debate, and left to the discretion of the reader.

1.7 Summary

As above stated, it is the aim of this study to provide a descriptive account of the author's (as therapist) interaction with a patient diagnosed with a factitious disorder. Also, the therapist is the primary subject of this study. It is a descriptive study of the therapist's interactions, experiences and hypothesising about his therapy with this difficult patient – placed within the context of a multidisciplinary academic hospital.

It highlights the therapist's difficulties in working with, conceptualising and adapting his therapeutic approach to the patient in therapy.

The difficulties and overall processes experienced by the therapist will add to the limited literature available on the difficulties of working with patients with factitious disorders. The description however will also serve to provide a psychological perspective to factitious disorders – from a therapeutic perspective – that is lacking within the predominant focus on medical and psychiatric symptomatology and presentation.

The psychological perspective, in offering a unique and different conceptualisation of factitious disorders, describes the experiences of the therapist and interactional style of the patient. These descriptions may aid the reader, and further researchers and medical health care professionals in recognising and even diagnosing (if necessary) factitious disorders and behaviour.

1.8 Overview of the Chapters

With the aims of the study, subjects, context and possible contributions already discussed, the author can now turn to an overview of the chapters to come. This provides a brief outline of what is to be expected in each of the subsequent chapters.

Chapter 2 concerns Methodology. This chapter precedes the rest of the study as it provides the theoretical groundwork for the descriptive qualitative study that will be applied. It addresses a Phenomenological methodology from within the context of qualitative research designs in general. The phenomenological concept of *bracketing* (described more fully in Chapter 2) will explain why the Phenomenological Study (Chapter 3) precedes the literature review (Chapter 4). We need to first distance ourselves from the theory and literature in order to experience the phenomenon – therapy with a factitious disorder patient - from a new perspective. Once this is achieved we can place the phenomenon within the existing theory.

Chapter 4 is the Literature Review. This chapter addresses factitious disorders in general from a medical and psychiatric perspective. Factitious disorders are placed within a spectrum of illness and somatizing disorders. Diagnostic criteria, typical clinical presentations, epidemiology, prognosis, ethical and legal issues, and management and treatment are addressed.

Chapter 5 is the concluding chapter. This chapter will provide the open-ended evaluation of the therapy. It will link the therapist's thoughts and comments with the feedback provided by the patient. It will also provide a brief comparison between the phenomenon of the therapy and the available literature. The study will be finished with some concluding comments by the author.

The author can now continue with a focus on the methodology of this study and particular method employed.

Chapter 2

Methodology

2.1 Introduction

The focus of this research is based upon the experiences that the author (as therapist) had while confronted in therapy with a difficult patient who eventually received a working diagnosis of a "factitious disorder". This occurred during his year of internship as a clinical psychologist. In this chapter, the author will address the research methodology and research method applied in this particular case study. As can be inferred, the research will take the form of a single case study, and will be mainly descriptive in nature. As such it tends to fall within the broad spectrum of qualitative research. The research will however be based upon the *phenomenological psychological method* of Giorgi (1985).

As author, I believe that it will be beneficial to place and discuss this method within a global view of qualitative research and research designs, and case studies in general. From this background one can then address the phenomenological methodology more specifically. The purpose of this structure is twofold. Firstly it orients the reader as to where phenomenological methodologies fit within the spectrum of research in general. This is important as phenomenology as a research methodology is relatively new in comparison with the older and more established quantitative and natural scientific research designs. And even though phenomenology tends to be categorised under the global qualitative research designs, it also differs from them. Secondly, it allows the reader to evaluate the specific research design within the broad global categories of qualitative research and case studies. Case study refers to a global concept that spans both qualitative and quantitative research designs. As the researcher's description of the therapy is the primary data in this study, the author believes that it is necessary to provide the reader with some criteria by which they may evaluate both the applicability of the data, and the research method.

During this chapter the author will therefore begin with an overview of qualitative research that will include common and general characteristics, as well as criteria by which one can evaluate qualitative research. This will be followed by criteria concerning qualitative research designs that are usually applied to evaluate such research. I shall then provide an overview of case studies including the possible value and limitations of these research designs. With this general background in place, the author can then address the specific phenomenological research methodology and method applied.

As the author aims to provide a descriptive account (qualitative research) of my experience with a (single) patient diagnosed with a "factitious disorder" (case study), he believes that the theoretical background is necessary. However, the methodology for this research is based upon the phenomenological approach to psychology (as a human science) (Giorgi, 1970). The method employed will be based upon that psychological phenomenological research method of Giorgi (1985), which he states, "is but one theory of treating descriptions" (p. 2). The phenomenological methodology will be discussed after the overview of qualitative research and case studies.

For the purposes of this chapter it is necessary to differentiate between *methodology*, and *method*. *Methodology* identifies "a general approach to studying research topics", while *method* refers to "a specific research technique" (Willig, 2001, p.8). Therefore, the methodology refers to the theory behind the specific research method that is adopted. However, Giorgi (1985) does differentiate a technique from a method. This will be addressed later, but an initial definition is required to orientate the reader.

The overview will therefore be followed by the research methodology, which will include a brief background of phenomenology as well as the phenomenological research method of Giorgi. The author will then conclude with an explanation of how the method has been adapted to suit the purposes of this research study. However, the global category of qualitative research will first need to be addressed.

2.2 Qualitative Research

Qualitative researchers are more concerned with the "quality" and "texture" of the experiences. They are less concerned with "cause-effect relationships" and therefore do not tend to work with variables. As such, they "tend to be concerned with meaning. That is, they are interested in how people make sense of the world and how they experience events" (Willig, 2001, p.9). Willig (2001) goes on to state that the objective of qualitative research is to describe events and experiences, possibly provide explanations, but never to predict. Qualitative researchers tend to study people within their own natural settings and contexts. These are referred to as "open systems", where there are ongoing processes of interaction and change. Both Willig (2001) and Neuman (2000) state that the interpretation of events, the tracing of processes and sequence of events, and the attaching of meanings is central to qualitative research. Prediction of outcomes is not seen as meaningful in qualitative research. In this study, the therapy and interaction with the client that are to be described (including the sequence of events), occurred within a natural context and setting. The author is interested in the describing the quality and texture of this experience.

Willig (2001) goes on to state that qualitative methodologies can differentiate according to the extent to which they emphasise "reflexivity", and the importance they place on the role of language. "*Reflexivity* requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining 'outside of' one's subject matter while conducting research" (p. 10). Willig further identifies two types of reflexivity: personal reflexivity and epistemological reflexivity. *Personal reflexivity* refers to the ways in which the researcher's own values, experiences, interests, and beliefs have impacted on and shaped the research. *Epistemological reflexivity* allows us to look at the assumptions about reality and knowledge that have impacted on the course of the research. An additional point to consider within reflexivity is the critical role of language awareness. The language one uses to describe their experiences plays a part in the construction of the meanings that are attributed to that experience (Willig, 2001).

As the researcher is the primary subject in this study, issues of reflexivity are of utmost importance to be explicitly stated and taken cognisance of. The researcher is both the therapist who conducted the therapy with the client, author of the naïve description of the therapy, and researcher in analysing the description. It is therefore extremely important for the reader to be aware of the impact the researcher has in this study both personally and epistemologically. The general and epistemological issues of reflexivity will be discussed as they apply to the phenomenological methodology. This methodology specifically takes cognisance of the impact and role of researchers in the research process. In the research study issues of reflexivity will also be specifically referred to and discussed in the explication of the research method (Refer to Heading 2.9).

Any form of research does need to be evaluated. Willig (2001), states that qualitative research can be evaluated in a meaningful manner according to what the objectives were and what kind of knowledge it aims to produce. In order to evaluate methodological approaches and the extent to which the research has met it's own objectives, there needs to be some understanding of the epistemological basis and methodological requirements. Willig suggests the following questions in order to identify a methodology's epistemological foundations:

1. *What kind of knowledge does the methodology aim to produce?* The view of what can be known, and how it is known. This is an epistemological question.
2. *What kinds of assumptions does the methodology make about reality?* Generally related to ontology, which is concerned with the nature of reality. If an epistemology asks 'how can we know?' then ontology asks 'what is there to know?'
3. *How does the methodology conceptualise the role of the researcher in the research process?* In qualitative methodologies, the researcher tends to always be implicated in the research process in some manner. The concept of reflexivity.

(Adapted from Willig, 2001, p.12-13)

In the phenomenological methodology, knowledge is seen within the context of discovery (and not verification). The methodology aims to develop descriptive strategies in addressing meaning and is not concerned with interpretation that is common to many qualitative research methodologies. Phenomenology also differs from both positivist and naturalist paradigms in that reality statements are *not* made. Kruger (1986) stated that all psychological observation is participant observation. In phenomenology, the researcher is seen as part of the process. For a more comprehensive account of the phenomenological methodology, the reader is referred to Heading 2.5. The discussion will now return to a more specific look at aspects of qualitative research design.

2.3 Qualitative Research Design

The specific aspects of qualitative research design that will be discussed in light of this particular study are: the type of data used; validity; reliability; representativeness and generalisability; the role of participants; a discussion on ethical considerations; the research question; and the method.

The type of *data* that is collected in qualitative research needs to be *naturalistic*. This implies that it should not be categorised, coded, summarised or otherwise reduced at the point of collection. However, strictly speaking, this is actually impossible, as any process of collecting data requires some form of translation from one medium to another (Willig, 2001). In this study, the data is derived from the therapist's process notes (Bosch, 2002), as well as his recollection of the experience of the therapy. These are combined by the author into the writing of a naïve description of the therapy. The therapy however was however entirely 'naturalistic' and took place prior to the decision to use the data for research purposes.

Validity in qualitative research can be defined "as the extent to which our research describes, measures or explains what it aims to describe, measure or explain" (Willig, 2001, p.16). The research in this case aims to provide a description of therapy with a client (case study) that has a factitious disorder, from the perspective of a

psychological paradigm. Thus the validity is based upon whether this study describes what it aims to describe.

Reliability in qualitative research is far less of a concern as it is within quantitative research. This is because qualitative research tends to explore a particular and possibly unique phenomenon or experience in great detail (Willig, 2001). In this study, a factitious disorder is generally a rare and unique phenomenon to experience in therapy. The aim is to describe and explore this phenomenon in great detail and as such reliability is not a concern.

Representativeness and *generalisability* are also not usually issues of concern in qualitative methodologies. Whether a population sample needs to be representative depends largely upon the research question that the research is designed to address. For example, in a case study, very often representativeness is not an issue (see Case Study) (Willig, 2001). This applies to this study.

The *role of participants* in qualitative designs also differs greatly from quantitative studies, but also can show a great degree of variability between qualitative methodologies. In some cases, the distinction between *researcher* and *participant* can be blurred as the researcher takes part in the research. In other cases, there is no distinction between the researcher and participant as the researchers actually study themselves (Willig, 2001). In this study, the researcher essentially takes part in the research, as he was therapist, author and researcher. This is discussed in relation to reflexivity and in depth with the explication of the research method (Refer to Heading 2.9).

Willig (2001) does however highlight a number of basic *ethical considerations*. These are:

1. *Informed consent*. The researcher should ensure that participants are fully informed about the research procedure and give their consent to participate in the research *before* data collection takes place.
2. *No deception*. Deception of participants should be avoided altogether. The *only* justification for deception is when there is no other way to answer the

research question *and* the potential benefit of the research far exceeds any risk to participants.

3. *Right to withdraw*. The researcher should ensure that participants feel free to withdraw from participation in the study without fear of being penalized.
4. *Debriefing*. The researcher should ensure that, after data collection, participants are informed about the full aims of the research. Ideally, they should also have access to any publications arising from the study they took part in.
5. *Confidentiality*. The researcher should maintain complete confidentiality regarding any information about participants acquired during the research process.

(Willig, 2001, p.18)

In this study, informed consent was obtained. While the therapy took place before consent was obtained, the data was collated (and the naïve description written) only after the conclusion of therapy. Confidentiality of all involved parties has been considered (Refer to Chapter 1, Heading 1.4). The issues of no deception, right to withdraw and debriefing are not applicable to this case as the researcher is the primary subject, the study is retrospective, and the patient has signed and given informed consent.

The *research question* differs from the *hypotheses* that characterise quantitative methodologies. "A hypothesis is a claim derived from existing theory, which can be tested against empirical evidence. It can be either rejected or retained. A research question, by contrast, is open-ended. That is, it cannot be answered with a simple 'yes' or 'no'. A research question calls for an answer which provides detailed descriptions and, where possible, also explanations of a phenomenon" (Willig, 2001, p.19). A qualitative research question thus identifies the process, object or entity that the researcher is interested in investigating. It does not aim to predict what will be found. In many qualitative methodologies, the research question is directly influenced by the methodology itself. Therefore, it is important to address the aspects of reflexivity when asking a research question (Willig, 2001). The research question is outlined in the research method (Refer to Heading 2.9.1).

The *method* adopted in qualitative research can only be evaluated in terms of the research question. There are no right or wrong methods, rather just appropriate and less appropriate ways of addressing the research question (Willig, 2001). The research method and research question are discussed in Heading 2.9, and the evaluation of the method in Heading 2.10.

With the outline of qualitative research and methodology discussed, as well as the criteria by which to evaluate such research, attention can now be turned to the second global category of case studies, before addressing the specific methodology and method of this study.

2.4 Case Studies

The case study in not itself a research method. It is rather an approach to study singular entities that may involve the use of a variety of diverse methods in data collection and analysis (Kazdin, 1982, 1992, Willig, 2001). Case studies are therefore not characterised by the methods they use to collect and analyse data, but rather by their focus upon a particular unit or area of analysis: the *case*. A case can range from a singular person to any specific grouping of people (Kazdin, 1982, Willig, 2001). They are thus "natural occurrences with definable boundaries … The case study involves an in-depth, intensive and sharply focussed exploration of such an occurrence" (Willig, 2001, p. 70). This research is in the general definition essentially a case study. It is the description of the therapy as experienced by the therapist (subject) with a patient who was diagnosed with a specific disorder (factitious disorder) within a specific context (multidisciplinary hospital).

Case studies have made use of both quantitative and qualitative research methods. They have a long and varied history, and have been employed in a number of disciplines (psychology, psychoanalysis, sociology, social anthropology etc.) as well as various disciplines within psychology (Kazdin, 1982, Kvale, 1986, Willig, 2001). Kazdin (1982, 1992) states that the study of individual cases has been more important and played a more central role in clinical psychology than in other areas of psychology. This is because group research often excludes important and vital

information about the individual. He states that this point was emphasised by the personality theorist Gordon Allport. Allport recommended that intensive studies of the individual would be able to supplement the study of groups, as these would provide information about individuals. "Scientific psychology, as usually conceived, does not include a place for the uniqueness of the individual subject" (Kazdin, 1992, p.153). It is hoped that the uniqueness of this individual experience with a rare phenomenon (factitious disorder) can aid to the furthering of the body of psychological information. This research is very specifically focused on the description of the experiences of the therapist working in therapy with an individual patient diagnosed with a factitious disorder.

According to Kazdin (1992) the case study "usually consists of uncontrolled observations of the individual client in situations where concrete and immediate concerns of that person must be given high priority" (p.153). Kruger (1986) agrees that while psychotherapy is not a form of experimental research, it can contribute and add to research in general. In this particular case, the therapy preceded and took priority over the decision to use the therapy for research purposes. However, the description of this therapy can contribute to research in the field of clinical psychology and more generally the health professions.

Let us now turn to some general defining features of case study research and how they apply to this particular study. Willig (2001) identifies a number of these defining features of case study research:

1. *An ideographic perspective*. The aim is to understand the individual case in its particularity.
2. *Attention to contextual data*. Case study research takes a holistic approach. It considers the case within its context. Attention is paid to ways in which the various dimensions of the case relate to or interact with its environment.
3. *Triangulation*. In triangulation, the researcher will integrate information from diverse sources and use different methods of data analysis to arrive at a better understanding of the phenomenon.
4. *A temporal element*. Case studies involve investigation of occurrences over a period of time.

5. *A concern with theory*. Case studies facilitate theory generation.

(Adapted from Willig, 2001, p. 70-71)

This particular case study has a strongly ideographic perspective. It addresses and describes the experience of a therapist (intern psychologist) working with a particular patient (factitious disorder) within a particular context (multidisciplinary hospital). Therefore attention is also paid to contextual data and how the various dimensions of the case interact with each other (interdisciplinary health care professionals, patient, and therapist) in the specific environment and context (hospital). The temporal elements are specifically stated in the naïve description as well as Chapter 1. In this case, however, the use of triangulation is not formally applied in the sense of conducting the research – a single phenomenological method is used. However, as therapist, the researcher was exposed to other health care disciplines and conceptualisations of the phenomenon (patient with a factitious disorder). This is also reflected within the naïve description. Further, the phenomenological method does not discount alternative explanations for phenomena. This case study is however *not* concerned with theory generation; it is predominantly descriptive in nature.

Case studies can be seen as intrinsic or instrumental. *Intrinsic case studies* represent nothing other than themselves. They are chosen because they are interesting in their own right. *Instrumental case studies* represent examples of more general phenomena (Willig, 2001). This case study is intended to be intrinsic, representing the therapist's experiences of working in therapy with a patient with a factitious disorder. However, the patient, as having received a diagnosis of a factitious disorder, can be argued to represent a more general phenomenon of factitious disorders – thus implying an instrumental element.

Case study designs can also be single or multiple. *Single case study* designs are chosen for a number of reasons. They may constitute an important test for a well-formulated theory. They may represent a unique or extreme case that is of interest to the researcher. Or they may be important due to the fact that the case in question was previously inaccessible. *Multiple case study* designs can tend to provide a researcher with an opportunity to generate new theories. Theoretical formulations are developed or refined as a result of comparative analysis between a series of interrelated cases

(Willig, 2001). This case study is however, firmly represented as a single case design. It involves only one therapist, one patient, and one hospital context. The case represents a unique case as factitious disorders are relatively rare or go undetected, and thus often inaccessible for research purposes (DSM-IV, 1994; Feldman & Ford, 1994; Ford, 1984; Kaplan & Sadock, 1998). It will also be suggested that the patient represented an extreme form of the disorder.

While all case studies will include descriptions of the cases under study, some do remain purely descriptive. "*Descriptive case studies* are concerned with providing a detailed description of the phenomenon within its context. Here, the case is not explored in terms of existing theoretical formulations; instead, it is hoped that detail provided by the description will generate new insights into, and a better understanding of, the nature of the phenomenon under investigation" (Willig, 2001, p. 74). *Explanatory case studies* on the other hand aim to generate explanations for those phenomena that were observed. As stated in Chapter 1, this study will be principally one that is descriptive. It is a descriptive account of the experiences and clinical observations of the therapist.

Kvale (1986) quotes Rapaport who stated that the "major body of positive evidence for [psychoanalytic] theory lies in the field of accumulated clinical observations" (p.156). Theories about the aetiology of psychopathology, the development of personality and behaviour, and psychotherapy techniques have been developed from the study of individual cases. And even though many case studies are studied individually, they can have a remarkable impact when a number of similar cases are accumulated (Kazdin, 1982).

Kazdin (1992) states that the even though case studies' lack of "scientific rigor" may have limited it as a research tool, their very naturalistic and uncontrolled characteristics also make them a "unique source of information that complements and contributes to experimental research" (p.154). Kazdin continues further to highlight the value of case study research:

1. Case study research has served as a *source of ideas and hypotheses*. Thus it helps in developing and advancing theories of human behaviour.
2. It has often served as a *source for developing therapy techniques*.

3. The use of case studies permits the *study of rare phenomena*. A variety of problems seen in treatment can be rare, and these clients rarely are present in sufficient numbers to be evaluated in a controlled group situation. Case studies thus provide unique information that may not be accessible otherwise.
4. Case studies can provide a *counterinstance for ideas* that are considered to be universally applicable. This is essentially the ability to challenge accepted beliefs and theories about treatment.
5. Case studies have a *persuasive and motivational value*. Case studies mostly are unable to show strong causal knowledge, and have weak ability for drawing inferences. However, they can provide a persuasive (and sometimes dramatic) demonstration of principles in a concrete manner that might have otherwise been rather abstract.

This particular case primarily permits the study of a rare phenomenon – a patient with a factitious disorder. Inferences may be drawn as to the possible therapeutic techniques and approaches when faced with such patients. The psychological (as it applies to therapy) perspective of this therapy may also add to the available medical and psychological knowledge already available.

Kazdin (1992) also highlights some limitations of case studies:

1. In case studies many *alternative explanations* are usually available. There is also no way to test a hypothesis if it assesses a causal relationship in the past.
2. Case studies are often criticised for a heavy reliance on *anecdotal information*. This suggests a strong possibility for quite biased representations. Often due to the absence of objective measures, and the reliance on clinical judgement and interpretation, the conclusions are not accorded scientific status.
3. A major concern with these studies is the *generalisability* to other individuals or situations.

In this particular study (as discussed) generalisability is not an aim or concern of the research. In the phenomenological methodology, alternative explanations and the use of anecdotal information are actually viewed as useful or even positive aspects of the methodology. The author can therefore now turn to the primary account for the methodology and method used in this study.

2.5 Research Methodology

Kvale (1986) states that the eclecticism and atheoretical presentation of many of the current qualitative research methodologies, is one of the main problems in this field of research. He does however add that the one exception is the "phenomenological tradition, which involves a conception of man and of the scientific study of man (*see* Giorgi, 1970)" (Kvale, 1986, p.175). Giorgi states:

> It would be realistic to assume that the expression "scientific research" would quickly bring the association "incontrovertible fact" to the minds of members of the scientific community. Indeed, science's main claim to fame is that it has the means to establish irrefutable facts, and it has a rich and successful tradition of establishing and building upon such solid facts. It is well known, however, that this tradition began and continues to be most successful with the phenomena of nature, but the application of the same procedures and mentality to human phenomena has met with only partial success. Some take this partial success to be a sign that more of the same, with proper modifications, will lead to the same success as the natural sciences enjoy. Others note the same partial success and interpret it to mean that a radical shift of perspective is necessary to do justice to human phenomena.
>
> (Giorgi, 1985, p.vii)

Giorgi (1994) states that the qualitative research methodologies often reflect a situation known as *mixed discourse*. This means that they often mix the criteria and practices in science from different philosophies of science. Giorgi adds that what is appealing to him about phenomenology is its comprehensiveness. It always starts from a perspective of consciousness (to be discussed later) and allows whatever presents itself to consciousness to be a legitimate point of departure in research. The author views this comprehensiveness to point to extend that in phenomenology, the method tends to flow from the methodology. Giorgi goes on to add that the phenomena of research interests should guide us in selecting the appropriate model, and not the criteria of science that are established in accordance with entirely different phenomena. Giorgi does caution that the phenomenological method does not critique natural scientific methods as such, but merely states that they may not serve all purposes, and especially the human sciences.

The phenomenological method of Giorgi (1985) refers to the practice of science within the "context of discovery" rather than the "context of verification" (p.14). Additionally, Giorgi (1992) adds that the phenomenological method is concerned with descriptive strategies in addressing meaning and not the approaches of interpretation common in qualitative research (this is one departure of method from technique). This distinction however depends on the epistemological assumptions about meaning. The phenomenological paradigm does not only differ from the positivist paradigm (in which reality is single, tangible, and fragmentable), but also from the naturalist paradigm (where realities are multiple, constructed and holistic). In this paradigm, reality statements are not made; only precisely how the phenomenon presents itself is described (Giorgi, 1983, 1994).

Kruger (1986), following Giorgi, compares the natural scientific approaches with the human scientific approaches. The natural scientific approach is summarised as being empirical, positivistic, reductionistic, quantitative and deterministic. Empirical refers to the point of departure in the study of behaviour as being through controlled observation (perception). The positivistic aspect of natural scientific approach requires that speculative content must be dismissed or translated into known empirical and mechanical laws (objective). The approach is reductionistic in that phenomena must be made equal to their operational definitions. The approach is further quantitative and deterministic in that it must be precise, with the aim is to discover laws, which will enable us to predict behaviour. Natural scientific approaches are further analytic in that phenomena are broken down into essential elements. Experiments must be repeatable and observers must be independent of the phenomenon being studied.

The phenomenological approach towards research on the other hand is characterised by "an attitude of openness for whatever is significant for the proper understanding of the phenomenon. The method uses processes of intuition, reflection and description" (Kruger, 1986, p.202). Giorgi has pointed out that not all research needs to necessarily be experimental, and while natural scientific methods concentrate on quantities, phenomenological approaches are directed towards the quality of experience. Phenomenological research focuses primarily on explication (Kruger, 1986).

Kruger (1986) highlights that all psychological observation is participant observation. The observer cannot be independent of what he or she observes. Kruger goes on to state that the characteristics of phenomenological research, as opposed to the natural sciences, parallels with the processes of psychotherapy itself. This is as psychotherapy is not a form of experimentation, but can be seen to parallel with research in a wider sense. It is able to generate a new body of knowledge. It can be seen as an unsystematic method of research.

As the methodology is based within the philosophy of phenomenology, let us now turn our attention to a brief discussion on phenomenology. This will be followed by a discussion on the link between phenomenology and psychology before proceeding onto the psychological phenomenological method and specific method of this study.

2.6 Phenomenology

The principles and methods of psychological phenomenology are associated with a branch of philosophy known as phenomenology. Edmund Husserl started phenomenology in 1900. It has gradually developed over the years. "Husserl, as a logician and mathematician, was always a believer in universal, objective knowledge, but he was also interested in trying to understand how it was possible for humans to accomplish such absolute truths" (Shapiro, 1985, p. ix). For a long time, the phenomenological contributions to psychology have been a critique to the dominant concepts and practices. Giorgi (1970, 1985) shows how phenomenology can serve psychology as a human science and as a research method.

Phenomenology is concerned with the manner in which human beings gain knowledge and understanding of the world around them. Phenomenology is able to identify different approaches to human understanding but also argues that certain forms of knowing and understanding may be more constructive than others (Willig, 2001). "Phenomenology is the discipline that devotes itself to the study of how things appear to consciousness or are given in experience. Thus it is concerned with phenomena in the strict sense: that is, how things and events are for the consciousness

that beholds them and not how they are in themselves. Whatever presents itself in experience is to be understood precisely as it presents itself even though one may know that the given contains more than appears or may be different from how it presents itself" (Giorgi, 1986, p. 6). The phenomenon in this study is the patient diagnosed with a factitious disorder, precisely as she presented herself to the consciousness of the therapist and thus his experience of the therapy. It is to be expected that the givens of the patient (or even the disorder) contain more than was experienced by the therapist.

Giorgi (1985) argues that the guiding theme of phenomenology according to Husserl is to go "back to the 'things themselves'" (p. 8). The phenomenal realm is better characterised as a *living presence* rather than knowledge. Therefore phenomenology makes use of *bracketing*. Bracketing is the setting aside of what we know about things in order to experience them fresh and renewed. One thus talks about appearances or presences and not existences or knowledge (Aanstoos, 1986, Giorgi, 1986, Kruger, 1986).

In order to attend to a phenomenon as it is lived, it is necessary to obtain what is experienced just as it presents itself in any instance. "Phenomenology is concerned with the phenomena that appear in our consciousness as we engage with the world around us" (Willig, 2001, p. 51). From the phenomenological perspective, it would not make sense to think of a world of objects and subjects as separate from our experience of them. This means that in order to understand a person's *intentional* reality (intentionality explained next) of a lived experience, it is necessary to approach it by *bracketing* (or suspending) presumptive constructs about it. Through bracketing, a phenomenological method aims to achieve a direct contact with the world. This is not a disinterest with theory on the behalf of the researcher, but rather a suspension of predetermined concepts that can be seen as restricting. Phenomenological methods can be seen as non-inferential. The aim is not to provide a hypothesis that will be tested (Aanstoos, 1986, Willig, 2001). The author, as researcher, will bracket the presumptive constructs of factitious disorders in an attempt to describe the lived experience of therapy with the patient.

Giorgi (1986, 1987) states that because the phenomenological approach does not assume that a psychological reality is already understandable, it was able to discover an essential feature of consciousness: *intentionality*. Intentionality differentiates consciousness or experience from things (subjects and objects). Intentionality "allows objects to appear as phenomena" which means that the self and the world are "inseparable components of meaning" (Willig, 2001, p.51). Meaning is therefore not something that is added to perception as an afterthought, but rather, perception can be seen as always intentional, and therefore a component of experience itself. The meaning is however often only discovered through reflection.

If an experience is intentional, it essentially means that it is directed towards the givens of experience. "These givens may be internal or external to consciousness but they always transcend the acts in which they appear" (Giorgi, 1986, p.7). This therefore means that an object of psychology is not necessarily given or understood perceptually, but rather that the object of perception is neither necessarily exhausted nor primarily defined by its material aspects. For phenomenology, behaviour is part of consciousness. Thus, if one were to focus on behaviour, the structure of the object of psychology would be "a behavioral act directed towards a transcendent situation that is directly but perspectivally modified. In other words, the object of psychology is a complex whole consisting of discernable but inseparable parts" (p.7). Kruger (1986) states that man is intentional, and is always directed towards something – he never simply thinks or feels, but rather these acts are directed towards or about something.

The author highlights that in this study, the patient and the factitious disorder are not studied as either separate subjects or objects. Rather, the process of therapy, as a human interaction, contains the essential features of consciousness and intentionality. The experiences of the therapist within the therapy are thus inseparable from the patient or her disorder.

It is following this understanding that leads phenomenologists to refer to categorical objects. Giorgi (1986) believes that a genuine object of psychology has to presuppose something similar to a categorical object as it is always relational and can never be

reduced to simple material components. Because it is relational, it requires both sensory givens and non-sensory aspects as part of the whole.

> Phenomenology is also the discipline that seeks meaning of experience rather than its sheer facts. Facts are obtained, of course, and indeed they are necessary, because they are the points of departure for the discovery of meanings. Reference to a subject is intrinsic to the understanding of a meaning, but facts can be known without such references. If phenomenologically grounded science is different from other sciences, it is because of its rigorous pursuit of the clarification of meaning (including an awareness of its limits). Thus, a phenomenologically grounded science uses a descriptive approach in order to obtain the facts of a given experience in order to clarify their meaning.
>
> (Giorgi, 1986, p.8)

Giorgi (1986) believes that positivistic empirical approaches have created problems for descriptive research in psychology and that the assumptions of phenomenological philosophy would better suit the aims of descriptive psychology. He further adds that descriptive philosophy and descriptive science should be judged by their own internal criteria, and not by the criteria of other philosophical systems or sciences. Therefore, it should be cautioned that until the criteria for descriptive research are better specified, it is necessary to present these criteria with our research – which is why the phenomenological methodology is extensively described in this study. The ability to predict or replicate (a criteria of natural sciences) for example, are not adequate measures of description.

Meaning in phenomenology has certain characteristics. Firstly is the idea that an expressive act is intentional. "The core meaning of intentionality is that consciousness is always directed to something that is beyond the act of consciousness in which that something appears" (Giorgi, 1986, p.12). Meanings are not entities in themselves, but can rather be understood as *ideal unities*. Secondly, there is a distinction between meaning-intending acts and meaning-fulfilling acts. There are two poles to a relationship: an act side (noetic sphere) and an object side (noematic sphere). Meaning is to be found in the intention of acts, and not the fulfilment of acts. Thirdly, there is a distinction between the sense of an object and reference to an object. "The reference is that about which an expression says something, the sense is what it says about it" (p.12). The two are never exactly the same. This can be shown by the fact that an expression can refer to different objects, or that different meanings

can refer to the same object. Finally, meanings are only discovered reflectively. Experiences are spontaneous and directed towards objects or situations, but not directly to the meanings. Therefore to clarify the meaning of an experience we need to reflect upon it (Giorgi, 1986).

Giorgi (1986) states that from a phenomenological perspective, psychology should concentrate on meanings rather than facts. For phenomenologists, a fact is a "categorical arrangement articulated in objects" (p.14). Facts are different from the perceptual experience of objects because facts arise when we make statements about things. A fact is therefore a categorical object. It goes beyond the perceptual presence of an object to include an articulated arrangement of aspects of the object that include language and other references. Psychology as a discipline depends on presences and the way things are *experienced* by subjects. Attention can now be turned to a discussion on the applicability of phenomenology to psychology.

2.7 Phenomenology and Psychology

Before moving towards a psychological phenomenological method, one must briefly differentiate psychological meaning from philosophical meaning. Firstly, psychological meaning is much more dependant on *personal* subjectivity than philosophy. Secondly, the objects of fulfilled acts are as important in the psychological analysis of meaning. Therefore, the noematic object is more a result of personal consciousness than the object would be in itself. This can be demonstrated with the psychological concept of apperception. Thirdly, for psychological meaning to be addressed, a *psychological attitude* is necessary to discern the meaning from either everyday meaning or philosophical meaning. A fourth point is that descriptions can reveal psychological meaning adequately because the type of description revealing the situation of the experiencer also reveals information about how the experiencer is within the world and attempting to understand or grasp the meaning of their experience (Giorgi, 1986).

Willig (2001) adds that phenomenological psychology "is more concerned with the diversity and variability of human experience than with the identification of essences

in Husserl's sense" (p. 53). Phenomenological researchers in psychology would hesitate to state that it is possible to suspend all presuppositions in ones reflection on a phenomenon. It is rather the attempt to bracket the phenomenon that allows the researcher to engage in a critical examination of their traditional ways of knowing about the phenomenon. It is also important to differentiate between the phenomenological experience and the phenomenological analysis of a description of a particular experience. As therapist it was impossible not to conceptualise the diagnoses of the patient. As researcher, the attempt is to bracket this knowledge in order to address the essences of the experience.

Kruger (1986) also states that descriptions can reveal much more than we are aware of or intending. However, the feasibility of a description is one point, the explanation of it is another. Descriptions can be the basis of a research topic if the psychological meanings are being sought rather than objective facts. It is important to remember that the experience takes place *prereflectively*, but the discovery of meaning requires reflection. Giorgi does feel that these (and above) considerations are not inconsistent with the philosophical phenomenological approach to description (Giorgi, 1986).

Giorgi (1994) states that the psychological phenomenological method essentially involves three interrelated steps: 1) *descriptions*, 2) *the reduction*, and 3) s*earch for essences*. Firstly, the phenomena studied have to be described precisely as they present themselves. Nothing should be added or subtracted from what is given. Secondly, the description takes place within an attitude of phenomenological reduction. This means that the researcher disengages (or brackets) from all previous theories or knowledge about the phenomena. Thirdly, the researcher begins a process of free imaginative variation. Aspects of the concrete phenomenon are subjected to variations until its essential characteristics begin to show. These characteristics become the structure of the phenomenon. The therapist's naïve description of the therapy is the description that will undergo reduction in search of its essences. However, it is important to caution that this account (of the method) is somewhat abstract and idealistic. A practical and general approach to this psychological phenomenological method is outlined next. This will be followed by an account of the specific application of this method that will be used for this study.

2.8 Psychological Phenomenological Method

For the psychological phenomenological method, depending on the phenomenon we are interested in researching, we will be interested in obtaining descriptions of that phenomenon. Giorgi (1985), states that from a pragmatic level this does not seem difficult as questions or statements are usually followed by a concrete description of the experience. The method begins after the description has been obtained.

> The method contains four essential steps; expressed most generally, they are as follows: (1) One reads the entire description in order to get a general sense of the whole statement. (2) Once the sense of the whole has been grasped, the researcher goes back to the beginning and reads through the text once more with the specific aim of discriminating "meaning units" from within a psychological perspective and with a focus on the phenomenon being researched. (3) Once "meaning units" have been delineated, the researcher then goes through all of the meaning units and expresses the psychological insight contained in them more directly. This is especially true of the "meaning units" most revelatory of the phenomenon under consideration. (4) Finally, the researcher synthesises all of the transformed meaning units into a consistent statement regarding the subject's experience. This is usually referred to as the structure of the experience and can be expressed at a number of levels.
>
> (Giorgi, 1985, p.10)

2.8.1 Sense of the Whole

For this step not much can be said other than what is involved is the simple reading of the text, and the ability to understand the language of the describer. The text should however be read as often as possible in order for the researcher to grasp the whole. In this step, the text is not interrogated, reduced, or made explicit in any way. This step only serves as a foundation for the next step: the discrimination of meaning units (Giorgi, 1985).

2.8.2 Discrimination of Meaning Units (Within a Psychological Perspective and Focussed on the Phenomenon Being Researched)

Since it is very rarely possible to analyse a whole text simultaneously, it is necessary to break it down into manageable units. And because it is a psychological analysis that we are interested in, the units should be made with psychological criteria in mind.

Therefore, the meanings that emerge in analysis are "spontaneously perceived discriminations within the subject's description arrived at when the researcher assumes a psychological attitude toward the concrete description" (Giorgi, 1985, p.11).

The meaning unit discriminations should be noted in some form directly on the original description. They should represent whenever the researcher, upon reading the text, becomes aware of changes in meaning or situations that may be psychologically significant. It is important in this step that the subject's language is not changed or in any way modified. It is essential to the method that discriminations take place first (Giorgi, 1985).

Giorgi (1985) refers to a *psychological attitude* when distinguishing meaning units. This is based upon the assumption that a psychological reality is not readily available in the world, or easily seen and identifiable. It rather has to be represented by the psychologist. This is because the complexity of everyday reality is greater than the psychological perspective. Therefore, a description could just as easily lend itself to interpretation from a philosophical, sociological, or anthropological perspective. Therefore, one adopts a *set*. This simply means that limits are set to analyse and thematise only a particular aspect of a more complex reality (Giorgi, 1985).

Giorgi (1985) does state that how one defines or enters into a psychological attitude is difficult to articulate theoretically. He does say that it does tend to be realised more successfully in a lived sense, and that this method allows for the lived sense to operate spontaneously first. Later, one can try to analyse the set adopted. Therefore, while a researcher may not always be able to articulate the precise meaning of psychology that he or she lives, they can through their spontaneous discriminations of the description (and later language they use) express more concretely than can be articulated, the set or meaning of psychology they adopt. "What differentiates the phenomenologically inspired method is the fact that a disciplined spontaneity is allowed to function whereby one first discovers the relevant meaning unit, or its category, and only later, based upon subsequent analysis, explicates its actual full import" (Giorgi, 1985, p.14). This does not mean, however, that one should not still

try to be as theoretical as possible, or make their meaning of psychology as clear as possible (Giorgi, 1985).

The meaning units are understood as *constituents* and not *elements*. "A constituent is a part determined in such a way that it is context-laden. An element is a part determined in such a way that its meaning is as much as possible independent of context" (Giorgi, 1985, p.14). This illustrates why the phenomenological method is differentiated from traditional content analysis methods. Content analysis is a research technique. Giorgi (1985) stresses that the phenomenological approach is a method, and not a technique.

It is finally important to remember that the constitution of meaning units do not actually *exist* in the description as such. They rather exist only in relation to, and as a reflection of, the attitude and set of the researcher. Therefore, what will stand out a great deal will be the researcher's perspective. Therefore, the meaning units established are neither universal nor arbitrary, and any effort to clarify them will often tend towards self-correction (Giorgi, 1985).

2.8.3 Transformation of Subject's Everyday Expressions into Psychological Language (with Emphasis on the Phenomenon Being Investigated)

The transformations in step 2 basically take place through the processes of reflection and imaginative variation. There is to be expected a tension between the specifics of a concrete description and situation, and the more general psychological categories that are evoked by the description or situation. "The intent of the method, however, is to arrive at the general category by *going through* the concrete expressions and not by abstraction or formalization, which are selective according to the criteria accepted. These transformations are necessary … because the descriptions by the naïve subjects express in a cryptic way multiple realities, and we want to elucidate the psychological aspects in depth appropriate for the understanding of the events" (Giorgi, 1985, p.17). This is done by reflection and imaginative variation.

The researcher reflects upon possibilities and discards those that do not withstand criticism. We try to make thematic the subject's perceptions and intentions within this stage in order to understand how the description can evolve into an example of the phenomenon (Giorgi, 1985).

The analysis is repeated for each meaning unit, and through reflection and imaginative variation; the naïve description is transformed from the everyday language of the subject into psychological language by the experimenter. As has already been highlighted, a major obstacle is that there is "no already established consensual psychological language" (Giorgi, 1985, p.19). The only alternative is for the researcher to state their psychological perspective.

2.8.4 Synthesis of Transformed Meaning Units into a Consistent Statement of the Structure of the Phenomenon

Giorgi (1985) firstly does caution that it is difficult to conduct research with this method on one subject as it becomes more difficult to refer to an essential general structure. More subjects lead to greater variations and a better ability to see what is essential. However, he does add that in certain instances, specific situated structures may be desired, and these can be based upon single subjects.

The "last step of the analysis is for the researcher to synthesize and integrate the insights contained in the transformed meaning units into a consistent description of the psychological structure of the event" (Giorgi, 1985, p.19). In synthesis it is important that *all* the transformed meaning units must be accounted for. "The criterion would be that all of the meanings of the transformed meaning units are at least implicitly contained in the general description. The structure is then communicated to other researchers for the purposes of confirmation or criticism" (Giorgi, 1985, p.19). This situated structures communicated to other researchers can take two forms.

Descriptions of the situated structure of the phenomenon can either be stated as specific or general. The *specific description of the situated structure* tends to remain more faithful to the concrete subject and specific situation described, whereas the

general description tries if possible to depart from the specifics and articulate the most general meaning of the phenomenon. This last step can be more difficult than traditional research methods as the researcher has the freedom to express their findings in multiple ways. How the findings and essential features are presented may depend largely on the expected audience (Giorgi, 1985).

Having outlined the general psychological phenomenological method proposed by Giorgi (1985), the author can turn his attention to the specific research method employed by the researcher in this study.

2.9 Research Method

The research method used in this study is outlined in Steps 1 to 4 (Headings 2.9.1 to 2.9.4). It is based upon Giorgi's method, but adapted where applicable.

2.9.1 Step 1

The researcher, as therapist will begin the method by providing a description of his experience of the therapy with the patient. As the researcher is essentially the participant-researcher in this study, it will be his description (as therapist) that will be used. Therefore, the author, as researcher believes that it is necessary to outline the criteria for how this description is obtained.

Giorgi (1987b) has also addressed the use and problems of self-description in a phenomenological analysis of experiences from a psychological perspective (in his particular instance, on imaginative experiences). Even if a critical attitude is maintained by the *researcher-subject* certain problems may nevertheless arise. These seem to arise in the uncovering of the hidden assumptions and presuppositions of the researcher-subject on reflection. Giorgi does not however appear to criticise the approach as intrinsically flawed. The author's understanding is that one needs to be aware that the researcher-subject's presuppositions are part of the experience to be discovered upon reflection. Descriptions by oneself can allow for greater explication of contextual factors.

A phenomenological analysis will begin by obtaining descriptions of the "experience from others, as experimental psychologists [do], but without physical manipulation, and without constraining the subjects in any way" (Giorgi, 1987a, p.30). In many experimental situations, the context belongs to the experimenter. Firstly, the researcher does not want to discount his role in the therapy and research. Secondly, therapy is not experimental, but can contribute to research in general as highlighted by Kruger (1986). Therefore, following Kazdin's (1992) principle that the concerns of the client should be given highest priority, the author, as researcher, feels that it would have been unethical to introduce an experimental aspect into therapy.

In order to provide the therapist's description, it is of further importance to include the ethical aspect of confidentiality. Even though the therapist's *process notes* for the therapy were written mainly from a first person perspective, they cannot be included as the naïve description for Step 1. This is because the confidentiality of the patient must be maintained, and all identifying data removed. The author, as researcher, therefore decided to turn to the clarification of the research question in order to address this problem.

The research question can be stated as such: "Provide an account of you experience while working in therapy (till completion) with a patient that eventually received the working diagnosis of a factitious disorder". With this in mind the author, as therapist, could then turn to rereading his process notes, thinking back on his thoughts, and providing a written account. These are the processes the author believes another therapist would go through if the question were posed to them.

