

**AN EXPLORATIVE STUDY OF SOCIAL WORKERS' KNOWLEDGE,  
EXPERIENCE AND APPROACH TO FACTITIOUS DISORDER.**

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A minor dissertation submitted in partial fulfilment of the requirements for  
Masters of Social Science in Clinical Social Work

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Submitted: June 2014

**DECLARATION**

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced using the Harvard referencing style.

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## Acknowledgements

I would like to acknowledge and express my appreciation to the people who have made this research journey possible:

To my participants, thank you for sharing with me.

To my supervisor Ronald, thank you for guiding me.

To my friend Keir, thank you for supporting me.

To my family, thank you for encouraging me.

To my Mom, thank you for nurturing me.

To my Creator, thank you for the gift of life.

# AN EXPLORATIVE STUDY OF SOCIAL WORKERS' KNOWLEDGE, EXPERIENCE AND APPROACH TO FACTITIOUS DISORDER.

By Dina Maria Oosthuysen

## Abstract

Factitious disorder is characterised by a compulsion with an unconscious motivation to intentionally fabricate signs and symptoms of physical or psychological illness. Factitious disorder by proxy is a form of abuse which usually presents as a parent portraying their child as being ill. Factitious behaviour indicates severe psychological dysfunction, and these clients could pose a danger to themselves as well as their families. There is limited research on factitious disorder in social work practice. This study aimed to explore social workers' knowledge of factitious disorder, the presentation and prevalence of factitious disorder in social work practice, the experience of social workers with clients with factitious behaviour, and social workers' approach to the assessment and treatment of factitious disorder.

This study used a qualitative exploratory research approach with a phenomenography design that enabled the researcher to explore the variation in social workers' knowledge, experience and approach to factitious disorder. Sixteen participants were recruited using purposive and snowball sampling. The participants were social workers registered with the South African Council for Social Services Professions, with social work qualifications from South African Universities or Colleges. The data were collected using face to face interviews guided by a semi-structured interview schedule. The recorded interviews were transcribed and the data analysed using a combination of phenomenography and thematic qualitative data analysis methods.

The research findings indicated that the participants were not well informed about factitious disorder. The findings suggested that participants could have encountered clients with factitious behaviour in practice. Recommendations were made on addressing the current lack of knowledge, and preventing the future lack of knowledge of factitious disorder in social work practice. Recommendations were also made to address the research needs of factitious disorder in social work practice.

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# CHAPTER ONE

## INTRODUCTION

### 1.1 Introduction

This chapter describes the background and rationale for the research. The topic and problem formulation are presented and are followed by the research questions and objectives, and clarification of concepts. Ethical considerations and reflexivity are also addressed, followed by an overview of the dissertation.

### 1.2 Background to the research topic

*“Perhaps no phenomenon in medical practice is as daunting to caregivers. It seems flatly counterintuitive that anyone would batter, bleed, or even blind himself in the quest for illusory emotional gratification. For this reason, and also because their behaviour involves the deliberate deceit of others, these patients have had few advocates among members of consumer, family, or professional organizations.”* (Feldman, 1998:1)

Feldman (1998:1) is describing a condition called factitious disorder. It is present in most of the helping professions, which includes the medical professions, psychiatry, nursing, physiotherapy, psychology, clinical social work and generic social work. Factitious disorder can present with biopsychosocial issues and symptoms, and is characterized by the intentional feigning or simulating of signs and symptoms of physical or psychological illness, possibly motivated by an unconscious need to be in the sick role (Bass & Gill, 2009:1049).

The true incidence of factitious disorder is not known, and research has indicated a range between 0.032% and 9.36% depending on the research setting and criteria

(Fliege, Grimm, Eckhardt-Henn, Gieler, Martin & Klapp, 2007:60-61; Wang, Nadiga & Jenson, 2005:1832). It is accepted that at least 1% of all hospital admissions are due to factitious disorder (Othmer et al., 2002:390). According to these statistics, factitious disorder could be having a significant impact on the health care resources in South Africa, yet there appears to be very little indigenous research on this disorder (Govender, Oosthuizen & Cloete, 2011:26).

Factitious disorder can present with predominantly physical signs and symptoms, psychological signs and symptoms, or a combination (APA, 2000:515). The majority of research on the disorder has been conducted by the medical community and focused on the presentation of physical signs and symptoms, and the subsequent medical and legal approaches that medical personnel should employ.

This disorder has been described as a disruption of the power balance between the practitioner and the client, where the client is expected to be truthful about their illness symptoms, and the practitioner is expected to have the knowledge for identifying and treating a disorder (Fisher, 2006:138). Quest and Hyler (1980:412) describe what happens to this relationship if factitious disorder is present in a medical setting:

*“Through the subversion of the power structure, physicians’ identities are transformed in their relationship to the Munchausen patients... and the bonds of the doctor-patient relationship become supplanted by suspicion... The patient is treated with a mixture of bemusement, bewilderment, contempt, and anger. The patient’s success in subverting and sabotaging the well-meaning physicians’ efforts becomes a source of shame and embarrassment for the physicians. Whether or not these feelings are admitted, these are one of the few*

*types of patients who kindle aversion, fear, despair, or downright malice in their doctors” (Quest & Hyler, 1980:412)*

Factitious disorder can present in clinical social work practice when clients display fabricated biopsychosocial issues and symptoms, and also when clients are referred to them by health care professionals specifically for the treatment of this disorder. Factitious disorder can also present in generic social work practice case management. In social work intervention, the relationship between a practitioner and a client is often a key element in the intervention process. For clients with factitious disorder this relationship can become the centre of the pathology, as it is the nature of the disorder to hijack the therapeutic relationship, and set the practitioner up to play a part in the client’s fantasy. These clients tend to sabotage the helping process by putting up walls, breaking rapport, framing the practitioner as an adversary and challenging their expertise (Othmer et al., 2002:316, 317).

The description by Quest and Hyler (1980:412) shows the intensity of the negative feelings that can be evoked by working with people with factitious disorder. Such intense feelings could influence the way practitioners treat these clients. One of the motivating factors for research is the drive for ethical conduct (Rubin & Babbie, 2005:81). The researcher is not aware of any research that explores how social work practitioners experience working with clients with this disorder.

### **1.3 Rationale and significance**

Research examining health care professionals’ knowledge of factitious disorder indicates that a third of the participants were not well informed about the disorder, did not consider it a relevant disorder, and were not optimistic about treatment outcomes (Fliege et al., 2007:62, 63). It further indicated a link between the knowledge a health

care professional had about factitious disorder and the appropriateness of their choice of treatment approach. The researcher suspects that the same could be true for social work practitioners, that their assessment and intervention approaches to factitious disorder is influenced by their knowledge of the disorder. The researcher is not aware of any research focusing on the knowledge base and treatment approaches used by social workers for factitious disorder. The National Association of Social Workers (NASW) state in their code of ethics that "*Social workers should base practice on recognised knowledge, including empirical based knowledge relevant to social work and social work ethics.*", and "*Social workers should critically examine and keep current with emerging knowledge relevant to social work and use evaluation and research evidence in their professional practice*" (Sundet & Kelly, 2007:164). The researcher agrees that social workers have an ethical responsibility to use appropriate and accurate evidence based assessment and intervention methods. The researcher is of the opinion that this research study can contribute to evidence based practice through exploring social workers' knowledge, experience and approach to factitious disorder, and identifying areas that could benefit from further professional development, and areas where further research is needed.

Factitious disorder by proxy is when illness signs and symptoms are produced in a person by their caregiver, most often a parent (APA, 2000:517). From a literature search, the researcher has found research articles by social workers on factitious disorder by proxy, focussing on the effect of this serious and potentially deadly form of abuse, especially in vulnerable populations such as children, the elderly and persons with disability. As many as seventy five percent of caregivers that commit factitious disorder by proxy also suffer from factitious or somatoform disorder (Bass & Jones, 2009:160; Meadow, 2000:61). Factitious disorder and factitious disorder by proxy can co-occur, and detection of one should trigger a suspicion of the other (Bass & Jones,

2009:160). Even though the link between the incidence of factitious disorder and factitious disorder by proxy is significant and has direct practice implications, the researcher is not aware of any research in social work that focuses on the occurrence of factitious disorder in social work practice.

The researcher has found that most research on factitious disorder has focussed on the biological and psychological presentation of this disorder. Looking at factitious disorder from a biopsychosocial perspective, it is interesting to note that there is limited research on the social presentation and aetiology of the disorder, even though it is mentioned in some of the literature. (Turner, 2006:25; Othmer et al., 2002:416). Exploring factitious disorder from a social work perspective, which embraces the importance of a biopsychosocial approach, could reveal social aspects of this disorder that have not yet been considered.

Govender et al. (2011:26) report that health care providers frequently encounter patients with symptoms which cannot be explained medically or are suspected of being fabricated for primary or secondary gain. These include 10% to 15% of cases treated in primary care, and 20% of cases treated in secondary care, accounting for a high proportion of health care costs. Despite the burden this places on health care resources, very little research has been done in South Africa on medically unexplained symptom conditions which includes the somatic disorders, malingering and factitious disorder (Govender et al., 2011:26,27).

The rationale and significance of this study is that it will contribute to establishing a general understanding of how factitious disorder is perceived and experienced by social workers in a South African context. Evaluating social workers' knowledge of the disorder as well as assessment and treatment approaches will contribute toward

evidence based practice, and identify areas that could benefit from continuing professional development. Exploring social workers' experience of factitious disorder from a biopsychosocial perspective will contribute to understanding social aspects of this disorder.

#### **1.4 Research topic**

Fouché and De Vos (2011:80) describes the importance of the research topic as both a 'signpost' and 'boundary marker' because it indicates the path the researcher will follow as well as the area of exploration. The researcher has chosen the following topic: An explorative study of Social Workers' knowledge, experience and approach to factitious disorder.

#### **1.5 Research questions**

The research topic is focused by the development of specific research questions. These questions are influenced by the researcher's knowledge of the topic, previous research, theory, and the researchers own thoughts on the topic (Fouché & De Vos, 2011:89). The researcher has developed the following questions:

1. What are social workers' knowledge of factitious disorder?
2. What is the prevalence of factitious disorder in social work practice?
3. How does factitious disorder present in social work practice?
4. What are social workers' experience with clients with factitious disorder?
5. How do social workers approach the assessment and treatment of factitious disorder?

#### **1.6 Research objectives**

The exploratory objective in research can be used to gain insight into a situation, phenomenon, community or individual (Fouché & De Vos, 2011:95). This type of

objective is often used when there is a lack of basic information on a new area of interest, or in order to get a basic understanding of a situation in order to formulate a problem or develop a hypothesis (Fouché & De Vos, 2011:95). The area of focus for this research study has not yet been explored from a social work perspective, and there is a lack of a basic understanding of social workers' knowledge, experience and approach to factitious disorder. For this reason the researcher has chosen to develop exploratory objectives:

1. To explore social workers' knowledge of factitious disorder.
2. To investigate the prevalence of factitious disorder in social work practice.
3. To investigate how the phenomenon of factitious disorder present in social work practice.
4. To examine social workers' experience of factitious disorder in practice.
5. To examine how social workers approach the assessment and treatment of factitious disorder.

## **1.7 Research assumptions**

The researcher has identified the following underlying assumptions:

- Social workers may have been exposed to information about psychopathology as part of their undergraduate training in mental health.
- Social workers may or may not have knowledge of factitious disorder.
- Factitious disorder may have a prevalence in social work practice.
- Factitious disorder may manifest in a particular way in social work practice.
- Social workers may have a particular experience of factitious disorder.
- Social workers may have a particular approach to the assessment and treatment of factitious disorder.

## 1.8 Concept clarification

**Factitious:** This term is derived from the Latin 'facticius', meaning 'made by art', and refers to something that is artificially produced not authentic (Dyer & Feldman, 2007:1).

**Factitious behaviour:** Refers to behaviour where a person attempts to create evidence of a disorder (Othmer et al., 2002:389). This term will be used to refer to factitious behaviour of clients that have not yet been assessed for factitious disorder.

**Factitious disorder:** According to the DSM-IV factitious disorder can be confirmed if there is intentional production or feigning of physical or psychological signs and symptoms, where the motivation for the behaviour is to assume the sick role, and external incentives for the behaviour are absent (APA, 2000:517). The DSM-5 was published in May 2013, but for this study the criteria in the DSM-IV will be used, as the bulk of the literature referred to in this study referenced the DSM-IV. Additionally, the research interviews were conducted in the period shortly after the DSM-5 release, and as far as the researcher was aware, at that time there were no articles published in accredited social work journals featuring factitious disorder using the DSM-5 criteria.

**Factitious disorder by proxy:** Refers to the intentional production or feigning of physical or psychological signs and symptoms in another person who is under the individual's care, with the purpose of indirectly assuming the sick role (APA, 2000:517).

**Munchausen syndrome by proxy:** Experts debate whether Munchausen syndrome by proxy and factitious disorder by proxy are separate conditions or whether they are different terminology for the same condition. For the purposes of this study factitious

disorder by proxy is seen as synonymous for Munchausen syndrome by proxy. Only the term factitious disorder by proxy has been included in the DSM IV (Dyer & Feldman, 2007:2), and will be used in this study.

**Munchausen syndrome:** This is a rare form of severe and chronic factitious disorder, usually with physical signs and symptoms, a history of repeated hospitalization, wandering, pathological lying and pseudologia fantastica (dramatic and improbable stories of past experiences) (Kay & Tasman, 2006:680).

**Malingering:** The intentional production of physical or psychological symptoms, motivated by external incentives such as avoiding work, getting financial compensations, evading criminal procedure, avoiding military service, or obtaining drugs (APA, 2000:739).

**Somatoform disorders:** A group of disorders (including hypochondriasis, somatisation disorder, conversion disorder, pain disorder and body dysmorphic disorder) where the individual is pathologically concerned with the appearance or functioning of their body, or believe that they have a medical condition, but where there is no medical explanation for their symptoms (Barlow & Durand, 2005:169).

## **1.9 Ethical considerations**

Strydom (2011:114) states that the researchers has two categories of ethical responsibility: firstly the research participants; and secondly the discipline of science to be accurate and honest in the reporting of research. In social science research where human beings are the objects of study, unique and complex ethical issues can arise (Strydom, 2011:113). The researcher has identified the following ethical aspects as relevant to this study, and will discuss them in more detail: Actions and

competence of the researcher; Avoidance of harm; Voluntary participation; Informed consent; Confidentiality and anonymity; Debriefing of participants.

### **1.9.1 Actions and competence of the researcher**

Walliman (2006:148 in Strydom, 2011:123) states that researchers are ethically obliged to ensure that they are competent, honest and adequately skilled to undertake the research project. The researcher is a qualified, registered and experienced social worker, and understands and abides by the South African Council of Social Service Professions' ethical code of conduct. All aspects of the research process were conducted in an ethical and honest manner. The researcher guarded against plagiarism by acknowledging and referencing sources.

### **1.9.2 Avoidance of harm**

Babbie (2007:27) states that the fundamental ethical rule for social research is that it must not bring harm to participants. Researchers can be privy to private and sometimes sensitive or controversial opinions, behaviour and beliefs which could cause problems for the participants if these were revealed (Strydom, 2011:115). The researcher was aware that this research related to areas of practice, and would require participants to disclose their level of knowledge, personal opinions and experience with clients. The researcher's commitment to anonymity of the participants was crucial to avoidance of harm to their professional reputation. The researcher was aware that the nature of the research topic could cause participants to feel their professional knowledge and conduct was being scrutinized and judged, and purposefully used a gentle and non-judgemental interviewing style to ameliorate this.

### **1.9.3 Voluntary participation**

Rubin and Babbie (2005:71) state that participation in a research study should at all times be voluntary and never forced. At the start of the interview the researcher informed the participants of the nature of the study, and assured them that it was voluntary and that they can terminate participation at any time during the interview.

### **1.9.4 Informed consent**

As guided by Strydom (2011:117), the researcher informed participants about the goal, expected duration, level of participant involvement, research procedures, possible advantages and disadvantages of the study, and the credibility of the researcher (see Appendix I). Before the interview commenced participants were given the opportunity to ask questions regarding the study objectives and the credibility of the researcher.

