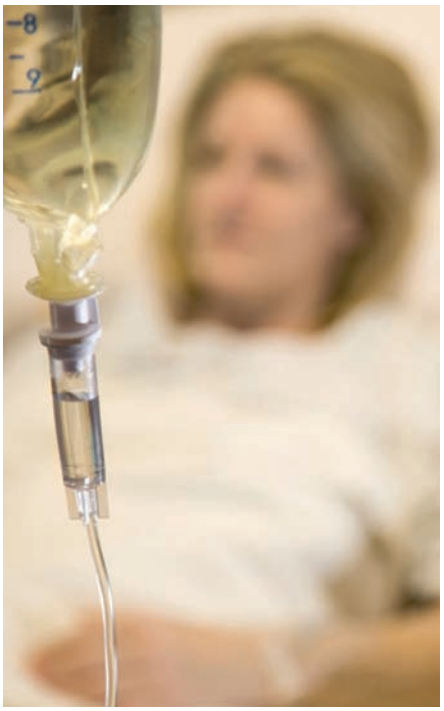

[CASE REPORT]

Factitious Disorder as Repeated Diabetic Ketoacidosis: A Case Report

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ABSTRACT

Factitious disorder is a challenging entity, both in diagnosis and treatment. The clinical presentation is variable in feigned symptoms and spans virtually all organ systems. The diagnostic criteria are simple, yet making the diagnosis is often complicated and can be delayed by focusing on the urgent or readily observable diagnosis. In this article, the authors present a case of factitious diabetic ketoacidosis resulting from the deliberate withholding of exogenous insulin. This particular case is dissected in order to portray the underlying psychopathology. In doing so, the authors illustrate how a patient with factitious disorder might fulfill unmet, presumably unrealized needs. The authors also discuss the diagnostic criteria and treatment strategies of factitious disorder, both of which are of considerable debate within the psychiatric community.

INTRODUCTION

Factitious disorder (FD) is characterized by intentional production or feigning of physical or psychological signs or symptoms in order to assume the sick role, without evidence for any external incentives (Table 1).[1] Symtoms and diseases manifested through FD span the gamut. Examples include cases of subcutaneous emphysema,[2] hyperthyroidism,[3] hypoglycemia through self-injection of exogenous insulin,[4,5] and proteinuria.[6]

The name *factitious disorder* is thought to come from the 1843 publication by Gavin,[7] entitled, "On Feigned and Factitious Diseases." This is also known as Munchausen's syndrome, so named after the German baron who exaggerated stories for effect. There is also a lesser used, forensically feigned form of psychosis known as Ganser syndrome. FD first appeared in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III) in 1980, and the *DSM-IV-Text Revision* (TR) has estimated an incidence of FD to be one percent of psychiatry consults in the inpatient setting.[8] The exact incidence of FD is unknown, but studies have suggested upwards of nine percent of hospitalized patients have FD.[8] Its frequency is likely understated in the general population, and there

TABLE 1. *DSM-IV-TR* criteria for factitious disorder*

A	Intentional production or feigning of physical or psychological signs or symptoms
B	The motivation for the behavior is to assume the sick role
C	External incentives for the behavior (such as economic gain, avoiding legal responsibility or improving physical well being, as in malingering) are absent.

* *DSM-IV-TR = Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*[1]

appears to be a female preponderance.[8,9] Psychiatric literature proposes two distinct subclasses of FD patients. The first category is the Munchausen classification, in which individuals demonstrate antisocial traits, pathological lying, a limited social support system, and a poor work ethic.[10] Hales et al[12] cite that only approximately 10 percent of FD cases display Munchausen syndrome (or symptoms by proxy). The second class (non-Munchausen) is much more typical, and individuals typically do not demonstrate the pathological lying tendencies. These patients often have a stable social environment and are able to provide some consistent contribution in the workplace. These patients (unlike the Munchausen class) do tend to become well known in the local medical community, they and do not continually transfer medical care between physicians and facilities.[11]

