

The intersubjective and the factitious

Exploring Munchausen Syndrome

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Munchausen Syndrome (MS) is a disorder consisting of signs and symptoms of illness, which the medical professional, after much mistake, judges to be falsifications or imitations. MS is thus a factitious disease or pathomimesis. Asher who gave the condition its name wondered about 'the psychological kink' producing the disease. Since then, many have been striving for understanding. We asked ourselves what medical anthropology could do to help clarify the issues under consideration. What is at stake between the patient/sufferer/perpetrator and the doctor/caregiver/unwilling target? Who are these patients trying to be ill? From the history of the first Munchausen stories onwards, we explore a struggle behind the metonym, featuring misinterpretation, delusion, deception, manipulation, miscommunication, collusion, collusion, complicity and misconduct. Difficult to understand as MS may appear, the interplay involving sufferer and caregiver illustrates that illness narratives are intersubjective. The intersubjective space between doctor and patient is an arena for establishing rules on 'how sickness is to be played out'. MS is a reciprocal fabrication: patients and care providers define one another. Any attempt to study the truly factitious is fraught with difficulty but may be an opportunity to examine the intersubjective in the complexities of medicine.

[disease, deception, factitious disorder, Munchausen syndrome, intersubjectivity, illness narrative]

Medical anthropologists interested in the intersubjective of the medical arena will find in Munchausen Syndrome (MS) a script worthy of attention. One particular medical history, which prompted our interest in reviewing the factitious for intersubjective ambiguity, can be summarized thus:

A was a 25 year old female university student when admitted to hospital because of insulin-dependency and hypo- or hyperglycemias, *procuring constant attention* from *unsuspecting* physicians. Her diabetes and insulin administration was proven factitious

after several months only. From the age of 12 onward she had *modeled insulin-dependency* after the diabetic mother of her best friend. During childhood her family life was centered on family secrets. Controlled *hypoglycemia was experienced* by her as a means of reducing the strain. The *identity of being a diabetic child ensured compassion* which, however short-lived and superficial, *could not be obtained in any other way*. After unmasking by friends, the *pseudo-identity* fell apart. Borderline behavior took its place and she was convicted of arson. Again, in the penitential institution, her 'brittle diabetes' was unmanageable and she was referred to a psychiatric institution while remaining under judiciary custody. She faked hyperglycemias by tampering with the glucometer and *MS was diagnosed*. Her unique behavior helped the psychiatric caregivers to investigate the design of a factitious disorder as *a strategy matching a need for emotional expression, dependency and mastery* in posttraumatic stress (Oomen et al. 1999).

What is at stake in this case? In the vignette we *italicized* the aspects which we will amplify in the course of this paper. We will first discuss the construction of the factitious disorder in the medical literature, and then assess by what specific acts patients merit the categorization imposed on them. Next we review the antecedents, looking behind the name of an 18th century baron for a historical introduction to the discourse. The use of intersubjectivity in this paper refers to the interaction between the subjects most involved in the factitious design: the patient and the caregiver. We will discuss what the one is articulating in the other. To show intersubjectivity at work in the factitious, we investigate the predicaments of both parties, and their interplay, from a medical anthropological perspective. In the final part we try, as observers and participants, to envisage what one could achieve in medical anthropological fieldwork and research. Finally, by way of conclusion we offer some lines of thinking on the question, how medical anthropology may help clarify MS by contributing to the analysis of the intersubjective in the production of disease.

Questioning the factitious¹

In Western hospital settings, where MS is a diagnostic entity, the qualification indicates those patients presenting signs and symptoms of disease, which do not come about in any of the usual ways. The professionals, after much mistake, judge the signs and symptoms imitated or elicited by the patient him- or herself.² One common characteristic is that both patient and professional remain unshaken in their opinions and a fierce mental struggle between them ensues. The professional considers the fabricating itself the disorder, while the patient denies that. The refusal to meet the patient's demands results in angry reactions and a disturbance in the relationship: the patient walks out to turn to another caregiver and tries the same plot again. The arguments to qualify MS a medical disorder are the assumptions that (1) the suffering is real; (2) behind the factitious is not a conscious strategy; and (3) the consequent illness is disproportionate to any obvious advantage. In fact, in the original case descriptions there is no gain at all. MS hinges on the fact that the patients cannot accept disclosure,

whereas the doctors can only accept the patients after disclosure. Accepting disclosure *and* continuing the fabrication takes the patient's unintended factitious disorder into intended malingering:

Dozens of writers have referred to this seeming senselessness as the paradox of MS, and the motivations of patients are still considered unclear. Despite the supposed discomfort, these patients seem not at all discomfited. This paradoxical senselessness differentiates MS from sensible if dishonest malingering. MS is defined as a psychiatric and not a moral or legal category because the behavior of the person in question does not make sense and is therefore interpreted to be pathological. Whereas most diagnostic categories are based on what doctors know about their patients, MS is *constructed precisely by what doctors do not know about their patients*. Defining MS as a diagnostic category is part of what Kathryn Hunter (1991: 37) calls medicine's *flight to certainty*, doctors' on-going negotiation of the *fragility of their knowledge* (Amirault 1995: 173).