### **1.9.5 Confidentiality and anonymity**

Confidentiality implies that the participant's identity is known only to the researcher and possibly staff members involved in the research, while anonymity means that no one, including the researcher, should be able to identify any subject afterward (Strydom, 2011:120). For this study the researcher is the sole person that knows the identity of the participants and confidentiality is assured. All measures have been taken to ensure anonymity, including not recording any of the participants' identifying information on documents, and deleting the interview recordings after the transcriptions were completed.

### **1.9.6 Debriefing of participants**

Strydom (2011:122) states that the easiest way to debrief participants is to discuss their feelings about the project immediately after the session or to send a newsletter

telling them the basic results of the study. Most participants had questions after the interview regarding the theory, research and best practice regarding factitious disorder, and the researcher engaged them in an appropriate informative discussion. Participants were told that they will receive a copy of the research report when the study is completed.

### **1.10 Reflexivity**

De Vos (2005:363) states that reflexivity is a quality of metacognition – the thinking about one's perceptions and ideas. This occurs when a researcher formulates an integrated understanding of their own cognitive world, which includes an understanding of their influence and role in a set of human relations (2005:363). The researcher incorporated reflective practice from the initial problem formulation throughout each phase of this research project – continuously becoming mindful of her own perceptions and ideas, and consciously taking a neutral stance to maintain the research integrity.

The researcher's initial interest in this topic stems from her experience with clients with factitious disorder as well as discussions with colleagues. The researcher noticed strong negative feelings towards clients that were later identified as having factitious disorder. The researcher also experienced feelings of vulnerability to deception and manipulation after these clients' deceptions were revealed. Casual discussions with colleagues indicated that they lacked knowledge about the disorder and they expressed strong emotions and judgments towards clients who were deceitful. This experience triggered the question of how practitioners experienced working with clients with factitious disorder.

## 1.11 Brief overview of the research report

**Chapter one:** Introduction to the research topic with a focus on the background, rationale and significance of the research. It includes concept clarification, the research goal, research questions, research objectives, research assumptions, ethical considerations and the researcher reflexivity.

**Chapter two:** A literature study of the theoretical framework for the study as well as the key aspects of factitious disorder that relate to the research objectives. This includes the importance of knowledge for assessment and treatment, the ambiguity present in literature, the prevalence of the disorder, the phenomenon of countertransference, clinical presentation, aetiology and treatment approaches.

**Chapter three:** The choice of research approach and design is discussed, including the relevant methodological considerations. A qualitative research approach was used, with a phenomenography design. A combination of purposive and snowball sampling strategy was used, a one pass approach using a semi-structured interview schedule was used for data collection, a phenomenography data analysis method was used to identify themes and categories of description. Data verification as well as the limitations of the study are explored.

**Chapter four:** The collected data is organised using a framework of analysis. The relevant themes are identified and the data is categorised according to the emergent categories of description. Sample quotations are included in the categories of description, and the relevant theory is discussed and integrated with the findings.

**Chapter five:** The identified themes with their categories of description and integrated theory inform the conclusions that are drawn, and the recommendations that are made.

### **1.12 Summary**

This chapter presented an introduction to the topic with a focus on the background, rationale and significance of this research. It detailed the research questions, research objectives, concept clarification, ethical considerations, and reflexivity. A brief overview of the research report was provided. Chapter two will discuss the literature review, with specific focus on the areas of literature that are relevant to this study.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This research study focuses on social workers' knowledge, experience and approach in working with clients with factitious disorder. These can be clients that have been diagnosed with factitious disorder by other professionals and have been referred for therapy, or clients that seek help with various biopsychosocial issues and are then identified as fabricating symptoms and experiences. The researcher will discuss the Biopsychosocial and Psychodynamic models as conceptual frameworks for the research. Guided by the research objectives, the literature review will then explore the impact of knowledge on identification, assessment and treatment of the disorder, as well as the prevalence, clinical presentation, identifying criteria, aetiology and treatment approaches. It will also explore how the element of deception, central to this disorder, makes it difficult to detect and how it has a unique effect on the countertransference experienced by the practitioner.

#### **2.2 Conceptual frameworks for the research study**

De Vos and Strydom (2011:35) state that the nature of the conceptual framework is determined by the function that the framework has to fulfil. For this research the Biopsychosocial and Psychodynamic models have been chosen as the theoretical base, and the researcher will discuss their key functions for this study.

##### **2.2.1 Biopsychosocial model**

The researcher is of the opinion that the Biopsychosocial model provides a key to understanding the biological, psychological and social aspects that combine in the

aetiology, presentation and treatment of factitious disorder, and will discuss how this model is functional for this study.

#### **2.2.1.1 The biopsychosocial model's foundation in systems theory**

Systems theory holds the assumption that reality is complex and that the characteristics of systems underlie all processes (Visser, 2007:23). It provides a theoretical framework with which both the organised whole and component parts can be studied, and proposes that nothing exists in isolation and that every system is influenced by the configuration of other systems of which it is a part (Frankel, Quill & McDaniel, 2003:2). George Engel (Glen, 1987) understood the world as a continuum of systems that interact at different levels, from subatomic particles, to atoms, molecules, organisms, individuals, couples, families, communities and so forth, and developed the biopsychosocial model to describe how this interrelatedness impacted on health.

#### **2.2.1.2 A biopsychosocial understanding of illness behaviour**

Engel viewed a person as part of a world of interconnected systems, as well as having biological, psychological and social systems that are interconnected. He felt that a person's medical illness could not be understood without knowing their emotional state and the social context in which they lived. The biopsychosocial model considered the biological, psychological and social variables in human functioning as essential areas in the study of disease (Pereira & Smith, 2006:458). According to this model, a disorder in any system can have an impact on other system levels, for example psychological factors influence biological processes that in turn influence the social system of the client (Pereira & Smith, 2006:458). Factitious disorder can be understood as a psychological disorder with an unconscious motivation, which often presents as a medical or psychiatric illness, and has a strong

social aspect in that it is thought to be a learnt behaviour that can be multigenerational, and it can involve the fabrication of symptoms in others (Bass & Gill, 2009; Kay & Tasman, 2006). The researcher is of the opinion that the biopsychosocial model provides a clear structure in which to explore the interconnectedness of the biological, psychological and social aspects of the aetiology, presentation and treatment of factitious disorder.

### **2.2.1.3 A biopsychosocial understanding of the practitioner and client interaction**

Engel understood that if you attempt to understand a system from the inside you disturb it in some way, and he included the dimension of the practitioner and client interaction as part of the biopsychosocial approach to scientific study (Borrell-Carrio, Suchman & Epstein, 2004:578). A key feature in the presentation and treatment of factitious disorder seems to be the power dynamic and interaction between the practitioner and the client, which is often experienced as strong countertransference in the practitioner (Bass & Gill, 2009; Kay & Tasman, 2006). The researcher is of the opinion that in order to understand the complex presentation, aetiology and treatment of factitious disorder, the interaction of the practitioner and the client needs to be viewed from the biopsychosocial model, because the practitioner as a biopsychosocial system has an impact on the client as a biopsychosocial system, and vice versa.

### **2.2.2 The psychodynamic model**

The researcher is of the opinion that the psychodynamic model can provide a means of understanding the unconscious mental and emotional processes and motivations that are at the core of clients' compulsion to repeated factitious behaviour. Psychodynamic psychotherapy has a broad theoretical base, and it is not possible to present a comprehensive overview in this literature review. The researcher will limit

this discussion to some of the core tenants of the psychodynamic model that are relevant to the assessment and treatment of factitious disorder: Object relations; Reality testing; Transference; The therapeutic alliance; Defensive functioning; and Repetition compulsion.

### **2.2.2.1 The development of the psychodynamic model**

The psychodynamic model has its roots in the four major schools of psychoanalytic theory: Freudian psychology; Ego psychology; Object relations; and Self psychology (Haggerty, 2006). The term 'Psychodynamics', developed by Freud in 1874, can be described as the psychology of mental or emotional forces or processes which develop in early childhood that effect behaviour and mental states at an unconscious level (Stedman's Medical Dictionary, 2006). Leichsenring and Rabung (2011:15) describe psychodynamic psychotherapy as an umbrella term that encompasses all psychotherapeutic interventions that are on a continuum of supportive and interpretive approaches, where the supportive approaches aim to strengthen coping abilities that are temporarily inaccessible or that are underdeveloped, and the interpretative approaches aim to enhance client's insight into repetitive conflicts sustaining their issues. The psychodynamic approach recognises that the relationships and circumstances of early life continue to affect people as adults, and that human behaviour results from unconscious as well as conscious motives, and that the act of talking about problems can help people to find ways to solve them (Miller, 2010).

### **2.2.2.2 Object relations**

St.Clair (2004:1) refers to object relations as the inner residues of past relationships that shape an individual's current interactions with people. They are the earliest interpersonal relationships, either real or fantasised, that are internalised as intra-

psychic representations (Corey, 2009:81; Cashdan, 1988:1). These internalised objects can influence a client's current relationships, and in the presentation of factitious disorder it influences the therapeutic relationship with the practitioner.

### **2.2.2.3 Reality testing**

Goldstein (1996:197) explains that reality testing involves the ability of a person to accurately perceive their external environment as well as their internal world, and to be able to differentiate between the two. The most severe manifestations of the failure of reality testing are seen in delusions and hallucinations (Goldstein, 1996:197). The researcher agrees with this, and postulates that clients with factitious behaviour could demonstrate a failure of reality testing, where they re-experience the unresolved needs in their internal world through external interaction with perceived authority figures such as medical, psychological and social work professionals.

### **2.2.2.4 Transference**

Malan (2007:77) states that working with transference is one of the main factors in dynamic psychotherapy. From a psychodynamic model transference can be understood as the repetition of past experiences in present interpersonal relations (Leichsenring & Rabung, 2011:15). Some professions tend to bring up transference feelings in clients, often where the professional person is in a position of power or authority, where the client experience feelings towards the practitioner which they previously experienced towards their parents (Gray, 1994:21).

Clients with factitious disorder often experienced emotional deprivation in early childhood, and unconsciously try to recreate a corrective emotional experience with the practitioner as representation of the internalised parental object. (Lasich & Wilson, 2007:170). The therapeutic alliance creates a safe environment where the

practitioner can help the client become aware of transference feelings and explore the internalised object relations they originate from.

#### **2.2.2.5 The therapeutic alliance**

The therapeutic alliance that forms between the practitioner and client is a crucial part of the therapeutic process, and this personal connection enables the client to work with the therapist in order to gain insight into aspects of experiences that may be difficult to talk or think about (Hobbs, 1998:77). As the therapeutic alliance deepens the practitioner helps the client to understand themselves, their thoughts, actions, and their compulsion for factitious behaviour, in new ways.

#### **2.2.2.6 Defensive functioning**

People develop unconscious internal mechanisms to shield them from painful experiences of anxiety or fear-inducing situations: Adaptive defences protect a person from anxiety while promoting effective coping. Maladaptive defences also protect a person from anxiety, but they do so at the expense of optimal functioning (Goldstein, 1996:198). Some of the common defences are: Repression; Reaction formation; Projection; Isolation; Undoing; Regression; Introjections; Reversal; Sublimation; Intellectualization; Rationalization; Displacement; Denial; Somatisation; Idealization; Compensation; Altruism; and Splitting (Goldstein, 1996:200). Clients with factitious disorder often display multiple maladaptive defences (Bass & Gill, 2009; Kay & Tasman, 2006).

#### **2.2.2.7 Repetition compulsion**

Freud described the phenomenon of 'repetition compulsion' as an instinctual characteristic of mental functioning, and a characteristic feature of psychopathology, where a person repeats painful childhood experiences over and over throughout

adult life (Greenberg & Mitchell, 1983:173). Howard (2010:16) explains that within the therapeutic relationship repetition compulsion functions as a mechanism whereby developmental failures from the past can be repeated in the present, so that the client can successfully work through them in the safety of the therapeutic environment. The researcher is of the opinion that viewing a client's repeated factitious behaviour as a repetition compulsion, empowers the practitioner to understand the nature of the behaviour as a childhood injury that can be ameliorated through the establishment of a non-punitive therapeutic relationship.

### **2.3 The importance of knowledge of factitious disorder for assessment and treatment**

A study in Germany assessed medical professionals' knowledge about factitious disorder (Fliege et al., 2007:62, 63). They found that a third of the participants were not well informed. They also found a correlation between the level of knowledge about the disorder and whether participants considered it a relevant disorder. Participants in private practice were found to be more uncertain in diagnosing the disorder, and were less optimistic about treatment outcomes. Only 50% of participants reported that they refer clients with factitious disorder for further treatment by a mental health professional, 15% reported clients receiving treatment by members of their own staff with some mental health training, 15% reported clients receiving treatment by members of their own staff without special training, and 15% reported that there was no further treatment given. This study concluded that there was a need for professional training in the recognition and treatment of factitious disorder.

This study reveals the link between how a practitioner's knowledge about a disorder influences their perception of the disorder, which in turn influences their ability to identify it. It is interesting to note that from the participants that were able to

recognise factitious disorder, only 50% saw the importance of referring clients to mental health professionals, possibly due to a limited understanding of the complex dynamics of the disorder. A practitioner's lack of knowledge about factitious disorder can result in the disorder not being correctly identified, leading to non-treatment, or incorrect or inadequate treatment.

## **2.4 Literature on factitious disorder**

A disorder with characteristics of factitious behaviour was first described in the *Lancet* in 1843 with following papers strongly focused on a medical, surgical and legal view of the phenomenon (O'Shea, 2003:33). In 1951 Richard Asher first described criteria for what he coined Munchausen syndrome (Parrish & Perman, 2004:139). In 1968 Barry Blackwell was first to suggest that it should be viewed as a psychiatric disorder (O'Shea, 2003:33). In 1977 Roy Meadow was first to publish articles on what he termed Munchausen by proxy, describing cases of parents deliberately creating children's medical conditions (Parrish & Perman, 2004:139). Literature played an important role in the development of the identification, understanding and classification of factitious disorder. The researcher will discuss social work's contribution to literature on this disorder, as well as ambiguity in the literature.

### **2.4.1 A lack of social work representation in literature on factitious disorder**

Gray (2001:129) states that factitious disorder by proxy has been extensively documented in medical and to a lesser extent in psychiatric literature, but even though it is considered to be a form of child abuse, and social workers play a crucial role in child protection, social work research and literature on this disorder is sparse. Parrish and Perman (2004:137) state that the role of social work in interdisciplinary responses to factitious disorder and factitious disorder by proxy is crucial, yet under-represented in existing literature. The researcher agrees with these statements and

after a thorough literature search of articles pertaining to factitious disorder found only limited social work contributions.

#### 2.4.2 Ambiguity propagated in the literature

In studying the literature on factitious disorder, the researcher became aware of ambiguity and repeated contradictions in many of the literature sources on this phenomenon. Following are a few examples:

- *“In some cases it is a diagnosis of exclusion in an otherwise inexplicable case...The differential diagnosis of factitious disorder includes rare or complex physical illness”* (Kay & Tasman, 2006:681). This statement can be seen as elliptical reasoning – that if the cause of the symptoms cannot be discovered the physician should consider factitious disorder, while at the same time reminding the physician to look for the cause of the problem as it can be a rare or complex illness.
- *“A true physical or psychiatric disorder is the main consideration in the differential diagnosis”* (Wang et al., 2005:1839). *“It is especially important to rule out genuine physical illness since patients with factitious disorder often induce real physical illness”* (Kay & Tasman, 2006:681). These statements imply that the physician should discern between ‘true’, ‘genuine’ and ‘real’ illness.
- *“The irony, therefore, is that these patients may actually have a genuine psychiatric disorder underlying their factitious one.”* (Gabbard, 1995:1813). Factitious disorder is a recognised genuine psychiatric disorder, people with this disorder might have or develop additional psychiatric disorders.
- *“...a diagnosis of factitious disorder always implies psychopathology.”* (APA, 2000:513). *“Factitious disorder must be distinguished from a true mental disorder”* (APA, 2000:516). Factitious disorder is a recognized mental disorder

in the DSM-IV, but it is stated that it should be distinguished from 'true' mental disorders, implying that it is not a true mental disorder.