The attitude the author had to adopt was that of therapist and not researcher when providing this account (Appendix A). The question may be posed as to whether, being the researcher the author (as therapist) was already thinking of categories and explanations. The answer honestly would be 'yes'. However, even when engaged in therapy, one is questioning and formulating hypotheses for a client's behaviour. For this step, the author, as therapist, wished to bracket any presuppositions about the research in order to reflect as best as possible his actual experience. Any psychological thinking reflected is part of the therapist's thinking, and thus part of his

experience and therefore part of the phenomenon. As Giorgi (1985) states, psychologists are "first and foremost human beings living [in] the everyday world" (p. 1) and clients "talk about their worlds" (p. 3). The author therefore believes that both experiences can be subjected to research.

The therapist's description (Appendix A) is the naïve description that will be subjected to the psychological phenomenological method. Therefore, Step 1 will also include and be concluded by the reading and rereading of the therapist's description in order to obtain a *sense of the whole*. This will not only be done by the author, as researcher (entering the other pole of the dichotomy of researcher-subject), but will be available to any reader who might wish to evaluate his description from a different perspective or paradigm. The description will inherently include the therapist's assumptions about psychology and therapy.

2.9.2 Step 2

Step 2 involves the discrimination of meaning units where the author, as researcher, will break down the naïve description into manageable and distinct units without any modification of the language. The attitude the author will have to adopt for this phase will not only be a psychological attitude but also an attitude of researcher.

2.9.3 Step 3

The third step involves the transformation of the meaning units into psychological language. One may argue that as therapist, the naïve description is already in psychological language. Yes, but the attitude adopted was different – it was one of recounting therapy. Also as Giorgi has highlighted, the discrimination of meaning units already reveals much about the researcher's assumptions – and therefore the researcher's intentionality would be an aspect of the research at this point. In this research study, it is essentially one level beyond. The author, as researcher, does not feel that this necessarily limits the study, but is merely a level of subjectivity that should be taken cognisance of. Also as researcher, author aims to look for differing meanings of experience than he hypothesised as therapist.

2.9.4 Step 4

Step 4 will involve the synthesis of the transformed meaning units into a consistent statement. In this context, the statement will be a specific description of the situated structure.

The author can now turn to an evaluation of the method.

2.10 Evaluation of the Method

In concluding this chapter, the author wishes to provide a brief evaluation of the psychological phenomenological method according to the various criteria outlined for qualitative research and case studies in general.

Firstly, the validity will be evaluated in terms of the research question. As author wishes to describe his own experiences (as therapist) within therapy, the validity of the research can be evaluated in terms of the description, method, and methodology employed.

The ethical considerations of informed consent and confidentiality have been addressed with the patient. The criteria of right to withdraw, no deception, and debriefing are not applicable considerations as the author is also the primary subject and the research is in no way experimental (it is retrospective).

As this is a single case design, it has been selected because of its interest as well as the scarcity of patients with "factitious disorders". For this reason, representativeness and generalisability are not goals of the research. The case can be seen as intrinsic (as this was a difficult therapy for the therapist to be involved in) or instrumental (represents an example of a factitious disorder). However, these distinctions are not necessary as the phenomenological method is interested in the meaning of the experience and not the facts.

The description of the case serves only the purpose of describing an interesting and rare case. According to the phenomenological method, the author is merely looking to describe an experience and look for meaning, not facts. Therefore, according to Kazdin's (1992) criteria, theory and therapy techniques generation is not the aim.

Kazdin's (1992) limitations for case study research tend not only to be acknowledged by phenomenological methods, but also appear to be their strengths. In this method, alternative explanations are expected and provide meaning to the research. Therefore, the author believes that the proposed method fits the research question fairly well.

With the specific research method outlined, as well as the evaluation of the method, the author can now turn in the next chapter to the application of the method. Chapter 3 contains the phenomenological explication of the naïve description provided by the therapist.

Chapter 3

Phenomenological Study

3.1 Introduction

This chapter contains the phenomenological study of the author's experience, as therapist, with a patient who was diagnosed with a "factitious disorder". As an intern psychologist, the therapist entered into therapy with the patient within the context of a multidisciplinary academic hospital in the Gauteng region. The patient was a white, English, married woman in her early 30's. She had two young daughters (pre-teens).

As a rule, the therapist generally refers to those he sees in therapy as *clients*. However, due to the prominence of this client's sick-role identity and presentation of physical symptoms, the author made the decision to refer to her as a *patient*.

This chapter follows the method described and outlined in Chapter 2 (Heading 2.9). As such each heading in this chapter will be labelled according to the steps that are outlined in the method. Each step will also contain a brief summary of what is to be accomplished.

3.2 Step 1

The whole description in its entirety can be read in Appendix A in order to gain a sense of the whole.

3.3 Steps 2 and 3

The table below displays Steps 2 and 3. Step 2 is the discrimination of natural meaning units (NMU) within a psychological perspective and focussed on the phenomenon being researched. Step 2 is depicted by the left hand column and Step 3

in the right-hand column. Step 3 reflects the transformation of the NMU's into psychologically transformed meaning units (TMU). The TMU's reflect the transformation of the descriptions everyday expressions into psychological language with emphasis on the phenomenon being investigated. As both the NMU's and TMU's are essentially written by the author (as therapist and researcher), the language used will tend to show the difference in attitude respectively from a therapist to researcher – from when the description was written, through Step 1, to Step 2 being implemented, and Step 3 written. The NMU's and TMU's are numbered to facilitate referencing.

No	**Natural Meaning Units (NMU)**	**Transformed Meaning Units (TMU)**
1.	Upon thinking about writing a description of my therapy with Mrs. S, I was struck by the difficulty and enormity of the task. Reading and re-reading my process notes, thinking back over my thoughts, emotions, interactions and hypotheses, I started to stress about how exactly to describe my experience. Each process note for each therapy contained and reminded me of copious amounts of information and interesting interpretations.	The therapist highlights that even in thinking retrospectively and writing a descriptive account of his therapeutic encounter with the patient, that a great amount of personal time and energy is expended. Due to excessive information, there appears to be numerous ways and variations of approaching the task that stimulates a level of self-doubt within the therapist.
2.	However, even a summarised account from my process notes would be too lengthy for these purposes.	The therapist acknowledges that a level of practicality needs to be applied within the specific context.
3.	Even though the process notes were written in first person, they would also not suffice as a genuine description on their own. I feel it is necessary to include the experience of the therapy as it lives within me at the point of writing the description – including its ambiguities.	The therapist describes that his experience was monitored throughout the therapy, but was not limited by it. The therapy has created a lasting impression on the therapist that still maintains a level of ambiguity.
4.	However, I feel that it is necessary to provide some structure for the purposes of the reader. I decided upon an approach that seems best suited for organising the progression of therapy, as well as my experiences. Although I will have to concede that it will not and cannot be fully comprehensive.	The therapist believes that it is necessary to provide structure to his description of the therapy in order to facilitate the understanding and comprehension of the process. Even though the therapist would prefer his description to be comprehensive, he understands that with the complexity of the case that it cannot be.

5.	I have chosen to follow the chronology of the therapy, using the process notes as a structure. The sessions will be numbered and referred to in their chronological order,	The therapist selects an approach that will possibly allow the process of therapy to be followed as it developed.
6.	including both scheduled sessions, as well as non-scheduled "emergencies" where therapy was included.	Patient emergencies appear to have been a notable characteristic of the therapy.
7.	All other information about my own thinking as well as external (to therapy) interactions of both Mrs. S and myself will blend around this structure.	The therapist would like to include a comprehensive account of the therapy that includes interactions he experienced both within and external to therapy. This account includes his experiences and hypothesising about the processes.
8.	Descriptions will be grouped in themes that not only make sense to me, but also attempt in some way to structure the description.	The therapist highlights that the approach he chose reflects his hypothesising about the therapy.
9.	As the dates of the sessions will not be given, the chronology of events will assist the reader in following.	Issues of confidentiality as well as practicality have also influenced the approach.
10.	I saw Mrs. S for 28 sessions over a period of a little over 3 months. I saw her on average for two sessions a week until discharge from the hospital and final termination of therapy.	The therapist in a brief outline highlights the intensity of the therapy.
11.	I entered into therapy with Mrs. S on my day on call. A psychologist was requested by the ward staff at one of the general medical wards in the hospital to come assess Mrs. S and manage further.	The therapist was working within the context of a hospital setting. He was requested by the medical staff to assess and manage a medical patient. The patient did not request therapy herself.
12.	She was reportedly talking about suicide.	The assessment was seen as an emergency as the patient was apparently expressing suicidal ideation.
13.	My initial goal was to assess the seriousness of the suicide and whether follow up therapy, or a referral to psychiatry was necessary.	The therapist's initial therapeutic goals reflect certain hospital procedures that are required to be adhered to in cases of suicidal ideation. These are to assess the risk and then decide on a suitable treatment plan. The hospital has a psychiatric department.
14.	I approached the initial session with the aim of being client-centred – the Rogerian principles of warmth and empathy.	The therapist's preferred initial approach to therapy is to maintain an attitude of client-centeredness. He prefers to approach therapy initially with warmth and empathy. The therapist does not suggest a conflict between his preferred mode of approach and the required hospital procedures.

15.	My general approach to therapy is to allow the client to introduce into therapy what their main concerns or problems are. I believe the role of the therapist is to help facilitate change.	The therapist prefers an open-ended approach to therapy that allows the client to direct the therapeutic goals. The therapist believes his aim in therapy is to facilitate change based upon the goals the client introduces.
16.	Mrs. S upon our first encounter was extremely tearful and volatile. She spoke about being unable to carry on any more, and that she would just rather die.	The patient initially presents with a depressed and irritable mood. The patient describes a significant amount of frustration with her present condition.
17.	She spoke initially about having an immune system deficiency that was rare and the doctors seemed unable to explain (she was HIV negative). She related a story of being extremely ill and in great amounts of pain for the past 8 or 9 years of her life. She was constantly in hospital and on excessively expensive medication to supplement her defective immune system. She further was subjected to numerous and expensive operations and painful procedures.	The patient spontaneously introduces physical symptoms and illness as a focal point in therapy. The characteristics of the illness are: that it is supposedly rare and unexplainable; that it is extremely chronic; that it involves extensive hospitalisations; requires numerous expensive medications and procedures; and that it results in extensive and chronic pain for the patient.
18.	She was frustrated that no one could help her, the doctors could not help, her husband and family were not there to support her, and she was unable to support and be there for her children.	The patient's frustrations are that there is no help and support for her. Professionals cannot help her. Her family does not support her. She cannot support her children because no one can support or help her. There is a conflict of needs and roles.
19.	All her frustrations centred on her illness and Mrs. S seemed to fatalistically believe that she had no hope of ever getting well. She therefore wished that she would rather just be allowed or able to die.	The patient expresses and emphasises extreme levels of hopelessness and helplessness that are linked to her illness. She cannot be helped. She cannot help herself. All control of her life is described as being beyond her and suggested to be in the hands of others.
20.	She stated that she would not actually commit suicide because of her religious beliefs as a Christian, her desire to be there for her children, and that she believed that she was actually not capable of doing so.	Suicide does not appear to be a risk. The ability to take her own life is described as beyond the patient's control.
21.	She just felt utterly hopeless and helpless and was tired of everyone telling her that all would be "ok" and that she must just be strong.	The patient feels that people's attempts to console and reassure her is what frustrates her. Consolation and reassurance are paradoxically interpreted as unsupportive, unsympathetic, and the cause of her frustration.

22.	I felt that I could through a client-centred approach to therapy, at least be able to allow her space to express her feelings even though I could do nothing for her medical condition.	The therapist believes that in the case chronic physical illness that psychotherapy can still be beneficial. The aim is to facilitate the emotional well being, even if the physical health cannot be directly addressed.
23.	Mrs. S for almost the entire span of our therapeutic interactions looked the part of a chronic ward patient. She was almost always in her hospital robes. She looked sick, and consistently spoke of being sick.	The patient looked visibly ill. Her illness and sick-role were consistent characteristics of her identity.
24.	Yet she was consistently a difficult, strong and frustrating person to encounter. She was argumentative, and could often be scathing with her comments and remarks.	The personality of the patient paradoxically contrasts both her self-reports and physical appearance. The patient was often argumentative and verbally abusive.
25.	Her eyes were however her most defining feature for me. They were a deep rich blue. They sometimes appeared to be able to express a helpless, hopeless and pleading quality, while at other times they were piercing, harsh and scornful. Both qualities were incredibly powerful, but what was most striking for me was the fact that the two seeming polarities of expression often occurred simultaneously.	The effect of the patient's appearance would often create a paradoxical confusion within the therapist. The therapist felt uncertain as to whether the patient was asking him for help or challenging him.
26.	Mrs. S had another commonly observed behaviour of covering her mouth and laughing incongruently when talking about difficult or unspeakable topics.	The patient's mannerisms were paradoxically incongruent with the content and topics she introduced.
27.	A significant event on our first encounter was towards the end of the session. Upon asking Mrs. S whether she would like to continue with therapy, it became apparent that she had thought that I was a social worker and not a psychologist – even though I had introduced myself.	The patient apparently had a misconception about the therapist. The therapist however does not appear to be convinced that this was a genuine misconception.
28.	During the session, Mrs. S was derogatory towards doctors and extremely aversive towards psychiatry and psychiatrists. She had also listed psychologists amongst the professions that were unable to help her.	The patient is oppositional to most health care professionals directly involved with her. The patient insinuates that psychotherapy cannot help her current situation. The patient further expresses a strong aversion to psychiatric care.
29.	However, upon clarifying this misconception, Mrs. S was still willing and rather agreeable to continuing with	The patient however paradoxically expresses a willingness to continue with psychotherapy.

	me as her therapist.	
30.	The first three sessions were characterised by an overwhelming wealth of information.	The therapist experiences the patient as overwhelming him with information.
31.	Mrs. S's illness was at the forefront of her complaints, and linked to almost every aspect of her life.	The therapist experiences the patient's medical complaints as predominating the psychological focus.
32.	I tried initially to focus upon how she copes with the illness working towards and exploring a mind-body link. I thought and believe that mental and emotional states can impact the body and vice versa.	The therapist initially attempted to facilitate the patient in emotionally coping with her illness. The therapist displays a belief in an interaction between mental, emotional and physical states. His focus appears to be towards the more mental and emotional states of the duality while expressing recognition of the interaction between states. The therapist appears to accept the patient's physical illness as a reality.
33.	Mrs. S agreed with the principle, but was consistently pessimistic, providing reasons and excuses for why it was not and could not be applicable in her case.	The patient overtly expresses a cognitive and intellectual agreement with the therapist's therapeutic focus, but averts the process by stressing the rareness and exceptionality of her condition.
34.	Mrs. S spoke a great deal about the social difficulties in her life.	The patient expresses many interpersonal and social problems.
35.	Her husband (Mr. S) was portrayed as short tempered, aggressive, and non-supportive. Mrs. S has two daughters (M, 11 years and Y, 7 years), although the youngest, Y is not the biological daughter of Mr. S. Mrs. S had known Mr. S since childhood, and they had married in their early twenties. They had their first daughter, M, together, but their marriage was described problematic. In an argument one night Mr. S had kicked out and locked out Mrs. S from their apartment. She had sought support from an older man X, who was a neighbour and friend to the couple. This led to a sequence of events in which he took advantage of her, the couple divorced, and Y was conceived. X was described to be obsessive, abusive, violent, an alcoholic and drug addict. Mrs. S a few years later fled this relationship and eventually remarried Mr. S who adopted Y.	The patient describes a dysfunctional family history, as well as marital environment. The patient tends to provide a rich and detailed account of her interpersonal and social problems, with many concrete examples to exemplify the severity.
36.	Mrs. S however also raised questions	The patient tries to coerce the therapist

	and suspicions of Mr. S molesting M and believed that he strongly needed professional help. She often tried to force Mr. S into therapy.	into persuading her husband into therapy. The patient paradoxically tends to refer to others needing assistance rather than herself.
37.	Their marriage and relationship was constantly described in many different contexts as being in crisis.	The patient consistently describes marital problems.
38.	Mrs. S would often move between extremes of wanting her husbands support to wanting nothing to do with him.	The patient's needs from her marital relationship displays a paradoxical fluctuation between desiring for and needing support and devaluation.
39.	Both Mr. And Mrs. S's families were described to be pathological.	The patient describes her family environment as pathological. This tends to suggest that external factors are responsible for her condition.
40.	Mrs. S's parents had divorced when she was about 14.	The patient experienced her parent's divorce in her teenage years.
41.	Mrs. S recounted stories in which her own needs were constantly set aside for the needs of others. She used a metaphor-story of as a child hurting herself walking into a table, and being made to apologise to the table.	Throughout childhood, the patient experienced / recalled her emotional needs as constantly being frustrated and not met by her parents. She attributes her insignificant feelings of self-worth as a consequence of her family environment. The patient describes her experiences remarkably descriptively and metaphorically.
42.	She feels that her family (mother, father, husband) are not supportive of her with her illness.	The patient describes typical patterns of family neglect and abandonment.
43.	Mrs. S often described her children as the most important focus and biggest accomplishment in her life. She believed that her parents and her illness are taking her children away from her.	The patient describes her parental role as important and significant in her life. The patient however addresses positive aspects of her life from the perspective of the sick role, and elaborates how her illness, as well as others suppresses anything positive.
44.	Mrs. S also made reference to having been psychiatrically hospitalised in her late teens. She spoke of being in and out of a psychiatric institution for about two years and of attempting suicide on a couple of occasions, once even swallowing razor blades.	The patient reports a severe psychiatric history with severe suicide attempts in her late teenage years.
45.	She said she had rebelled against her parents at 14, disobeyed them, and that this resulted in her being "badly hurt" by a man. She had not received sympathy or support from her parents, only blame.	The psychiatric history is chronologically linked to her parents divorce. Descriptively the patient's parents are implied to be responsible for her psychiatric history.
46.	She later broke down and had to punish herself.	The patient describes a need and desire to punish herself. This is contradictory

		to her ascription of the blame to her parents.
47.	These descriptions were always vague and Mrs. S would tend to justify this by stating that she did not want to talk about it or that her thoughts were "fuzzy".	Even though the patient's descriptions are remarkable, they tended to be vague. When questioned, the patient would further justify her vagueness with additional vague responses.
48.	In these first sessions, my approach was to be client-centred and establish for myself the patterns of interaction.	The therapist attempted to approach the therapy from an attitude of client-centeredness and to focus on interactional patterns.
49.	I was however, overwhelmed with the details and content, as well as the numerous possibilities for approach to therapy. I did not really know where to tackle the wealth of problems and issues.	The therapist's experience of the patient was that she overwhelmed him with information. The impact of this style resulted in the therapist experiencing an inability and uncertainty in approaching his aims for therapy.
50.	Mrs. S had never verbalised any specific goals for therapy. She would just say that she needed help. It felt to me as if she would only complain, expressing the futility of her situation.	The patient expressed no specific goals or aims for psychotherapy. Her characteristic style was only to complain. This contrasts with the numerous issues that she stated were necessary for her husband to address.
51.	Even early on, Mrs. S was dominating my discussions within supervision. I believed that therapy should involve some facilitation of change.	The therapist describes that this particular patient impacted upon him more so than his other clients. The therapist was frustrated that his aim to facilitate change in therapy was not being attained.
52.	The 4th session was not scheduled. Mrs. S had managed to track me down at the psychology department and was insistent upon seeing me.	The patient insisted upon seeing the therapist in a time of supposed crisis. Within the context of available personnel the patient appears to elevate (idealise) the status of the therapist. The patient is powerful in manoeuvring for her desires.
53.	She was extremely tearful, irritable and physically agitated. She complained that she wanted to go back to Natal, that things were too much for her,	The patient exhibits psychiatric symptoms of anxiety and depression that serve to emphasise her crisis. The crisis as described is however beyond the role and responsibility of the therapist to assist or help.
54.	and she needed my help.	The patient implies that the therapist is able to help her. The patient paradoxically requests or demands the help that cannot be offered to her.
55.	She believed that it was the hospital environment and its staff that were making her feel the way she did. She described a recurrent dream in which	The patient displays a tendency to assign blame to others, and external to herself. She describes others as responsible for her emotional state. She

	'monkeys came down from the mountain, through her window, and ripped her to pieces'. She interpreted that the monkeys were most probably the doctors.	was derogatory towards healthcare professionals and inferred their incompetence. The patient makes use of very descriptive, metaphorical and emotive language.
56.	I tried to explore what she wanted out of therapy with me, as I obviously could not and would not help her in leaving the hospital.	The therapist asserts his role and boundaries, and once again tries to address the aims and goals of the patient.
57.	She kept circularly stating that she does not know what she wants, she can't have what she wants, or gave vague descriptions about what she wants ("I just don't want to be here").	The patient remained vague in providing aims, goals, direction, or needs for therapy. The main need of therapy appears to remain a forum for complaints about her condition and treatment.
58.	She would explain that she did not know what was real or not real anymore - things were "blurry".	The patient would accentuate the urgency of her condition by describing a psychological symptom of derealization. This disturbance can be associated with dissociative phenomena, however is only vaguely alluded to.
59.	This was both literal and figurative as she accounted for a problem with her eyes and vision.	The psychological state of the patient is linked to her illness and physical state in both metaphorical and literal explanations by the patient.
60.	She further introduced that there were two sides to her. A 20% that is the "real me" and "wants to get better", and an 80% that is dark and dangerous and "wants to kill me".	The patient refers to a split in her psychological state that is dramatically emphasised. The description by the patient not only alludes to dissociative states, but also appears to both challenge the therapist and plead for help.
61.	She stated that there was a black hole in her mind, sucking in everything till she did not know what was real anymore.	The descriptive and metaphorical language of the patient, although descriptive of dissociative experiences, remains exceptionally vague and indicative of a variety of psychiatric symptoms.
62.	She felt trapped by everyone.	The patient expresses that others are responsible for her emotional state.
63.	Not wanting to trap her myself I decided and told her that I would give her the freedom to decide for herself what she wants to do.	The therapist overtly states that he is giving the client freedom the to decide her actions. In his response to her tendency to blame others, and not her psychological symptoms, it can be inferred that the therapist experienced these expressions of symptoms as manipulative and possibly exaggerated.
64.	I did feel that she needed to be referred to psychiatry, so this decision did leave me with an uneasy feeling. The session	The therapist in believing that the psychiatric symptoms are serious enough to involve a referral to the

	was left hanging, and I was not really sure what she was going to do or capable of doing once she left my office.	psychiatric department has adopted a more strategic approach to the therapy. This appears to be based upon a cognisance of the patient's wishes, but an awareness of her manipulation. The change in therapeutic approach did however leave the therapist with uncertainty and doubt.
65.	The following day, for our scheduled appointment, I encountered both Mr. and Mrs. S in her wardroom.	The therapist's uncertainty and doubt was reduced.
66.	Mrs. S had convinced Mr. S to take her back to Natal.	The patient had transferred her demands for help to others.
67.	However, when he had complied, she had confronted him stating that they could not leave, as she needed to stay in order to get better. It was suggested that he did not care for her health and recovery.	When her husband tried to accommodate her demands, she paradoxically confronted him and challenged his motives.
68.	It also appeared as though the ward staff had also tried to accommodate Mrs. S's feelings of confinement, but no compromise seemed to be accepted.	The pattern that the patient exhibits is one in which even when her demands are met, they do not appear to be sufficient. The patient creates an atmosphere of uncertainty when others attempt to help or assist her.
69.	I took the opportunity to talk to the couple together.	The therapist used the opportunity to gain as much collateral information as possible.
70.	Mr. S did not appear to be the monster described. Although some of his interactional patterns (as described by Mrs. S) were accurate, they were greatly exaggerated.	Collateral information tends to suggest that the patient greatly exaggerates the truth. The patient does however show an ability to observe interaction patterns and styles.
71.	On the whole Mr. S appeared just as frustrated. He appeared to care for and love Mrs. S, but did not know how to approach her.	The patient appears to typically bring about uncertainty and doubt in her interpersonal interactions.
72.	He was aware of the various problems and complaints that Mrs. S avoided or stated, "we never talk about".	The patient's family displays an interactional style that suggests and awareness of family secrets even if they are not spoken about.
73.	I decided to follow with a session a week of the couple in therapy together	The therapist attempts a different approach to therapy in which he feels that he may better be able to address interactional styles.
74.	with my supervisor as co-therapist.	The therapist enlists experienced assistance.
75.	In this 6th session, Mrs. S had snidely remarked, "I thought you might call for reinforcements".	The patient attacks the therapist's competence. It is also implicit that the patient is aware of the necessity for a

		change in the therapeutic approach. The patient appears to pride herself on being a difficult client.
76.	I wanted to focus on the couple's patterns of interaction. My interest in introducing Mr. S's conceptualisations of the process and interactions in their marriage	The therapist's goals are to approach the interactional styles between the patient and her husband.
77.	soon led to the focus again being drawn to Mrs. S.	The patient is able to dominate and draw the focus of attention.
78.	The therapy turned to focussing on the conflict between what is real or not for Mrs. S (the idea that her life feels like a movie), and the rage of emotions inside of her that were bursting to get out, together with the fear of what would happen if they did.	The focus of the therapy was drawn to the patient's dissociative experiences. It once again included an emphasis on urgency, and introduced new symptoms of possible violent behaviour (once again vaguely, but expressively described).
79.	After these sessions, I was becoming more frustrated at not knowing what was going on. I knew that Mrs. S was not always entirely truthful, but did not know where to proceed with therapy.	The therapist was continually frustrated by the uncertainty in therapy. The uncertainty appears to be precipitated by the interactional style of the client that facilitated doubt in the therapist. The patient exaggerates information and cannot be seen as entirely truthful.
80.	With the dominance of her sickness and the sick-role, my supervisor and myself began deliberating on the possibility of Munchausen.	The powerful and consistent sick-role of the patient prompted the therapist and his supervisor towards considering Munchausen syndrome.
81.	However, we also began to contemplate the idea that there could very well be a personality disorder.	The therapist and his supervisor also considered a personality disorder.
82.	I needed to reassess my goals for therapy. I had no idea, but only knew that I would like to in some way facilitate change. This did not seem to be more than minimally attainable at this stage.	The therapist believed that his main aim for therapy – to facilitate change – could not be achieved, and therefore would need to reassess his approach. The therapist remained in a state of confusion and doubt that began to tend towards pessimism. .
83.	I did however know that I would have the time frame of while Mrs. S was in hospital (as she was from Natal) and my goal would be to at least make some difference till then.	The only direction the therapist maintained was that the therapy would have a limited time frame.
84.	The 7th session was again an unscheduled session. On this occasion Mrs. S had gotten her doctor to contact me and stress the urgency of seeing her. There was something she had to tell me only, and no one else. She needed to tell me urgently.	The patient again created an atmosphere of emergency and urgency. She did however modify her approach, suggesting an awareness of the therapist's frustration. This was however not an empathic awareness, and rather a manipulative awareness.

		The approach of the patient was however still to idealise the therapist.
85.	The frustration of the medical ward staff with Mrs. S was apparent.	The patient was generally experienced as exceptionally frustrating.
86.	He related to me that they were unsure of what was wrong with her and that they had found bacteria common in faeces in some of her abscesses. He asked whether I believed that it was possible that she could be self-inflicting the wounds.	The medical doctors were beginning to query a factitious component to the patient's illness. The therapist was approached for his professional opinion.
87.	I could not rule out the possibility.	The therapist was in agreement with the query but reluctant to diagnose.
88.	I did go and see Mrs. S though.	The therapist conceded once more to the patient's manipulation to see him.
89.	She wanted to confess to me that the miscarriage that she had between M and Y was not actually true. She had in fact "murdered" this child by piercing herself with a knitting needle and then waiting a few days before going to the hospital.	The patient confessed a highly emotional revelation about her past. This confession suggested an intimate trust in the therapeutic relationship. It further impacted the therapist on an emotional and moral level.
90.	She told me in more detail how abusive X was and that she had feared for her own and M's lives. She could not at that time imagine bringing another child into that environment.	The patient provides graphic, emotional and detailed descriptions of the events surrounding the revelation. The patient can be seen to justify her actions.
91.	The confession was incredibly emotional for both Mrs. S and myself.	The revelation had a strong emotional impact on the therapist and patient.
92.	Even though I was torn with conflicting emotions and morals, I felt and believed that I was able to understand her reasoning at the time, and reinforced that she did what she believed was best at the time given her limited resources.	In exploring the revelation, the therapist seems convinced that the patient did not act with consciously malicious intent, and had very few resources available to her. The therapist felt that the revelation could be dealt with therapeutically.
93.	Mrs. S then added further information to her family picture.	The patient then proceeded to add further information about her family problems. This tends to suggest an opportunistic and manipulative approach to therapy. The patient still displays a characteristic style of providing extreme amounts of information.
94.	Her sister was anorexic	The patient's sister suffers from anorexia. This suggests a familial pattern of physical psychiatric symptoms.
95.	and a conversation between the two of them before Mrs. S had come to Gauteng had precipitated her emotional	The patient suggests a family history of alleged sexual abuse for both her and her sister. The patient also displays a

	state. Mrs. S told me that she believed that both she her sister had been sexually molested by a family member.	pattern of assigning external factors as responsible for her emotional state.
96.	Mrs. S had never told anyone these things.	The patient suggests the importance of the revelations by emphasising their secrecy. This also suggests that she view the therapist as exceptional.
97.	She later explained to me that she could tell me as I was leaving in a few weeks.	The patient however provides an explanation that suggests she was manoeuvring for some form of response from the therapist. Although it is unclear what her intentions were, it appears that the patient introduces information for effect rather than genuinely addressing issues.
98.	I informed her that she was mistaken and I was not leaving (her doctor was). She even appeared angry that I had apparently tricked her.	When the therapist informed the patient of her fallacy, she responded with anger as if to suggest that the therapist was in fact responsible.
99.	I asked her why she seems to like to play games.	The therapist believed that the patient was manipulating him and confronted her on this behaviour.
100.	She only told me that it was because she was good at it, and could only tell things to people when she knew it would not matter.	The patient conceded that she was good at manipulating people. The patient tends to supply information when she believes that it will be too late to be used constructively. There appeared to be a level of vindictiveness in this behaviour.
101.	The 8th session was characterised by a great amount of circumstantial and vague topics covering what had already been addressed.	The patient appears to respond to confrontation or accounts of her interactional patterns by reverting to vagueness and avoiding topics.
102.	Mrs. S did however have a very large bruise on her cheekbone. She would bash her head	The patient also responded to confrontation or accounts of her interactional style by engaging in self-mutilative behaviour.
103.	in order to get the “images” to stop.	The patient vaguely describes the self-mutilative behaviour as being in response to eidetic images. The patient appears to imply PTSD-symptoms.
104.	I tried addressing these thoughts but she remained vague.	The therapist again tried to focus upon symptoms but was counteracted by vagueness.
105.	I questioned her as to why she wants help, but will not allow herself to be helped? Why it was that she constantly spoke in circles.	The therapist confronted the paradox that the patient claims to want to be helped, but does not allow others to help her.
106.	She stated that her only defence has always been to “fuck with peoples	The patient states that her only defence is to manipulate others thoughts and

	minds".	emotions. The behaviour is described as a self-preservation method that suggests the patient believes people to have primarily malevolent intentions. The behaviour serves to keep the patient isolated from close interactions with others.
107.	She also stated that she wanted to exonerate me from anything that happens to her, saying that I should not feel like a failure.	The patient adopts a one-up position and subtly suggests both the therapists incompetence and the severity of her condition.
108.	We decided that it would be better to bring in the assistance of psychiatry.	The therapist manages to convince the patient into considering psychiatric management as an addition to her treatment.
109.	I referred her to Dr. A at psychiatry.	The therapist refers the patient to a doctor at the psychiatric department.
110.	Mrs. S did however contact me via department phone the next day stating that the doctors were "pissed off" with her non-compliance in going for a procedure and were going to lock her up at psychiatry.	The patient contacted the therapist once more proclaiming an urgent situation.
111.	I informed her that the two events were not related and that I had referred her to Dr. A who would see her external to the psychiatric ward.	The therapist, aware of events, was able to make note of the inconsistencies. The therapist highlighted the misunderstanding and reassured the patient
112.	The 9th session was scheduled to be a couple's therapy. My supervisor and I had decided to discontinue with this approach after the session, as I would carry on individually with Mrs. S and Mr. S could be referred for individual therapy if necessary. My supervisor did not make the session, and I conducted it alone.	The therapist in conjunction with his supervisor came to the conclusion that couple's therapy was not beneficial. The decision was to continue with the patient on an individual basis. The husband could be referred for individual therapy if it was requested. This suggests that the change in approach to therapy was not beneficial.
113.	Mrs. S informed me that Dr. A had asked her if our therapies were pushing her too hard.	The patient provides information that suggests an interdisciplinary disagreement between psychology and psychiatry. This appears to serve to promote a split between the disciplines.
114.	She had answered "no" on my behalf.	The patient suggests a form of alliance with the therapist.
115.	He had instructed her not to get too upset.	The patient uses another discipline to inform the therapist of what he is supposed to do. This appears to undermine his competence.
116.	I at this stage firmly believed that Mrs. S was the one who would manoeuvre us	The therapist hypothesised that the patient would manoeuvre the therapy

	into discussing issues that were too difficult for her to cope with.	into discussing issues that were too difficult for her to cope with. This suggests that the patient displays strong masochistic behaviour in interpersonal relationships.
117.	The goal for this therapy was however only to terminate the couple's therapy and focus superficially on the interactional patterns.	The therapist's aims for the therapy were contrary to what the patient suspected or wanted them to be. The therapist maintained an interest in addressing the interactional patterns of the couple.
118.	I was interested as to why the couple who knew each other so well, chose rather to hurt, attack and counter-attack each other, rather than providing help and support to each other.	The therapist noted a symmetric interactional style where the couple remained in a pattern of conflict. He was curious as to whether this pattern could be changed to one of symmetric support.
119.	Throughout the session, Mrs. S gradually appeared to withdraw from the process.	The patient displayed avoidant behaviour.
120.	I requested that she join Mr. S and myself on a number of occasions, but allowed her the freedom and the choice.	The therapist provided the patient with the freedom and choice to become involved in the therapy.
121.	However, by the end of the session, the behaviour was that of a severe dissociative experience. Mrs. S had curled up on her chair and was mumbling and shaking.	The avoidant behaviour exemplified a dissociative episode.
122.	I tried in vain to convince her that she had to leave the session (I had other appointments).	The dissociative episode created a commotion by exceeding therapeutic boundaries. The therapist could not prevent the behaviour.
123.	Mr. S also tried to gently persuade Mrs. S into leaving. He put his hand on her leg trying to reassure her, to which she sharply and angrily replied, "stop it!".	The patient's husband also had no effect in impeding the patient's behaviour. The patent displayed a high level of contempt for her husband.
124.	She kept stating that she could not move, because if she moved "it" would see her and "it" would "kill" her. She was adamant in wanting to be left alone. She then spontaneously began a terrifying scream that lasted a couple of minutes.	The dissociative experience was extremely dramatic and served to create a high level of emergency.
125.	I had sought help, but no one had greater success than I had had.	The therapist sought for help, suggesting that he felt that the situation was beyond his control. He did not however receive any assistance beyond what he had already attempted.
126.	For me it qualitatively felt as though we were non-entities within the room, and	The dissociative experience felt qualitatively real for the therapist.

	nothing we said would have made a difference.	
127.	When she eventually stopped, she appeared very disoriented, confused, and suspicious. She had wanted to know who I was and where she was.	The patient exhibited symptoms of disorientation and paranoia following the dissociative episode.
128.	Informing Dr. A about the event,	The therapist maintained an attitude of interdisciplinary communication by informing the doctor at psychiatry.
129.	he suggested that it was merely attention-seeking behaviour. I disagreed, but merely wanted to inform him of events. For me the event felt very real.	The therapist and doctor at psychiatry disagreed about the nature of the client's behaviour. This appears to suggest a level of distrust between the disciplines and different treatment aims.
130.	The following day, having consulted Mrs. S, Dr. A informed me that the event did appear to be a dissociative experience,	Upon consulting the patient, the psychiatrist displays a greater agreement with the symptom diagnoses of the therapist.
131.	although she reported it to be her first.	The information that the patient provides the doctor at psychiatry differs from the information that she provides to the therapist. (Refer to 144)
132.	He believed that Mrs. S had a borderline personality disorder with histrionic traits, and that these behaviours tended to fit.	The psychiatric doctor provides a diagnosis of borderline personality disorder with histrionic traits. The psychiatrist is content that this diagnosis corresponds well with the patient's behaviour.
133.	Mrs. S also contacted me the same day, wanting to apologise to me and confirm our next appointment.	The patient contacts the therapist to apologise for her behaviour. She displays a need to maintain the therapeutic relationship.
134.	She needed to apologise immediately as she was not sure what mood or state of mind she would be in our next session.	The patient uses the opportunity of an apology to create a further sense of urgency. In this context referring to her mental state as being beyond her control.
135.	At this stage in the process of our therapeutic encounters, I was becoming increasingly annoyed at having Mrs. S as a client. She occupied a great amount of my time, both in therapy, and in my thoughts.	The therapist was becoming increasingly frustrated at having the patient as a client. The frustration centred on the immense amount of time, emotional and cognitive resources that the patient necessitated.
136.	I had confirmed with another doctor that all the tests they were doing were coming back negative. I was almost convinced at this stage of my own diagnosis of Munchausen. The clinical picture of the literature I consulted seemed to fit.	The therapist confirmed with further medical doctors that the patient's medical condition did not appear to be what the patient portrayed it to be. This discrepancy began to convince the therapist of a diagnosis of Munchausen syndrome.

137.	However, as warned in the literature, and my experience of Mrs. S, I would not be able to confront this behaviour. She would most definitely deny it, and it might be wrong.	The therapist had consulted literature on Munchausen syndrome. He was aware that he could not confront the behaviour directly. He also expressed concern about misdiagnosing.
138.	At this stage my supervisor was also suggesting that the two of us both go for external supervision.	The difficulties that the patient presented with as a client prompted both the therapist and his supervisor to consider additional supervision.
139.	I decided, for my own sanity, and against my general therapeutic principles to diagnose within my mind Mrs. S as a borderline at least. The statement I told myself was that "even if I deny pathology, it does not mean that it does not exist".	The therapist was faced with conflicting issues concerning diagnosis. The therapist believed that psychiatric diagnostic criteria were not necessities of his therapeutic approach. The therapist however, conceded for himself that there were benefits afforded to him by making use of diagnostic criteria in his conceptualisation of the therapy. The diagnosis benefits the therapist in this context.
140.	In consulting with various colleagues I decided to set the goals for therapy simply to be: (1) to provide structure and consistency in the sense of fixed therapy sessions, with no deviations tolerated, (2) to allow Mrs. S the freedom to introduce topics in therapy, but to keep her to only one or two main topics a session, (3) and accept that I can only do as much as I can while she was in the hospital, to hopefully facilitate at least minimal change.	By focussing on a diagnosis of borderline personality disorder and consulting various colleagues, the therapist is able to focus on certain therapeutic aims. These aims are to provide structure and consistency for the client. The therapist appears to be able to merge these aims with his focus on client-centeredness. The therapist acknowledges that in the case of a personality disorder that he should not have high expectations for change, with the minimal therapeutic time available.
141.	In the 10th session Mrs. S was visibly sedated and had difficulty in expressing herself. Mrs. S often complained of the adverse effects of her medication.	The patient appears to suggest that the psychiatric medication is having an adverse effect upon her.
142.	She told me however that she was now "good" and that she had to be "good" or else "they" (psychiatry) would lock her up. She was "good" because she did not want to go "crazy" again.	The patient makes use of simple, immature and child-like language to emphasise her compliance with psychiatric treatment. The patient once again emphasises a crisis, but in a naïve child-like manner.
143.	I felt that this was quite passive-aggressive as knowing Mrs. S's history, I knew the contempt that she had for psychiatry.	The therapist hypothesised that the patient's compliance was rather passive-aggressive resistance in the context of her expressed contempt for psychiatric treatment.
144.	She did also provide an account of her dissociative experience. She stated that	The patient suggests an ability to dissociate in distressing situations. This

	she usually had the ability to withdraw herself into a "cocoon",	contrasts with the information provided to the psychiatric doctor.
145.	but this time had not been able to control the process.	The patient expresses an escalating inability to control her mental state.
146.	She described seeing a "it / thing" under my desk that was trying to speak or be allowed to speak. It was a beaten, skinless, unimaginable version of her that apparently represented all her hurt, pain, anger and rage.	The patient graphically and dramatically describes her dissociative experience. The description highlights the split in her mental state and creates a sense of urgency in healing the split. The description vividly, but vaguely depicts traumatic events.
147.	She felt that it was dying and wanted to know whether it should be allowed to speak.	The patient suggests urgency in addressing her trauma.
148.	She asked me whether she should confront this part of herself.	The patient asks for the therapist's advice and permission to confront the traumatic events.
149.	I informed her that I was not going to tell her what to do.	The therapist would not concede to the patient's request.
150.	This I believed because I did not think she could handle it, and she knew she couldn't. I also felt that she was trying to put the responsibility on someone else and that way she could have another person to blame.	The therapist hypothesised that the patient would put responsibility on other people to satisfy her masochistic tendencies. In this sense, the patient would believe she had no responsibility for the trauma she subjected herself to, and could oppose others on their malevolent treatment of her. .
151.	She first became angry and then later begged and pleaded that I tell her what to do – playing upon my humanity as a therapist.	The patient responds to the therapist's reluctance to comply initially with anger and then with pleading. The patient powerfully tries to manipulate the therapist into aiding her masochistic tendencies.
152.	She later added that she had really wanted someone to hold her hand and tell her everything would be fine (during her dissociative experience).	The patient suggests a paradoxical need for support during her dissociative experience. The patient had not tolerated any support.
153.	I highlighted for her the paradox that she would not have allowed this to happen.	The therapist highlights the paradox to the client.
154.	A few days later Mrs. S again tracked me down at the department complaining about an event that had happened in the ward.	The patient once again suggests an emergency and tries to coerce the therapist into transgressing the therapeutic boundaries by granting additional therapy.
155.	I informed her that I would see her at the scheduled appointment and could not see her now.	The therapist maintains the therapeutic boundaries and does not concede to seeing the patient.
156.	In the 11th session, Mrs. S again spoke solely about all her medical problems.	The patient responded in therapy by only introducing medical symptoms and complaints.

