•> CASE 45

An 18-year-old man presents to a psychiatrist insisting, "I have schizophrenia and need to be admitted." For the past several days, he heard voices telling him to kill himself. He says that he is possessed by the devil. The patient denies feeling depressed, but thinks he will hurt himself if he is not admitted to a hospital immediately. However, he denies having any specific suicide plan. He has no prior history of psychiatric treatment or complaints, no medical problems, and is not taking any medication. He drinks one or two beers a week and denies using drugs. At the end of the interview, he again requests hospitalization. He then adds that he is currently on leave from the Navy and is due back on his ship, which is leaving in 2 days.

On **a** mental status examination, the patient is initially cooperative and forthcoming but becomes increasingly irritated when asked to give more details about his symptoms. His mood and affect are euthymic but full-range. His thought processes are logical, without looseness of association or thought blocking, and his thought content has suicidal ideation but no homicidal ideation. He reports having delusions and auditory hallucinations. His insight seems good considering the severity of his symptoms.

- **What is the most likely diagnosis?**
- **How would you approach this patient?**

ANSWERS TO CASE 45: Malingering

Summary: An 18-year-old man without a psychiatric or medical history presents with a sudden onset of hallucinations, delusions, and suicidal ideation and asks to be admitted to the hospital. His social history is notable for his upcoming deployment with the Navy. His mental status examination is relatively unremarkable except for his reported symptoms, some irritability when he is questioned, and his high level of insight.

- **Most likely diagnosis:** Malingering.
- **Best approach:** Obtain collateral information (if possible) from family and/or friends, gently confront the inconsistencies in the patient's presentation, explore and validate his feelings regarding his military duty, and refer him for an appropriate follow-up (if possible).

Analysis

Objectives

1. Recognize malingering.
2. Differentiate malingering from factitious and conversion disorders.
3. Understand how to approach a patient suspected of malingering.

Considerations

This man initially presents with symptoms of a psychotic disorder. Although he admits to some criteria consistent with schizophrenia, such as hallucinations and delusions, the time course is too brief. There does not appear to be any substance use or a medical condition causing his symptoms. An important factor seems to be his upcoming military duty. His mental status examination is remarkable for the lack of a flat or inappropriate affect, loose associations, or thought blocking commonly seen in a psychotic disorder. In fact, **he displays a surprisingly high level of insight into his "illness"** considering his lack of a psychiatric history. He insists that his self-diagnosis is correct and that he needs immediate hospitalization. He becomes irritable only when pressed for more details. Although a psychotic disorder should be considered, the patient's reluctance to provide more details, a lack of objective findings on the mental status examination, and his intact insight in the context of required military duty make malingering the most likely diagnosis.

APPROACH TO MALINGERING

Definition

Malingering: The intentional feigning, production, or exaggeration of psychiatric or medical signs/symptoms to obtain external gain (e.g., financial compensation or avoidance of work, a prison sentence, or military service)

Thought blocking: The unpleasant experience of having one's train of thought curtailed absolutely

Clinical Approach

Diagnostic Criteria

Malingering is not a psychiatric or medical diagnosis, but in the *Diagnostic and Statistical Manual of Mental Disorders, text revision (DSM-1V-TR),* it is listed as an additional condition that can be the focus of clinical attention (a V code), which is listed under axis 1. Factors consistent with malingering are an unusual history or presentation, a vague or inconsistent history, a history of antisocial behavior, defensiveness in response to questioning, and a lack of findings on a mental status or physical examination and/or in laboratory studies. A necessary component is the *intentional* production of symptoms or signs in order to achieve some *tangible external gain.*

Differential Diagnosis

The primary, most essential differentiation must be made between malingering and an actual psychiatric or medical diagnosis. Collateral information gathered from family or friends can be helpful in further elucidating the diagnosis. Also important in the differential diagnosis for malingering are both factitious and conversion disorders. In factitious disorder, a patient *intentionally* produces a physical or psychiatric illness in order to assume the *sick role.* In conversion disorder, a patient *unconsciously* produces a physical or neurologic symptom as the result of an *intrapsychic conflict.* Table 45-1 illustrates these differences.