The typical FD patient is a young woman who is characterized as passive and immature, with either a health-related profession or training.[12] Differential diagnosis for FD includes medical causes for the constellation of symptoms displayed by the patient (e.g., poorly controlled diabetes in our patient), or other psychiatric disorders, such as somatoform disorders or malingering. FD has been linked to comorbid eating disorders, somatoform disorders, and conversion disorders.[13–15] Although there are a wide array of psychotherapeutic approaches, there are insufficient data to specifically recommend any one form of treatment for FD in an evidence-based fashion.[16]

CASE PRESENTATION

Ms. J (alias) was a 21-year-old woman with well-known and well-managed diabetes mellitus type 1 who was repeatedly seen in the emergency department of our facility for care. These visits to the emergency department resulted in multiple hospital admissions for confirmed diabetic ketoacidosis (DKA). These admissions were ultimately the result of Ms. J voluntarily withholding doses of her insulin, to which she eventually admitted. Her low-normal hemoglobin A1C suggested she possessed the knowledge of how to control her disease and generally did so. Further investigation revealed that every episode of DKA was preceded by a pre-arranged set of circumstances, which allowed for easy access to care and hospitalization. These characteristic episodes involved the following elements: her husband being out of town for work-related trips, the patient arranging pet sitting for an extended period of time for her dog, and an emergency room visit resulting in an expected admission on the part of the patient. These hospital admissions typically occurred early in the weekend, with resolution of symptoms and discharge prior to the start of the next work week and/or the return of her husband to town. The patient readily admitted to omitting her insulin during this period of time. Repeated consultation by endocrine educators did not find anything lacking in her fund of knowledge with regard to her disease and outpatient management.

The psychiatrist's first encounter with Ms. J was during her third admission for the same constellation of symptoms within a two-month period. On Hospital Day 2, Ms. J was offered a consultation with a psychiatrist to "explore possible anxiety or mood issues that may be contributing to her presentations." The patient initially refused the consultation. However, after discovering that she was to be discharged home that afternoon (as her diabetic ketoacidosis had resolved), she changed her mind and consented.

When interviewed, Ms. J appeared anxious but disinterested in the consultation. She could easily recite her prescribed insulin regimen, and she readily admitted to having ceased taking her insulin in the days prior to admission. Yet, she was unable to provide any rationale for doing so, and promptly changed the subject. From a psychological standpoint, Ms. J appeared comfortable detailing a tumultuous developmental history, and she described a poor parental attachment to her mother, whom she described as "in and out" of the criminal justice system. When asked about her father, Ms. J stated that he left at an early age and she had no further connection to him. With some hesitation, she identified her primary guardians as a collection of aunts or secondary family members, and she recounted frequent moves in-between guardianships. When asked, she reported a turbulent history of sexual and emotional abuse from her parents' friends, as well as from other family members. Ms. J also reported a history of significant drug and alcohol use and that she was a recovering substance abuser. She reported that this pattern of abuse and maltreatment ultimately led to the first of her three foster placements.

Psychiatrist: "Tell me a little about your foster families."
Ms. J: "Oh. It was horrible. I mean, I missed my mother, but had no other family that I could trust. And after a while, the foster parents stopped caring. So in small-town Pennsylvania, there wasn't much else to do. And that's when the drugs started."
Psychiatrist: "I'm sorry, I am a little confused. Did you feel safe in your foster homes? Did your foster guardians or anyone else hit you to the point of leaving marks?"
Ms. J: "Oh no, nothing like that. I mean, like all that stuff happened from my mom's boyfriends. They hit me, and they raped me. But that was way back then."
Psychiatrist: "I'm sorry to hear that. That's horrible. Did anyone ever report it? Did you ever..." *(interrupted)*
Ms. J: "Oh yeah. That's how I ended up with my first foster family. I mean, I dealt with all that back then. I went to therapy, and psychiatrists, and all that..."
Psychiatrist: "Do you think any of that has anything to do with why you're in the hospital now?"
Ms. J: "No. And I don't want to bring all that up. I mean, I'm past that."

