Psychiatry Research ■ (■■■■) ■■■–■■■

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

When the lie is the truth: Grounded theory analysis of an online support group for factitious disorder

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ARTICLE INFO

Article history:
Received 15 April 2013
Received in revised form
25 March 2014
Accepted 28 March 2014

Keywords:
Factitious disorder
Munchausen ayndrome
Online support groups
Grounded theory
Addictive behaviour

ABSTRACT

Factitious disorder (FD) is poorly understood because of the elusiveness of sufferers. What is known is based on speculation from observational case studies and this is evident by the manifold diagnostic and treatment issues associated with FD. This study sought to fill the gap in the literature and overcome the elusiveness of FD sufferers by analysing their text communications in two online communities. One hundred twenty four posts by 57 members amounting to approximately 38,000 words were analysed using grounded theory. The analysis showed that contrary to current theories of FD, motivation is conscious and not unconscious, members did experience symptoms associated with the disorder, and they were also upset by their behaviour and wanted to recover but were deterred by fear. Furthermore, using the excessive appetitive model by Orford (2001) it is hypothesised that the characteristics of FD described by the members were congruent with those associated with addiction.

1. Introduction

1.1. Diagnosis

The DSM-IV-TR categorises factitious disorder (FD) into three subtypes: FD with predominantly psychological signs and symptoms; with predominantly physical signs; and symptoms and with combined psychological signs and symptoms. According to the DSM-IV-TR, diagnosis is dependent on clinicians establishing "A: the intentional production or feigning of physically or psychological signs or symptoms; B: the motivation for the behaviour is to assume the sick role; C: the external incentives for the behaviour are absent". In practice criteria B and C are very difficult for a clinician to establish and instead they rely on criterion A, establishing intentionality (Kanaan and Wessely, 2010). Clinicians must collect circumstantial evidence to develop an index of suspicion and then confirm suspicion through irrefutable evidence of deception (Steel, 2009; McDermott et al., 2000; Meadows, 1982). Therefore formal diagnosis only occurs when the patient either admits to feigning or is caught producing symptoms (Guzman and Correll, 2008).

1.2. Revision of DSM criteria

As the criteria set out by the DSM-IV-TR are not utilised in diagnosis their revision has long been debated. The debate centres on overcoming the violation of nosologic principals including validity, reliability, usability, distinctive observable characteristics and self-identification (Hamilton et al., 2009). For example, Turner (2006) has argued that criterion A does not capture the essential features of the disorder and should be changed to '*lying or deliberate autobiographical falsification*'. Allowing for the inclusion of pseudologia fantastica, voluntary false confessions, impersonations and to distinguish between self-harm and FD. However, Hamilton et al. (2009) argue that confining FD to the 'sick role' is justifiable because it is the aim of the behaviour regardless of means. Furthermore, Krahn et al. (2008) highlight that such a revision would not aid diagnosis as detecting and defining what is a lie or falsification is notoriously problematic. Turner (2006) also proposed that criterion B should be descriptive and based on what is known '*the behaviour leads to, or is likely to lead to, self harm*' and criterion C removed. This revision counteracts the false premises of intentionality and incentives currently in the DSM-IV-TR. Turner (2006) argues that FD behaviour is not intentional because deceptively harming one's self does not follow common logic. With regard to incentive, the inference that motivation is based on external disincentives (self-harm) being perceived as internal incentives is unfounded. All that can be reliably observed is that sufferers self-harm despite the external disincentives. Hamilton et al. (2009) and Krahn et al. (2008) are critical of defining FD solely in terms of self-harm. It excludes cases of FD where there is no self-harm or threat and those which occur outside of a medical context and also fails to distinguish Somatoform Disorder (SD) from FD. Although Turner's (2006) revisions are open to criticism, the crux of the argument that criteria should be based on what is

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http://dx.doi.org/10.1016/j.psychres.2014.03.034
0165-1781/

known rather than inferred is an important one which sheds light on the lack of direct research which is needed to revise the DSM-IV-TR criteria.

1.3. Dependence on case studies

The relative rarity of direct research and consequent dependence on observational case studies has been widely lamented (Taylor and Hyler, 1993; Eastwood and Bisson, 2008). The dearth of such research is attributable to the elusiveness of FD sufferers who once confronted are known to strongly deny accusations of feigning even when presented with evidence of their deception (Pridmore, 2006). Of those who do admit to feigning very few will seek professional help making long term studies of FD difficult (Krahn et al., 2003). If they do enter treatment it is for a short period of time and they tend to be reluctant to open up about their experience (Eastwood and Bisson, 2008). The lack of firsthand accounts of the disorder means that basic information necessary for the formulation of diagnostic criteria including motivation and symptoms is scarce and as Turner (2006) highlighted is based on inference from observations.