In a recent clinical review O'Shea (2003) concludes that the factitious, however baffling, has to be accepted by the caregivers without reproach. The disorder is due to a repressed need, finding no relief in more adaptive ways. In the preparation of the DSM-IV-TR³ one other aspect has been emphasized: the repressed need is assumed to be *to play the sick role*:

When symptoms are produced voluntarily but the only apparent goal is the adoption of the sick-role itself, the person is considered to have a factitious disorder (Kirmayer 1994: 194-195).

The question we will address later is, who wants to be sick and why?

The naming for Munchausen

Reviewing how the syndrome got to be named after the notorious baron von Münchhausen explains the historical context. Before MS entered psychiatry as a diagnostic entity, a well known generalist physician, Richard Asher (1951), coined the eponym:

Here is described a common syndrome which most doctors have seen, but about which little has been written. Like the famous Munchausen, the persons affected have always traveled widely and their stories, like those attributed to him,⁴ are both dramatic and untruthful. Accordingly the syndrome is respectfully dedicated to the baron, and named after him. The patient showing the syndrome is hospitalized with an apparent acute illness supported by a plausible and dramatic history. Usually his story is largely made up of falsehoods: he is found to have attended, and deceived, an astounding number of other hospitals; and he nearly always discharges himself against advice, after quarrelling violently with both doctors and nurses. A large number of abdominal scars is particularly characteristic of this condition. That is a general outline; and few doctors

can boast that they have never been hoodwinked by the condition. These patients waste an enormous amount of time and trouble in hospitals. If any correspondence follows this account, exposing other cases, perhaps some good will have been done. It would be even better if an explanation for the condition could be found, which might lead to a cure of the psychological kink which produces the disease.

This description highlights ‘the doctor being made a fool of’, transforming an out-of-the-ordinary interaction into medical parody. Ashers’s *cri de coeur* is memorable by the jest and the wink: “... if there is this medical syndrome, than it better be not known for me, but for that character Munchausen, familiar to the English child.” In addition, Asher later paraphrased a Churchill quote: “never in the history of medicine have so many been so annoyed by so few”. Therefore, the afterthought: “to be on the lookout for a specific psychological kink” has a false ring to it. We posit that *he* needed *this* description to contain *his* annoyance. Basically Asher sets out to help doctors to deal with the unpleasantness of being fooled by the self-induced signs and symptoms. So, we submit, Munchausen arose as an *entre nous* (doctor-to-doctor) joke to overcome anger by self-criticism, mixing both emotions in an extreme, entertaining and ornate typology, ‘name calling’ to mock the patients. Munchausen is an apt metonym for an extravagancy (Turner & Reid 2002). Discussing history, hysteria and psychiatric reasoning, Young calls the approach *a style of reasoning*:

... useful for describing how clinical knowledge is produced by a characteristically *self-authenticating* way of making facts, generating its own truth conditions, *self-vindicating*, adjusting to anomalies and to challenges to their authority (Young 2000: 158).

The next turn of the diagnostic signification in MS is accompanied by a shift of focus:

In 1976, Money & Werlwas described a case of dwarfism caused by starvation in which the parents presented misleading accounts of the child’s illness, suggesting an analogy (by proxy i.e. to act for another) with MS. The term MS by proxy (MSBP) received wider publicity when in 1977 Meadow reported two case studies with deliberate fabrication of bizarre symptoms. Many manifestations of MBSP are now recognized (Craft & Hall 2004).

Roy Meadow (1977), a pediatrician, became the second authority in the MS naming exercise by pointing out many hospitalizations of children due to deliberate harm done to them by Munchausen patients. Leaving the jest behind, the appellation now concentrates on the suffering and abuse which is incurred. This is a remarkable and unusual strategy for (Western) medicine because not the individual illness but the whole abusive situation is now the diagnostic feature. Our intention in this historical retrospective is to review the metonymic construction only and so we continue the design after Munchausen ‘*himself*’. Meadow characterized the patients as having “a history of falsifying their own medical records and treatment”, which, in his judg-

ment, entitled them to be diagnosed as 'Munchausens'. MBSP as a disorder was set apart by the Rosenberg-criteria:

1. Illness in a child (or other victim) that is simulated or produced by a parent or someone who is 'in charge'.
2. Presentation of the victim for medical assessment and care, usually persistently, often resulting in multiple medical procedures.
3. Denial of knowledge by the perpetrator as to the etiology of the victim's illness.
4. Acute medical symptoms in the victim (Rosenberg 1987: 547).