Ms. J reported foster care as "the worst" time, but preferable to her biological family. She implied that a constant during this period of time were her medical appointments for her diabetes, which her family and the foster families maintained at a minimum. She also reported that several childhood hospitalizations for DKA occurred during this period of time. She detailed a history of using multiple illicit drugs during the foster care years in order to "escape life," without any admission of suicidal ideation or attempts. Foster guardians did refer her to therapy, but she did not actively engage in any form of therapy or treatment. Ms. J's tone changed and she smiled when she talked about her husband, whom she met in their rural Pennsylvania hometown approximately three years ago and whom she described as "loving."

Ms. J: "No. *(her mood flattens)* He's on a training exercise. He won't be back until day after tomorrow." *(she stops eating again)*
Psychiatrist: "Does that happen often?"
Ms. J: "No, not really. *(a brief pause)* Well, sometimes. He'll, like, have to leave for a few days here and there every month for training."
Psychiatrist: "That must be pretty hard for you. You guys just moved here right?"
Ms. J: "Yeah, kinda. I mean, *(stops making eye contact)* he's not gone often..."
Psychiatrist: "So who do you hang out with when he's gone? Do you have anyone you know around here or on base?"
Ms. J: "Yeah, a few people. But all our neighbors are so stuck up. It's hard to find good people, you know?"
Psychiatrist: "Did you have a lot of friends in Pennsylvania?"
Ms. J: "Yeah, a lot. I grew up there."
Psychiatrist: "Do you keep in touch with those folks?"
Ms. J: "No, not really. I mean, I've moved on."

Ms. J seemed to attempt to sabotage the interview several times by eating throughout the interview, answering her cell phone mid-sentence, and even getting up to go to the bathroom for extended periods of time during the evaluation. She did not endorse any mood, anxiety, posttraumatic stress, or psychotic symptoms. She readily admitted that she knew how to care for her diabetes, but occasionally omitted her insulin dosing when her husband was out of town and she feels lonely. She repeatedly said that she never did this without first arranging dog-sitting services for her dog, since she knows she will be coming in for admission.

She terminated the interview by informing the team that she was not interested in any therapeutic plans or scheduling outpatient follow-up care. She refused medication trials and requests for further interviews. She also refused to consider the possibility that there may be underlying psychological factors contributing to her repeated presentations, and she continued to state that she was admitted for a simple case of DKA from which she is "better now."

Ms. J subsequently refused additional psychiatric consultation or outpatient intervention. Repeated education, including endocrine nurse educators, revealed that she had no deficits in her knowledge about her diabetes mellitus or the medications used for treatment. The psychiatrist on the treatment team suggested to the team that the patient may purposefully be withholding her insulin in order to be hospitalized and thus fill an interpersonal need for attention and being cared for, which became deficient when her husband left for business.

DISCUSSION

The *DSM IV-TR* criteria for FD includes the following: A) intentional production of feigning of physical or psychological signs or symptoms, B) assuming the sick role as motivation for the behavior, and c) absent external incentives for the behavior.[1] However, there remains some debate within the psychiatric community as to whether the diagnostic criteria should be modified in *DSM-V*.[17,18] The typical differential diagnosis for FD includes malingering. Malingering is differentiated from FD by the concept of gain. Malingering involves clear gain for which the patient feigns his or her symptoms volitionally, such as to get out of military service, earn disability, or evade criminal prosecution. By contrast, although FD patients may have a component of secondary gain, these individuals are generally unaware of their motivations and their gain, and are, therefore, not intentionally feigning symptoms.

