Suicidality in Factitious Disorder

Eric M. Blumenfeld, BS[a,*]; Mohan Gautam, DO, MS[b]; Esther Akinyemi, MD[b]; and Gregory Mahr, MD[b]

Factitious disorder (FD) is common in clinical settings yet is often underrecognized. While limited studies[1–5] have demonstrated high rates of comorbid suicidal ideation and completed suicide, the assessment of suicidal intent in FD becomes challenging, as suicidality may be a manifestation of symptom falsification. The literature[6] suggests that presumed suicide completion in FD may be a consequence of patients' underestimation of the lethality of their self-injury methods and that self-inflicted accidental death may be a more significant comorbidity. We present the case of patient who was hospitalized for a presumed act of attempted suicide requiring urgent and invasive medical intervention, which was later found to be more consistent with a manifestation of her FD.

Case Report

Ms A is a middle-aged woman who presented to our urban tertiary care hospital after swallowing 2 batteries and a segment of a TV antenna in a stated attempt to kill herself. Emergent endoscopy confirmed the presence of the antenna and batteries, which were subsequently removed without complication. Ms A was then admitted to a medical service to prepare for discharge; however, manifestations of FD including deliberate starvation and nonepileptiform seizures ultimately led to a nearly 3-month stay in the hospital.

Shortly after Ms A was medically cleared, she declared that she would kill herself by not eating. Over the course of several days, concern for metabolic derangement from malnutrition necessitated placement of a nasogastric feeding tube, which led to decreased interviews for placement in adult foster care homes and a preponderance of rejections. As her discharge prospects were rapidly diminishing, Ms A's mood improved. She spontaneously began to drink water and eat food with the feeding tube still in place. Eventually, when no adult foster care group homes would accept her, she agreed to removal of the feeding tube.

During this hospitalization, Ms A also developed highly atypical seizure-like activity, which correlated with particular social interactions (ie, when her 1-to-1 sitter was not sufficiently interactive with her). The medical team discovered that on several incidences, she not only displayed blink to threat, but also attempted to suppress a laugh from certain jokes. After uncoupling a team response to her behavior on several consecutive occasions, her seizure-like symptoms abruptly ceased.

Discussion

Throughout the course of Ms A's hospital stay, her falsification of symptoms and deliberate acts of self-harm were found to be consistent with a diagnosis of FD (*DSM-5* criteria).[7] While Ms A's avoidance of adult foster care home placement raised concerns for malingering, the risks and consequences of her deliberate starvation, feeding tube placement, and antiepileptic drug regimen alterations appeared out of proportion to external rewards. The absence of a more sensitive external motivator (ie, litigation or narcotics), along with attempts to maximize hospital staff interactions and her full cooperation with medical treatment, provided greater evidence for sick role assumption as the primary motivation and highlighted significant psychopathology unaccountable by malingering alone.[8,9] Additionally, Ms A was found to have no coexisting or underlying mental disorder attributable to her factitious behavior. She lacked a history to suggest a contributory eating disorder or additional signs or symptoms to suggest an underlying mood disorder, further substantiating her presumed suicidality to be a factitious manifestation.

Unlike the *DSM-5*, the *DSM-IV-TR*[10] described a distinct, predominantly psychological subtype of FD in which the feigning of psychological symptoms was the predominant factitious manifestation. In contrast to the classical "Munchausen" or physical subtype, the psychological subtype of FD was vague in description and poorly sourced in the scientific literature, most likely leading to its removal in the *DSM-5*.[11] This gap or bias in the medical literature explains why cases like that of Ms A are underrecognized, poorly understood, and challenging to manage. Furthermore, there is no literature to guide the clinician in differentiating between true and factitious suicidality in FD.

In the absence of true suicidal intent, the decision to promptly discharge a patient with FD without advanced notice may be made over concerns that having advanced knowledge of discharge would put the patient at increased risk of further self-injury. However, this scenario poses a difficult ethical dilemma, as some may view this decision in support of beneficence while others may question autonomy. From a psychodynamic frame of reference, FD is

[a]Wayne State University School of Medicine, Detroit, Michigan
[b]Department of Psychiatry, Henry Ford Hospital/Wayne State University, Detroit, Michigan
*Corresponding author: Eric M. Blumenfeld, BS, Wayne State University School of Medicine, 540 E. Canfield St, Detroit, MI 48201 (eblumenf@med.wayne.edu).

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viewed as a complex manifestation of sadomasochistic issues in which complex hostile ego introjects are projected onto caregivers,[12,13] and this perspective holds that falsification and self-injurious behaviors are often beyond volitional control.[4,9,14] This inference supports the decision to regard beneficence over autonomy and withhold certain aspects of discharge implementation to reduce the duration of hospitalization and lessen the risk of further self-harm.

Self-injurious behavior in FD bears some similarities to nonsuicidal self-injury as a compulsive means of relieving anxiety or garnering attention.[1,15] Curiously, FD and borderline personality disorder, which is frequently associated with nonsuicidal self-injury, have long been identified as common comorbidities sharing an underlying etiology.[4,14,16] Thus, psychotherapeutic approaches with demonstrated efficacy in borderline personality disorder, such as dialectical behavioral therapy, may be of clinical utility in patients with FD even in the absence of a comorbid personality disorder,[17,18] although with the exception of a single case report,[19] this has yet to be detailed in the literature. Despite most available interventions, FD carries a poor prognosis, mainly due to poor adherence to treatment plans, with more than 60% of patients refusing treatment or being lost to follow-up.[3]

The assessment of suicidality depends to a significant degree on a patient's self-report. While most clinicians realize that patients underreport suicidality, we are generally less comfortable with patients who falsify their own suicidality. With a lack of present-day literature and guidelines, it is important to carefully assess for suicidality in these patients, but not to overtreat it, as this may reinforce the pathology of FD and lead to unnecessary interventions and expenditures. Providers may choose to withhold discharge information in favor of beneficence, although this generally requires significant ethical deliberation. Treatment of FD often necessitates longitudinal psychotherapy in the outpatient setting, although adherence and prognosis are generally poor. Further studies are necessary to further characterize suicidality in FD and develop more efficacious treatment approaches, with dialectical behavioral therapy an option yet to be explored.

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