

The woman who kept passing out

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How would you handle this case?

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After becoming unresponsive, Ms. B, age 44, is admitted, sedated, and intubated. She has had 3 similar episodes, and each time left the hospital AMA. Is this a medical crisis, or something else?

CASE An apparent code blue

Ms. B, age 44, has posttraumatic stress disorder (PTSD), bipolar disorder, and chronic obstructive pulmonary disease. She presents to the hospital for an outpatient orthopedic appointment. In the hospital cafeteria, she becomes unresponsive, and a code blue is called. Ms. B is admitted to the medicine intensive care unit (MICU), where she is sedated with propofol and intubated. The initial blood work for this supposed hypoxic event shows a P_{O_2} of 336 mm Hg (reference range: 80 to 100 mm Hg; see *Table 1*,¹ page 45). The MICU calls the psychiatric consultation-liaison (CL) team to evaluate this paradoxical finding.

HISTORY A pattern of similar symptoms

In the 12 months before her current hospital visit, Ms. B presented to the emergency department (ED) on 3 occasions. These were for a syncopal episode with shortness of breath and 2 incidences of passing out while receiving diagnostic testing. Each time, on Ms. B's insistence, she was admitted and intubated. Once extubated, Ms. B left against medical advice (AMA) after a short period. She has an allergy list that includes more than 30 drugs spanning multiple drug classes, including antibiotics, contrast material, and some

gamma aminobutyric acidergic medications. Notably, Ms. B is not allergic to benzodiazepines. She also has undergone more than 10 surgeries, including bariatric surgery, cholecystectomy, appendectomy, neurostimulator placement, and colon surgery.

EVALUATION Clues suggest a potential psychiatric diagnosis

When the CL team initially consults, Ms. B is intubated and sedated with dexmedetomidine, which limits the examination. She is able to better participate during interviews as she is weaned from sedation while in the MICU. A mental status exam reveals a woman who appears older than 44. She is oriented to person, place, time, and situation despite being mildly somnolent and having poor eye contact. Ms. B displays restricted affect, psychomotor retardation, and slowed speech.

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Table 1

Arterial blood gas findings based on respiratory rate

	Normal breathing	Hyperventilation	Hypoventilation	Comorbidities
P _O ₂ (mm Hg)	65 to 85	>85	<65	Variable
P _{CO} ₂ (mm Hg)	35 to 45	<35	>45	Variable

Source: Reference 1

Table 2

Methods and symptoms of factitious disorder

Methods of feigning symptoms	Common fabricated symptoms
Ingesting or injecting medications or contaminants	Chest pain
Self-mutilation	Coagulopathy
Exacerbating existing illness	Hyperthyroidism
Reporting normal findings as pathological	Hypoglycemia
Tampering with diagnostic tests	Infections
Forging medical records	Seizures
Coaching others to report false information	Poor healing wounds

Source: Reference 3

Clinical Point

Ms. B's ABG revealed paradoxical findings of elevated P_{CO}₂, likely due to hyperventilation

She denies suicidal or homicidal thoughts, intent, or plans; paranoia or other delusions; and any visual, auditory, somatic, or olfactory hallucinations. Her thought process is goal-directed and linear but with thought-blocking. Ms. B's initial arterial blood gas (ABG) test is abnormal, showing she is acidotic with both hypercarbia and extreme hyperoxemia (pH 7.21 and P_{CO}₂ of 62 mm Hg, but a P_O₂ of 336 mm Hg, HCO₃ of 25 mmol/L, 0% methemoglobin, and total hemoglobin of 17.5 g/dL).

What underlying psychiatric issue may need to be considered in Ms. B's care?

- Panic disorder
- Major depressive disorder
- Substance use disorder (eg, intoxication, withdrawal)
- Factitious disorder
- PTSD

The authors' observations

Under normal code blue situations, patients are expected to have respiratory acidosis, with low P_O₂ levels and high P_{CO}₂ levels.

However, Ms. B's ABG revealed she had high P_O₂ levels and high P_{CO}₂ levels. Her paradoxical findings of elevated P_{CO}₂ on the initial ABG were likely due to hyperventilation on pure oxygen in the context of her underlying chronic lung disease and respiratory fatigue.

The clinical team contacted Ms. B's husband, who stated that during her prior hospitalizations, she had a history of physical aggression with staff when weaned off sedation. Additionally, he reported that 1 week before presenting to the ED, she had wanted to meet her dead father.