Ms. J eventually admitted to us that she knew how to dose her insulin and prevent hospital

admissions. We believe Ms. J was of the more common subtype (non-Munchausen) of FD in that she sought care at the same facility, had a seemingly stable social support network, and did not demonstrate any identifiable pathological lying tendencies. Some of Ms. J's story and developmental history could be verified by third party input, but much of her history could not. This underscores the importance of third-party corroboration can play in distinguishing pathological lying from true history. Another FD characteristic seen in this case is that most FD patients come into contact with a psychiatrist through emergency rooms or inpatient hospitalizations. Furthermore, they lack readiness to engage in long-term psychotherapy.[19]

FD is often associated with contemporaneous pathology. Although most commonly seen within the Munchausen subclass, substance abuse is a recognized association.[20] As briefly mentioned, Ms. J had a longstanding struggle with alcohol abuse and had experimented with multiple other illicit substances.

In one analysis of 18 patients with FD, the authors found that nine (50%) patients had borderline personality disorder, six (33%) had narcissistic personality disorder, and three (17%) did not demonstrate coexisting self pathology.[21] Ms. J demonstrated borderline tendencies; however, her lack of follow up and participation in therapy made a diagnosis of borderline personality disorder difficult.

Psychodynamics. Current psychodynamic theory suggests that patients with FD create illness in order for them to compensate for an underlying psychological deficiency.[22] The underlying deficits are categorized as falling into one or more of the following categories: 1) pursuing the "sick role" in order to establish a defined identity and form a foundation of a sense of self; 2) seeking to meet dependency needs; 3) believing he or she should suffer at the hand of his or her physician(s) in order to address "forbidden" feelings; 4) manipulating physician(s) into demonstrating retaliation and countertransference in order to address feelings of anger toward healthcare clinicians; 5) attempting to gain mastery over past traumas by creating a situation in which the patient has complete control; 6) enacting suicidal wishes through factitious behaviors.[23,24]

In 1951, Talcott Parsons described the social duties and rights of "the sick role."[25] In essence, an individual in the sick role can be exempt from his or her normal social role, cannot be blamed for his or her condition, and deserves to be taken care of. In return, society expects the sick individual to work toward health and to cooperate with those professionals who are offering help. For most individuals, becoming sick is an emotionally uncomfortable situation that opens them up to feeling vulnerable. For this reason, most individuals voluntarily seek help and actively work toward returning to a healthy state. It is a rarity that a sick individual would choose to remain sick and work against the efforts of professionals to return them to health. Possible motivations to remain in the sick role include the evasion of responsibilities that society confers upon a sick individual and the nurturing relationship that healthcare professionals exhibit toward an ill patient.

The psychodynamic make up of FD is not well understood, but tends to be characterized by childhood abuse or trauma, during which the child finds nurturing in the healthcare provider rather than home environment.[8,26,27] The cardinal features seen within the developmental history of a patient with FD are a serious childhood illness, past anger with the medical profession, a past significant relationship with a healthcare provider, and FD in a parent.[28] Two of these features were prevalent in Ms. J' development. She had a serious childhood illness (type-1 diabetes) and had a significant relationship with her pediatrician, in that she reported that her multiple trips to the doctor were the only constant forms of feeling cared for as a child. One theory involves the idea that basic needs are met by the medical institution rather than a healthy home environment. The pattern of basic need, seeking acceptance and love, and expecting rejection from parents continues into adulthood when the parental roles are taken over by the healthcare providers.[8,26,27]

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We believe this is a viable psychodynamic hypothesis for our patient. Ms. J reported a developmental history consistent with poor parental attachment due to emotional and sexual abuse. We believe she feigned symptoms to overcome a nurturing deficiency and that she sought the sick role both to provide a well-defined identity and to meet dependency needs. We inferred that nurturing was most likely only received from healthcare providers during Ms. J's formative years while being treated for her newly diagnosed type 1 diabetes mellitus. Early life experiences usually shape the belief of a patient with FD that feigning symptoms will provide him or her with a nurturing environment. Perhaps nurturing was missing in Ms. J's daily life when her husband left, and her social support network was lacking. In the absence of her husband, perhaps Ms. J had a dependency void that was left unfilled. Instead of reaching out, making close friends, and enjoying

the interactions of social support networks in her community, it seems Ms. J would visit the emergency department of the hospital for care for a medical disorder she knew healthcare providers were unable to ignore.