- *"factitious illness is limited only to the imagination of the perpetrator"* (Elwyn, 2011). The terms perpetrator and victim are used in factitious disorder by proxy, because it is a criminal act and a form of abuse (Wang et al., 2005:1829), but it is not clear why people with factitious disorder are referred to as 'perpetrators' – implying that factitious disorder is a criminal act instead of a psychological disorder.

These are just some of the many examples that suggest an underlying conflict in the way this disorder is viewed and described in literature. Literature is an important source of information on best practice, and the researcher is of the opinion that the ambiguity in the literature could influence practitioners' perception of factitious disorder and clients they suspect of illness fabrication.

## **2.5 Prevalence of factitious disorder**

A literature review by Kocalevent, Fliege, Rose, Walter, Danzer and Klapp (2005:202) of 18 empirical studies totalling over 52 000 cases, indicate the incidence of factitious disorder ranging between 0.032% and 9.36%. This variation is caused by multiple factors: The covert nature of the disorder may result in the failure of clinicians to recognise the condition (Lasich & Wilson, 2007:169); Clients might be counted multiple times in a study if they falsify their details or visit multiple hospitals (Leamon, Feldman & Scott, 2003:695); The clinician's knowledge of the disorder, because it affects their ability to identify it (Fliege et al., 2007:62); The willingness to document factitious disorder varies, and many retrospective analysis research methods rely on the quality of client records (Fliege et al., 2007:61). Recognition of this disorder in different specialist units differ in prevalence, with psychological signs and symptoms

in psychiatric settings appearing least prevalent (0.5% in one study), and physical signs and symptoms in general hospitals most prevalent, especially fever of unknown origin (9.3% in one study) (Kay & Tasman, 2006:682). Even though the prevalence of factitious disorder has not yet been clearly established, it is accepted that at least 1% of all hospital admissions are due to factitious disorder (Othmer et al., 2002:390; APA, 2000:516). The researcher is not aware of any literature on the prevalence of factitious disorder in clinical social work or generic social work practice.

## **2.6 Clinical presentation and features of factitious disorder**

Clients with factitious disorder with predominantly physical signs and symptoms fabricate illness by giving false histories, faking clinic and laboratory findings and causing illness through self-harm (Kay & Tasman, 2006:680).

Clients with predominantly psychological signs and symptoms feign psychological or psychiatric disorders, for instance psychosis, bereavement, post-traumatic stress disorder, or pretend to be victims of rape, harassment or stalking (Wang et al., 2005:1837).

Munchausen syndrome has predominantly physical signs and symptoms, but can include psychological symptoms, and is seen as a chronic and severe form of factitious disorder with repeated hospitalizations, pathological lying, bizarre and improbable stories of past experiences, and wandering from hospital to hospital (Wang et al., 2005:1835). This group make up less than 10 percent of factitious disorder cases, and are usually male, with poor work and relationship functioning (Kay & Tasman, 2006:680).

Factitious disorder by proxy presents as someone, often in a caring role, creating or feigning illness signs and symptoms in another, usually a child, but it can also be an elderly or disabled person, and even a pet (Kay & Tasman, 2006:683).

The typical person presenting with factitious disorder does not display pathological lying or wandering, and can become known in the same medical community because of recurrence, is predominantly female (78%), is often in a medical related profession (58%), and more likely to accept psychiatric referral and show improvement (Kay & Tasman, 2006:681). Factitious disorder can also present as a single episode in reaction to a life stressor, and after the stressor has been resolved, the person returns to pre-morbid functioning (Kay & Tasman, 2006:681). All types of factitious disorder show a strong association with substance abuse, and borderline and narcissistic personality disorders (Lasich & Wilson, 2007:169).

## **2.7 Assessment for factitious disorder**

The researcher will present three sets of criteria for factitious disorder currently in use: The International Classification of Disease (ICD), the Diagnostic and Statistical Manuals DSM-IV-TR and DSM-5. The reason for elaborating on these three diagnostic classification systems is that there are significant differences between them which could impact on the study objectives and findings. The researcher will also discuss the difficulty in the detection and confirmation of factitious disorder, and the danger of factitious disorder as a misdiagnosis.

### **2.7.1 Criteria in the ICD-10**

The ICD codes are used by WHO member states (including South Africa) as the standard diagnostic tool for epidemiology, clinical purposes, as well as for the

medical scheme reimbursement of treatment (WHO, 2010). The ICD-10 classifies factitious disorder as follows:

*'Factitious disorder (F68.1): Intentional production or feigning of symptoms or disabilities, either physical or psychological. The patient feigns symptoms repeatedly for no obvious reason and may even inflict self-harm in order to produce symptoms or signs. The motivation is obscure and presumably internal with the aim of adopting the sick role. The disorder is often combined with marked disorders of personality and relationships. Classification includes Hospital hopper syndrome, Munchausen's syndrome and Peregrinating patient. Classification excludes Factitial dermatitis L98.1 and Person feigning illness with obvious motivation Z76.5.'*

#### **2.7.2 Criteria in the DSM-IV-TR**

Factitious disorder was only recognized in the DSM III in 1980, which is relatively recent compared to other disorders (Dyer & Feldman, 2007:2). The first edition included factitious disorder, but focused on Munchausen syndrome. Subsequent publications recognized that Munchausen syndrome, an extreme form of factitious disorder, was very rare, and the DSM IV reclassified factitious disorder as a single category with three subtypes. The DSM-IV-TR classifies factitious disorder and factitious disorder by proxy as follows (APA, 2000:517):

##### **'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 behaviour (such as economic gain, avoiding legal responsibility, or improving physical well-being, as in malingering) are absent.*

1. *With predominantly psychological signs and symptoms: if psychological signs and symptoms predominate in the clinical presentation.*
2. *With predominantly physical signs and symptoms: if physical signs and symptoms predominate the clinical presentation.*
3. *With combined psychological and physical signs and symptoms: if psychological physical signs and symptoms are present, but neither predominates the clinical presentation.'*

*'Factitious disorder by proxy (listed under factitious disorder not otherwise specified)*

- A. *Intentional reproduction of or feigning of physical or psychological signs or symptoms in another person who is under the individual's care*
- B. *The motivation for the perpetrator's behaviour is to assume the sick role by proxy.*
- C. *External incentives for the behaviour are absent.*
- D. *The behaviour is no better accounted for by another mental disorder.'*

### **2.7.3 Criteria in the DSM-5**

The DSM-5 was released in May 2013. The workgroup for factitious disorder for the new publication stated that factitious disorder is 'not routinely considered' partly due to it being listed in a separate chapter to other illness-perception disorders, and suggested classification under somatic symptom disorders in order to help clinicians compare and consider it as a differential diagnosis (APA, 2014). The subtypes have been updated to the following two categories (APA, 2014):

***'Factitious disorder imposed on self:***

*To meet criteria for factitious disorder imposed on self, all four criteria must be met.*

*A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.*

*B. Presenting oneself to others as ill, impaired, or injured.*

*C. The deceptive behaviour is evident even in the absence of obvious external rewards.*

*D. The abnormal illness behaviour is not better accounted for by another mental disorder such as delusional disorder or other psychotic disorder.'*

***'Factitious disorder imposed on another (previously, factitious disorder by proxy):***

*To meet criteria for factitious disorder imposed on another, all four criteria must be met. Note that the perpetrator, not the victim, receives this diagnosis.*

*A. Falsification of physical or psychological signs or symptoms or of induction of injury or disease in another, associated with identified deception.*

*B. Presenting another (victim) to others as ill, impaired, or injured.*

*C. The deceptive behaviour is evident even in the absence of obvious external rewards.*

*D. The abnormal illness behaviour is not better accounted for by another mental disorder such as delusional disorder or other psychotic disorder.'*

A significant change in the proposed classification is that the assumption of motivation as well as the criteria of intentional fabrication is removed. These criteria received much critique, because both motivation and intent are subject to the practitioner's interpretation, and are difficult to discern (Wang et al., 2005:1831). The

classification in the DSM-5 will shift the focus in assessment from the assumed motivation and intent of the behaviour to the deception, falsification and fabrication of symptoms.

#### **2.7.4 Critique on the assessment criteria used for factitious disorder**

The overwhelming focus in literature on factitious disorder is on the presentation and treatment of physical signs and symptoms, as experienced in medical treatment settings. To a lesser degree literature includes the presentation and treatment of psychological signs and symptoms, as experienced in psychiatric treatment facilities. Turner (2006:23, 24) explains that the factitious disorder criteria in the DSM-IV of 'intentional production of physical signs and symptoms' was first introduced in early descriptions of Munchausen syndrome, where the main presentation was persons deliberately harming themselves to get medical attention. The later recognition of a psychological presentation led to appending the criteria to include 'intentional production of psychological signs and symptoms'. Turner (2006:24, 25) proposes that in factitious disorder with psychological symptoms it becomes clear that the act of lying about a symptom is the true symptom, and that the key component of factitious disorder is fabrication, and not 'symptoms'. Turner (2006:25) states that:

*'The consequences of this is that the most important psychiatric classification system artificially restricts the scope of academic attention by obfuscating the diagnostic issues and excluding, by the front door, what clinical psychiatry has already started to let in through the back.'*

There are various examples in the literature on factitious behaviour which do not clearly fall in either a physical or a psychological category. In *Cinderella syndrome: Children who simulate neglect*, case reports are presented of a rare phenomenon in adoption, where adoptive children fabricate stories of being mistreated by their

adoptive mother, of being dressed in rags, of having to do all the chores, and that their adoptive mother favours their stepsiblings (Goodwin, Cauthorne & Rada, 1980:1224). In *Factitious mourning: Painless parenthood*, factitious bereavement is described where persons claim to have lost loved ones through dramatic accidents, which turn out to be fabrications, apparently this is a common presentation in people being treated for factitious disorder with psychological symptoms (Phillips, Ward & Ries, 1983:421).

Othmer et al. (2002:416) proposes that factitious disorder is not limited to the fabrication of physical or psychological signs and symptoms, but that persons with factitious disorder can also present themselves as victims of various circumstances. This research study is explorative, researching a phenomenon that has not been thoroughly researched in social work from a biopsychosocial perspective. For this reason this study will consider the fabrication of physical and psychological signs and symptoms as described in the DSM-IV (APA, 2000:517), as well as fabricated events as proposed by Othmer et al. (2002:214).

### **2.7.5 Detection and confirmation of factitious disorder**

Deception is a key characteristic of factitious disorder and can make detection and confirmation very difficult. O'Shea (2007:61) states that practitioners need to have knowledge about factitious disorder's general features, breadth of presentation, and a high index of suspicion in order to identify factitious behaviour. A detailed medical history and collateral information from the family can assist the practitioner in confirming the disorder (McCullumsmith & Ford, 2011:626). Sometimes the disorder is discovered accidentally when the client is caught in the act of fabricating symptoms, or pathological lying is discovered (Wang et al., 2005:1833). Identifying factitious disorder with psychological signs and symptoms can be particularly difficult because

the practitioner relies on the client's self-report of symptoms (Kay & Tasman, 2006:681).

Factors that can be clues to the possibility of factitious disorder include: A history of unexplained signs and symptoms and failure to respond to treatment; Unusual and dramatic presentation; Development of new and unusual symptoms when the initial symptoms resolve; History of multiple surgical procedures; Medical history that does not correspond to the client's apparent state of health; Reluctance to disclose full medical history, or to allow collateral information from family; Clinical presentation that is almost textbook like; Sophisticated medical vocabulary; Eagerness for and demanding of specific treatments and investigations; The ability to forecast unusual progression of symptoms and predict the response to treatment. (Lasich & Wilson, 2007:151; Kay & Tasman, 2006:681; Wang et al., 2005:1835).

Some authors propose that factitious disorder does not have to be confirmed, as long as general medical and psychological illness has been factored out, and that clients can then be treated indirectly (Leamon et al., 2003:694). The rationale behind this is that clients with factitious disorder often leave treatment if confronted with the deception or if their behaviour is labelled as a disorder. The researcher is of the opinion that this approach can be potentially harmful to the client because it relies on the practitioner to be able to exclude all other possible causes of symptoms, instead of proving the client's deception or fabrication. Some disorders are rare, some are difficult to identify or present in unique ways, and some symptoms can as yet not be explained. Treating clients with idiopathic symptoms as if they have factitious disorder puts them at risk of their true illness not being correctly identified or treated. Ensuring that clients are treated ethically is important in social work, and the

researcher is of the opinion that it is necessary to understand how social workers treat clients that they suspect of having factitious disorder.

### **2.7.6 Factitious disorder as a misdiagnosis**

Leamon et al. (2003:696, 694) notes that some conditions can be difficult to recognise initially, have a fluctuating course, or give inconsistent findings, and that this could lead to the erroneous suspicion of factitious disorder. Wrongful identification of factitious disorder can result in trauma, and can be perpetuated in future consultations if it is recorded in medical records (Leamon et al., 2003:694). Misdiagnosis as factitious disorder can lead to the withholding of care, which in the worst case scenario can result in disability or death. The researcher has noticed a lack of discussion in literature and research on the issue of outcomes when clients were incorrectly labelled as having factitious disorder.

A South African study by Govender et al. (2011:49) found that 28% of cases referred to the psychiatric ward at Tygerberg hospital with 'medically unexplained symptoms' were found to have an organic illness upon further investigation. They report that a systematic review of misdiagnosis revealed rates of around 4%, making the 28% found in the psychiatric ward much higher than expected. They postulate that this could indicate prejudice of health care professionals towards persons with suspected psychiatric illness, where their symptoms are not thoroughly investigated. The term 'medically unexplained symptoms' is used in the South African context to include somatoform disorders as well as factitious disorder (Govender et al., 2011:46).

## **2.8 Practitioners' experience of countertransference evoked by factitious disorder**

Greenberg and Mitchell (1983:389) states that countertransference is an inevitable product of the interaction between the client and the practitioner, rather than a simple interference stemming from the practitioner's own infantile drive-related conflicts. Howard (2010:72) notes that the feelings evoked in the practitioner can either be originating from their own inner world – their transference feelings toward the client, or it can be an unconscious response to the client's transference feelings. The way the term 'countertransference' is used and defined depends on the theoretical model used, but generally it refers to feelings that the practitioner experience that are evoked by the client.

Quest and Hyler (1980:412) explained that the practitioner can feel shame, embarrassment, aversion, fear, despair and even malice toward the client, caused by the way their genuine efforts were subverted and sabotaged, and they could treat the client with a mixture of bemusement, bewilderment, contempt, and anger. Extreme countertransference feelings could cause a practitioner to dismiss, avoid or refuse to treat clients with factitious disorder (Wang et al., 2005:1829). Strong negative feelings can interfere with appropriate client care, and the countertransference needs to be managed constructively by using the feelings of frustration and anger as a way to understand the client's deep seated emotions (Wang et al., 2005:1841, 1842).

Unfortunately by the time factitious disorder is recognised, the relationship between the practitioner and the client could be irreparably damaged, and the practitioner needs to deal with their negative emotions before attempting a therapeutic intervention (Bass & Gill 2009:1052). Therapeutic nihilism can occur, where an assumption forms that the client cannot or should not be treated, and subsequently

the client is not assessed further, nor referred for alternative treatment (Leamon et al., 2003:696).

## **2.9 Aetiology of factitious disorder**

The precise aetiology of factitious disorder is not known because there is a lack of large studies and the self-report data is often unreliable, but there does seem to be common themes in the various literature:

**Physical causes:** Numerous case reports have indicated that factitious disorder might run in families. This could be explained by environmental factors, genetic factors or both. Neurobiological factors could have a role in the development of this disorder. One review found evidence of central nervous system abnormalities in 40% of factitious disorder cases. (Bas & Gill, 2009:1051; Kay & Tasman, 2006:682).

**Developmental causes:** Childhood developmental disturbances, such as early childhood sexual abuse, physical abuse, deprivation, and disturbed parental relationships can leave unfulfilled cravings for attention and care. Early childhood experience of chronic illness, hospitalisation or illness in the family, where illness is associated with attention and nurturing in otherwise distant families, could lead to positive reinforcement of the sick role. Early childhood experiences with the medical profession could result in feelings of anger towards medical staff. (Bas & Gill, 2009:1051; Kay & Tasman, 2006:682).

