

FELLOWSHIP FORUM/CASE REPORT

Adolescents With Factitious HIV Disease

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Purpose: To describe two cases of factitious HIV disease and their implications for clinical practice and research.

Methods: Review of medical records and literature search.

Results: A 19-year-old female and 17-year-old male were referred to an adolescent HIV clinic for evaluation and treatment of HIV disease. The former reported having been tested at a primary care clinic because of her history of transfusions, although the likely route of infection was intravenous drug use. The 17-year-old claimed to have contracted HIV through unprotected vaginal intercourse. Both patients reported HIV-related symptoms and prior seropositive HIV antibody test results which could not be corroborated. Other important features were histories of mental health problems, lack of apparent distress regarding HIV infection, and extensive knowledge of HIV disease.

Conclusions: In both cases, the most likely diagnosis was Factitious Disorder with combined psychological and physical signs and symptoms, based on the feigning of seropositive HIV test results, report of physical symptoms undocumented by physical examination, the need to assume the sick role, and the absence of obvious secondary gain. This report serves to underscore the need to confirm the presence of HIV infection in young people who seek treatment for HIV disease, especially when clinical presentations resemble these cases. © *Society for Adolescent Medicine, 1997*

KEY WORDS:

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Since the human immunodeficiency virus (HIV) was first described, there have been case reports of uninfected people who claim to be HIV seropositive (1-22). In some cases, this is the consequence of diagnoses because of human error, false positive results, or patient misunderstanding (9). Patients may believe they are infected because of their high-risk behavior (8). For example, a man who was HIV seronegative was mistakenly enrolled in a placebo-controlled trial of azidothymidine treatment. He was convinced that the negative HIV antibody test result was a mistake because he had regular, unprotected anal intercourse with a partner who had died of acquired immune deficiency syndrome (AIDS) (8). Malingering and Factitious Disorder are additional causes of misdiagnoses (1-23).

Factitious Disorder has been defined as the intentional production or feigning of physical or psychological symptoms with the psychological need to assume the sick role (23). Unlike malingering, external incentives, such as economic gain or better care, are absent (23). Factitious AIDS was first described in 1986 in two adults (16). Subsequently, there have been other adult cases reported (2-4,6-8,9-12,15-22). Although the prevalence of factitious HIV disease is not known, only 4 in a series of 163 HIV-related cases in a New York City psychiatric hospital were labeled factitious (24).

To the best of our knowledge, factitious HIV disease has not previously been described in an adolescent. The purpose of this article is to describe two cases of factitious HIV disease in adolescents and their implications for clinical practice and research.

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Methods

Data for the cases were collected by the author (G.R.) and consultants (the first patient's psychologist and the second patient's primary physician), and retrieved from medical records. This methodology did not allow for follow-up data about the cases, or information from other providers these patients may have been seeing. In the interest of confidentiality, patient identifying information (names, initials, residences, dates, and locations of clinic visits) were removed. Procedures were approved by the University of Minnesota Institutional Review Board.

Case 1

C.T. was a 19-year-old white female who sought treatment for HIV infection from an adolescent HIV/AIDS clinic. The patient said that she was diagnosed at her primary care clinic 6 months earlier during follow-up for transfusions that were administered during treatment of acute lymphoblastic leukemia (ALL) at age 13 years. She claimed that a repeat test confirmed her initial seropositive results.

C.T. reported that the most likely route of infection was not by blood products, but by injecting heroin and cocaine in the past 6 years. Peak chemical use at age 17 years included 8 g of injected cocaine daily, injected heroin two to three times a week, as well as alcohol and marijuana. She denied any recent substance use or ever having had sexual intercourse.

C.T. claimed that her adjustment to being HIV seropositive was initially difficult, but that she had come to terms with her illness, without symptoms of depression. Further, C.T. claimed to have disclosed her condition to her mother, father, ex-boyfriend, roommate, and some needle-sharing partners.

The physical examination was unremarkable except for a clumsy gait, a mild tremor, and synkinesis with rapid alternating movements. The following laboratory results were obtained; white blood cells (WBC) $6.5 \times 10^9/L$ (60% neutrophils, 32% lymphocytes, 8% monocytes), hemoglobin (Hgb) 12.3 g/dL, Plt $219 \times 10^9/L$. The absolute CD4 count was 1,310 cells/ μL ; absolute CD8, 437 cells/ μL ; and CD4/CD8 ratio, 3.00. An HIV-1 antibody enzyme linked immunosorbent assay (ELISA) and an HIV blood culture were negative. Permission for release of medical records was obtained.

One week after the clinic visit C.T. sent a letter which indicated that she had developed a rash, diarrhea, dry, itchy eyes, emesis, fever, anorexia, and 8–10-lb weight loss, and hearing loss. She also wrote

that her records would be difficult to obtain because they had been destroyed in a fire. However, records that were obtained from her primary care clinic failed to substantiate a history of HIV infection or ALL.

