

When Munchausen Becomes Malingering: Factitious Disorders That Penetrate the Legal System

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Psychiatrists and other physicians are usually familiar with factitious disorders, but attorneys and judges usually are not. Cases involving factitious disorders may enter the civil legal system in a number of ways and cause incorrect judgments, financial costs, and inappropriate medical care if these disorders are not identified. Psychiatric consultants may play a key role in identifying these cases and educating legal personnel about factitious disorders. This article describes three cases in which persons with factitious disorders entered the civil litigation system. The role of the psychiatrist in these cases is discussed. Clues to the identification of factitious disorders are described. The article also discusses the differentiation of factitious disorders from malingering and other forms of abnormal illness behavior, such as conversion, hypochondriasis, and somatization disorders. The concepts of primary and secondary gain in relationship to illness behaviors are elaborated.

Factitious disorders are those conditions in which individuals actively create signs or symptoms of physical or psychological disease states.¹ Although there are numerous reports of factitious psychological disorders,²⁻⁵ there is controversy about the legitimacy of the diagnosis.⁶ This paper will limit its focus to factitious physical disorders and how they may enter the legal system in civil litigation.

Although most psychiatrists are famil-

iar with factitious disorders from their medical training, many attorneys and judges have had not any exposure to such cases. As these cases appear to be developing more frequently in legal and other nonmedical settings,⁷ it is important for these nonpsychiatrists to become aware of the factitious disorders in order to deal with cases appropriately. Considerable education may be necessary to inform legal staff about factitious disorders because the entity is so counterintuitive—no one expects an apparently reasonable person to actively create a disease in him- or herself. Identification of factitious cases and early intervention may lead to cessa-

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tion of costly litigation and more appropriate treatment. This article will discuss several illustrative cases of factitious disorders and will also describe clues to their detection. Finally, we will also examine theoretical issues raised by these cases, which differentiate factitious behavior from other abnormal illness behaviors such as malingering.

Perhaps the most notorious factitious disorder is Munchausen syndrome by proxy, in which a mother creates illness in her child.^{8, 9} This condition is a form of child abuse and is handled in the criminal justice system. In adults, the most well-known factitious physical disorder is the Munchausen syndrome.^{10, 11} As with sufferers of other factitious disorders, these individuals may produce serious medical problems, but in addition, travel widely, appear to be highly sociopathic, and have a history of unceasing patienthood. Usually, these individuals are identifiable as soon as any corroborative history is obtained. More difficult to diagnose are the individuals without an unceasing history of hospitalizations and medical treatments. These individuals may produce factitious physical disorders as a response to a stressful life situation that exceeds their usual coping strategies.¹² Because of this uncommon reaction, others may not be aware of, or even suspect, the factitious etiology.

Case 1

Mr. B, a 32-year-old African-American male, filed suit against several physicians who had treated him for an arm wound. Allegedly, he injured the arm in a work-related incident in which he scraped his

arm against a metal shelf in a manufacturing plant. He was taken to an emergency room and had a superficial laceration sutured and was given prophylactic tetanus toxoid and antibiotics. He then developed signs of a wound infection and saw an occupational medicine specialist who changed the antibiotic regimen. When this treatment failed to improve the condition, the plaintiff was referred to an orthopedist. That physician performed an incision and drainage and carefully documented the exploration of the wound. Leaving the wound open to drain, the plaintiff had improved for several weeks, but shortly before he was to go back to work, signs of infection recurred. The orthopedic surgeon reopened the wound and discovered some foreign bodies in the deeper layers of the tissues. Pathological examination suggested that the foreign bodies had been recently placed in the tissue and had not been present at the time of the original injury.

Claiming dissatisfaction with his surgeon, the plaintiff changed to a new orthopedist who immediately obtained an infectious disease consultation. These physicians decided to try a new antibiotic regimen. When this failed to heal the wound, the orthopedist decided to place the plaintiff's arm in a cast to investigate the possibility that the plaintiff was interfering with the healing process. After several weeks, the cast was removed and the wound had essentially healed. Two days later, however, the wound appeared to be swelling with infection. Antibiotics were changed again and the arm was again placed in a cast. When the cast was removed, the wound had almost completely

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healed. The orthopedist raised the idea of the plaintiff interfering with the healing process, but the plaintiff vehemently denied any manipulation of the wound and changed physicians. Eventually, this pattern was replicated with five other physicians and the plaintiff underwent multiple surgical debridements of his arm wound, which had not healed over a four-year period. Over the course of treatment, significant amounts of muscle and nerve tissue were removed. Most recent investigations showed evidence of osteomyelitis in the deepest areas of the wound and amputation was being considered as the only means of obtaining a cure. The plaintiff remained on total disability and began litigation against all of the physicians except for his current ones.

