

# Deceiving Others/Deceiving Oneself: Four Cases of Factitious Rape

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**ABSTRACT:** Although patients with factitious disorders typically seek the "patient" role through illness portrayals, some instead portray themselves falsely as "victims." We discuss the cases of four women who claimed to have been victims of rape; the allegations ultimately were disproved. Factitious rape may be prompted by a search for nurturance; by dissociation, leading individuals to believe that trauma earlier in life is ongoing; by a need to be rescued from real, current abuse; and by projection of anger onto specific male targets. Although dramatic, factitious rape is rare, we advocate thorough investigation of rape claims even when patients have known histories of deceptive behavior.

FACTITIOUS DISORDERS involve the production, feigning, or exaggeration of physical and/or psychologic symptoms. The symptoms, which are volitional, facilitate the individual's objective of assuming the sick role. Persons with factitious disorders lack easily recognizable external incentives for their behavior, such as obtaining drugs or evading criminal prosecution. Instead, the individual seeks the "patient" role.<sup>1</sup>

In a similar manner, some patients adopt the "victim" role. Factitious bereavement, in which an individual typically claims to have lost one or more loved ones through dramatic but unverifiable accidents,<sup>2</sup> appears to be common among individuals seeking treatment with fabricated psychologic symptoms. Falsified accounts of victimization through physical abuse or neglect have also been generated,<sup>3</sup> with the potential to create confusion, if not cynicism, within child protection and law enforcement agencies. In this paper, we describe four cases on which we consulted in which victim status was appropriated through fabricated reports of rape. In each case, no tangible incentives for the behaviors could be identified.

A literature search disclosed relatively few articles reporting factitious rape. Unlike the cases presented in this paper, some of the previous cases are notable for troubling uncertainty about whether the allegations of sexual assault were true. In 1926 Healy and Healy<sup>4</sup> described the case of a 16-year-old girl who claimed first that a neighbor had raped her and then that she had become

pregnant. Medical examination yielded negative results, but her contention of rape was never firmly disproved. However, she was described as prone to falsehoods, self-harm, and fabricated fainting spells, and factitious rape was presumed. More recently, Dohn's<sup>5</sup> patient did confess to falsifying three reports of rape; in two of the three instances, she superficially cut herself to support the impression that violence had been perpetrated. Discussing pseudologia fantastica (pathologic lying) in the borderline patient, Snyder<sup>6</sup> reported on one woman who made doubtful claims that she had been sexually abused by an uncle, another who alleged after consensual sex that rape had occurred, and a third who acknowledged being gratified by the attention elicited by her episodic reports of sexual assault. All of these patients were known to have engaged in chronic and egregious lying, leading to heightened suspicions that the claims were false; however, none of the allegations was clearly disproved. Finally, Matas and Marriott<sup>7</sup> discussed the case of a young woman with pseudologia fantastica who professed repeated rape and incest. Ultimately, she admitted that she had fabricated the allegations of incest, as well as other salient elements of her history, but did not recant the report of rape.

## CASE REPORTS

**Case 1.** Ms. A, a 49-year-old married homemaker, elicited national sympathy when she claimed to have been raped in a dressing room at a prominent department store.<sup>8</sup> On the day of the alleged attack, she had emerged from the dressing room partially clad and disheveled, with blood from vaginal lacerations and semen on her clothing, and she had enlisted the help of a passing salesclerk. Accusations of lax security led to an extensive reevaluation of the store's safety measures. The police department's sex crimes division staged a news conference to ask for public assistance in finding the perpetrator,

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and the store offered a \$10,000 reward for information leading to an arrest. However, following a 12-day investigation, the police declared that the rape had never actually occurred. Instead, the woman had staged the rape: she had tossed pieces of duct tape on the dressing room floor, self-inflicted the wounds, and sprinkled herself with a vial of her husband's semen as part of the ruse. Her credibility was initially questioned because of her changing accounts of the assault and her attempt to avoid DNA testing of the seminal fluid. She also failed a polygraph test and ultimately admitted to the deception. The police department declined to press charges against her for the false police report, and the store opted not to file a civil lawsuit. The patient's anonymity was also guaranteed by the police.

**Case 2.** Ms. B, a student at a West Coast college, frantically called the police on numerous occasions with reports of having been harassed or assaulted. She also claimed to have been the victim of multiple rapes on campus. While she alleged that different assailants committed the rapes, composite sketches based on her descriptions were remarkably similar. Police investigation disclosed that Ms. B had filed three nearly identical reports of rape in another state but had concealed this information. In all of the cases, her depictions of the events associated with the attack were notably vague. A diary was eventually obtained in which she had plotted out the stories she would tell police. In the diary, she also asked for forgiveness "for doing this," but she refused to retract her stories even when confronted with her own writings.

**Case 3.** Ms. C, a 28-year-old laboratory technician, was admitted to a university hospital for treatment of recurrent seizures. She revealed that the seizures began shortly after she had been brutally assaulted and raped by two "foreign-looking" men. She stated that the men had subsequently banged her head against the sidewalk until she lost consciousness. Upon regaining consciousness, she had wandered about until a policeman had taken her to the emergency department at another hospital.

