CASE REPORT

Intentionally Ill' - A Case Report of Malingering in a Tertiary Care Hospital

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ABSTRACT

The word malingering derives from the Latin word "Malum" that means bad or harmful, and in this context refers to the bad intent of the offender's actions. It is regarded as fraud and may lead to charges of perjury or criminal fraud. In a clinical setting, various presentations include imitation of pain, insistence on the presence of bleeding, alleging the presence of PTSD-like symptoms, hallucinations, and/or delusions offering a psychosis like picture. "Psychosis" is a term that covers a wide range of clinical presentations making it attractive to malingerers, since inconsistent symptoms may be seen as simply atypical. Such presentations also often lead to a diagnostic dilemma as clinicians tend to group malingering along with factitious disorder and dissociative disorders. Establishing that a patient has a conscious primary motive behind feigning the illness is a key distinction between malingering and those other disorders. We hereby report a case of a 36-year-old male presenting with hallucinatory behavior, auditory hallucinations, delusions, dysphoria, before his marriage date which on detailed evaluation elucidated several inconsistencies between the reported and observed- symptoms, level of function and psychological test results.

KEY WORDS: Familial responsibilities, malingering, psychosis.

Introduction

American Psychiatric Association Diagnostic and Statistical Manual DSM-5 describes malingering as the intentional production of false or grossly exaggerated physical or psychological problems. Malingering may occur in circumstances where the person wishes to avoid legal, civil and/or familial responsibilities or in situations where benefits like compensation might be obtained.[1] Some studies have reported malingering in 10-12% of psychiatric inpatients.[2] A suspicion of malingering is particularly common in clinical settings where the complaint is of a subjective nature and is not accompanied by objectively demonstrable organic abnormalities. An inaccurate diagnosis of malingering may unjustly stigmatize a patient and deny him needed care, but at the same time deferring the diagnosis when clinical pointers and collateral data are pointing toward the same can have detrimental consequences to the significant others. Malingered psychiatric conditions may include dissociative disorder, psychosis, mood disorders, and PTSD.[3] Presentations are highly variable and often psycho-socio-culturally determined. Psychiatric Illnesses are attractive to malingers over their perception that such illnesses are easy to duplicate.

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A 36-year-old male was brought by his father with a history of talking to self, seeing images and hearing voices for last 2 days. It was of abrupt onset and a fluctuating pattern. The informants were particularly concerned about his scheduled wedding date in the forthcoming week. The patient had no prior psychiatric illness. There was no significant medical history. There was no family history of psychiatric illness.

The patient complained of continuous voices from the external environment commanding him to "not marry," or else they would "take care of him." He was uncertain whether the voices belonged to males or females. He said he heard voices even when asleep. He was concerned, and this gave him headaches and body aches. He remarked that he could see flashes of

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red light most likely like that of a "traffic signal" all over the walls and the floor.

Mental status examination revealed a middle-aged man who was calm and cooperative despite his reported level of distress. His speech was normal, and even though he subjectively reported depression, objectively he was euthymic. The stream and form of thought were normal. His cognitive functions were normal, with well-sustained attention, his abstraction and judgment were deemed to be fair. Psychometric evaluation with projective tests such as TAT test and the Rorschach test yielded no significant results.

He would refuse medications in ward frequently. He was sleeping well and was fully interactive and energetic as observed by his participation in all the ward-based activities more so when he believed there was no hospital staff around monitoring him. However, in the presence of the clinical team, he could be found muttering to himself.

Within the first 2 days of admission as a case of acute psychotic disorder, there were multiple queries regarding the patient's status from his fiancé's family. They gave a history of the patient calling off the wedding just before the alleged onset of symptoms without adequate clarifications. They cited their concerns regarding the good amount of cash and valuables collected by the patient and his family as part of the nuptial agreement.

The patient was approached with the inconsistencies of presentation and reassured that such a scenario might often be a primitive defence against a stressful situation. The need to consider constructive dialogue was encouraged to offer the possibility of a positive outcome. He revealed his perceived distrust on his fiancée when he got to know her communications with his brother. However, the distrust did not amount to delusions of infidelity. With a non-judgmental approach and gentle persuasion, the patient was encouraged to tell the full story. Thereafter, he confessed to feigning the illness by acting out symptoms that he had learnt from a friend in his village who had received treatment for similar complaints at a local clinic. The obvious motive behind the feigning of illness and the patient's acceptance of the fact now helped resolve the diagnostic dilemma and affirm a diagnosis of malingering. He was hoping the 'illness' would offer him a face-saving way out of the marriage.

Discussion

There are no published standards of practice or recognized algorithms for how to intervene if malingered psychosis is suspected. Each case is unique and will require a tailor-made approach for the specific symptomatology, cultural and educational background of the patient and the secondary gain associated. In differentiating malingering from factitious and dissociative disorders, we must keep in mind that in malingering the subject is conscious of the primary motive behind the feigning of symptoms. While in factitious disorders the patient intends to adopt a sick role rather than achieve any monetary benefit, avoidance of legal, civil/familial responsibilities. In dissociative disorders, on the other hand, the person is not aware of the "fake" nature of the symptoms or the driving force and truly believe that they have the ailments they are reporting. General principles that should be employed include a clear documentation and access to consultation for psychometric testing. Promoting a safe and supportive relationship to assist in eliciting possible underlying motivations. To have a mechanism for obtaining collateral information if available. Explore the client's knowledge of psychosis and symptoms of psychotic illnesses. Determine the nature of the secondary gain that is being sought. Consultations to other medical specialists should be avoided because such referrals only perpetuate malingering. The patient should not be accused directly of faking an illness as hostility/breakdown of the doctor-patient relationship/lawsuit against the treating team/hospital and, rarely, violence may result.[4] Provide a clear explanation of possible realistic options for services. Avoid accusations of lying, beware of countertransference, clarify not confront, security measures will help. Suspected malingerers with psychotic symptoms, however, are more likely to only describe vague/inconsistent visual hallucinations without the presence of other hallucinations, delusions, or other symptoms of psychosis.[5] It is always better to err on the side of caution. This is due to the hallmark symptoms of genuine psychosis can vary and appear over period of time/subside with time. Despite all this, the subject may still continue to malinger the symptoms, and the likelihood of success with such approaches is inversely related to the reward for the malingering behavior.

Conclusion

Malingering is a diagnosis of exclusion. With the internet and the easy availability of surplus medical

information, patients can easily learn the symptoms of nearly every disease. The patient must be thoroughly evaluated by taking a detailed history, mental status examination, relevant laboratory investigations, and psychometric evaluations. When a patient is found to be a malingerer, clinicians should tactfully and nonjudgmentally present inconsistencies to the patient and offer possible ways out of the said situation. Letting the patient know that the clinician will be doing an objective assessment and will act neutrally is key. Mental health specialists should not only act in the best interest of the patient but must find a way to act in a manner that is ethical, legal and professional in cases of malingering.

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