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DISSOCIATION, FACTITIOUSNESS AND MALINGERING – A CONTINUUM

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"'Nothing, it may be said, resembles malingering more than hysteria; nothing hysteria more than malingering. In both alike we are confronted with the same discrepancy—between fact and statement, between objective sign and subjective symptom.' – A. Bassett Jones & L. J. Llewellyn, Malingering, or, The Simulation of Disease, 1918.

Dissociative disorder, factitious disorder, and malingering all present usually as physical symptoms, which are not explainable by any medical disease. The features are sometimes so similar that it is difficult to dissect out the underlying psychic mechanism and delineate to discrete diagnosis. From The hysteria of Hippocratic times considered as vague symptoms caused by displacement of uterus to current neurobiological and psychological concept of somatization these disorders have always been a matter of confusion and controversies.

THE CONTROVERSY

From the Hippocratic concept of wandering uterus, which indicated an organic origin for the symptoms, via the Cartesian dualism of mind and the body altogether to Pierre Briquet who proposed a "neuro-cerebral" origin for these conditions, we have come a long way. A brief consideration for an organic perspective for Conversion disorders was entertained prior to Freud's psychoanalytic theory, but that view was shadowed by imputations of malingering. Freud served as a pioneer toward the separation of the mind and body again, though reluctantly. After a pause due to psychoanalytic domination this effort was followed later, in tune with the evolution of new cognitive psychological models proposed for psychiatric disorders as well as the emergence of new research methodologies such as functional neuroimaging, by a somewhat closer look into the functioning of the brain.

The controversies are still present regarding these disorders. First problem is with the diagnosis of dissociation, factitious disorder and malingering, they all are abnormal illness behavior and the elements like conscious or unconscious production of symptoms and motivation depends largely on interview and clinical judgement of the clinician which are subjective.

Physical disorders must be excluded as the neurological co morbidities are high with such patients, these fields are overlap areas of neurologists and psychiatrist. The temporal relation with a psychological stressor needs to be identified in

dissociative disorders, practically this is not always possible.

There is a phenomenal overlap also in recent studies the phenomena of “la belle indifference” was found to be more associated with factitious disorders than conversion (Stone et. al. 2006).

Malingering should be differentiated from factitious disorders and somatoform disorders including dissociation or conversion. These distinctions may involve difficult clinical judgment on intentionality and motives. As an alternative is has been suggested to place them in a continuum. See appendix 4
Imaging studies find different areas of brain activation among those with conversion disorders than among those simulating weakness, suggesting true physiological differences underlying unconsciously versus consciously motivated processes. fMRI studies demonstrate that patients with motor conversion symptoms had different areas of brain activation than patients who are feigning motor weakness. Whereas patients with conversion disorder activated bilateral putamen and lingual gyri, left inferior frontal gyrus, and left insula and deactivated right middle frontal and orbitofrontal cortices, those simulating weakness activated the contralateral supplemental motor area and not the above areas. Electrophysiological testing has been used more recently to assist in the diagnosis of simulated and somatization disorders, especially movement disorders. Psychogenic myoclonus shows pre-movement potentials indicative of voluntary movement. Individuals with psychogenic movement disorders had significantly increased startle eye blink reflex in response to negative affective stimuli compared with controls, who normally show inhibition of this reflex.

Liepert and colleague found that imagining movements decreased cortical excitability in the affected limb in motor conversion disorder patients but increased in the unaffected limb compared to control. Theoretically, these electrophysiological findings could differentiate conversion disorder from factitious disorder or malingering. However, it is unclear if patients with factitious disorder who have intentional production of symptoms for unconscious motivations would be discernible from malingering by imaging studies or not.

It cannot yet be claimed that a comprehensive theory emerges from this, and, of course, it would be absurd to ignore other investigative modalities currently yielding exciting insights (notably, but not exclusively, electrophysiology), but functional neuroimaging has given etiological hints to the specific diatheses, stressors, and mechanisms for enacting this most confounding condition. The results are in all cases preliminary, with confirmation typically relying on activation overlap rather than on paradigm replication, but given the tantalizing glimpses of answers to an age-old puzzle, the call for more studies must be as strident as it was predictable.

WHY A CONTINUUM

Remarkable overlaps of clinical features among patients with dissociative, somatoform, conversion, and borderline personality syndromes and malingering have been described. Patients with these disorders have been variously described as having in common a female preponderance; a multiplicity of symptom complaints; chronic course of illness; vague, circumstantial, imprecise, and exaggerated descriptions of their symptoms; dramatic style of presentation; suggestibility and hypnotizability; voluminous of symptoms of many types; extensive comorbidities; psychotic-like symptom presentations ; emotional instability and difficulties with affect regulation; impulsivity; suicidal ideation and attempts; marked and

persistent identity disturbance; intense and volatile personal relationships; stormy marital histories; chaotic family backgrounds; and histories of childhood neglect and abuse. There has always been a controversy regarding definition and categorization of dissociative disorders and its subtypes. The legitimacy of factitious disorders is still under debate as they often penetrate the legal issues and are difficult to differentiate from malingering. Moreover, malingering is not yet considered as a psychiatric disorder. As expected, there are very few studies about etiology, psychodynamic basis, neurophysiology and treatment of these disorders.

Evidence of similarities among patients with these disorders has been explained through psychological testing. Regarding MMPI2, MCMI and neuro-psychiatric tests the profiles are overlapping with a plethora of disorders including borderline histrionic and narcissistic personality disorders and factitious disorders, antisocial personality disorders and these can be sometimes misused by malingerers. The interview techniques are a help to distinguish the three which aims to tease out the consciousness levels and motivations, which is again something that cannot be commented with absolute surety. The motivation (primary or secondary gain) are sometimes difficult to understand as we have to see from individual's perspective as what matters more.

All these disorders have common psychological basis there is usually a history of childhood traumatic experiences or sexual abuse leading to faulty psychological development and use of in appropriate defense mechanism to face stressors of life which in turn leads to presentation in form of physical or psychological symptoms, or malingering.

The neuroimaging and physiological testing are coming up with results showing different brain region activation in these disorders. This can be a critical tool in diagnosing these disorders and can lead to categorization at appropriate places in the nosological systems. But considering the age-old puzzle and its complexities the research results are not enough.

CONCLUSION

Malingering should be distinguished from factitious disorder and other somatoform syndromes such as hypochondriasis, conversion/dissociation disorders. This distinction may involve difficult judgement as how intentional is the production of symptoms or how genuine it is. As an alternative it has been suggested that such patients lie on a continuum between those in whom the production of symptoms is assumed to be fully unconscious (conversion or dissociation disorders) and those in whom it is wholly conscious (factitious and malingering disorders). At least until we become sufficiently equipped with neurobiological markers and other frame works and treatment strategies to categorize them on basis of etiology and pathophysiology.

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