A review of Ms. B's medical records revealed she had been prescribed alprazolam, 2 mg 3 times a day as needed, so she was prescribed scheduled lorazepam in addition to the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) protocol to prevent benzodiazepine withdrawal. Ms. B had 2 prior long-term monitoring for epilepsy evaluations in our system for evaluation of seizure-like behavior. The first evaluation showed an episode of stiffening with tremulousness and eye closure for

Table 3

Differential diagnosis and distinguishing characteristics of factitious disorder

	Self-harm	Production of symptoms	Motivation	Willingness to change
Factitious disorder	Often	Deliberate, secretive	Unconscious with unclear incentives	Poor to ambivalent
Malingering	None or minimal	Deliberate, feigned	Conscious with clear incentives	None or minimal
Functional, dissociative, somatoform, and bodily distress disorders	None or minimal	Not deliberate	Unconscious with lacking or unclear incentives	High

Source: References 3,4

Clinical Point

Symptoms of factitious disorder include self-mutilation, forging medical records, and coaching others to report false information

20 to 25 minutes with no epileptiform discharge or other EEG changes. The second showed diffuse bihemispheric dysfunction consistent with toxic metabolic encephalopathies, but no epileptiform abnormality.

When hospital staff would collect arterial blood, Ms. B had periods when her eyes were closed, muscles flaccid, and she displayed an unresponsiveness to voice, touch, and noxious stimulation, including sternal rub. Opening her eyelids during these episodes revealed slow, wandering eye movements, but no nystagmus or fixed eye deviation. Vital signs and oxygenation were unchanged during these episodes. When this occurred, the phlebotomist would leave the room to notify the attending physician on call, but Ms. B would quickly return to her mildly impaired baseline. When the attending entered the room, Ms. B reported no memory of what happened during these episodes. At this point, the CL team begins to suspect that Ms. B may have factitious disorder.

TREATMENT Agitation, possibly due to benzo withdrawal

Ms. B is successfully weaned off sedation and transferred out of the MICU for continued CIWA protocol management on a different floor. However, she breaks free of her soft restraint, strips naked, and attempts to

barricade her room to prevent staff from entering. Nursing staff administers haloperidol 4 mg to manage agitation.

What is the next step for treating Ms. B?

- Maintain current medication recommendations
- Emergency involuntary psychiatric hospitalization
- Consultation with hospital's ethics committee
- Increase lorazepam to match prior alprazolam dosage
- Withhold all medications and employ continuous in-room video monitoring

The authors' observations

To better match Ms. B's prior alprazolam prescription, the treatment team increased her lorazepam dosage to a dose higher than her CIWA protocol. This allowed the team to manage her withdrawal, as they believed that benzodiazepine withdrawal was a major driving force behind her decision to leave AMA following prior hospitalizations. This enabled the CL team to coordinate care as Ms. B transitioned to outpatient management. The team suspected Ms. B may have factitious disorder, but did not discuss that specific diagnosis with the patient. However, they did talk through general treatment options with her.

Objective findings	Comorbidity
Abnormal to discrepant	Significant physical and psychological
Normal	Low
Typically normal	Significant psychological and potential physical

Challenges of factitious disorder

DSM-5 classifies factitious disorder under Somatic Symptoms and Related Disorders, and describes it as “deceptive behavior in the absence of external incentives.”² A prominent feature of factitious disorder is a persistent concern related to illness and identity causing significant distress and impairment.² Patients with factitious disorder enact deceptive behavior such as intentionally falsifying medical and/or psychological symptoms, inducing illness to themselves, or exaggerated signs and symptoms.³ External motives and rewards are often unidentifiable but could result in a desire to receive care, an “adrenaline rush,” or a sense of control over health care personnel.³ *Table 2³ (page 45)* outlines additional symptoms of factitious disorder. When evaluating a patient who may have factitious disorder, the differential diagnosis may include malingering, conversion disorder, somatic symptom disorder, delusional disorder somatic type, borderline personality disorder, and other impulse-control disorders (*Table 3^{3,4}*).

Consequences of factitious disorder include self-harm and a significant impact on health care costs related to excessive and inappropriate hospital admissions and treatments. Factitious disorder represents approximately 0.6% to 3% of referrals from general medicine and 0.02% to 0.9% of referrals from specialists.³

Patients may be treated at multiple hospitals, pharmacies, and medical institutions because of deceptive behaviors that lead to a lack of complete and accurate documentation and fragmentation in communication and care. Internet access may also play a role in enabling skillful and versatile feigning of symptoms. This is compounded with further complexity because many of these patients suffer from comorbid conditions.

Management of self-imposed factitious disorder includes acute treatment in inpatient settings with multidisciplinary teams as well as in longer-term settings with ongoing medical and psychological support.⁵ The key to achieving positive outcomes in both settings is negotiation and agreement with the patient on their diagnosis and engagement in treatment.⁵ There is little evidence available to support the effectiveness of any particular management strategy for factitious disorder, specifically in the inpatient psychiatric setting. A primary reason for this paucity of data is that most patients are lost to follow-up after initiation of a treatment plan.⁶