In our opinion, the amplification of the eponym leads to a completely different plot for the Munchausens. Instead of a joke between doctors, Meadow uses Asher's jest to deal with an unbelievably frustrating situation of serious harm, perpetrated to innocent and vulnerable dependents. The suffering and concealment in the 'by proxy' position of victims creates a nasty clinical confusion, turning indignant doctors into forensics. Since the 'by proxy' was added, the metonym Munchausen fuels vehement conflicts and the debates involve a widening circle of (para-)medical caregivers, victims, relatives, lawyers and advocacies, judiciaries, social and forensic workers, reporters, novelists and researchers (including medical anthropologists, such as Scheper-Hughes 2005). Unlike the benign, jocular MS, MSBP is an 'infamy' in the media causing a continuous stream of polemic publications. In the latest DSM Munchausen is still there, but now 'part of' the factitious disorders, sharing 'the voluntary production of disease for no apparent goal other than *to assume the patient role*', and so (partly!) disentangled from the by 'proxy' variant (O'Shea 2003; Folks & Houck 1993: 280). In the renaming exercise a most influential third personality, in line with Asher and Meadow, entered the arena. The psychiatrist Feldman (2004) takes the foreground to argue that MSBP is not a psychiatric diagnosis but a case of abuse. So, MSBP labels criminal acts but is unfortunately named after a medical disorder. Traces of diagnostic doubt remain, as MSBP is considered 'warranting further study' in an appendix of the latest DSM. Patient or perpetrator, the moving of MSBP from the medical to the criminal spheres reveals that the medical anthropologist is in the middle of a hotly contested arena in medicine.

... controversial because the establishment of diagnosis requires to deviate significantly from the traditional physician-patient relationship in order to determine a real disorder, the challenge becoming to distinguish between the actual and the feigned (Plewes & Fagan 1994: 623).

Recasting MS as factitious syndrome, we posit, made the diagnosis emotionally more acceptable to all parties, but we admit that another reason is the move away from eponym to descriptive terminology in psychiatry. We will not further explore the discourse on the conceptual distinctions. Neither do we attach value to the epidemiological reviews. In our perspective we aim to deal with a qualitative assessment. Until diagnostic consensus is achieved, quantification seems a waste of words (Pankratz 1994). Fisher (2006) offers a review of all English articles published in medical jour-

nals (from 1951 through 2000 numbering 576). To summarize, the baron's history in medical literature demonstrates the defining power of metonym in diagnosis. In the next Section, for a further demonstration how doctors wrestle with their 'professional' emotions – when confronted by acts outside what they experience as suitable in patient-doctor relations – we will add the intersubjective for an analysis of the performance character of MS.

The intersubjectivity of the factitious

Asher's reference to 'a plausible and dramatic history made up of falsehoods' takes Munchausen into the communicative clinical (i.e. 'at the bedside') interaction and brings storytelling by patients to caregivers, forcing caregivers to interpret that story. We think a clarification must concentrate on the formation of scientific opinion as "self-awareness in a reciprocal ability to understand another as oneself" (Jackson 1998: 10). Accordingly, the illness narratives are "politics of storytelling". "When life's misery is unsayable, life ought to be lived as a story, inventing a self as a coping strategy" (idem). For illustration Jackson (2002: 15) quotes Dennis Potter:

Speaking of his lifetime struggle with a hereditary skin disease (psoriatic arthropathy) that ossifies the joints, causes the body to lose control of its temperature, and induces hallucinations. When first afflicted by this illness, he thought: "The only way I can save my life is to invent my life. I hope I'm not being immodest, but I think there is a certain emotional power in my [artistic] work which I became aware of *later*. And I think that power is actually the result of the contest between my real self and my invented self. My invented self overcomes my illness... and keeps me sane.

Narratives need audiences. Jackson (2002: 21-25) supports Potter's autobiographical insight most emphatically:

Stories are neither the pure creations of autonomous individuals nor the unalloyed expressions of subjective views, but rather a result of ongoing dialogue and redaction within the fields of intersubjectivity, authored and authorized dialogically.

MS, we posit, is the effort of pathomimesis of the patient to lay a claim for a meaningful share of 'a life' in an intersubjective space created by the interaction which care provides, ensuring a means to establish 'a self', just as Potter's illness narratives are 'the key to his self'. Is this performance of storytelling also a *justifiable* way in medicine? We posit it is when the identity of a suffering person has no other means and opportunity, articulating the importance of care, attention, time, place and authority. The suffering self needs a face to be seen, a voice to be heard – a presence that *is*. The fact that the illness given in evidence is itself a delusion, to the self and to the other, is not an objection, by virtue of the fact that "for the desperate, *honesty* is... a psychological privilege one cannot afford" (Jackson 2002: 70). Munchausen offers

an autobiographical script for an encounter between patient and caregiver in a format which can have exceptional significance, being so much the patient's own elaborate design and so different from any of the usual ways of communication. As all social (medical, nursing, anthropological and sociological) researchers have emphasized again and again:

Life stories are interpretations of life, not descriptions of it. The storyteller 'selects' his or her own words, while being guided by the 'interpretative repertoires' functioning in his or her own social atmosphere. In such stories, therefore, life is constructed, not just personally, but also socially. The life stories are not assembled in order to trace the course of the informant's life, but to extract their own interpretations of it. Of concern, therefore, is not the validity but the authenticity of a story (Nijhof 1995: 59).