In a sense, the medical community enables FD behavior by providing a service-oriented dedication to the patient, which allows a patient with FD to have his or her needs for nurturing and dependency met. In return, however, the staff of the emergency deparment is unable to fulfill their duty of preventing a patient's return, and therefore the staff may retaliate with anger and frustration for their lack of ability to do their duty on the patient's behalf. In the case of Ms. J, with each subsequent return to the emergency department, the care provided by the healthcare staff increasingly focused on "controlling her diabetes" as a means of "treating her." However, when we took a step back to look at the case anew, we discovered that what was lacking in her treatment was not her knowledge of insulin and blood glucose regulation, but rather the nurturing so that Ms. J felt cared for.

Treatment approach to the FD patient. The old adage "ignorance is bliss" truly applies to this diagnosis. The patient with FD breaks with the social obligation of cooperating with healthcare providers to work toward a state of health. If the healthcare provider becomes aware of this lack of cooperation, ambivalence may build toward the patient. This ambivalence then becomes counteractive to the nurturing character that most healthcare providers naturally possess. Given that many healthcare providers enter the field because of their own tendencies to settle into a nurturing, protective, caring role—and the patient with FD works against this tendency—anger and a sense of frustration builds toward the patient with FD. If a provider believes that he or she is treating a patient with FD, it becomes imperative that the clinician avoid placing patient concession of the factitious state as the end goal of treatment. Not only would this be counterproductive in a therapeutic sense, but would serve only to increase the tension in an already strained therapeutic alliance. When working with a patient with FD, accept his or her symptoms (e.g., headaches, high blood sugars, fevers) not as indicators of the illnesses the patient is trying to portray (e.g., brain tumors, DKA, sepsis), but rather as a sign of the patient's need to be nurtured. In essence, the patient's symptoms are beacons sending out a call for help for unmet needs. The treatment should not merely include more labs, imaging studies, antibiotics, or analgesics. Rather, the treatment should be aimed at the underlying deficit that the patient is incapable of identifying. Rather than becoming angry at the patient's inability to express his or her need, and "needlessly wasting" your time with "fabricated" symptoms, realize that the patient needs the very nurturing environment that your anger and frustration are now preventing. Perhaps the next lab draw, MRI, or tissue biopsy is a way the patient keeps connected to you. The patient may endure the discomfort of the procedure because he or she feels he or she deserves it as a consequence of his or her inability to cooperate with you and work toward a state of health.

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Treatment strategies. There are several strategies commonly employed in the treatment of FD. In one case series, 33 patients were carefully confronted with the factitious nature of their illness. While only 13 of the 33 admitted feigned illness, most of the patients' illnesses improved following this strategic confrontation.[9] Inexact interpretation is described as a helpful method for gently confronting a patient with FD.[29] It often allows the patients to see their own feigned symptoms without being placed in a defensive posture. Eisendrath[29] also proposes the therapeutic double-blind technique as a useful treatment approach. In this approach, the patient is told that a new medical intervention exists. The patient is informed that his or her disease could either be of factitious or organic origin, but that the "new intervention" will only work on organic disease. In these situations, the treatment will "work" and the factitious illness will improve. Hypnosis and biofeedback are two additional treatment approaches described in literature.[29]

Although there are many commonly employed treatment modalities, there is no universally accepted, evidence-based treatment strategy for FD.[16] Treatment strategies for FD generally address the patient's maladaptive method of having his or her needs met and focus on finding a more appropriate method of meeting the same (deeper) underlying needs. First and foremost, the therapist should build a therapeutic alliance with the patient. This comes through regular contact with the patient, without the slightest sense of anger or frustration expressed by the provider. This requires the therapist to first acknowledge and address his or her own countertransference toward this difficult patient population. If the patient feels the therapist is able to

see him or her regularly, without fear of retaliation for behavior, trust builds in the relationship. Only with a firm foundation of trust can the psychiatrist begin to address the patient's need for nurturing, modeling a healthy dynamic for the patient to emulate outside of the office.