157.	I decided to discuss with her the concept of the appropriateness of her behaviour following the previous days event. I informed her that she could discuss her problems in the allocated session times.	The therapist decided to raise the topic of therapeutic boundaries and appropriate behaviour. The therapist was directive in explaining appropriate behaviour.
158.	Mrs. S got angry, stating that she only wanted advice, and that I was the person she trusted the most.	The patient responds with anger towards the therapist. She tries to enforce his exceptionality as justification for her behaviour.
159.	This escalated in the 12th session as she had began bashing her head again.	The patient also responded to the therapist's confrontation with self-mutilative and injurious behaviour.
160.	She stated that it was a reaction to her depressed mood following the last session. This was because I did not give any consideration to her feelings.	The patient claims that her self-injurious behaviour is in response to a depressed mood. The patient attempts to guilt the therapist by suggesting that he is responsible for her mood.
161.	She believed that I had told her that she could only have a crisis within our allotted therapy times each week.	The patient misinterprets the therapist's statements in order to enforce his responsibility. The patient attacks the therapist on his lack of sympathy for her.
162.	I then informed Mrs. S that I did not say that she could not be allowed to be in crisis, but only that she discusses the crisis with me during our sessions, and no other time.	The therapist elucidates his intentions and attempts to clear up the misconceptions.
163.	I added that if there was an emergency she could not cope with that psychiatry was available if necessary.	The therapist provides a practical example of how to cope with an emergency within the specific contextual environment.
164.	Throughout the 12th and 13th sessions, Mrs. S alluded to the reasons for her head bashing. However, I would (and often had to) avoid the topic until she was prepared to discuss it seriously.	The patient displays a tendency to be vague and not address issues sincerely. The therapist had adopted an approach to avoid topics unless they would be discussed sincerely.
165.	Mrs. S explained that she would actually bash her head in such a manner that she could inflict the most damage.	The patient describes her behaviour as intentionally self-mutilative and self-injurious.
166.	This behaviour was explained to be a way of temporarily stopping the unpleasant thoughts (or "flashes") and emotions that Mrs. S did not want to face. This concerned her guilt over her "murdered" child. The child had been a boy. She felt she needed to punish herself for this, but was also guilty that he had never received a proper burial.	The patient justifies her self-mutilative behaviour as being in response to her mental and emotional state. Her mental and emotional states are described as being caused by traumatic events that she subjected herself to, but was also a victim in.
167.	I began asking her what it would take for her to eventually forgive herself,	The therapist confronts the patient on the appropriateness of her coping

	considering she had been punishing herself for so many years.	mechanisms.
168.	I suggested that when she returns to Natal that she try bury something significant that she would have liked to have given him. She could say her goodbyes and apologies, and lay to rest much of the guilt and pain she had been carrying with her.	The therapist provides a specific and tangible example of addressing her emotional and mental state.
169.	Over the 11th to 13th sessions, Mrs. S also discussed her negative relationships towards men. She had friendships with women, but was avoidant of all men, including her husband. In fact, through much of the therapy it emerged that she had an incredible dislike and distrust of men.	The patient expresses a distinctive and pervasive dislike and distrust of men. This was a paradox in the therapy as the client had expressed a satisfaction with the therapist.
170.	I highlighted the paradox that I was in fact a male therapist, being that she reported to be comfortable around me.	The therapist highlights the paradox to the patient.
171.	She would justify this by stating that I was a professional and bound by rules, or that she chose to view me as an asexual being or feminine.	The patient justified herself by denying the therapist's personal traits.
172.	I challenged her into seeing me for what I was. I wanted to not only create a consistent therapeutic environment, but also believed that it would be beneficial if Mrs. S could learn to judge people by their behaviour and not her expectations.	The therapist believed that he could use his personal traits as a therapeutic tool in order to facilitate the client in developing more realistic and stable interpersonal relationships.
173.	In the 13th session, Mrs. S related how in an argument she had told Mr. S about the aborted child. She was surprised by his reaction, which was contrary to what she expected. He did not leave and abandon her, and actually listened and cried with her.	The patient reported an event in which her misconceptions had been challenged. This appeared to suggest that the therapeutic relationship was influencing the patient and facilitating change.
174.	In the 14th session I informed Mrs. S that I would be taking 2 weeks leave in a little over 2 weeks.	The therapist informs the patient in advance of the details of a scheduled break in the therapy.
175.	In this session, she informed me that she had thought carefully about what I had said in the previous session. I had asked her "what is it going to take for you to forgive yourself?"	The patient suggests a link to a previous session and statements by the therapist. The therapeutic relationship appears to have been impacting upon the patient.
176.	She stated that she had begun looking at the positives in her actions – that she had protected M and Y from X and had needed to be strong in order to do this. She stated that she needs to start putting	The patient appears to have been internalising the therapist's interpretations. The patient reports to have chosen a more positive and health oriented approach to her condition and

	herself and her health first, and that some good can be seen to have come out of her traumatic experiences.	mental state.
177.	Mrs. S informed me in the 16th session that she had informed Y about her biological father X.	The patient displays a rapid transition towards addressing family problems.
178.	She had also alluded to the fact that I told her to do so – which I had not. However, I questioned for myself as to whether this had more to do with her needs and fears of dying.	The patient claims that she is acting according to the therapist's wishes. This suggests that the patient is assigning responsibility for any possible consequences towards the therapist. The patient under the guise of therapeutic progress tends to introduce the urgency of her condition once more.
179.	For sessions 14 to 17 Mrs. S spoke increasingly of her medical condition. It appeared to be escalating, and though she had spoken fatalistically in the past, she appeared to do so more often.	The patient once again stresses the urgency of her medical condition. The severity of the sick-role of the patient however appears to escalate.
180.	Issues of death were constantly discussed and how these related to her children and her family.	The patient emphasised that the urgency of her condition impacted upon all aspects of her family relationships.
181.	I also noted typical interactional patterns within her family of people wanting to be close to others, but pushing others away.	The therapist noted typical interactional patterns in the patient's family that represented a paradox between members desiring close and supportive contact, while distancing themselves from close contact.
182.	She returned to vague recollections of her traumas in the past, and constantly made statements like "you won't believe how many times I've been raped" – apparently referring to her relationship with X.	The patient returned to a pattern of suggesting the significance of traumatic experiences, but only vaguely discussing them.
183.	I began to start querying possible PTSD-like symptoms.	The therapist hypothesised that the patient also displayed PTSD symptoms.
184.	It seemed as if the psychiatrists were also considering this diagnosis at certain stages.	The psychiatrists also appeared to consider a PTSD diagnosis at stages.
185.	She further believed that she was getting cancer over and above her immune deficiency, and was introducing more and more medical complications.	The patient began to introduce increasing and varied medical problems and complications into therapy. The medical symptoms were increasing in severity and urgency.
186.	She spoke more and more that a bone marrow transplant was the only solution to her immune deficiency.	The patient emphasised that an expensive and hazardous procedure was her only solution for health and well-being.
187.	She would get angry that the doctors did not seem to consider this an option.	The patient attacked the competence of the medical professionals for not

		considering the procedure.
188.	Even though it was an expensive procedure,	The procedure involved extensive costs.
189.	she believed it reflected more that they were treating her as a "number" and not a person.	The patient further attacked the humanity of the doctors for not considering the procedure.
190.	She often would ask me whether I would go to visit her if she was sent for such a procedure, as she would most probably die.	The patient tried to impress the urgency of her condition upon the therapist. The patient also appears to suggest the exceptionality of the therapist.
191.	In supervision, my supervisor suggested that she needed to know whether she was important to me. I agreed with this interpretation,	The therapist appears to have been aware that the patient was idealising him. The patient was also manoeuvring for confirmation from the therapist that she was significant to him.
192.	but was still struck by the fact that she had been "dying" for so many years already.	The therapist however believes that the patient's behaviour is excessively exaggerated and dramatic.
193.	It also followed in these sessions that Mrs. S commented excessively on my unique ability to help others. She referred to this as my "capacity to love that is beyond [myself]".	The patient excessively idealises the therapist.
194.	I initially tried to downplay her flattery	The therapist attempted to divert the idealisation towards more therapeutic goals.
195.	as it admittedly made me uncomfortable.	The patient's manner of praise did however have the ability to evoke feelings of uneasiness in the therapist.
196.	Mrs. S would often note my uneasiness, which I had thought I covered quite well.	The patient demonstrates a good ability to recognise interpersonal processes.
197.	However, due to her perception of my uneasiness I later decided to reflect on this positively. I enforced that she was very perceptive and had a good ability to read process.	The therapist uses the patient's behaviour by making it overt and reframes it in a positive manner.
198.	I asked and wondered why she used this ability to promote sickness rather than health.	The therapist then adopts the reframe to strategically confront the patient on her interactional patterns. He uses the behaviour to accentuate the patient's role in controlling her sick-role. The paradox is that the patient's ability serves to actually maintain her interpersonal difficulties and sick-role.
199.	I commented at stages that Mrs. S was extremely proficient in justifying how she feels, without ever actually having to disclose her true emotions. I would typically suggest an emotion to which	The patient displayed an excellent ability to keep others at an emotional distance. She managed to justify her behaviour as being due to her emotional state. Her emotional state was justified

	she would confirm or deny.	as being due to her illness. The therapist appeared to have to adopt the role of integrating the patient's emotional states with her behaviour.
200.	On a whole therapy at this stage felt stuck in a pattern of circularity. The same problems were discussed over and again.	The therapist felt once again that therapy was not making progress. The patient did not seem to exhibit any change in behaviour or focus.
201.	I did however feel more comfortable in the process with the limits I had imposed upon the therapy.	The therapist however felt more comfortable in his role with the boundaries he had strengthened and established in the therapy.
202.	The day following the 17th session – in the week before my scheduled leave – I received a phone call from Mr. S. He was quite distraught, informing me that Mrs. S had been forcibly admitted to psychiatry the night before.	The patient introduces another crisis that appears to be well timed with a scheduled break in therapy.
203.	Mr. S felt that psychiatry did not fully understand his wife.	The patient's husband appears to consider the psychiatric department as incompetent.
204.	I told him that I would follow it up.	The therapist responded to the crisis, but without violating the boundaries of the therapy.
205.	Dr. B had admitted Mrs. S to the psychiatric ward as Dr. A was on leave.	The patient's psychiatric symptoms appear to be escalating, as she required admission to the psychiatric ward.
206.	He informed me that Mrs. S had come down to psychiatry the previous afternoon highly anxious and panicking, dissociating and displaying psychomotor slowing. She was asking for help, relating the various problems with her health, and threatening suicide.	The patient creates a sense of urgency that necessitates the involvement of another doctor at the psychiatry department. The patient was paradoxically asking for help, but refusing help, as she required a forceful admission. The patient exhibited behaviour that would necessitate her admission, even if it was against her wishes. The patient displayed depressive, dissociative, and anxious symptoms.
207.	Dr. B felt compelled to admit her even though she resisted as he felt extremely convinced that the suicide threats were serious and well thought through.	The doctor was convinced of the seriousness of the patient's symptoms.
208.	I informed him that I was not going to see Mrs. S until our scheduled appointment and explained the structured goals for my therapy.	The therapist informed the doctor of his structured goals for therapy and that he would not respond to manipulative behaviour or attempts to transgress therapeutic boundaries.
209.	We compared the background history of Mrs. S, our clinical impressions, and the	The therapist and the doctor compared the case history and clinical

	query about possible self-infliction.	impressions. This shows a more collaborative approach to treatment between psychiatry and psychology than previously existed. The therapist introduces the possible factitious component of the clinical picture.
210.	A day later I was informed that the psychiatric panel was considering a diagnosis of Munchausen.	The psychiatric department began considering the spectrum of factitious disorders, including Munchausen syndrome.
211.	However, they were also considering a diagnosis of Munchausen syndrome by proxy for Y. Mrs. S had apparently related to Dr. B and the psychiatric panel that her daughter, Y, also has a lot of medical complications.	The department of psychiatry were additionally concerned about a diagnosis of Munchausen syndrome by proxy. The patient seemed to have wanted to highlight the genetic nature of her disorder.
212.	I was told that social work would be following this up.	The department of social work became involved in the case.
213.	It was generally felt that Mrs. S would be better handled within the psychiatric ward.	The psychiatric department believed that the patient would be treated more effectively in the psychiatric ward. This suggests the seriousness of her psychiatric symptoms and the inability of the medical ward to manage these symptoms.
214.	In our 18th session, Mrs. S was more animated, and in a better and apparently more stable mood.	The patient apparently responded well, but very rapidly to the psychiatric management.
215.	I was however suspicious that she was too compliant and appropriate.	The therapist was perturbed by the patient's sudden change in behaviour. This suggests that he suspected the patient's compliance to be manipulative.
216.	She stated that she was happy to be in psychiatry as she felt that she needed to "crack up" in order for the pieces to be put back together properly.	The patient provides a metaphorical, graphic and dramatic explanation for her eagerness to comply with psychiatric treatment.
217.	Her account for the previous few days' occurrences correlated well with what I already knew.	The patient provides the therapist with accurate information that correlates with what he knows. The therapist appears sensitive to any possible manipulative behaviour of the patient.
218.	She informed me that the precipitating factors for her breakdown had begun a few days before our previous session. She felt that she was trying too hard to be in control.	The patient suggests that her emotional and mental state is beyond her control. She suggests covertly that psychotherapy has precipitated the latest events.
219.	Following the 17th session, the medical doctors had apparently informed her that there was nothing wrong with her.	She overtly links the mental and emotional state to being caused by the medical doctors. The doctors believed that there was no diagnosable cause for

		her illness.
220.	This was too much for her to take, and we considered that it was because her identity - that she had held for so long - had been taken away from her.	The doctors had in proclaiming her health only succeeded in taking away an important identity of the patient: her sick-role.
221.	She had gone down to psychiatry looking for Dr. A.	The patient appeared to have sought help that would have resulted in further diagnosis.
222.	She explained that she began to see X everywhere, plants took on strange forms and apparently wanted to get her, and the walls began to ripple.	The patient describes symptoms of visual hallucinations and paranoia.
223.	She also stated that she had begun to get serious thoughts about killing herself.	The patient appears to want to emphasise the seriousness of her condition. The information is contradictory to what the patient has previously told the therapist.
224.	She asked about the appropriateness of going to psychiatry in this mental state and seemed pleased that she was learning the correct ways of responding to crisis.	The patient queried the therapist on changes in her behaviour. She apparently wanted to impress him.
225.	I agreed that it was more appropriate and even beneficial.	The therapist decided to reinforce positive changes in behaviour – regardless of motivation.
226.	With my leave pending, I was interested in and discussed with Mrs. S the circularity of problems that presented themselves. We kept seemingly addressing the same issues over and again with seemingly little progression or change.	The therapist confronted the patient on the apparent lack of progress and change within therapy.
227.	I began to question her about her identity. With these "sick" labels that she had, what would remain if they were removed?	The therapist displayed an interest in the sick-role of the patient. The patient identified with this label and it would not be possible to merely remove it.
228.	Mr. S by this stage had been referred to another psychologist for his own individual therapy.	The patient's husband was eventually involved in his own individual psychotherapy.
229.	I went on two weeks leave.	There was a significant break in the therapy with the patient.
230.	Upon returning from leave, Dr. B brought me up to speed on what had been occurring in my absence.	Interdisciplinary communication continued between psychiatry and psychology.
231.	He informed me that the medical doctors were at least 99% sure that Mrs. S did not have an immune deficiency.	The psychiatrists had confirmed with the medical doctors and were virtually convinced that the patient did not have the medical problems that she claimed.
232.	They would be doing some final tests to confirm this, but this itself did not rule	The medical doctors still were in the process of confirming the lack of the

	out the possibility that she could contaminate the results.	rare disease. The results however could no be conclusive as there was still a possibility for the patient to contaminate the tests.
233.	The consensus from the psychiatric panel was that Mrs. B did have some form of factitious disorder.	The psychiatric ward was in consensus that the patient had some form of factitious disorder.
234.	The working diagnoses were those of a factitious disorder, a major depressive disorder and a borderline personality disorder.	The working psychiatric diagnoses were a factitious disorder, a major depressive disorder and a borderline personality disorder.
235.	Dr. B informed me that the general consensus was that Mrs. S knew more about microbiology than would be expected of someone who had not studied medicine.	The patient reportedly understood more about the medical terminology and conditions surrounding her supposed illness than would be expected of the general public.
236.	The diagnosis of factitious disorder was also difficult to make without an admission. In a discussion with another psychiatrist, he told me that this is the reason why factitious disorders are "often a diagnosis of exclusion". Every other possibility as a cause for an illness needs to be ruled out.	The diagnosis of factitious disorders is difficult to make without proof or admissions. Without these confirmations, all other possible causes for an illness need to first be excluded.
237.	This was also complicated by the fact that at this stage, Mrs. S did have real medical complications.	Factitious behaviour can eventually cause real damage and illness to the patient that is difficult to distinguish from the factitious illness.
238.	Dr. B had chosen to ignore Mrs. S's physical symptoms and focus on her sick role and eventually confront the issue of self-infliction.	The psychiatrists had also chosen to focus on the sick-role of the patient rather than her physical symptoms. They did however express a desire to confront her on the query of self-infliction in order to confirm the diagnosis.
239.	For the 19th session, I decided to allow Mrs. S to explain the events of the past few weeks to me without knowledge of what I knew.	The therapist again wanted to test the patient for manipulative behaviour.
240.	Her medical and physical symptoms strongly predominated the picture once more.	The patient once again introduced only physical symptoms into the therapy.
241.	She was playing the various disciplines against one another, and exaggerating their perspectives. She told me that the medical doctors had told her that her problems were only medical, while the psychiatrists were telling her that all her problems were in her head.	The patient split the involved disciplines and members of the multidisciplinary team. She would exaggerate the information that was given to her.

242.	Dr. B was constantly derogatively referred to as an "it", "thing" or "just like my father".	The patient was extremely derogatory towards her doctor at psychiatry, devaluing him.
243.	For the 19th and 20th sessions there were consistent patterns of inconsistencies and of Mrs. S putting one discipline against the other.	The patient consistently split the various disciplines. The therapist monitored this by noting the inconsistencies that the patient introduced in therapy.
244.	In the sessions, she would try to ally me against the other disciplines; while the feedback I received was that she would be incredibly angry with me. At one stage she referred to me as "now part of that whole health care profession" (i.e. the psychiatric panel) and therefore also the enemy.	The patient split the therapist along with the other members and disciplines of the multidisciplinary team. The patient would idealise the therapist in therapy and devalue him outside of therapy. This behaviour was monitored through communication between the various members of the multidisciplinary team.
245.	She also complained that we were making no progress.	The patient also devalued the therapist within therapy, assigning blame and implying his incompetence.
246.	I told her that I could only work with what she brings to me.	The therapist attempted to revert responsibility back to the patient.
247.	Mrs. S would constantly refer to herself as a "bad" person in a very child-like manner,	The patient again behaved and spoke in a childish manner. She suggested that she was inherently bad. The patient split herself as all bad. The paradox was that she assumed responsibility for things that were not realistic.
248.	or that other people (often Dr. B) made her feel bad.	The patient also implied that other people were responsible for her emotional state and feelings of badness. The paradox was that she was both responsible for her badness and a victim of other people's maliciousness.
249.	I chose not to challenge her directly, but to rather highlight the incongruencies as they presented themselves, and focus of therapy on her - her own thoughts, feelings and reactions - without making value statements about others.	The therapist preferred to focus on the patient's interactional styles and mental and emotional state. He chose not to confront the patient's behaviour directly, but rather by highlighting incongruencies.
250.	I felt that it was necessary to bring the focus back to her, on her role in her sickness, and not on everyone else who persecutes her.	He felt that the patient always diverted the focus to others and wanted to bring the focus back to the patient.
251.	Mrs. S would complain that Dr. B only saw her as a textbook of symptoms and never a person.	The patient complained that the psychiatrists treated her as an object with symptoms, and not an individual.
252.	I challenged her by saying that she only ever showed people the textbook symptoms.	The therapist confronted the patient by highlighting the paradox that she would complain about not being treated as an individual, but would distance herself from people with her symptoms.

253.	She then defended that she would do that in order to protect herself.	The patient defended herself by suggesting the maliciousness and deceitfulness of others.
254.	In the 20th session Mrs. S was furious at the psychiatrists arguing that they had been accusing her of inflicting injuries upon herself and also on her children, and that they would be involving social work. She was very derogatory, attacking their competence, and blaming them for her emotional state.	The patient displayed very aggressive reactions to being confronted on her factitious behaviour. She attacked the competence of the psychiatrists and assigned blame to them for her emotional state.
255.	She went on to say that they were diagnosing her with "Munchausen… or something like that. Not that I was paying attention".	The patient displayed an awareness of the diagnosis of Munchausen syndrome.
256.	It was later confirmed that no one (either myself or the psychiatrists) had ever mentioned a label of Munchausen to Mrs. S.	The patient displays an awareness of the diagnosis that extends beyond the feedback given to her by the multidisciplinary team.
257.	I addressed the fact that if she denied it to me I would accept her answer at face value. For me it was not really an issue whether she admitted it or not or whether it was a correct diagnosis or not.	The therapist did not have the aim of confirming the diagnosis and could therefore accept and allow the patient to deny the behaviour.
258.	I wanted to focus on her behaviour and interactional styles.	The therapist wanted to focus on the patient's behaviour and interactional styles.
259.	I did however highlight the inconsistency without either attacking or accusing her that she was admittedly capable of self-inflicting harm, and that she often admitted to not complying with medical treatment.	Through the acceptance of the patient's statements at face value, the therapist was able to focus on the patient's inconsistencies without being either excessively confrontational or accusatory. The inconsistency was that the patient was admittedly capable of the behaviour she denied.
260.	I asked her as to what she was doing to prove or show her "innocence" if she really was innocent – trying to bring the focus back to her.	The therapist returned the focus to the patient's own responsibility and accountability in her situation.
261.	I followed on the textbook metaphor and stated that the way she approaches "health" or "getting better", whether it is physically or psychologically, was always one of exclusion. She would have to rule out every possible illness to be healthy, and as such, there was always something new that was making her ill.	The therapist used the patient's metaphors and the clinical features of factitious disorders metaphorically in order to address the patient's behaviour and sick-role. The patient paradoxically appears to approach issues of health by excluding illness. This maintains her illness.

262.	I asked her how long it would take to eventually go through every medical and psychiatric illness.	The therapist confronts the patient with the paradox.
263.	By this stage I was thinking that Mrs. S not only has a wealth of physical problems, she also tends to exhibit a wide range of psychiatric symptoms. I had thought back to Munchausen being a diagnosis of "exclusion". For me it was interesting that Mrs. S's behavioural styles tended to mirror the disorder.	The therapist believed that the patient exhibited as wide a range of psychiatric symptoms as she did of medical symptoms. The diagnosis of Munchausen syndrome was useful to the therapist because it appeared to parallel and predict the patient's paradoxical behaviour.
264.	It was therefore a useful metaphor to use in therapy without accusing Mrs. S of Munchausen. I could focus on the behaviour and not the label.	The therapist developed a way of using the diagnosis metaphorically, with the aim to focus on the behaviour of the patient without labelling the patient. This approach enabled the therapist to address the behaviour without accusing the patient.
265.	I also believed that Mrs. S was more knowledgeable and well read than she let on. This hypothesis being due to her apparent slip about her "Munchausen" diagnosis in therapy.	The therapist believed that the patient knew more about diagnostic criteria for psychiatric disorders than would be expected of the general public. It was also paradoxically too accurate.
266.	The 21st and 22nd therapies showed a dramatic shift in Mrs. S's behaviour. She once again became excessively compliant.	Following both overt and covert confrontation, the patient again appears to shift her behaviour to the extreme of excessive compliance.
267.	She came with a list of goals for the future as Dr. B had suggested she rather focus on future goals and behaviour changes rather than her past.	The patient responds to the psychiatrist's aims and treatment.
268.	She referred to Dr. B as "bug", being playful, but still derogatory.	Even though the patient's language reflects her shift in behaviour, she remains derogatory to the psychiatric doctor. This suggests that splitting behaviour is still evident. The patient paradoxically admits to this, but also justifies it.
269.	The means for achieving the goals were also rather superficial and not thought through.	The patient's shift in behaviour did not appear to be persuasive or sincere.
270.	Mrs. S appeared to be able to predict the topics that I had wanted to focus on, such as her attitude towards her own health, and the health care professionals in general.	The patient displayed her ability to read and monitor interactional processes. The patient appeared aware of many of the treatment goals.
271.	She spoke of a change towards a more positive attitude. I was not convinced. I suggested that she is very perceptive and wondered how she was using this	The therapist is not convinced by the patients' sudden change in behaviour. He did not believe that it was genuine. He believed that it was merely the

	ability. I suggested that she was only telling us what she thought we wanted to hear from her.	patient's use of her abilities to manipulate the multidisciplinary team.
272.	I believed that she was "bullshitting" us to get what she wants.	The therapist confronted the patient on her manipulative behaviour.
273.	She agreed, but stated that at least it was "playful" and therefore we could put up with her because she was not so malicious.	The patient paradoxically conceded to this, but then justified it.
274.	She stated that she was being "good" so that she would be allowed to leave.	The patient expressed her desire to remove herself from the healthcare environment.
275.	The approach seemed to be that if she makes others around her "happy", that this would be the solution to her health.	The patient appeared to believe that other people were responsible for her mental and emotional states.
276.	In the 22nd session, Mrs. S was pleased that she had finally been given a diagnosis: that of borderline personality disorder. It appeared as though she had insisted upon one.	The patient would insist upon being given a diagnosis, and was pleased when she received one.
277.	To her it fit, but not quite.	The patient however paradoxically finds fault with the very diagnoses that she desires.
278.	She approached me on my opinion of the diagnosis, suggesting that I was the expert and should know.	The patient requested a diagnosis from the therapist. The patient appeared to also attack the therapist's competence as she had already shown that she would find fault with the diagnosis she requested.
279.	I did not offer my opinion,	The therapist did not offer a diagnosis.
280.	and she soon followed by disagreeing with various criteria.	The patient continued to find fault with her diagnosis's criteria.
281.	On further discussing her need for diagnosis, she went on to state that if she heard "I don't know" one more time she was going to explode. She was frustrated at not getting answers to her condition.	The therapist chose rather to focus on the patient's need for a diagnostic label. The patient was frustrated that she was not being given answers and diagnoses and alluded to the incompetence of the healthcare professionals.
282.	I challenged her by stating that she was constantly being given answers, but they were just not good enough or the answers she wanted to hear.	The therapist confronted the patient by highlighting that she was in fact receiving answers and diagnoses. The therapist interpreted that the diagnoses only did not meet with the satisfaction of the patient. This suggests that the patient in some sense knew what type of diagnosis she wanted.
283.	I asked her what it was that she actually wants.	The therapist confronted the patient on what she expected from the healthcare professionals.

284.	She began to vaguely ramble on about why she is "bad" and "deserves to be punished".	The patient responded with vague answers that alluded to her badness. The patient suggested that she deserved punishment because she was inherently bad.
285.	Her illness and treatment appeared to be part of her punishment she deserves.	The patient perceived her illness and subsequent treatment by healthcare professionals as the punishment that she believed that she deserved.
286.	The 23rd session followed on a weekend where Mrs. S had gone back to Natal for her daughter's birthday.	The patient had interacted with her immediate family once again.
287.	For this session and a few others, Mrs. S carried around a stuffed toy tiger with her.	The patient began to display excessively child-like behaviour.
288.	When enquired about her weekend, she replied that it was "yucky". Her language for much of the 23rd to 25th sessions was very child-like once again, and even more so than before.	The patient's language was also excessively child-like and more pronounced than before.
289.	She spoke of how overwhelming and over involved her mother was in her life, her children's lives, and even interfering with and imposing on her relationship with Mr. S.	The patient's mother was described as over involved and domineering.
290.	She decided that she really did need help from psychology and psychiatry, as she needed to know how to get away from her parents.	The patient had suggested that she genuinely wanted to begin to comply with her psychological and psychiatric treatment. The patient stressed her need to be helped. The patient viewed avoidance as the only solution to her family problems.
291.	She believed that her parents were making her sick.	The patient believed that her parents were responsible for and maintained her illness.
292.	Her mother was over involved and would not allow her to get well.	It was alluded to that the over involvement of the patient's mother prevented her from getting well.
293.	Her father would oscillate between being excessively involved with his girlfriend and abnormally involved with Mrs. S's mother. His absence and availability would correspondingly vary.	The patient's father was described as frustrating the patient's needs for intimacy. He would oscillate between extremes of involvement in the patient's life and abandoning her.
294.	She told me how her sister was anorexic, had taken an overdose, and was "dying".	The patient's sister was described as suffering from a physically related psychological disorder: anorexia. The patient believed that the severity of the disorder and associated behaviours would result in death.

295.	Her parents had tried to keep this from her.	The patient's family displayed a pattern of promoting secrecy and an inability to address crisis.
296.	Mrs. S began talking about the link that both her and her sister had physical illnesses, and that the cause in both cases was their childhood and upbringing.	The patient believed that the physical illnesses and symptoms of both her and her sister were caused by their childhood and upbringing.
297.	She believed that the only solution was to get away from them.	The patient believed that the only solution to her health was to avoid contact with her family.
298.	In the 23rd to 25th sessions, Mrs. S began referring to an event from childhood that supported her belief that she was born "bad".	The patient however then began to promote her belief that she was inherently bad.
299.	She told me she had to talk about this "thing" as she did not want to "bullshit" in therapy any more.	The patient suggested that she wanted to genuinely work in therapy. The patient linked to and showed attentiveness to previous interactions with the therapist.
300.	This was the time at age 14 when she had disobeyed her parents. She was very vague in explaining or justifying the story or her beliefs. The "thing" or event was however only really spoken about vaguely, with Mrs. S strongly trying to convince me that she was a "bad" person.	The patient justified her belief in her inherent badness by providing an example of an event from childhood. The event could be linked to the time of her parent's divorce and preceding her psychiatric breakdown. The patient was however extremely vague.
301.	In the session she spoke vaguely about going with a friend to a party that she was not supposed to, and doing things that she was not supposed to.	The patient vaguely described events of teenage rebellion.
302.	She stated that the reason she hurts herself was in order to punish herself.	The patient linked her self-mutilative behaviour to need to punish herself due to her inherent badness.
303.	I asked whether this was because she didn't get punished for her transgressions, or whether it was because the alternative (not to punish herself) would be worse.	Due to the patient's vagueness the therapist questioned her directly as to whether she punished herself merely because she believed that she deserved it, or whether she believed that if she did not then something worse would happen.
304.	She appeared to confirm the latter,	The patient appeared to indicate that she believed that it would be dangerous not to punish herself. The patient appeared to feel compelled to self-mutilative behaviour.
305.	so I asked what could be worse than swallowing razor blades?	The therapist attempted to strategically confront the patient on her compulsions to self-mutilative behaviour by suggesting that they were far too severe.

306.	Mrs. S began to dissociate again.	The patient began to dissociate in response.
307.	However, this time I left her, and waited.	The therapist allowed the patient the freedom to experience and work through her dissociative experience. This suggests that the therapist believed that the patient retained some level of control over her dissociative behaviour.
308.	She later described the experience to me, stating that this time she forced herself "to come back".	The patient later explained to the therapist that she was able to gain some control over the dissociative experience. She described an awareness of the experience.
309.	I acknowledged that this must have been difficult and reinforced the change.	The therapist positively reinforced the change in behaviour and the patient's ability to control her behaviour.
310.	She described herself as existing in 3 parts: herself at age 5, at age 14 and at present. Upon exploring each age, she was unsure about the significance of herself at age 5, but felt that her at age 14 needed her forgiveness.	The patient describes her dissociate experience as representing split off parts of her personality. The patient suggests the fact that she is the person that needs to forgive herself.
311.	The full description of the event at 14 had only reached the following details by the end of the 25th session: She had gone to the party with her friend; against her parents wishes and/or behind their backs; had two drinks; suspects the drinks were spiked with something; felt ill and tired; went to go lie down on a bed.	When the patient describes significant events in her life, she maintains a style of vagueness. The therapist had to gradually put all the pieces of information together.
312.	She would try to emphasise her badness as being due to her naivety, the fact that she knew who's bed it was, and the fact that she was "obviously asking for it".	The patient would insist on her inherent badness and was self-deprecating.
313.	I hypothesised that she had possibly been raped.	Due to the vague information the therapist had to hypothesise about the trauma. The therapist hypothesised that the patient had been raped.
314.	In the 24th session, I discussed with Mrs. S the final date for termination of our therapy.	The therapist discusses termination with the patient in advance.
315.	It was to coincide with the day before she would be returning to Natal after being discharged from the hospital.	Therapy was to be terminated as the patient was concluding her stay in the hospital.
316.	Following this session, Mrs. S was also being discharged from the psychiatric ward.	The patient was discharged from the psychiatric ward.
317.	Before the 25th session, I was informed that Mrs. S was back in the medical	The patient was however soon readmitted to the medical ward due to

	ward after having developed a DVT (deep vein thrombosis).	an additional medical complication.
318.	Questions about the timing of this event were raised. Even though it was not something that could be induced actively, it could have occurred due to non-compliance with medication.	The psychiatric ward and the therapist believed that the event occurred too timely to be coincidental. It was confirmed that non-compliance with medication could have precipitated the medical complication.
319.	When I saw Mrs. S for the 25th session, she snidely remarked that psychiatry probably would accuse her of inducing the DVT herself.	The patient displayed an awareness of the multidisciplinary teams suspicions.
320.	I raised the issue of non-compliance with medication,	The therapist confronted the patient on her admitted ability to not comply with her medical treatment.
321.	to which she replied that she often did not comply with treatment, but always would tell the doctors when she was.	The patient admitted to this but denied it with a justification. This, and the further explanation that she preferred it to be known that she did not comply with her treatment, highlighted the paradoxes in her behaviour. The patient suggested that she wants to get well but sabotages treatment. It suggests an overt challenge to the healthcare professionals.
322.	She also spoke about another medical problem she was having. She was "becoming a cow": she was lactating. She stated that both she and the doctors believed this problem was possibly psychological.	The patient then also paradoxically introduced an unrelated physical symptom that she would concede to being psychological. The patient used metaphorical phrases.
323.	However, she was never entirely serious in discussing this topic, so it was never explored. I suggested we talk about something more pertinent.	The patient was admittedly not serious about the symptoms and the therapist did not respond.
324.	While discussing the childhood event, Mrs. S would describe her badness as infectious to others. She justified why she and her family "do not talk about it". She believed her parents probably saw themselves as failures, and she believed that this was because she was inherently bad ("born bad").	The patient describes her inherent badness as being able to affect those around her. She paradoxically takes on responsibility for her parent's faults when previously she blamed them. The patient again introduces the family pattern of secrecy and the inability to address crisis.
325.	She believed that she would infect me as well if she spoke about these events.	The patient appeared to have an overvalued idea that she could have an affect people's personalities. This was more than would commonly be expected.
326.	I reframed the notion of infection as a gift. I told her that I believed that what	The therapist reframed the patient's erroneous beliefs.

	she would tell people, and myself, was like a gift and not an infection. In this sense it was something she chose to give/tell, what she chose to give/tell was unique to each person, but how each person reacted to the gift/message was out of her control.	
327.	I believed this covered number of issues that I wanted to address. She should only take responsibility for those actions and behaviours that are in her control. She should be able to identify her individuality and responsibility as apart from others. That certain behaviours, actions and reactions of others are beyond her control.	The reframe addressed the issues of free choice over actions and behaviour, responsibility for behaviour that is realistic, and the distinction between individual responsibility and interpersonal responsibility. It also addressed the patient's apparent inability to individuate – the inability to draw realistic distinctions between herself and others.
328.	The day following the 25th session I was contacted by Mr. S who informed me that the previous night Mrs. S had tried to commit suicide in the bathroom by cutting her wrists with a broken mirror.	The patient was involved in further self-mutilating and injurious behaviour. The intensity had escalated.
329.	He was slightly distressed, but overall quite calm, stating that he only wanted to keep me informed. He described them as "little cuts" and believed the whole event to be quite manipulative.	The patient's husband displayed frustration and a belief that the patient's behaviour was manipulative.
330.	She was apparently starting to cut herself when he entered the bathroom.	The crisis event was apparently well timed.
331.	I was frustrated and angry at the escalating behaviour,	The patient's escalating self-mutilative behaviour frustrated the therapist.
332.	but decided to stick to the limits that I had set. I was not going to see her until the next scheduled session.	The therapist decided to vehemently maintain the limits and boundaries that he had set for the therapy.
333.	I informed Dr. B.	The therapist maintained the interdisciplinary communication.
334.	Dr. B also did not want to respond, having already terminated with Mrs. S.	The doctor at psychiatry also displayed a resolution to maintaining therapeutic boundaries. It seems as though he was also frustrated by the patient's manipulative behaviour.
335.	Dr. C was therefore requested to go and evaluate Mrs. S for the seriousness of the suicide attempt.	However, as hospital procedures needed to be adhered to, another doctor at the psychiatric ward became involved. The patient's behaviour appears to force a response from healthcare professionals.
336.	Mrs. S was then briefly admitted back to the psychiatric ward, as the general medical ward did not want to care for her.	The patient was difficult to manage by the medical staff. Psychiatric management was once again indicated.

337.	She remained briefly and was monitored by another psychiatrist, Dr. D, because Dr. C did also not want to see her further.	An additional psychiatrist became involved with the patient due to interpersonal difficulties.
338.	Dr. C had been of the impression that Mrs. S was rather low functioning – not having ever interacted with her before. The rest of the psychiatric panel disagreed with him	The patient was capable of presenting a differing psychiatric picture to another interdisciplinary member. The initial response of newly involved members tended towards disagreement between interdisciplinary team members.
339.	stating that Mrs. S was actually of above average intelligence. I agreed with this,	There was relatively consensual agreement that the patient had an above average intelligence.
340.	and was at this stage realising that Mrs. S was able to argue almost any aspect of her physical or psychological well being.	The therapist noted the patient's ability to present an exceptional range of physical, psychiatric and psychological symptoms. This ability was apparently intentional.
341.	When I saw Mrs. S for the 26th session, she was once again in the psychiatric ward.	The patient was once again receiving psychiatric treatment.
342.	Her wrists were bandaged after having been stitched up and her forearms displayed numerous scratches.	The patient's self-mutilative behaviour was visible.
343.	I directly addressed the issue of the suicide attempt.	The therapist overtly confronted the patient's excessive manipulative and self-mutilative behaviour.
344.	She explained that she did not want to kill herself. She wanted to maim herself by cutting her tendons and scratching off her skin.	The patient suggested a compulsion to mutilate herself.
345.	She claimed that she was distraught because Mr. S wanted to leave her and divorce her if she did not get well.	The patient blamed her mental and emotional state on events that she believed were beyond her control.
346.	She was suggesting a great deal of urgency in needing to resolve all her issues before it was too late – time was running out.	The patient tried to accentuate the urgency of her condition.
347.	I confronted her that if she really wanted to save her marriage, that she was going about it entirely counterproductively.	The therapist overtly confronts the patient on her counterproductive behaviour. He highlighted the paradox that if she really wanted to resolve her crisis, that she engaged in counterproductive behaviour that served to maintain them.
348.	I also added that she was running the serious risk of one day accidentally succeeding in killing herself.	The therapist confronted the patient on the dangers of her self-mutilative behaviour.
349.	She stated that this would never happen, as she knew what she was doing.	The patient justified this by implying her superior intelligence.

350.	I strengthened the point that I believed that Mrs. S was actually very intelligent.	The therapist overtly agreed with his belief that the patient had an above average intelligence.
351.	She acknowledged this and was content with the compliment.	The patient showed satisfaction with compliments and admiration of her abilities.
352.	I then confronted Mrs. S on her intelligence. I highlighted the fact that no matter what others or myself stated, suggested or interpreted, Mrs. S would always argue the point counter-productively.	The therapist made use of the compliments to strategically confront the patient on her paradoxical behaviour. She wanted help, but would not allow herself to be helped.
353.	I suggested that she actually uses her intelligence to 'infect' therapy and 'prevent well-ness'. She consistently complained of the ever-present feelings of "badness", and the impulses to hurt, harm and punish herself as excuses for her behaviour.	The patient would actively sabotage treatment and her health. She would provide counterproductive arguments and behaviour towards those attempting to help her. The patient would use her illness or impulses, emotional and mental state as an excuse for her behaviour.
354.	I asked why in that case she chose not to use her strengths and intelligence to control these impulses rather than using them to counter everyone's attempts to help her.	The therapist challenged the patient to make use of her intelligence and abilities constructively and towards the benefit of her health.
355.	She began arguing this point using the phrases of "clever" and "stupid" whenever it suited the counter-productive argument. She stated that I did not understand the severity of her situation.	The patient responded by cunningly arguing with the therapist's interpretation, suggesting that he did not understand. The patient again referred to the therapist's incompetence to help her.
356.	I merely stated that she was again using her strong intellectual abilities, and that I could never succeed in challenging them, so I was going to give up. I told her that I accepted the fact that she could and would always outsmart me.	The therapist conceded to the patient's challenge to his competence. He strategically confronted her that he would be ceasing in his attempts to help her. He stated that he was unable to help, so would no longer attempt to. This may be interpreted as a paradoxical intervention, but was also a congruent response. The therapist was frustrated at attempting to help the patient.
357.	Mrs. S then tried to again create a sense of urgency that she still needed to tell me about the events at age 14, but couldn't.	The patient once again addressed the urgency of confronting her traumatic event but stated in contradiction that she was unable to.
358.	I told her that I already knew what had happened (I believed she had been raped) and she did not need to tell me.	The therapist once again used a strategic approach of suggesting that she does not address the trauma, as he was aware of it.

359.	She argued that whether I knew or not, she needed to tell me.	The client urged that this was irrespective, and that addressing the trauma was what she needed to do.
360.	I then told her that she either tells me or she doesn't, but the choice was hers.	The therapist challenged the patient by accentuating her responsibility and choice in addressing therapeutic topics.
361.	She spoke more about the event, but it was still vague and very dramatic.	The patient once again addressed her trauma, but still only vaguely and dramatically. Paradoxically, for the importance she afforded the trauma in resolving her emotional and mental state, it was never addressed again.
362.	However, it did appear as though Mrs. S had been raped at age 14.	The therapist was able to still piece together more details to support his hypothesis on the trauma.
363.	She again tried to reinforce her badness as having "asked for it" by putting herself in the situation.	The patient wanted to convince the therapist of her inherent badness.
364.	Shortly after this session, Mrs. S was discharged once again from the psychiatric ward.	The patient was once again discharged from the psychiatric ward.
365.	For our 27th session, Mrs. S arrived at my office looking rather different. She was neatly dressed, wore make up, and even though she did not cover the scars on her arms, looked actually quite healthy. She had with her a pile of papers	The patient arrived for the second last session looking qualitatively different. She appeared healthy.
366.	and the stuffed tiger once again.	The therapist was concerned that the patient was not as healthy as she appeared. The therapist appears suspicious of dramatic changes in behaviour of the client.
367.	She showed me the papers, which she explained was homework she had set for herself since our last session. She had decided to engage in a form of introspection and reflect for herself upon the issues that had been discussed within our therapies.	The patient had taken it upon herself to engage in a structured form of introspection. The introspection focused on the events addressed in therapy that were seldom dealt with genuinely.
368.	She approached the topic of what kind of a person she wanted to be, she looked at what she had achieved within therapy, and she had approached various aspects in her life (especially the traumatic events: X, age 14, the aborted baby, sister, parents, etc.) where she usually persecuted herself in order to begin by defending herself and looking at these incidents from a more positive and	The patient appeared to have begun to genuinely and seriously address the various traumatic events and topics raised in therapy from a perspective of congruently wanting to improve her mental and emotional state and achieve health. The physical illness was no longer introduced into the therapeutic session.

	realistic perspective. She had also been thinking about goals for what she wants to do and achieve in the future.	
369.	I questioned Mrs. S as to what had caused this rapid change in her approach and behaviour.	The therapist appeared suspicious about the client's sudden change in behaviour.
370.	She informed me that it was my challenge that she uses her intelligence constructively, and that it was essentially her choice as to whether she wanted to get well, that had motivated her to reassess her situation.	The patient suggested that it was the therapist's challenge to her intelligence that had succeeded in motivating her to reassess her situation. The therapist believed in her ability, freedom and choice to control her behaviour.
371.	She realised that I was not asking her to deny her emotions, but only asking her to change her approach in taking control of her actions and not using her past or her emotions as an excuse. Once she is able to control her impulses and actions, she would then be able to assess why she feels the way she does. She could acknowledge that even though she believes she is essentially "bad" at present, after gaining control of her actions and impulses only then could she go further in gaining insight.	The patient appeared to have apparently internalised many of the goals that the therapist had set for the therapy. That the patient had the ability, freedom and responsibility to control her actions and behaviour. She did not have to deny her emotional and mental state in doing so. With control over her behaviour she could address the traumas more genuinely.
372.	She related an incident where she had spoken to Mr. S over the past few days. She had asked him if he had heard her knocking (the X incident), and he stated that he had. She told me that she could have reacted with anger again, and had in fact felt incredibly angry, but she chose to rather focus on the guilt that Mr. S had probably been living with up to this day. She also described his behaviour in her 'suicide attempt'. Mr. S had apparently held her firmly, but not roughly, so that she could not hurt herself further. This she interpreted as the incredible love and tenderness he must feel for her. For me this was the insight and change that I believed Mrs. S needed to and was capable of accomplishing.	The patient provided concrete examples of how she had gained control over her reactions and behaviour. In doing so she was able to focus on alternative explanations and demonstrate (more genuine) empathic responses in interpersonal relationships. The patient appeared to be actively changing her approach to her traumas.
373.	The tiger was essentially the object that Mrs. S wanted to bury for her son.	The concerns of the therapist were not substantiated. The patient demonstrated an internalisation of a suggestion provided by the therapist.
374.	She wanted me to tie a bow on it to signify my contribution towards her	The patient wanted to acknowledge the therapist's contribution to her change of

	health.	focus towards health.
375.	I agreed to this and actually felt incredibly honoured.	The therapist was touched and honoured by the gesture.
376.	Mrs. S informed me that it was my consistency and punctuality that she had most appreciated in our therapy. She referred to my consistency and patience no matter how much she frustrated me. I was always available when I said I would be, and would only make changes well in advance. I would be able to take the "abuse" without trying to outsmart her.	The patient spontaneously provided the therapist with feedback on what approaches she had felt were beneficial to the therapy. She referred to the consistency of the therapist and the structure of the therapy. She referred to the therapist's ability to tolerate the patient's behaviour, and his non-confrontational approach. The therapist's one down approach can also be assumed to have been beneficial.
377.	She added that even though the other disciplines may have said the correct things, that she found them too confrontational.	The patient highlighted that correct interpretations of her behaviour did not have an effect. Nor did a too confrontational approach to her behaviour.
378.	She explained to me that her instinctive approach would be to attack back. But even this behaviour had begun to change, she had rather started stand down when confronted and when she felt that she would be getting nowhere.	The patient explained how she had begun to change her interactional approaches in difficult situations. She appeared to have begun to internalise these experiences.
379.	She wanted to thank me overall, and stated that people too often criticise without ever thanking others.	The patient wanted to thank the therapist, highlighting that there is a societal tendency to criticise rather than thank people. This was paradoxically the very behaviour she so frequently displayed.
380.	I believe that her gratitude was sincere and heartfelt, and do not believe that she was merely telling me what I wanted to hear.	The therapist believed that the patient was sincere, and her changes in behaviour and cognition were genuine. The style of the patient was qualitatively different to her manipulative approaches.
381.	I had never told her my goals for therapy.	The therapist highlighted that he had never discussed his treatment goals with the patient. The therapist thus appears to believe that the therapeutic growth of the patient was genuine.
382.	The 28th session was scheduled to be our termination session. Mrs. S however felt that we had already discussed all that had been necessary to discuss. The session comprised mainly of light-hearted and social conversation. We said our farewells.	The positive changes of the patient appeared to have maintained themselves upon termination. This reaction itself is qualitatively different to the patient's prior reactions to termination.