Narrative truth refers to the construction of a coherent story out of current experience and the events of a life. Its truth is measured by *an inner or intersubjective feeling* of emotional 'rightness' more than by any historical accuracy (Kirmayer 1994: 198).

Thus, we posit, Munchausen patients construe illness for a purpose we can choose to understand. The (para-)medical professional is justified to take the Munchausen narrative into proper account, even if, for diagnostic purposes, the story is 'improperly worded'. In clinical practice, we need admit, the '(im)property' is a euphemism in view of the contest for mutual understanding. Without doubt, the patient's delusion unbalances relationships and threatens the transparency, which is necessary for clinical diagnosis and treatment:

Many and diverse models for physician-patient communication in clinical practice are described in literature, but none of them seems adequate for solving the communication problem in clinical practice that emerges in case of factitious disorder (Van der Feltz-Cornelis 2002: 253).

The MS, in any modern psychiatric clinical book, remains a challenging problem and the profession is looking for solutions. Van Moffaert and Michielsen wrote:

Patients with factitious disorders desire only the psychological aspects of the patient-role (pathomimesis): the consequences, invalidity and isolation, are misjudged more often than not (1997: 70-77).

Munchausen authorities refer to the pathomimesis as a pathologic agent by itself, not only by fabricating disease, but also by initiating risky and unnecessary diagnostic-therapeutic procedures, which can result in irreversible damage and even death. Emphasizing the patient's compulsion does not promote relationships: that is not what the patient can agree with. In the stalemate we need reconsider the intersubjective expectations:

To borrow a Kuranko metaphor, if positive intersubjectivity is a clear path through open grassland, negative intersubjectivity is a tortuous and obscure path through a dark forest (Jackson 2002: 149).

A medical relationship – from the patient's point of view – means the provision of cure-care-consolation – and is paralleled by the doctor's view – of curing if possible, caring always and consoling when necessary. In such usual medical relationship, the illness is objectified and binds sufferer and caregiver together. In the particular MS context, the illness has a factitious⁵ purpose offered by the patient as a resourceful design. The moment the disorder is recognized for its strategy, intersubjectivity turns from positive into negative. We believe the very aim for the mutual delusion in MS is to construe professional care in medicine for sympathy (co-suffering). If the patient wants to satisfy a need for sympathy by having an improperly founded relationship with the medical professional, we can call that a self-delusion. We posit that the precise distinction between co-suffering relatives (e.g. partner, parent, child or friend) and the best of caring professionals is the distance between sympathy and empathy. The practicing physician is unlikely to find the capacity for empathy, when the disease (s)he is trying to cure is self-induced by the patient. In the matter of care and consolation too, depending on the physician's field of practice, even 'heartfelt' empathy tends to evaporate with hints that (s)he is part of a delusion.

Nevertheless, in MS we cannot legitimate the caregivers as victims of deception, because we assume, by the factitious nature of the disorder, that the patients are neither autonomous nor conscious performers. The assumption cannot prevent the turning of intersubjectivity from positive into negative, the caregiver's empathy into antipathy and the patient's identity, as the proposed suffering self, into a misidentification. Disclosure does not end the entanglement. Caregivers stumble on in the unwanted, contradictory roles of forensic, victim, bystander or perpetrator of pointless interventions. The patients do not get the healing satisfaction that is their aim any more. Mutual coercion and the opposite, disenchantment, splits them into quarreling parties, causing a painful stalemate:

The centrality of a perceived conflict between physicians and their patients in the narratives about MS is structuring the relationships of the clinical interaction; Munchausen casts [these] to established patterns and imposes on the experiences of all participants (Fisher 2006: 260).

The more explicit the patient seeks a manifestation for his or her 'my-self-in-suffering', the more the caregivers tend to manifest 'that-self-is-artificial' and the more violent the contest becomes. To make a comparison to the intersubjectivity of violence:

The logic of reciprocity governs relations – giving, receiving, repaying. These modalities of intersubjectivity imply modalities of power, but power not reduced to the possession of a position or thing, but understood existentially – as the possession of Being (Jackson 2002: 43, 138).

Comments on the trappings of delusion

To obtain a presence that *is*, the Munchausen narratives, as we have argued, are neither senseless nor irrational – if their deconstruction is grounded in the intersubjective interplay of the doctor-patient relationship. In MS doctors and patients define each other in a way unknown in any other disorder. Tuberculosis, cancer and psychosis will run its course with or without doctors being present, but MS cannot be a disorder in the absence of a caregiver. To see how the deconstruction works, we will now consider a selection of observations, trying an approach from the perspectives of the patient, the medical professional and the medical anthropologist. To be sure, the part the patient plays is certainly difficult to study:

The first step ... in approaching the problem is for either to realize that [patients, victims and caregivers] are equally trapped and generally suffering greatly (Rosenberg 1987: 548)

In his Munchausen portrayals, Feldman (2004 140) stimulated MS patient Wendy Scott to speak out:

“I never intended to make doctors look stupid. I just wanted to be in hospital”. One of her few pleasant experiences was having her appendix out when she was about 16. “A nurse would come in the morning and plump up the pillows and say ‘How are you today, Wendy?’” she recalled. “It was just little things like that, asking how was your pain, how was your night.” It seemed to her that no one in the world cared about her. One day, she made believe she had a stomachache and went to the nearest hospital. “I thought, somebody will care”, she said. She spent several days there being tended to. “It recharged my batteries”, she said. Over the next year or so, she tried the tactic a few more times, at different hospitals. It worked, and soon she was spending all her time hitchhiking from town to town, trying to get into the hospital. “I didn’t have friends”, she said. “I didn’t want anybody. If I had friends, they might find out what I was doing.” Eventually, doctors began suggesting exploratory operations to find out what was wrong with her. She did not want surgery, she said, but went along with it because it meant that she would be allowed to spend more time in the hospital. She knew that what she was doing was wrong, she said, but she could not make herself stop. [Later] she found that the people who had treated her so kindly could turn very nasty indeed when they figured out what she was up to, and, even though she has not lied about her health for 20 years, her notorious record has made it difficult for her to get doctors there to take her seriously when she is truly sick. Although she had suffered abdominal pain and other symptoms for a year and a half, few tests were ordered and no diagnosis was made in London. On a visit to the US, she called Dr. Feldman, who urged her to come and discovered a large mass in her intestine that required immediate surgery. She learned she had a malignant tumor, too large to remove. The news came as a shock, and she wept. She wondered bitterly what her outlook might have been had British doctors paid attention to her when she first described her symptoms. “Once you’ve been branded it’s like you’ve got it written across your forehead: Not to be trusted.”

This interview records themes recurrent in patient-centered MS publications: escalation and blacklisting predicting an unhappy finale. The impact on the patient of the *distrust* is further elaborated by Kirmayer in ‘A case of hysterical physicians’:

One Sunday, I was called by a medical resident to discuss a remarkable case of what he believed to be Munchausen’s syndrome – chronic factitious illness. He found her a “demanding patient”. She had trained as a nurse, although she worked in another field, and retained some knowledge of medicine and of the hospital hierarchy which she used to ask pointed questions about her condition and, at times, to challenge his authority. Seeking clarification of her medical history, he called a neurologist who had treated her epilepsy for ten years with anticonvulsant medication. This senior physician bluntly stated: “She’s a faker, a hysteric. I don’t really think she has epilepsy, probably pseudo-seizures. She even faked an ocular muscle palsy”. Just as their claims had disturbed me, the attribution of volition to Mrs. D. made by the medical resident and neurologist created a profound sense of confusion and threatened self-alienation for Mrs. D. Over the next several months, she and I explored in many ways the possible sources of her symptoms as motivated behaviors. Throughout this work, Mrs. D. collaborated and appeared honest and sincere in her actions. Several months earlier, while in treatment with me, she had experienced a bout of intractable seizures – status epilepticus – that required admission to an intensive care unit. The neurologist who treated her at that time was puzzled by atypical features of her seizures and her EEG. Like her previous neurologist, he too thought she might have pseudo-seizures and asked for a psychiatric consultation. The consultant psychiatrist could find no evidence for severe stressors or secondary gain and doubted the diagnosis of pseudo-seizures. I too saw her in hospital at this time and also could not confirm a diagnosis of conversion disorder. She had some histrionic personality traits and some evidence of past dissociative experiences – using absorption in fantasies to escape from her intolerable family situation as a child – but there was little in her current life situation that would account for this acute episode. The issue remained unresolved but she was discharged on anticonvulsant medication. After some months of treatment, Mrs. D. was readmitted to another hospital in status asthmaticus and required an extended stay in the intensive care unit to stabilize her breathing. A new pulmonary specialist took over her care and a new neurologist supervised her anticonvulsant medication – both were convinced of the veracity of her symptom reports and the reality of her illness. Mrs. D. felt relieved that physicians took her serious but was once more demoralized by the recurrence of illness (1994: 185-189).

As Kirmayer concluded: “there is *no final truth or closure to settle once and for all the real nature or correct interpretation*” [emphasis added]. Dissatisfaction forces the medical profession to speculate. Psychiatrists acknowledge that their evidence base is shaky:

In factitious illness the truth is discoverable only in terms of an account of the fabric of the lives of the participants, including the professionals who have been caught up (or out) in the fiction. The clinician is dealing with uncertainty in most work in this area.

What is needed is a mature and balanced clinical judgment, especially in these days of too literal an interpretation of evidence based practice. Legislation is likely to interfere substantially with research on secretive disorders. Patients are unlikely to give consent for research (Eminson & Postlethwaite 2000). Compounding a patient's inherent propensity to falsify information, legislation may make it increasingly difficult for health-care-providers to understand the risk factors, appropriate interventions, and outcomes of patients with factitious disorders. Add to that the fact that the epidemiological data is confused (Krahn 2003: 1163).