Defense attorneys asked a psychiatric consultant to review the case because medical records had raised the question of the plaintiff manipulating his wound. The consultant reviewed medical records extending into the patient's teenage years. These records documented 12 injuries to the patient's arms over the prior 10 years. Most, but not all, of these had been associated with periods of one month of disability for industry-related incidents. His records noted a history of adolescent behavioral problems that eventuated in his being sent to a juvenile detention center for grand theft and one conviction for robbery as an adult. His work history was marked by a lack of continuity; he had held all jobs for less than one year.

The consultant performed a psychiatric examination during which the plaintiff minimized any responsibility for the crimes he had been convicted of, saying

they had been due to friends shifting blame to him. There was no overt evidence of psychosis, affective disorder, or cognitive disturbance. He acknowledged that the arm injury had occurred shortly after his wife had given birth to their only child. The plaintiff noted that this event had been stressful, but added that he did not have much time to worry about his new infant because he had been preoccupied with his own injury.

Mr. B denied having had any psychiatric treatment. Several of the doctors he had seen for his wound had suggested that he see psychiatrists for consultations, but he had refused, saying his only problem was his ongoing infection. His wife had separated from him on several occasions, reportedly due to her difficulties caring for both an infant and a disabled spouse. Nonetheless, he denied any current marital difficulties.

The consultant concluded that Mr. B had a factitious disorder that at times shifted into malingering. Some of Mr. B's arm injuries had not been associated with any apparent gain, but half of them were related to obtaining disability payments. The arm wound that led to the malpractice litigation may not originally have been produced factitiously, but it clearly was perpetuated in that manner. The consultant speculated that the wound may have represented the plaintiff's attempt to obtain support and attention from his wife when this was threatened with the birth of a child. Eventually, the perpetuation of the wound appeared to be aimed at financial gain via the litigation. The plaintiff's past history of sociopathic behavior strengthened the likelihood of malingering.

ing. The extent of his injury and the actual disability he suffered suggested that Mr. B had features of both factitious disorder and malingering. After the consultant was deposed by the plaintiff's counsel with the foregoing assessment, the plaintiff and his attorney decided to withdraw his lawsuit.

Case 2

Ms. A was a 35-year-old Caucasian female who claimed that she had been injured in a parking lot of a luxury hotel. She said that she had been hit on the head by a mugger who had tried but failed to steal her purse. She had been attending a corporate executive's meeting at the hotel at the time of the attack. Police investigators called to the hotel found her to be distraught, but otherwise she appeared to be healthy, except for bruises on her forehead and cheek.

She was taken to a nearby medical center for an emergency room evaluation and treatment. She had a CAT scan of her head that was normal. Nonetheless, she complained of persistent headache and vertigo. In addition, her intellectual functioning appeared to deteriorate over the next few days. She complained of feeling confused, disoriented, and having a poor memory. She could not recall many of the routines she had performed in her job as a corporate vice-president in accounting and went on disability. A neuropsychological test battery revealed findings suggestive of a significant postconcussion syndrome with marked cognitive impairment. She entered a program for brain-injured individuals and was cared for at home by her 17-year-old son who lived

with her. At the urgings of several friends, she began litigation against the hotel where the injury occurred, claiming security was inadequate.

As part of the litigation process, her attorney obtained a psychiatric evaluation of her to assess the level of depression that was present and what treatment might be necessary. The psychiatric consultant reviewed her medical records extending into her teenage years. One key finding was that she had been hospitalized as an adolescent for behavioral problems. During that two-month hospitalization, she was noted to have fabricated several stories of male patients sexually harassing or molesting her. Later psychiatric history included an episode in which she had fallen at her work as a nurse's aid and injured her neck and head. At that time she was regarded as having a postconcussive head injury with substantial cognitive impairment requiring total disability. She entered a rehabilitation program and eventually recovered to the extent that she was able to enter a graduate school and earn an advanced degree, which had led to her corporate position.

During her psychiatric examination, the consultant obtained social history that was notable for her having been in an intense relationship with a man who lived in a city several hundred miles distant. Earlier on the day of the alleged attack in the hotel parking lot, the man had told her in a telephone call that he was breaking off the relationship. Although this rejection clearly shattered many of her hopes, she denied being upset about the breakup.

