Managing Malingering in the Emergency Setting

May 01, 2007 | Munchausen Syndrome [1], Dependent Personality Disorder [2], Mania [3], Psychiatric Emergencies [4], Major Depressive Disorder [5], Addiction [6], Alcohol Abuse [7], Bipolar Disorder [8]By Jon S. Berlin, MD [9]

The following cases highlight some of the challenges clinicians face when treating patients in whom malingerling is suspected. One key aspect of these evaluations is not overlooking signs or symptoms that point to serious illness.

Source:

CASE 1: A CALM HALLUCINATOR?
A 52-year-old man presented voluntarily to a psychiatric emergency ser-vice (PES) one night seeking admission to the hospital for suicidal ideation and command hallucinations. He was nattily dressed and seemed comfortable in his surroundings. Although he was quite articulate and concisely described an onset of depression and hearing voices during the past week, he could not iden- tify any particular stressors that affected him at the time and was unable to explain why he had decided to seek professional help that night in particular.

The voice he was hearing was that of a man--someone he did not know--but he was not hearing the voice during the interview. Nothing seemed to make the voice come or go. His mood was euthymic, and his manner was relaxed. He did not appear distressed or troubled or internally preoccupied. The remainder of the mental status examination was negative for homicidal ideation, delusions, thought disorder, or cognitive impairment.

The patient politely demurred discussing his living arrangements, occupation, or social network. He had no specific suicide plan or overwhelming urge to commit suicide. He had never made nor aborted a suicide attempt.

He had lived in the city all his life and knew about the existence of the PES but had never visited it before. He was not in counseling or being treated for any psychiatric illness. He had no vegetative symptoms of clinical depression, and he denied any symptoms of mania. Both his and his family's psychiatric history were negative.

The patient denied any history of substance abuse. Point-of-care urine drug screens had not yet been made available in the PES. However, his vital signs were normal. He was in good health, had no physical pain, and had no history of physical or sexual abuse. His medical history was unremarkable. He took no medication or herbal products.

Before conducting the psychiatric assessment, the evaluator had observed the patient talking on the public telephone in the waiting room after the triage nurse interviewed him. As he joked and chatted with the person to whom he was speaking, he sat with his legs outstretched and crossed and had the telephone propped up against his ear by his shoulder. As he spoke, he examined his fingernails with his hand spread out in front of him and then palm up with his fingers curled down into a half fist.

The psychiatric interview was conducted in a side room with the door open so that security could see him. Upon completion of the interview, the psychiatrist pointed out to the patient the striking disparity between his reported complaint and his objective appearance. The psychiatrist said, "Forgive me. I don't mean to offend you, but it's not entirely clear to me why you're here tonight. Maybe I'm missing something, but you seem to be doing better emotionally and psychologically than you say you are. I'm not saying you don't have a psychiatric problem--perhaps you do--but if you do, I don't think it's the kind of thing that requires hospitalization. I also get the feeling that there's a lot you're not telling me. That makes it very hard for me to know what your problem really is and how best to help you. That's my impression anyway. What do you think?"

The patient took these comments in stride and repeated his presenting complaints without offering any additional information. He was told he could stay in the waiting room until he felt better and was offered an outpatient referral, which he declined. The patient asked to be discharged from the PES, and his request was granted.

Discussion

Busy emergency clinicians often work with incomplete information. Therefore, most tend to be risk-averse and correctly err on the side of caution. However, most emergency psychiatrists are hesitant to diagnose malingering after 1 interview. Patients do not typically admit to malingering, and one often finds in their old chart, if they have one, only "Rule out malingering" listed as a diagnosis. Until a patient establishes a history of malingering with an emergency service, clinicians are likely to admit him or her for further evaluation.

In the case of this patient, however, everything points to a nonclinical reason for the visit. What is really going on with him is never made clear: perhaps he has been kicked out of the house or is hiding out from someone on the street, or maybe he wants to see a lady friend who is in the hospital. However, the decision to discharge him is entirely justified.