The patient returned to clinic 3 months later after two failed appointments. She claimed to have been hit by a car on the way to clinic and to have neglected to mention having diabetes mellitus at the previous visit. The physical examination was unchanged. A mental status examination revealed loose associations, flat affect, and inappropriate laughter. Thought blocking also was observed; when questioned about incongruities in her history she commented repeatedly, "file not found."

C.T. was told that there was no evidence of HIV infection, and that the records did not support a history of diabetes mellitus or leukemia. C.T. attributed this to poor medical records or her faulty recollection of the site of HIV antibody testing. She admitted that she had read medical textbooks. C.T. was referred to a psychologist for evaluation. The first interview with C.T. included her adoptive father. He revealed that she had problems with her peers since childhood, and had engaged in lying since junior high school. At age 13 years, C.T. attempted suicide by ingesting bleach and aspirin. She has had contact with six or seven counselors; however, she has had no psychiatric hospitalizations and never used psychiatric medications. Her adoptive father noted that she had been unable to maintain employment because of poor skills and problems with authority.

While participating in outpatient psychotherapy, C.T. was referred for psychiatric consultation. A diagnosis of organic brain syndrome, with organic personality disorder and antisocial traits was entertained. No medications were prescribed. Psychotherapy was terminated by C.T. after 22 visits.

Case 2

F.R. was a 17-year-old white male who was referred to an adolescent HIV/AIDS clinic by his primary pediatrician for treatment of HIV disease. The patient reported that he received a seropositive HIV antibody test result at a public health clinic approximately 1 month earlier. A repeat test was said to be pending. The patient's self-reported results were brought to the attention of the pediatrician by the director of the group home where F.R. was living. The patient volunteered this information about his

HIV serostatus and claimed that the testing site would not release documentation of the HIV antibody test results.

F.R. had had a history of alcohol, marijuana, and LSD use for approximately 3–4 years. He said that he had been smoking cocaine for 5–6 months before admission to the group home, but denied intravenous drug use. F.R. identified unprotected vaginal intercourse with female partners as his only risk factor. However, he described blackouts during substance use and intimated possible other risk factors that he could not remember. He had no history of psychiatric problems. The patient said that he became a ward of the state after 3 years as an emancipated minor because he had abused general assistance benefits. He was found to have been collecting general assistance benefits from a state in which he did not reside.

F.R. complained of night sweats for 2 months and a swollen cervical gland for 2 weeks. His physical examination was negative except for a single, small, soft, mobile lymph node in the left axilla. The following laboratory results were within normal limits: WBC $7.1 \times 10^9/L$ (54% neutrophils, 30% lymphocytes, 6% monocytes, 8% eosinophils, 2% basophils), Hgb 15.8 g/dL, Plt $183 \times 10^9/L$. Absolute CD4 count was 1,065 cells/ μL ; absolute CD8, 596 cells/ μL ; and CD4/CD8 ratio, 1.79. An HIV-1 antibody ELISA and an HIV blood culture were negative.

F.R. returned to clinic for laboratory results after 2 weeks. He was noted to be pleased by the results, but not surprised. To provide post-test counseling he was asked about his sexuality, and appeared anxious. He said that his sister is a lesbian activist and he preferred having gay or lesbian friends; however, he reported feeling comfortable with his heterosexuality. He did not rule out the possibility of having sex with men in the future. F.R. returned to his primary physician, where he continued to be followed for approximately 1.5 years.

Discussion

The *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM IV) (23) classifies Factitious Disorder by the subtype that best characterizes the predominant signs or symptoms: psychological, physical, or combined. The differential diagnosis includes bona fide medical conditions, misunderstanding, and mental disorders such as depression, somatoform disorder, hypochondriasis, and malingering. The cases presented here are examples of

factitious HIV disease with combined psychological and physical signs and symptoms. Meeting the first DSM IV criterion for Factitious Disorder, both patients apparently feigned positive HIV tests and physical symptoms. C.T. reported a number of physical complaints by letter. F.R. complained of night sweats and cervical lymphadenopathy. The psychological need to assume the sick role, DSM IV Criterion B, appeared to be both patients' motivation. While patients with Factitious Disorder produce their signs and symptoms consciously, their motives are primarily unconscious (25). Neither C.T. nor F.R. obtained monetary or other discernible external benefits in claiming to have HIV. The absence of external incentives, DSM IV Criterion C, distinguishes Factitious Disorder from malingering. However, F.R. had a history of abusing general assistance benefits, raising the possibility of ulterior motives in reporting HIV infection.