The staff assumed that her seizures were due to head trauma. Anticonvulsants were prescribed, and a rape counselor and hospital chaplain made lengthy daily visits. However, her seizures became more frequent and bizarre, and a 24-hour video-monitored electroencephalogram (EEG) disclosed that there was no EEG evidence of seizure activity during her convulsions. A presumptive diagnosis of pseudoseizures due to post-traumatic stress disorder was then entertained. However, 2 weeks later it was learned from the emergency department physician who had treated her that there had been no evidence of rape or head trauma at that time; instead, she had been treated for a dermatologic problem. Shortly thereafter, Ms. C's parents visited. They informed the staff that the patient had been hospitalized repeatedly under similar scenarios. As a teenager, she had on several occasions called the police claiming that she was being assaulted, and was often found "tied up" and "unconscious." It became clear to the police that she was merely smashing items around the house, then crudely tying herself to a chair as if violent behavior had been perpetrated against her. Ms. C was angered by exposure of the ruse and left the hospital the same afternoon that her parents arrived.

**Case 4.** Ms. D reported in psychotherapy an early childhood of sexual abuse perpetrated by both parents as well as several other family members. She was known to have had a long history of self-mutilation and had been formally diagnosed with borderline personality disorder. During the course of therapy, she began to state that she was being raped on a weekly basis by yet another family member, and she subsequently filed charges against this individual. The case was

dropped due to a lack of evidence. Over the next 3 years, Ms. D went on to allege five separate rapes, now perpetrated by strangers. The timing of each report correlated with major life changes such as eviction from lodging, change in therapist, and the pending vacation of her therapist. Despite her firm reluctance, in two instances she was examined shortly after the alleged rape, and in each case there was no evidence of sexual assault. On one occasion, she was hospitalized because of suicidal thinking she attributed both to a recent rape and the death of a close family member. Investigation revealed that the relative was very much alive. When the patient was confronted with this fact, she left the hospital. However, she was readmitted 2 days later at another facility in the same city, voicing identical complaints. Other episodes followed in which deceptive behavior was clear-cut. Ultimately, the patient admitted that at times she had generated "crises" either to force rejection by or gain the attention of her clinical caregivers.

## DISCUSSION

In the cases of Ms. A and Ms. C, physical manifestations of the consequences of rape were manufactured in addition to reports of emotional sequelae. Such combinations of physical and psychologic symptoms appear to be the most common way in which factitious disorders manifest themselves.<sup>9</sup> Like Dohn's<sup>5</sup> patient, Ms. A engaged in self-mutilation, and Ms. B reported multiple rapes—separated in time and location—that involved assailants described in nearly identical terms. Ms. D mutilated herself but did not claim that her injuries were attributable to assault. Although formal psychiatric evaluations did not take place in the first three cases, neither they nor Ms. D appeared to have other Axis I disorders driving the deceptive behaviors; thus, the diagnosis of "factitious" rape is appropriate. Similarly, while misuse of legal and medical resources did occur in each case, none of the women tried to obtain financial compensation through litigation or victims' funds (as might have occurred in malingered rape). Such requests might have arisen in the future if detection had not occurred, but other potential motives for lying, such as revenge or—as in the celebrated case of Cathleen Webb and Gary Dotson<sup>10</sup>—a wish to conceal consensual activity, were not evident. Their falsifications probably do not represent pseudologia fantastica in that they were not gratuitous and apparently not inherently satisfying.<sup>11</sup>

There are several possible hypotheses for the deceptions that are central to understanding the behavior of these individuals. One is that these women had been unable to obtain nurturance in more adaptive ways.<sup>12</sup> Attention and sympathy were thus mobilized by their assuming the role of victim, and Ms. D was explicit about her desire for attention. These patients may have chosen rape, a form of violence especially charged with emotion, since authorities and medical profes-

sionals might be loathe to question its veracity. Another hypothesis implicates a predisposition to dissociation; under stress, these women may have come to believe that early trauma, such as actual sexual abuse in childhood, was occurring in the present. Wholly "false memories" may emerge in a similar way; in a paper by Ofshe,<sup>13</sup> induction of a dissociative state followed by suggestion led one man to develop "pseudo-memories" of having engaged in rape and infanticide. Third, the deceptions may have represented disguised efforts to be rescued from ongoing abuse (perhaps sexual) that was not a remnant of childhood trauma. Finally, the women whose cases are reported above may have projected the diffuse anger characteristic of patients with borderline personalities onto specific male targets, who were then viewed as abusive. There is conscious intent to deceive under the first and third hypotheses; the deception is primarily unconscious under the other two. Varying elements of all four may be applicable in any given case.

The atmosphere surrounding rape allegations is highly charged, and accusations must be explored with great sensitivity. Victim advocates have cautioned that actual rapes frequently go unreported, and it is also clear that only a small minority of reported rapes are proved to be false.<sup>7</sup> Despite Dohn's<sup>5</sup> advice that caregivers "develop an index of clinical suspicion in patients presenting as victims of rape" (p 230), we would emphasize that factitious rape is an unusual phenome-

non that should not be distorted to delegitimize valid reports. Thus, all allegations of rape need to be pursued, at least on a preliminary basis, even among patients with histories of pseudologia fantastica.

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