With Step 2 (the discrimination of meaning units) and Step 3 (the transformation of the meaning units into psychological language) attended to, Step 4 can now be attended to.

3.4 Step 4

Step 4 involves the synthesis of the TMU's into a consistent statement. In this context, the statement will be a *specific description of the situated structure*. However, in order to write a specific description of the phenomenon, it seemed practical to first cluster the TMU's into consistent themes. The consistent themes are followed by references (in brackets) to the specific TMU's (and NMU's) they refer to. It may appear to the reader as if some concepts and themes are repeated. These are however, only in relation to the perspectives that they refer to. Various consistent themes will refer to the perspective of the therapist, or the perspectives of the patient or multidisciplinary team members, as they were experienced by the therapist.

3.4.1 Consistent Themes of Transformed Meaning Units

1) The sick-role of the patient was a defining feature of the patient's identity. The patient consistently looked sick and spoke about being sick or in chronic pain. The patient consistently wanted and manoeuvred for diagnoses. The patient was consistently insistent upon receiving diagnoses for her conditions (medical and psychiatric). The patient would however paradoxically find fault with her diagnoses. It was observably dangerous to remove the patient's sick labels. (17, 19, 23, 24, 31, 42, 43, 57, 78, 80, 179, 192, 198, 206, 219, 220, 221, 227, 238, 250, 261, 263, 276, 277, 278, 280)

2) The patient would describe her illness due to its rarity and exceptionality. It was described as unexplainable and untreatable by the medical profession. It would require expensive and risky procedures. It was described as probably terminal and the patient characteristically spoke fatalistically about her condition. (17, 19, 33, 50, 178, 179, 186, 190, 192)

3) The patient's medical illness was reportedly and observably characterised by: numerous and extensive hospitalisations and admissions, the involvement of numerous healthcare professionals within a multidisciplinary context, numerous and expensive medications, and numerous and expensive medical procedures and investigations. (17, 109, 188, 212, 317, 335, 337, 341)

4) The patient's illness dominated many of the psychotherapy sessions. The patient's medical and physical symptoms and complaints were consistently introduced as topics. The quantity and severity of the patient's medical complaints escalated through the course of the therapy. (17, 31, 42, 43, 59, 156, 178, 179, 185, 240, 322)

5) The patient would consistently link her psychological and emotional states to her illness, medical and physical states. The patient's medical problems were described as pervasive, and as impacting upon all levels of her interpersonal relationships. (19, 31, 42, 43, 53, 59, 178, 180, 199, 322)

6) The patient would often suggest a need for medical and psychological help, and later in therapy for psychiatric help. The patient would periodically imply this need, ask for it, or plead for it. (25, 29, 50, 52, 58, 60, 105, 108, 133, 142, 146, 147, 151, 186, 206, 221)

7) The patient would periodically state, suggest or imply that psychological (and the psychologist) and psychiatric treatment could not help her or her condition. The patient was often extremely antagonistic and hostile to psychiatry and psychiatric treatment. She was often derogatory towards psychiatrists and continually attacked their competence. (19, 28, 60, 105, 141, 142, 160, 203, 206, 211, 242, 252, 254, 268, 319)

8) The patient exhibited a wide range of psychiatric symptoms and behaviour over the course of therapy. The quantity and severity of the patient's psychiatric symptoms escalated through the course of the therapy and the subsequent involvement of psychiatry. The wealth and variety of psychiatric symptoms often led the therapist and psychiatric department into considering varying diagnoses.

The patient often consciously provided and communicated her psychiatric symptoms. (12, 16, 20, 53, 58, 61, 63, 64, 78, 103, 104, 121, 127, 129, 130, 132, 139, 140, 145, 160, 183, 184, 205, 210, 211, 222, 234, 338, 340)

9) Through the course of therapy, the patient displayed two dissociative episodes – one severe. The dissociative episodes felt qualitatively real to the therapist, although he acknowledged that there was possibly manipulative component to them. The patient reported that they occurred in distressing situations, and articulated that she had a certain level of awareness and control over the process. The dissociative episodes therefore appeared to be defence mechanism of severe avoidance that the patient had developed to negate topics or situations that she did not want to address or face. (121, 122, 123, 124, 126, 144, 146, 206, 306, 307, 308, 310)

10) The therapist and psychiatrists frequently considered a personality disorder. The patient was considered to have borderline and histrionic traits. The patient was eventually diagnosed with a borderline personality disorder. (81, 132, 139, 140)

11) The therapist and various members of the multidisciplinary team consistently considered the possibility of Munchausen syndrome due to the prominence of the patient's sick-role identity. A factitious disorder with predominantly physical symptoms was eventually diagnosed as the working diagnosis at the psychiatric department. (80, 86, 87, 136, 209, 210, 231, 232, 233, 234, 263)

12) There was a characteristic tendency towards caution in diagnosing a factitious disorder. Confirmations of a lack medical cause aided the acceptance and strengthening of these tentative diagnoses, but were never conclusive. The patient had real medical complications over her suspected factitious illness. (86, 87, 137, 232, 233, 236, 237)

13) The patient was perceived as more of a psychiatric case, and it was believed that the psychiatric department could manage her more efficiently. (64, 108, 109, 204, 213, 336, 341)

14) The patient consistently displayed an extensive personal knowledge of medical, psychiatric, and psychological terminology, symptoms, and diagnoses. Her knowledge was not only extremely accurate, but also more extensive than would have been expected of the general public. (17, 33, 235, 255, 256, 265)

15) The patient periodically created contexts of severe urgency, crisis, and emergency, both within therapy and the hospital setting (context external to therapy). This was often achieved through the presentation and/or exaggeration of numerous medical and psychiatric symptoms, the patient's dissociative episodes, the patient's mannerisms and style of interpersonal interaction, and the patient's acting out and self-mutilative behaviour. (6, 11, 12, 16, 25, 26, 36, 52, 53, 58, 61, 63, 78, 84, 107, 110, 122, 124, 127, 134, 145, 146, 147, 154, 160, 178, 179, 180, 182, 190, 202, 207, 223, 322, 328, 346, 357)

16) The urgency and crisis that the patient created often resulted in various members of the multidisciplinary team (including the therapist) reconsidering alternative options of treatment and/or ways to accommodate the patient. (11, 64, 68, 82, 108, 109, 122, 183, 184, 205, 212, 238, 335, 336, 337, 341)

17) The patient was experienced as extremely difficult and frustrating by most members of the multidisciplinary team. The patient was often perceived as frustrating due to her behaviour and interactional style, and the immense time, energy and resources that she utilised. (1, 11, 51, 79, 85, 135, 138, 334, 336, 337)

18) The patient often appeared to pride herself on being a difficult patient to treat or manage. She would further often interact from a position of superiority (one-up). The patient was believed to have been of above average intelligence. The therapist, the psychiatric team, and the patient believed and reported this. (25, 33, 75, 107, 187, 339, 349, 350, 351, 356, 370)

19) The patient's characteristic approach to therapy was to complain. The patient would complain about: her medical condition and physical problems, her emotional and mental state, her interpersonal problems, and lack of support. The patient consistently complained of not being seen as an individual or a human

being. It was however generally experienced that the patient did not genuinely or sincerely work towards these problems. The patient throughout the course of therapy did not express specific goals or aims that she wished to attain – apart from complain about her condition. (18, 19, 21, 33, 34, 42, 43, 47, 50, 53, 56, 57, 77, 97, 141, 164, 281, 361)

20) In therapy, the patient consistently made use of highly descriptive and/or metaphorical language. The patient was often found to greatly exaggerate or distorts facts and events. The patient's language served to create a dramatic effect and/or sense of urgency. (16, 35, 36, 41, 43, 55, 58, 59, 60, 61, 63, 70, 78, 79, 84, 89, 90, 103, 107, 110, 124, 134, 146, 192, 216, 241, 268, 361)

21) The patient's language and approach to addressing therapeutic topics were consistently vague and lacking in essential detail. The vagueness often served to keep the therapist confused, interfere with the establishing of therapeutic aims, and create a sense of urgency and/or uncertainty. The patient tended to justify the vagueness as an inability to deal with emotional and mental states. (47, 57, 58, 61, 78, 101, 104, 146, 164, 181, 284, 300, 303, 311, 361)

22) The patient periodically throughout therapy (with an escalation in the final phases) displayed a tendency towards using child-like language and displaying regressive behaviour. The behaviour was often in reaction to events and served to create a dramatic effect and emphasise crisis. (142, 247, 284, 287, 288)

23) The patient displayed a characteristic style in therapy of overwhelming the therapist with information, content, problems, and trauma. This served to maintain an atmosphere of chaos and uncertainty within the therapy, and make the establishment of therapeutic aims very difficult. The therapists had to consistently and gradually put pieces of information together throughout the course of therapy and create his own hypotheses. (1, 30, 34, 35, 39, 40, 41, 44, 45, 49, 89, 90, 93, 94, 95, 182, 290, 291, 292, 293, 294, 295, 296, 300, 301, 310, 311, 313, 357, 361, 362)

24) The patient consistently reported an extensive history of trauma, interpersonal and social problems. The patient had a severe psychiatric history when she was a teenager. She had severe suicide attempts. The patient would urge the significance of these traumas for her present emotional and psychological states. (18, 21, 34, 35, 39, 40, 41, 42, 43, 44, 45, 89, 90, 95, 146, 147, 166, 182, 290, 291, 292, 293, 296, 300, 301, 310, 313, 357, 361, 362)

25) The patient's family history was consistently portrayed as pathological. There was a reported consistency of physical and somatic psychiatric symptoms in the family. (35, 39, 40, 41, 42, 94, 95, 291, 292, 294, 296)

26) Throughout therapy the patient presented with numerous social, familial, marital and interpersonal problems. (18, 21, 35, 36, 37, 40, 41, 42, 43, 180, 286, 289, 290, 291, 292, 293)

27) The patient's family patterns of interaction were characterised by a tension between wanting closeness and support, and interactional styles of pushing members away. The family had reportedly severe family secrets, of which members were nevertheless aware. The patient's marital relationship was characterised by symmetrical patterns of conflict. (18, 21, 25, 26, 35, 36, 37, 38, 41, 42, 71, 72, 96, 118, 123, 152, 181, 295)

28) The patient's emotional state was often characterised by frustration, due to a frustration of needs. The patient would complain of low self-esteem and a negative self-image. The patient also consistently suggested feelings of futility, helplessness and hopelessness. There was often a frustration due to a conflict of expected roles and needs. The frustrations were numerous and appeared to be seldom elaborated upon, with exploration tending towards vagueness. (16, 18, 19, 21, 38, 41, 43, 53, 55, 62)

29) The patient's mental states often portrayed dissociative and personality splits. The patient described her mental state and personality as having split off parts that were depicted as bad, malevolent, anger, rage and pathological. The patient was periodically self-deprecating, adamant and resolute in her belief of her inherent

badness. The belief in her badness was provided as justification for her compulsions towards self-mutilative behaviour as punishment. The patient saw her illness and hospitalisations as further punishment for her badness. Her badness also portrayed an overvalued idea that she was able to affect others emotional and mental states more so than is commonly accepted. The patient would display poor conceptualisations of interpersonal influence in relationships. (35, 40, 46, 60, 78, 89, 142, 146, 166, 171, 247, 284, 285, 298, 300, 301, 302, 304, 310, 312, 324, 325, 363)

30) The patient displayed a prominent tendency to assign blame for her condition and behaviour to external events and people. She consistently accused other people (family, husband, doctors, therapist), or her illness, as being responsible (in either past or present) for her emotional and psychological states and hence her behaviour. The patient viewed herself as a victim of her condition and situation. The patient consistently complained of an inability to do things for herself. (18, 19, 20, 21, 35, 36, 39, 40, 41, 42, 43, 45, 55, 62, 63, 90, 98, 134, 142, 145, 148, 149, 150, 160, 161, 166, 178, 217, 219, 220, 248, 250, 254, 275, 291, 292, 296, 345)

31) The patient consistently viewed other people as threatening and as having malicious intentions towards her. The patient also had a persistent and pervasive distrust of men. (21, 35, 36, 39, 41, 42, 43, 55, 62, 67, 90, 98, 106, 123, 142, 150, 160, 161, 166, 169, 242, 248, 253, 291, 292)

32) The therapist displayed a primarily client-centred approach to therapy. (14, 15, 22, 32, 48, 120, 140, 249)

33) The therapist's typical approach to therapy was from an interactional and interpersonal perspective. As such he was interested in and focussed on patterns of interpersonal interaction and behaviour. As such, the therapist makes use of his self in interaction with the patient. The focus and goal of therapy for the therapist was in some manner to involve and be able to facilitate positive change. (48, 51, 73, 76, 82, 117, 139, 140, 172, 181, 195, 200, 249, 258, 264, 281, 378)

34) The therapist also approached therapy from an existential belief system. People are seen as having the freedom to make choices and therefore also have responsibility and a level of accountability for their choices and behaviours. The therapist often attempted to bring the focus of the therapy back to the patient and her choices and responsibilities within her circumstances and condition. (15, 22, 32, 63, 120, 149, 246, 250, 260, 309, 327, 354, 360, 371)

35) The therapist employed a number of strategic approaches in therapy. The goal was to be able to facilitate some form of positive change in the patient's cognitions and interactional style. The therapist would often attempt to reframe the patient's cognitions, address her avoidant defences, or redirect the patient's strengths towards more therapeutic goals. (63, 64, 65, 92, 194, 197, 198, 246, 261, 305, 323, 326, 350, 351, 352, 358, 359, 360)

36) The therapist attempted to facilitate the patient in developing more realistic and stable interpersonal relationships. The therapist would also reinforce positive change, regardless of motivation. (92, 118, 172, 225, 249, 252, 309, 327)

37) Through the course of therapy, the therapist revised various goals and aims for therapy, and attempted varying approaches to therapy. Some approaches were found to be beneficial whereas other were not. (13, 22, 32, 33, 51, 63, 69, 73, 76, 79, 82, 112, 139, 140, 197, 198, 261, 262, 263, 264, 351, 352, 353, 354)

38) The therapist periodically confronted the patient on her sick-role, her intentions and her behaviour. The confrontations were seldom accusatory and served to merely highlight the various paradoxes and query the inconsistencies. The therapist often highlighted misconceptions. The therapist was direct in addressing the inappropriate behaviours and responses of the patient. The therapist would often attempt to reframe the patient's negative cognitions or behaviours, or promote the patient's strengths. The therapist would occasionally be directive in suggesting appropriate or alternative responses. The patient was seen to have poor coping mechanisms. (92, 98, 99, 105, 111, 137, 153, 157, 162, 163, 167, 168, 170, 198, 225, 226, 227, 249, 259, 262, 272, 282, 283, 303, 320, 343, 347, 348, 352, 376)

39) The patient would often not comply with, and sabotage treatment and medication. The patient would tend to arrogantly admit to non-compliance. Even though the patient would occasionally admit to non-compliance with treatment and much anti-therapeutic behaviour, she would also be able to justify them to herself, often priding herself on her ability to interfere with treatment. (53, 100, 105)

40) When the patient's needs were met, or complaints attempted to be resolved, the patient would reject and undermine the help or assistance. She would often introduce a new problem that necessitated different needs. The patient would also paradoxically request help that could not be offered or was beyond reasonable request. (18, 21, 53, 54, 56, 67, 68, 152)

41) The patient was often perceived as argumentative and powerfully manipulative. She had the ability to be verbally abusive. The patient would often undermine and attack the competence and/or humanity of the healthcare professionals and those who tried to help her. (18, 21, 24, 25, 28, 55, 57, 123, 151, 187, 189, 219, 242, 251, 254, 268, 319)

42) The patient would often provide strong arguments to justify her condition, emotions, cognitions, beliefs, actions and behaviours. Her behaviour was justified as being due to her emotional and mental states. These were however never directly addressed, but rather further justified as being due to her illness and physical symptoms. (33, 43, 90, 100, 158, 166, 171, 199, 253, 268, 273, 300, 321, 349, 355, 359)

43) The patient displayed a good ability to manipulate various contexts. The context of the hospital and the required procedures allowed the patient the ability to manipulate the various disciplines. The patient was powerful in manoeuvring for results and responses. The patient would generate a need for help from others if her needs were not met. The patient would often admit to her manipulative abilities, but justify them as a method of self-preservation. (11, 12, 27, 52, 64, 68, 77, 84, 93, 97, 98, 100, 106, 110, 116, 203, 317, 329, 334, 335, 340)

44) The patient displayed a good ability to observe the interactional styles of others, the multidisciplinary teams responses, and the various contexts and processes in the hospital. The patient also often appeared to be aware of the treatment and therapeutic goals. (70, 75, 84, 196, 270, 319)

45) The therapist developed sensitivity towards the manipulative components of the patient's behaviour and interactional style. The therapist monitoring the patient's splitting behaviour, inconsistencies and exaggerations, facilitated this. (27, 63, 64, 65, 79, 84, 87, 97, 99, 111, 143, 208, 215, 217, 239, 241, 269, 271, 307, 329, 340, 366, 369)

46) The patient's behaviour and interactional style often served to create an atmosphere of uncertainty for those that attempted to help her. The patient's characteristic interactional style served to isolate and distance her in interpersonal relationships. (25, 26, 27, 56, 64, 68, 71, 79, 82, 106, 152, 181, 252)

47) Throughout therapy the patient periodically displayed self-mutilative and self-injurious behaviour, as well as threats and attempts at suicide (although possibly a para-suicide). The patient also described past and present abilities to self-inflict harm upon herself. The patient described the self-mutilative behaviour as a compulsion. The compulsion was due to the belief that she needed to be punished. The patient tended to display masochistic tendencies, as she would often manoeuvre others into facilitating her self-mutilative behaviour. In therapy she would lead the therapist into topics that she was unable to cope with. The patient would often respond to frustration or confrontation with anger, acting out behaviour, and self-mutilative behaviour. (89, 98, 102, 103, 116, 148, 149, 150, 151, 158, 159, 165, 166, 207, 254, 302, 304, 328, 342, 344)

48) The patient was able to generate a level of self-doubt within the therapist concerning his therapeutic approaches and competence. The therapist often felt a need to consult experienced/expert professionals. As the therapist was an intern, the availability of supervision was a characteristic feature of the therapy. The therapist however felt more of a need for supervision with this patient as a client. The therapist's questioning of his competence was often due to uncertainty. The

patient could also generate feelings of uneasiness in the therapist, often catching him off guard. (1, 49, 51, 64, 74, 79, 80, 81, 82, 108, 112, 125, 129, 138, 183, 191, 195)

49) The patient would often idealise the therapist. She would describe him as exceptional and unique. The patient would appear to show an excessive need to maintain the relationship beyond normal boundaries. The patient often tried to impress the therapist. The therapist displayed an awareness of the patient's splitting behaviour (idealising certain professionals and devaluing others). The patient would often manoeuvre for an alliance with the therapist. (29, 52, 54, 55, 84, 89, 96, 114, 133, 151, 158, 169, 190, 191, 193, 194, 224, 241, 242, 244)

50) The patient would often attempt to manoeuvre or manipulate the therapist into transgressing the normal therapeutic boundaries and limits. The awareness and necessary setting and maintaining therapeutic boundaries were a characteristic feature of the therapy. The therapist progressively enforced and strengthened the focus on therapeutic boundaries, structure and consistency in therapy. The therapist felt more comfortable within the therapy once the structure and boundaries were strengthened and maintained. The therapist would inform the patient in advance of changes in therapy. (52, 56, 64, 83, 84, 88, 140, 154, 155, 157, 174, 201, 204, 208, 314, 332, 376)

51) The patient would also subtly undermine the competence, ability to help and/or humanity of the therapist. This was often when the patient was frustrated with changes or advances in therapy. (25, 28, 33, 75, 107, 115, 151, 160, 161, 218, 244, 245, 278, 355)

52) The patient periodically appeared to show movement in therapy, and the internalisation of the therapeutic goals. The patient would tend to be pleased with her apparent progress and overtly highlight them to the therapist. The positive changes were however, often found to be manipulative. They were too rapid and suggested a "flight into health". The patient's compliance to treatment was similarly often found to be passive-aggressive. Upon exploration, the patient could be seen to be subtly sabotaging treatment or manipulating health-care

professionals. The patient displayed shifts in therapy from excessive compliance with treatment to acting out behaviour and non-compliance. (89, 90, 92, 93, 97, 108, 110, 142, 143, 173, 175, 176, 177, 178, 179, 182, 206, 214, 224, 240, 261, 266, 267, 269, 271, 290, 299, 310, 318, 321, 328, 347, 352, 353, 371, 373)

53) The patient expended an excessive amount of the therapist's time and resources. The therapy with the patient was extremely intensive and had a powerful and intense emotional and moral impact upon the therapist. The therapist was often frustrated due to a lack of change in the patient and lack of therapeutic progress – the complaints and behaviour of the client tended to escalate. (1, 3, 10, 51, 52, 79, 82, 88, 89, 90, 91, 92, 122, 126, 135, 138, 192, 200, 226, 329, 331, 356)

54) The patient also displayed a characteristic avoidant style to addressing therapeutic goals, or interpersonal problems. Her solution to very many interpersonal problems, psychiatric and psychological problems, was often one of avoidance. The patient would often respond to frustration, therapeutic advancements or confrontation of her interactional styles with vagueness and avoidant behaviour. (26, 47, 53, 101, 119, 156, 164, 179, 240, 274, 284, 290, 297, 335)

55) The patient's statements, behaviour and interactional style often served to facilitate or promote interdisciplinary splits and disagreement. The patient would often do so by exaggerating or distorting information. (113, 115, 129, 130, 141, 142, 144, 187, 203, 241, 242, 243, 244, 268, 338)

56) The therapist throughout the therapy facilitated, promoted and benefited from interdisciplinary communication. The improved interdisciplinary communication allowed for the improved monitoring of the patient's splitting behaviour as well as her illness symptoms. (85, 86, 87, 128, 129, 130, 144, 208, 209, 230, 241, 242, 244, 333)

57) There were often discrepancies and inconsistencies between the patient's reports on her medical condition or interpersonal problems that became evident with collateral information and improved interdisciplinary communication. The patient's reports of her medical conditions often did not correlate with the medical

findings. People did not always fully correlate with the patient's depictions of them. The patient also displayed discrepancies in her behaviour when compared to her reports on her wishes or goals. The patient was generally experienced as not entirely truthful, with a tendency to exaggerate. (21, 27, 29, 35, 36, 70, 79, 86, 111, 131, 136, 144, 209, 217, 223, 231, 241, 243, 259, 320)

58) The therapist often found it necessary and beneficial to obtain collateral information to the information provided by the patient. (69, 70, 79, 86, 131, 136, 144, 209, 217, 231, 239, 256)

59) The timing of the various crisis, self-mutilative behaviour, behaviour changes, and presentation of new psychiatric and medical symptoms often appeared to be linked to various treatment and therapeutic events. More so than could be suggested by chance. (101, 102, 117, 119, 121, 149, 151, 153, 154, 155, 156, 158, 159, 164, 179, 185, 202, 229, 254, 274, 315, 316, 317, 318, 328, 330)

60) There were observable differences in the interdisciplinary approaches of the therapist as a psychologist and the psychiatrists. The department of psychiatry appeared to be more concerned with a focus on management of the patient and providing the patient with the correct medication, which necessitated the making of a correct diagnosis. (129, 130, 132, 139, 141, 238)

61) The therapist's focus was not on confirming a diagnosis even though he showed an initial concern with the patient's diagnosis. The diagnoses served to aid him in the monitoring of the patient's interactional styles and behaviour. (76, 129, 130, 139, 257, 263, 264, 279, 376)

With the consistent themes of the TMU's summarised, the author can now turn to the specific description of therapy with a "factitious disorder" patient. The author again cautions the reader that some concepts and themes may appear to be repeated. These are however only in relation to the relative perspectives (therapist, patient, multidisciplinary team) that they refer to.

3.4.2 Specific Description of the Situated Structure of Therapy with a "Factitious Disorder" Patient.

The therapy with the patient has created a lasting impression on the therapist. The patient impacted upon him more so than his other clients. This is highlighted by the difficulty the therapist has in writing and conceptualising the therapy even in retrospect. The ambiguity that the therapist is left with creates a sense of self-doubt. This tends to translate into a need for the therapist to be as inclusive of relevant information as is possible. The therapist tried to be as practical as possible, but still however doubts as to whether he was able to provide a comprehensive account. It is evident that the therapist sees himself as part of the therapeutic interaction he is describing. He therefore includes his own thoughts and emotions alongside his description of the patient.

The therapy took place within the context of a multidisciplinary academic hospital with the various disciplines that were also involved, or became involved with the patient. The therapist equally became more involved with and communicated with the various members of the multidisciplinary team. The therapist, as an intern psychologist received supervision throughout the course of the therapy.

The therapist entered into therapy with the patient due to set hospital procedures. The patient herself had never formally requested a psychologist, or to enter into therapy. The patient did however suggest an eagerness to enter therapy and maintain the therapeutic relationship. The therapist's initial therapeutic goals reflected certain hospital procedures that were required to be adhered to. The therapist however does not seem to report any conflict with his approach to therapy within the context of the hospital and required procedures. The therapist assesses each new client, with a primary focus of client-centeredness. His approach, after following hospital procedures, is to further allow the client to introduce their own focus, aims, goals and direction into therapy. The patient in this particular context however seems to have presented the therapist with a unique and distinctive set of problems that challenged his own assumptions and approach to therapy.

The sick-role of the patient was a defining feature of the patient's identity. The patient consistently looked sick and spoke about being sick or in chronic pain. The patient would describe her illness due to its rarity and exceptionality. It was described as unexplainable and untreatable by the medical profession. It would require expensive and risky procedures. It was described as probably terminal and the patient characteristically spoke fatalistically about her condition. The patient's medical illness was reportedly and observably characterised by: numerous and extensive hospitalisations and admissions, the involvement of numerous healthcare professionals within a multidisciplinary context, numerous and expensive medications, and numerous and expensive medical procedures and investigations. The patient consistently wanted and manoeuvred for diagnoses. The patient was consistently insistent upon receiving diagnoses for her conditions (medical and psychiatric). The patient would however paradoxically find fault with her diagnoses. It was throughout the course of her treatment observably dangerous to remove the patient's sick labels.

The patient's illness dominated many of the psychotherapy sessions. The patient's medical and physical symptoms and complaints were consistently introduced as topics. The quantity and severity of the patient's medical complaints escalated through the course of the therapy. The patient would consistently link her psychological and emotional states to her illness, medical and physical states. The patient's medical problems were described as pervasive, and as impacting upon all levels of her interpersonal relationships.

The patient would often suggest a need for medical and psychological help, and later in therapy for psychiatric help. The patient would periodically imply this need, ask for it, or plead for it. The patient would however periodically state, suggest or imply that psychological (and the psychologist) and psychiatric treatment could not help her or her condition. The patient was often extremely antagonistic and hostile to psychiatry and psychiatric treatment. She was often derogatory towards psychiatrists and continually attacked their competence.

The patient exhibited a wide range of psychiatric symptoms and behaviour over the course of therapy. The patient showed evidence of depression, anxiety, dissociative

states, and post-traumatic stress. The quantity and severity of the patient's psychiatric symptoms escalated through the course of the therapy and the subsequent involvement of psychiatry. The wealth and variety of psychiatric symptoms often led the therapist and psychiatric department into considering varying diagnoses. The patient often consciously provided and communicated her psychiatric symptoms.

Through the course of therapy, the patient displayed two dissociative episodes – one severe. The dissociative episodes felt qualitatively real to the therapist, although he acknowledged that there was possibly manipulative component to them. The patient reported that they occurred in distressing situations, and articulated that she had a certain level of awareness and control over the process. The dissociative episodes therefore appeared to be defence mechanism of severe avoidance that the patient had developed to avoid topics or situations that she did not want to address or face.

The patient was perceived as more of a psychiatric case, and it was believed that the psychiatric department could manage her more efficiently. The therapist and psychiatrists frequently considered a personality disorder. The patient was considered to have borderline and histrionic traits. The patient was eventually diagnosed with a borderline personality disorder. The therapist and various members of the multidisciplinary team consistently considered the possibility of Munchausen syndrome due to the prominence of the patient's sick-role identity. A factitious disorder with predominantly physical symptoms was eventually diagnosed as the working diagnosis at the psychiatric department. There was a characteristic tendency towards caution in diagnosing a factitious disorder. Confirmations of a lack medical cause aided the acceptance and strengthening of these tentative diagnoses, but were never conclusive. The patient had real medical complications over her suspected factitious illness.

The patient consistently displayed an extensive personal knowledge of medical, psychiatric, and psychological terminology, symptoms, and diagnoses. The patient displayed an awareness of the diagnosis of Munchausen syndrome. This awareness was independent of information she received from the multidisciplinary team. Her knowledge was not only extremely accurate, but also more extensive than would have

been expected of the general public. Thus, she also had the ability to contaminate any tests results.

The patient periodically created contexts of severe urgency, crisis, and emergency, both within therapy and the hospital setting (context external to therapy). This was often achieved through the presentation and/or exaggeration of numerous medical and psychiatric symptoms, the patient's dissociative episodes, the patient's mannerisms and style of interpersonal interaction, and the patient's acting out and self-mutilative behaviour. The urgency and crisis that the patient created often resulted in various members of the multidisciplinary team (including the therapist) reconsidering alternative options of treatment and/or ways to accommodate the patient. The patient was experienced as extremely difficult and frustrating by most members of the multidisciplinary team.

The patient was often perceived as frustrating due to her behaviour and interactional style, and the immense time, energy and resources that she utilised. The patient often appeared to pride herself on being a difficult patient to treat or manage. She would further often interact from a position of superiority (one-up). The patient was believed to have been of above average intelligence. The therapist, the psychiatric team, and the patient believed and reported this.

The therapist displayed a primarily client-centred approach to therapy. His approach is open-ended and allows the client to set the course of therapy. The therapist's typical approach to therapy is from an interactional and interpersonal perspective. As such he was interested in and focussed on patterns of interpersonal interaction and behaviour. The therapist would make use of his self and his responses in interaction with a client to form hypotheses of possible problems that could be the focus of therapy. The focus and goal of therapy for the therapist was in some manner to involve and be able to facilitate positive change. The therapist believes his aim in therapy is to facilitate change based upon the goals that the client introduces. The client however, never introduced any goals.

The therapist believes that in the case of chronic physical illness that psychotherapy can still be beneficial. The aim would be to facilitate emotional well being even if the

physical health may not be directly addressed. Indirectly, emotional well-being can have a positive effect on the patient's health. He displays a belief in an interaction between emotional, cognitive and physical states.

The therapist also approached therapy from an existential belief system. People are seen as having the freedom to make choices and therefore also have responsibility and a level of accountability for their choices and behaviours. The therapist often attempted to bring the focus of the therapy back to the patient and her choices and responsibilities within her circumstances and condition. The therapist employed a number of strategic approaches in therapy. The goal was to be able to facilitate some form of positive change in the patient's cognitions and interactional style. The therapist would often attempt to reframe the patient's cognitions, address her avoidant defences, or redirect the patient's strengths towards more therapeutic goals. The reframes often addressed existential issues of free choice and responsibility over actions and behaviour. The therapist attempted to facilitate the patient in developing more realistic and stable interpersonal relationships, and to be able to distinguish between personal responsibility and realistic interpersonal responsibility. The therapist would also reinforce positive change, regardless of motivation.

Through the course of therapy, the therapist revised various goals and aims for therapy, and attempted varying approaches to therapy. Some approaches were found to be beneficial whereas other were not. It was not beneficial to ignore, or otherwise divert attention from, the patient's sick-role. The therapist initially attempted to facilitate the patient in emotionally coping with her illness. The therapist initially took the patient's reports on her physical condition at face value.

The patient's characteristic approach to therapy was to complain. The patient would complain about: her medical condition and physical problems, her emotional and mental state, her interpersonal problems, and lack of support. The patient consistently complained of not being seen as an individual or a human being. It was however generally experienced that the patient did not genuinely or sincerely work towards these problems. The patient throughout the course of therapy did not express specific goals or aims that she wished to attain – apart from complain about her condition.

In therapy, the patient consistently made use of highly descriptive and/or metaphorical language. The patient was often found to greatly exaggerate or distorts facts and events. The patient's language served to create a dramatic effect and/or sense of urgency. The patient's language and approach to addressing therapeutic topics were consistently vague and lacking in essential detail. The vagueness often served to keep the therapist confused, interfere with the establishing of therapeutic aims, and create a sense of urgency and/or uncertainty. The patient tended to justify the vagueness as an inability to deal with emotional and mental states. The patient periodically throughout therapy (with an escalation in the final phases) displayed a tendency towards using child-like language and displaying regressive behaviour. The behaviour was often in reaction to events and served to create a dramatic effect and emphasise crisis.

The patient displayed a characteristic style in therapy of overwhelming the therapist with information, content, problems, and trauma. This served to maintain an atmosphere of chaos and uncertainty within the therapy, and make the establishment of therapeutic aims very difficult. The therapists had to consistently and gradually put pieces of information together throughout the course of therapy and create his own hypotheses. The patient consistently reported an extensive history of trauma, interpersonal and social problems. The patient had a severe psychiatric history when she was a teenager. She had severe suicide attempts. The patient would urge the significance of these traumas for her present emotional and psychological states. Throughout therapy the patient presented with numerous social, familial, marital and interpersonal problems.

The patient's family history was consistently portrayed as pathological. There were allegations of some form of sexual abuse and emotional neglect at a young age. There was a reported consistency of physical and somatic psychiatric symptoms in the family. The patient's sister reportedly suffered from anorexia nervosa. The patient would further claim that her mother interacted with her in such a manner as to promote illness and keep her ill. The patient's mother was described as over involved and her father as an inconsistent figure (fluctuating between involvement and absence). The patient's family patterns of interaction were characterised by a tension between wanting closeness and support, and interactional styles of pushing members away. The family had reportedly severe family secrets, of which members were

nevertheless aware. The patient's marital relationship was characterised by symmetrical patterns of conflict.

The patient's emotional state was often characterised by frustration, due to a frustration of needs. The patient would complain of low self-esteem and a negative self-image. The patient also consistently suggested feelings of futility, helplessness and hopelessness. There was often a frustration due to a conflict of expected roles and needs. The frustrations were numerous (going back into childhood) and appeared to be seldom elaborated upon, with exploration tending towards vagueness.

The patient often portrayed her mental states as having dissociative personality splits. The patient described her mental state and personality as having split off parts that were depicted as bad, malevolent, anger, rage and pathological. The patient was periodically self-deprecating, adamant and resolute in her belief of her inherent badness. The belief in her badness was provided as justification for her compulsions towards self-mutilative behaviour as punishment. The patient saw her illness and hospitalisations as further punishment for her badness. Her badness also portrayed an overvalued idea that she was able to affect others emotional and mental states more so than is commonly accepted. The patient would display poor conceptualisations of interpersonal influence in relationships.

The patient showed a prominent tendency to assign blame for her condition and behaviour to external events and people. She consistently accused other people (family, husband, doctors, therapist), or her illness, as being responsible (in either past or present) for her emotional and psychological states and hence her behaviour. The patient viewed herself as a victim of her condition and situation. The patient consistently complained of an inability to do things for herself. The patient consistently viewed other people as threatening and as having malicious intentions towards her. The patient also had a persistent and pervasive distrust of men. The patient's characteristic interactional style served to isolate and distance her in interpersonal relationships.

The therapist periodically confronted the patient on her sick-role, her intentions and her behaviour. The confrontations were seldom accusatory and served to merely

highlight the various paradoxes and query the inconsistencies. The therapist often highlighted misconceptions. The therapist was direct in addressing the inappropriate behaviours and responses of the patient. The therapist would often attempt to reframe the patient's negative cognitions or behaviours, or promote the patient's strengths. The therapist would occasionally be directive in suggesting appropriate or alternative responses. The patient was seen to have poor coping mechanisms. Confrontations and reframes only had limited and little effect on creating any significant change in the patient.

The patient would often not comply with and sabotage treatment and medication. The patient would tend to arrogantly admit to non-compliance. Even though the patient would occasionally admit to non-compliance with treatment and much anti-therapeutic behaviour, she would also be able to justify them to herself, often priding herself on her ability to interfere with treatment. When the patient's needs were met, or complaints attempted to be resolved, the patient would reject and undermine the help or assistance. She would often introduce a new problem that necessitated different needs. The patient would also paradoxically request help that could not be offered or was beyond reasonable request.

The patient was often perceived as argumentative and powerfully manipulative. She had the ability to be verbally abusive. The patient would often undermine and attack the competence and/or humanity of the healthcare professionals and those who tried to help her. The patient would often provide strong arguments to justify her condition, emotions, cognitions, beliefs, actions and behaviours. Her behaviour was justified as being due to her emotional and mental states. These were however never directly addressed, but rather further justified as being due to her illness and physical symptoms.

The patient displayed a good ability to manipulate various contexts. The context of the hospital and the required procedures allowed the patient the ability to manipulate the various disciplines. The patient was powerful in manoeuvring for results and responses. The patient would generate a need for help from others if her needs were not met. The patient would often admit to her manipulative abilities, but justify them as a method of self-preservation (as she saw others as malevolent). The patient

displayed a good ability to observe the interactional styles of others, the multidisciplinary teams responses, and the various contexts and processes in the hospital. The patient also often appeared to be aware of the treatment and therapeutic goals. The therapist developed sensitivity towards the manipulative components of the patient's behaviour and interactional style. The therapist monitoring the patient's splitting behaviour, inconsistencies and exaggerations, facilitated this.

Throughout therapy the patient periodically displayed self-mutilative and self-injurious behaviour, as well as threats and attempts at suicide (although possibly para-suicide attempts). The patient also described past and present abilities to self-inflict harm upon herself. The patient described the self-mutilative behaviour as a compulsion. The compulsion was due to the belief that she needed to be punished. The patient tended to display masochistic tendencies, as she would often manoeuvre others into facilitating her self-mutilative behaviour. In therapy she would lead the therapist into topics that she was unable to cope with. The patient would often respond to frustration or confrontation with anger, acting out behaviour, and self-mutilative behaviour.

The patient's behaviour and interactional style often served to create an atmosphere of uncertainty for those that attempted to help her. The patient was able to generate a level of self-doubt within the therapist concerning his therapeutic approaches and competence. The therapist often felt a need to consult experienced/expert professionals. As the therapist was an intern, the availability of supervision was a characteristic feature of the therapy. The therapist however felt more of a need for supervision with this particular patient as a client. The therapist's questioning of his competence was often due to uncertainty. The patient could also generate feelings of uneasiness in the therapist, often catching him off guard.

The patient would often idealise the therapist. She would describe him as exceptional and unique. The patient would appear to show an excessive need to maintain the relationship beyond normal boundaries. The patient often tried to impress the therapist. The patient would also subtly undermine the competence, ability to help, and/or humanity of the therapist. This was often when the patient was frustrated with changes or advances in therapy. The therapist displayed an awareness of the patient's

splitting behaviour (idealising certain professionals and devaluing others). The patient would often manoeuvre for an alliance with the therapist.

The patient would often attempt to manoeuvre or manipulate the therapist into transgressing the normal therapeutic boundaries and limits. The awareness and necessary setting and maintaining therapeutic boundaries were a characteristic feature of the therapy. In the early stages of therapy, the patient consistently pushed the boundaries of therapy. The therapist however progressively enforced and strengthened the focus on therapeutic boundaries, structure and consistency in therapy. The therapist felt more comfortable within the therapy once the structure and boundaries were strengthened and maintained. The therapist would inform the patient in advance of changes in therapy.

The patient periodically appeared to show movement in therapy, and the internalisation of the therapeutic goals. The patient would tend to be pleased with her apparent progress and overtly highlight them to the therapist. The positive changes were however, often found to be manipulative. They were too rapid and suggested a "flight into health". The patient's compliance to treatment was similarly often found to be passive-aggressive. Upon exploration, the patient could be seen to be subtly sabotaging treatment or manipulating health-care professionals. The patient displayed shifts in therapy from excessive compliance with treatment to acting out behaviour and non-compliance.

The patient expended an excessive amount of the therapist's time and resources. The therapy with the patient was extremely intensive and had a powerful and intense emotional and moral impact upon the therapist. The therapist was often frustrated due to a lack of change in the patient and lack of therapeutic progress – the complaints and behaviour of the client tended to escalate. The patient also displayed a characteristic avoidant style to addressing therapeutic goals, or interpersonal problems. Her solution to very many interpersonal problems, psychiatric and psychological problems, was often one of avoidance. The patient would often respond to frustration, therapeutic advancements or confrontation of her interactional styles with vagueness and avoidant behaviour.

The patient's statements, behaviour and interactional style often served to facilitate or promote interdisciplinary splits and disagreement. The patient would often do so by exaggerating or distorting information. The therapist throughout the therapy facilitated, promoted and benefited from interdisciplinary communication. The improved interdisciplinary communication allowed for the improved monitoring of the patient's splitting behaviour as well as her illness and disease symptoms. There were often discrepancies and inconsistencies between the patient's reports on her medical condition or interpersonal problems that became evident with collateral information and improved interdisciplinary communication. The patient's reports of her medical conditions often did not correlate with the medical findings. People did not always fully correlate with the patient's depictions of them. The patient also displayed discrepancies in her behaviour when compared to her reports on her wishes or goals. The patient was generally experienced as not entirely truthful, with a tendency to exaggerate. The therapist thus often found it necessary and beneficial to obtain collateral information to the information provided by the patient.

The timing of the various crisis, self-mutilative behaviour, behaviour changes, and presentation of new psychiatric and medical symptoms often appeared to be linked to various treatment and therapeutic events. This tended to be more than could be suggested by chance.

There were prominent paradoxes evident within the therapy and interaction with the patient:

Many of the communications and behaviours of the patient were paradoxical. When addressing and meeting her needs, the patient was consistently rejecting and undermining the help and introducing new problems and needs. She would often ask for help from others, but reject assistance when given. The patient would show a tendency to request help that could not be offered. When helped, the patient would show a tendency to sabotage the help or not comply with treatment.