The cases illustrate other aspects of Factitious Disorder. C.T. related a striking, unsubstantiated history of substance abuse and medical problems, similar to the pathologic lying or "pseudologia fantastica" seen in other patients with Factitious Disorder (23). As in her case, an extensive knowledge of medical conditions may be part of the history. Similar to other patients with Factitious Disorder, C.T. did not admit that she did not have HIV disease when confronted with the laboratory results and her previous medical records. F.R., however, seemed relieved that he was not infected. Therefore, the possibility of a false positive result, a laboratory error, or misunderstanding of the test results remained. Hypochondriasis was considered in the differential diagnosis, but ruled out by the facts of the case. Patients with hypochondriasis worry that they have HIV disease because of high-risk behavior or other reasons, but do not feign symptoms and abnormal laboratory tests (25).

Possible predisposing factors to Factitious Disorder include the presence of other mental disorders or medical conditions during childhood and adolescence that lead to extensive medical treatment and hospitalizations (23). C.T. began counseling in the sixth grade and had had extensive mental health treatment thereafter. F.R. had a history of substance abuse and chemical dependency treatment. However, mental health disorders, substance abuse, and social problems are not uncommon among adolescents with HIV infection (26).

These two cases differ from reported cases of adults with factitious HIV disease, most of which have involved Caucasian men (25–41 years of age)

who had sex with men (1,2,4,7,8,10-13,16-18,20). Although F.R. considered himself to be heterosexual, he intimated other possible risk factors and did not exclude the possibility of having sex with men in the future. C.T.'s claim of intravenous drug use without a history of sexual activity was inconsistent with the literature. A study of 112 intravenous drug users (IDU) with HIV revealed all to have a history of sexual activity, with 89% of the women reporting sex with another IDU (27). Other clues that the two patients were falsely claiming HIV seropositivity included their apparent lack of distress about being HIV seropositive despite recent diagnosis, and the fact that prior reportedly seropositive HIV antibody test results could not be documented.

The reasons that persons with Factitious Disorder may focus on HIV disease are uncertain. It has been postulated that health care providers' empathy for people with HIV disease may fulfill the need for nurturance among individuals with Factitious Disorder (28). Also, the widespread notoriety of HIV may result in an increasing number of factitious infections (28). Finally, detecting factitious HIV antibody test results can be difficult because of confidential and anonymous testing practices.

These cases of factitious HIV disease underscore the need to verify a patient's HIV serostatus before providing nonemergency HIV-related care. In light of the use of confidential or anonymous test sites, it can be difficult to substantiate a claim of HIV seropositivity. False-positive test results also can occur with either ELISA or Western blot tests, although they are less common with the latter (29). The combined specificities of the tests may be as high as 99.9%, with sensitivities of 100% (except in the seronegative window period). However, the positive predictive value of the tests depends on the prevalence of HIV in a population. For example, among intravenous drug users with seroprevalence of 50%, the probability of a positive test occurring in a truly infected person will approach 100%. In contrast, testing a group with a low seroprevalence can result in a high percentage of false-positive results (29). Finally, laboratory errors can occur.

Seropositive test results can be confirmed by the provider of HIV-related care in a variety of ways. If an individual is thought to be unlikely to have been exposed to HIV, the ELISA and Western blot might be repeated by a different laboratory (29). Other tests, such as the radioimmunoprecipitation antibody assay, immunofluorescent antibody assay, polymerase chain reaction assay, or HIV-1 isolation by cell culture, may be necessary (29).

Conversely, it would be misleading to assume that self-reported seropositive results are correct solely because an individual is likely to have been exposed to the virus. Factitious HIV disease may not be suspected by clinicians because such patients typically offer a history of high-risk behaviors (1,2,4,7,8,10-13,16-18,20,28). Minimally, documentation of an HIV antibody test that is consistent with the overall clinical picture is necessary for all people who request HIV-related care.

There is no specific, effective treatment for Factitious Disorder (25,30). Once it has been documented that the patient does not have HIV infection, it is recommended that the primary provider consult a psychiatrist. The psychiatrist can help determine what function the disorder serves for the patient and begin to develop a therapeutic relationship (30). Confronting a patient with Factitious Disorder remains controversial (30). The goals of treatment are to build rapport with the patient, discourage the use of multiple providers, and encourage follow-up (30). Providers may allow patients to save face by eliminating positive reinforcement for illness in lieu of direct confrontation (30). Future research is needed to determine the prevalence of factitious HIV disease, better describe its unique manifestations, and study long-term outcomes in adolescents.

In summary, two cases of factitious HIV disease in adolescents are presented. The clues that they involved something other than HIV disease included incongruities in the histories, the absence of apparent emotional distress, objective clinical evaluation that was inconsistent with HIV disease despite claimed symptoms, and the inability to document prior test results. The cases also illustrate the need to substantiate HIV infection prior to the provision of HIV-related care.

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