Suicidal and asking for money for food

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How would you handle this case?

Answer the challenge questions throughout this article

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?

CASE Suicidal and hungry

Mr. L, age 59, attempts suicide by taking approximately 20 acetaminophen tablets of unknown dosage. He immediately comes to the emergency department where blood work reveals a 4-hour acetaminophen level of 94.8 µg/mL (therapeutic range, 10 to 30 µg/mL; toxic range, >150 µg/mL); administration of *N*-acetylcysteine is unnecessary. Mr. L is admitted to general medical services for monitoring and is transferred to our unit for psychiatric evaluation and management.

During our initial interview, Mr. L, who has a developmental disability, is grossly oriented and generally cooperative, reporting depressed mood with an irritable affect. He is preoccupied with having limited funds and repeatedly states he is worried that he can't buy food, but says that the hospital could help by providing for him. Mr. L states that his depressed mood is directly related to his financial situation and, that if he had more money, he would not be suicidal. He cites worsening visual impairment that requires surgery as an additional stressor.

On several occasions, Mr. L states that the only way to help him is to give him $600 so that he can buy food and pay for medical treatment. Mr. L says he does not feel supported by his family, despite having a sister who lives nearby.

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

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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

Clinical Point

Although not strictly considered a diagnosis, clinicians must differentiate malingering from other psychiatric disorders

Clinical Point

The treatment challenges include clinician uncertainty in making the diagnosis and high variability in occurrence across settings

Table 1

Challenges clinicians face when identifying and managing malingering

Variability across clinical settings
Fear of liability and litigation, especially in cases with suicidal behaviors, gestures, or attempts
The risk of completed suicide is not known in patients who malinger
Incomplete access to patient history and poorly documented records
Malingering often co-occurs with psychiatric and substance use disorders
Countertransference reactions that may prompt feelings to rescue or reject a patient

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.[6] 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.[7] 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
- wanting to make someone angry or feel sorry
- 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[8] 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

b) immediate discharge once malingering is identified
c) evaluation for possible comorbid psychiatric conditions
d) neuropsychiatric consultation

The authors' observations

The challenges of treating patients who malinger include clinician uncertainty in making the diagnosis and high variability in occurrence across settings (***Table 1***). Current estimates indicate that 4% to 8% of medical and psychiatric cases not involved in litigation or compensation have an element of feigned symptoms.[3,9] The rate could be higher in specific circumstances such as medicolegal disputes and criminal cases.[10]

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 malinger

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,

Table 2

Recommendations for evaluating and managing a malingering patient

Obtain collateral history and previous medical records
Perform a comprehensive psychosocial assessment
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
Provide supportive psychotherapy
Build a strong therapeutic alliance
Employ face-saving mechanisms that allow patients to discard feigned symptoms
Be mindful of countertransference reactions in yourself and the staff
Evaluate for the presence of co-occurring psychiatric disorders
Thorough documentation and administrative review could mitigate medicolegal risk

Clinical Point

It is important to acknowledge that genuine psychiatric illness could be comorbid with malingering

Related Resources

- Feldman MD. Playing sick? Untangling the web of Munchausen syndrome, Munchausen by proxy, malingering, and factitious disorder. New York, NY: Brunner-Routledge; 2004.
- Rogers R. Clinical assessment of deception and malingering. 3rd ed. New York, NY: Guilford Press; 2012.
- Brady MC, Scher LM, Newman W. "I just saw Big Bird. He was 100 feet tall!" Malingering in the emergency room. Current Psychiatry. 2013;12(10):33-38,40.

Drug Brand Names

Acetaminophen • Tylenol
N-acetylcysteine • Mucomyst
Risperidone • Risperdal

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 countertherapeutic and reinforces maladaptive behaviors and coping processes.[13]

References

1. Diagnostic and statistical manual of mental disorders, 5th ed. Washington DC: American Psychiatric Association; 2013.
2. Fedoroff JP, Hanson A, McGuire M, et al. Simulated paraphilias: a preliminary study of patients who imitate or exaggerate paraphilic symptoms and behaviors. J Forensic Sci. 1992;37(3):902-911.
3. Mittenberg W, Patton C, Canyock EM, et al. Base rates of malingering and symptom exaggeration. J Clin Exp Neuropsychol. 2002;24(8):1094-1102.
4. Waite S, Geddes A. Malingered psychosis leading to involuntary psychiatric hospitalization. Australas Psychiatry. 2006;14(4):419-421.
5. Hall RC, Hall RC. Malingering of PTSD: forensic and diagnostic consideration, characteristics of malingerers and clinical presentations. Gen Hosp Psychiatry. 2006;28(6):525-535.
6. Yates BD, Nordquist CR, Shultz-Ross RA. Feigned psychiatric symptoms in the emergency room. Psychiatr Serv. 1996;47(9):998-1000.
7. Rissmiller DJ, Wayslow A, Madison H, et al. Prevalence of malingering in inpatient suicidal ideators and attempters. Crisis. 1998;19(2):62-66.
8. Rissmiller D, Steer RA, Friedman M, et al. Prevalence of malingering in suicidal psychiatric inpatients: a replication. Psychol Rep. 1999;84(3 pt 1):726-730.
9. Sullivan K, Lange RT, Dawes S. Methods of detecting malingering and estimated symptom exaggeration base rates in Australia. Journal of Forensic Neuropsychology. 2007;4(4):49-70.
10. Bass C, Halligan P. Factitious disorders and malingering: challenges for clinical assessment and management. Lancet. 2014;383(9926):1422-1432.
11. Chafetz M, Underhill J. Estimated costs of malingered disability. Arch Clin Neuropsychol. 2013;28(7):633-639.
12. Peebles R, Sabella C, Franco K, et al. Factitious disorder and malingering in adolescent girls: case series and a literature review. Clin Pediatr (Phila). 2005;44(3):237-243.
13. Malone RD, Lange CL. A clinical approach to the malingering patient. J Am Acad Psychoanal Dyn Psychiatry. 2007;35(1):13-21.

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.