When a patient visits a PES or an emergency department (ED), the evaluation involves more than 1 interview. Typically, there is an interview with a triage nurse and one with a psychiatrist; there are also observations of the patient's behavior in the waiting room, interactions with other patients, telephone calls, and conversations with security staff. There may be a record of previous visits and sources to contact for collateral history. Compiling and documenting all this data helps arrive at a diagnosis and support the appropriate intervention. In this case, everything pointed to an absence of major mental illness, the possible presence of personality issues, and an overall impression of malingering with low psychiatric acuity. It would have been helpful to take a careful legal history. In some states, it can be accessed on the Internet.

Clinicians are sometimes unsure of how to convey their diagnosis of malingering to the patient. In many cases, especially with new patients, it is more prudent not to confront the patient directly[1] but instead to say something such as "I don't feel like you're telling me the whole truth." In cases similar to those of this patient, it should not be too difficult to confront the issue directly. The patient's nonchalant reaction should be documented. However, it does not hurt to keep an open mind that one may be wrong.

CASE 2: MISDIAGNOSIS

A 47-year-old man presented voluntarily to a PES one afternoon and requested admission for bipolar disorder. He stated that he had not been taking his carbamazepine and olanzapine for several months and thought he needed to be in the hospital to restart it.

He had relocated to town 4 or 5 months earlier to move in with his new girlfriend. Previously, he had been seeing a psychiatrist regularly but had not yet found a new one locally. Things in his life had been going along "okay." He said he just needed to get back into treatment.

The patient was casually dressed, neat, clean, and appeared to be in no acute distress. He seemed neither manic nor depressed. There were no signs of euphoria or irritability. He was well spoken and polite. Although he had no empty pill bottles with him, he knew his medication names and dosages. He denied having thoughts of hurting himself or others. There was no evidence of impaired reality testing or cognition.

He had a distant history of treatment in the hospital affiliated with the PES. The old chart was no longer available, but the patient was able to describe clearly a history of depressive and manic episodes and minor attempts to harm himself or others. He also had a history of substance abuse problems, primarily with cocaine. The patient had been in jail once for disorderly conduct. He had no significant medical history and was free of any acute medical problems. Results of a urine drug screen were positive for tetrahydrocannabinol.

The evaluating psychiatrist had the impression that the diagnosis of bipolar disorder could be correct, but the absence of presenting mood symptoms and the apparent absence of significant acuity to justify hospitalization made him begin to wonder about other diagnostic possibilities, such

as impulse control disorder or malingering. He remarked that he was glad the patient had decided to get back into treatment but wanted to get a clearer idea about what had led him to decide to restart treatment at this particular point.

Showing the slightest trace of annoyance, the patient said there was no particular reason; he just thought it was a good idea. The psychiatrist agreed again that it was a good idea but reiterated that he wanted to get a clearer sense of what was going on in the patient's life that might be motivating him right now. The patient said there was nothing.

During a psychosocial review of systems, the psychiatrist learned that the patient was unemployed but had hopes of finding work soon. He looked after his girlfriend's house and kids while she worked. Finances were not a problem. She gave him enough pocket money, and their relationship was going fine.

The psychiatrist asked how things were going with the kids. The patient said tersely, "Fine." Sensing some increased tension, the psychiatrist asked to hear a little bit more about that, but the patient said he did not want to go into it. After another appeal for more information and refusal by the patient, the evaluator said, "You don't have to if you don't want to. I respect your decision not to. It's just that the better I understand your situation, the better I can help you. I want to be useful to you. At this point, you're saying you need hospitalization, but I don't have enough information yet to justify that. I know some things can be very hard to talk about, but one of the things we do for people in this hospital is to listen to what is really bothering them most, and then help them to understand and handle their feelings better."

The patient's expression darkened, and he said, "I can't . . ." The evaluator paused for several seconds and then said carefully, "Let me ask a different question. What are you concerned would happen if you were to talk about it?"

The patient closed his eyes slightly. Suddenly, he opened them again, flashing with anger. He erupted into a loud tirade about his girlfriend's teenaged children. They disobeyed him, they made fun of him, and they called him "Loser!"