The patient's appearance and mannerisms were often paradoxical when contrasted with her personality, behaviours and interpersonal interactions. The patient would appear and report to be exceptionally ill, yet she was consistently perceived as a

strong, difficult, manipulative and argumentative personality. She would report frustrations that she wanted to be treated as an individual, but then act in such a manner as to manoeuvre for diagnoses or distance herself in interpersonal relationships.

The patient's thought processes and cognitions were often paradoxical. The patient was perceived as highly intelligent and regarded herself as such, yet displayed thought processes and beliefs that might not be expected (i.e. child-like behaviour). The patient's intelligence appeared to often hinder, rather than aid the therapeutic process. The patient would initially suggest a need for help from the multidisciplinary healthcare professionals. This was however followed by the devaluation of them – often referring to them as her persecutors – and attacks to their competence.

The patient's sick-role was the most prominent paradox – it tended to incorporate most of the mentioned paradoxes. The patient would need to maintain her illness and diagnoses in order to remain a patient. In order to be a patient, she needed to be sick, and therefore needed to be treated. However, in order to remain a patient, she needed to remain sick, and therefore needed the treatments not to be effective. It was strongly evident that even though she would manoeuvre for diagnoses or answers to her illness, she would never be satisfied with her given diagnoses or explanations.

Changing approaches to therapy was often not seen as beneficial. Even though the patient had a great many interpersonal, family and marital problems, focusing on these tended to escalate the patient's pathological behaviours. This tended to be due to the fact that emphasis was taken away from the patient's sick-role identity. However, any direct focus on the patient's symptoms also yielded little positive progress as the patient tended to manoeuvre towards vagueness. With direct confrontation, the patient would generally be able to creatively and dramatically justify herself back into the sick-role. With more accusatory confrontation (as was evident from the psychiatric department) the patient would act out with anger, disparagement, and a desire to leave treatment.

Over the course of therapy, there was improved communication, but also observable differences in the interdisciplinary approaches of the therapist as a psychologist and

the psychiatrists. The department of psychiatry appeared to be more concerned with a focus on management of the patient and providing the patient with the correct medication, which necessitated the making of a correct diagnosis. The therapist through the course of therapy had been confronted with conflicting issues concerning diagnosis. The therapist believes that psychiatric diagnostic criteria are not necessities of his therapeutic approach. The therapist did not have the aim of confirming the diagnosis and could therefore accept and allow the patient to deny her factitious behaviour. The therapist's focus was not on confirming a diagnosis even though he showed an initial concern with the patient's diagnosis. The diagnoses served to aid him in the monitoring of the patient's interactional styles and behaviour. The therapist was therefore able to concede to the benefits afforded to him by making use of diagnostic criteria in his conceptualisation of therapy.

By focusing on the diagnosis of a borderline personality disorder, the therapist was able to focus upon specific therapeutic aims. These aims were to provide structure and consistency for the patient in therapy. The therapist appears to have been able to merge these aims with his focus on client-centeredness. The therapist was also able to acknowledge that in the case of a personality disorder, only minimal change could be expected in the short time frame. These focuses allowed the therapist to feel more comfortable in therapy. As the therapist appears to have had to facilitate the patient in integrating her emotional and mental states, the consistency could be seen as therapeutically beneficial. The therapist could thus become a stable object for the patient for the duration of therapy. The therapist further benefited himself from reduced frustration due to the boundaries and structure established in the therapy. However, the boundaries of therapy were still pushed by the patient.

Therapy however showed a significant progression shortly before termination. The patient had shown an escalation in pathological behaviour with a suicide (or para-suicide) attempt. The therapist confronted her directly on the paradoxes between her wishes and her behaviour. The therapist faced once again with argumentative justifications from the patient; strategically approached the patient's paradoxical interactional style by complementing the patient on her intellect. The therapist challenged the patient to use her intelligence productively and constructively rather than her characteristic counter-productive behaviours that served to maintain her sick-

role. The therapist conceded to the fact that he could not outwit or outsmart the patient, and therefore was not going to attempt to. What appears to have made the strategic intervention apparently successful appears to have been the congruence with which the therapist expressed his frustration. The intervention also highlights the therapist's existential beliefs.

There was a qualitative change in the patient, in both her appearance and interactions. The patient had appeared to change her focus of identity to that of health rather than illness. The patient engaged in a structured form of introspection in which she genuinely and sincerely appeared to address her topics of concern. The catalyst appeared to have been the therapists, challenge to her intelligence – although it may be prudent not to rule out the significance of the impending termination. The patient appeared to have internalised many of the existential aspects of the therapist's therapeutic focus, while also attributing importance to the mental and emotional states.

The patient spontaneously provided the therapist with feedback on what approaches she had felt were beneficial to the therapy. She referred to the consistency of the therapist and the structure of the therapy. She referred to the therapist's ability to tolerate the patient's behaviour, and his non-accusational and non-confrontational approach. The patient highlighted that correct interpretations of her behaviour – regardless of how correct or accurate - did not generally have a productive effect on her. Nor did a too confrontational approach to her behaviour. The therapist believed that the patient was sincere, and her changes in behaviour and cognition were genuine. The style of the patient was qualitatively different to her manipulative approaches.

The therapist highlighted that he had never discussed his treatment goals with the patient. The therapist thus appears to believe that the therapeutic growth of the patient was genuine. The positive changes of the patient appeared to have maintained themselves upon termination. This reaction itself is qualitatively different to the patient's prior reactions to termination.

3.5 Summary

This chapter contains the phenomenological analysis of the naïve description of the therapist, who was confronted in psychotherapy with a patient who was diagnosed with a "factitious disorder". The method follows an adaptation of Giorgi's (1985) psychological phenomenological method, and is outlined in Chapter 2 (Heading 2.9).

The author, as researcher, following this method, arrived at a specific description of the situated structure of therapy with a "factitious disorder" patient (Refer to Heading 3.4.2). This is the description of the therapy as it was experienced by the therapist (subject to phenomenological analysis for its lived experience). It is this structure that is communicated to the reader and other researchers for purposes of confirmation or criticism.

By stepping away from the process of bracketing, we can now turn to a process by which we can place and compare this phenomenon (therapy with a factitious disorder patient) to the existing literature and theory on factitious disorders.

The following chapter will provide a literature review on factitious disorders for the purposes of placing the therapist's experiences within the existing literature and theory. This allows the author to evaluate and compare the therapist's experience within the existing literature and theory. It also allows the reader and other researcher's a forum by which to evaluate the therapist's experience.

The literature review is to be followed by the evaluation and conclusion chapter (Chapter 5). In this chapter, the author provides his tentative and subjective evaluation. This is achieved by comparing the therapist's experience to the available literature, as well as the patient's feedback.

The author continues first with Chapter 4, the literature review.

Chapter 4

Literature Review

4.1 Introduction

This literature review aims to focus upon a thorough description of factitious disorders. Factitious disorders involve patients who actively and voluntarily portray, feign, simulate or produce illness and sickness for the apparent sole purpose of receiving and maintaining a sick or patient role (Barlow & Durand, 1999; DSM-IV, 1994; Ford, 1996b; Freyberger et. al., 1994; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Meyer, 1989; Meyer & Salmon, 1984; Nordmeyer, 1994; Stoudemire & Fogel, 1993; Wedel, 1995). Factitious disorders thus fall within a spectrum of people for whom illness is a way of life:

> Health is accorded a positive value in Western society, yet paradoxically many persons choose illness as a way of life. This choice is usually, but not always, unconsciously determined, and the patient will state that health is preferable and indeed repetitively seek medical care.
>
> (Ford, 1984, p. 1)

In order to focus upon factitious disorders, they need to be discussed within the spectrum of people who choose illness and sickness as a way of life and seek medical care. The author therefore first places factitious disorders within a global spectrum of somatization. The conceptualisations of disease, illness, health and their typical psychological responses as well as the sick role (prominent in factitious disorders) will thus first need to be discussed before a more in depth view of the factitious disorders. This is in an attempt to conceptualise factitious disorders within a spectrum of sickness as a way of life. It also serves to clarify some terminology that will be used in reference to factitious disorders.

This chapter will begin with the concept of somatization (Heading 4.2). The author then continues by defining the global concepts of disease, illness, and health (Heading 4.3) as they pertain to the spectrum of illness in general, and including some typical psychological responses. This allows for the deviations in somatization – from

normal disease and illness – to be noted. The "sick role" (Heading 4.4) will then be attended to as it pertains to factitious disorders specifically. The author then places factitious disorders within a spectrum of illness (Heading 4.5) – specifically somatization – before discussing the factitious disorders exclusively (Heading 4.6). The global concept of somatization is discussed first.

4.2 The Concept of Somatization

Freud and Breuer in their studies on hysteria were the first to consider the translation of unconscious emotional conflicts into more acceptable physical symptoms (Barlow & Durand, 1999; Richards, 1974). Ford (1984) states that somatization "is a process by which the body (the soma) is used for psychological purposes or for personal gain. Any one symptom or constellation of symptoms may concurrently serve more than one function, including issues related to intrapsychic conflicts, interpersonal relationships, and social and environment problems" (p. 1). Ford states further that the interpersonal and psychological gains from somatization are often not distinct from the gains in genuine organic illnesses. It is not uncommon for people with legitimate illnesses (caused by unquestionable organic aetiology) to capitalise on their illness to serve a variety of needs.

There are however, certain individuals who go beyond normal capitalising on illness and who repetitively use their bodies (soma) as a means of handling and coping with psychological and life stresses (Barlow & Durand, 1999; Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1984; Lipsitt, 1996; Nadelson, 1996; Plassmann, 1994d). As such, the concepts of disease, illness, health, and the "sick-role" need to be discussed before the spectrum of illness or factitious disorders can be considered.

4.3 Concepts of Disease, Illness and Health

Ford (1984) highlights that when considering illness, people who may have similar symptoms, often display remarkably individual and different *illness behaviour*. Illness behaviour is a term to describe the various types of behaviour that people may

have in regard to their perceptions of bodily symptoms and their evaluation of these symptoms. This behaviour also refers to the course of action that they take (or do not take) in response to their illness. It is also important to remember that illness behaviour elicits differing responses from those in interaction with the ill person (Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1984; Lipsitt, 1996; Nadelson, 1996). The illness behaviour (and responses to it) will be an important concept to consider in factitious disorders.

For the purposes of this study, the author believes that it is important to clarify the conceptual distinctions between disease, illness and health.

Ford (1984) refers to *disease* as "objective anatomic deformations and pathophysiologic conditions" (p. 8). The causes may vary aetiologically, but the changes can usually be demonstrated objectively (even though diagnostic equipment may be required). The variety of aetiological factors can often be classified as degenerative processes, trauma (physical), toxins, and infectious agents. "The study of disease has been the almost exclusive focus of the bioscientific medical model which has increasingly predominated modern medicine" (Ford, 1984; p. 9). This is often why doctors and physicians are often derogatory towards patients whose condition is not believed to be medical, or at the very least do not regard them as real patients (Feldman & Ford, 1994; Ford, 1984; Kaplan & Sadock, 1998; Lipsitt, 1996; Maxmen & Ward, 1995; Meyer, 1989; Meyer & Salmon, 1984; Nadelson, 1996; Stoudemire & Fogel, 1993). Ford (1984) however, highlights the fact that in general, patients may become dissatisfied with doctors who because of their preoccupation with disease, focus on only one aspect of illness (to the detriment of other aspects).

Illness refers in general to "experiences of disvalued changes in states of being and social function" (Ford, 1984, p. 9). Illness, therefore takes into account the personal nature of suffering, separation from and loss of usually gratifying activities, and the decreased capacity to participate in society. Illness can be seen to have a subjective quality with many personal aspects being unique to each individual (Feldman & Ford, 1994; Ford, 1984; Lipsitt, 1996; Nadelson, 1996). It is this subjectivity of illness that the author believes psychologists are often able to address and work with.

It can generally be accepted from the definitions that the concepts of disease and illness often accompany one another. They can be seen to interact with one another. It is often assumed that a person's symptoms and resultant illness behaviour will parallel the nature and degree of the disease. However, this is even under normal circumstances often not the case. Divergences can occur in either direction. There can be extensive disease but little evidence of illness, or a strong portrayal of illness with little evidence of disease (Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1984; Lipsitt, 1996; Nadelson, 1996).

It is therefore useful to also consider the concept of *health*. Health is a term that many people take for granted, and is usually defined in terms of the absence of either disease or illness. This suggests a rather passive approach to health. It is however notable that one's perception of health may still remain even in the presence of considerable disease. A person's perception of health is often related to their belief in their ability to carry out everyday tasks. Ford (1984) suggests viewing health as an active homeostatic process. Health can thus be seen as an "active process of maintaining a disease-free state" (Ford, 1984, p. 10). Health behaviour is therefore complementary to rather than opposite to illness behaviour.

A person is not necessarily a patient when they are seen to have a disease. Ford (1984) states that a person becomes a "patient" from the moment a medical consultation is sought. This is very often due to the fact that "(1) the symptoms have become intolerable in terms of pain, discomfort, or disability; (2) the symptoms have caused anxiety and the patient fears their consequences; and (3) the symptoms are actually a mask for a problem in living" (Ford, 1984, p. 12). Therefore, the point at which a person becomes a patient reflects more social decision points than boundaries reflected by changing biological factors.

A person's illness behaviour will very often reflect their attitudes towards the concepts of health and illness. Various psychological processes (such as denial) may either block the perception of symptoms, or others (such as anxiety) may actually intensify the perception of symptoms. Various symptoms themselves may even occur directly from psychological reactions and emotional states (Barlow & Durand, 1999; DSM-IV; Feldman & Ford, 1994; Ford, 1984; Griffith & Griffith, 1994; Kaplan &

Sadock, 1998; Lipsitt, 1996; Maxmen & Ward, 1995; Meyer, 1989; Meyer & Salmon, 1984; Stoudemire & Fogel, 1993).

The experience of disease and illness is often a personal and subjective experience based upon the person's own strengths and assets. Stress can also be seen to influence the process of disease and/or the perception of illness (Barlow & Durand, 1999; Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1984; Lipsitt, 1996; Nadelson, 1996). "The symptoms that a patient experiences may elicit a wide range of different interpretations. Evaluating the patient from the narrow perspective of the disease model may lead to inappropriate or inadequate treatment" (Ford, 1984, p. 20) and the neglecting of the subjective experience of illness. It is therefore important to take cognisance of the patient's interpretation of their disease and their subjective experience of illness and health.

Disease itself can have very personal aspects and meanings for an individual. These meanings relate to the reality of how the disease influences the patient's life, the intrapsychic and psychological perception of the disease, and the variety of coping mechanisms that are initiated in order to cope with the disease.

In referring to psychological responses to both acute and chronic disease, there can be a number of psychological processes that can be regarded as normal responses to disease (but too extensive to address in detail). The disease process is often perceived as a *threat* in that it threatens and interferes with the usual health state of a person's life. As patients are often faced with limitations imposed by the disease and the state of being sick, or threatened by its possible implications, the sick person often has to engage in the cognitive activity of searching for the *personal meaning* of their illness (Eisendrath, 1996; Ford, 1984; Ford, 1996b; Lipsitt, 1996; Nadelson, 1996). The perceptions of threat and personal meaning are subjective and individual and thus incredibly diverse.

There are numerous personal and individual factors influencing the perceptions of both threat and meaning of illness. Any individual may construct their own personal meaning of their illness that may incorporate more than one element. There are therefore numerous psychological reactions to disease. However, a number of

reactions can be considered to fall within a broad definition of normal responses. Psychological examples are (but not exclusively): denial, regression, anxiety, and grief. It is only when these responses are exaggerated in extent or overly prolonged that the responses may be considered abnormal, atypical or pathological (Feldman & Ford, 1994, Ford, 1984; Lipsitt, 1996; Plassmann, 1994a; Plassmann, 1994d).

Coping with disease and illness according to Ford (1984) can be categorised according to cop*ing style* and *coping techniques*, tactics or mechanisms. Coping style reflects a person's long-standing characteristic manner of coping with stress. As such it has a close relationship with personality – as personality is determined by the characteristic style that a person uses to deal with everyday life situations. Coping techniques refer to the more specific psychological mechanisms or behaviours that are used to adapt to the presence of a disease or illness.

With the general concepts of disease, illness, and health – as well as some characteristic psychological responses to disease and illness – discussed, the specific societal concept of the "sick role" can now be addressed.

4.4 The "Sick Role"

The *sick role* is a sociological term that was initially proposed by Parsons (1951). The term "role" is used by sociologists to define an individual's relationship to society with regards to a number of rights and obligations that are assumed a priori because of the individual's occupation, social status, or personal circumstances. A person is capable of occupying several roles, although behaviour is usually consistent with one role at a time (Ford, 1984; Ford, 1996b; Lipsitt, 1996).

> The sick role as described by Parsons is viewed as having a deviant status from the rest of society; to be sick is to be different. Associated with this deviant position are two major rights and two major obligations. The first right is that the sick person is released from the normal and usual social obligations of society, for example, attending school or work. The second right is that the sick person is absolved from blame for his condition; he cannot be expected to get well merely by will power and he must be cared for by others. In regard to the

> obligations, the sick person is expected to want to get well, to seek competent technical help, and to cooperate with such help in an effort to get well.
>
> (Ford, 1984, p. 24)

The model of a sick role concept may have "severe limitations when the illness is chronic or of less well-determined etiology such as psychiatric disorders" (Ford, 1984, p. 25). Therefore, there may be a variety of sick roles and not just one single sick role. Factors that may affect the entry into a sick role are age, gender, and socio-economic status. Cultural attitudes towards being sick and the implications of illness also affect the sick role. Self-reliance, which is the belief that one should be able to handle and cope with one's own problems, may also determine a person's willingness to adopt a sick role. There is thus a subjective and personal component to the sick role. Psychosocial stress and social support are strong factors influencing the adoption of a sick role (Eisendrath, 1996; Feldman & Ford, 1994, Ford, 1984; Lipsitt, 1996; Nadelson, 1996).

Because the Parsonian model of the sick role exempts the patient from usual social obligations, this not only affects the adoption of a sick role, but also the relinquishing of the sick role. Due to the subjective and personal experience of the illness and the sick role, certain individuals may be reluctant to assume the sick role and eager to exit from it, while others may easily adopt (or seek) a sick role, and reluctantly surrender it. It is not only the attitude of the patient that influences the adoption and relinquishing of the sick role, but also those around the patient (especially family members) (Eisendrath, 1996; Feldman & Ford, 1994, Ford, 1984; Ford, 1996b; Lipsitt, 1996; Nadelson, 1996).

The sick role as described by Parsons best fits with societal expectations when the illness is acute, visibly disabling, and a specific known cure is available. There is less of a willingness from society to accept the sick role (or afford its benefits) if the person is seen to be the cause of the illness. People with psychiatric or psychosocial problems are often not accepted as legitimate occupants of a sick role. Chronic disease requires a special consideration, as very often the patient is still able to fulfil many of their other roles (Eisendrath, 1996; Feldman & Ford, 1994, Ford, 1984; Lipsitt, 1996; Nadelson, 1996).

Through evaluation and consideration of the concept of the sick role it can be postulated that somatization may be motivated - either consciously or unconsciously - by the desire to seek those privileges that society provides to the sick person. The characteristics that therefore seem to predispose a person towards the sick role are: (1) when it is culturally more acceptable, (2) when social support systems are perceived to be inadequate, (3) when the individual feels themselves under psychosocial stress, (4) the sick role can resolve personal or social problems, (5) an individual is less self-reliant, and (6) an individual has decreased coping skills (Feldman & Ford, 1994, Ford, 1984; Ford, 1996b; Lipsitt, 1996; Nadelson, 1996).

Because society generally does not tend to accept emotional and psychological disorders, or difficulties in coping with life's problems and stresses as an acceptable entry into a sick role, the stress that a patient experiences can be translated into somatic complaints (Feldman & Ford, 1994, Ford, 1984; Ford, 1996b; Lipsitt, 1996).

The sick role is therefore an important concept of somatization – as well as factitious disorders specifically. Before considering factitious disorders in general, it is necessary to address some form of categorisation of factitious disorders within the spectrum of illness. The author now turns to an explication of perspectives on the spectrum of illness and related somatization disorders (disorders where the body is used for purposes of psychological or personal gain).

4.5 Perspectives on the Spectrum of Illness

Nadelson (1996) suggests that most physicians informally group their patient's somatic complaints into categories of either "real" symptoms or "false" symptoms. In the first category, the symptoms that the patients report can be seen to clearly derive from an anatomic or physiologic disturbance. The second category are "symptoms that appear more murky and emotionally coloured" (Nadelson, 1996, p. 1). Nadelson adds that the move within psychiatry has been to provide sharply defined and validated criteria for these psychological entities. While the Ford (1984) describes factitious disorders and Munchausen syndrome under a global concept of somatizing disorders, in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV,

1994), factitious disorders are housed in a different section to the somatoform disorders. What is needed therefore in discussing factitious disorders within a spectrum of sickness and somatizing, is to briefly distinguish the somatizing disorders from "real" illness, and then distinguish between the somatizing disorders themselves.

Nadelson provides what he refers to as a "common sense" approach to synthesising the ideas of sickness with the formal psychiatric diagnostic criteria in which somatizing is present. He states that the spectrum he suggests is intended not only to interconnect the somatizing disorders present in the DSM-IV, but also to integrate an understanding of the relationship between the "real", the "psychiatric" and the "factitial". "This schema has proved helpful to both psychiatric and nonpsychiatric clinicians by bringing into clearer focus the confusing confluence of a particular patient's personal responsibility and unconscious motivation" (Nadelson, 1996, p. 2). The following table suggests a brief overview:

Sickness assignment	Medical category A	Psychiatric category B	Legal category C1	C2
General diagnostic groupings	Infection, trauma, metabolic disease, cancer	Somatoform disorders Somatization disorder Undifferentiated somatoform conversion disorder Body dysmorphic disorder Pain disorder Hypochondriasis Somatoform disease NOS	Factitious disorders Prototypical factitious disorder Munchausen syndrome	Malingering
Character diagnosis	Not relevant	Various (neurotic, character disorder, alexithymic)	Borderline personality	Borderline or antisocial
View of specificity	Assumed specificity	Psychological mechanisms presented as aetiology		Fraud
Reason for medical problem	"Accident"; patient as victim	Sensitive to emotional stress; diathesis	Abnormal illness behaviour; expression of severe psychopathology	Personal gain
Physician's attitude towards patient	"This is a real patient, a legitimate victim"	"This is a psychiatric patient, a crock, but still a patient"	"This is a false patient, not a patient"	"This is a crook"
Patient role	Afflicted	Welcoming sickness; care-eliciting behaviour	Causing sickness; care-coercing behaviour	Causing sickness: Fraud
Sickness source as viewed by physician	"Body"	"Mind"	"Character"	
Sickness source as viewed by patient	Body	Body	Confused	Self
Goal of most caretakers	Cure, manage, palliate	Stabilise, manage, cure	Neutralise, help	Reveal fraud, punish

(Adapted from Nadelson, 1996, p.3-4)

Nadelson (1996) highlights the difference between malingering and factitious disorders. Firstly, malingering is not a DSM-IV diagnosis. However, due to the conscious (often wilful) nature of symptom production in both disorders, the distinction can often be blurred. The symptom production in malingering is prompted by a specific external incentive, whereas in factitious disorders (including Munchausen syndrome), it is for the "sick role" itself. It seems to be the conscious nature of the production of symptoms that leads Nadelson to place factitious disorders in the legal category (as it has possible legal implications). The DSM-IV also differentiates factitious disorders from malingering. However, they suggest that the psychological need to assume the sick role tends to rather imply psychopathology. This suggests that factitious disorders fall under the psychiatric category. Either way, "[f]actitious disorders lie in the middle of a continuum between the outright fakery of physical symptoms (malingering) and their unconscious production (somatoform disorders)" (Maxmen & Ward, 1995, p. 304). As such factitious disorders occupy a difficult middle ground in the somatizing spectrum from somatoform disorders to malingering (Barlow & Durand, 1999; DSM-IV, 1994; Feldman & Ford, 1994; ICD-10, 1992; Meyer, 1989; Nadelson, 1996).

Eisendrath (1996) suggests that in order to sharpen the factitious diagnosis, one needs to address Pilowsky's (1978) term of the *abnormal illness-affirming behaviour*. This term is used to describe the behaviour when "an individual amplifies signs or symptoms of illness out of proportion to the biomedical disease present" (Eisendrath, 1996, p. 30). These behaviours may be conscious or unconscious in production, and conscious or unconscious in motivation (Eisendrath, 1996; Eisendrath, Rand & Feldman, 1996, Feldman & Ford, 1994). The following table demonstrates how this conceptualisation is useful in differentiating between somatoform disorders, factitious disorders, and malingering:

	Signs and Symptoms	
	Production	**Motivation**
Malingering	Conscious	Conscious
Factitious disorders	Conscious	Unconscious
Conversion disorder	Unconscious	Unconscious
Somatization disorder	Unconscious	Unconscious
Hypochondriasis	Unconscious	Unconscious
Pain associated with psychological factors	Unconscious	Unconscious

(Adapted from Eisendrath, 1996, p. 30)

Eisendrath, Rand and Feldman (1996) add that in malingering, the secondary gain (i.e. financial gains or relief from difficult situations) is greater than the secondary cost (i.e. loss of income, prestige, or physical abilities). However, in factitious disorders, the secondary cost is often greater than the secondary gain (if there is any), but it is the primary gain that is seen to be greater than the secondary cost. Primary gain is seen as the gratifying some psychological need of the patient. The primary gain – which is the trigger for the factitious disorder – is not always obvious or apparent to an outside observer. "The motivations underlying factitious disorders may be unconscious even though the choice of symptoms is deliberate" (Feldman & Ford, 1994, p. 141). Malingering by contrast can be understandable by apparent incentives and circumstances in the given situation, rather than from the patient's individual psychology (Eisendrath, Feldman & Ford, 1994; ICD-10, 1992; Maxmen & Ward, 1995; Meyer, 1989; Meyer & Salmon, 1984; Rand & Feldman, 1996; Ford, 1984; Ford, 1996b; Stoudemire & Fogel, 1993).

Having contextualised factitious disorders within a spectrum of somatizing illness and disorders, factitious disorders can now be focussed upon with greater specificity. The review of factitious disorders will begin with a general description of factitious disorders (Heading 4.6) that includes the diagnostic criteria and diagnostic considerations. Munchausen syndrome will be referred to as an extreme of factitious disorders. The general description will then turn to differential diagnosis, epidemiology and prognosis. This section will be followed by the clinical features of factitious disorders (Heading 4.7) that includes the physical and psychological subtypes of the disorder as well as Munchausen syndrome. Personality disorders (Heading 4.8) will be discussed as they specifically relate to factitious disorders. This

will then be followed by some of the aetiological conceptualisations (Heading 4.9) of factitious disorders before addressing the ethical and legal issues (Heading 4.10) involved in factitious disorders, as well as the personal and interpersonal consequences and patterns of the disorder (Heading 4.11). The literature review on factitious disorders will be concluded with a discussion on management and treatment (Heading 4.12) as well as some thoughts on therapy (Heading 4.13) with factitious disorder patients. This literature review continues with the definition and discussion of factitious disorders.

4.6 Factitious Disorders

Factitious in its most general definition essentially means: not genuine or real. "Factitious disorders are characterized by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role" (DSM-IV, 1994, p. 471). The symptoms of the disease or illness can be perceived as simulated, produced by, and under the voluntary control of the individual. The only apparent goal of the behaviour is to assume the sick/patient role without an external incentive. For many individuals, hospitalisation itself is a primary objective and even a way of life (Barlow & Durand, 1999; DSM-IV, 1994; Ford, 1996b; Freyberger et. al., 1994; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Meyer, 1989; Meyer & Salmon, 1984; Nordmeyer, 1994; Stoudemire & Fogel, 1993; Wedel, 1995).

Factitious disorders offer a unique and challenging approach to physicians expected views of illness. "If we impute a conscious motive to the wish to be sick, we regard this as strange behavior indeed; only in the case of the true malingerer, whose behavior is quite transparently designed for some personal gain, does logic prevail" (Lipsitt, 1996, p. xx). It is suggested that it is counter-intuitive that a person would willingly accept and even produce or feign illness.

However, even though factitious disorders refer to conditions in which individuals wilfully create and produce signs and symptoms of physical and psychological illness, nearly everyone can themselves be aware of at least some times in their lives amplifying their own physical symptoms to fulfil a psychological need. Therefore

Eisendrath (1996) suggests that factitious behaviours themselves can be conceptualised on a spectrum that ranges from normal adaptive functioning to severe disability. Factitious types of behaviour are generally only considered to become a disorder when they significantly or persistently interfere with a person's normal functioning. This exaggerated outgrowth from relatively harmless and normal behaviour ("playing sick") is what makes factitious disorders according to Feldman and Ford (1994) simultaneously both frightening and familiar. Factitial patients take "playing sick to pathological extremes" (Feldman & Ford, 1994, p. vii). So let us now turn to the diagnostic criteria and diagnostic considerations of factitious disorders.

4.6.1 Diagnosis

It is necessary with the various perspectives and views on the classification of factitious disorders within the somatizing spectrum of disorders and behaviour, and various presentations of factitious behaviour itself, to first have diagnostic criteria for factitious disorders. The essential features of a Factitious Disorder are "the intentional production of physical or psychological signs or symptoms" (DSM-IV, 1994, p. 471). The goal is to assume the sick or patient role – with an absence of external incentives as being the primary goal (DSM-IV, 1994; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Meyer, 1989; Meyer & Salmon, 1984; Stoudemire & Fogel, 1993). The subtypes according to the DSM-IV are Factitious Disorders with Predominantly Physical Signs and Symptoms, Factitious Disorders with Predominantly Psychological Signs and Symptoms, or Factitious Disorders with Combined Psychological and Physical Signs and Symptoms (DSM-IV, 1994; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Meyer, 1989). Throughout this chapter, factitious disorders will be referred to generally, and where applicable may be differentiated into their relevant diagnostic subtypes. The diagnostic criteria are as follows:

Diagnostic criteria for Factitious Disorder

A. Intentional production or feigning of physical or psychological signs or symptoms.
B. The motivation for the behaviour is to assume the sick role.
C. External incentives for the behavior (such as economic gain, avoiding legal responsibility, or improving physical well-being, as in Malingering) are absent.

Code based on type:

300.16 With Predominantly Psychological Signs and Symptoms: if psychological signs and symptoms predominate in the clinical presentation

300.19 With Predominantly Physical Signs and Symptoms: if physical signs and symptoms predominate in the clinical presentation

300.19 With Combined Psychological and Physical Signs and Symptoms: if both psychological and physical signs and symptoms are present but neither predominates in the clinical presentation

(DSM-IV, 1994, p. 474)

While the diagnostic criteria may appear to be quite simple in presentation, there are a number of diagnostic considerations that must be taken cognisance of.

4.6.2 Diagnostic Considerations

According to the DSM-IV, Factitious Disorders need to be differentiated from Somatoform Disorders and Malingering. This in itself is a major diagnostic consideration. In Somatoform Disorders, physical symptoms and complaints are also not fully attributable to a true medical condition or illness, but the symptoms are not intentionally or consciously produced. These patients are unaware of their role in producing their disorders. "Patients with factitious disorders generally are aware of their role in producing their illness but do not clearly understand why they are doing so" (Eisendrath, 1996, p. 30). The symptoms in somatoform disorders usually do not always conform to the expected patterns of the anatomical illness they mimic, are usually associated with a great amount of anxiety, and are not under voluntary control. Factitious Disorders differ from Malingering in that the motivation for the symptom production in malingering is an obvious, recognisable external incentive (Eisendrath, 1996; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Meyer & Salmon, 1984; Stoudemire & Fogel, 1993).

Another major diagnostic consideration for factitious disorders is the lengthy time period taken before they are correctly diagnosed. "The delay in diagnosis is unfortunate because it often leads to inappropriate interventions and iatrogenic complications" (Eisendrath, 1996, p. 28). The problem often arises later in that it becomes virtually impossible to distinguish the original disease (if any) of the patient from the complications of the self-injurious nature of factitious behavior or from iatrogenic complications occurring during the treatment the factitious behavior (Paar, 1994). Stoudemire and Fogel (1993) perceive the ability to protect the patient from iatrogenic risk as often the only acceptable or viable treatment.

The diagnosis of a factitious disorder, while seen as a necessity, is itself difficult to make. "Factitious disorders are rare, and … they comprise the most difficult DSM category to diagnose, in part because the feigned symptoms are often accompanied by a more subtle, though actual, physical disorder" (Meyer, 1989, p. 303). There are a number of clues that may lead to the considering of a diagnosis of a Factitious Disorder. Suspicion that an apparent general medical condition or mental disorder represents a Factitious Disorder should be aroused if any combinations of the following are noted in a hospitalised individual:

1. Atypical or dramatic presentation of symptoms that does not conform to an identifiable general medical condition or mental disorder. Vague or confusing depictions of symptoms are not unusual.
2. Medical and/or psychiatric conditions do not respond to seemingly correct medical treatment.
3. Symptoms or behaviours are often only present when the individual is being observed.
4. Fluctuating clinical course with rapid development of complications or new pathology when tests are negative and/or the patient may be notably accurate in predicting the fluctuations.
5. Difficulty in obtaining medical histories and collateral information that is usually vague. The patient usually justifies discrepancies with convoluted answers.
6. Disruptive behaviour in the hospital (non-compliance with hospital regulations, arguing excessively with healthcare professionals). Excessive drama.

7. Extensive knowledge of medical terminology and hospital routines. Comments by patient may sound like they come straight from a textbook, suggesting an extraordinary amount of research done by the patient.
8. An occupational history that sometimes shows links to healthcare professions.
9. Covert use of substances – often used to induce physical symptoms.
10. Evidence of multiple treatment interventions and the extensive consumption of medical resources. Patient has been subjected to numerous surgical procedures.
11. Extensive hospitalisations, or extensive history of travelling (to differing hospitals and clinics as in Munchausen syndrome).
12. Pseudologica fantastica (Refer to Heading 4.6.3.1 for definition).
13. Observing visitors, family and friends in hospital context (Munchausen patient's for example would have few, if any, visitors. A finding inconsistent with their grandiose portrayals and pseudologia fantastica).

(DSM-IV, 1994; Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1984; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Meyer & Salmon, 1984; Parker, 1996).

The above list is not exhaustive, and many patients with factitious disorders show various combinations and degrees of the above characteristics. These characteristics (although not diagnostic) tend to predominate the clinical picture, and can therefore raise suspicion for a factitious disorder diagnosis. Due to the great variety in factitious presentation and the false nature of the patients, it is especially essential that physicians seek outside collateral sources of information (Eisendrath, 1996; Kaplan & Sadock, 1998).

Patients who present with a factitious disorder with predominantly psychological signs and symptoms are often difficult to diagnose and present a unique challenge for even the physician who is aware of and alert for the factitious phenomenon. This is as physicians often depend on concrete evidence (such as laboratory results) for diagnosis (Maxmen & Ward, 1995; Parker, 1996). The DSM-IV states that the "subtype describes a clinical presentation in which psychological signs and symptoms predominate. … The presentation usually represents the individual's concept of mental disorder and may not conform to any recognized diagnostic category" (DSM-IV, 1994, p. 472). Feldman and Ford (1994) suggest that it might generally be easier

to portray a psychological illness because of the fact that psychological phenomena can often be entirely subjective and therefore harder to confirm or dispute.

Parker (1996) states that the psychological subset of factitious disorders tends to only "identify a hazy spot in the spectrum of factitious disorder" (p. 38) and that the distinction between physical and psychological factitious disorders servers only "as a convenience but not always a clarification" (p. 38). There have been very few cases of factitious disorders that lack a physical component and have solely psychological symptoms. There has been a great debate as to whether the diagnostic category of a factitious disorder with psychological symptoms is valid, due to the difficulty in distinguishing real psychological symptoms from factitious ones, and the fact that often some symptoms do respond to treatment. However, in general factitious disorders with psychological symptoms tend to have the same psychodynamic origins as factitious disorders with physical symptoms, and the goal is generally the same – to assume the sick role (Feldman & Ford, 1994; Meyer, 1989; Meyer & Salmon, 1984).

The diagnosis of a psychological factitious disorder also does not preclude the existence of genuine psychological problems and diagnoses. "Factitious disorder with psychological symptoms *and* another mental disorder can both be diagnosed, as long as the factitious symptoms are produced without an ulterior motive (as in malingering)" (Maxmen & Ward, 1995, p. 309). The distinction as to whether a patient's symptoms and associated psychological disorder are factitious or not tends to be based on whether the motive for their behaviour is to assume the sick role or not.

Parker (1996) additionally cautions that psychological symptoms "lack the biological markers that might be available in the factitious physical disorder patient" (p. 42). Therefore, to make a diagnosis of a factitious disorder with purely psychological symptoms can be much more difficult than a diagnosis of factitious physical disorder. A main complicating factor in psychological factitious disorders (as stated above) is the difficulty in distinguishing between the psychiatric disorder and other similar psychiatric syndromes. There is a difficult overlap between dissociation and other somatizing disorders. It has been reported that some patients with factitious disorders may experience genuine dissociative episodes (Feldman & Ford, 1994).

In addition it is believed that physicians would be more inclined to believe patients with falsified psychological symptoms. Firstly, this tends to be because psychological disorders are still associated with a stigma and it seems counter-intuitive that an individual would feign these symptoms. Secondly, symptoms of depression and bereavement are rarely questioned. Finally, the resources needed to confirm psychosocial data and obtain collateral information are often not as accessible as laboratory results. The clues for detecting the deception, often tend only to lie within the discrepancy between what the patient reports and their actual appearance or behaviour. Sometimes the only distinction between a real psychological disorder and a factitious one is the fact that the factitious disorder patient *intentionally* chooses their disorder – and this is not always known (Feldman & Ford, 1994; Parker, 1996).

Factitious disorders, by differing in presentation and degree are often referred to as acute/simple or chronic factitious disorders, and Munchausen or non-Munchausen patients. A simple factitious disorder (the production of one predominant factitious illness) no matter how long it is maintained (sometimes years in the case of factitious cancer) is generally not regarded as Munchausen syndrome because it involves a single deception. Simple factitious disorders in some cases do not flee when confronted, and may be relieved to admit the deception. This is more often the case when a depression is underlying the factitious behaviour (Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1996b). The author can now turn to a discussion and definition of Munchausen syndrome that as a variation of factitious disorders is fascinating, extreme, chronic and often cited in the literature.

4.6.3 Munchausen Syndrome

> With few exceptions in the last 30 years, the term factitious disorders and Munchausen syndrome have been used interchangeably, but a distinction must be made between them. Not all patients who suffer factitious disorders have Munchausen syndrome. Munchausen syndrome is an especially extreme and dangerous form, the pinnacle of a pyramid in which the benign use of illness is the base, factitious disorders are the centre, and chronic factitious disorder – or Munchausen syndrome – is the top.
>
> (Feldman & Ford, 1994, p. 25)

In 1951, Asher had described a previously undefined syndrome, "consisting of the deliberate seeking of repetitive hospitalization through the use of simulated disease and the association with fantastic storytelling" (Ford, 1984, p. 155). According to Asher (1951), Munchausen syndrome was defined by three major characteristics: 1) malingered or simulated diseases, 2) pseudologia fantastica (pathological lying), and 3) peregrination (travelling). Munchausen syndrome is not a diagnostic category in the DSM-IV. The DSM-IV does however *refer to* Munchausen syndrome under the category of Factitious Disorders with Predominantly Physical Signs and Symptoms. The syndrome is generally referred to as a chronic factitial disorder not necessarily exclusive to physical signs and symptoms, although they tend to predominate (Ford, 1984; Ford, 1996b; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Meyer, 1989; Meyer & Salmon, 1984; Plassmann, 1994a; Stoudemire & Fogel, 1993).

Asher advised that physicians could be alerted to the possibility of a Munchausen syndrome if a patient had: "(1) numerous surgical scars, usually in the abdominal area; (2) a truculent and evasive manner; (3) personal and medical histories that were fraught with acute and harrowing adventures that seemed to fall just on the wrong side of truth; and (4) a history of many hospitalizations, malpractice claims, and insurance claims" (Feldman & Ford, 1994, p. 24).

Munchausen syndrome is generally characterised by its rareness (even relative to factitious disorders) and its apparent resistance to treatment. Ford (1984) states that even due to its rarity, Munchausen syndrome is worthwhile studying, as it tends to represent the extreme of a continuum of somatization behaviour. "Their behavior, and the underlying psychodynamics, often demonstrate, in bold relief, that which may be more subtle in other patients whose somatizing behavior is less extreme" (Ford, 1984, p. 156). As Munchausen syndrome is on a continuum, only the more extreme cases have the features of grandiosity with pseudologia fantastica (Refer to Heading 4.6.3.1), the extensive travels, and the dramatic presentation of simulated rare diseases. Therefore comparatively few patients with Munchausen syndrome have been studied. This is understandable considering the nature of the disorder (Eisendrath, 1996; Eisendrath & Feder, 1996; Ford, 1984; Ford, 1996b; Lipsitt, 1996; Nadelson, 1996).

The concept of a continuum is useful for describing the conscious production of illness. At the lower end of this spectrum is the conscious nonpathological feigning of illness – "playing sick". This is the common use of mild symptoms as avoidance or attention getting tools. It is generally accepted that there is no malicious intent, and there are only minor emotional or material gains. At the more extreme end of this spectrum is the conscious pathological feigning of illness. Malingering is the intentional use of exaggerated or false symptoms to obtain tangible material gains. While the act is despicable, it makes intuitive sense. Factitious disorders are seen at the end of this spectrum, as there is a deliberate forgery as in malingering, but the goal is intangible and psychologically complex. The behaviour appears to fulfil an emotional need or satisfaction for the patient. Munchausen syndrome, Munchausen by Proxy, and Munchausen by Adult Proxy are seen to be the extreme variants of factitious behaviour and disease simulation (Feldman & Ford, 1994; Ford, 1996b; Wedel, 1995).

Patients with Munchausen syndrome are often reported to have superior intelligence with impressive knowledge of medical disease, illness and terminology. The cases of Munchausen syndrome show an essential feature of plausible presentations of (factitious) physical symptoms in order to sustain multiple hospital admissions (Feldman & Ford, 1994; Ford, 1984; Ford, 1996b; Meyer & Salmon, 1984; Stoudemire & Fogel, 1993).

Having discussed factitious disorders in general and Munchausen syndrome, it is possible to briefly divert to a clarification and definition of a term that has emerged: pseudologia fantastica.

4.6.3.1 Pseudologia Fantastica

Although pseudologia fantastica is a defining feature in Munchausen syndrome, it is not exclusive to it. In pseudologia fantastica, patients offer fantastic, yet plausible descriptions of their history and background (Feldman & Ford, 1994; Kaplan & Sadock, 1998; Maxmen & Ward, 1995). Feldman and Ford (1994) describe three criteria for pseudologia fantastica: "the story must be probable and maintain a reference to reality; the fanciful adventures must be able to be applied to any number

of circumstances in a reasonable manner; and, while the theme of the adventures may vary, the distinctive role of hero, heroine, or victim is almost always reserved for the storyteller" (p. 71). Pseudologia fantastica therefore serves not only to deceive the physician – and other health care professionals – but also to elevate the narcissistic importance of the patient.

With a description and definition of pseudologia fantastica in mind, the author can now return to the discussion of factitious disorders with a focus on differential diagnosis, epidemiology and prognosis.

4.6.4 Differential Diagnosis

The most important things to rule out when faced with a probable factitious disorder case are genuine medical conditions or real mental disorders that might be producing or responsible for the symptoms. In cases of factitious disorders with predominantly physical symptoms, physicians need to rule out all possible abnormalities. The diagnosis is thus generally represents an *exclusion diagnosis* (DSM-IV, 1994; Eisendrath, 1996; Feldman & Ford, 1994; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Paar, 1994; Stoudemire & Fogel, 1993). "Medical professionals often must also show through conclusive tests that the condition cannot be otherwise explained. In other words, one is presumed ill until proved guilty or faking" (Feldman & Ford, 1994, p. 125). Once genuine disease has been excluded, wilfully self-destructive acts such as suicide and self-mutilation (evident in other psychopathology) also need to be considered. Self-mutilation and overt self-injury usually involve the injuring of the skin. These patients usually acknowledge their role in their injuries and self-destructive behaviour. Individual's performing these acts will also need medical care as a secondary treatment (Eisendrath, 1996; Sachsse, 1994).