Examination revealed a woman who

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appeared to be amplifying cognitive deficits. For example, although complaining of severely impaired memory, she had arrived on time for her appointment by herself—despite having to travel over 50 miles to do so. Other cognitive tasks revealed inconsistencies as well. As part of the psychiatric assessment, a second neuropsychological test battery was given. On this testing she showed marked deterioration on several scales, despite the extensive rehabilitation she had undergone and the general trend for postconcussion syndromes to plateau or improve with time. A mental status examination demonstrated no overt evidence of psychosis. She did, however, appear mildly depressed about the multiple losses she had suffered: a well-paying and satisfying job, a strong social network, and an intimate relationship.

The psychiatric consultant explained to the plaintiff's attorney that there was a strong likelihood of a factitious component to the plaintiff's symptoms. The consultant noted that her current apparent cognitive impairment was quite similar to one she had experienced earlier in her life and, in fact, might be modeled after that as a way of coping. Her prior history of fabricating stories when hospitalized as an adolescent suggested that she was prone to conscious prevarication. Similarly, her ability to turn her cognitive deficit on and off seemingly at will (e.g., being able to drive by herself) suggested a conscious component. Her current complaints appeared to have been activated after she was rejected by her boyfriend and may have been an attempt to restore some sense of control. Using this infor-

mation, the plaintiff's attorney decided to agree to a settlement that was considerably below his original estimates of the damages. The attorney decided that going to trial would expose his client to claims of malingering.

Case 3

Mrs. S, a 38-year-old Asian female, was a litigant in a case of product liability. She was a medical technologist who had suffered chemical burns to her eyes after using an over-the-counter eyedrop solution. In the course of examining her, the ophthalmologist discovered that the eyedrops had been tampered with and were highly caustic. As police and the Federal Bureau of Investigation (FBI; brought in due to interstate shipment of the product) investigated the case, Mrs. S underwent treatment with atropine drops and eye patches to heal her corneal burns. As healing progressed, and despite her doctor's advice to discontinue the atropine, she continued to come in for follow-up visits with atropine-dilated pupils. Then as her corneas cleared, the ophthalmologist discovered evidence of retinal burns. Upon referral to a retinal specialist, Mrs. S was discovered to have severe burns of both retinas with profound loss of vision. The specialist concluded that the only way she could have developed such severe burns was if she had stared at the sun with atropine-dilated pupils with a light-focusing device such as binoculars. The severity of her burns meant her visual loss was permanent. She denied any involvement in producing her blindness. The police and FBI investigators, however, concluded that there had been no

product tampering until after the point of sale of the eyedrops.

Despite the above situation, the plaintiff's husband believed a legal claim against the eyedrop manufacturer was appropriate. The plaintiff did not agree fully but decided not to resist her husband's pursuit of litigation. They engaged an attorney who obtained a new independent ophthalmological evaluation. Corneas and retinas seemed essentially normal, which is typical of the type of injuries she had suffered six months earlier. The ophthalmologist did not have her prior records and concluded that her blindness may have had a conversion component. He suggested a psychiatric consultation to her attorney and this was obtained.

During the psychiatric examination, the consultant learned that her initial eye injury occurred shortly after her husband had been severely injured in a motor vehicle accident. Her husband was 20 years her senior and she was highly dependent on him. He had married her when she was 18 years old, rescuing her from a physically and sexually abusive home. She had a history of abdominal and pelvic pain that had never had a specific etiological diagnosis established.

The psychiatrist reviewed all of the plaintiff's medical records from the date of injury. The psychiatrist realized that the retinal specialist had described factitious behavior on the part of the patient. In fact, her initial corneal burns appeared to be related to some self-injury following her husband's accident. She had felt severely threatened when her husband had been injured. Psychodynamically, the consultant speculated that her blinding

herself could have been considered an attempt to shut out the threatened loss of her husband. The psychiatrist explained the factitious etiology to the plaintiff's attorney who had reviewed the medical records but had failed to understand the implications of the retinal specialist's findings. In addition, the attorney was dumbfounded that an apparently healthy and well-functioning woman would have produced her own blindness. The attorney decided to terminate the litigation at that point.

Discussion

The foregoing cases are examples of the rather porous boundary between factitious disorders and other forms of abnormal illness behavior such as malingering and somatization. Many lay individuals, including attorneys and judges, are not familiar with factitious disorders and therefore are not able to identify them. It is difficult for most people to accept the concept of factitious disorder even when it is presented quite clearly. Indeed, in some malpractice trials, juries have found the concept difficult to grasp and have not understood physicians' legal defenses that used the concept of factitious disorder.¹³

The reason factitious disorders are difficult to understand is that the main motivation of this behavior is to achieve some *primary* (internal or purely psychological) gain.^{14, 15} These gains often include such motives as getting cared for or reducing guilt over angry or sexual feelings. Indeed, the primary gain is typically not even within the consciousness of the person creating the factitious disorder. Frequently, the factitious behavior allows

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the individual to act out some transference interaction with physicians and nurses as symbolic caregivers and parental surrogates. An observer would have to develop a psychological hypothesis to try to explain or understand the individual's behavior, since there is no obvious benefit for the individual except achieving the sick role.