**Underlying psychiatric disorder:** An underlying psychiatric illness may predispose persons to factitious behaviour, and case studies indicate a lessening or alleviation of factitious symptoms when major depression is treated (Wang et al., 2005:1832). People that initially feign psychosis often develop genuine psychotic disorder later on.

Feigning of psychosis could be a defence against the emergence of genuine psychosis, by creating a feeling of being in control of the symptoms. (Wang et al., 2005:1833; Gabbard, 1995:1812).

**Underlying psychological dysfunction:** Literature on factitious disorder with psychological symptoms indicate the presence of severe psychological dysfunction, and a high rate of substance abuse and suicide (Gabbard, 1995:1812). These clients often demonstrate immature coping skills, possibly due to the absence of nurturing during childhood. Poor coping could also be part of a personality disorder, such as antisocial or borderline personality disorder, with dependant and narcissistic personality traits evident (Kay & Tasman, 2006:682). Factitious disorder has been conceptualised as a manifestation of borderline character pathology where the person is both the victim and the victimiser, by gaining medical, psychological and social attentions while at the same time defying and devaluing the practitioners, through projection of hostility and worthlessness onto them, being both desired and rejected (Leamon et al., 2003:695).

**Psychodynamic motivations:** Psychodynamic theories have focussed on the concepts of mastery, masochism and mothering. People who experienced traumatic illnesses as children and have factitious behaviour as adults, may feel a sense of mastery of the situation which they could not feel as children. They may relive childhood trauma and abuse through a form of masochism where they endure painful or deforming medical procedures and surgeries, in a repetition compulsion where they re-enact dependency, idealization and anger toward the symbolic parent – the health care system, which responds with caring but also a sort of physical and emotional abuse in the form of medical procedures, and ultimately abandonment or rejection when the deception is exposed. The health care system can become the

main object relation in the person's life, the substitute mother, to whom they turn for nurturing in times of stress or loss, obtaining emotional support while avoiding emotional intimacy (Wang et al., 2005:1833).

## **2.10 Treatment approaches for factitious disorder**

People identified with factitious disorder so rarely engage in long-term psychotherapy that those cases often become the subjects of case studies (Bass & Gill, 2009:1051). There are no systematic treatment studies on factitious disorder, because these clients usually stop treatment if their deception is exposed, or if they are identified as having factitious disorder (Bass & Gill, 2009:1052).

It is essential that the client is allowed to save face in order to establish a therapeutic alliance and to avoid the client from abruptly terminating treatment (Wang et al., 2005:1841). The practitioner needs to be aware of the impact of countertransference on the therapeutic process, as strong negative feelings are often evoked by these clients (Wang et al., 2005:1841). By the time factitious disorder is recognised, the doctor, therapist or social worker's relationship with the client may have been irreparably damaged, and these negative emotions have to be dealt with before any therapeutic engagement is made (Bass & Gill, 2009:1052).

There are three main goals in treatment: To reduce the risk of morbidity and mortality; to address the underlying emotional needs or psychiatric disorder; and to be mindful of legal and ethical issues (Wang et al., 2005:1841). Documented interventions favour either a confrontational, non-confrontational or multidisciplinary approach (Bass & Gill, 2009:1052, 1053), and will be discussed in more detail.

### **2.10.1 Confrontational treatment approach**

Initial approaches to clients with factitious disorder were to vigorously confront them about the deception, resulting in clients absconding and finding new doctors, therapists or social workers, unaware of their disorder (Kay & Tasman, 2006:682). Confrontational approaches work best if there is evidence of fabrication which can be presented to the client, and in a hospital setting it is helpful to have a psychiatrist present. The type of confrontation that is suggested is non-punitive and supportive, which emphasises that the client is indeed a sick person that needs help, but for the underlying psychological disorder, and not necessarily for the presented fabricated symptoms. Multiple studies on this type of confrontation has shown that the majority of clients did not develop serious psychological disturbance or suicidality if confronted in a supportive manner, and for most the physical symptoms stopped, but clients did not acknowledge the factitious behaviour and reacted with hostility, most often refusing psychiatric treatment, and sometimes seeking care in a different hospital where they were not known. (Bass & Gill, 2009:1052, 1053; Kay & Tasman, 2006:682; Wang et al., 2005:1841).

### **2.10.2 Non-confrontational treatment approach**

These types of treatment approaches for factitious symptoms are focussed on creating a face-saving way for the client to stop their fabrication of symptoms without having to admit that their condition was factitious. One such strategy is to use a therapeutic double-bind: The client is presented with a scenario that if their symptoms respond to treatment the symptoms are real, but if the symptoms do not respond to treatment they are probably factitious. There have been some reports of this approach being successful, possibly because it provides a face-saving legitimization of both the client's illness and recovery after treatment (Bass & Gill, 2009:1053). An example of the therapeutic double bind would be a client with fabricated amnesia,

where the practitioner explains to the client that the medication they have received (actually a placebo) would make their amnesia symptoms go away, but if the medication does not work, the symptoms are probably not real.

A second strategy is to use inexact interpretations. This is done by suggesting a relationship between certain stressors in the client's life and the emergence of the symptoms (which the practitioner suspects are fabricated), without labelling the symptoms as factitious, thus giving the client an opportunity to relinquish the symptoms while still feeling in control. Using this approach with the example of the client with fabricated amnesia, the practitioner would explain to the client that it is very likely that the current amnesia was caused by a stressful event in the client's life, and as the client starts to feel less stressed the amnesia will go away. (Bass & Gill, 2009:1053; Kay & Tasman, 2006:682; Wang et al., 2005:1841). The researcher notes that this method requires the practitioner to lie, thus treating lying with lying, and is of the opinion that it might not be successful with clients experienced in illness fabrication. The researcher also notes that this approach does not allow for the possibility that the client's symptoms are genuine, and not fabricated, and as the client is not confronted about the origin of their symptoms they do not have the opportunity to contest the presumed factitious disorder, and could result in medical or psychological illness not being recognised or treated.

### **2.10.3 Multidisciplinary treatment approach**

Parrish and Perman (2004:137) states that the medical and psychosocial complexities involved in factitious disorder and factitious disorder by proxy, necessitates a carefully organised multidisciplinary response, and is of the opinion that the role of social work is crucial in the effectiveness of such an approach. A multidisciplinary approach acknowledges the complexity of the biological, psychological and social aspects to

the aetiology, presentation and treatment of this disorder, and emphasize the countertransference of extreme negative emotions that is often experienced by all members of staff toward clients with factitious disorder. In a multidisciplinary approach the team meets to discuss their experience of the client, and to develop practical treatment guidelines. It is advisable to include a member from the hospital's medico-legal department, as there can be legal considerations in the choice of treatment (Bass & Gill, 2009:1053; Kay & Tasman, 2006:683; Wang et al., 2005:1841). The researcher notes that even though a multidisciplinary approach is often advocated in the literature, the precise treatment methods, tasks and responsibilities of the different professionals in the team are not defined.

#### **2.10.4 Long-term psychotherapy**

The researcher notes that all three of the intervention approaches discussed previously seem appropriate as they could lead to the client's symptoms resolving temporarily, but they do not address the underlying psychiatric disorder, and the client is very likely to continue the factitious behaviour in a different hospital or with a different doctor, therapist or social worker (Leamon et al., 2003:696). Kay & Tasman (2006:683) reflect this dichotomy in treatment approaches in their statement: *'However, expectations must be realistic as improvement in the disorder itself can take several years. Techniques that target short-term reduction in the production of factitious symptoms can be effective more quickly.'* In reality the three 'treatment approaches' advocated by Bass and Gill (2009:1052) are actually 'symptom management approaches', as the client is forced to temporarily stop their factitious behaviour because their deceit has been uncovered, while the factitious disorder - which is the underlying psychiatric condition that is causing the client's behaviour, is not treated.

There are numerous case reports on the efficacy of long-term psychotherapy in the treatment of factitious disorder (Kay & Tasman, 2006:683). Wang et al. (2005:1842) explain that once factitious disorder is confirmed or deemed highly probable, the client should be 'artfully steered' toward psychiatric help by using an approach that allows the client to save face, for instance explaining in an empathetic way how factitious symptoms are an expression of intense emotional need or distress caused by past trauma the client endured. Focussing on the clients genuine emotional needs instead of the factitious symptoms is an effective strategy to engage the client in psychotherapy, as they usually crave to be understood and to have their emotional needs recognised (Wang et al., 2005:1842). Leamon et al. (2003:696) states that there is usually an element of confrontation at the point where the treatment plan is changed from focussing on the factitious symptoms to addressing the factitious disorder, but that this is done indirectly and delicately, using face-saving techniques, without expecting the client to acknowledge their deception.

The central therapeutic elements in psychodynamic psychotherapy are summarised by Kay (2006:167) as follows:

- *People feel and behave as they do for specific reasons.*
- *People are frequently unaware of why they feel or behave in a certain fashion.*
- *Past events and experiences are often outside of a person's awareness and determine how they feel about themselves and their world.*
- *The need to master psychological pain and discomfort is compelling and accounts for why many people behave consistently and predictably in often self-defeating or disappointing ways.*
- *The power of the therapeutic relationship is predicated on the practitioners ability to provide a safe forum for examining psychological problems, feelings,*

*and behaviours by maintaining an open, nonjudgmental, and empathic rapport with the client.*

- *The past experiences of both the client and the practitioner have a role in determining the valence and power of the therapeutic relationship.*
- *Successful treatment must integrate both cognitive and affective components of the patient's self-awareness and includes supportive as well as interpretive interventions.*

Psychodynamic approaches to treatment do not focus on the factitious behaviour, but rather the underlying dynamic issues (Leamon et al., 2003:696). One case study describes the use of a combination strategy, where the client received weekly psychotherapy and a carefully designed paradoxical unrestricted hospital admission policy to control the factitious symptoms (Leamon et al., 2003:694).

Leamon et al. (2003:697) reports that there are numerous case reports that show with skilled therapeutic intervention there is hope for improvement for clients with factitious disorder, however the scientific research on the efficacy of specific psychotherapy approaches in the treatment of factitious disorder is limited.

## **2.11 Summary**

This chapter examined the literature that relates to the study objectives. It explained the choice of theoretical frameworks for the study. It discussed the clinical features, aetiology, diagnostic criteria and treatment approaches used for factitious disorder. It also critically examined the importance of knowledge of the disorder, the difficulty in detecting the disorder, the phenomenon of countertransference, and the danger of misdiagnosis. The research methodology will be discussed in chapter three.

## CHAPTER THREE

### METHODOLOGY

#### 3.1 Introduction

In this chapter the researcher will discuss the research approach, research design and methodology used in this research, including the sampling strategy, data collection, data analysis, data verification and limitations of the study.

#### 3.2 Research approach

A qualitative research approach was chosen for this study. Leedy and Ormond (2005:94) explain that qualitative research is used to answer questions about a complex phenomenon from the participant's point of view, and it enabled the researcher to focus on participants' knowledge, experience and approach with regards to factitious disorder. Fouché and Delport (2011:65) state that qualitative research can be used to identifying participant's beliefs and values that underlie a phenomenon, and this approach allowed the researcher to gain a deeper understanding of how participants perceived factitious disorder. Kumar (2005:12) explains that the qualitative approach not only purposes to describe a phenomenon, but can also establish variations, as was done in this research.

This research study is exploratory, as it aims to gain understanding of a phenomenon and answers a 'what' question: 'What are social workers' knowledge, experience and approach to factitious disorder?' (Fouché & De Vos, 2011:95). Exploratory research aims at understanding a situation, phenomenon, community or individual. This topic has not been extensively researched, and exploratory research can be the first step to multiple studies on a specific phenomenon. (Fouché & De Vos, 2011:95).

### **3.3 Research design**

A phenomenography research design was used for this research study, as it aims to identify the qualitatively different ways in which practitioners experience the phenomenon of factitious disorder in practice. In phenomenography different themes emerge as the variation in the ways of experiencing the phenomena are explored and described (Pang, 2003:154; Marton & Pong, 2005:35; Reed, 2006:1). Marton first described phenomenography as follows:

*'The kind of research we wish to argue for is complementary to other kinds of research. It is research which aims at description, analysis, and understanding of experiences; that is, research which is directed towards experiential description. Such an approach points to a relatively distinct field of inquiry which we would like to label phenomenography.'* (Marton, 1981:185)

Phenomenography was chosen as the research design because it complements the qualitative exploratory nature of this study. The focus on identifying variation will enable a thematic exploration of the knowledge, experience and approaches social workers have regarding the phenomenon of factitious disorder.

### **3.4 Sampling**

The researcher will discuss the population from which participants were chosen, the sampling techniques used, and the sample size.

#### **3.4.1 Population**

The term 'universe' refers to all individuals who possess the attributes in which the researcher is interested, while the term 'population' refers to individuals within the universe who possess specific characteristics as determined by the set boundaries of the research study (Strydom, 2011:223). The characteristics of the population from

which the sample for this research study was taken were: Social workers that were registered with the South African Council of Social Service Professions; That received their training at a South African University or College; That had a minimum qualification in social work equal to a four year honours degree; That had a minimum of one year working experience after qualifying as a social worker.

### **3.4.2 Sampling technique**

A sample can be defined as a portion of the population from which a representative selection is made (Barker, 2003:380). In phenomenography, sampling is often designed to maximize the diversity of participants who share experience of the particular phenomenon, rather than a statistically balanced representation (Marton & Booth, 1997:130). The researcher chose to use a combination of purposive and snowball sampling in order to produce a diverse sample of social workers from various areas of specialisation and with various years of practice experience.

In purposive sampling the researcher considers the parameters of the population and then chooses the sample accordingly (Strydom & Delpont, 2011:392). In order to include participants with private practice experience, the researcher contacted the initial four participants telephonically from their details on the South African Association for Social Workers In Private Practice website. In snowball sampling the researcher is informed of potential participants by current participants (Strydom & Delpont, 2011:393). The four initial participants were asked to identify social workers that they felt might be interested in participating in the research, and to contact them to enquire if they would be willing to participate. The participants then gave the contact details of these potential participants to the researcher. The researcher then chose the next group of participants from the pool of potential participants generated by the first four participants, and approached them - some telephonically and some in

person. The researcher repeated the snowball sampling technique with each chosen participant, so increasing the pool of potential candidates. When selecting participants from the pool of potential participants, the researcher considered their level of education, years in practice, and areas of practice experience in order to maximise the diversity of the sample.

### **3.4.3 Sample size**

The sample size for this study was 16 participants. The reason for this limited sample size was due to the time intensiveness of the chosen qualitative approach, which required in-depth interviewing followed by transcription of the interviews. The sample size fulfilled the prescribed minimum required by the University of Cape Town for a minor dissertation.

## **3.5 Data collection**

The researcher will discuss the choice of data collection method, data collection instrument, data collection tools, and piloting of the data collection instrument.

### **3.5.1 Data collection method**

The data collection method for this research was a one pass approach, using face to face semi-structured interviewing, which is consistent with how qualitative accounts are collected in phenomenography (Marton & Booth, 1997:131, 132). Semi-structured interviews can be defined as being organised around areas of particular interest, while still allowing flexibility in the scope and depth (Greef, 2011:348). Using a semi-structured interview schedule enabled the researcher to focus the interview on the research topic and objectives, while still having the flexibility to explore the detail and depth of what the participants were saying. It also allowed the researcher to explore the participant's beliefs, perceptions and accounts of factitious disorder (Greef,

2011:352). Greef (2011:352) state that by using a semi-structured interview approach, participants share closely in the direction the interview takes, and can introduce issues that the researcher had not thought off. This data collection method served the exploratory nature of the research, as the researcher was not bound to the semi-structured interview, but rather guided by it, and could explore additional areas of possible interest as revealed by participants during the interview.

Face to face interviewing allowed the participants to take an active role in exploring their beliefs, perceptions and accounts of factitious disorder, and enabled the interviewer to gain a deeper understanding of how factitious disorder is experienced in their reality (Greef, 2011:351). The researcher found face to face communication beneficial as she could pick up on and respond to the more subtle body and facial expressions of the participants, and guide the interview by using communication skills such as clarification, reflection, probing and paraphrasing, in a timely manner.