Addressing factitious disorder with patients can be particularly difficult; it requires a thoughtful and balanced approach. Typical responses to confrontation of this deceptive behavior involve denial, leaving AMA, or potentially verbal and physical aggression.⁴ In a review of medical records, Krahn et al⁶ found that of 71 patients with factitious disorder who were confronted about their role in the illness, only 23% (n = 16) acknowledged factitious behavior. Confrontation can be conceptualized as direct or indirect. In direct confrontation, patients are directly told of their diagnosis. This frequently angers patients, because such confrontation can be interpreted as humiliating and can cause them to seek care from another clinician, leave the hospital AMA, or increase their self-destructive behavior.⁴ In contrast, indirect confrontation approaches the conversation with an explanatory view

Clinical Point

The key to achieving positive outcomes is negotiation and agreement with the patient on their diagnosis and treatment

Clinical Point

No evidence supports the efficacy of one form of psychotherapy over another for treating patients with factitious disorder

Table 4

VENTILATE: Management of patients with factitious disorder with a respiratory/pulmonary presentation

View ⁵	View the patient's chart and gain a comprehensive knowledge of their psychiatric timeline
Engage ⁵	Engage the patient in active participation in their treatment plan
Negotiate ⁴	Negotiate realistic goals of treatment with the patient
Teamwork ⁵	Collaborate with all members of the treatment team, including family, nursing, physicians, specialists, administrators, and, if applicable, the hospital attorney and hospital ethics committee
Indirect approach ⁷	Use an indirect approach focused on symptom control or relief, rather than direct confrontational style of interaction with the patient, which would be more likely to result in the patient leaving AMA
Lab evaluation	Obtain and review appropriate lab testing and medical evaluation to rule out other confounding medical issues
Agreement ^{8,9}	The patient, treatment team, and CL psychiatrist must agree on the goals of treatment
Treatment ⁷	Treat any psychiatric conditions as indicated with benzodiazepines, beta blockers, or other appropriate pharmacologic interventions
Exercises in breathing and relaxation ¹⁰	Psychotherapy exercises such as relaxation training and breathing techniques are especially useful for patients with factitious disorder, hyperventilation subtype
AMA: against medical advice; CL: consultation-liaison	

of the maladaptive behaviors, which may allow the patient to be more open to therapy.⁴ An example of this would be, "When some patients are very upset, they often do something to themselves to create illness as a way of seeking help. We believe that something such as this must be going on and we would like to help you focus on the true nature of your problem, which is emotional distress." However, there is no evidence that either of these approaches is superior, or that a significant difference in outcomes exists between confrontational and nonconfrontational approaches.⁷

The treatment for factitious disorder most often initiated in inpatient settings and continued in outpatient care is psychotherapy, including cognitive-behavioral therapy, supportive psychotherapy, dialectical behavioral therapy, and short-term psychodynamic psychotherapy.^{4,8,9} There is, however, no evidence to support the efficacy of one form of psychotherapy over another, or even to establish the efficacy of treatment

with psychotherapy compared to no psychotherapy. This is further complicated by some resources that suggest mood stabilizers, antipsychotics, or antidepressants as treatment options for psychiatric comorbidities in patients with factitious disorder; very little evidence supports these agents' efficacy in treating the patient's behaviors related to factitious disorder.⁷

No data are available to support a management strategy for patients with factitious disorder who have a respiratory/pulmonary presentation, such as Ms. B. Suggested treatment options for hyperventilation syndrome include relaxation therapy, breathing exercises, short-acting benzodiazepines, and beta-blockers; there is no evidence to support their efficacy, whether in the context of factitious disorder or another disorder.¹⁰ We suggest the acronym VENTILATE to guide the treating psychiatrist in managing a patient with factitious disorder with a respiratory/pulmonary presentation and hyperventilation (*Table 4*^{4,5,7-10}).

Bass et al⁵ suggest that regardless of the manifestation of a patient's factitious disorder, for a CL psychiatrist, it is important to consult with the patient's entire care team, hospital administrators, hospital and personal attorneys, and hospital ethics committee before making treatment decisions that deviate from usual medical practice.

OUTCOME Set up for success at home

Before Ms. B is discharged, her husband is contacted and amenable to removing all objects and medications that Ms. B could potentially use to cause self-harm at home. A follow-up with Ms. B's psychiatric outpatient clinician is scheduled for the following week. By the end of her hospital stay, she denies any suicidal or homicidal ideation, delusions, or hallucinations. Ms. B is able to express multiple protective factors against the risk of self-harm, and engages in meaningful discussions on safety planning with her husband and the psychiatry team. This is the first time in more than 1 year that Ms. B does not leave the hospital AMA.

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Related Resources

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Drug Brand Names

Alprazolam • Xanax	Haloperidol • Haldol
Dexmedetomidine • Precedex	Lorazepam • Ativan

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Clinical Point

Before making treatment decisions, consult with a patient's care team, hospital administrators, attorneys, and hospital ethics committee

Bottom Line

Patients with factitious disorder may present with respiratory/pulmonary symptoms. There is limited data to support the efficacy of one approach over another for treating factitious disorder in an inpatient setting, but patient engagement and collaboration with the entire care team is critical to managing this difficult scenario.