Because eventually these patients may frustrate all providers who are unable to meet their repetitive surface needs by tending to their feigned symptoms, countertransference may steadily grow with every visit of the patient to the healthcare facility. Healthcare providers' feelings of anger, contempt, futility, confusion, and frustration may interfere with treatment. The psychiatrist may experience these feelings in response to his or her own feelings of being unable to meet the patient's repetitive needs, but also may feel anger and frustration once it becomes obvious to the provider that the patient is feigning symptoms. The provider should not focus on a cure, but rather on regular appointments to meet the patient's needs before the unmet needs manifest into another emergency room visit with a different, unsuspecting emergency room staff who will admit the patient and attempt to treat the patient with potentially harmful or painful procedures. Regular therapy appointments that address meeting nurturing needs may help prevent the burden of utilizing limited emergency room and hospital resources on an emergent basis. The conservation of time and healthcare resources would be the main goal of the healthcare system. In contrast, meeting the patient's needs in a healthy and mature manner should be the main goal of the therapist. Providers should not focus on the fact that symptoms are being feigned, and therefore that the patient lacks genuine illness, but rather should consider the feigned symptoms as an indication of the patient's need for human contact and nurturing.

A noteworthy 1988 review article covering 72 described cases of pseudologia fantastica revealed evidence of organic central nervous system dysfunction in at least 40 percent of cases.[30] Thus, an appropriate medical workup is also clinically indicated, even in the known FD patient.

During the evaluation period when a clinician is attempting to confirm his or her suspicion that a patient may indeed be feigning symptoms, the clinician must take care not to accuse or provoke the patient. Maintain regular appointments, with the therapeutic goal being to improve rapport and gain trust—not have the patient "admit" that his or her symptoms are not the reason for the visits. If the clinician falls into the trap of trying to make the patient admit his or her illness is not "real," more than likely the result will be loss of the patient's trust and alienating the the individual. The patient may then stop coming to his or her appointments and may turn to another hospital to seek to have his or her needs met. This would serve only to displace the symptomatology upon a new set of healthcare providers who are unaware of this individual's issues and may further provoke the patient's symptoms to continue in an unhealthy manner.

In our case example, the DKA was not an example of poorly controlled diabetes; the DKA, purposely caused by the patient, was a symptom of an inability to tolerate a lack of social contact during her husband's absences. The main goal, which may or may not have been recognized by the patient, of the visits to the emergency room were replace the absent husband's nurturing with the nurturing provided by the healthcare system.

SUMMARY

This case of DKA in a patient with otherwise well-controlled diabetes mellitus type 1 was actually a case of FD. The patient's under-dosing of insulin in discrete amounts to allow visitation and admission to our institution seemed less about her diabetes and more about fulfilling dependency and self-identity needs. Although this individual would best be served by the mental health community, as with most patients with FD, this patient may continue to present to the primary care and emergency departments. Sparing scarce resources without compromising her need to have her required nurturing met should be the therapeutic endpoint in this type of patient. This is done through frequent outpatient therapy sessions focused on building trust and rapport. Early identification and controlling countertransference toward this patient population is also critical to the provider's effectiveness in caring for this repetitive patient type. Confrontation may be of some benefit if used appropriately (gently with inexact interpretation). Therapeutic double-blind, biofeedback, and hypnosis are also therapeutic options for the treating mental health provider. However, further study may be required in order to statistically validate any one treatment modality employed in FD psychotherapy.

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