### **3.5.2 Data collection instrument**

An interview schedule was used to guide the semi-structured interviews (Appendix 2). An advantage to preparing an interview schedule is that the researcher can think beforehand about what they want the interview to cover (Greef, 2011:352). The researcher chose questions that would focus the interview on the research topic, phrased the questions in a non-judgemental tone, arranged the questions in a logical manner, and allowed for open ended questions (Greef, 2011:352).

### **3.5.3 Data collection tools**

The researcher utilised a good quality digital recorder which ensured that the data generated during the interview was captured, and could be transcribed verbatim for analysis (Greef, 2005:298). Using a digital recorder allowed the researcher to

concentrate on the participant and the interview process without having to make detailed process notes. The researcher transcribed each interview as soon as it was reasonably possible, using a Dictaphone computer program. After each interview the researcher reflected on the process, and made field notes on her impressions, observations, questions and thoughts (Greef, 2005:298).

#### **3.5.4 Piloting of data collection instrument**

Strydom (2011:242) states that the pilot study offers an opportunity to test the interviewing schedule with the interviewer as well as the kind of participant that will be used in the main research study. The researcher piloted the semi-structured interview schedule with a participant selected using the chosen sampling strategy. The researcher was able use the pilot study to refine the wording, reduce the number of questions and improve the order of questions (Strydom, 2011:242).

#### **3.6 Data analysis**

De Vos (2011:403) explains that a researcher should report on the analytical process followed in a research study. For this study the researcher found the phenomenography data analysis method as described by Alsop and Tompsett (2006:247) and the thematic qualitative data analysis method described by De Vos (2005:334) complimentary and appropriate, and used the following combined approach for the data analysis process:

- 1) The data analysis process starts with data collection: Conducting face to face interviews, making field notes, and transcribing the interviews. In qualitative research, data collection is seen as inseparable from data analysis, because the researcher is constantly thinking about the collected data as well as reviewing the research process (De Vos, 2011:405).

- 2) Organising the data: The data from qualitative research can become voluminous, and needs to be organised in appropriate text units (De Vos, 2011:408). The researcher did the transcription of the interviews, and organised the data into an Excel spreadsheet, grouping sentences together according to their focus.
- 3) Reading and writing memos: The researcher read and reread the data several times, gaining an understanding of the data from the perspective of each participant, as well as a broader view of the overall data. The researcher made notes in the margins of the transcripts of key aspects of ideas and concepts.
- 4) Generating themes and categories: Initially the researcher was focussed on exploring the patterns and topics in the data, marking key paragraphs using different colourer pens as well as notes in the margin. This first-level coding identified the main themes. In the second-level coding the researcher identified emergent categories of description within each theme, which described the variation in the qualitatively different ways the participants experienced key aspects of factitious disorder.
- 5) Coding the data: The researcher captured the themes and categories of description from the margin notes and the marked paragraphs in the printed transcripts, by applying a coding scheme. Columns for themes and categories were added in line with the electronic transcript in Excel, with themes coded numerically and categories within each theme coded alphabetically.
- 6) Testing the emergent understanding and searching for alternative explanations: During the coding process the researcher critically evaluated the data for its usefulness and relevance.
- 7) Presenting the data: De Vos (2011:419) states that writing the final research report and presenting the data are central to qualitative analysis, as writing

about the findings are an integral part to understanding the data. The researcher organised the themes and emergent categories of description in a data analysis framework, and critically discussed each category of description in relation to the relevant literature.

### **3.7 Limitations of the study**

Fouché and Delport (2011:111) state that potential limitations of a study and the steps to ameliorate the limitations should be clearly listed. The researcher will discuss limitations in the following areas of this research study: Research approach; Research design; Sampling strategy; Data collection; Data analysis.

#### **3.7.1 Limitations in the research approach**

Qualitative research is used to answer questions about the complex nature of a phenomenon, with the purpose of describing and understanding the phenomenon from the participants point of view (Fouché & Delport, 2011:64). This creates a limitation to the research as the findings do not establish, confirm or validate relationships among variables, as is the case with quantitative research (Fouché & Delport, 2011:63). The researcher is of the opinion that this limitation is acceptable, as the goal of this research study is not to establish relationships among variables, but to explore how a complex phenomenon is experienced from the point of view of the participants.

Qualitative research is more likely to end with tentative answers, as opposed to quantitative research that aims to confirm or disconfirm hypothesis (Fouché & Delport, 2011:63). This limitation is in line with the explorative objective of this research, as it is a topic that has not been extensively researched, and tentative

hypotheses may form the basis for future studies designed to test these proposed hypotheses (Fouché & Delpont, 2011:64).

### **3.7.2 Limitations in the research design**

Phenomenography as a research design is aimed at describing and understanding the participants experience of the phenomenon, and not to create meaning of the lived experience (Marton & Pong, 2005:35). Thus the phenomenography design of this research study is limited to the exploration of the variations in the knowledge, experience and approach of social workers to the phenomenon of factitious disorder. The researcher finds this limitation appropriate, because initial exploration of this topic is needed as there is no current research on factitious disorder as it relates to social work practice, and it is functional in that it allows for the goal of this research to be exploratory.

### **3.7.3 Limitations in the sampling strategy**

A combination of purposive and snowball sampling was used in this research study. In purposive sampling the researcher chooses the participants according to pre-selected criteria within the parameters of the population (Strydom & Delpont, 2011:392). In snowball sampling participants were asked to identify possible participants that meet the criteria for participation in the research study (Strydom & Delpont, 2011:395). These non-probability sampling methods are limited in that they are not representative, and the size of the sample is not statistically significant, but it does serve the overall purpose of selecting a sample that is diverse and can provide a richness of information (Strydom & Delpont, 2011:391). In phenomenography, sampling is often designed to maximize the diversity of participants who share experience of the particular phenomenon, rather than a statistically balanced

representation, in order to maximise the depth of variation in emergent categories of description (Marton & Booth, 1997:130).

The sample size in qualitative research should ideally be based on reaching a saturation point in the data collection (Sarantakos, 2000:156). Qualitative data collection, processing and analysis are time consuming and can influence the size of the sample that is practically feasible. This research has a relatively small sample size of sixteen participants. The researcher is of the opinion that even though clear patterns and repetition of information occurred in the data collection process, the saturation point was not reached. This limitation is ameliorated by the fact that the research is exploratory, and that further research could build on the themes and categories of description that have emerged.

#### **3.7.4 Limitations in data collection**

The nature of this research study required participants to reflect back on their practice experience in order to identify clients which match criteria for factitious disorder. Similar approaches have been the basis of the majority of research on factitious disorder (Fliege et al., 2007:62). The researcher acknowledges that there are inherent weaknesses to this method. The research is dependent on practitioners' memory and ability to recollect past experiences with clients, as well as their ability to comprehend and internalise new information, in this case the criteria for factitious disorder, and apply it retrospectively. The researcher notes this limitation, but concludes that the participants' reflective-practice provided an opportunity to explore their knowledge and experience of factitious disorder as a starting point for further research into an area that has not been researched previously.

### **3.7.5 Limitations in data analysis**

In phenomenographic data analysis 'bracketing' refers to the researcher consciously taking an objective approach to the initial analysis of each new transcript, to identify the themes and emergent categories of description (Richardson, 1999:63). The researcher is aware of the potential limitation in data analysis where the outcome of the analysis relies on the researcher's skill. The researcher was mindful of this potential limitation, and purposefully followed the phenomenographic data analysis guidelines which included using the technique of bracketing, multiple readings of transcripts, making notes and using a coding technique that can be audited to verify findings.

### **3.8 Data verification**

Lincoln and Guba (1995) proposed criteria for evaluating qualitative research that reflect the assumptions of the qualitative paradigm. The researcher will discuss these criteria as they pertain to the research study.

#### **3.8.1 Credibility and authenticity**

Credibility and authenticity in qualitative research is demonstrated by the accuracy of the identification and description of the subject being researched, showing the complexity of variables and interactions within the parameters of the population and theoretical framework (De Vos, 2011:346). The researcher ensured credibility and authenticity by using well established research methodology, and clearly describing the integration of the methodology throughout the research study. Sampling was done in accordance with the phenomenography approach to ensure a variety of participants and a depth of data. Interviews were recorded and transcribed verbatim to ensure accuracy. Coding of data was done systematically and captured in an

easily accessible format. The data capturing and analysis process was done in such a manner that it can be easily verified by a third party.

### **3.8.2 Transferability**

Shenton (2003:69) states that findings of qualitative research are often specific to a particular situation and population, and it is not possible to demonstrate that the findings and conclusions are applicable to other situations and populations, and that results from qualitative research are understood within the parameters of the research. The researcher agrees with this statement, and is of the opinion that the exploratory nature of this research study does not attempt to produce results that can be generalised outside of the chosen population. The theoretical frameworks and research methodology used in this research were clearly described, thus the researcher is of the opinion that the research process could be transferred to another setting.

### **3.8.3 Dependability**

Qualitative research findings are often tied to the situation of the study, the ethnographic present, because of the changing nature of the phenomena being studied (Shenton, 2003:71). Dependability in qualitative research can be addressed by reporting the detailed research process, so that future researchers can repeat the work, even if they will not necessarily gain the same results (Shenton, 2003:71). The researcher has described the research design and implementation in detail, enabling future replication of the research.

### **3.8.4 Confirmability**

In qualitative research confirmability refers to the steps taken by the researcher to help ensure that the research findings are the result of the data gathered from the

participants, rather than the characteristics and preferences of the researcher (Shenton, 2003:72). To ensure confirmability the researcher declared her own beliefs regarding the research topic and maintained objectivity in capturing and analysing the data and reporting on the results. The researcher captured, coded, analysed and presented the data in such a manner as to allow an external audit and confirmation of the findings.

### **3.9 Summary**

This chapter discussed the use of a qualitative research approach with a phenomenography research design. It explained the methodological strategies for sampling, data collection, and data analysis. It discussed possible limitations as well as data verification. The data analysis and research findings will be presented in chapter four.

## CHAPTER FOUR

### ANALYSIS OF FINDINGS

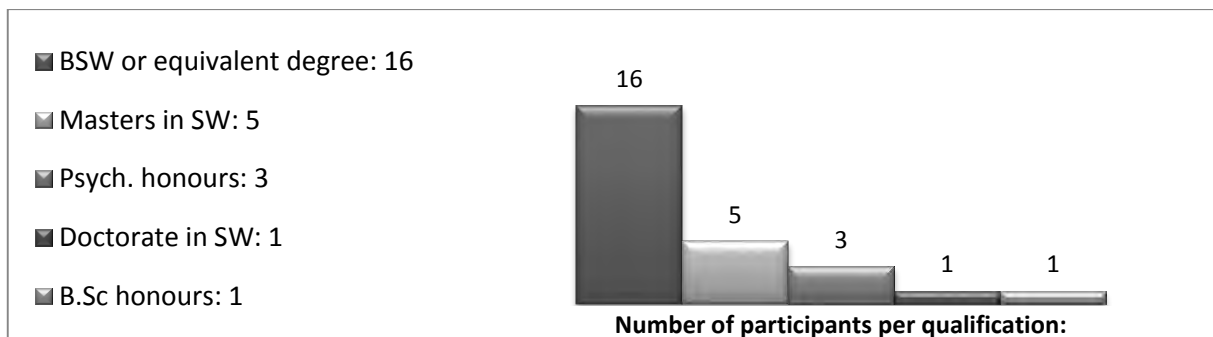
#### 4.1 Introduction

In this chapter the researcher will present the participant profile and discuss the data analysis findings and integrate it with relevant literature.

#### 4.2 Participant profile

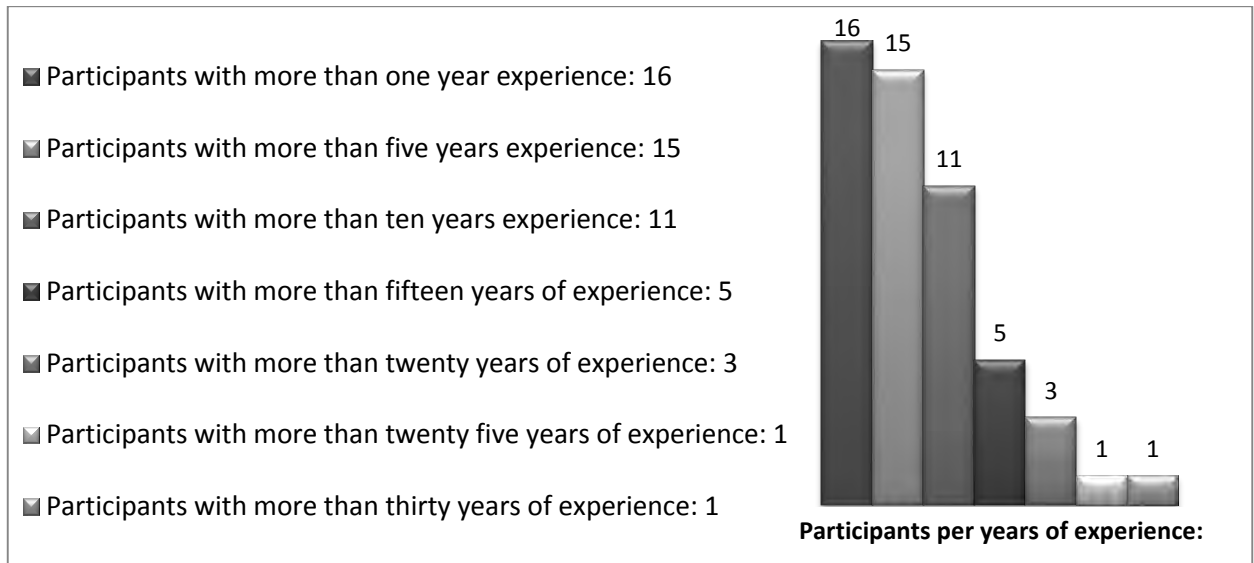
A total of 16 participants were included in the study. The minimum qualification for all participants were a four year degree in social work from a South African College or University. Some participants had additional qualifications, which included: 3 with Honours in Psychology; 1 with Honours in Bachelor of Science; 1 with Masters in Social Work specialising in Administration; 1 with Masters in Social Work specialising in Mental Health; 2 with Masters in Clinical Social Work; 1 with Masters in Social Work specialising in Play therapy; 1 with Doctorate in Social Work specialising in Play therapy. Some participants were in the final stages of completing additional qualifications: 1 in Masters in Medical Social Work; 1 in Masters in Social Work; 1 in Doctorate in Social Work.

**Figure1: Participant qualification**



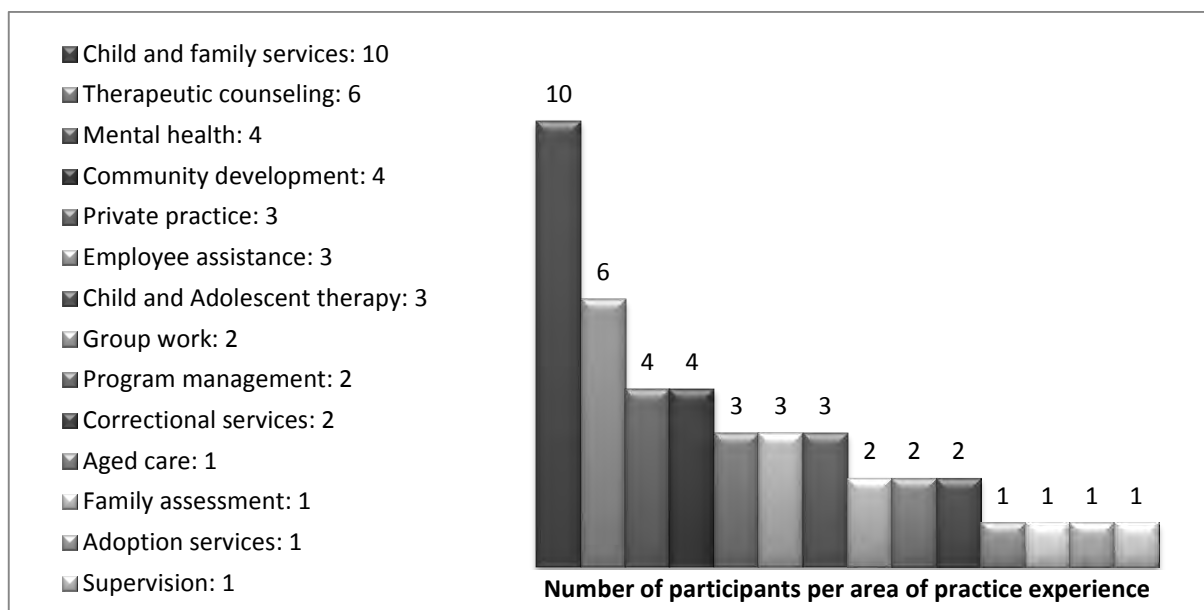
Participants years of practice experience can be distributed as follows: 1 participant having between one and four years, 4 participants having between five and nine years, 6 participants having between ten and fourteen years, 2 participants having between fifteen and nineteen years, 2 participants having between twenty and twenty four years, and 1 participant having between thirty and thirty four years.