As stated above (under Heading 4.6.2), Factitious disorders need to be differentiated from Somatoform disorders and malingering (Eisendrath, 1996; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Meyer & Salmon, 1984; Stoudemire & Fogel, 1993). Dissociative disorders should also be considered in the diagnosis of factitious disorders (Parker, 1996). This is complicated by the fact that Feldman and Ford

(1994) state that some patients with factitious disorders may actually experience genuine dissociative episodes.

Therefore, Eisendrath's (1996) table for *abnormal illness-affirming behaviours* is useful in the differential diagnosis. To differentiate as to whether a particular behaviour is being produced consciously or unconsciously may however be more difficult than it seems. There are a number of factors that may aid in the identifying of conscious or voluntary productions of signs or symptoms: (1) direct admission of fabrication from patient, (2) direct observation of the patient's fabrication of symptoms, (3) signs or symptoms that contradict laboratory findings, (4) non-physiologic response to treatment, and (5) physical evidence of the patient's fabrication (finding pills, syringes, etc.) (Eisendrath, 1996). It does however remain difficult to distinguish between conscious and behaviour and motivation (especially in the case of psychological factitious disorders) (Parker, 1996).

A further problem with diagnosis is that when clinicians do suspect deception, and illness and disease production, patients tend to initially be suspected to be (or diagnosed as) malingerers or antisocial personality disorders, and then given little further attention. Antisocial people however would not usually volunteer for invasive procedures or resort to hospitalisation as a way of life (Kaplan & Sadock, 1998; Meyer, 1989; Meyer & Salmon, 1984).

The DSM-IV cautions that the presence of factitious symptoms does not exclude the coexistence of true physical or psychological symptoms (DSM-IV, 1994). Parker (1996) adds that in the case of factitious psychological disorders that the patient might actually have the very disorder that they are attempting to simulate. In other instances, the patient's simulations of a mental disorder "may actually be the prodrome to an authentic mental disorder with a serious outcome" (p. 44). Freyberger and Schneider (1994) go further to suggest that the diagnostic systems have to include the phenomenological and aetiological relationship between factitious disorders and borderline personality, (acute, transient, and atypical) psychotic disorders, and dissociative states.

The aetiological conceptualisations of factitious disorders and possible links with personality disorders will be discussed later (Headings 4.9 and 4.8). The discussion first continues with the general characteristics of factitious disorders. A brief look at the epidemiology and prognosis of the disorder follows.

4.6.5 Epidemiology and Prognosis

The epidemiology and prevalence of factitious disorders is based upon limited data. This is because it is a rarely reported diagnosis and may often go unidentified and unrecognised, mainly because these disorders may not be part of the usual differential diagnosis. Many clinicians believe that factitious disorders are more common than are reported. On the other hand, the chronic forms of the disorder (often Munchausen syndrome) may be over reported in the medical literature as the same affected individual may appear to different physicians, at different hospitals, and under different names. Factitious disorders tend to develop in the third and fourth decades of life although precursors can be present in childhood and adolescence (DSM-IV, 1994; Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1984; Kaplan & Sadock, 1998; Lipsitt, 1996; Maxmen & Ward, 1995; Nordmeyer et. al., 1994; Stoudemire & Fogel, 1993).

Many patients with factitious disorders do not suffer from Munchausen syndrome. It is estimated that only 10% of patients with factitious disorders have Munchausen syndrome. It generally appears as though two-thirds of Munchausen patients are male. In the more simple forms of factitious disorders (non-Munchausen), patients more commonly tend to be female by a ratio of 3:1. The non-Munchausen patients appear to share features with patients with Somatoform Disorders, expressing their conflicts without overt acting out (Eisendrath, 1996; Plassmann, 1994a; Stoudemire & Fogel, 1993).

The epidemiology of factitious disorders with predominantly psychological signs and symptoms is extremely difficult to measure. "Only a handful of factitious disorder cases that contain psychological symptoms exclusive of physical symptoms have been reported" (Parker, 1996, p. 39). This tends to be because of the patient's intended deception of the physician; the diagnosis may often be completely missed.

On a whole, the prognosis for factitious disorders is generally quite poor. It is regarded as *exceptionally poor* in the case of Munchausen syndrome. A variety of psychiatric diagnoses have been associated with factitious disorders. Patients with a factitious disorder on Axis I often meet the criteria for a personality disorder on Axis II (commonly Cluster B). Many patients commonly are seen to have the most consistent clinical congruence with a borderline personality disorder. Axis II pathology also tends to suggest a poor prognosis. Depression is another co-morbid psychiatric diagnosis that is commonly a major component of the clinical picture. However, in cases when depression is a co-morbid feature, it has been considered to be a good prognostic variable (Eisendrath, 1996; Nadelson, 1996; Stoudemire & Fogel, 1993).

Having discussed the definition, diagnosis, and common characteristics of factitious disorders (including Munchausen syndrome), some of the more specific clinical features of factitious disorders can now be focus upon.

4.7 Clinical Features

> Features that are overrepresented in patients with factitious disorder include normal or above-average intelligence quotient (IQ); absence of a formal thought disorder; poor sense of identity; including confusion over sexual identity; poor sexual adjustment; poor frustration tolerance; strong dependence needs; and narcissism.
>
> (Kaplan & Sadock, 1998, p. 655)

Many of the clinical features have been addressed in general, but will now be addressed more specifically. The typical clinical features of factitious physical disorders, factitious psychological disorders, and Munchausen syndrome respectively will be addressed.

4.7.1 Factitious Physical Disorders

Eisendrath (1996) states that any individual studying factitious physical disorders will soon appreciate human creativity. Almost any and every illness known to man has

been produced factitiously. "Individuals have been remarkable inventive" (Eisendrath, 1996, p. 25). Patients with factitious disorders are generally considered to be of above average to superior intelligence, and are described as being devious and clever. A list of all the possible types of factitious behaviour and productions of physical signs and symptoms would be extremely extensive (limited only by the patient's imagination and degree of medical information), and therefore, not necessary for the purposes of this review. Common productions do however include factitious fever (possibly the most common), factitious infections, skin lesions, blood disease, endocrine disease, neurological symptoms, gastrointestinal disease, cancer, and even AIDS. Factitious illness and disease generally represents a phenomenon that is not confined to any specific medical disciplines (Eckhardt, 1994; Feldman & Ford, 1994; Ford, 1984; Gieler, 1994; Kaplan & Sadock, 1998; Meyer, 1989; Maxmen & Ward, 1995; Meyer & Salmon, 1984; Nordmeyer, 1994; Paar, 1994; Plassmann, 1994a; Stoudemire & Fogel, 1993; Wedel, 1995).

The deceptions in creating physical signs and symptoms can occur at three levels (Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1984; Nordmeyer, 1994; Stoudemire & Fogel, 1993; Wedel, 1995):

1. Patients can do so by providing a factitious history alone to convince physicians of their illness. This may be through *total fabrications* of symptoms or *exaggerations* of symptoms.
2. Patients may also *simulate* medical illness. In these cases, the patients mimic symptoms by manipulating test results, instruments, or providing expected symptoms. Patients may even use a pre-existing condition to suggest another medical disease or trauma.
3. Some patients actually create a pathophysiologic state with *self-induced disease*. This often involves a patient infecting themselves (often through the injecting of foreign substances, bacteria or faeces).

Ford (1984) states that it is remarkable what these patients will accept and subject themselves to in the way of diagnostic procedures for an illness that they themselves know the aetiology. It is also increasingly interesting, and quite disturbing, that these patients have the ability to convince health care professionals – who are constantly exposed to true illness and disease – that they are sick. It is however generally not as

hard to fool physicians as one might think. This is because the feigned or factitiously produced symptoms also so closely resemble the known illnesses and diseases that the patient wishes to portray. It is not expected that a person would willingly want to make himself or herself ill (Feldman & Ford, 1994; Maxmen & Ward, 1995).

However, once being treated, patients can often be found to be uncooperative and not complying with treatment or medication, often with the result of furthering symptoms and preventing the effective treatment, or creating new symptoms and problems. The patients are also often disparaging towards the physician and medical health care professionals for their inability to treat their symptoms – to the extent of often attacking their competence. They may be overtly hostile, difficult and demanding in their requests for care and treatment (Feldman & Ford, 1994; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Meyer & Salmon, 1984; Wedel, 1995).

Patients with factitious disorders often interact with many different physicians within the hospital setting. Patients are often able to split the hospital staff, creating disagreements amongst health care professionals. When patients are eventually confronted with suspicions of their factitious behaviour they tend to respond with vociferous and often angry denial, and often attack the competence of the physician and staff treating them. They then tend to discharge themselves from the hospital or otherwise flee treatment (Feldman & Ford, 1994; Kaplan & Sadock, 1998; Maxmen & Ward, 1995).

Patients with factitious physical disorders may often have stable work histories and strong family connections. They often tend to work within the healthcare professions, and in such cases it is usually a single or acute factitious disorder in response to a certain life stressor. The factitious behaviour often diminishes after the life stressor is addressed or dealt with. Factitious illness can represent these patients' attempts to cope with emotional problems (Eisendrath, 1996; Feldman & Ford, 1994; Maxmen & Ward, 1995; Plassmann, 1994a; Wedel, 1995).

4.7.2 Factitious Psychological Disorders

Patients with predominantly psychological signs and symptoms will now be addressed. "Patients with factitious psychological disorders sometimes become the quintessential Munchausen patients, relating the most vivid, exciting, and dramatic stories" (Parker, 1996). It is because these patients tend to have to rely on their verbal skills to capture the attention of medical professionals and caregivers, that they tend to be notably skilled in presenting their stories. Pseudologia fantastica may be more prominent with patients with psychological symptoms than patients with physical symptoms, with some degree of pathological lying often present. The true history of the patient may often contain some severe emotional trauma, but is often different to the trauma that the patient presents (Kaplan & Sadock, 1998; Parker, 1996).

Presentation of symptoms or complaints can again be almost anything, but patients commonly tend to portray: bereavement, Post-Traumatic Stress Disorder (PTSD), rape, depression, or psychosis. The symptoms or complaints are conveyed with strong emotion and great urgency. "Beyond the greater flair with which the history is given, the characteristics of patients with factitious psychological symptoms are similar to those of patients with physical symptoms; this finding is not surprising, because the two classifications of symptoms are often found in the same patient" (Parker, 1996, p. 41). Deception of the physician and control issues are often characteristic features, as well as the tendency to discharge themselves from hospital if confronted. And as with factitious physical disorders, symptoms may be more pronounced when the physicians and hospital staff are present (Ford, 1996b; Kaplan & Sadock, 1998; Parker, 1996; Stoudemire & Fogel, 1993).

The main distinction between factious patients with psychological symptoms is that they tend to be more willing to accept psychiatric hospitalisation than patients with factitious physical symptoms. "A common pattern for the factitious patient with physical symptoms is to leave the hospital against medical advice when referred to the psychiatric unit; the patient with factitious psychological symptoms, however, seeks hospitalization on the psychiatric unit" (Parker, 1996, p. 41). However, the author believes that this may not necessarily represent a better prognosis to treatment for

these patients. The psychiatric unit merely represents the patient's sick role much the same as the hospital ward does for the physical factitious disorder patient.

4.7.3 Munchausen Syndrome

The more specific Munchausen syndrome will now be focussed upon. Munchausen patients are significantly different from the majority of patients with a factitious physical disorder. They represent the extreme on a continuum of somatization disorders, and the extreme of factitious disorders, where the patient's entire life is centred on disease portrayals. They are "itinerant hospital seekers, usually covering a number of cities … in their travels" (Eisendrath, 1996, p. 27). They have often been referred to as "doctor shopping", "peregrinating problem patients", "hospital hopper syndrome" or "hospital hoboes" – a clear element of devaluation by healthcare professionals (Eisendrath, 1996; Ford, 1984; ICD-10, 1992; Meyer & Salmon, 1984; Plassmann, 1994a).

As previously described, they often tell fantastic tales (those labelled pseudologia fantastica). "The stories often include an element of impostorship where the individual portrays him- or herself in some grandiose role" (Eisendrath, 1996, p. 27-28). The patient's stories according to the original description by Asher contain a pattern of fantasy and falsehood in which the fragments of the complete truth were surprisingly embedded (Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1984; Ford, 1996b; Maxmen & Ward, 1995).

The patients can simulate almost any physical symptoms, limited only by their imagination and medical knowledge. The simulated illnesses and diseases are usually *rare* and *dramatic*. In general, there does not appear to be an apparent symbolic choice for the simulated disease, and the same patient has often used different symptoms at different times. However, as a rule patients do tend to develop a particular routine or *modus operandi*. No single underlying psychiatric diagnosis typifies a Munchausen patient, and they often factitiously present with various psychiatric symptoms. Generally though, the borderline personality disorder appears most congruent with these patients (Ford, 1984; Maxmen & Ward, 1995).

Munchausen patients often present to emergency rooms at hospitals (often large academic hospitals) with dramatic symptoms in need of immediate attention or those that are inclined to stimulate the interest and curiosity of the physician. The visit to the emergency room is usually made at times when access to senior staff or medical records is more difficult – such as evenings or weekends. They submit themselves to all medical procedures and examinations, and display an almost unbelievable tolerance for the uncomfortable and often painful procedures. Once established in the ward, the Munchausen patient tends to obtain a disproportionate amount of the health care team's time – either being a "star patient", a patient of great interest, or a patient of extreme difficulty. The fantastic stories that these patients tell make them more interesting to the staff (Feldman & Ford, 1994; Ford, 1984; Ford, 1996b; Maxmen & Ward, 1995; Plassmann, 1994a).

The reactions of Munchausen patients to confrontation and suspicion are much the same as for those with physical factitious disorders. "When the hoax is eventually discovered and confrontation takes place, the patients often refuse psychiatric evaluation, react with indignity or anger, sign out of the hospital against medical advice … and/or frequently threaten to sue the hospital and physicians because of the "unfair" accusations" (Ford, 1984, p. 162). Munchausen syndrome appears to represent the extreme of this reaction to confrontation, being more likely to seek admission to other hospitals.

Munchausen patients tend to show patterns poor adjustment and repetitive maladjustive behaviour. They have turbulent marriages (if any) and interpersonal relationships – that may conflict with their self-reports or be even more greatly exaggerated. They often have a history of one or more psychiatric hospitalisations as well as suicide attempts. These patients may have or develop drug addictions, but this is more often likely due to the administrations of medications by doctors for trying to alleviate various factitious symptoms. Rather than the patients conversely presenting the symptoms for the drugs (as the goal), the patients generally do so for the sick role or the thrill deceiving the physician. Just as these patients subject themselves to various operations and procedures, so do they submit themselves to various medications (Feldman & Ford, 1994; Ford, 1984; Ford, 1996b; Maxmen & Ward, 1995; Meyer & Salmon, 1984).

It has been suggested in the above presentations that factitious disorders have a strong link to various personality disorders. The specific aspect of personality disorders in relation to factitious disorders will therefore address before moving on to the aetiological conceptualisations.

4.8 Personality Disorders

Numerous patients with factitious disorders and behaviour have been linked within the literature to comorbid personality disorders. The personality disorders and traits commonly linked with factitious disorders are the Cluster B disorders: antisocial, borderline, histrionic, and narcissistic. It has also been suggested that the prognoses for a factitious disorder is better if depression (which is regarded as a treatable disorder) is present, as opposed to a personality disorder. Personality disorders therefore also appear to affect the prognosis of a factitious disorder. The personality disorders sometimes appear to be more prominent, for which the factitious disorder is more a manifestation of the personality disorder (Ehlers & Plassmann, 1994; Feldman & Ford, 1994; Ford, 1984; Ford, 1996b; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Paar, 1994; Stoudemire & Fogel, 1993).

The ICD-10 classifies factitious disorders with respect to personality disorders within the category *other disorders of adult personality and behaviour* (F68). Factitious disorders are more specifically categorised under *intentional production or feigning of symptoms or disabilities, either physical or psychological [factitious disorder]* (F68.1) (Freyberger & Schneider, 1994; ICD-10, 1992). Patients with factitious disorders "usually show signs of a number of other marked abnormalities of personality and relationship" (ICD-10, 1992). This tends to suggest that the personalities of these patients play an important role within the disorder. Ehlers and Plassmann (1994) suggest that factitious disorder patients tend to display an infantile personality.

However, the most prominent personality disorder that is associated in the literature with factitious disorders and Munchausen syndrome is the borderline personality disorder. Specific attention is therefore given to this personality disorder.

4.8.1 Borderline Personality Disorder

Nadelson (1996) states that "[p]atients with factitious disorder, an Axis I diagnosis, may satisfy the criteria for other mental disorders as well. The diagnosis that seems to have the most consistent clinical congruence is borderline personality disorder … coded on Axis II" (p. 10). Borderline personality disorder appears to have the greatest comorbidity with factitious disorders and behaviour reported in the literature (Ehlers & Plassmann, 1994; Feldman & Ford, 1994; Ford, 1984; Maxmen & Ward, 1995; Nordmeyer et. al., 1994; Stoudemire & Fogel, 1993).

Borderline personality disorder is characterised by hostility, dependency, intense but unstable interpersonal relationships, a poor sense of personal identity, conflicts with identity, mood swings, manipulative behaviour, and poor impulse control particularly evidenced by self-destructive and self-mutilative behaviour (Feldman & Ford, 1994; Ford, 1984). Feldman and Ford (1994) also add that "[s]elf-mutilation is scary, regardless of the underlying problem, and it creates a sense of helplessness in the treatment team" (p. 8). Nadelson (1996) states that for a person with factitious disorder and borderline personality, the production of illness and disease provides a focus for the anger of the patient and thus serves to transiently stabilise the continually shifting affective state of the patient.

The discussion continues with a focus on the various aetiological conceptualisations of factitious disorders.

4.9 Aetiological Conceptualisations

What actually causes factitious disorders is generally unknown. Factitious disorders probably and most likely develop from a confluence of factors that may vary depending on the patient. "Factitious physical disorders represent a unique attempt by

the individual to cope with the world. Once the physician gains some understanding of the disorder, the door is opened to therapeutic interventions that will allow the individual to cope more effectively" (Eisendrath, 1996, p. 33). For psychological factitious disorders, the psychodynamic underpinnings are often even more elusive and poorly understood. However, the aetiological theories tend not to be too different from those proposed for physical factitious disorders. The motivations for the behaviours tend to be the same. For all factitious disorders, the difficulties in providing aetiological explanations tend to arise because the patients are often themselves difficult to engage in psychotherapy. It is through the longer duration of psychotherapy that therapists would be able to gain insight into the psychodynamics of factitious disorders. Most explanations do however tend to be anecdotal (Eisendrath, 1996; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Parker, 1996; Plassmann, 1994a).

Eisendrath (1996) states that there are several ways to conceptualise the aetiology of factitious physical disorders. From a broad perspective, there are psychodynamic conceptualisations and behavioural conditioning concepts.

From a psychodynamic perspective, one factor is the individual's sense of mastery and control that is achieved via their factitious behaviour. Patients may have suffered traumatic illnesses as children, to which the factitious disorder now provides them with the feelings of control they lacked as children. A suggestion is that the lying evident in factitious disorders is intended to protect secrets and avoid anxiety and emotions, although what these secrets are is often not known and must be inferred (Eisendrath, 1996; Eisendrath & Feder, 1996; Eisendrath, Rand & Feldman, 1996; Feldman & Ford, 1994; Feldman & Smith, 1996; Ford, 1996b; Kaplan & Sadock, 1998; Lipsitt, 1996; Maxmen & Ward, 1995; Parker, 1996; Stoudemire & Fogel, 1993).

A second prominent concept in the psychology of factitious disorders is the suggestion of an underlying masochism (or self-defeating behaviour). "We infer a basic sadomasochistic style of interpersonal behavior" (Lipsitt, 1996, p. xxi) in factitious disorders. The factitious behaviour provides atonement and self-punishment for marked feelings of guilt or anger – often based on childhood

experiences of physical or sexual abuse – to which the physician also becomes a symbolic representation of the abusing perpetrator. (Eckhardt, 1994; Ehlers & Plassmann, 1994; Eisendrath, 1996; Eisendrath & Feder, 1996; Eisendrath, Rand & Feldman, 1996; Feldman & Ford, 1994; Feldman & Smith, 1996; Ford, 1984; Ford, 1996b; Gieler, 1994; Kaplan & Sadock, 1998; Lipsitt, 1996; Maxmen & Ward, 1995; Parker, 1996; Stoudemire & Fogel, 1993).

A third conceptualisation is that the individuals use their illness to ventilate rage at symbolic caregivers. The rage is often a result of deprivation and mistreatment as a child – to which by allowing the factitious behaviour to be detected, the individual may feel a sense of superiority and conquest and simultaneously generates anger from the physicians allowing them to re-enact earlier relationships. (Eisendrath, 1996; Eisendrath & Feder, 1996; Eisendrath, Rand & Feldman, 1996; Feldman & Smith, 1996; Kaplan & Sadock, 1998; Lipsitt, 1996; Maxmen & Ward, 1995; Parker, 1996).

A fourth conceptualisation suggests that factitious physical disorders may represent an individuals attempt to defend against a loss. The factitious disorder may provide a substitute for the trauma of a lost object (e.g. death of loved one) by establishing a connection between the patient and a nurturing caregiver. These explanations are often also explained as the patient employing counterphobic mechanisms. By simulating illness, the patient seeks out what they fear most and rises above their anxiety over illness and death by obtaining mastery and control (Eisendrath, 1996; Eisendrath & Feder, 1996; Eisendrath, Rand & Feldman, 1996; Feldman & Ford, 1994; Feldman & Smith, 1996; Ford, 1996b; Kaplan & Sadock, 1998; Lipsitt, 1996; Meyer & Salmon, 1984; Parker, 1996; Plassmann, 1994a; Wedel, 1995).

Finally, the motivation of a need for nurturing (often at any cost) and gratification of dependency needs, in the patient is often a powerful factor that leads towards factitious disorders. It reportedly prominent how the behaviour of factitious disorder patients reflects a desperate need to find caring and nurturing that they have not been able to receive elsewhere in their lives. It is believed that factitious disorder patients assume the "sick role" for gains such as nurturance. (Eisendrath, 1996; Eisendrath & Feder, 1996; Eisendrath, Rand & Feldman, 1996; Feldman & Ford, 1994; Feldman &

Smith, 1996; Ford, 1996b; Lipsitt, 1996; Meyer & Salmon, 1984; Parker, 1996; Stoudemire & Fogel, 1993).

It is however cautioned that much theorising may arise more from the physician's countertransference (i.e. a need to understand) than from the actual reality (Eisendrath, 1996; Parker, 1996). In fact many of the approaches to prove that behaviour is factitious often results in the physician attempting "to match wits with these individuals who demonstrate sometimes extraordinary cunning and innovation. In doing so, the physician likewise adopts a bit of a Munchausenian stance, attempting to devise ways to outfox the faux" (Lipsitt, 1996, p. xxi). The focus thus seems to often be more on the proving of the factitious behaviour, than the understanding of it.

Nadelson (1996) pointed to a strong comorbidity between factitious disorders and borderline personality disorder. Many studies have reported strong correlations between a history of physical and sexual abuse and the development of borderline personality disorder. "Though there is no confirming evidence at present, it is possible that many factitious disorder patients, especially those with borderline character pathology, were abused as children" (Nadelson, 1996, p. 11). For these patients, the psychic trauma contributing to the borderline personality structure, may also contribute to a tendency towards chronic disease and illness production. The disease production can be seen as a mode of interaction with a powerful figure (the physician) in which that figure is controlled in a manner that expresses the ambivalence between the inherent dependency of a child and the hostile resentment of a child who has been abused. Factitious behaviour can be seen to gratify a borderline patient because it temporarily stabilises affective states and helps prevent further disintegration (Kaplan & Sadock, 1998; Nadelson, 1996; Plassmann, 1994a). Maxmen and Ward (1995) suggest that a severe personality disorder – most often borderline – is a predisposing factor for factitious disorders.

Ford (1984; 1996b) states that Munchausen syndrome is best described in terms of borderline personalities, and regards the syndrome as a defence against overwhelming anxiety and psychotic decompensation. "Both pseudologia phantastica and impulsive peregrination can be viewed as a defence against threatening psychotic disintegration" (Plassmann, 1994a, p. 9). The choice of the simulation of illness possibly arises from

previous life experiences. Patients with Munchausen syndrome often have a poor sense of self. Lacking personal identities that can define their value systems, goals, and role in life, they assume a sick role, and through pseudologia fantastica, become interesting and important patients (Ford, 1984; Ford, 1996b; Kaplan & Sadock, 1998).

The relationships with parents are only briefly referred to in factitious disorder case studies. However, the parents of the patient are generally alluded to as having had certain characteristics. The mothers tend to be authoritarian, over-involved, and/or unpredictable. Their fathers are seen to be aloof, cold, distant, and generally indifferent. The characteristic of the mother and father thus described may be reversed, but nevertheless, the same general pattern appears to apply. The patient's behaviour often is described as an attempt to gain the attention of the parents (Feldman & Ford, 1994; Ford, 1996b; Kaplan & Sadock, 1998; Meyer & Salmon, 1984; Plassmann, 1994a). Ford (1996b) states that Munchausen syndrome patients have many similarities with impostors and confidence artists. For impostors and confidence artists, the typical parenting styles – for the limited information available – depict an over involved, intrusive mother, and an often powerful (or at least so perceived), but absent or disinterested father.

It is generally accepted that early development and the relationships with parents is also the basis for the development of Munchausen syndrome. Early deprivation, an incomplete development of a sense of self, deficits in conscience, and failed attempts at the mastery of early traumas are suggested to set the tone for behaviour that expresses itself within the hospital context. Hospitalisation can be seen as an escape from the traumatic home situation. The simulation of illness and disease is used to recreate the desired parent-child bond. Munchausen patients are characterised by their simultaneous search for and rejection of intimacy (Feldman & Ford, 1994; Kaplan & Sadock, 1998).

Plassmann (1994a) states that the DSM classification and diagnostic system focuses on the diagnosis of deception, and tends to neglect the patient's disturbed relationship to his or her own body. Factitious disorders, overt self-injury, Munchausen syndrome, and Munchausen by proxy can all be seen as based upon severely disturbed relationships to the body. On an unconscious level, patients with factitious disorders

do not appear to assign parts of their bodies to their own selves. They perceive them as external objects. Parts of the body can be fantasised as being dead, without boundaries, divided (the idea of a good part and bad part of the body), and devalued. In cases of self-mutilation, the body has usually been characterised as a transitional object. It is experienced as external and not part of the self. It can be managed like an external object, often for the goal of providing relief from extreme tension and anxiety. Factitious disorders do differ from typical self-mutilation by involving external objects (doctors and healthcare professionals). As such, there is a triangulation between the patients self, their body as an external (maternal) object, and the doctors as external objects (as a paternal figure). The pathological body experience results from early deprivation and traumatic body experiences in childhood – whether they were necessary medical interventions or physical and sexual abuse. There is a splitting (a dissociation) between the self and the body self (Hirsch, 1994; Plassmann, 1994a; Plassmann, 1994b; Sachsse, 1994).

Behavioural conditioning concepts may also play a key role in the onset and recurrence of factitious physical disorders. Factitious physical disorders often have precursors in childhood. A child's feigning of illness for parental attention may lead to the positive reinforcement of these behaviours. "Pathological amplification of the factitious behavior might occur based upon learning concepts. The individual is rewarded for sick role behavior by getting his or her needs met. This pattern of reinforcement may lay the groundwork for the later dysfunctional utilization of factitious behavior, although most children obviously do not develop full-blown factitious disorders later in life" (Eisendrath, 1996, p. 32). At least in the early stages, a factitious disorder can bring certain rewards. These rewards of the sick role (i.e. reduced responsibilities) may help reduce anxieties that may be present. "We can assume that people who choose illness as a way of life might be attempting to derive some kind of meaning out of suffering, presumably suffering that has stemmed from early life experience, various kinds of trauma, hospitalisations, and family dysfunction" (Lipsitt, 1996, p. xxii). Factitious patients often have a history of childhood hospitalisation, or have been exposed to a close family member who has been hospitalised. Munchausen syndrome patients often report to have found their own early hospitalisations positive experiences (Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1996b; Kaplan & Sadock, 1998; Meyer & Salmon, 1984).

Eisendrath and Feder (1996) state that recent literature tends to suggest that various conditions of factitious physical disorders might be part of the obsessive-compulsive spectrum. In many cases the behaviour of the patients is seen to have compulsive qualities. "Their illness-feigning behavior is deliberate and purposeful, but their motivations are not; for reasons beyond their control, they are impelled to be a patient" (Maxmen & Ward, 1995, p. 304). Even though the intentionality of factitious disorders is suggested by the patient's adeptness at consciously simulating illness and disease, they are regarded as compulsively driven to do so. They compulsively subject themselves to procedures that they know are needless and dangerous (Eisendrath & Feder, 1996; Feldman & Ford, 1994; Ford, 1984; Gieler, 1994; Kaplan & Sadock, 1998; Maxmen & Ward, 1995).

There is also speculation that underlying organic brain dysfunction might be the cause of some of the cases of factitious disorders. It is suggested that these patients have a greater verbal ability than logical or organisational ability (Feldman & Ford, 1994; Ford, 1984; Ford, 1996b). "This may facilitate pseudologia fantastica and its associated assumption of the patient role as an unconsciously motivated coping strategy" (Ford, 1996b, p. 164-165). However, no specific or general brain dysfunction has been proved.

The above aetiological explanations for factitious disorders appear to be rather disjointed. An attempt to merge the suggested theories into a consistent whole is nevertheless elusive, but possibly inferred. The author will address his own interpretation of the aetiology of factitious disorders in Chapter 5. However, regardless of the causes or aetiology of factitious disorders, they nevertheless include a number of ethical and legal considerations. Some of these ethical and legal considerations are discussed next.

4.10 Ethical and Legal Issues

> Patients who have or are suspected to have factitious disorders create unique ethical and medicolegal issues for physicians and other health care

> professionals. In the past, the rights of these patients have often been ignored. Recent case reports, however, suggest that such attitudes not only are countertherapeutic but may also precipitate medicolegal conflicts; these patients can and do retain attorneys and initiate malpractice suits.
>
> (Ford, 1996a, p. 51)

Ford (1996a) describes various ethical and medico-legal issues that may be anticipated when a physician encounters a patient with a factitious disorder. He further suggests recommendations for appropriate interventions. The ethical and medico-legal issues are addressed separately, even though they can be expected to influence each other.

4.10.1 Ethical Issues

The expected ethical issues are considered first. "The doctor-patient relationship becomes problematic when it involves wilful deceit by the patient. The physician, after learning of such deceit, may react with anger or vindictiveness that has the effect of undermining any potential therapeutic progress" (Ford, 1996a, p. 51). These issues will be addressed under the issues of confidentiality, invasion of privacy, and the misuse of scarce resources (by the patient).

Confidentiality is an important principle in the doctor-patient (and psychologist-patient) relationship. A physician's obligation to secrecy is described as "absolute except when it is *imperative* to violate it" (Ford, 1996a, p. 52). The converse of this requirement is also applicable, and it is expected that it is the duty of patient's to "communicate faithfully and unreservedly" (p. 52) to physicians about their symptoms. Ethically, physicians can only relinquish confidentiality when they are required to do so by law or in order to protect the welfare of the individual or community. Ethical dilemmas are created when the two principles are in conflict. Frequently with factitious disorder patients, the confidentiality demanded by the patient can prove harmful to the patient and may be harmful to others. Resolution of these conflicts often enters the philosophical realm. Whether one should focus on the greatest good for the greatest number of people (utilitarian approach), or whether even the slight compromise of a principle (confidentiality) is destructive to the basic foundations of medical care, is a difficult question. It has been argued that in the case

of factitious disorders, the patient is the perpetrator of deceit, as they do not fulfil their role, and thus no genuine doctor-patient relationship exists, and the physician should not be bound by the code of ethics. This argument has often led to the proposal for "blacklists" for patients with factitious disorders (Eisendrath & Feder, 1996; Feldman & Ford, 1994; Ford, 1984; Ford, 1996a; Lipsitt, 1996). Ford (1996a) suggests that it is better for the physician, regardless of intellectual arguments, to honour confidentiality. He adds that the benefit of a multidisciplinary team aids in the creation of policies and shared responsibility for the difficult decisions in treating a factitious disorder patient.

Invasion of privacy is a crucial ethical concept when considering factitious disorder patients. This is as there are abundant examples in the literature of a factitious disorder diagnosis being made through the searching of a patient's belongings and the finding of medical paraphernalia (i.e. syringes) and concealed medication. Some physicians even devised elaborate diagnostic procedures to catch out the patient and confirm the factitious disorder diagnosis. Lipsitt (1996) states that the techniques of detection, if used, "should not be used simply to establish our reputations as medical detectives" (p. xxvi). There is however presently more of a move towards honouring patient's rights and their right to privacy. There should be the rights of informed consent and informed refusal, and no procedure should be initiated without the patient's knowledge or consent (Feldman & Ford, 1994; Ford, 1984; Ford, 1996a; Lipsitt, 1996). Ford (1996a) does suggest that if factitious behaviour is suspected, that the physician should first communicate to the patient that a factitious disorder is being considered and that it has been incorporated into the differential diagnosis, and then request the permission of the patient for further exploration of that possibility.

The *misuse of scarce resources* is often of concern, as patients with factitious disorders tend to use up enormous quantities of medical care in terms of time, expenses and resources (Feldman & Ford, 1994; Ford, 1996a). The question often is; that once the factitious disorder is established, "what is the obligation to permit the misuse of resources as well as the time of physicians and other health care personnel? … In theory, a physician, with appropriate notice to the patient, can withdraw from a case" (Ford, 1996a, p. 54). The question however, then remains as to who will treat

these patients. Again, Ford (1996a) suggests that a multidisciplinary team in cooperation is best suited to discussing the specifics of each individual case.

> It would seem that ethical dilemmas in working with all factitious disorders … should be resolved essentially on the basis of the principle of "first, do no harm," which is applied in most medical situations. They should not be derived from anger and frustration…
>
> (Lipsitt, 1996, p. xxvi)

Often, ethical issues may even become legal issues. The legal issues associated with factitious disorders are now addressed.

4.10.2 Legal Issues

The *involuntary hospitalisation or treatment* of a factitious disorder patient can often be a medico-legal concern. This is because patients with factitious disorders often engage in self-destructive behaviour that can lead to permanent maiming or even death. It often has to be considered whether these patients should be committed or treated without their consent (often by appointing a guardian) (Feldman & Ford, 1994; Ford, 1984; Ford, 1996a). This is not only a legal issue, but an ethical one as well.

The question as to whether patients should be *prosecuted for fraudulent abuse of medical services* can be considered. The behaviour of factitious disorder patients "can be viewed as the stealing of the time and expertise of health care professionals and abuse of other resources" (Ford, 1996a, p. 56). As such the patient's themselves are subjected to possible legal repercussions.

Malpractice liability is a legal concern that physicians need to be aware of. The diagnosis of a factitious disorder does not make the physician immune to a possible lawsuit filed by the patient. It is often believed that because the patient is deceiving, that the physician cannot be held accountable for any medical consequences. However, many patients do initiate lawsuits (founded or not) – often after being confronted. One tactic is for the patient to deny any factitious behaviour "and sue for an apparent untoward response to a procedure, though, in reality, the patient may have self-induced the response" (Ford, 1996a, p. 56). In the legal arena, when considering

feigned or self-induced illness, the line between malingering and factitious disorder is often unclear. A second tactic may be for the patient with factitious disorder to use the disorder itself, if not diagnosed, to sue the physician by claiming negligence in treating their disorder correctly. Or even sue for the unnecessary procedures that were manoeuvred for (by the patient), but a "more astute clinician" (Ford, 1996a, p. 57) would have avoided (Feldman & Ford, 1994; Ford, 1996a; Kaplan & Sadock, 1998; Maxmen & Ward, 1995).

Munchausen Syndrome by Proxy – the producing of illness and disease in another - is generally regarded as a crime. In the case of children (where it is more common), it is viewed as a form of child abuse (Ford, 1996a; Maxmen & Ward, 1995; Plassmann, 1994a).

According to Eisendrath, Rand and Feldman (1996), factitious disorders can also penetrate the legal system in other ways. Factitious disorders are largely unknown outside of hospital settings, and especially with non-psychiatrists. "Attorneys, judges, and law enforcement personnel are often taken in by such a patient. As with most lay persons, they do not suspect that individuals will do something overtly to harm themselves" (Eisendrath, Rand & Feldman, 1996, p. 72). This is often because the factitious behaviour is not readily explainable by external rewards (such as in Malingering). As such, factitious patients often appear extremely believable. Often, while factitious disorder patients may be working with unconscious psychological processes, needs for nurturance or childhood trauma, they often enter the legal arena as an attempt at face saving. This is often because those around them are unaware of their role in producing their illnesses.

However, apart from the direct and observable ethical and legal impacts of factitious disorders, there are a number of more subtle (and often neglected) personal and interpersonal consequences of the disorder. These consequences will now be focussed upon.

4.11 Personal and Interpersonal Consequences and Patterns

Feldman and Smith (1996) state that "[v]ery little has been written about the personal and interpersonal consequences of factitious disorders" (p. 175). The focussing primarily on "objective medical consequences" tends to only portray a portion of the reality. Apart from the severity of the physical consequences that these patients face, the disorder also takes a toll in "psychosocial terms that are not easily measured but are equally devastating" (p. 175). The primary psychological motivation for the factitious behaviour is often neglected, but even more so is the fact that there are many "believers" who are profoundly affected – family members, friends, and healthcare professionals (who became unsuspecting participants in the patient's deception and factitious behaviour). "One of the most disturbing characteristics of patients with factitious disorders is their uncanny ability to perpetuate lies so convincingly that they directly shape the perceptions of those around them" (Feldman & Smith, 1996, p. 176). For anyone confronting the factitious behaviour (if suspected), this decision can be regarded as an "emotional Catch-22" (p. 182). This is because if the emotional or physical symptoms turn out to be true, the caregiver or family member then bears the responsibility of increasing the patient's anguish and trauma. There is always the risk of a false accusation (Feldman & Ford, 1994).

Victims of factitial patients are not always primary victims as in the case of Munchausen syndrome by proxy. Very often secondary victims are more common and a part of every factitial case – and very often overlooked. The interpersonal tolls can range for everyone involved, from family members and friends to professional caregivers. Even in cases of Munchausen Syndrome by Proxy, the other parent of the child often is faced with an incredible emotional conflict, as it is difficult to comprehend the possibility that a spouse could engage in such behaviour. The victimisation of others that factitial patients often create, in not necessarily intentional or a deliberate goal (except in the wilful deception of others, especially physicians), but sometimes rather a by-product of their own masochism (Feldman & Ford, 1994; Feldman & Smith, 1996).

For professional caregivers and healthcare professionals, the toll can be diverse. Physicians expect their patients to be honest about their complaints and symptoms, and to verbalise them in such a manner that they can be treated correctly and effectively. "It is hard enough to accept that a person is engaging in self-harm; the fact that he or she is seeking emotional gratification through such behavior predictably elicits little sympathy" (Feldman & Smith, 1996, p. 186). In fact many professional caregivers and healthcare professionals have admitted to finding factitious disorder patients reprehensible. An additional toll on healthcare professionals is that once it is discovered that there is a factitial illness (and thus that they have been duped), they receive marginal to no support from other professionals. It has often been the case that they themselves have their own conduct and behaviour criticised for their "rescue fantasies", "delusions of grandeur" in their ability to help, or general lack of "professional judgement" (Feldman & Ford, 1994; Feldman & Smith, 1996).

With the difficulties of being faced with patients with a factitious disorder outlined, attention can now be turned to the proposed management and treatment suggestions for the disorder. This will include general thoughts on pharmacotherapy and psychotherapeutic strategies. This section will be followed by some concluding thoughts on the possibility of conducting therapy with factitious disorder patients.

4.12 Management and Treatment

Many physicians believe that factitious disorders are inherently untreatable, due to the intrinsic feature of deception. "As for treatment of factitious disorders, we are still at something of a loss. For the most part, attempts to influence the behavior have been unsuccessful" (Lipsitt, 1996, p. xxvii). Patients are even openly hostile to treatment. Most cases of psychotherapy do not go beyond the initial psychiatric interviews, and the patient's ending the therapy is especially acute in the beginning phases. After Asher's (1951) description of the Munchausen syndrome there has been a debate amongst physicians and attempts to develop a systematic approach to managing factitious physical disorders. One idea was to form a registry (or "black list") to identify and track factitious disorder cases. This was however never actually

implemented and often criticised due to its various legal and ethical considerations (Eisendrath & Feder, 1996; Feldman & Ford, 1994; Kaplan & Sadock, 1998; Lipsitt, 1996; Maxmen & Ward, 1995; Meyer, 1989; Plassmann, 1994c; Wedel, 1995).

Very often factitious disorders themselves are only considered after all other possibilities have been excluded and the patients have undergone months (or even years) of observation, extensive and expensive medical care, procedures, testing, medication and operations (Feldman & Ford, 1994). Eisendrath and Feder (1996) state that the "[g]rowing awareness of the economic costs of factitious disorders have added urgency to finding effective interventions" (p. 195-196). Stoudemire and Fogel (1993) state that in all cases of factitious disorders, a psychiatric consultation should be encouraged.

The typical psychiatric management and treatment approaches of pharmacotherapy and psychotherapeutic strategies are addressed.

4.12.1 Pharmacotherapy

Some physicians have found that medication can be of value for certain patients with a factitious physical disorder. As it is often suggested that many patients with a factitious physical disorder have a borderline personality, they may benefit from the use of antipsychotic medication during brief periods of psychosis and disorganisation. In some cases of patients where depression appeared prominent, the improvement of mood with the aid of antidepressant medications helped reduce factitious behaviour. The notion that factitious disorders may be part of the obsessive-compulsive spectrum – the behaviour is often seen to have compulsive qualities – would suggest that patients might be responsive to selective serotonin reuptake inhibitors (Eisendrath & Feder, 1996; Stoudemire & Fogel, 1993).

Eisendrath and Feder (1996) caution that there have been no systematic pharmacological trials for factitious disorders. This deficit is likely to be due to the fact that it is difficult to engage these patients in ongoing psychiatric treatment. "Despite these prospects, patients with factitious physical disorders infrequently present with another overarching Axis I disorder such as major depression that readily

responds to medication trials" (Eisendrath & Feder, 1996, p. 197). Eisendrath and Feder also add that many patients will not comply initially with psychiatric medications, as they cannot admit to the factitious nature of their illness. "Unfortunately many of these patients would rather have the disease of their choice than accept psychiatric help" (Ford, 1984). Eisendrath and Feder (1996) go on to suggest that the primary approach to the treatment of factitious physical disorders may remain with psychological interventions. Psychotherapeutic strategies will therefore be given specific attention.

4.12.2 Psychotherapeutic Strategies

Psychotherapeutic strategies for factitious disorder patients tend to focus predominantly on the decision as to whether and how the patient should be confronted on their factitious behaviour. Therefore, there is often a general grouping into confrontational approaches and nonconfrontational strategies (Eisendrath & Feder, 1996). The psychotherapeutic strategies will therefore be addressed by looking at the comparison between confrontational and nonconfrontational strategies. This will be followed by a focus on countertransference as it applies to psychotherapeutic strategies with factitious disorder patients. This in turn is followed by some general management suggestions for working with factitious disorder patients. Factitious psychological disorders will be considered separately as they involve various management and treatment variations from the more common physical factitious disorders.