Then he slammed his open hand onto the interview room table and jumped up, kicking his chair back against the wall. He shouted, "I'm not going to take that shit anymore! I'm going to kill those little bastards! I'm going to wring their fucking necks until their goddamn heads pop off!" He pounded his fist on the table. "I swear, I'll kill them, so help me God, I will!"

The psychiatrist sat very still. He glanced at the closed door, and then back at the patient. "I see now why you need to be in the hospital. How about if I go get you some of that medicine you were asking for?" he asked. The patient glared at him and said, "Godammit! That's what I asked you for in the first place, isn't it?" The psychiatrist calmly apologized for not offering the medication sooner, then briefly discussed with the patient what would be the best dosages and excused himself from the room.

Security staff had heard the shouting and were approaching as the psychiatrist opened the door. He asked them to stand by outside the interview room. When the psychiatrist returned with the agreed-on doses of olanzapine and carbamazepine, the patient took them without hesitation and reassured everyone that he was not going to become violent. The patient stayed alone in the interview room until his agitation subsided, then sat quietly in the waiting room while his admission to the hospital was arranged.

Discussion

There is an old saying in emergency psychiatry about patients' tendencies to either minimize or exaggerate their psychiatric acuity: If they don't want to be in the hospital, they need to be, and if they do want to, they don't. Although this is a disparaging oversimplification that has no place in one's professional mindset, it is true often enough in daily practice to warrant examination.

Patients who can use words to accurately describe their level of distress tend not to act out as much and tend not to be seen in emergency settings. By definition, they are more likely to be seen in an outpatient office setting. On the other hand, as we observe in this man, there are persons seeking

hospitalization who just need some pharmacological and psychological help to express clearly what they are thinking and feeling, not to mention the many patients brought to a PES against their will who resist hospitalization and are perfectly appropriate candidates for an outpatient referral.

Ferreting out the acute precipitant in a psychiatric interview is often the key to determining acuity. Whereas malingering persons typically are unable to produce an acute precipitant that is congruous and meaningful, persons in crisis are generally undergoing one or more stresses that have culminated in a "last straw" that tips their equilibrium. The patient described in the first case was completely imperturbable, but the patient in this second case became unhinged.

Although the evaluating psychiatrist's sensitive persistence in trying to get the patient to answer the question "Why now?" about the visit to the PES was commendable, it turned out to be like removing a thorn from a lion's paw without the foundation of adequate rapport or anesthetic. In retrospect, the psychiatrist should have adjourned to a less secluded area of the PES and granted the patient appropriate doses of his requested medication before starting to probe for sensitive material.

CASE 3: A MATTER OF THE HEART

A 35-year-old woman presented voluntarily with a complaint of chronic depression and a request for hospitalization. She was stressed by a letter she had just received from the Social Security Administration that stated her disability status was coming up for review. She had not worked in 10 years and was despondent over the possibility of losing her apartment. She had a few friends but none with whom she could stay for any length of time. If she lost her disability, she was afraid that she would become homeless.

A well-kempt woman in old but clean clothes, the patient's mental status was remarkable. She had a mildly depressed mood. Sometimes she did not care whether she was alive or dead, but she had no suicidal thoughts or intent until the possibility of not being admitted was brought up to her. If that were to happen, she said, she would become very hopeless and self-destructive. She had no thoughts of harming anyone else (eg, someone in the disability office). There were no symptoms of psychosis or cognitive impairment.

Depression had been a problem since childhood. Vegetative symptoms, including sleep discontinuity, decreased energy, and decreased interest in her usual activities, were all long-standing. There was no history of mania or psychosis. She was in good health and denied a history of substance abuse. However, her routine point-of-care urine drug screen was positive for cocaine and marijuana.

The patient had a case manager and a psychiatrist, who prescribed maintenance treatment with antidepressants and mood stabilizers. The case manager was contacted; he said the patient was medication-compliant and had not appeared to him more depressed than usual. She used street drugs infrequently. Her diagnoses in the outpatient clinic record were recurrent major depression, cocaine abuse, and dependent personality disorder.