**Figure 2: Participant years of practice experience**



The number of participants with experience in various fields of practice were: 10 in Child and family services; 6 in Therapeutic counselling; 4 in Mental health services; 4 in Community development; 3 in Private practice; 3 in Employee assistance; 3 in Child and Adolescent therapy; 2 in Group work; 2 in Program management; 2 in Correctional services; 1 in Aged care; 1 in Assessment for the Family Advocate; 1 in Adoption services; 1 in Supervision;

**Figure 3: Participant area of practice experience**



### 4.3 Data analysis

The interview transcripts were analysed using a combination of a phenomenography and a thematic qualitative data analysis approach. The emergent data was coded and the resulting themes and categories of description were organised in a data analysis framework (Table 1). The researcher will now discuss the research findings according to the five themes and their categories of description. Example quotations for each category of description will be provided. The findings will be integrated with relevant literature.

**Table 1: Data analysis framework**

Themes	Emergent categories of description
<b>Theme 1:</b> Social workers' knowledge of factitious disorder.	1. No knowledge of the term 'factitious disorder'.
	2. Some knowledge of the term 'Munchausen syndrome'.
	3. Incorrect knowledge of factitious disorder.
	4. Knowledge about a disorder is needed in order to identify it.

<b>Theme 2:</b> Occurrence of clients with factitious symptoms in social work practice.	1. Social workers who have never suspected fabrication of symptoms in a client.
	2. Social workers who can identify possible fabrication of symptoms in a client, but feel reluctant to do so.
	3. Social workers who can identify fabrication of symptoms in multiple clients.
<b>Theme 3:</b> Presentation of factitious disorder in social work practice.	1. Fabrication of symptoms by children and adolescents in foster care.
	2. Factitious accounts of rape.
	3. Factitious accounts of problems in personal and family functioning.
<b>Theme 4:</b> Social workers' experience of factitious behaviour.	1. The uncertainty of knowing when a person is fabricating a story.
	2. Giving the client the benefit of the doubt if fabrication is suspected.
	3. Initial emotional reaction to the discovery of the client's deception.
<b>Theme 5:</b> Social worker's approach to clients with suspected factitious disorder.	1. Evidence of fabrication needs to be obtained if factitious disorder is suspected.
	2. Confronting the client about the factitious behaviour.
	3. Careful consideration whether it will be in the client's best interest to use a confrontational approach.
	4. Referral to a psychiatrist and therapeutic intervention.

#### 4.3.1 Theme 1: Social workers' knowledge of factitious disorder.

The participants were asked if they had heard of the terms 'factitious disorder', 'factitious disorder by proxy', 'Munchausen syndrome' or 'Munchausen by proxy', and if so to describe it. Four categories of description emerged: No knowledge of the terms 'factitious disorder' or 'factitious disorder by proxy'; Some knowledge of the terms 'Munchausen syndrome' or 'Munchausen syndrome by proxy'; Incorrect

knowledge of factitious disorder; Knowledge about a disorder is needed in order to identify it.

**4.3.1.1 Category 1: No knowledge of the term ‘factitious disorder’ or ‘factitious disorder by proxy’.**

Thirteen participants reported that they had never heard the terms ‘factitious disorder’ or ‘factitious disorder by proxy’ before. Two participants reported that they might have heard the term ‘factitious disorder’ before, but could not recall what it referred to. One participant said that she might have heard the term before, but gave an incorrect description (this will be discussed under 4.3.1.3).

Participant 4	<i>‘Never, no, factitious?... This is the first time I have heard about it’</i>
Participant 11	<i>‘No, never, factitious? Can I Google it?’</i>
Participant 12	<i>‘Factitious disorder? Let me think... might have heard about it when doing my psychology degree but can’t off hand tell you what it is, but it does ring a bell’</i>

The finding that only three of the sixteen participants have heard the term ‘factitious disorder’ and that none of the participants were able to describe any characteristics for this disorder could indicate an absence of knowledge about factitious disorder in social work education. A study by Fliege et al. (2007) revealed the link between a practitioner’s knowledge of factitious disorder and their perception of the disorder as a relevant disorder, their ability to identify it, and their ability to treat it or to refer clients for treatment. The researcher is of the opinion that a lack of knowledge about factitious disorder in social work could influence practitioners’ ability to identify and treat this disorder.

Factitious disorder was officially included in the DSM, which is the standard manual for mental health professions, in 1980, over 24 years ago. Even though most participants received their qualifications well after factitious disorder's official inclusion in the DSM III, and half have additional qualifications in mental health, most report that they have not even heard the term 'factitious disorder' before. None of the participants had heard of the term 'factitious disorder by proxy' even though it is a serious form of child abuse and more than half of them had experience in child and family services.

The researcher agrees with Fliege et al. (2007) that there is a link between knowledge of the disorder and the perception of the disorder as a relevant disorder. The researcher is of the opinion that research is needed to identify the cause of the lack of knowledge of factitious disorder, as it could become a perpetual cycle, where social workers that lack knowledge of factitious disorder become social work educators, and their lack of knowledge about the disorder impact their perception of the disorder as a relevant disorder, resulting in avoidance of this disorder in social work curriculums.

#### **4.3.1.2 Category 2: Some knowledge of the terms 'Munchausen syndrome' and 'Munchausen by proxy' .**

Seven participants reported that they had heard the term 'Munchausen syndrome' or 'Munchausen by proxy' before. Two of these seven participants could not describe any identifying signs or criteria for Munchausen syndrome. Five of these seven participants were able to describe some aspects of the criteria of 'the production of illness symptoms in order to attain the sick role', which included two who were aware that a person could produce these symptoms in themselves as well as in another, one that was aware that a person could produce these symptoms in themselves, and

two who were aware that a person could produce these symptoms in another (Two of the five participants that could describe some aspects of the criteria for Munchausen syndrome also included incorrect criteria. This will be discussed in 4.3.1.3.).

Participant 7	<i>'When parents make their children ill to get attention'</i>
Participant 1	<i>'I know Munchausen syndrome by proxy is where the mother takes the children to hospital because she gets attention from it, so she makes the children ill in order to get attention. I think Munchausen syndrome is where you make yourself ill to get attention'</i>
Participant 2	<i>'That's the one where the child is not really ill but the mother projects onto the child and keeps the child ill. Is that the one? And the child gets hospitalised and needs treatment but it does not work because the mother sabotages the process'</i>

The finding that only four out of sixteen participants were able to describe the production of symptoms in another, could indicate social workers' lack of knowledge of the basic characteristics of factitious disorder by proxy, also referred to as Munchausen by proxy. This finding has negative implications for the recommendation made by Parrish and Perman (2004:138, 152), where they state that social workers in the medical, psychiatric and child protection fields are in key positions to identify this disorder and to lead the intervention team through the complex treatment process. The researcher is of the opinion that a lack of knowledge could prevent practitioners from recognising factitious disorder by proxy as a form of child abuse, and would limit their ability to plan and implement appropriate interventions.

Willson (2001:297) explains the importance of joint training for medical practitioners, social workers and police officers in the recognition and treatment of factitious disorder by proxy, and adds that the earlier a physician identifies inappropriate parental care and refers a family to social services on the grounds of need, harm to a child and their siblings may be prevented. The researcher is of the opinion that the protocol described by Willson (2001:297), where physicians refer families with suspected factitious behaviour to social services, would not be helpful if social workers are unaware of the basic features of this complex phenomenon.

The researcher notes that the sample size of this study is small and cannot be used to make a general inference to the extent of the lack of knowledge about factitious disorder by proxy in social work in South Africa. The findings do however indicate a potential lack of knowledge, which could be impacting on the child protection and therapy services offered by social workers. The researcher is of the opinion that because children are a vulnerable population and child abuse is a serious crime, further research on social workers' knowledge of factitious disorder by proxy is indicated.

Seven participants reported having heard the phrase 'Munchausen or Munchausen by proxy' before, compared to only three having heard the term 'factitious disorder or factitious disorder by proxy'. The researcher has observed that many articles relating to factitious disorder by proxy incorrectly use the phrase 'Munchausen by proxy', and is of the opinion that the history of the development of the classification and naming of factitious disorder could be included in training, in order to avoid confusion. There is a possibility of more classification confusion in the future, as factitious disorder by proxy has been renamed in the DSM-5 as 'factitious disorder imposed on another'.

#### 4.3.1.3 Category 3: Incorrect knowledge of factitious disorder.

One participant reported that they had heard the terms 'factitious disorder' before but gave an incorrect description (as reported in 4.3.1.1). Two participants reported that they had heard the term 'Munchausen syndrome', or 'Munchausen by proxy' before, and even though they were able to describe some aspects of this disorder correctly, they also included incorrect information (as reported in 4.3.1.2).

Participant 3	<i>'I suspect that it is something, like psychosomatic...where the person thinks they are ill but actually isn't, it's emotional or psychological, and then they start experiencing real symptoms...'</i>
Participant 5	<i>'When you consider the somatic disorders that you can get...where you create an idea for yourself that this is the disorder that I have, and then you believe it so much that it becomes part of the person and they take ownership of it and it becomes their identity.'</i>

These three participants incorrectly described aspects of somatoform disorders in referring to the term 'factitious disorder'. Barlow and Durand (2005) state that it is important to have a clear understanding of the distinction between different disorders, as they have different aetiologies and treatment approaches. The researcher is of the opinion that practitioners with incorrect knowledge of factitious disorder would not be able to correctly identify the disorder, nor implement correct treatment approaches.

#### 4.3.1.4 Category 4: Knowledge about a disorder is needed in order to identify it.

The researcher explained the presentation and identifying criteria of factitious disorder as described in section 2.6, as well as the DSM-IV criteria as described in section 2.7.2. to the participants. Three participants commented on the link between knowledge of a disorder and the practitioner's ability to identify it.

Participant 11	<i>'I have come across this before, I just did not know it had a name'</i>
Participant 16	<i>'You don't give it a name, you deal with it but you don't give it a name - a condition'</i>
Participant 9	<i>'Because I never knew about this disorder maybe I never picked it up'</i>

This finding corresponds with literature on the importance of having nomothetic knowledge, which is the ability to classify the presenting problem according to general assessment principles, known disorders, and diagnostic categories (Barlow & Durand, 2005). The naming and classification of observations and experiences is at the core of enabling scientific knowledge to be shared and to be grown, and for the psychosocial practitioner to have access to clinical and research information (Barlow & Durand, 2005:86). O'Shea (2003:1) explains that in order to recognise factitious disorder successfully, mental health professionals need to be familiar with its general features, the breadth of presentation, have a high index of suspicion, and have knowledge of the literature on this disorder. The researcher is of the opinion that social workers need to be able to identify and name factitious disorder, which will enable them to access literature and research on assessment and treatment approaches.

#### **4.3.2 Theme 2: Occurrence of clients with factitious symptoms in social work practice.**

After explaining the presentation and identifying criteria of factitious disorder as described in section 2.6, as well as the DSM-IV criteria as described in section 2.7.2. to the participants, the researcher asked the participants to reflect back on their years in practice and identify clients that demonstrated signs and symptoms of factitious disorder. Three categories emerged: Social workers who have never suspected factitious behaviour in a client; Social workers who can identify possible factitious

behaviour by a client, but feel reluctant to do so; Social workers who can identify factitious behaviour in multiple clients.

**4.3.2.1 Category 1: Social workers who have never suspected factitious behaviour by a client.**

Five participants reported that they had never come across clients where they suspected factitious behaviour.

Participant 2	<i>'I think because people have to pay for it, I do not think I have had clients like this.'</i>
Participant 6	<i>'I did not have... In all my years, I think it is because all our intervention was solution based and short.'</i>
Participant 15	<i>'Never, not even in psychiatry where I am now.'</i>

This finding could indicate that there are social workers that have not encountered clients with factitious behaviour in their practice. However, O'Shea (2007:61) states that practitioners that do not have knowledge about factitious disorder's general features, breadth of presentation, and a high index of suspicion are unlikely to identify factitious behaviour. From the findings of theme 1 categories 1 and 2, the majority of participants of this research study showed a lack of knowledge of factitious disorder. Fliege et al. (2007:61) states that research into the prevalence of factitious disorder is most often done through retrospective analysis, as is the case in this study. The researcher is of the opinion that due to the participants lack of knowledge on factitious disorder the accuracy of a retrospective case study analysis in determining the prevalence of factitious disorder in social work is limited, because having a 'high index of suspicion' is an element in the recognition of factitious symptoms that cannot easily be applied retrospectively, as the practitioner cannot retrospectively test their hypothesis or get additional information from the client to confirm or rule out the

disorder. The researcher is of the opinion that research attempting to determine the prevalence of factitious disorder in social work will have to address the lack of knowledge of the disorder in the research design.

**4.3.2.2 Category 2: Social workers who can identify possible fabrication of symptoms in a client, but feel reluctant to do so.**

Two participants reported that they could identify clients where they suspected factitious behaviour, but they could not confirm with certainty that these clients were fabricating their symptoms.

Participant 4	<i>'That's difficult to say, I don't know if they were lying ... I am specifically thinking of one client, I wonder if she was not doing this.'</i>
Participant 5	<i>'When I think back to clients that could be this, I am hesitant to say they were because I can't prove it'</i>

This finding is in line with literature that explain that practitioners can experience personal difficulty when confronted with clients who falsify, lie or fabricate symptoms (Othmer et al., 2002). Practitioners sometimes suspect certain things of a client, but find it difficult to accept their own suspicion, and have a tendency to deny such socially scorned behaviour, possibly because they are trained to be understanding, nonjudgmental and empathic towards their client's pathology (Othmer et al., 2002:315). In social work practice, acceptance of the client and having a nonjudgmental attitude are core values that are strongly instilled (Potgieter, 1998:43). The researcher is of the opinion that social workers can find it difficult to identify and acknowledge their client's deceptive behaviour, and that by not having a 'high index of suspicion' as described by O'Shea (2007), clients' factitious behaviour can remain unchallenged.

#### 4.3.2.3 Category 3: Social workers who can identify fabrication of symptoms in multiple clients.

Six participants reported that they have encountered clients that exhibited factitious disorder signs and symptoms on more than one occasion.

Participant 11	<i>'I have noticed a few, but cannot say a lot.'</i>
Participant 14	<i>'Definitely. I especially saw it with teenage girls when I was doing statutory work...'</i>
Participant 1	<i>'Hmm, I think I have had such clients.'</i>

This finding supports literature that factitious disorder is a relevant disorder in social work practice (Parrish & Perman, 2004). The accounts in literature of social workers working with clients with factitious disorder are usually anecdotal, based on case studies, or from a medical perspective where the social worker was part of a treatment team. As stated in 4.3.2.1, the researcher acknowledges that due to the participants lack of knowledge on factitious disorder prior to the research interview, the accuracy of a retrospective case study analysis in determining the prevalence of factitious disorder in social work is limited. The researcher is of the opinion that scientific research is needed to determine the true prevalence of factitious disorder in social work, in order to clearly demonstrate the extent to which social workers are exposed to clients with this disorder.

#### 4.3.3 Theme 3: Presentation of factitious disorder in social work practice.

The participants were asked to describe the cases where they felt clients exhibited signs and symptoms of factitious disorder. The participants' response to this question did not stay within the DSM-IV or ICD diagnostic criteria of physical or psychological signs and symptoms. As previously discussed in 2.7.5, because of the exploratory nature of this research as well as the use of the biopsychosocial model, the researcher has chosen to include a broader scope of factitious behaviour, and has

included participants' reports of fabricated events. Three categories in the presentation of factitious disorder and factitious events emerged, namely: Fabrication of symptoms by children and adolescents in foster care; Factitious accounts of rape; Factitious accounts of problems in personal and family functioning.