To accept 'a play for being sick', medical science requires evidence of unconscious intra-psychic needs. To the reasoning mind, the MS delusion is generating not one but myriads of clues:

Masochism, dependency and mastery; the desire to be the center of attention; grudges against physicians to be satisfied through frustrating the staff; the enactment of past and present developmental disturbances within the medical setting; an escape from and a make up for stressful situations.. As to the 'conscious': the deception may be distinguished in that patients may suffer from underlying disturbances in the sense of reality and in reality testing, associated with a poorly consolidated sense of self and with difficulty regarding the emotional experience as real (Folks & Hoeck 1993: 280). The behavior may serve to stabilize the sense of self by concretizing and legitimizing the subjective experience of distress and by evoking responsiveness of a caregiver in a relatively safe, structured context (Spivak et al. 1994). Adaptive behavior can be construed as that which is intelligible to others in the group and aimed at achieving goals understood with reference to shared individual values. Psychiatrists cannot begin to explain the behavior in factitious disorder. It is no accident that although they are clearly ill they are not easily classifiable (Turner 1999: 201).

Take, for example, the present day Dutch conditions (formalized by law⁶) of a proper medical relationship: that is one between equal and autonomous parties, with a mutual obligation to honor an agreement in which both are informed about what is at stake. In MS the link between *autonomous-conscious-informed* is the crux. Just as patients are compelled by the sick role (Wendy Scott's: "she could not make herself stop fantasizing for reasons unclear to her-self"), the doctor needs to believe that stopping the fabrication will make both disease and problems disappear. Because disclosure is blocked in clinical practice, caregivers continue caring for the factitious disease and the patient continues to increase the claims and complications, rightfully expecting treatment. Treatment causes the fabrication to escalate. Patient and caregiver are trapped by each other and both become increasingly equally responsible: the collusion deteriorates to complicity.

Some cultures seem to interpret lying, more than ours does, as an adaptive mechanism. Can such an approach be helpful in the treatment of factitious disorder? If we look at it from this perspective, it may be that if a patient is self-mutilating but unable to speak

about it, it could be an adaptation mechanism to fend off more serious problems (Van der Feltz-Cornelis 2002: 256).

In this medical perspective, the suggestion offered is: a binding relationship, which is mutually deceiving, can best be continued. But then again, in this way self harm will not be stopped. If the factitious behavior is considered to be, definitely and forever, beyond awareness or adaptation, the 'imprisoned' patients of Munchausen are stuck and the result is complete loss of control over the suffering.

A conclusion on intersubjectivity

As argued above, sharing cognitions and emotions creates the operating space that is essential in the shaping of the narrative of illness. Medical anthropologists regard both the patient and the caregiver as performers acting in the intersubjective interplay: agencies. Can we, as medical anthropologists, be useful? Drawing on concepts of 'what is at stake', while avoiding the painful question of 'who is responsible', we could possibly direct our craft and experience to MS to find what the suffering narrative is standing for. Clearly, the patients' suffering is understated or neglected once their behavior is considered deviant only, as Amirault (1995: 175) highlights:

Medical writing is believed to be nonliterary, to state objective scientific knowledge. Yet the proliferation of literary effects throughout the writing on Munchausen syndrome reveals that the medical discourse does not simply pronounce scientific knowledge. Ironically, the medical writing of Munchausen syndrome, which strives to categorize and contain this storytelling malady by describing its diagnosis and treatment, is itself contaminated by literature.

The factitious behavior evokes strong emotional responses in relationships, soliciting help, sympathy, indignation, frustration, all of which apparently have difficulty to be expressed in any other way. The essence from the cases, in both the professional and the patient-centered literature, and the explanation approved by most, is, that the factitious is a flight from rejection in search of commitment. If we consider the intersubjective space between doctor and patient as an arena for establishing the rules on how sickness is to be played, MS might become better researchable by cultural analysis. Intersubjectivity emphasizes MS as a reciprocal fabrication manifesting how patients and caregivers define one another. We posit that by looking for innovative answers, medical anthropologists will be drawn into subjectivity. Are the unconscionable designs and deviant logics per se knowable? Bear in mind that patients do not agree with the category imposed. Do not forget that to contact participants is not possible by an open invitation. Patients are not likely to participate in a research on something they do not suffer from. The researcher, in a medical anthropological fieldwork, might enter in a dislocated scenario of 'hide-and-seek'. In order to conduct the research, establishing contact with doctors who published on MS is an entry point,

which the patient is likely to disagree with. Yet, once contact is made, the researcher may proceed, via snowballing, to a sufficient number of doctors, but remain devoid of patient responses. To reconstruct a MS case, ideally the research must include nursing staff, who play a key role in the day-to-day care of MS patients. The best way to reach nursing staff is through the doctors, who have worked with them. For building, as methodologically complete as possible, the central story or general narrative, the clinical ethnographic account must include:

- (a) Interviews with both doctors/nurses in which the particular of MS would be explored and asked individually to reflect on a case brought in. Independently, participants would reconstruct the case, from the first encounters with the patient, until the moment of MS diagnosis.
- (b) With the same participants, focus group discussion on consensus in the clinical understanding;
- (c) Independent focus groups discussions amongst experts, in order to understand how doctors arrive at categorization and how nurses, and caregivers in general, relate to such a diagnosis;
- (d) An *ethnographic reading*, i.e. a careful and deep exploration of the discussed patient's records, in order to explore the conditions that brought the patients in, how nurses and doctors referred to the patient while hospitalized, what type of procedures were followed and any other information that regards the patients' well-being (diaries, visits and visitors, relatives and patients' fears, sense of humor, anger, depression, etc); anything, that could help to co-experience the patients' history and relationships while in care; and finally
- (e) A solution for the problem of the confidentiality of medical records.