On the other hand, individuals with factitious disorder may also suffer substantial real losses: these include the somatic dysfunction as well as the loss of a self-esteem-enhancing career, financial self-support, or prestige. These features differentiate the disorder from malingering. The individual who is malingering acts to create signs or symptoms of disease, but the main motivation is to obtain some *secondary* (external or material) gain.^{16, 17} Malingerers rarely reach the same level of actual biological injury that a person with factitious disorder will create. Often the malingerer will only give a false history (e.g., lie about signs or symptoms) or simulate a disease (e.g., squeeze drops of blood into a urine sample). An observer would be able to understand the malingering behavior by knowing the individual's circumstances and the material rewards the illness would bring. These may include monetary awards in litigation, workers' compensation bene-

fits, relief from a noxious situation such as prison, or obtaining narcotics. The secondary gain of a malingerer is intuitive to an observer, in contrast to the counterintuitive nature of a factitious disorder.

The concepts of primary and secondary gain and loss highlight the differences between factitious disorder and malingering. With a factitious disorder, the individual achieves a primary gain of getting some psychological need met. Counterbalancing the primary gain, there are usually substantial secondary losses. The presence of these losses is evident in Cases 1, 2, and 3, in which the individuals suffered such marked losses that it was hard for some physicians, a spouse, and several attorneys to accept the factitious etiologies. The primary gain from the individual's viewpoint, however, was greater than the secondary costs. In malingering, the situation is in contrast. The secondary gains far exceed any secondary losses or primary gain. For example, a pure malingerer would not be expected to be willing to sacrifice a limb for any financial settlement. Mr. B's self-destructive disorder suggested that psychological motivations played an important role beyond financial gain. His history suggests an oscillation between factitious disorder and malingering. These concepts are illustrated in Table 1.

Table 1
Differentiation of Malingering and Factitious Disorders^a

Malingering	Factitious Disorders
Secondary gain > Secondary loss	Secondary loss > Secondary gain <i>But</i> Primary gain > Secondary loss

^aSee Eisendrath (19).

Table 2
Abnormal Illness-Affirming Behaviors^a

Disorder	Signs and Symptom Production	Motivation
Malingering	Conscious	Conscious
Factitious disorder	Conscious	Unconscious
Conversion disorder		
Somatization	Unconscious	Unconscious
Hypochondriasis		
Pain associated with psychological factors		

^aSee Eisendrath (10).

Looking at factitious disorders in a broader context, they can be seen as an example of abnormal illness-affirming behavior.¹⁸ They are similar to somatization disorders, conversion disorders, hypochondriasis, and pain associated with psychological factors (formerly somatoform pain in DSM-III-R).¹⁹ In all of these conditions, the individual behavior is driven by psychological factors that can be considered to represent primary gains. These other disorders differ from factitious disorders because they are produced unconsciously by the individual; this is in contrast to the conscious production that is evident in factitious disorder. These features are illustrated in Table 2.

Deciding that factitious disorders are produced consciously requires either an admission by the individual or an inference from the behaviors. For example, Overholser¹⁶ has described several criteria: direct observation of fabrication; signs or symptoms that contradict laboratory testing; nonphysiologic responses to treatment; finding physical evidence such as pills or syringes.

Teasell and Shapiro²⁰ have added another criterion that may be useful in identifying behavior as consciously produced.

This factor occurs when an individual acts one way when they are being observed and differently when they believe they are not being watched. For example, the individual who feigns paralysis during an examination but moves the paralyzed limbs when he feels he is not being observed would be presumed to be acting consciously and volitionally. Individuals with factitious disorder or malingering appear to fall into this category. Persons exhibiting the other forms of abnormal illness-affirming behaviors appear to create their signs or symptoms of disease without conscious awareness. Obviously, however, many individuals may fluctuate between conscious and unconscious awareness at different times, making the differentiation quite difficult in some cases.

