Mr. L, age 59, attempts suicide by overdosing on acetaminophen. He says he is depressed because he can’t pay for food or medical expenses, and asks for $600. How would you handle his request?

What would you include in the differential diagnosis for Mr. L?

- a) major depressive disorder (MDD)
- b) depression secondary to a medical condition
- c) neurocognitive disorder
- d) adjustment disorder with depressive features
- e) factitious disorder

The authors’ observations

Our differential diagnosis included MDD, adjustment disorder, neurocognitive disorder, and factitious disorder. He did not meet criteria for MDD because he did not have excessive guilt, loss of interest, change in sleep or appetite, psychomotor dysregulation, or change in energy level. Although suicidal behavior could indicate MDD, the fact that he immediately walked to the hospital after taking an excessive amount of acetaminophen suggests that...
he did not want to die. Further, he attributed his suicidal thoughts to environmental stressors. Similarly, we ruled out adjustment disorder because he had no reported or observed changes in mood or anxiety. Although financial difficulties might have overwhelmed his limited coping abilities, he took too much acetaminophen to ensure that he was hospitalized. His motivation for seeking hospitalization ruled out factitious disorder. Mr. L has a developmental disability, but information obtained from collateral sources ruled out an acute change to cognitive functioning.

**HISTORY**

Repeated admissions

Mr. L has a history of a psychiatric hospitalization 3 weeks prior to this admission. He presented to an emergency department stating that his blood glucose was low. Mr. L was noted to be confused and anxious and said he was convinced he was going to die. At that time, his thought content was hyper-religious and he claimed he could hear the devil. Mr. L was hospitalized and started on low-dosage risperidone. At discharge, he declined referral for outpatient mental health treatment because he denied having a mental illness. However, he was amenable to follow up at a wellness clinic.

Mr. L has worked at a local supermarket for 19 years and has lived independently throughout his adult life. After he returned to the community, he was repeatedly absent from work, which further exacerbated his financial strain. He attended a follow-up outpatient appointment but reported, “They didn’t help me,” although it was unclear what he meant.

Between admissions to our hospital, Mr. L had 2 visits to an emergency department, the first time saying he felt depressed and the second reporting he attempted suicide by taking 5 acetaminophen tablets. On both occasions he requested placement in a residential facility but was discharged home after an initial assessment. Emergency room records indicated that Mr. L stated, “If you cannot give me money for food, then there is no use and I would rather die.”

**What is the most likely DSM-5 diagnosis for Mr. L?**

a) schizophrenia
b) malingering
c) brief psychotic disorder
d) dependent personality disorder

**The authors’ observations**

Malingering in DSM-5 is defined as the “intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.”1 These external incentives include financial compensation, avoiding military duties, evading criminal charges, and avoiding work, and are collectively considered as secondary gain. Although not considered a diagnosis in the strictest sense, clinicians must differentiate malingering from other psychiatric disorders. In the literature, case reports describe patients who feigned an array of symptoms including those of posttraumatic stress disorder, paraphilias, cognitive dysfunction, depression, anxiety, and psychosis.2-5

In Mr. L’s case, malingering presented as suicidal behavior with an inadvertently high fatality risk. Notably, Mr. L came to an emergency room a few days before this admission after swallowing 5 acetaminophen tablets in a suicide attempt, which did not lead to a medical or psychiatric hospitalization. In an attempt to ensure admission, Mr. L then took a potentially lethal dose of 20 acetaminophen tablets.

In our assessment and according to his statements, the primary motivation for the suicide attempt was to obtain reliable food and housing. Mr. L’s developmental disability might have contributed to a relative lack of understanding of the consequences of his actions. In addition, poor overall communication and coping skills led to
an exaggerated response to psychosocial stressors.

Malingering and suicide attempts
Few studies have investigated malingering in regards to suicide and other psychiatric emergencies. In a study of 227 consecutive psychiatric emergencies assessed for evidence of malingering, 13% were thought to be feigned or exaggerated. Interestingly, the most commonly reported secondary gain was food and shelter, similar to Mr. L. This study did not report the types of psychiatric emergencies, therefore suicidal actions associated with malingering could not be evaluated.

In another study, 40 patients hospitalized for suicidal ideation (n = 29, 72%) or suicidal gestures (n = 11, 28%) in a large, urban tertiary care center were evaluated for malingering by anonymous report of feigned or exaggerated symptoms. Most of these patients were diagnosed with a mood disorder (28%) and/or an adjustment disorder (53%). Four (10%) admitted to malingering. Among the malingerers, reasons for feigning illness included:

- wanting to be hospitalized
- gaining access to detoxification programs
- getting treatment for emotional problems.

Interestingly, an analysis of demographic factors associated with malingering reveals an association with suicide attempts but not persistent suicidal ideations. This could be because of selection bias; patients who reported a suicide attempt might be more likely to be hospitalized.