To overcome the division between the patient's and the doctor's categorization, an intersubjective understanding and acknowledgement of different subjectivities, including the researcher's, may be necessary to facilitate comprehension. The role of the critical medical anthropologist in this would be to understand both what is *at stake* for all and how each subjectivity relates, influences and ultimately shapes an other. Jointly with participants, from a stage of disappointment (what deception!), progress could be made to wondering (what maneuver!) to a stage of grasping, what essentially the role is of all involved in MS. As Scheper-Hughes did by describing MSBP as:

... a perverse by-product of the doctor-patient relationship, due to the fact that the physician is blinded and cannot see the harm done (2005: 114-15).

In this, she reveals that the illness pretension is a blindfold, a weapon of the weak, and she implies that the willful medical unawareness of social realities is underlying MSBP. Scheper-Hughes' style of reasoning leads to reconsidering whose disease MS is. The fact cannot be denied that by not recognizing the factitious immediately as embodiment of suffering, in a disease different from the usual, physicians play a decisive role in the syndrome's history. Must we not reframe the patient's behavior?

From – in search of the exciting context of hospitals and in the support of devoted physicians (Pharis 1995) – to – being in false admiration for a naïve and self-concerned medical attitude (Scheper-Hughes 2005). When intersubjectivity is taken to be a *state of shared understanding to occur between humans*, the factitious will prove dodgy fieldwork but the results might be worthwhile nonetheless.

Notes

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- 1 In the Concise Oxford Dictionary of Current English, 5th ed., 1964, 'factitious' refers to: designedly got up, not real, artificial (from the Latin *facere* – to make). The matching Dutch term in clinical psychiatry is *nagebootst*, meaning 'imitated' and synonymous with pathomimesis.
- 2 Diagnostic criteria in the DSM-IV-TR are: intentional production and/or feigning of signs and/or symptoms to assume the sick role; external incentives as in malingering are absent; not caused by any other psychiatric disorder.
- 3 American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. Commonly used to describe all persons who intentionally feign or produce illness in order to assume the sick role, yet MS is not included as a discrete mental disorder in the World Health Organization's International Statistical Classification of Diseases, 10th Revision (ICD-10) or in the DSM-IV-TR. In both manuals the official diagnosis is *factitious disorder* (FD) (F68.1-ICD-10; 300.16, 300.19 – DSM-IV-TR). Münchausen Syndrome is reserved for a 'severe' subset matching the original Asher definition.
- 4 Raspe, R. E., et al. (1785) *Singular travels, campaigns and adventures of Baron Munchausen*. A recent edition is published by the London Cresset Press (1948). The reconstruction of the fabled von Münchhausen persona, in the context of Asher's time and place, is not simple, but it is easy to see why the eponym stuck and was accepted as an excellent choice for the purpose. The 'Munchausen stories' had been for over a century very popular English children books, featuring an 'extravagantly mendacious baron' recounting his military exploits, which were absurd beyond belief, but had nothing to do with faked illnesses. If we try to look at the narrative source with a serious historical interest, we meet a tangle of contradictions. The author, Raspe, was at his time considered a talented crook. He composed the first stories, in English, as a fugitive from Germany in Britain, presenting a narrative featuring the baron, anglicized to Munchausen from von Münchhausen, who he says told him several, which is clearly a lie. In further historical reconstruction, a real Baron von Münchhausen existed too, who is said to have been deeply ashamed of the blackening of his family name, which is surprising because even that name is miss-spelled and the stories are maniacal nonsense. The books became standard jocular 'nursery' texts for many generations, both in England and elsewhere, often rewrought or illustrated by talented authors: e.g.

in French editions the illustrations are by Gustave Doré (1862); a Dutch edition is by Godfried Bomans and a Monty Pythonesk film 'The Adventures of Baron Munchausen' was directed by Terry Gilliam (1988). The movie in the German version is called 'Die Abenteuer des Baron von Münchhausen', reclaiming the proper naming for the still famously misspelled and misinterpreted baronesk personality for his fatherland – and, as we have argued, making the original baron now turn in his grave for shame. In recent years, the eponym, as introduced by Asher and Meadow, has, in the media of the present, surpassed the original connotation of tall fairy tales (see Fisher 2006: 250).