1.4. Motivation and aetiology

The motivation to occupy the sick role is believed to be largely dependent on pre-disposing factors that result in the psychological deficits caused being balanced by enacting FD (Tasman and Mohr, 2011). These psychological deficits are rooted in early childhood trauma including physical and mental abuse (Sadock and Sadock, 2008). This early trauma is also associated with Personality Disorders (PD) and it has been suggested that there is strong co-morbidity between FD and PD, more specifically Borderline Personality Disorder (BPD) (O'Shea, 2003). Theories regarding the psychological deficits that motivate FD are abundant and largely unsubstantiated (Ford, 2010). They include, gratification of dependency needs, defence against psychosis, need for identity, need for mastery, internalised anger/masochism, learnt behaviour, problematic child/parent relationship, need for distraction and self-enhancement, displacement of rage, defence against loss, substitute for 'lost object', seeking sympathy/attention and using FD as a psychological coping mechanism (Ford, 1996; Maldonado, 2002; Dryer and Feldman, 2007). The problem with trying to determine the salient motivational factors underlying FD is that the research has been primarily observational. Even if it was possible to directly evaluate FD sufferers, the common view is that while FD sufferers intentionally produce symptoms their motivation to assume the sick role is unconscious (Feldman and Eisendrath, 1996). However, there is no evidence to support this distinction. In fact, Bass and Halligan (2007) have argued that because making the distinction between medical (involuntary action, unconscious motivation) and non-medical deception (voluntary action, conscious motivation) are not attainable it should be excluded from the DSM. Instead the focus would be on the underlying psychiatric problems which precipitated the deceptive behaviour in the first place as opposed to trying to establish a diagnosis based on motivation which could be highly variable and impossible to establish.

1.5. Symptoms

The internal subjective symptoms experienced by people with FD are largely unknown. There is a significant amount of information about the observable symptoms of the disorder, which are used to form an index of suspicion (Catalina et al., 2008). However, the question of internal symptoms tends to be ignored, because the motivation to assume the sick role is believed to be unconscious and therefore people with FD are perceived as being unable to self-identify. Hamilton et al. (2009), for example, claim that the majority of people with FD do not express dissatisfaction with their deceptive behaviour, supporting the belief that people with FD are not perturbed by their behaviour. This lack of negative symptoms may explain the reluctance to seek help however it also may also be linked to the fear of losing trust by admitting to deception and the stigma associated with violating the social norms of the sick role (Pridmore, 2006; Hagglund, 2009). Of the few FD sufferers who enter treatment, there is no significant difference in outcome compared to those who receive no treatment (Eastwood and Bisson, 2008). This was attributed to sufferers not admitting to their behaviour or engaging in long-term treatment.

1.6. Aims of the study

There is a significant gap in FD literature with regard to the lack of firsthand accounts of the disorder which has led to difficulties in reformulating the DSM-IV-TR criteria. Core questions such as whether the motivation to occupy the sick role is conscious or unconscious; whether symptoms are experienced; whether sufferers are disturbed by their behaviour, do they want to recover and if so why are they reluctant to engage in treatment have been left to speculation. The aim of the study is to help close this gap, by using a novel method to overcome the elusiveness of FD sufferers, through the analysis of their text communications in online communities for FD. The information obtained from the analysis will be compared and contrasted with previous FD research and will be used to develop new theories based on the accounts of FD from those directly suffering from the disorder as opposed to observational accounts.

2. Method

2.1. Sample

Online support groups for FD were located using the Google search engine. The search terms used were 'factitious disorder', 'Munchausen syndrome', 'online support group' and 'discussion forum'. Two groups were identified, for Munchausen syndrome and factitious disorder. They were both established in 2002 and were located within a larger forum for various mental health problems. The groups cannot be regarded as active as there were only 30 new topics posted in 2011 in the Munchausen syndrome group and eight in the factitious disorder group. Although it is standard practice to use active online groups for analysis it was not possible in this study, as there were only two such groups. Both groups are completely accessible to the public. However, registration is required to participate in the group and view other member's profiles. Therefore it was not possible to ascertain the participants' sociodemographic details. Both groups were moderated by the same person whose primary role was to provide emotional support.

2.2. Limitations of sample

The current sample is not without its limitations. The members of the online support group are largely self-diagnosed as having FD as opposed to being formally diagnosed. Therefore it could be questioned as to whether they genuinely did have FD. As formal diagnosis requires intention to assume the sick role to be established, the fact that members who were included in the study admitted to assuming the sick/victim role for emotional gains, means they most likely do have FD. However, the anonymity afforded by online support groups makes it impossible to assess the truthfulness of these posts. As all the members are anonymous it is also impossible to assess if they were all unique individuals or whether there were 'sock puppets' among the sample pretending to be multiple members. This is further confounded by the association between FD and Munchausen by internet (Feldman, 2000). Whereby FD is enacted online, members with FD could have been creating a false version of their FD and enacting it in the online support group in a double bluff. There is also the possibility that the members used in this study are not representative of the general population as they may possess characteristics unique to those who use online support groups. Although the integrity of the sample and resulting posts can be criticised it is the largest collection of firsthand accounts of the disorder available because of the elusiveness of sufferers. On this basis alone it

Please cite this article as: Lawlor, A., Kirakowski, J., When the lie is the truth: Grounded theory analysis of an online support group for factitious disorder. Psychiatry Research (2014), http://dx.doi.org/10.1016/j.psychres.2014.03.034