#### 4.3.3.1 Category 1: Fabrication of symptoms by children and adolescents in foster care.

Three participants reported that they had encountered children or adolescents in foster care that exhibited signs and symptoms of factitious disorder or the fabrication of events.

Participant 3	<i>'...adolescent clients at the children's home where I worked, that went through pretty serious trauma and would present with a lot of things, and often you don't know how much of it is real and true and how much of it is made up, possibly to get attention. Especially in the children's home set-up they are all looking for attention and it is one way to get it, by saying "I am seeing things" or "I am hearing things", which is not necessarily the case, especially where there was a lot of trauma and pathology you get this.'</i>
Participant 5	<i>'I am thinking about a girl where the parents were going through a divorce and she was put in a place of safety. She was always playing for time to get attention, and claiming to have a pain here or there.'...[another case] where the child said he used drugs but in the end he hadn't, it was to get attention – again also from a broken family... also a child that was placed in foster care. '</i>
Participant 14	<i>'I especially saw it with adolescent girls when I was doing statutory work, especially between age 14 and 17. One specific case, a 16 year old girl, we repeatedly took her to Weskoppies and she was diagnosed</i>

<p><i>with bipolar mood disorder, but she always told stories about trauma that happened in the house but when we follow up there wouldn't be proof, or she would contradict herself. She made up stories about being raped, then we would take her to hospital for a medical exam and then the doctor would say that she was not raped.'</i></p>
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This finding supports literature that there is a link between children and adolescents fabricating symptoms and their experience of general emotional neglect and significant family stressors, for instance the loss of a parent from the support system, the lack of parental involvement, disturbed family relationships, family violence, divorce, abuse, and early medical exposure (Libow, 2000; Stutts & Hickson, 1999). The researcher is of the opinion that children and adolescents in foster care often experience these emotional stressors, and are at risk for developing factitious disorder. The researcher is not aware of research on factitious disorder aimed at this specific vulnerable population.

Libow (2000:1) found that there is very little awareness in the medical professions that children and adolescents can falsify illness symptoms, and reports that a significant proportion of reported adult factitious disorder cases started in childhood but were not identified. A dilemma in diagnosing factitious disorder in children and adolescents is that illness, whether real or fabricated, most often result in secondary gain such as missing school, making it more difficult to differentiate factitious disorder from malingering (Libow, 2000:4; Stutts & Hickson, 1999:3).

The recommended treatment approach for children and adolescents with factitious disorder is psychotherapy with the involvement of a multidisciplinary team, which could include the primary physician that continues medical care, a mental health

practitioner, and a social worker if there is evidence of social stressors (Libow, 2000:6; Stutts & Hickson, 1999:6). Children seem to respond better to therapeutic confrontation than adults, with reports indicating that half of children with factitious disorder were able to acknowledge and desist the fabricated symptoms when confronted (Stutts & Hickson, 1999:5). The researcher agrees with Stutts and Hickson (1999:5) that early detection and appropriate treatment could lessen the long term severity and chronicity of this disorder. The researcher is of the opinion that social workers working with children, either as part of child protection services, in the foster care system, in children's homes or in therapeutic practice, are in a position to identify children with factitious behaviour and initiate appropriate treatment plans.

#### 4.3.3.2 Category 2: Factitious accounts of rape.

Three participants reported that they had encountered clients that fabricated accounts of rape.

Participant 14	<i>'The girls make you feel terrible, there are tears, they explain the rape in the scariest detail, then you go for the medical exam and the doctor says there is nothing. Then it is really...I mean, we as social workers are not stupid, I have seen a lot, then it is someone you really believed, you were ready to open a case then you find there is nothing.'</i>
Participant 10	<i>'If I remember correctly, she started with everything that happened to her, it was a rape, and just as you were getting over the gruesome rape, then she would add something else to make it worse – it left me in a place where I thought can this many things happen to one person? In the end I found out none of it was true.'</i>
Participant 15	<i>'She phoned me one night and said she was raped, I was hysterical, I immediately phoned the doctor at the crisis centre and asked her to see this lady. She was very professional, when I asked her how it went</i>

	<i>she said 'This woman was not raped', I told her that makes it worse, because who makes something like this up?'</i>
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This finding supports literature on the occurrence and presentation of factitious rape (Feldman & Ford, 1994; Dohn, 1986). Incidence of factitious accounts of rape have been reported as early as 1926 (Dohn, 1986:230). Factitious behaviour usually present with clients seeking to be in the 'patient' role, but some seek be in the 'victim' role instead, possibly motivated by a search for nurturance, earlier experiences of trauma, projection of anger onto specific targets, or the need to be rescued from real and current abuse (Feldman & Ford, 1994:2,3). It is believed that the incidence of rape could be more prevalent than statistics indicate as many cases go unreported, and the existence of factitious rape creates an added complication for medical and psychosocial professionals supporting victims of this violent crime (Feldman & Ford, 1994:1).

Some experts advise practitioners to develop an index of clinical suspicion in clients presenting as victims of rape (Dohn, 1986:230), however Feldman and Ford (1994:6) emphasizes that factitious rape is an unusual phenomenon that should not delegitimize valid reports, and that all allegations of rape need to be pursued, even in persons with a history of fabrication. False claims of rape can have devastating consequences on the life of the reported perpetrator as well as on the families of all involved. The researcher is of the opinion that social workers need to be aware of the possibility of factitious rape to avoid inadvertently participating in the victimisation of innocently accused persons. The researcher is not aware of current research or clear guidelines for social work practice on the presentation of factitious rape.

#### 4.3.3.3 Category 3: Factitious accounts of problems in personal and family functioning.

Six participants reported accounts where they suspected the client was fabricating problems in personal or family functioning in order to get the attention of the social worker.

Participant 14	<i>' You get people that are almost addicted to [the social work system] and it is a form of emotional stimulation – not that they necessarily have a physical or psychological disorder, but that they are always coming with a problem, my husband and I had a fight, or I need a food parcel... some people just come to the office too many times, actually, you probably can't say it, but it is impossible to have that many issues'</i>
Participant 5	<i>'...where the child said that he was using drugs but in the end he never used drugs, it was to get attention.'</i>
Participant 11	<i>'I saw that the granny had many holes in her story, and that she would lie and make up things. Why would she do that? She would even lie about things I said'...'the magistrate also picked up on that the old woman was lying about things she did not need to lie about'...'She then wanted that attention, she would come, it was time consuming and traumatic, she would go straight to my office because she needs priority attention.'</i>

The respondents' report of clients presenting with factitious accounts of personal or family dysfunction corresponds with literature that proposes that factitious disorder is not limited to the fabrication of physical or psychological signs and symptoms (see 2.7.4), but that persons with factitious disorder can also present themselves as victims of various circumstances (Othmer et al., 2002:416).

The criteria in the DSM or ICD are used for the clinical diagnosis of factitious disorder, and is limited to the fabrication of physical or psychological signs and symptoms (see 2.7.1 and 2.7.2). Factitious disorder with 'psychological signs and symptoms' was only recognised in the DSM after extensive case reports and research by mental health practitioners. The researcher finds it significant that six participants identified cases in which clients would repeatedly fabricate events, placing themselves in a victim role, with the only apparent gain being the attention of the social worker. The researcher is of the opinion that the manner in which factitious behaviour presents in social work practice could be an area for research, as it could be different to the way it presents in medical or psychiatric settings.

#### 4.3.4 Theme 4: Social workers' experience of factitious behaviour.

The participants were asked to describe how they felt when they suspected that a client's story might be a fabrication, and how they felt when they discovered that the client's story was indeed a fabrication.

##### 4.3.4.1 Category 1: The uncertainty of knowing when a person is fabricating a story.

Six participants reported that it was challenging when they had some suspicion that the client was fabricating something, but they did not have proof.

Participant 1	<i>'I have come across people where I wonder if they are just making this story up.'... 'How do I prove someone is not telling the truth...'</i>
Participant 16	<i>'It is sometimes difficult to become aware of lying during the interview, but when I sit and write the report afterwards and I recap, then I will wonder.'</i>
Participant 3	<i>'often you don't know how much of it is real and true and how much of it is made up.'</i>

This finding supports literature that practitioners find it difficult to determine with certainty when a client is fabricating symptoms (Fliege et al., 2007; Othmer et al., 2002). Fliege et al. (2007:62) found that hospital physicians rated only 50% of the factitious disorder cases they identified as diagnosed with certainty, and private practice physicians rated only 36% as diagnosed with certainty. Othmer et al. (2002:397) explains that practitioners face a dilemma: clinical interviewing requires them to use empathy, but in clients with factitious disorder the use of attention, empathy and support stimulates the client to exploit the interviewer's understanding attitude, and to continue their deceit. The researcher is of the opinion that social workers do not expect deceit from their clients, and are not trained or prepared in how to react to a situation where they suspect a client is fabricating symptoms or stories about events.

Othmer et al. (2002) focuses on the difficulty of detecting deceit. They state that clients that show deceptive behaviour display two affects, the suppressed true one and the emphasized false one, and that a double message sometimes emerges if a person's planned response differs from their spontaneous response which does not fit with their fabricated story. The detection of deceit and confirmation of fabrication of symptoms is further discussed in the emergent theme 'Evidence of fabrication needs to be obtained if factitious disorder is suspected'.

#### **4.3.4.2 Category 2: Giving the client the benefit of the doubt if fabrication is suspected.**

Three participants explained that even if they suspected that their client was fabricating signs, symptoms or events, they would not challenge it but rather gave the client the benefit of the doubt if the fabrication was not clearly evident.

Participant 11	<i>'As a social worker you always give the benefit of the doubt, but you also need to look for underlying factors.'</i>
Participant 10	<i>'I was taught you always give the client the benefit of the doubt.'</i>
Participant 5	<i>'When I think back on the clients that could have been factitious I am hesitant to say that they were, because I cannot prove it. That is where I am very factual in those areas, unless I can definitely see it.'</i>

This finding of social workers giving the client 'the benefit of the doubt', is contrary to literature on best practice, which indicate that clients with factitious disorder who are not found out can feel compelled to escalate their fabrication, possibly to the point of endangering themselves and others (Othmer et al., 2002). The practitioner can become a victim to the client's lies, and inadvertently become an enabler of their pathological behaviour (Othmer et al., 2002:391). The researcher is of the opinion that in the case of clients with factitious disorder giving the 'benefit of the doubt' is not necessarily in their or their family's best interest.

#### **4.3.4.3 Category 3: Initial emotional reaction to discovery of the client's deception.**

Three participants that have had clients that were confirmed to have fabricated symptoms report initially feeling angry, disappointed and upset at their client, but that these feelings were tempered with a sense of understanding.

Participant 14	<i>'I feel sad for the person, very sad'... 'When I just started working there were many times that I was angry but the older you get and the more you work the more understanding you get, but especially in the beginning when you start doing cases and something took so much time then you are angry for a brief moment but I have never been that angry that – there is always that little bit of understanding, there is a reason that this person [did this].'</i>
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Participant 10	<i>'Do you know, I was angry, I was angry, I was disappointed, but on the other hand I had understanding, this is part of the pathology. A part of it was intentional but the motivation behind it, the underlying problem I realised is more than just normal manipulation. It made me feel powerless and betrayed.'</i>
Participant 3	<i>'When you expect it the least it hits you the hardest and upsets you the most ....'if it is that important for them to tell that untruth, it might be their reality that you need to accommodate to some degree'</i>

This finding concurs with literature on psychosocial and medical professionals' negative transference experienced when working with clients with factitious disorder (McCullumsmith & Ford, 2011; Quest & Hyler, 1980). The practitioner can experience transference as feelings of being upset, angry, disappointed and betrayed when discovering the client's deceit or fabrication (Quest & Hyler, 1980:411). These feelings can escalate to experiencing aversion, fear, despair, and even malice, resulting in clients being treated with a mixture of bemusement, bewilderment, contempt, and anger (Quest & Hyler, 1980:412). Psychosocial and medical professionals are trained to treat a client's presumed valid symptoms and are not trained as forensic lie detectors, and can feel humiliated, frustrated and angry when deceit is confirmed (McCullumsmith & Ford, 2011:624). Huffman and Stern (2003:362) warn that the client's ability to humiliate the practitioner can lead to anger and punitive confrontation, which can result in errors in treatment. Much of the literature on factitious disorder includes the strong transference experienced by psychosocial and medical professionals working with clients with factitious behaviour. The researcher is of the opinion that social workers need information about the potential transference feelings that can be evoked when working with clients with factitious behaviour, in

order to discuss such feelings in supervision, and to avoid potential unethical conduct towards these clients.

The participants were able to identify and admit their initial emotional reactions, and also identified a second reaction – that of empathic understanding. Empathy is a core skill in social work, and can be described as grasping the meaning of what the client is saying, going beyond the obvious feelings to the more subtle experiences, while remaining detached enough to not become overwhelmed by what the client is experiencing (Potgieter, 1998:103). The researcher is of the opinion that participants' experience of empathic understanding following their initial emotional reaction demonstrates how social work's core values and skills have a protective function for clients, and future research on social workers' approach to clients with factitious behaviour could contribute to the knowledge on best practice in treatment of clients with factitious disorder.

#### **4.3.5 Theme 5: Social workers' approach to clients with suspected factitious disorder.**

Participants were asked what they would do if they suspected that a client had factitious disorder. Four categories emerged: Evidence of fabrication needs to be obtained if factitious disorder is suspected; Confronting the client about the factitious behaviour; Careful consideration whether it will be in the client's best interest to use a confrontational approach; Referral to a psychiatrist and therapeutic intervention.

##### **4.3.5.1 Category 1: Evidence of fabrication needs to be obtained if factitious disorder is suspected.**

Five participants reported that it was important to them to be sure of the facts, and have evidence of the client's fabrication before addressing it.

Participant 1	<i>'After a while when I have enough evidence I would corner the person.'</i>
Participant 12	<i>'I think sometimes in our practice we have a sense that the client is lying but depending on where you are in the helping relationship and on what evidence you have, you can confront the client.'</i>
Participant 10	<i>'I would keep it in the back of my mind that maybe it is this pathology, and make very sure that I do the diagnosis correctly, and ask for permission to check out the facts, that which they presented to you, I think it's important but that we sometimes tend to avoid it.'</i>

This finding supports literature on the importance of verifying suspected factitious behaviour (Bass & Gill, 2009; Othmer et al., 2002). The challenge psychosocial and medical professionals face is how to prove or disprove suspected fabrication of physical or psychological signs and symptoms or factitious events. The recommended approach to the suspicion of factitious behaviour in hospital settings is to talk to the client about the possibility of factitious behaviour, and request permission to search their room for evidence of fabrication (Bass & Gill, 2009:1053). Othmer et al. (2002:316) suggests that if factitious behaviour is suspected, the starting point should be to use interviewing techniques that combine empathy and the wish to help with a toughness and willingness to identify and detect deceit. Kadushin and Kadushin (1997:3) describes interviewing as the most important and most frequently used skill in social work, and states that social workers can adjust their interview style and method according to the purpose of the interview, including the use of specialised interview schedules.

Kadushin and Kadushin (1997:19) states that it is important to remember that information gained from an interview is the client's subjective experience, and that interviewing is not the only way to get information, that it can be combined with other

strategies such as direct observation of family functioning, reading documents and reports from other agencies, as well as requesting medical and psychological reports. Coid and Yang (2006:430) report that collateral information from clients' family and friends can be helpful when formulating a psychiatric assessment, but sometimes this information is of a poor standard and should be evaluated in context. The researcher is of the opinion that if a social worker suspects that a client is fabricating symptoms or stories they need to actively employ various methods to either confirm or dispel the possibility of factitious disorder, because the behaviour can escalate and endanger the client and their children in the case of factitious disorder by proxy.

#### 4.3.5.2 Category 2: Confronting the client about the factitious behaviour.

Nine participants reported that they would confront the client about the factitious behaviour, but emphasized that therapeutic confrontation should be done gently, respectfully, and in a tactful manner.

