Case Report Of A Suicide Ideation, A Suspected Case Of Malingering

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Citation

L Santos, F Rodríguez, X Rocha, M O'Brien, P Thomas. *Case Report Of A Suicide Ideation, A Suspected Case Of Malingering*. The Internet Journal of Psychiatry. 2009 Volume 1 Number 1.

Abstract

Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives. (1)Although it is widely accepted that some suicide threats and gestures are manipulative; psychiatrists rarely diagnose hospitalized suicidal patients as malingering. (2)

CASE REPORT

The patient is a 65 year old Hispanic male, from Puerto Rico currently living in his van driven with his son, which they park in Manhattan and the Bronx. He presented to the hospital complaining of chest pain and itching. The patient reports scabies for 4-5 months, was seen and treated in dermatology clinic several times without improvement. He feels depressed and says his wife kicked him out of the home because she was afraid of being contaminated and now he is homeless and wants to kill himself. The patient was admitted to the Medical floor due a Right Hip MRSA Abscess, Diabetes, Hypertension, he also had a rash with other nonspecific skin eruption, probable scabies/eczema as well as Suicidal Ideations with Adjustment Disorder and depressed mood. On Psychiatry interview, at emergency department patient reports he feels depressed and is tired of his diagnosed Scabies as his itching has worsened. He states he has passive thoughts of death but denies a current plan or past suicide attempts. He refers poor sleep, denies worthlessness or hopelessness, anhedonia, mania, psychosis or anxiety. He denies formal psychiatric history and current alcohol or illicit drug use. The patient was placed 1:1 observation for safety and started on Paxil 20 mg daily and Ambien 10 mg at bed time, as well as being placed on contract isolation due to his skin condition. At floor, the patient stated that he has been feeling extremely depressed and now suicidal. He reported feeling sad, has decreased sleep, and feels worthless and hopeless. During the course of his admission, for more than 1 month, the patient presented improvement in his conditions; reporting that he is less depressed and less itchy, but because of his rash and the poor support of his family. The patient confers his thoughts about "I don't know what I'm going to do when I get out of here because I cannot take this anymore.", and "what he would do to himself if he was discharged.", presenting a problem of conditionally suicidal if he is discharged from the hospital and because of this patient remains on one to one for suicidal ideation without any plan. In the middle of his admission and almost ready for discharge, the patient was offered different places to be relocated, like shelters, his daughter's house or nursing home, but the patient always refers the same thought about killing himself if he is discharged, and asking to be relocated to an apartment of his own or go back to his van and live in the street. Transfer to the Psychiatry Inpatient service was not possible because contact isolation. After one month of his admission the patient remains vague when speaking about what he will do if he is discharged, neither confirms or denies suicide ideations and complains about the miserable support of his family. This long admission ended undesirably, after his refusal to being discharge and his co-morbidities, the patient developed a serious infection with clostridium difficele, which sent the patient to MICU with a severe metabolic acidosis and impending respiratory failure. The patient died after 14 days at MICU due to failed extubation and cardio arrest

DISCUSSION

There are more than 32,000 suicides in the US annually, with firearms, poisonings, and suffocation being the most common methods used. There are an estimated 10× more than that number of attempted suicides (3). Few literatures exits about what percentages of reported suicidality is malingering, one study found that only 10% rate of self-reported malingering in a sample of 40 patients admitted for

suicidal ideation or attempts(1).

Although suicidal ideation and attempts are associated with increased suicide risk, most individuals with suicidal thoughts or attempts will never die by suicide. It is neither possible to prevent all suicide nor to totally and absolutely protect a given patient from suicide. All suicide threats, attempts and gestures must be carefully evaluated. Not all self-destructive acts are suicidal. Some patients make such gestures as a cry for help, to show their anger at themselves, to obliterate depressed feelings or to manipulate and control other people (4). Unable to differentiate between patients likely and unlikely to kill themselves, psychiatrists will feel pressure to hospitalize patients who threaten suicide (2). Even despite the lack of empirical data suggesting that acute hospitalization is effective in reducing suicide risk (5). In this case it is evident that the psychiatrist faced the problem of when to discharge a patient with suicidal ideation, when the patient is looking for some kind of benefits from our social and/or monetary benefits system and without considering how a long term admission could harm our patients.

CONCLUSION

In conclusion, this case serves to promote awareness about the problem of do not having a reliable suicide risk assessment and the increase urge of our patient to get some benefits from our system, being these; one of the greatest challenges in psychiatric practice.

Another topic which is good to talk about is the high cost in the treatment of suicidal patients, increased by several problems, like the absence of specific predictors or a cost effective screening method, the high number of malingering patients, and the significant liability incurred when treating suicidal patients, which tempts clinicians to practice defensive psychiatry by over utilizing inpatient service. (6)

Suicide is to the psychiatrist as cancer to the internist—the psychiatrist may provide optimal care, yet the patient may die by suicide nonetheless. (7)

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Table of Contents> Volume II > 29- Psychiatric Emergencies> 29.1 – Suicide

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