A follow-up study evaluated 50 additional consecutive psychiatric inpatients admitted to the same tertiary care hospital for suicide risk. Unlike the previous study, a larger proportion of these patients had made a suicide attempt (n = 21, 42%) and a greater number had made a previous suicide attempt (n = 33, 66%). Primary mood disorders comprised most of the psychiatric diagnoses (n = 28, 56%). In this study, the exact nature of the suicide gestures was not documented, leaving open the question of lethality of the attempts. These studies do not suggest that those who malinger are not at risk for suicide, only that these patients tend to exaggerate the severity of their ideations or behaviors.

OUTCOME
Reluctantly discharged
We contact Mr. L’s siblings, who offer to provide temporary housing and financial support and assist him with medical needs. This abated Mr. L’s suicidal ideation; however, he wishes to remain in the hospital with the goals of obtaining eyeglasses and dentures. We explain that psychiatric hospitalization is no longer indicated and he is discharged.

Which of the following is the most effective management strategy for malingering?

a) direct confrontation of the malingering patient
It is important to acknowledge that genuine psychiatric illness could be comorbid with malingering.

**Clinical Point**

### Recommendations for evaluating and managing a malingering patient

<table>
<thead>
<tr>
<th>Recommendations</th>
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<tr>
<td>Obtain collateral history and previous medical records</td>
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<tr>
<td>Perform a comprehensive psychosocial assessment</td>
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<tr>
<td>Complete psychological testing including tests that can detect malingering such as the Personality Assessment Inventory, Structured Interview of Reported Symptoms, or Miller Forensic Assessment of Symptoms Test</td>
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<tr>
<td>Provide supportive psychotherapy</td>
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<tr>
<td>Build a strong therapeutic alliance</td>
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<tr>
<td>Employ face-saving mechanisms that allow patients to discard feigned symptoms</td>
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<tr>
<td>Be mindful of countertransference reactions in yourself and the staff</td>
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<tr>
<td>Evaluate for the presence of co-occurring psychiatric disorders</td>
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<td>Thorough documentation and administrative review could mitigate medicolegal risk</td>
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**Table 2**

The societal impact of malingering is significant. Therefore, identifying these patients is an important clinical intervention that can have a wide impact.11 However, it is also important to acknowledge that genuine psychiatric illness could be comorbid with malingering. Although differentiating a patient’s true from feigned symptoms can be difficult, it is critical to carefully evaluate the patient in order to provide the best treatment.

It seems that physicians can detect malingering, but documentation often is not provided. In the Rissmiller et al study,7 all 4 cases of malingering were identified retrospectively by study psychiatrists; however, none of their medical records included documentation of malingering, a finding also reported in the Yates et al study.6 Also concerning, the clinicians suspected malingering in some patients who were not feigning symptoms, suggesting that a relatively high threshold is necessary for making the diagnosis.

**How to help patients who mangle**

Identifying malingering in patients with obvious secondary gain is important to prevent exposure to potential adverse effects of medication and unnecessary use of medical resources. In addition, obtaining collateral information, records from previous admissions or outpatient treatment, and psychological testing adds to the body of evidence suggesting malingering. We also recommend a comprehensive psychosocial evaluation to identify the presence of secondary gain.

Management of malingering (Table 2) includes building a strong therapeutic alliance, exploring reasons for feigning symptoms, open discussion of inciting external factors such as interpersonal conflict or difficulties at work, and/or confrontation.10 In addition, supportive psychotherapy might help strengthen coping mechanisms and problem solving strategies, thereby removing the need for secondary gain.12 Additionally, face-saving mechanisms that allow the patient to discard their feigned symptoms, or enable the person to alter his (her) history, could be to his benefit. Lastly,
**Clinical Point**

Certain patients could trigger countertransference reactions that impel clinicians to take on a significant caretaking role.

and importantly, clinicians should focus efforts on ruling out or effectively treating comorbid psychiatric conditions.

From a risk management standpoint, include all available data to support the malingering diagnosis in your progress notes and discharge summaries. A clinician seeking to discharge a patient suspected of malingering who is still endorsing suicidal or homicidal intent will benefit from administrative review, including legal counsel to mitigate risk, and be more confident discharging somebody assessed to be malingering.

We recognize that certain patients could trigger countertransference reactions that impel clinicians to take on a significant caretaking role. Patients skillful at deception could manifest a desire to rescue or save them. In these instances, clinicians should examine why and how these feelings have come about, particularly if there is evidence that the individual could be attempting to use the interaction to achieve secondary gain. Awareness of these feelings could help with the diagnostic formulation. Moreover, a clinician who has such strong feelings might be tempted to abet a patient in achieving the secondary gain, or protect him (her) from the natural consequences of individual's deception (eg, not discharging a hospitalized patient). This is counter-therapeutic and reinforces maladaptive behaviors and coping processes.13

**References**


**Related Resources**


**Drug Brand Names**

Acetaminophen - Tylenol
Risperidone - Risperdal
N-acetylcycteine - Mucomyst

**Bottom Line**

Suspect malingering in patients who have attempted suicide and have an obvious secondary gain. Perform a thorough psychosocial assessment, evaluate the patient’s history through collateral sources and medical records, and carefully assess and treat comorbid psychiatric disorders. Helping malingering patients starts with a strong therapeutic alliance; however, be vigilant for countertransference reactions.