4.12.2.1 Confrontational Approaches

Confrontational approaches are addressed first. "Early attempts to manage factitious physical disorders typically involved confronting the patient with evidence of the factitious behaviour" (Eisendrath & Feder, 1996, p. 197). The literature is replete with case examples where the patient was confronted with evidence of their factitious behaviour. The confrontations by the physician had generally tended to be an angry one – often due to being duped by the patient. This could be regarded as a countertransference reaction (discussed later). This was however, generally not experienced as effective in changing the patient's behaviour. For the patient, any

suggestion of a psychiatric consultation was often angrily rejected. "From a psychotherapeutic point of view, this denial appears to be a necessary endopsychic defence mechanism" (Plassmann, 1994c, p. 96). Any further confrontation suggesting a factitious disorder thus tends to result in the patient's vociferous denial, discharging themselves and leaving to seek help elsewhere (Eisendrath & Feder, 1996; Feldman & Ford, 1994; Ford, 1984; Gieler, 1994; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Stoudemire & Fogel, 1993; Wedel, 1995).

It was then suggested that the confrontation should be creatively refined so as to attempt to avoid any punitive tone. It was advocated that a psychiatrist should consult with the primary physician and then participate conjointly in confronting the patient. The primary physician would inform the patient in a direct manner of the factitious diagnosis. The psychiatrist would help interpret to the patient that the factitious behaviour was a cry for help. The physicians would then attempt to reframe the disorder as a psychiatric one and encourage the patient to enter psychiatric treatment (Eisendrath & Feder, 1996; Kaplan & Sadock, 1998; Plassmann, 1994a; Plassmann, 1994c; Stoudemire & Fogel, 1993; Wedel, 1995). Ford (1984) reminds us that one should keep cognisance of the fact that the patient is indeed sick, psychologically even if not physically.

It is generally suggested that after confrontation, a factitious disorder patient should ideally enter an initial 2 to 6 month period of inpatient psychotherapy, so that the patient can first be removed from their usual environment and that the psychiatrist can build an alliance and therapeutic relationship with the patient. This should then be followed by several years of psychodynamically oriented therapy. The goal is to focus on the poorly regulated self-concepts that these patients often have, as well as exploring the unconscious themes that are considered to be playing significant roles in the patient's behaviour. The goal is then to educate the patient on how to express their feelings more adaptively. The unfortunate reality is that such lengthy treatments (especially the inpatient setting) are very often not practical or viable (Eisendrath & Feder, 1996; Gieler; 1994; Plassmann, 1994a; Plassmann, 1994c). It has even been found that the provision of psychological insight often leads to a weakening of the patient's control over their self-destructive impulses (Ford, 1984).

> Despite some success, however, confrontational approaches have had significant limitations. It is often difficult for a patient with factitious disorder to accept psychotherapy because this act may appear as an admission of the psychiatric origin. In many cases, confrontation does not accomplish much beyond driving the patient to seek care elsewhere. Clinicians have therefore been obliged to develop nonconfrontational strategies.
>
> (Eisendrath & Feder, 1996, p. 199)

Some suggested nonconfrontational strategies are addressed next.

4.12.2.2 Nonconfrontational Strategies

There have been a number of behavioural approaches to the treatment of factitious disorders described in the literature. These approaches are less concerned with the aetiology and origin of the disorder and more concerned with the shaping of future behaviours. The behavioural approaches have been varied and adapted to the symptoms that the patient presents and the context within which they present the symptoms. However, a common and crucial element to the success of behavioural modification approaches is an element of face-saving that was involved (Eisendrath & Feder, 1996; Feldman & Ford, 1994; Stoudemire & Fogel, 1993). The "intervention[s] would allow the patient to have an acceptable rationale to explain his or her recovery" (Eisendrath & Feder, 1996, p. 201). Face-saving is seen as crucial in the treatment of factitious disorders – to maintain a level of compliance – but there is no specific approach and there are a number of strategies that can be employed.

> Another strategy the Eisendrath has advocated is the therapeutic double bind. In this approach, the patient is offered two choices: 1) prove that his or her disorder is not factitious by responding to a relatively minor and benign medical intervention; or 2) prove that the disorder is factitious by failing to respond.
>
> (Eisendrath & Feder, 1996, p. 201)

This technique could also be used in psychotherapy by the use of "inexact interpretations" – and facilitate face-saving. The psychiatrist could give the patient psychotherapeutic interpretations that were partially correct, but incomplete. The interpretation would capture the majority of the psychodynamic formulation for the patient's behaviour, but would stop short of overtly identifying any factitious origin. By avoiding any overt confrontation of the factitious aetiology of the sickness, the psychiatrist could make it safer for the patient to relinquish their symptoms while

saving face and feeling in control. It has been reported that in a number of these cases, the patients even revealed the factitious aetiology of their illness, presumably because they were not forced to do so (Eisendrath & Feder, 1996).

The treatment and management of patients with factitious disorders – including the decision to confront the patient – is very often effected by the countertransference reactions of the physician.

4.12.2.3 Countertransference

> It is important for the clinician to be aware of his or her own countertransference concerning patients with factitious disorders. The manipulations and deceits these patients exercise may produce a sense of betrayal and anger in the caregiver … In some instances, this anger leads the psychiatrist to become only a medical detective trying to catch an elusive villain.
> Ideally, the psychiatrist will benefit from using countertransference feelings to enhance the understanding of the patient.
>
> (Eisendrath & Feder, 1996, p. 203)

Often, when a patient continues to generate factitious disease and illness during prolonged hospitalisation, the psychotherapist often begins to feel helpless and unable to improve his or her condition. There is further anger and rage when the patients are found to be deceitful and lying. Being in touch with these feelings not only helps to monitor the behaviour of the patient, but also assist in establishing an empathic connection with the patient, who themselves often feel helpless and frustrated (Eisendrath & Feder, 1996; Kaplan & Sadock, 1998; Willenberg, 1994).

Let us now address some general management suggestions when confronted by patients with factitious disorders.

4.12.2.4 Management Suggestions

The treatment of factitious disorders is suggested to be best focussed on management rather than cure. Firstly, it is suggested that patients with a factitious physical disorders are best managed by a multidisciplinary team. "Medical caregivers must maintain consistent and clear communication amongst themselves and with the

patient" (Eisendrath & Feder, 1996, p. 205). Care for the patient should ideally be centralised at one hospital with one primary physician who coordinates various specialist consultations. The psychiatric consultant can help the staff in understanding the likely psychodynamics underlying the factitious disorder. This can serve to diminish anger and thus allow for the better care of the patient. The patient should not be allowed to split the staff on the ward or the various involved physicians (on either an inpatient or outpatient basis) (Eisendrath & Feder, 1996; Feldman & Ford, 1994; Kaplan & Sadock, 1998; Wedel, 1995).

Secondly, patients need to be treated similarly to somatization disorder and be allowed regular medical visits even if they have no immediate or active crisis. Regular visits will serve to diminish the positive reinforcement of acute illness, by allowing the patient to receive nurturance and support while exhibiting "healthy" behaviours. There is reassurance to the patient that he or she will not be abandoned (Eisendrath & Feder, 1996; Gieler, 1994).

Thirdly, despite any history of factitious disorders, physicians should remain alert and aware of the possibility of genuine organic illness. Patients, by creating their factitious disease may also cause real biological problems. As discussed, when comorbid psychiatric illnesses are present, medication and treatment may still be of value (Eisendrath & Feder, 1996; Feldman & Ford, 1994; Ford, 1984; Kaplan & Sadock, 1998).

Fourthly, "as in other psychiatric conditions, the overall aim of treatment is to replace maladaptive behaviors with healthier ones. … Offering the patient a face-saving way to relinquish his or her factitious disorder is often critical to a strategic intervention. The goal of treatment is recovery, not confession" (Eisendrath & Feder, 1996, p. 205).

Fifth, it should be kept in mind that as with other recovery processes, relapses should be expected in times of stress. The patient's condition also tends to worsen during periods of separation from the therapist. These should not be viewed as failures or permanent setbacks. They may rather even "represent a chance to learn more about the motivations driving the factitious behavior" (Eisendrath & Feder, 1996, p. 206). Lipsitt (1996) goes further to caution that "[w]hile a few patients with factitious

disorder have agreed to a course of psychotherapy, most often the therapy provides only a short sabbatical from their profession of illness" (Lipsitt, 1996, p. xxi). In fact, in some cases improvements that are seen often turn out to be pseudo-improvements (Eisendrath & Feder, 1996; Feldman & Ford, 1994; Lipsitt, 1996; Plassmann, 1994a).

Finally, physicians need to be aware of their countertransference. Psychotherapists however need to go further and use their countertransference therapeutically to better understand the patient (Eisendrath & Feder, 1996; Kaplan & Sadock, 1998).

Let us now address some of the specific considerations of psychological factitious disorders.

4.12.2.5 Psychological Factitious Disorders

In addition to the inherent difficulty in diagnosing a factitious psychological disorder, patients with these symptoms may initially appear to be more receptive to treatment. They in fact actively seek psychiatric help (Eisendrath & Feder, 1996). Some authors believe that this is a positive prognostic sign:

> These patients may be steps closer to successful treatment than their counterparts with physical symptoms because they acknowledge the need for mental health care. If the physician understands that the factual content of a particular patient's complaints may be tainted but still addresses the distress of the patient, there is more likely to be a response to intervention. In contrast, patients with factitious physical symptoms are generally unable to discuss their feelings and thus may be much less amenable to addressing their internal distress.
>
> (Parker, 1996, p. 41)

Eisendrath and Feder (1996) however highlight that a single-treatment approach to factitious psychological disorders will not work for the following three basic reasons:

1. There is a motivational continuum for symptom production from unconscious to fully conscious, and it may be very difficult to differentiate malingering from factitious symptoms.
2. The literature describes a vast array of different psychiatric symptoms and presentations. Some patients oscillate among several factitious symptoms.

3. Some patients present with both factitious physical and psychological symptoms.

As with most factitious physical disorders it is necessary to differentiate between the longer standing abnormal illness behaviour, and the factitious psychological symptoms produced under acute stress. The treatment will then vary according to the specifics of the case and the above considerations. Close observation of the patient on the ward is often useful to detect incongruencies in the patient's symptom portrayal – however; this does require a strong initial suspicion. One successful case reported that the therapist initially focussed on limit-setting, attention-seeking behaviour was ignored, and the therapy was characterised by a nonconfrontational approach (Eisendrath & Feder, 1996; Meyer & Salmon, 1984).

All therapeutic approaches to treatment basically seem to require the clinician's flexibility and creativity (Eisendrath & Feder, 1996). Therefore, having concluded a focus on management and treatment, the possible implications that these have for therapy with factitious disorder patients can now be addressed.

4.13 Therapy?

In the case of Munchausen syndrome, almost all attempts to treat these patients have been unsuccessful. "This is not surprising considering the paradoxical situation of trying to establish a therapeutic relationship with a patient whose symptoms are predicated upon deceit of the physician" (Ford, 1984, p. 168). In general though, for patients with factitious disorders, mental health treatment is seen as essential, but it is often refused. The patients tend to deny the physicians (and often themselves) their true illness to avoid possible treatment of it. Where successful therapy is experienced, there is usually a negative therapeutic reaction to the termination of therapy. The patients often do not appear to maintain the therapeutic advances (Feldman & Ford, 1994; Kaplan & Sadock, 1998; Plassmann, 1994c).

In fact in many cases where a factitious disorder has been treated, it might merely be argued that the patient has substituted one factitious symptom or illness with another.

This seems to be the case with depression, which is often given a good prognostic sign in terms of a factitious physical disorder. Is the presence and treatment of the depression over the physical symptoms a real progression or the underlying cause? Or is the patient merely substituting a factitious psychological disorder for the factitious physical disorder? Even in purely factitious physical disorders, symptoms are often substituted by others (Feldman & Ford, 1994).

Goals in therapy can be for the patient to learn and be challenged to be open and honest with others, and in particular to learn to accept responsibility for the consequences of their behaviour (Meyer, 1989; Meyer & Salmon, 1984). However, one must keep in mind that treatment or psychotherapy tends to imply that the patient will move towards health and relinquish their sick role. With this in mind it can be expected that the patient will tend towards sabotaging any attempts to help or assist them.

It may be useful to attempt to refocus more pathological needs for control into more adaptive and healthy focuses on control. "One can't help but think that if factitious patients took the creativity they put into their deceptions and applied it in more constructive ways, they could probably do and be anything" (Feldman & Ford, 1994, p. 88).

4.14 Summary

This chapter has focused on factitious disorders within a spectrum of illness – having defined the concepts of somatization, disease, illness, health, and the "sick role". Typical psychological responses to illness were included as well as where the somatizing range of disorders differs from the expected normal responses.

The chapter then continued with a focus on the factitious disorders specifically. A definition and diagnostic criteria were given as well as the various diagnostic criteria and general features associated with factitious disorders. Munchausen syndrome, as a form of factitious disorders was given specific attention. The epidemiology and prognosis of the disorder was briefly addressed before moving on to a description of

the more specific clinical features associated with factitious physical disorders, factitious psychological disorders, and Munchausen syndrome respectively.

This was then followed by a discussion on personality disorders – more specifically borderline – as they pertain to factitious disorders and Munchausen syndrome. A great deal of attention was then given to the various aetiological conceptualisations and theorising on factitious disorders. This remained open-ended and disjointed, but will be attended to again in Chapter 5 with some thoughts from the author.

The ethical and legal issues, personal and interpersonal consequences and patterns of factitious disorders were then addressed to provide a conceptualisation of the various impacts involved in the disorder. The chapter was then concluded by a discussion on the management and treatment of factitious disorders, as well as some concluding thoughts about the applicability of therapy with these patients.

The author now continues with the final chapter in this study where he provides an open-ended evaluation and some concluding comments. The literature review on factitious disorders contained in this chapter will be linked and compared to the phenomenological study (Chapter 3) of the therapist's experience in working with a patient who was diagnosed with a factitious disorder.

Chapter 5

Evaluation & Conclusion

5.1 Introduction

In this chapter the author will briefly link the phenomenological study (Chapter 3) with the literature on factitious disorders (Chapter 4). The author will do so in order to highlight some of the similarities and differences of this particular case with the literature. In this comparison, the author will briefly evaluate this particular case in light of the literature, but also provide some comments on the literature, based upon this particular case.

The phenomenological study will also be compared to feedback both from the patient within therapy (referred to in the phenomenological description) and from the patient after therapy was concluded (Patient, 2002). The respective evaluations of the therapy – both from the phenomenological study and the literature – will be compared to the feedback from the patient.

It should be reminded that the aim of this study is not to provide an evaluation of the therapy that was conducted with a factitious disorder patient. The aim was to provide a phenomenological description of the therapy - of the experience of a therapist working in therapy with a patient diagnosed with a factitious disorder. The aim was further not to critique the current available literature on factitious disorders. Therefore, the focus of this concluding chapter to this study is more on a comparison of the phenomenological study (Chapter 3) with the literature available on factitious disorders. Any evaluation is thus mainly tentative, not conclusive, and not exhaustive. However, the author does believe that it is beneficial in some way to link the phenomenon of the therapy with the literature and the experience of the patient. This is because it brings one full circle back to the research attributes of psychotherapy (Kruger, 1986).

Similarly, the study will be concluded with some thoughts and concluding comments. These are thoughts of the author as therapist and researcher, the thoughts that were began in therapy, were raised in the phenomenological study, and further highlighted by a review of the literature. As stated above that this is not an evaluative study, these thoughts and concluding comments are by no means conclusive. They serve merely to highlight questions that were raised and that could be the focus of further research.

5.2 Comparison with the Literature

During this section, specific emphasis will be given to a comparison of this particular patient (diagnosed with a factitious disorder) and case, to the available literature on factitious disorders. To facilitate referencing to the phenomenological study (Chapter 3), the following abbreviations will be made use of: When referring to Consistent Themes of Transformed Meaning Units (Heading 3.4.1), the abbreviation CT will precede the relevant unit number (i.e. CT3); or when referring to specific Natural Meaning Units (NMU's) or Transformed Meaning Units (TMU's), the relevant units will be preceded by the abbreviation MU (i.e. MU123).

This section will further place specific attention on the patient's diagnostic agreement (Heading 5.2.1) with factitious disorders (including Munchausen syndrome). This will be followed by a comparison between the patient's clinical presentation, and the expected clinical picture (Heading 5.2.2) as highlighted in the literature review (Chapter 4). This section will be concluded by a discussion of the possible links of personality disorders (or deficits) in the aetiological assumptions on factitious disorders (Heading 5.2.3) – as are relevant to this particular patient and case.

5.2.1 Diagnostic Agreement

The author believes that it prudent to begin a comparison with the patient's diagnosis of a factitious disorder. The patient was given a DSM-IV diagnosis of a Factitious Disorder with Predominantly Physical Signs and Symptoms. The patient does appear to meet the criteria of the intentional production of physical and psychological signs or symptoms for the purpose of assuming the sick or patient role (DSM-IV, 1994;

Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Meyer, 1989). In the phenomenological study, the patient was seen to intensely focus on and manoeuvre for the 'sick role' (CT1; CT3; CT4). The doctors raised the suspicion that she could be self-inflicting harm and consciously producing physical illness and disease. The finding of faecal material in some of the patient's abscesses tends to strongly indicate some form of conscious symptom production (MU86).

The primary diagnostic requirement of ruling out genuine medical conditions or real mental disorders also appears to have been met, at least to a certain level of confidence (DSM-IV, 1994; Eisendrath, 1996; Feldman & Ford, 1994; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Paar, 1994; Stoudemire & Fogel, 1993). Tests were repeatedly negative for the immune system dysfunction that the patient was reportedly suffering from. Some of the patient's infections also became in themselves suspicious, even though there was *no direct proof* or admission (CT12; MU17; MU86; MU136; MU231). And even though the psychiatrists did suspect some genuine illness and disease, the DSM-IV does warn that the presence of a factitious disorder does not rule out the coexistence of true physical or psychological symptoms. If the patient had been intentionally creating illness and disease for the length of time she reported to have been sick and suffering from the unexplainable disorder, then it seems reasonable to expect that she would have developed various iatrogenic complications, and done her body some real damage.

Pilowsky's term of the *abnormal illness-affirming behaviour* appears particularly useful in the differential diagnosis of a factitious disorder (Eisendrath, 1996). The patient's disease production could be hypothesised to be conscious due to the nature of the inconsistencies, and the negative findings of various medical investigations. However, her motivation could be assumed to be unconscious. The patient herself even referred to much of her behaviour as compulsions (CT29; CT47). Additionally, for all accounts and purposes, the secondary cost could be assumed to be far greater than any secondary gain. No team member, during her treatment in the hospital, could note any secondary gain that might account for the conscious production of her symptoms. In therapy, the patient's sole focus was often on her illness and sick role, suggesting a strong primary and psychological motivation (CT4; CT5).

The diagnostic criteria of predominantly physical signs and symptoms also appear to fit well with this particular case. Even though the patient presented with various psychiatric complaints during her treatment, the focus was always predominantly on her illness (CT1; CT4). Therefore as Parker (1996) suggests, the diagnosis of physical or psychological signs and symptoms may merely serve only as convenience. The author, as therapist, found that regardless of whether the signs and symptoms were physical or psychological, the goal appeared to remain the same – to assume the sick role (CT1). In the context of this particular hospital setting, the psychological signs and symptoms actually allowed for further hospitalisation – in the psychiatric ward - and thus aided in maintaining the sick role (CT6; CT8; CT13). And as Parker (1996) further suggests, patients with psychological factitious symptoms often become "quintessential Munchausen patients".

This particular patient tends also to meet the criteria for Munchausen syndrome theoretically and diagnostically. Although this was not used as a diagnostic description or category, it was a query of the therapist, and referred to by a number of team members (CT11). The patient could be seen to simulate disease, showed evidence of pseudologia fantastica, and peregrination (travelling). The peregrination was evidenced by the fact that she had reported to have been admitted to a number of hospitals in South Africa in a number of provinces. She also had seen numerous specialists, and even reported psychiatric hospitalisations. The pseudologia fantastica could be implied by the history she reported. These were reports of a number of severe infections that brought her to near death experiences. These were plausible, but dramatic. On a whole, the patient was often found to be overly dramatic, inconsistent, and not entirely truthful in her portrayals of events, people or symptoms. The patient also displayed many of Asher's warning signs, including numerous surgical scars and a history of numerous hospitalisations and surgical procedures.

According to the DSM-IV diagnostic criteria, the patient appears to fit the category of a chronic factitious disorder with *predominantly* physical signs and symptoms. The author can now compare the patient's clinical presentation to that expected in the literature.

5.2.2 Clinical Picture

Eisendrath (1996) warns that there is often a delay in the diagnosis of factitious disorders, and that this in turn often leads to iatrogenic complications. Both these aspects appear to be evident in this case. The patient reported an extensive history of many hospitalisations, operations, and medical procedures and investigations (CT3). This not only is an enormous financial drain, but may also account for the possibility that the patient reached a point of also creating disease – often evident in Munchausen syndrome. It becomes difficult to distinguish between the "real" and the "factitious". Although the "real" may also be a result of years of factitial symptom production.

According to the various general clinical presentations of factitious disorders, the patient in this particular case presented with a number of similarities (DSM-IV, 1994; Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1984; Kaplan & Sadock, 1998; Maxmen & Ward, 1995; Meyer & Salmon, 1984; Parker, 1996). The patient showed and reported evidence of extensive hospitalisations, multiple treatment interventions, numerous surgical procedures and the extensive consumption of medical resources. She displayed an atypical and dramatic presentation of symptoms that did not always conform to an identifiable general medical conditions or mental disorders. She often had vague and confusing depictions of symptoms. She did not appear to respond to seemingly correct medical or psychiatric treatment and medication. She had a fluctuating clinical course and presentation with rapid development of new complications and new pathology when tests were negative and especially when improvement was expected. She was notably accurate in predicting her clinical responses. The patient was further seen to constantly manoeuvre for a diagnosis – whether it was medical or psychiatric (CT1; CT3; CT8; CT21; CT39; CT52; CT57).

The patient was extremely disruptive in the hospital and excessively non-compliant with hospital regulations, treatment and medication. She was excessively dramatic and argued excessively with healthcare professionals and staff. She interacted with many different physicians and team members and was often derogatory towards the competence of the various physicians (CT7; CT15; CT17; CT41; CT43; CT51). The patient attempted to and was often able to split the hospital staff, in an attempt to create disagreements amongst the team members (CT49; CT55). The patient also

responded with angry and vociferous denial when confronted by suspicions of the factitious nature of her illness – and even showed signs of leaving the hospital before the focus was downplayed (MU254-275).

The features that Kaplan and Sadock (1998) state are over represented in factitious disorder patients, the author believes were further dominant characteristics of this particular patient. It was strongly believed by not only the therapist, but also many of the team, as well as the patient herself, that she had an above average intelligence (CT18). The patient displayed an extensive knowledge of medical terms and terminology (CT14). This was displayed for both medical and psychiatric terminology. There was never a formal though disorder, but there were consistent and strong issues in therapy concerning a poor sense of identity. While not delved into in depth, reports of the relationship with her husband further suggested a poor sexual adjustment and possibly a problem with sexual identity. The poor frustration tolerance and strong dependence needs were also strongly evident.

In relation to the patient's physical signs and symptoms, the patient displayed a *self-induced* pathophysiologic disease state (Eisendrath, 1996; Feldman & Ford, 1994; Ford, 1984; Nordmeyer, 1994; Stoudemire & Fogel, 1993; Wedel, 1995). This was suggested by the types of disease states and infections reported (one suggesting the injection of faeces). In this case there was no suggestion or evidence of simulated illness. With the suggestion of pseudologia fantastica, it might also be possible that the patient maintained a sick role through fabrications and exaggerations of symptoms and personal history, but not necessarily so. The self-induced production of symptoms is often common in the severe cases of Munchausen syndrome.

In Munchausen syndrome, the presentation of physical symptoms is usually dramatic and rare. In this particular case the patient complained of some rare and little-understood immune system dysfunction as the cause of her illness, diseases and infections (CT2). This could be referred to as her modus operandi as it was the common complaint for all hospitalisations (Ford, 1984; Maxmen & Ward, 1995). No specific – if any – immune dysfunction was reported after numerous and expensive tests and diagnostic procedures (MU231).

In presentation, the patient was further characteristic of Munchausen syndrome. She was consistently a patient of great difficulty, but also great interest – for the hospital staff, physicians and the therapist. She occupied a disproportionate amount of the health care team's time (CT15; CT16; CT17; CT53). She submitted herself to all medical procedures and examinations (CT3). And even though she complained of some procedures and requested others, she displayed an almost unbelievable tolerance for the uncomfortable and often painful procedures (Feldman & Ford, 1994; Ford, 1984; Ford, 1996b; Maxmen & Ward, 1995; Plassmann, 1994a).

Throughout the course of therapy, the patient displayed a number of psychological signs and symptoms that are commonly feigned by factitious disorder patients. She suggested depression, PTSD, and rape (CT8; CT9; CT10). As has been suggested, a patient may have genuine disease, and thus in the case of psychological symptoms, may even have a genuine psychiatric disorder. The fine line comes in, in trying to determine whether the symptoms are given and produced consciously for the sick role or not. As Parker (1996) warns, the patient may have the very disorder that they are attempting to simulate. The distinction essentially comes in when the patient intentionally chooses their particular psychiatric disorder (Feldman & Ford, 1994; Parker, 1996). The patient's eventual willingness to submit to psychiatric treatment may have had more to do with an additional illness with which to maintain hospitalisation, rather than an admission of the psychological origins of her problem. She in fact constantly became angry at the notions that it was 'in her head' (MU241). Feldman and Ford (1994) suggest that factitious disorder patients may nevertheless experience genuine dissociative episodes. The author, as therapist, felt that the patient's dissociative episodes were genuine, even though they may have been interpreted as manipulative.

The author now turns to a discussion on the possible links of personality disorders (or deficits) to the aetiological assumptions on factitious disorders. It is cautioned that this applies predominantly to the context and specifics of this case. Generalised statements will be avoided.

5.2.3 Personality Disorders and Aetiological Assumptions

Personality disorders – more commonly borderline personality disorder– tend to be associated with a poor prognosis, whereas depression as a co-morbid factor in factitious disorders is generally regarded as having a good prognostic value. Borderline personality has the most consistent clinical congruence with factitious disorders (Eisendrath, 1996; Nadelson, 1996; Stoudemire & Fogel, 1993). The patient in this case was diagnosed as having a borderline personality, but also had a diagnosis of, and was being treated for, major depression. However, personality not only affects prognosis, but it also can be hypothesised as related to the aetiology of factitious disorders due to the high co-morbidity.

The ICD-10 classification of factitious disorders with respect to personality disorders tends to suggest that personality is an important factor. In reviewing therapy with this particular patient, the author strongly believes that the patient's personality predisposed her towards factitious behaviour. Nadelson (1996) suggests that the psychic trauma contributing to the borderline personality structure, may also contribute to a tendency towards chronic factitious disease and illness production. The patient displayed many of the borderline characteristics (Refer to Heading 4.8.1) of hostility, dependency, intense but unstable interpersonal relationships, a poor sense of personal identity, conflicts with identity, mood swings, manipulative behaviour, and poor impulse control particularly evidenced by her self-destructive and self-mutilative behaviour (CT15; CT24; CT26; CT27; CT28; CT29; CT41; CT43; CT47).

However, even though the author believes that personality may be a predisposing factor, as Maxmen and Ward (1995) state, little is known of the aetiology of factitious disorders, and they may develop from a "confluence of factors". And as most explanations tend to be anecdotal, a review of the aetiology tends to show common characteristics even though the interaction of these characteristics is not yet well understood.

The sense of mastery and control could also be assumed in this particular case if one considered the pride and one-up approach (CT39) to which the patient would admit to non-compliance – and thus possibly the deceiving of the physicians. There was

further also a prominent element of masochism displayed by the patient. Even in therapy, the patient would appear to manoeuvre the therapist (as persecutor) into assisting in her masochistic tendencies to harm and mutilate herself (MU116). Rage was another component of the patient's psychological state and interaction with others, and as such, her factitious behaviour may have assisted her in the ventilation of this rage. Death and dying were further preoccupations of the patient during therapy, and it could be hypothesised that her factitious behaviour also served counterphobic mechanisms. The assuming of a sick role for gains such as nurturance that the patient feels is lacking elsewhere in their lives is again as cautioned only assumed. However, it is notable that the patient responded very well to empathy in therapy and manoeuvred constantly to increase the boundaries of the therapeutic relationship (CT50).

The common factors in the proposed aetiologies – either explicitly or implicitly stated – appear to be a history of deprivation in childhood, sexual or physical abuse, or some form of necessary yet painful hospital association. These in combination may not only provide the basis for the development of a personality deficits, but in the context of learned behaviour – together with the reinforcement of the sick role – may contribute to the development of factitious disorders. This particular patient also tended to display the expected parental relationships of an authoritarian and over-involved mother, with an aloof, cold, distant, and mostly indifferent father (MU292; MU293).

However, together with a poor sense of self, the patient did display a poor relationship to her body as suggested by Plassmann (1994a). The healthcare professionals and her body were often regarded and treated as external objects. She engaged in self-mutilative behaviour and often reported a dissociative split between herself and her body (CT29; CT47). There also appears to be a familial consistency in poorly developed body images as evidenced by the fact that the patient's sister suffers from anorexia – and as was later reported by the patient had also been diagnosed with a borderline personality (Patient, 2002). This body relationship, the author believes, is the closest in distinguishing why these patients with their particular character deficits engage in factitious behaviour.

However, there also appears to be evidence that, according to Eisendrath and Feder (1996), factitious disorders may also be part of the obsessive-compulsive spectrum. The patient described much of her self-mutilative and self-injurious behaviour as a compulsion – she felt compelled to hurt herself. This compulsion was based upon the *obsession* that she was inherently bad. The unconscious nature of the motivation for factitious behaviour also tends to suggest that there are compulsive qualities to it. These may be as a possible defence against the psychic trauma involved in borderline pathology (Nadelson, 1996).

The author has not included a formal evaluation on management and treatment. This is because this is firstly not an evaluative study. Secondly, the author does not believe it is his place to criticise or otherwise comment on other disciplines. The author also wished only to describe his own therapy with the patient. As such there will be a few isolated suggestions about management and treatment to be found in the concluding comments. The patient also provided the therapist with her own feedback of what she perceived as beneficial (Patient, 2002). The author will provide his interpretations on the patient's feedback. It is only within this context that the author will base the isolated suggestions about management –which essentially is only focused on therapy with this particular factitious disorder patient.

5.3 Feedback from Patient

With this particular patient, during her involvement at the hospital, direct confrontation – with the aim of leading towards confession of factitious behaviour – was not seen as particularly beneficial. The patient responded with the expected anger, indignation, vociferous denial, and threats to discharge herself from the hospital. The patient did however maintain that the "extremely direct" approach of the therapist in therapy was beneficial. It gave the patient a sense that she was understood and that her problem was treated as a realistic one, which is what she felt she needed – "You took me seriously" (Patient, 2002).

The author makes sense of this from the perspective that in therapy it was not important or necessary for the therapist to obtain a confession from the patient for her

factitious behaviour. The therapist could accept her denials at face value even if he was suspicious of them. This, the author believes, keeps with the importance of face saving in factitious disorders (Eisendrath & Feder, 1996; Feldman & Ford, 1994; Stoudemire & Fogel, 1993). The need for the sick role is extremely powerful in factitious disorders and the author believes that this needs to be understood and respected if therapy is to progress. However, by being direct in confronting behaviours and suggesting your suspicions (preferably implicitly), the patient is able to maintain their sick role, but also feel understood in the sense that on some level the therapist knows what they are doing – or even *need* to do.

The patient referred to the fact that the therapist validated her feelings: "You always respected what I felt regardless if the emotions were healthy or unhealthy" (Patient, 2002). The patient stated that this allowed her to tell the therapist horrific things that she otherwise believed she could not. The patient added that it was important to be allowed to progress at her own pace, and be allowed setbacks in certain areas, while progressing in others. The patient stated that it was important to be left with a feeling that she was in control. With this in mind, the author believes that it is ideal for a factitious disorder patient to be in long-term therapy. However, in this particular case it was not a practical or viable option.

The patient found the focus on consistency and the setting of boundaries to be extremely beneficial in the therapy.

> The setting of boundaries during our sessions and in between our sessions gave me a sense of security. I eventually knew where the lines were and how to stay within them. More importantly it gave me a respect for you. I understood that I could not push you around or demand your attention. I needed to feel that in order to feel you had a strength of character which would be able to handle things if/when they went wrong. An unfortunate part of my temperament is that it can be manipulative. I needed someone to lean on who could stand up to me. Most people if I chose to I could flatten. I need someone who could challenge me [,] not a puppet. The fact that you were set in your ways fostered respect for you.
>
> (Patient, 2002)

The importance of therapeutic boundaries displayed a number of benefits. As suggested in the phenomenological study it provided the therapist with a greater sense of ease and control in dealing with the patient. This served to reduce negative

countertransference towards the patient. The setting of boundaries also not only fits with the patient's character deficits, but can also be seen to have been therapeutic. The boundaries and consistency is what the patient needed to experience. The patient referred to consistency as something her "life sorely lacked". The author would advise therapists to maintain strict boundaries, but also be open and consistent characters for their patients - in the case of factitious disorders.

The patient stated that couples therapy with her husband was not beneficial – an event notable by the patient's severe dissociative experience. As stated in the phenomenological study the therapist hypothesised that this was due to the focus being away from the patient's sick role. The patient stated that at that point she "had no real feeling of myself. I found it impossible to focus on anything outside of myself and extremely threatening to do so" (Patient, 2002). Again the author finds it important not to downplay the patient's need for the sick role.

The patient also stated that focussing on what she wants and attempting to set goals for herself was not very beneficial. This was frustrating for her, as she could not foresee of a future, and only wanted to hurt herself and others: "Part of my disorder is wanting destruction" (Patient, 2002). The patient added that one of the procedures she was manoeuvring for was because of its high potential to be lethal. She felt that in that context she was suicidal, but with this procedure she could "give up and die" without anyone knowing she had done so (a need to save face?). It is important to take cognisance of the confusion that the patient feels within her own feelings, emotions and cognitions. The patient felt that it was beneficial for her to focus on what she needed to do, rather than what she wanted to do.

> I think one of the smartest things you did in treating me was to admit that no amount of convincing would win. My mind was set on destruction and we could have 'argued' forever. When I stopped fighting what you were saying I had to start thinking. You made me aware I could go on doing that forever but would it get me anywhere? I had to stop and think about that and realised I would just go on and on as I was. Together with the realisation that I needed to be there for those I loved [,] it was enough.
>
> (Patient, 2002)

Allowing/helping the patient to come to the realisation that she is ultimately responsible for her behaviour seems to have been beneficial. As the patient stated, it is difficult to deal with her emotions, and possibly better to first address her compulsions (her behaviours). It seems that it was important to highlight that the patient's very strengths were being used destructively rather than productively.

The patient concluded with: "I am not saying I'm 100% now but at least I am planning for my future and my days are often fill of more smiles than tears" (Patient, 2002). The author now turns to his concluding comments.

5.4 Concluding Comments

The author believes that the most important concluding comment can be summed up in the following sentence: "One can't help but think that if factitious patients took the creativity they put into their deceptions and applied it in more constructive ways, they could probably do and be anything" (Feldman & Ford, 1994, p. 88). One of the reasons for which the author believes that this therapy was successful is because the patient was able to – at least for a substantial period of time – apply her strengths in more constructive ways. Since the conclusion of therapy till the time of the writing of this study, the team knew of no further hospital admissions or consultations. It may be that over time, due to the character deficits, that the patient may revert back to factitious behaviour or substitute for other symptoms. That is why the author does believe that long-term therapy is the ideal therapeutic option. However, even positive change can be regarded as therapeutically significant.

With this patient, the necessity of a sick role identity was the most prominent feature – as expected in factitious disorders. The sick role itself creates an interesting paradox. The patient needs to maintain her illness and diagnoses in order to remain a patient. In order to be a patient, she needs to be sick, and therefore needs to be treated. However, in order to remain a patient, she needs to remain sick, and therefore needs the treatments (and therapy) not to be effective. It was strongly evident that even though she would manoeuvre for diagnoses or answers to her illness, she would never be satisfied with her given diagnoses or explanations.

The acknowledging of the need for the sick role is possibly the most important aspect of the therapy. In doing so it is also necessary to confront the patient in a manner that allows them plausible deniability and face-saving. This allows the patient to feel understood, but remain with a sense of mastery and control.

The author believes that further research and case descriptions might help to unravel the aetiological factors in factitious disorders. However, the author does not feel that they are a necessity for therapy. The feelings that the author is left with following this therapy are that in factitious disorders – especially in this case – a character deficit or pathology, most often borderline, predominates. The author therefore believes that therapy focused on the patient's personality deficits, consistency, and the strict setting of therapeutic boundaries to be beneficial. The author finally provides some brief therapeutic possibilities for treatment.

5.4.1 Therapeutic Possibilities for Treatment

The author believes that first and foremost, the therapist should accept and acknowledge the patient's *need* for the sick role. The patient should be treated as a real patient, with real problems – even if they may only be psychological. The ability to therapeutically provide an avenue for 'face-saving' is in the author's opinion a necessity for therapy – not only for the success of therapy, but even simply to maintain a level of compliance and cooperation from the patient. Face-saving does not mean denying the patient's possible factitious behaviour. It can even be further beneficial to implicitly imply to the patient that the therapist acknowledges the possibility of factitious symptom production. This can allow the patient to feel understood, but also deny their factitious behaviour.

The therapist further suggests that within therapy strong emphasis should be placed on consistency (by the therapist) and the setting of rigid, but overt, therapeutic boundaries. This serves not only to reduce the therapist's negative countertransference reactions to the patient, but will also be therapeutic for the patient by addressing character deficits. The ideal however, is to establish a long-term therapeutic relationship with the patient in order to address the character deficits.

5.5 Summary

This study has focussed on the phenomenological description (Chapter 3) of the therapist's experience while working in therapy with a patient who was diagnosed with a factitious disorder. This was then followed by an overview of factitious disorders according to the available literature (Chapter 4). This final chapter served to provide a comparison between the description of the therapist's experience, the patient's experience, and the literature.

The comparisons – with the author's tentative thoughts - were followed by some concluding comments by the author and suggestions of therapeutic possibilities in therapy. In light of this particular case, the author strongly believes that character and personality deficits provide the foundation for the development of factitious behaviour. The aetiology of the disorder will however – possibly through the accumulation of case reports – need further attention and research. From a practical therapeutic approach, the author suggests the importance of acknowledging the 'sick role', 'face-saving', consistency by the therapist, and the setting of rigid, but overt, therapeutic boundaries.

References

Aanstoos, C.M. (1986). Phenomenology and psychology of thinking. In Ashworth, P.D. Giorgi, A. & de Koning, A.J.J. (Eds), **Qualitative research in psychology** (pp. 79-116). Pittsburgh, PA: Duquesne University Press.

American Psychiatric Association. (1994). **Diagnostic and statistical manual of mental disorders (4th Ed.).** Washington, DC: American Psychiatric Association.

Asher, R. (1951). Munchausen's syndrome. **Lancet, 1,** 339-341.

Barlow, D.H. & Durand, V.M. (1999). **Abnormal psychology (2nd Ed.).** New York: Brooks/Cole Publishing Company.

Eckhardt, A. (1994). Factitious disorder in the field of neurology and psychiatry. **Psychotherapy and Psychosomatics, 62,** 56-62.

Ehlers, W. & Plassmann, R. (1994). Diagnosis of narcissistic self-esteem regulation in patients with factitious illness (Munchausen syndrome). **Psychotherapy and Psychosomatics, 62,** 69-77.

Eisendrath, S.J. (1996). Current overview of factitious physical disorders. In Feldman, M.D. & Eisendrath, S.J. (Eds), **The spectrum of factitious disorders** (pp. 21-36)**.** Washington, DC: American Psychiatric Press, Inc.

Eisendrath, S.J. & Feder, A. (1996). Management of factitious disorders. In Feldman, M.D. & Eisendrath, S.J. (Eds), **The spectrum of factitious disorders** (pp. 195-213)**.** Washington, DC: American Psychiatric Press, Inc.

Eisendrath, S.J. Rand, D.C. & Feldman, M.D. (1996). Factitious disorders and litigation. In Feldman, M.D. & Eisendrath, S.J. (Eds), **The spectrum of factitious disorders** (pp. 65-81)**.** Washington, DC: American Psychiatric Press, Inc.

Feldman, M.D. & Ford, C.V. (1994). **Patient or pretender: Inside the strange world of factitious disorders.** New York: John Wiley & Sons, Inc.

Feldman, M.D. & Smith, R. (1996). Personal and interpersonal toll of factitious disorders. In Feldman, M.D. & Eisendrath, S.J. (Eds), **The spectrum of factitious disorders** (pp. 175-194)**.** Washington, DC: American Psychiatric Press, Inc.

Ford, C.V. (1984). **The somatizing disorders: Illness as a way of life.** New York: Elsevier Biomedical.

Ford, C.V. (1996a). Ethical and legal issues in factitious disorders: An overview. In Feldman, M.D. & Eisendrath, S.J. (Eds), **The spectrum of factitious disorders** (pp. 51-63)**.** Washington, DC: American Psychiatric Press, Inc.

Ford, C.V. (1996b). **Lies! Lies!! Lies!!!: The psychology of deceit.** Washington, DC: American Psychiatric Press, Inc.

Freyberger, H. Nordmeyer, J.P. Freyberger, H.J. & Nordmeyer, J. (1994). Patients suffering from factitious disorders in the clinicopsychosomatic consultation liaison service: Psychodynamic processes, psychotherapeutic initial care and clinicointerdisciplinary cooperation. **Psychotherapy and Psychosomatics, 62,** 108-122.

Freyberger, H.J. & Schneider, W. (1994). Diagnosis and classification of factitious disorder with operational diagnostic systems. **Psychotherapy and Psychosomatics, 62,** 27-29.

Gieler, U. (1994). Factitious disease in the field of dermatology. **Psychotherapy and Psychosomatics, 62,** 48-55.

Giorgi, A. (1970). **Psychology as a human science: A phenomenologically based approach.** New York: Harper & Row.

Giorgi, A. (1983). Concerning the possibility of phenomenological psychological research. **Journal of Phenomenological Psychology, 14(2),** 129-169.

Giorgi, A. (Ed). (1985). **Phenomenology and psychological research.** Pittsburgh, PA: Duquesne University Press.

Giorgi, A. (1986). Theoretical justification for the use of descriptions in psychological research. In Ashworth, P.D. Giorgi, A. & de Koning, A.J.J. (Eds), **Qualitative research in psychology** (pp. 3-22). Pittsburgh, PA: Duquesne University Press.

Giorgi, A (1987a). Phenomenology and the research tradition in the psychology of imagination. In Murray, E.L. (Ed.). **Imagination and phenomenological psychology** (pp. 1-47). Pittsburgh, PA: Duquesne University Press.

Giorgi, A (1987b). Problems in self-descriptive research as exemplified in a phenomenological analysis of imaginative experiences. In van Zuuren, F.J. Wertz, F.J & Mook, B. (Eds.). **Advances in qualitative psychology: Themes and variations** (pp.41-51). Berwyn, PA: Swets North America.

Giorgi, A. (1992). Description versus interpretation: Competing alternative strategies for qualitative research. **Journal of Phenomenological Psychology, 23(2),** 119-135.

Giorgi, A. (1994). A phenomenological perspective on certain qualitative research methods. **Journal of Phenomenological Psychology, 25(2),** 190-220.

Griffith, J.L. & Griffith, M.E. (1994). **The Body Speaks.** New York: Basic Books.

Hirsch, M. (1994). The body as a transitional object. **Psychotherapy and Psychosomatics, 62,** 78-81.

Kaplan, H.I. & Sadock, B.J. (1998). **Synopsis of psychiatry: Behavioral sciences / clinical psychiatry (8th Ed.).** New York: Lippincott Williams & Wilkins.

Kazdin, A.E. (1982). **Single-case research designs: Methods for clinical and applied settings.** New York: Oxford University Press.

Kazdin, A.E. (1992). **Research design in clinical psychology (2nd ed.).** Boston: Allyn and Bacon.

Kruger, D. (1986). Existential-phenomenological psychotherapy and phenomenological research in psychology. In Ashworth, P.D. Giorgi, A. & de Koning, A.J.J. (Eds), **Qualitative research in psychology** (pp. 185-214). Pittsburgh, PA: Duquesne University Press.