What makes factitious disorder so counterintuitive and difficult to understand is the common misunderstanding of the concept of primary gain and the fact that the secondary gain appears to be relatively small. For example, in Cases 2 and 3, the women were successful in their careers and earning significant salaries at the time the disorder developed. Indeed, the factitious disorder in each case ap-

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peared to be aimed primarily at meeting a psychological need and only secondarily shifted into a litigation setting. In Case 3, this shift was actually resisted by the plaintiff, but it was difficult for her to rebuff her husband's demands without admitting that she had been the cause of her blindness. The secondary gain of any potential litigation monetary award surely was offset by the secondary loss of her vision and her career. In other words, in her factitious disorder the secondary loss was greater than any apparent secondary gain such as disability payments or litigation award. An observer, such as her husband or attorney, found it difficult to grasp that the primary gain (i.e., the psychological benefit) from the blindness would be more important to her than her vision (see Table 1).

In Case 2, the plaintiff again had substantial secondary losses (such as her career and salary in excess of her disability income), thus highlighting the fact that the primary motivation appeared to be a reaction to the break-up of her relationship rather than one aimed at producing a monetary award in litigation. As her disability persisted, however, the spread into malingering and the secondary gain may have outweighed the secondary losses and served to perpetuate her illness.

In Case 1, Mr. B appeared to have a long-standing propensity to create injuries. Prior to the most recent case, however, he had workers' compensation disability awards for rather brief periods of between one and two months, in contrast to his current disability of five years. It seemed that the injury to his arm occurred coincident with the birth of his only child

and the inherent stresses that may have played on him. Within a short period, his injury claim shifted into a picture in which secondary gain in the form of permanent disability and a litigation award moved to center stage. His case illustrates the confluence of primary and secondary factors in stimulating illness behavior.

There are a number of clues to consider in identifying individuals who may be exhibiting factitious disorders in the legal setting.²¹ One clue is that the individual usually has a history of using somatic complaints as a way of coping with past stressors. These complaints may have symptoms of many disorders for which there is no objective finding to explain the symptoms. A second clue relates to those individuals who have factitious disorders in general: there is a predominance of individuals with a work history in health-care. This may relate to the individual wanting to give care or be taken care of at different times. Other important clues to the identification of factitious disorders include the following:

- The illness does not respond to appropriate treatment (e.g., wound infections fail to respond to appropriate antibiotics).
- The illness worsens, contrary to the normal course of the genuine disorder.
- The individual is repeatedly able to predict a worsening.
- The individual undergoes invasive diagnostic or therapeutic procedures quite willingly or even enthusiastically.
- Multiple physicians have been un-

able to explain the course of the individual's illness.

- Multiple physicians have raised the diagnosis of factitious disorder at some point, usually followed by the patient transferring care to another physician.
- The number of difficulties or bad outcomes from treatment seem unusually high, so that the patient is considered to have had extremely "bad luck" at a relatively young age.

It appears that cases involving factitious disorders may be penetrating the legal arena more frequently. For example, Ford and Feldman¹³ have noted several malpractice cases involving factitious disorders. In most instances, as with Case 1, the individual with the factitious disorder attempts to attribute his or her medical condition to physician malpractice. In these cases, the individual shifts from a factitious motivation to a malingered one, anticipating a litigation-related monetary award. The defense of such a case is challenging because it requires explaining the concept of factitious disorder to a judge and/or jury: convincing such lay individuals that an apparently normal (i.e., nonpsychotic) individual has severely damaged his or her own body may not be easy. Some courts have even attempted to deny admission of a Munchausen diagnosis as prejudicial.²² Appellate rulings, however, have allowed such a diagnosis as relevant to the credibility of the plaintiff.²³ On the other hand, failing to detect a factitious disorder and inappropriately performing invasive pro-

cedures may also expose a physician to malpractice claims.¹³

The foregoing discussion leads to a comment on the key role that the psychiatric consultant often plays in the diagnosis and management of individuals with factitious disorders. By the very fact of shifting from one physician to another, factitious disorder patients make it difficult for any one physician to accurately assess them. For example, in one series of patients with factitious cellulitis, Reich and Gottfried¹¹ found that it took an average of six years before the factitious etiology of the infection was identified. The psychiatric consultant is often the only one who has the medical expertise to review and interpret a complete set of the individual's medical records. A busy clinician would simply not have the time, presuming he or she was familiar with the diagnosis of factitious disorder.

The role of the psychiatric consultant may reach beyond synthesizing cases from medical records and examinations. Often, the consultant can educate other professionals in the legal community regarding the concept of factitious disorder. This alone may improve the chances for the appropriate disposition of cases. The consultant is well-positioned to help the legal community meet the challenges of dealing with factitious disorder.

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