- 5 Interestingly 'factitious', as also 'fetish' (from the Portuguese), indicates which creation by man can have supernatural power in human relationships – according to the popular concept introduced by Charles de Brosses (1760).
- 6 Wet Geneeskundige Behandeling Overeenkomst (WGBO): Dutch Law on the Medical Treatment Agreement.

References

- Amirault, C.
 1995 Pseudologica fantastica and other tall tales: The contagious literature of Munchausen syndrome. *Literature and Medicine* 1995(2): 169-90.
- Asher, R.
 1951 Munchausen syndrome. *Lancet* 1951, I: 339-41.
- Craft, A.W. & M.B. Hall.
 2004 Education and debate. Munchausen syndrome by proxy and sudden infant death. *British Medical Journal* 328: 1309-12.
- De Brosses, C.
 1760 Du culte des dieux fétiches ou parallèle de l'ancienne religion de l'Egypte avec la religion actuelle de Nigritie, [no place; no publisher].
- Eminson, M. & R.J. Postlethwaite
 2000 *Munchausen syndrome by proxy abuse: A practical approach*. Oxford: Butterworth Heinemann.
- Feldman, M.D.
 2004 *Playing sick?* Hove, East-Sussex: Routledge.
- Fisher, J.A.
 2006 Investigating the Barons: Narrative and nomenclature in Munchausen syndrome. *Perspectives in Biology and Medicine* 49: 250-62.
- Folks, D.G. & C.A. Houck.
 1993 Factitious disorders and malingering. In: A. Stoudemire & B. S. Fogel (eds) *Psychiatric care of the medical patient*. New York: Oxford University Press, pp. 267-89.
- Hunter, Kathryn M.
 1991 *Doctors' stories: The narrative structure of medical knowledge*. Princeton, N.J, Princeton University Press.
- Jackson, M.
 1998 *Minima ethnographica: Intersubjectivity and the anthropological project*. Chicago: University of Chicago Press.
- 2002 *The politics of storytelling: Violence, transgression, and intersubjectivity*. Copenhagen: Museum Tusculanum Press.

- Kirmayer, L.
1994 Improvisation and authority in illness meaning. *Culture, Medicine and Psychiatry* 18: 183-214.
- Krahn, L.E., Hongzhe Li & M. Kevin O'Connor
2003 Patients who strive to be ill: Factitious disorder with physical symptoms. *American Journal of Psychiatry* 160: 1163-68.
- Meadow, R.
1977 Munchausen syndrome by proxy: The hinterland of child abuse. *Lancet* II: 343-5.
- Nijhof, G.
1996 Uncertainty and lack of trust with Parkinson's disease. *European Journal of Public Health* 6: 58-63
- Oomen, H.A.P.C., T.M.J. Huygen & F.C.M. de Laat
1999 Factitious disorders express repressed emotions. *2d International Conference – The (Non-) Expression of Emotions in Health and Disease*. Tilburg, the Netherlands.
- O'Shea, B.
2003 Factitious disorders: The Baron's legacy. *International Journal of Psychiatry in Clinical Practice* 7: 33-39.
- Pankratz, L.J.J.
1994 Habitually wandering patients. *New England Journal of Medicine* 33: 1752-55.
- Pharis, M.E.
1995 Book review. Hurting for Love: MSBP, by H. A. Schreier & J. A. Libow, 1993. *Child and Adolescent Social Work Journal* 12: 71-4.
- Plewes, J.M. & J.G. Flagan.
1994 Factitious illness. In: R. E. Hales (ed). *The APP textbook of psychiatry*. Washington D.C., American Psychiatric Press, pp. 623-4.
- Rosenberg, D.A.
1987 Web of deceit: A literature review of MSBP. *Child Abuse & Neglect* 11: 547-63.
- Scheper-Hughes, N.
2005 Disease or deception: Munchausen by Proxy as a weapon of the weak. In: E. van Dongen & S. Fainzang (eds). *Lying and illness*. Amsterdam: Het Spinhuis, pp. 113-38.
- Spivak, H., H.G. Rodin & A. Sutherland
1994 The psychology of factitious disorders: A reconsideration. *Psychosomatics* 35: 25-34.
- Turner, J. & S. Reid
2002 Eponym: Munchausen syndrome. *Lancet* 359: 346-9.
- Turner, M.
1999 Malingering, hysteria and the factitious disorders. *Cognitive Neuropsychiatry* 4: 193-201.
- Van der Feltz-Cornelis, C.M.
2002 The impact of factitious disorder on the physician-patient relationship: An epistemological model. *Medicine, Health Care and Philosophy* 5: 253-61.
- Van Moffaert, M. & W. Michielsen.
1997 Nagebootste stoornissen (Factitious disorders). In: M. W. Hengeveld (ed). *Psychiatrie in de somatische praktijk* (Psychiatry in somatic practice). Houten: Bohn Stafleu van Loghum, pp. 71-77.
- Young, A.
2000 History, hysteria and the psychiatric styles of reasoning. In: M. Lock, A. Young & A. Cambrosio (eds), *Living and working with the new medical technologies*. Cambridge: Cambridge University Press, pp.135-62.