Kvale, S. (1986). Psychoanalytic therapy as qualitative research. In Ashworth, P.D. Giorgi, A. & de Koning, A.J.J. (Eds), **Qualitative research in psychology** (pp. 155-184). Pittsburgh, PA: Duquesne University Press.

Lipsitt, D.R. (1996). Introduction. In Feldman, M.D. & Eisendrath, S.J. (Eds), **The spectrum of factitious disorders** (pp. xix-xxviii)**.** Washington, DC: American Psychiatric Press, Inc.

Maxmen, J.S. & Ward, N.G. (1995). **Essential psychopathology and its treatment (2nd Ed.).** New York: W.W. Norton & Company.

Meyer, R.G. (1989). **The clinician's handbook: The psychopathology of adulthood and adolescence (2nd Ed.).** Boston: Allyn and Bacon, Inc.

Meyer, R.G. & Salmon, P. (1984). **Abnormal psychology.** Boston: Allyn and Bacon, Inc.

Nadelson, T. (1996). Historical perspectives on the spectrum of sickness: From "crock" to "crook". In Feldman, M.D. & Eisendrath, S.J. (Eds), **The spectrum of factitious disorders** (pp. 1-20)**.** Washington, DC: American Psychiatric Press, Inc.

Neuman, W.L. (2000). **Social research methods: Qualitative and quantitative approaches.** London: Allyn and Bacon.

Nordmeyer, J.P. (1994). An internist's view of patients with factitious disorders and factitious clinical symptomatology. **Psychotherapy and Psychosomatics, 62,** 30-40.

Paar, G.H. (1994). Factitious disorders in the field of surgery. **Psychotherapy and Psychosomatics, 62,** 41-47.

Parker, P.E. (1996). Factitious psychological disorders. In Feldman, M.D. & Eisendrath, S.J. (Eds), **The spectrum of factitious disorders** (pp. 37-49)**.** Washington, DC: American Psychiatric Press, Inc.

Parsons, T. (1951). **The social system.** Glencoe: Free Press.

Pilowsky, I. (1978). A general classification of abnormal illness behaviours. **British Journal of Medical Psychology, 51,** 131-137.

Plassmann, R. (1994a). Műnchhausen syndromes and factitious diseases. **Psychotherapy and Psychosomatics, 62,** 7-26.

Plassmann, R. (1994b). Structural disturbances in the body self. **Psychotherapy and Psychosomatics, 62,** 91-95.

Plassmann, R. (1994c). Inpatient and outpatient long-term psychotherapy of patients suffering from factitious disorders. **Psychotherapy and Psychosomatics, 62,** 96-107.

Plassmann, R. (1994d). Introduction. **Psychotherapy and Psychosomatics, 62,** 5-6.

Richards, A. (Ed.). (1974). **Studies on hysteria: Sigmund Freud and Joseph Breuer.** The Pelican Freud Library (Volume 3). London: Penguin Books.

Sachsse, U. (1994). Overt self-injury. **Psychotherapy and Psychosomatics, 62,** 82-90.

Shapiro, K.J. (1985). **Bodily reflective modes: A phenomenological method for psychology.** Durham: Duke University Press.

Stoudemire, A. & Fogel, B.S. (Eds.) (1993). **Psychiatric care of the medical patient.** Oxford: Oxford University Press.

Wedel, K.R. (1995). Factitious illness: A therapeutic confrontation approach to treating patients with factitious illness. In Turner, F.J. (Ed), **Differential diagnosis and treatment in social work** (pp. 386-391). New York: The Free Press.

Willenberg, H. (1994). Countertransference in factitious disorder. **Psychotherapy and Psychosomatics, 62,** 129-134.

Willig, C. (2001). **Introducing qualitative research in psychology: Adventures in theory and method.** Buckingham: Open University Press.

World Health Organization. (1992). **The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines.** Geneva: World Health Organization.

Appendix A - Description of Therapy

Upon thinking about writing a description of my therapy with Mrs. S, I was struck by the difficulty and enormity of the task. Reading and re-reading my process notes, thinking back over my thoughts, emotions, interactions and hypotheses, I started to stress about how exactly to describe my experience. Each process note for each therapy contained and reminded me of copious amounts of information and interesting interpretations. However, even a summarised account from my process notes would be too lengthy for these purposes. Even though the process notes were written in first person, they would also not suffice as a genuine description on their own. I feel it is necessary to include the experience of the therapy as it lives within me at the point of writing the description – including its ambiguities.

However, I feel that it is necessary to provide some structure for the purposes of the reader. I decided upon an approach that seems best suited for organising the progression of therapy, as well as my experiences. Although I will have to concede that it will not and cannot be fully comprehensive. I have chosen to follow the chronology of the therapy, using the process notes as a structure. The sessions will be numbered and referred to in their chronological order, including both scheduled sessions, as well as non-scheduled "emergencies" where therapy was included. All other information about my own thinking as well as external (to therapy) interactions of both Mrs. S and myself will blend around this structure. Descriptions will be grouped in themes that not only make sense to me, but also attempt in some way to structure the description. As the dates of the sessions will not be given, the chronology of events will assist the reader in following.

I saw Mrs. S for 28 sessions over a period of a little over 3 months. I saw her on average for two sessions a week until discharge from the hospital and final termination of therapy.

I entered into therapy with Mrs. S on my day on call. A psychologist was requested by the ward staff at one of the general medical wards in the hospital to come assess Mrs. S and manage further. She was reportedly talking about suicide. My initial goal was to assess the seriousness of the suicide and whether follow up therapy, or a referral to psychiatry was necessary. I approached the initial session with the aim of being client-centred – the Rogerian principles of warmth and empathy. My general approach to therapy is to allow the client to introduce into therapy what their main concerns or problems are. I believe the role of the therapist is to help facilitate change.

Mrs. S upon our first encounter was extremely tearful and volatile. She spoke about being unable to carry on any more, and that she would just rather die. She spoke initially about having an immune system deficiency that was rare and the doctors seemed unable to explain (she was HIV negative). She related a story of being extremely ill and in great amounts of pain for the past 8 or 9 years of her life. She was constantly in hospital and on excessively expensive medication to supplement her defective immune system. She further was subjected to numerous and expensive operations and painful procedures. She was frustrated that no one could help her, the doctors could not help, her husband and family were not there to support her, and she was unable to support and be there for her children. All her frustrations centred on

her illness and Mrs. S seemed to fatalistically believe that she had no hope of ever getting well. She therefore wished that she would rather just be allowed or able to die. She stated that she would not actually commit suicide because of her religious beliefs as a Christian, her desire to be there for her children, and that she believed that she was actually not capable of doing so. She just felt utterly hopeless and helpless and was tired of everyone telling her that all would be "ok" and that she must just be strong. I felt that I could through a client-centred approach to therapy, at least be able to allow her space to express her feelings even though I could do nothing for her medical condition.

Mrs. S for almost the entire span of our therapeutic interactions looked the part of a chronic ward patient. She was almost always in her hospital robes. She looked sick, and consistently spoke of being sick. Yet she was consistently a difficult, strong and frustrating person to encounter. She was argumentative, and could often be scathing with her comments and remarks. Her eyes were however her most defining feature for me. They were a deep rich blue. They sometimes appeared to be able to express a helpless, hopeless and pleading quality, while at other times they were piercing, harsh and scornful. Both qualities were incredibly powerful, but what was most striking for me was the fact that the two seeming polarities of expression often occurred simultaneously. Mrs. S had another commonly observed behaviour of covering her mouth and laughing incongruently when talking about difficult or unspeakable topics.

A significant event on our first encounter was towards the end of the session. Upon asking Mrs. S whether she would like to continue with therapy, it became apparent that she had thought that I was a social worker and not a psychologist – even though I had introduced myself. During the session, Mrs. S was derogatory towards doctors and extremely aversive towards psychiatry and psychiatrists. She had also listed psychologists amongst the professions that were unable to help her. However, upon clarifying this misconception, Mrs. S was still willing and rather agreeable to continuing with me as her therapist.

The first three sessions were characterised by an overwhelming wealth of information. Mrs. S's illness was at the forefront of her complaints, and linked to almost every aspect of her life. I tried initially to focus upon how she copes with the illness working towards and exploring a mind-body link. I thought and believe that mental and emotional states can impact the body and vice versa. Mrs. S agreed with the principle, but was consistently pessimistic, providing reasons and excuses for why it was not and could not be applicable in her case. Mrs. S spoke a great deal about the social difficulties in her life.

Her husband (Mr. S) was portrayed as short tempered, aggressive, and non-supportive. Mrs. S has two daughters (M, 11 years and Y, 7 years), although the youngest, Y is not the biological daughter of Mr. S. Mrs. S had known Mr. S since childhood, and they had married in their early twenties. They had their first daughter, M, together, but their marriage was described problematic. In an argument one night Mr. S had kicked out and locked out Mrs. S from their apartment. She had sought support from an older man X, who was a neighbour and friend to the couple. This led to a sequence of events in which he took advantage of her, the couple divorced, and Y was conceived. X was described to be obsessive, abusive, violent, an alcoholic and drug addict. Mrs. S a few years later fled this relationship and eventually remarried

Mr. S who adopted Y. Mrs. S however also raised questions and suspicions of Mr. S molesting M and believed that he strongly needed professional help. She often tried to force Mr. S into therapy. Their marriage and relationship was constantly described in many different contexts as being in crisis. Mrs. S would often move between extremes of wanting her husbands support to wanting nothing to do with him. Both Mr. And Mrs. S's families were described to be pathological. Mrs. S's parents had divorced when she was about 14. Mrs. S recounted stories in which her own needs were constantly set aside for the needs of others. She used a metaphor-story of as a child hurting herself walking into a table, and being made to apologise to the table. She feels that her family (mother, father, husband) are not supportive of her with her illness. Mrs. S often described her children as the most important focus and biggest accomplishment in her life. She believed that her parents and her illness are taking her children away from her. Mrs. S also made reference to having been psychiatrically hospitalised in her late teens. She spoke of being in and out of a psychiatric institution for about two years and of attempting suicide on a couple of occasions, once even swallowing razor blades. She said she had rebelled against her parents at 14, disobeyed them, and that this resulted in her being "badly hurt" by a man. She had not received sympathy or support from her parents, only blame. She later broke down and had to punish herself. These descriptions were always vague and Mrs. S would tend to justify this by stating that she did not want to talk about it or that her thoughts were "fuzzy".

In these first sessions, my approach was to be client-centred and establish for myself the patterns of interaction. I was however, overwhelmed with the details and content, as well as the numerous possibilities for approach to therapy. I did not really know where to tackle the wealth of problems and issues. Mrs. S had never verbalised any specific goals for therapy. She would just say that she needed help. It felt to me as if she would only complain, expressing the futility of her situation. Even early on, Mrs. S was dominating my discussions within supervision. I believed that therapy should involve some facilitation of change.

The 4th session was not scheduled. Mrs. S had managed to track me down at the psychology department and was insistent upon seeing me. She was extremely tearful, irritable and physically agitated. She complained that she wanted to go back to Natal, that things were too much for her, and she needed my help. She believed that it was the hospital environment and its staff that were making her feel the way she did. She described a recurrent dream in which 'monkeys came down from the mountain, through her window, and ripped her to pieces'. She interpreted that the monkeys were most probably the doctors. I tried to explore what she wanted out of therapy with me, as I obviously could not and would not help her in leaving the hospital. She kept circularly stating that she does not know what she wants, she can't have what she wants, or gave vague descriptions about what she wants ("I just don't want to be here"). She would explain that she did not know what was real or not real anymore - things were "blurry". This was both literal and figurative as she accounted for a problem with her eyes and vision. She further introduced that there were two sides to her. A 20% that is the "real me" and "wants to get better", and an 80% that is dark and dangerous and "wants to kill me". She stated that there was a black hole in her mind, sucking in everything till she did not know what was real anymore. She felt trapped by everyone. Not wanting to trap her myself I decided and told her that I would give her the freedom to decide for herself what she wants to do. I did feel that

she needed to be referred to psychiatry, so this decision did leave me with an uneasy feeling. The session was left hanging, and I was not really sure what she was going to do or capable of doing once she left my office.

The following day, for our scheduled appointment, I encountered both Mr. and Mrs. S in her wardroom. Mrs. S had convinced Mr. S to take her back to Natal. However, when he had complied, she had confronted him stating that they could not leave, as she needed to stay in order to get better. It was suggested that he did not care for her health and recovery. It also appeared as though the ward staff had also tried to accommodate Mrs. S's feelings of confinement, but no compromise seemed to be accepted. I took the opportunity to talk to the couple together. Mr. S did not appear to be the monster described. Although some of his interactional patterns (as described by Mrs. S) were accurate, they were greatly exaggerated. On the whole Mr. S appeared just as frustrated. He appeared to care for and love Mrs. S, but did not know how to approach her. He was aware of the various problems and complaints that Mrs. S avoided or stated, "we never talk about".

I decided to follow with a session a week of the couple in therapy together with my supervisor as co-therapist. In this 6th session, Mrs. S had snidely remarked, "I thought you might call for reinforcements". I wanted to focus on the couple's patterns of interaction. My interest in introducing Mr. S's conceptualisations of the process and interactions in their marriage soon led to the focus again being drawn to Mrs. S. The therapy turned to focussing on the conflict between what is real or not for Mrs. S (the idea that her life feels like a movie), and the rage of emotions inside of her that were bursting to get out, together with the fear of what would happen if they did.

After these sessions, I was becoming more frustrated at not knowing what was going on. I knew that Mrs. S was not always entirely truthful, but did not know where to proceed with therapy. With the dominance of her sickness and the sick-role, my supervisor and myself began deliberating on the possibility of Munchausen. However, we also began to contemplate the idea that there could very well be a personality disorder. I needed to reassess my goals for therapy. I had no idea, but only knew that I would like to in some way facilitate change. This did not seem to be more than minimally attainable at this stage. I did however know that I would have the time frame of while Mrs. S was in hospital (as she was from Natal) and my goal would be to at least make some difference till then.

The 7th session was again an unscheduled session. On this occasion Mrs. S had gotten her doctor to contact me and stress the urgency of seeing her. There was something she had to tell me only, and no one else. She needed to tell me urgently. The frustration of the medical ward staff with Mrs. S was apparent. He related to me that they were unsure of what was wrong with her and that they had found bacteria common in faeces in some of her abscesses. He asked whether I believed that it was possible that she could be self-inflicting the wounds. I could not rule out the possibility.

I did go and see Mrs. S though. She wanted to confess to me that the miscarriage that she had between M and Y was not actually true. She had in fact "murdered" this child by piercing herself with a knitting needle and then waiting a few days before going to the hospital. She told me in more detail how abusive X was and that she had feared

for her own and M's lives. She could not at that time imagine bringing another child into that environment. The confession was incredibly emotional for both Mrs. S and myself. Even though I was torn with conflicting emotions and morals, I felt and believed that I was able to understand her reasoning at the time, and reinforced that she did what she believed was best at the time given her limited resources. Mrs. S then added further information to her family picture. Her sister was anorexic and a conversation between the two of them before Mrs. S had come to Gauteng had precipitated her emotional state. Mrs. S told me that she believed that both she her sister had been sexually molested by a family member. Mrs. S had never told anyone these things. She later explained to me that she could tell me as I was leaving in a few weeks. I informed her that she was mistaken and I was not leaving (her doctor was). She even appeared angry that I had apparently tricked her. I asked her why she seems to like to play games. She only told me that it was because she was good at it, and could only tell things to people when she knew it would not matter.

The 8th session was characterised by a great amount of circumstantial and vague topics covering what had already been addressed. Mrs. S did however have a very large bruise on her cheekbone. She would bash her head in order to get the "images" to stop. I tried addressing these thoughts but she remained vague. I questioned her as to why she wants help, but will not allow herself to be helped? Why it was that she constantly spoke in circles. She stated that her only defence has always been to "fuck with peoples minds". She also stated that she wanted to exonerate me from anything that happens to her, saying that I should not feel like a failure. We decided that it would be better to bring in the assistance of psychiatry. I referred her to Dr. A at psychiatry. Mrs. S did however contact me via department phone the next day stating that the doctors were "pissed off" with her non-compliance in going for a procedure and were going to lock her up at psychiatry. I informed her that the two events were not related and that I had referred her to Dr. A who would see her external to the psychiatric ward.

The 9th session was scheduled to be a couple's therapy. My supervisor and I had decided to discontinue with this approach after the session, as I would carry on individually with Mrs. S and Mr. S could be referred for individual therapy if necessary. My supervisor did not make the session, and I conducted it alone. Mrs. S informed me that Dr. A had asked her if our therapies were pushing her too hard. She had answered "no" on my behalf. He had instructed her not to get too upset. I at this stage firmly believed that Mrs. S was the one who would manoeuvre us into discussing issues that were too difficult for her to cope with. The goal for this therapy was however only to terminate the couple's therapy and focus superficially on the interactional patterns. I was interested as to why the couple who knew each other so well, chose rather to hurt, attack and counter-attack each other, rather than providing help and support to each other.

Throughout the session, Mrs. S gradually appeared to withdraw from the process. I requested that she join Mr. S and myself on a number of occasions, but allowed her the freedom and the choice. However, by the end of the session, the behaviour was that of a severe dissociative experience. Mrs. S had curled up on her chair and was mumbling and shaking. I tried in vain to convince her that she had to leave the session (I had other appointments). Mr. S also tried to gently persuade Mrs. S into leaving. He put his hand on her leg trying to reassure her, to which she sharply and

angrily replied, "stop it!". She kept stating that she could not move, because if she moved "it" would see her and "it" would "kill" her. She was adamant in wanting to be left alone. She then spontaneously began a terrifying scream that lasted a couple of minutes. I had sought help, but no one had greater success than I had had. For me it qualitatively felt as though we were non-entities within the room, and nothing we said would have made a difference. When she eventually stopped, she appeared very disoriented, confused, and suspicious. She had wanted to know who I was and where she was.

Informing Dr. A about the event, he suggested that it was merely attention-seeking behaviour. I disagreed, but merely wanted to inform him of events. For me the event felt very real. The following day, having consulted Mrs. S, Dr. A informed me that the event did appear to be a dissociative experience, although she reported it to be her first. He believed that Mrs. S had a borderline personality disorder with histrionic traits, and that these behaviours tended to fit. Mrs. S also contacted me the same day, wanting to apologise to me and confirm our next appointment. She needed to apologise immediately as she was not sure what mood or state of mind she would be in our next session.

At this stage in the process of our therapeutic encounters, I was becoming increasingly annoyed at having Mrs. S as a client. She occupied a great amount of my time, both in therapy, and in my thoughts. I had confirmed with another doctor that all the tests they were doing were coming back negative. I was almost convinced at this stage of my own diagnosis of Munchausen. The clinical picture of the literature I consulted seemed to fit. However, as warned in the literature, and my experience of Mrs. S, I would not be able to confront this behaviour. She would most definitely deny it, and it might be wrong. At this stage my supervisor was also suggesting that the two of us both go for external supervision. I decided, for my own sanity, and against my general therapeutic principles to diagnose within my mind Mrs. S as a borderline at least. The statement I told myself was that "even if I deny pathology, it does not mean that it does not exist". In consulting with various colleagues I decided to set the goals for therapy simply to be: (1) to provide structure and consistency in the sense of fixed therapy sessions, with no deviations tolerated, (2) to allow Mrs. S the freedom to introduce topics in therapy, but to keep her to only one or two main topics a session, (3) and accept that I can only do as much as I can while she was in the hospital, to hopefully facilitate at least minimal change.

In the 10th session Mrs. S was visibly sedated and had difficulty in expressing herself. Mrs. S often complained of the adverse effects of her medication. She told me however that she was now "good" and that she had to be "good" or else "they" (psychiatry) would lock her up. She was "good" because she did not want to go "crazy" again. I felt that this was quite passive-aggressive as knowing Mrs. S's history, I knew the contempt that she had for psychiatry. She did also provide an account of her dissociative experience. She stated that she usually had the ability to withdraw herself into a "cocoon", but this time had not been able to control the process. She described seeing a "it / thing" under my desk that was trying to speak or be allowed to speak. It was a beaten, skinless, unimaginable version of her that apparently represented all her hurt, pain, anger and rage. She felt that it was dying and wanted to know whether it should be allowed to speak. She asked me whether she should confront this part of herself. I informed her that I was not going to tell her

what to do. This I believed because I did not think she could handle it, and she knew she couldn't. I also felt that she was trying to put the responsibility on someone else and that way she could have another person to blame. She first became angry and then later begged and pleaded that I tell her what to do – playing upon my humanity as a therapist. She later added that she had really wanted someone to hold her hand and tell her everything would be fine (during her dissociative experience). I highlighted for her the paradox that she would not have allowed this to happen.

A few days later Mrs. S again tracked me down at the department complaining about an event that had happened in the ward. I informed her that I would see her at the scheduled appointment and could not see her now. In the 11th session, Mrs. S again spoke solely about all her medical problems. I decided to discuss with her the concept of the appropriateness of her behaviour following the previous days event. I informed her that she could discuss her problems in the allocated session times. Mrs. S got angry, stating that she only wanted advice, and that I was the person she trusted the most. This escalated in the 12th session as she had began bashing her head again. She stated that it was a reaction to her depressed mood following the last session. This was because I did not give any consideration to her feelings. She believed that I had told her that she could only have a crisis within our allotted therapy times each week. I then informed Mrs. S that I did not say that she could not be allowed to be in crisis, but only that she discusses the crisis with me during our sessions, and no other time. I added that if there was an emergency she could not cope with that psychiatry was available if necessary.

Throughout the 12th and 13th sessions, Mrs. S alluded to the reasons for her head bashing. However, I would (and often had to) avoid the topic until she was prepared to discuss it seriously. Mrs. S explained that she would actually bash her head in such a manner that she could inflict the most damage. This behaviour was explained to be a way of temporarily stopping the unpleasant thoughts (or "flashes") and emotions that Mrs. S did not want to face. This concerned her guilt over her "murdered" child. The child had been a boy. She felt she needed to punish herself for this, but was also guilty that he had never received a proper burial. I began asking her what it would take for her to eventually forgive herself, considering she had been punishing herself for so many years. I suggested that when she returns to Natal that she try bury something significant that she would have liked to have given him. She could say her goodbyes and apologies, and lay to rest much of the guilt and pain she had been carrying with her.

Over the 11th to 13th sessions, Mrs. S also discussed her negative relationships towards men. She had friendships with women, but was avoidant of all men, including her husband. In fact, through much of the therapy it emerged that she had an incredible dislike and distrust of men. I highlighted the paradox that I was in fact a male therapist, being that she reported to be comfortable around me. She would justify this by stating that I was a professional and bound by rules, or that she chose to view me as an asexual being or feminine. I challenged her into seeing me for what I was. I wanted to not only create a consistent therapeutic environment, but also believed that it would be beneficial if Mrs. S could learn to judge people by their behaviour and not her expectations. In the 13th session, Mrs. S related how in an argument she had told Mr. S about the aborted child. She was surprised by his reaction, which was contrary

to what she expected. He did not leave and abandon her, and actually listened and cried with her.

In the 14th session I informed Mrs. S that I would be taking 2 weeks leave in a little over 2 weeks. In this session, she informed me that she had thought carefully about what I had said in the previous session. I had asked her "what is it going to take for you to forgive yourself?" She stated that she had begun looking at the positives in her actions – that she had protected M and Y from X and had needed to be strong in order to do this. She stated that she needs to start putting herself and her health first, and that some good can be seen to have come out of her traumatic experiences. Mrs. S informed me in the 16th session that she had informed Y about her biological father X. She had also alluded to the fact that I told her to do so – which I had not. However, I questioned for myself as to whether this had more to do with her needs and fears of dying.

For sessions 14 to 17 Mrs. S spoke increasingly of her medical condition. It appeared to be escalating, and though she had spoken fatalistically in the past, she appeared to do so more often. Issues of death were constantly discussed and how these related to her children and her family. I also noted typical interactional patterns within her family of people wanting to be close to others, but pushing others away. She returned to vague recollections of her traumas in the past, and constantly made statements like "you won't believe how many times I've been raped" – apparently referring to her relationship with X. I began to start querying possible PTSD-like symptoms. It seemed as if the psychiatrists were also considering this diagnosis at certain stages. She further believed that she was getting cancer over and above her immune deficiency, and was introducing more and more medical complications. She spoke more and more that a bone marrow transplant was the only solution to her immune deficiency. She would get angry that the doctors did not seem to consider this an option. Even though it was an expensive procedure, she believed it reflected more that they were treating her as a "number" and not a person. She often would ask me whether I would go to visit her if she was sent for such a procedure, as she would most probably die. In supervision, my supervisor suggested that she needed to know whether she was important to me. I agreed with this interpretation, but was still struck by the fact that she had been "dying" for so many years already.

It also followed in these sessions that Mrs. S commented excessively on my unique ability to help others. She referred to this as my "capacity to love that is beyond [myself]". I initially tried to downplay her flattery as it admittedly made me uncomfortable. Mrs. S would often note my uneasiness, which I had thought I covered quite well. However, due to her perception of my uneasiness I later decided to reflect on this positively. I enforced that she was very perceptive and had a good ability to read process. I asked and wondered why she used this ability to promote sickness rather than health. I commented at stages that Mrs. S was extremely proficient in justifying how she feels, without ever actually having to disclose her true emotions. I would typically suggest an emotion to which she would confirm or deny. On a whole therapy at this stage felt stuck in a pattern of circularity. The same problems were discussed over and again. I did however feel more comfortable in the process with the limits I had imposed upon the therapy.

The day following the 17th session – in the week before my scheduled leave – I received a phone call from Mr. S. He was quite distraught, informing me that Mrs. S had been forcibly admitted to psychiatry the night before. Mr. S felt that psychiatry did not fully understand his wife. I told him that I would follow it up. Dr. B had admitted Mrs. S to the psychiatric ward as Dr. A was on leave. He informed me that Mrs. S had come down to psychiatry the previous afternoon highly anxious and panicking, dissociating and displaying psychomotor slowing. She was asking for help, relating the various problems with her health, and threatening suicide. Dr. B felt compelled to admit her even though she resisted as he felt extremely convinced that the suicide threats were serious and well thought through. I informed him that I was not going to see Mrs. S until our scheduled appointment and explained the structured goals for my therapy. We compared the background history of Mrs. S, our clinical impressions, and the query about possible self-infliction. A day later I was informed that the psychiatric panel was considering a diagnosis of Munchausen. However, they were also considering a diagnosis of Munchausen syndrome by proxy for Y. Mrs. S had apparently related to Dr. B and the psychiatric panel that her daughter, Y, also has a lot of medical complications. I was told that social work would be following this up. It was generally felt that Mrs. S would be better handled within the psychiatric ward.

In our 18th session, Mrs. S was more animated, and in a better and apparently more stable mood. I was however suspicious that she was too compliant and appropriate. She stated that she was happy to be in psychiatry as she felt that she needed to "crack up" in order for the pieces to be put back together properly. Her account for the previous few days' occurrences correlated well with what I already knew. She informed me that the precipitating factors for her breakdown had begun a few days before our previous session. She felt that she was trying too hard to be in control. Following the 17th session, the medical doctors had apparently informed her that there was nothing wrong with her. This was too much for her to take, and we considered that it was because her identity - that she had held for so long - had been taken away from her. She had gone down to psychiatry looking for Dr. A. She explained that she began to see X everywhere, plants took on strange forms and apparently wanted to get her, and the walls began to ripple. She also stated that she had begun to get serious thoughts about killing herself. She asked about the appropriateness of going to psychiatry in this mental state and seemed pleased that she was learning the correct ways of responding to crisis. I agreed that it was more appropriate and even beneficial. With my leave pending, I was interested in and discussed with Mrs. S the circularity of problems that presented themselves. We kept seemingly addressing the same issues over and again with seemingly little progression or change. I began to question her about her identity. With these "sick" labels that she had, what would remain if they were removed?

Mr. S by this stage had been referred to another psychologist for his own individual therapy.

I went on two weeks leave.

Upon returning from leave, Dr. B brought me up to speed on what had been occurring in my absence. He informed me that the medical doctors were at least 99% sure that Mrs. S did not have an immune deficiency. They would be doing some final tests to

confirm this, but this itself did not rule out the possibility that she could contaminate the results. The consensus from the psychiatric panel was that Mrs. B did have some form of factitious disorder. The working diagnoses were those of a factitious disorder, a major depressive disorder and a borderline personality disorder. Dr. B informed me that the general consensus was that Mrs. S knew more about microbiology than would be expected of someone who had not studied medicine. The diagnosis of factitious disorder was also difficult to make without an admission. In a discussion with another psychiatrist, he told me that this is the reason why factitious disorders are "often a diagnosis of exclusion". Every other possibility as a cause for an illness needs to be ruled out. This was also complicated by the fact that at this stage, Mrs. S did have real medical complications. Dr. B had chosen to ignore Mrs. S's physical symptoms and focus on her sick role and eventually confront the issue of self-infliction.

For the 19th session, I decided to allow Mrs. S to explain the events of the past few weeks to me without knowledge of what I knew. Her medical and physical symptoms strongly predominated the picture once more. She was playing the various disciplines against one another, and exaggerating their perspectives. She told me that the medical doctors had told her that her problems were only medical, while the psychiatrists were telling her that all her problems were in her head. Dr. B was constantly derogatively referred to as an "it", "thing" or "just like my father". For the 19th and 20th sessions there were consistent patterns of inconsistencies and of Mrs. S putting one discipline against the other. In the sessions, she would try to ally me against the other disciplines; while the feedback I received was that she would be incredibly angry with me. At one stage she referred to me as "now part of that whole health care profession" (i.e. the psychiatric panel) and therefore also the enemy.

She also complained that we were making no progress. I told her that I could only work with what she brings to me. Mrs. S would constantly refer to herself as a "bad" person in a very child-like manner, or that other people (often Dr. B) made her feel bad. I chose not to challenge her directly, but to rather highlight the incongruencies as they presented themselves, and focus of therapy on her - her own thoughts, feelings and reactions - without making value statements about others. I felt that it was necessary to bring the focus back to her, on her role in her sickness, and not on everyone else who persecutes her. Mrs. S would complain that Dr. B only saw her as a textbook of symptoms and never a person. I challenged her by saying that she only ever showed people the textbook symptoms. She then defended that she would do that in order to protect herself.

In the 20th session Mrs. S was furious at the psychiatrists arguing that they had been accusing her of inflicting injuries upon herself and also on her children, and that they would be involving social work. She was very derogatory, attacking their competence, and blaming them for her emotional state. She went on to say that they were diagnosing her with "Munchausen… or something like that. Not that I was paying attention". It was later confirmed that no one (either myself or the psychiatrists) had ever mentioned a label of Munchausen to Mrs. S. I addressed the fact that if she denied it to me I would accept her answer at face value. For me it was not really an issue whether she admitted it or not or whether it was a correct diagnosis or not. I wanted to focus on her behaviour and interactional styles. I did however highlight the inconsistency without either attacking or accusing her that she was

admittedly capable of self-inflicting harm, and that she often admitted to not complying with medical treatment. I asked her as to what she was doing to prove or show her "innocence" if she really was innocent – trying to bring the focus back to her.

I followed on the textbook metaphor and stated that the way she approaches "health" or "getting better", whether it is physically or psychologically, was always one of exclusion. She would have to rule out every possible illness to be healthy, and as such, there was always something new that was making her ill. I asked her how long it would take to eventually go through every medical and psychiatric illness. By this stage I was thinking that Mrs. S not only has a wealth of physical problems, she also tends to exhibit a wide range of psychiatric symptoms. I had thought back to Munchausen being a diagnosis of "exclusion". For me it was interesting that Mrs. S's behavioural styles tended to mirror the disorder. It was therefore a useful metaphor to use in therapy without accusing Mrs. S of Munchausen. I could focus on the behaviour and not the label. I also believed that Mrs. S was more knowledgeable and well read than she let on. This hypothesis being due to her apparent slip about her "Munchausen" diagnosis in therapy.

The 21st and 22nd therapies showed a dramatic shift in Mrs. S's behaviour. She once again became excessively compliant. She came with a list of goals for the future as Dr. B had suggested she rather focus on future goals and behaviour changes rather than her past. She referred to Dr. B as "bug", being playful, but still derogatory. The means for achieving the goals were also rather superficial and not thought through. Mrs. S appeared to be able to predict the topics that I had wanted to focus on, such as her attitude towards her own health, and the health care professionals in general. She spoke of a change towards a more positive attitude. I was not convinced. I suggested that she is very perceptive and wondered how she was using this ability. I suggested that she was only telling us what she thought we wanted to hear from her. I believed that she was "bullshitting" us to get what she wants. She agreed, but stated that at least it was "playful" and therefore we could put up with her because she was not so malicious. She stated that she was being "good" so that she would be allowed to leave. The approach seemed to be that if she makes others around her "happy", that this would be the solution to her health.

In the 22nd session, Mrs. S was pleased that she had finally been given a diagnosis: that of borderline personality disorder. It appeared as though she had insisted upon one. To her it fit, but not quite. She approached me on my opinion of the diagnosis, suggesting that I was the expert and should know. I did not offer my opinion, and she soon followed by disagreeing with various criteria. On further discussing her need for diagnosis, she went on to state that if she heard "I don't know" one more time she was going to explode. She was frustrated at not getting answers to her condition. I challenged her by stating that she was constantly being given answers, but they were just not good enough or the answers she wanted to hear. I asked her what it was that she actually wants. She began to vaguely ramble on about why she is "bad" and "deserves to be punished". Her illness and treatment appeared to be part of her punishment she deserves.

The 23rd session followed on a weekend where Mrs. S had gone back to Natal for her daughter's birthday. For this session and a few others, Mrs. S carried around a stuffed

toy tiger with her. When enquired about her weekend, she replied that it was "yucky". Her language for much of the 23rd to 25th sessions was very child-like once again, and even more so than before. She spoke of how overwhelming and over involved her mother was in her life, her children's lives, and even interfering with and imposing on her relationship with Mr. S. She decided that she really did need help from psychology and psychiatry, as she needed to know how to get away from her parents. She believed that her parents were making her sick. Her mother was over involved and would not allow her to get well. Her father would oscillate between being excessively involved with his girlfriend and abnormally involved with Mrs. S's mother. His absence and availability would correspondingly vary. She told me how her sister was anorexic, had taken an overdose, and was "dying". Her parents had tried to keep this from her. Mrs. S began talking about the link that both her and her sister had physical illnesses, and that the cause in both cases was their childhood and upbringing. She believed that the only solution was to get away from them.

In the 23rd to 25th sessions, Mrs. S began referring to an event from childhood that supported her belief that she was born "bad". She told me she had to talk about this "thing" as she did not want to "bullshit" in therapy any more. This was the time at age 14 when she had disobeyed her parents. She was very vague in explaining or justifying the story or her beliefs. The "thing" or event was however only really spoken about vaguely, with Mrs. S strongly trying to convince me that she was a "bad" person. In the session she spoke vaguely about going with a friend to a party that she was not supposed to, and doing things that she was not supposed to. She stated that the reason she hurts herself was in order to punish herself. I asked whether this was because she didn't get punished for her transgressions, or whether it was because the alternative (not to punish herself) would be worse. She appeared to confirm the latter, so I asked what could be worse than swallowing razor blades? Mrs. S began to dissociate again. However, this time I left her, and waited. She later described the experience to me, stating that this time she forced herself "to come back". I acknowledged that this must have been difficult and reinforced the change.

She described herself as existing in 3 parts: herself at age 5, at age 14 and at present. Upon exploring each age, she was unsure about the significance of herself at age 5, but felt that her at age 14 needed her forgiveness. The full description of the event at 14 had only reached the following details by the end of the 25th session: She had gone to the party with her friend; against her parents wishes and/or behind their backs; had two drinks; suspects the drinks were spiked with something; felt ill and tired; went to go lie down on a bed. She would try to emphasise her badness as being due to her naivety, the fact that she knew who's bed it was, and the fact that she was "obviously asking for it". I hypothesised that she had possibly been raped.

In the 24th session, I discussed with Mrs. S the final date for termination of our therapy. It was to coincide with the day before she would be returning to Natal after being discharged from the hospital. Following this session, Mrs. S was also being discharged from the psychiatric ward. Before the 25th session, I was informed that Mrs. S was back in the medical ward after having developed a DVT (deep vein thrombosis). Questions about the timing of this event were raised. Even though it was not something that could be induced actively, it could have occurred due to non-compliance with medication. When I saw Mrs. S for the 25th session, she snidely remarked that psychiatry probably would accuse her of inducing the DVT herself. I

raised the issue of non-compliance with medication, to which she replied that she often did not comply with treatment, but always would tell the doctors when she was. She also spoke about another medical problem she was having. She was "becoming a cow": she was lactating. She stated that both she and the doctors believed this problem was possibly psychological. However, she was never entirely serious in discussing this topic, so it was never explored. I suggested we talk about something more pertinent.

While discussing the childhood event, Mrs. S would describe her badness as infectious to others. She justified why she and her family "do not talk about it". She believed her parents probably saw themselves as failures, and she believed that this was because she was inherently bad ("born bad"). She believed that she would infect me as well if she spoke about these events. I reframed the notion of infection as a gift. I told her that I believed that what she would tell people, and myself, was like a gift and not an infection. In this sense it was something she chose to give/tell, what she chose to give/tell was unique to each person, but how each person reacted to the gift/message was out of her control. I believed this covered number of issues that I wanted to address. She should only take responsibility for those actions and behaviours that are in her control. She should be able to identify her individuality and responsibility as apart from others. That certain behaviours, actions and reactions of others are beyond her control.

The day following the 25th session I was contacted by Mr. S who informed me that the previous night Mrs. S had tried to commit suicide in the bathroom by cutting her wrists with a broken mirror. He was slightly distressed, but overall quite calm, stating that he only wanted to keep me informed. He described them as "little cuts" and believed the whole event to be quite manipulative. She was apparently starting to cut herself when he entered the bathroom. I was frustrated and angry at the escalating behaviour, but decided to stick to the limits that I had set. I was not going to see her until the next scheduled session. I informed Dr. B. Dr. B also did not want to respond, having already terminated with Mrs. S. Dr. C was therefore requested to go and evaluate Mrs. S for the seriousness of the suicide attempt. Mrs. S was then briefly admitted back to the psychiatric ward, as the general medical ward did not want to care for her. She remained briefly and was monitored by another psychiatrist, Dr. D, because Dr. C did also not want to see her further. Dr. C had been of the impression that Mrs. S was rather low functioning – not having ever interacted with her before. The rest of the psychiatric panel disagreed with him stating that Mrs. S was actually of above average intelligence. I agreed with this, and was at this stage realising that Mrs. S was able to argue almost any aspect of her physical or psychological well being.

When I saw Mrs. S for the 26th session, she was once again in the psychiatric ward. Her wrists were bandaged after having been stitched up and her forearms displayed numerous scratches. I directly addressed the issue of the suicide attempt. She explained that she did not want to kill herself. She wanted to maim herself by cutting her tendons and scratching off her skin. She claimed that she was distraught because Mr. S wanted to leave her and divorce her if she did not get well. She was suggesting a great deal of urgency in needing to resolve all her issues before it was too late – time was running out. I confronted her that if she really wanted to save her marriage, that she was going about it entirely counterproductively. I also added that she was running

the serious risk of one day accidentally succeeding in killing herself. She stated that this would never happen, as she knew what she was doing. I strengthened the point that I believed that Mrs. S was actually very intelligent. She acknowledged this and was content with the compliment. I then confronted Mrs. S on her intelligence. I highlighted the fact that no matter what others or myself stated, suggested or interpreted, Mrs. S would always argue the point counter-productively. I suggested that she actually uses her intelligence to 'infect' therapy and 'prevent well-ness'. She consistently complained of the ever-present feelings of "badness", and the impulses to hurt, harm and punish herself as excuses for her behaviour. I asked why in that case she chose not to use her strengths and intelligence to control these impulses rather than using them to counter everyone's attempts to help her. She began arguing this point using the phrases of "clever" and "stupid" whenever it suited the counter-productive argument. She stated that I did not understand the severity of her situation. I merely stated that she was again using her strong intellectual abilities, and that I could never succeed in challenging them, so I was going to give up. I told her that I accepted the fact that she could and would always outsmart me.

Mrs. S then tried to again create a sense of urgency that she still needed to tell me about the events at age 14, but couldn't. I told her that I already knew what had happened (I believed she had been raped) and she did not need to tell me. She argued that whether I knew or not, she needed to tell me. I then told her that she either tells me or she doesn't, but the choice was hers. She spoke more about the event, but it was still vague and very dramatic. However, it did appear as though Mrs. S had been raped at age 14. She again tried to reinforce her badness as having "asked for it" by putting herself in the situation.

Shortly after this session, Mrs. S was discharged once again from the psychiatric ward. For our 27th session, Mrs. S arrived at my office looking rather different. She was neatly dressed, wore make up, and even though she did not cover the scars on her arms, looked actually quite healthy. She had with her a pile of papers and the stuffed tiger once again. She showed me the papers, which she explained was homework she had set for herself since our last session. She had decided to engage in a form of introspection and reflect for herself upon the issues that had been discussed within our therapies. She approached the topic of what kind of a person she wanted to be, she looked at what she had achieved within therapy, and she had approached various aspects in her life (especially the traumatic events: X, age 14, the aborted baby, sister, parents, etc.) where she usually persecuted herself in order to begin by defending herself and looking at these incidents from a more positive and realistic perspective. She had also been thinking about goals for what she wants to do and achieve in the future.

I questioned Mrs. S as to what had caused this rapid change in her approach and behaviour. She informed me that it was my challenge that she uses her intelligence constructively, and that it was essentially her choice as to whether she wanted to get well, that had motivated her to reassess her situation. She realised that I was not asking her to deny her emotions, but only asking her to change her approach in taking control of her actions and not using her past or her emotions as an excuse. Once she is able to control her impulses and actions, she would then be able to assess why she feels the way she does. She could acknowledge that even though she believes she is essentially "bad" at present, after gaining control of her actions and impulses only

then could she go further in gaining insight. She related an incident where she had spoken to Mr. S over the past few days. She had asked him if he had heard her knocking (the X incident), and he stated that he had. She told me that she could have reacted with anger again, and had in fact felt incredibly angry, but she chose to rather focus on the guilt that Mr. S had probably been living with up to this day. She also described his behaviour in her 'suicide attempt'. Mr. S had apparently held her firmly, but not roughly, so that she could not hurt herself further. This she interpreted as the incredible love and tenderness he must feel for her. For me this was the insight and change that I believed Mrs. S needed to and was capable of accomplishing.

The tiger was essentially the object that Mrs. S wanted to bury for her son. She wanted me to tie a bow on it to signify my contribution towards her health. I agreed to this and actually felt incredibly honoured. Mrs. S informed me that it was my consistency and punctuality that she had most appreciated in our therapy. She referred to my consistency and patience no matter how much she frustrated me. I was always available when I said I would be, and would only make changes well in advance. I would be able to take the "abuse" without trying to outsmart her. She added that even though the other disciplines may have said the correct things, that she found them too confrontational. She explained to me that her instinctive approach would be to attack back. But even this behaviour had begun to change, she had rather started stand down when confronted and when she felt that she would be getting nowhere. She wanted to thank me overall, and stated that people too often criticise without ever thanking others. I believe that her gratitude was sincere and heartfelt, and do not believe that she was merely telling me what I wanted to hear. I had never told her my goals for therapy.

The 28th session was scheduled to be our termination session. Mrs. S however felt that we had already discussed all that had been necessary to discuss. The session comprised mainly of light-hearted and social conversation. We said our farewells.

Appendix B - Consent Form

Consent Form: Research Case Study

1. I, (name & surname) …….. the undersigned, do hereby willingly give consent to my participation in the research case study.

2. Further, I give permission to Mr. A.F. Bosch so that he may use information regarding my therapy for research purposes, as well as the publication of such information. This permission is given with the condition that all information will be handled confidentially, and that I will remain anonymous, with no identifying information regarding me being made known.

3. In the event of me having any questions that may arise as a result of the research project, I am free to contact the researcher at the address and contact number given.

If at this point you have any more questions or uncertainties regarding the research project, you are welcome to discuss it with the researcher.

Signature ……...…… Date ……..