Participant 7	<i>'I would confront it. I am not someone that shy away from things like this, I would aim to get to the root of the problem in a tactful way.'</i>
Participant 9	<i>'I think it is needed to identify the lying, to sit someone down and tell them that you think they are not telling the truth, not to disrespect the person. Confront them in a way that will not damage them, but that they understand the consequences of lying and the importance of coming out and telling the truth.'</i>
Participant 10	<i>'...in a subtle but direct manner tell the client that what we are seeing here is a symptom of something else, this is the feeling I get, and this is my suggestion for the way forward...'</i>

This finding with the participants' emphasis on the gentle and respectful manner in which therapeutic confrontation should be made, concurs with literature (Catalina,

Ugarte & Moreno, 2009; Kay & Tasman, 2006). Kay and Tasman (2006:682) state that confrontation can be an effective approach to factitious disorder, but that it needs to be non-punitive and supportive. Catalina et al. (2009:39) note that confrontation in cases of factitious disorder have been criticized because it usually results in the client rejecting further therapeutic intervention, but suggests that this is only the case when confrontation is done aggressively, and that non-punitive confrontation where the client's behaviour is reframed as a request for help, favours adherence to further therapeutic intervention. Because of the limited amount of research on this disorder, there is no definitive data on the efficacy of different treatment approaches. The researcher is of the opinion that there is a need for research on the effectiveness of intervention methods so that practitioners can make informed decisions on which intervention approach to use.

#### 4.3.5.3 Category 3: Careful consideration whether it will be in the client's best interest to use a confrontational approach.

Four participants reported that it is important to assess the client's situation and the strength of the therapeutic relationship before deciding to use confrontation – as it might result in alienating the client and thus not be therapeutically beneficial in the long run.

Participant 3	<i>'I think you have to maintain a balance...if it is that important for them to tell that untruth it might be their reality which you have to accommodate to an extent, so it's a very fine line when do you confront and when do allow the person'...'I do not think you can really confront until there is a therapeutic relationship. The patient has to feel safe enough with you...'</i>
Participant 11	<i>'You got to maintain a line, how far do you challenge your client and say they are lying and then you can lose them as a client, and you lose</i>

	<i>the relationship with them and the family.'... 'Where do you draw the line with what is effective challenge and what is not useful, especially with lying it can be difficult.'</i>
Participant 12	<i>'I think sometimes in our practice we have a sense that the client is lying but depending on where you are in the helping relationship and on what evidence you have, you can confront the client. But if you have nothing and it is still early days in the relationship then you have to tread carefully and use empathy. It depends on where you are in the relationship, whether you are at the point where you can confront them.'</i>

This finding supports literature on the problem with using confrontation as an intervention approach to factitious disorder (Bass & Gill, 2009; Wang et al., 2005). Practitioners face a dilemma when choosing to confront a client with their factitious behaviour, as clients often terminate all contact with the practitioner and the institution where they were confronted, and continue with their factitious behaviour with a different practitioner (Bass & Gill, 2009:1053). Moore (1995:824) confirms that social workers can reduce the client's emotional needs by building a nonthreatening and supportive therapeutic relationship, but states that they face a paradox when trying to establish a therapeutic relationship with a client whose symptoms are based on deception and manipulation, and who actively use anger and rejection to challenge the practitioner's feeling of competence.

A case study by Wedel (1971) suggests that in institutional settings where social workers are part of a multidisciplinary team, they can build a supportive relationship with the client before the team confronts them about the fabricated symptoms. During the confrontation the social worker has a supportive role, demonstrating

acceptance and commitment. The hope is that the client will remain in long term treatment with the social worker. The researcher is not aware of research that can demonstrate that establishing a therapeutic relationship prior to confrontation would have an impact on the client's adherence to further treatment or absconsion. If a practitioner feels that confrontation would not benefit a specific client, there are alternative treatment approaches like the therapeutic double-bind or using inexact interpretations (Bass & Gill, 2009:1053; Kay & Tasman, 2006:682; Wang et al., 2005:1841).

#### 4.3.5.4 Category 4: Referral to a psychiatrist and therapeutic intervention.

Four participants reported that they would refer the client to a psychiatrist for a formal diagnosis, and feel long term therapy is appropriate. Participants indicated that for long term intervention for clients with factitious disorder they would prefer to work as part of a multidisciplinary team that included a psychiatrist .

Participant 14	<i>'I would refer the client for long term therapy. If it is so severe that I think there is an added psychological disorder, like schizophrenia or something like that, I would refer to a psychiatrist.'</i>
Participant 7	<i>'I would be reluctant to make a diagnosis with a patient, I would refer them to a psychiatrist to make a formal diagnosis.'</i>
Participant 10	<i>'I would not want to address something like this alone, I think you need a multi-professional team, I would definitely want a psychiatrist's opinion...!...'I would work with the psychiatrist, we can have panel discussions and include other professionals also.'</i>

This finding supports literature that the assessment and treatment of clients with factitious disorder should be done by a multidisciplinary team of psychosocial and medical professionals, which includes a psychiatrist (Bass & Gill, 2009; O'Shea, 2002).

Bass and Gill (2009:1053) states that a multidisciplinary team is needed to develop the practical treatment guidelines for a client with factitious disorder, and that it is beneficial to have a psychiatrist as part of the team to help members understand the mechanisms underlying the factitious behaviour as well as helping the members to identify and cope with negative feelings evoked by the client. O'Shea (2002:37) states that practitioners need to acknowledge their vulnerability and the danger of manipulation by clients with factitious disorder, and seek a therapeutic alliance with another practitioner in order to work through negative countertransference. He further suggests that in cases of physical symptoms the psychosocial professional should work in collaboration with the referring medical professional (O'Shea, 2002:37). Kay and Tasman (2006:683) suggest that there should be a coordinated effort amongst a team of psychosocial and medical professionals that support one another in the long term psychotherapy treatment of a client with factitious disorder.

The researcher has found that the majority of research on treatment of factitious disorder were done in hospital settings and focussed on factitious disorder with physical signs and symptoms, which necessitates medical intervention. The researcher is of the opinion that there is a need for research and literature on the treatment of factitious disorder with psychological signs and symptoms, as well as guidelines on treatment approaches in a social work agency or in a private practice setting.

#### **4.4 Summary**

In this chapter the researcher reported on the participant profile as well as the data analysis findings. The themes and emergent categories of description were organised in a data analysis framework, and each category of description was discussed in detail with example quotations and integration of the relevant literature.

This was used to develop the conclusions and recommendations that will be presented in chapter five.

## CHAPTER FIVE

### CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 Introduction

In this final chapter the researcher will discuss the conclusions drawn from the research findings, and make recommendations for education and training, and for further research.

#### 5.2 Conclusions

This research has exploratory objectives in order to gain insight into a phenomenon that had not yet been described in social work literature, namely social work practitioners' knowledge, experience and approach to factitious disorder. The conclusions that have been drawn from the research findings will be organised according to the research objectives.

##### 5.2.1 Objective 1: To explore social workers' knowledge of factitious disorder

- It was found that participants were not familiar with the term 'factitious disorder', and could not recall learning about it during their social work training.
- It was found that participants were not familiar with the term 'factitious disorder by proxy', even though it is a serious form of child abuse and half of the participants had experience working in child protection services.
- It was found that a small number of participants had heard the term 'Munchausen by proxy', and could describe falsification and seeking the sick role as features of this disorder.
- It was found that a small number of participants confused Munchausen syndrome with somatoform disorders.

- The findings could indicate that in order to have access to literature about a disorder, practitioners need to be able to identify and name it.

#### **5.2.2 Objective 2: To investigate the prevalence of factitious disorder in social work practice**

- It was found that half of the participants thought they could retrospectively identify clients with factitious behaviour, suggesting a possibility that social workers could encounter clients with factitious disorder in practice.
- It was found that participants' lack of knowledge about factitious disorder could have influenced their ability to correctly identify clients with symptoms of the disorder retrospectively.
- The researcher notes that this research cannot comment on the prevalence of factitious disorder in social work in South Africa, because of the small sample size, and the reliance on a retrospective analysis alone.

#### **5.2.3 Objective 3: To investigate how the phenomenon of factitious disorder presents in social work practice**

- It was found that some participants thought that they had encountered factitious behaviour and factitious disorder symptoms in children and adolescents in foster care.
- The researcher found that literature on the presentation of factitious disorder in children and adolescents was limited, and that there was a lack of focus on children and adolescents with factitious disorder symptoms in foster care.
- It was found that some participants thought that they had encountered clients with fabricated accounts of rape.

- The researcher found that literature did not provide clear guidelines for practitioners on how to approach and work with clients where they suspect fabricated accounts of rape.
- It was found that some participants thought that they had encountered clients that presented with fabricated events, portraying themselves in a victim role, with the only apparent gain being the attention of the social worker. The researcher is of the opinion that there is a possibility that clients could present with factitious behaviour differently in a social work setting than they would present in a medical or psychiatric setting.

#### **5.2.4 Objective 4: To examine social workers' experience of factitious disorder in practice**

- It was found that participants thought that they struggle to determine with certainty when a client is being deceptive.
- It was found that some participants thought that they preferred to give a client 'the benefit of the doubt' if they suspected deception, and did not attempt to prove or disprove the client's deception.
- It was found that participants thought they experienced feelings of anger, disappointment and betrayal when a client's fabrication or deception was discovered.
- It was found that participants' thought their initial negative feelings were tempered with feelings of empathy and understanding towards the client.

### 5.2.5 Objective 5: To examine how social workers approach the assessment and treatment of factitious disorder

- The findings indicate that participants thought they would need proof of fabrication or deception before confronting a client about factitious behaviour.
- It was found that participants thought they would use a gentle therapeutic confrontational approach towards a client if they were convinced that the client was being deceptive.
- It was found that participants thought they would first assess the situation to see if confronting the client about their factitious behaviour at that time would be in the best interest of the client.
- It was found that participants were aware that confronting a client about their factitious behaviour could result in the client terminating contact with the social worker.
- It was found that some participants thought that they would first build a relationship of trust with the client before confronting them about their factitious behaviour.
- It was found that participants thought that they would refer a client to a psychiatrist for a formal diagnosis if they suspected factitious disorder.
- It was found that participants thought that clients with factitious disorder would require long term psychotherapy.
- It was found that participants would prefer to treat a client with factitious disorder with the support of a multidisciplinary team.

### **5.3 Recommendations**

From the research findings the researcher has made the following recommendations to universities training students in social work, to service providers of continuing professional development for social work, to social work agencies, and to further research relating to factitious disorder.

#### **5.3.1 Universities training students in social work**

- Social workers are sometimes the only mental health workers available at grass roots level in a community, and should be able to inform and refer clients for appropriate mental health treatment. Basic training for social workers need to include the recognition of mental health disorders as described in the DSM or ICD, which includes factitious disorder.
- Training on factitious disorder should include theory about the aetiology of the disorder, the different ways it can present in social work practice, the different treatment approaches and referral options.
- Training on factitious disorder should include awareness of the negative feelings these clients often evoke in practitioners, and how to understand and manage these feelings in order to treat clients in an ethically sound manner.
- Social workers could benefit from training in how to react in situations where they have a high level of suspicion that the client is being deceitful or fabricating symptoms.
- Social workers could benefit from training in the use of interviewing techniques that are designed to help the practitioner detect or confirm deceit.

#### **5.3.2 Service providers of continuing professional development for social work**

- Training should include sessions on basic mental health disorders, which includes factitious disorder.

- Training should address the current lack of knowledge about factitious disorder in social work practice.
- Training should include sessions on changes and amendments in the DSM, in order to keep social workers up to date and able to participate in a multidisciplinary team.
- Social workers should be trained in the awareness of fabrication, deceit and on having a high index of suspicion.
- Social workers should be trained on the use of specialised interviewing techniques that can assist them in determining if a client is being deceitful.
- Social workers in child and family services should be trained in recognising and addressing factitious disorder by proxy (originally called 'Munchausen by proxy' in the DSM-III and now renamed 'factitious disorder imposed on another' in the DSM-5), as it is potentially a life threatening form of child abuse.

### **5.3.3 Social work agencies**

- Social work agencies should establish guidelines and protocols for social workers on how to approach and evaluate clients where they suspect factitious behaviour.
- Social work agencies should establish guidelines and protocols for social workers on how to approach and evaluate clients where they suspect factitious disorder by proxy.
- Social work agencies should establish guidelines and protocols for social workers on how to approach and evaluate clients where they suspect factitious accounts of rape.

### 5.3.4 Research

- There is a need for research on the prevalence and presentation of factitious disorder by children and adolescents in foster care.
- There is a need for research on the prevalence and presentation of factitious rape.
- There is a need for research on the prevalence and presentation of factitious disorder with physical and psychological signs and symptoms in social work practice.
- There is a need for research on the prevalence and presentation of clients with factitious behaviour that does not fall into the categories of either physical or psychological signs and symptoms, where clients present to social workers with fabricated events with the apparent motivation of gaining the attention of the social worker.
- The researcher has noticed that the retrospective case study analysis method has been used frequently in research on the prevalence and presentation of factitious disorder. Social workers' lack of knowledge on factitious disorder makes it difficult for them to correctly identify cases of the disorder retrospectively. An alternative research approach would be to train social workers on the diagnostic criteria for factitious disorder, and then follow up on their experience with the disorder in practice at certain intervals in the future.

### 5.4 Summary

This research study explored social workers' knowledge, experience and approach to factitious disorder. The findings indicate that there currently is a lack of knowledge on this disorder in social work. Factitious disorder is a complex phenomenon, which can be difficult to identify, and challenging to manage. The literature indicates that a

lack of knowledge will negatively impact on the recognition and appropriate treatment of the disorder. The findings suggest that social workers could have encountered factitious disorder in various forms and in a variety of contexts. The researcher made recommendations to address the education, training as well as research needs in social work practice in relation to factitious disorder.

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## Appendix 1: Informed consent

The following information is verbally communicated with each participant:

- The researcher, Mari Oosthuysen, is a qualified social worker and a student at the University of Cape Town, Department of Social Development.
- This interview might be used as part of a research study for a mini-dissertation as fulfilment of part of an M. SocSc. Clinical Social Work degree.
- The supervisor for this study is Mr. Ronald Addinall, department of Social Development, UCT.
- Participation in this research is completely voluntary.
- The participant can choose to terminate the interview or withdraw from the research at any time.
- The participant is aware that the interview will be recorded.
- The participant participates in this research as an individual, and not as a representative of their place of work or any organisation or institution.
- The participant shall remain anonymous, and their identity will not be revealed in any form.
- The participant will have an opportunity after the interview to ask questions about any aspect relating to the research.
- The nature of this research relates to the knowledge and experience of social workers with regards to a specific disorder.
- If the participant so chooses, the researcher will forward them a copy of the completed research, and any articles that may arise from it.

The researcher confirms with the participant that they understood the points discussed, and gives an opportunity for questions relating to the study before the interview starts.

## Appendix 2: Interview schedule

1. Demographic information:
  - What is your age?
  - What qualification/s do you have?
  - When did you achieve this qualification/s?
  - Which university did you graduate from?
  - How long have you been practicing social work?
  - In what areas of social work have you practiced?
2. Social workers' knowledge of factitious disorder:
  - Have you heard of factitious disorder?  
(if 'no': Have you heard of Munchausen syndrome or Munchausen by proxy?)
  - How would you describe it?
  - Do you think it is different to malingering? How?
3. The prevalence of factitious disorder in social work:
  - Have you had clients that you suspected of fabricating events or symptoms for no obvious reason?
  - Have you had clients that you suspected of having FD?
  - Have you had clients that have been diagnosed with FD?
  - Have clients been referred to you for treatment of FD?
4. The presentation of factitious disorder in social work practice:
  - Why was the client seeing a social worker?
  - What were the social work issues the client was experiencing?
  - How did the client behave?
  - What did the client lie about?
5. Social workers' experience of factitious disorder in practice:

If we look at some of the cases that stand out for you...

  - At what point in the intervention process did you suspect the client was lying, or making up stories?
  - How did it make you feel to discover the client had been deceiving you?
6. Assessment and treatment of factitious disorder:
  - What did you do when you discovered that the client had been fabricating information?
  - Which diagnostic criteria do you use to assess a client with FD?
  - Do you share your hypothesis of FD with them?
  - Which treatment approaches would you use to treat clients with FD?