Approach to the Malingering Patient

As malingering is not a psychiatric disorder, there is no specific treatment for it. However, there are several factors that can be helpful to both the clinician and the patient. An important issue to keep in mind is the physician's own feelings toward malingering. Accusations, anger, and rejection serve only to inflame the situation, promote further defensiveness, send the patient elsewhere, or perhaps provoke the individual to violence. As in all other psychiatric and medical interventions, maintenance of a therapeutic alliance is

Table 45-1
DIFFERENTIAL DIAGNOSIS FOR MALINGERING

CONDITION	PRODUCTION OF SYMPTOMS OR SIGNS	MOTIVATION
Malingering	Conscious	External gain
Factitious disorder	Conscious	Assumption of the sick role
Conversion disorder	Unconscious	Unconscious conflict

essential. Whereas gentle confrontation can be necessary, empathic exploration and understanding of the feelings and issues contributing to the feigning of illness can lead to increased trust in the clinician and truth telling by the individual. If it is practical or desired, a referral for further supportive therapy can then be made to address the underlying issues.

Comprehension Questions

For the following clinical vignettes (questions [45.1] through [45.4]), choose the one descriptor (A through D) that *best* describes the situation:

A. Conscious production of symptoms because of a desire to assume the sick role
B. Conscious production of symptoms to obtain external gain
C. Unconscious production of symptoms as the result of an unconscious conflict
D. Unconscious production of symptoms based on imitative behavior
E. Referred symptoms caused by transference

[45.1] A 23-year-old pregnant female complains of an inability to feel her legs. She wonders if the fetus is grabbing her spinal cord. Although she does not appear concerned about her condition, on further questioning she admits that her pregnancy was unplanned and that it has been a source of stress for her and her husband. Her neurologic examination is unremarkable except for decreased sensation below her waist. The results of a computed tomography scan and magnetic resonance imaging of her brain and spine are normal.

[45.2] A 45-year-old male complains of lower back pain and weakness in his legs after lifting heavy boxes while at work. He has not been able to go to work for several days, and he requests treatment and a letter excusing him from work. On examination, he is found to have significant lumbar pain without spasms. The strength in his legs is decreased because of a lack of effort. His reflexes are within normal limits.

[45.31 A 38-year-old woman comes in for evaluation of an abscess on her thigh. Her chart documents numerous out- and inpatient hospital visits. She is admitted, her abscess is drained, and she is treated with antibiotics. Culture studies demonstrate microorganisms consistent with fecal matter, and a further physical examination reveals many old scars, presumably self-inflicted.

[45.4] A 50-year-old male is referred to a physician because he has ongoing migraine headaches. His headaches are chronic and bilateral, are worse with loud noises and light, and occur without aura or vomiting. His physical examination is unremarkable except that the patient does not appear be in significant distress. When he is presented with various options for treatment, including nonsteroidal anti-inflammatory medications, he becomes angry, demanding that Tylenol with codeine is the only thing that helps him. When he is told that nonnarcotic medications should be tried first, he accuses the doctor of not believing him and walks out of the room.

Answers

[45.1] C. The most likely diagnosis for this woman is conversion disorder. She presents with symptoms of a neurologic disorder without an obvious cause or trauma. She does not appear particularly concerned about her symptoms *(la belle indifference),* and there is no obvious possibility of obtaining external gain. Her motivation does not seem to be assuming the sick role but rather expressing an unconscious conflict involving her unwanted pregnancy.

[45.2] B. In this case the most likely diagnosis is malingering. Although this man can indeed have a minor injury, his physical examination is remarkable only in revealing tenderness without spasms. His complaints of weakness and inability to work appear exaggerated given the lack of objective findings. The patient clearly has an obvious external motivation for embellishing his symptoms, namely, avoiding work.

[45.3] A. The most likely diagnosis for this woman is factitious disorder. She presents with a self-induced infection, as well as a history of other self-inflicted injuries that have resulted in numerous hospitalizations. Her illnesses are consciously created, without a desire to obtain obvious external gain other than assumption of the patient role.

[45.4] B. In this case the most likely diagnosis is malingering. This man presents with only subjective complaints; there are no significant medical findings or apparent suffering. He is angry and defensive, and he appears to be motivated solely by a desire to obtain narcotics rather than appropriate treatment.

CLINICAL PEARLS

- Consider malingering when there is an inconsistent history or presentation, coupled with the possibility of obtaining an obvious external gain.
- Patients with factitious disorder also consciously produce symptoms, but their motivation is to assume the patient/sick role.
- Gentle confrontation can be necessary with malingerers, but an empathic stance often promotes a more effective physician-patient alliance.
- Referral to a mental health professional can be indicated to help a malingering individual cope with the ongoing stressors promoting the deception.

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