Her old PES chart listed an additional diagnosis of "rule out malingering." There was also mention in one of her previous visits of a supposed history of a self-inflicted gunshot wound to the chest many years ago. When asked about this, the patient said she did not like to talk about it and did not wish for anyone to see the scar; she declined the physical examination.

The patient was admitted to the observation unit. The next day, her psychiatrist was contacted. He was familiar with her history and confirmed that the report about the gunshot wound was true. It had been self- inflicted and was a very serious suicide attempt. Throughout her 2-night stay in the observation unit, the patient's mood did not improve and multiple observers charted that she looked lifeless and despondent. She was admitted to the acute service.

Discussion

Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms. It is motivated by external incentives, such as avoiding work or military duty, obtaining drugs or financial compensation, or evading criminal prosecution.[2]

One concern about this patient is that her visit to the PES may be motivated by her wish to avoid work and to seek continuation of her financial compensation. She could be requesting admission to the hospital to prepare for her disability review. A lawyer specializing in disability claims may have

even advised her to do this. There is also good literature on contingent suicide threats, indicating a low frequency of actual suicides by persons who transparently use the threat of suicide to scare their physician into a hospital admission.[3]

In this case, however, the picture is anything but clear. One ought to consider the possibility of a factitious disorder, which involves the feigning of signs or symptoms for the purpose of assuming the sick role.[2] Perhaps this patient was clinging to Social Security more for the sense of legitimacy it conferred on her pathological need to exist in the matrix of a doctor-patient relationship than for the money and health insurance coverage she received.

There may be an element of malingering, but there probably is a psychiatric disorder present as well. Emergency clinicians must avoid the either-or thinking that says a person either has a bona fide mental illness or a problem with malingering. They can have both. The patient's dependency and possible lack of motivation are unappealing, but they may partially be ingrained products of the Social Security Administration's disability program itself. According to her history, she is capable of experiencing very severe regressions. The decision to end hospitalization and refer her back to the ambulatory care setting needs to be handled very judiciously.

SUMMARY

The growing shortages of psychiatric facilities and negative countertransference are 2 very powerful factors threatening to cloud the judgment of emergency clinicians in the handling of patients who malinger. It is easy to get angry about feeling manipulated and overlook important clinical data pointing to serious illness. It may also be tempting to gloss over pathology to avoid the frustrating search for an available bed.

Clinicians can ignore or suppress the unpleasant feeling of being manipulated that might be an important tip-off to the presence of malingering. They also can be aware of the feeling but feel guilty about having retaliatory fantasies and overcompensate by giving in to the patient's request. It takes some practice to say "no" safely and diplomatically.

The disrepair of the nation's mental health system and social programs must also be taken into account. For example, would persons needing ambulatory care or homeless persons without high suicide risk present to EDs or PESs and report suicidal ideation as often as they do if there were more appropriate places for them to go?

Working in an emergency setting sometimes feels like doing a fellowship in the assessment and management of malingering. In actuality, because of the complexity and difficulty of the condition, the development of genuine expertise and compassion with this patient population actually rewards many years of practice and study. *

REFERENCES1. Resnick PJ, Knoll J. Faking it: how to detect malingered psychosis. *Current Psychiatry*. 2005;4(11): 12-25.2. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders. 4th ed, text revision*. Washington, DC: American Psychiatric Association; 2000.3. Lambert MT. Seven-year outcomes of patients evaluated for suicidality. *Psychiatr Serv*. 2002;53:92-94.

Links:
[1] http://www.psychiatrictimes.com/munchausen-syndrome
[2] http://www.psychiatrictimes.com/dependent-personality-disorder
[3] http://www.psychiatrictimes.com/mania
[4] http://www.psychiatrictimes.com/psychiatric-emergencies
[5] http://www.psychiatrictimes.com/major-depressive-disorder
[6] http://www.psychiatrictimes.com/addiction
[7] http://www.psychiatrictimes.com/alcohol-abuse
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