



ISSN: 2578-3335 (Print) 2578-3343 (Online)

Volume 1 | Issue 1

Article 4

2019

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Cooper Rowan Medical Journal: <https://rdw.rowan.edu/crjcsm>

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Recommended Citation

Ellis, Joshua S. (2019) "The "M" Word: Accusations of Malingering are Harmful to Patient Care," *Cooper Rowan Medical Journal*: Vol. 1: Iss. 1, Article 4.

DOI: 10.31986/issn.2578-3343_vol1iss1.4

Available at: <https://rdw.rowan.edu/crjcsm/vol1/iss1/4>



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Cover Page Footnote

The author would like to thank Kenan Penaskovic, MD for his support in editing this manuscript.

The "M" Word: Accusations of Malingering are Harmful to Patient Care

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It starts as a small seed of doubt. It can be planted by anyone: the physician, the nurse, a family member, or even the patient. But once the seed gets planted in the minds of those involved in caring for the patient, every word and action from the patient function as water and sunshine, encouraging the seed to grow. The seed of doubt grows into a small tree of criticism which blooms into a collection of judgment and prejudice that prevent the patient from receiving the care that he or she deserves. All of this can happen after a patient is accused of malingering.

Malingering is defined as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives”.¹ Though it is not classified as a diagnosis in the DSM-5, the psychiatry bible guiding all diagnostic and therapeutic decisions regarding mental illness, malingering is one of the easiest concepts to understand but hardest to diagnose. There are special interview and intervention techniques that have been described to help clinicians identify malingered psychosis, but it remains a difficult entity to certify.² In addition, it can be one of the most detrimental accusations to ethical and comprehensive care.

I first saw this happen on my psychiatry rotation on the psychotic disorders unit. Mr. Smith had been a patient committed voluntarily for over a month, continuously endorsing delusions of a former Central Intelligence Agency (CIA) agent who was assigned to kill the patient and was chasing the patient all over the country. Mr. Smith had been homeless for as long as he could remember, running away from this CIA agent and living in fear for decades. Since being hospitalized at our institution, his condition was refractory to multiple antipsychotic trials; he continued to live in fear of the CIA. He was so terrified of being murdered that he disclosed he would rather commit suicide than allow himself to be killed by his hunter. Though he had no prior suicide attempts, he had a plan for how he would do it, explaining he would overdose on alcohol and narcotics. The plan per nurse charting:

“Patient states he would like to get really drunk on vodka and then take a big handful of barbiturates. This plan is not very realistic as barbiturates are not readily available – question malingering.”

The seed was planted. Our treatment team had interviewed him every morning throughout his hospital course and had never suspected that he was malingering. He seemed so genuinely in agony over whether or not he would even be alive much longer should he leave the safety of the unit. You can lie about your mood, but it is really hard to fake a dysthymic, tearful affect over a month. But had we been duped? Had this homeless man been so comfortable in the warm hospital bed that he was putting on an Oscar-worthy performance that could only be debunked by the nursing staff who was around him for much longer every day? Or was the nurse wrong to use the “m” word?

“Patient continues to tell same suicide story. Withdrawn to room all day, staff continues to question his motives.”

The next morning, we asked Mr. Smith how he was feeling. His response of “fine” watered the seed again; if he truly had suicidal ideation with a plan, could he be just “fine” the next day? Over the next week our multi-disciplinary team meetings with the nursing staff and social workers were consumed with debates over how long Mr. Smith should be allowed to stay. While we continued to give him his daily antipsychotic medications and feed him and house him, there was a certain attitude around his care that what we were doing was fruitless, not because his case was hopeless or his psychosis was too far gone, but because some believed he was playing us all.

Though I’m not naïve enough to think that it is impossible or even unlikely a man without a home who has been suffering from schizophrenia for decades would make up or embellish his symptoms, I wanted to give Mr. Smith the benefit of the doubt. He had done nothing over the course of a month to suggest that he was malingering, but the initial seed of doubt had grown into constant thoughts of judgment and criticism. We failed Mr. Smith by allowing his low socioeconomic status and chronic mental illness to overshadow his suffering.

The International Statistical Classification of Diseases and Related Health Problem’s (ICD) 11th edition defines a malingerer as “a person feigning illness with obvious motivation” and it specifically excludes factitious disorder, a mental illness characterized instead by intentional deceit of the care team by which the patient has the need to play the sick role.³ The DSM’s diagnosis of factitious disorder, on the other hand, is said to have little clinical validity, as it has been proposed to be a way to bridge diagnoses between unconsciously mediated psychiatric disorder and consciously mediated malingering.⁴

It is possible that Mr. Smith’s underlying psychosis induced his actions that appeared to be malingering, as this has been described in the literature.⁵ One study reported that 10% of their hospitalized suicidal patients admitted in anonymous surveys that they had lied or purposefully exaggerated suicidal ideation to gain admission. However, the clinicians were able to detect all of these cases before seeing the results of the surveys, and they even had several “false positives.”⁶ In our situation, his care team could not come to a

consensus on what was happening – had he been falsely identified as malingering, he might have been discharged inappropriately. This would have resulted in him going back to his life on the streets without receiving adequate medical care.

How would those who had decided he was malingering feel if he was discharged and committed suicide?

How would those who felt he was legitimately suicidal feel if they heard him telling a fellow patient and friend how he had duped his treatment team?

In reality, Mr. Smith's actions were the evidence of the legitimate disease process of schizophrenia and were not simply an act, unconsciously motivated or otherwise. Throughout the rest of his stay in the psychotic disorders unit – 4 months in total – he continued to endorse fears of being murdered and plans for harming himself. He was eventually transferred to the state psychiatric hospital for continued care. When the APA eliminated the term “malingering” from the diagnostic codes of the DSM-5, it was a step in the right direction. The “m” word should be reserved for patients who are taking advantage of the system beyond a shadow of a doubt. The accusation of malingering is one of the most legally implicating statements a clinician can make, as it puts him or her in the position to be both the judge and the jury. As in our legal system, all patients should be innocent until proven guilty. Mr. Smith and others in his situation deserve that and more.

**Patient's name changed for privacy.*

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