In The Perfect Storm, Sebastian Junger describes the desperate plight of sailors and fisherman who, in the fall of 1991, were caught out in the Atlantic Ocean as 2 powerful storms converged into 1. Like those mariners, emergency department (ED) clinicians find themselves at the confluence of 2 powerful trends in modern society.

The first of these trends is the medicalization of misery, in which an ever-expanding list of human discontents, such as inattentiveness, wrinkled skin, and inconsistent erections, are being recategorized as medical diseases. At the same time, there has been a trend toward reductions in social entitlement programs. As more and more avenues for securing basic human needs have been closed off, the needy have increasingly turned to the ED as a place to get those needs met. For some members of our society, the hospital may be their only refuge from the pressures, deprivations, and even dangers of modern life.

Looked at in this light, malingering can be understood as a perfectly predictable by-product of a society that not only promotes the view that sickness is the underlying cause of most human distress but also attaches so many entitlements uniquely to the sick role. It is left up to Dr Berlin and physicians such as him to face the waves of patients who come to the ED seeking the stamp of medical legitimacy on their claims to the benefits of the sick role.

Dr Berlin's reflections about his work with malingerers feature 2 important and inter-related themes: the enmity that develops in the doctor-patient relationship and the importance of an honest and earnest individual assessment of each case. We share Dr Berlin's view that these are the major impasses that characterize encounters with suspected malingerers. Our discussion here is intended to elaborate on Dr Berlin's excellent analysis.

**The Many Faces of Malingering**

Malingering is not a genuine illness, at least as far as the DSM-IV-TR is concerned. Even referring to a malingerer as a "patient" is controversial. However, malingering may become a principal focus of clinical attention much more frequently than ED clinicians and staff would like.

The malingerer often presents with a subacute or chronic problem for which the ED appears particularly unsuitable. This population is easily among the least gratifying that professional caregivers face, and it is understandable that some clinicians view the malingerer, along with other patients who present very repeatedly, as a "hateful patient." The malingerer mobilizes intense countertransference, ranging from perplexity to anger, aversion, and a feeling of being exploited. These negative reactions toward the malingerer may be reinforced by a staff that clearly views offering assistance--such as an opioid or benzodiazepine prescription--as betraying personal and professional weakness.

At the heart of these scornful feelings is the assumption that the malingerer is trying to get something to which he or she is not entitled. The common view of malingering is that it is defined by 2 criteria: (1) lies or misrepresentations (2) intended to secure some benefit to which the malingerer is not otherwise entitled. Even this simplistic view of malingering may be replaced in clinical practice by an even simpler heuristic: if a patient is being dishonest, the patient must be trying to secure a benefit to which he is not entitled. Accordingly, the management of malingering is often reduced to uncovering the patients' lies or deceptions and sending them packing. Apart from the probable incorrectness of the underlying assumptions of this approach, Dr Berlin also notes astutely that handling malingerers this way may do little more than relocate a difficult patient from one ED to another.

Dr Berlin points out incisively that a patient's dishonesty about his presenting complaint does not necessarily mean that the patient does not have a legitimate need that he is trying to meet through enactment of the sick role. Understandably, Dr Berlin focuses on patients whose manifest psychiatric problem is somehow covering up another, different type of psychiatric issue (eg, in Case 2 [page 23],...
in which bipolar disorder served as a pretext for securing help in a homicidally distressed patient). For our part, we would like to extend Dr Berlin’s analysis by highlighting the wide diversity of malingering presentations and of underlying motivations that may lead persons to enact the sick role in the ED.

One can envision 5 patients who come to the ED at 1 am seeking a medical admission to the hospital. In a manner of speaking, they are all seeking the same thing; in another way, they may all be looking for something different. One might be seeking refuge from domestic violence, another might be looking for a warm bed on a cold winter's night, another may be executing the first part of a complex plan to extract a medical liability settlement from the hospital, another may be seeking to avoid the unbearable social anxiety of a job interview scheduled for later that morning, and yet another may simply be looking for basic human caring and kindness.

Arguably, all of these persons are malingering, and they all want the same thing: to be admitted to the hospital. However, if ED staff focuses only on the malingering and concludes that these patients' complaints are not legitimate, or at least not treatable, the staff has missed an important opportunity to help these patients and, ultimately, themselves.

A psychiatrist may have nothing to offer the sociopath bent on bilking the hospital and might rightfully conclude that the patient does not have a legitimate claim to aid or assistance. In addition, there may be little that clinicians can offer a homeless person who is seeking physical comfort, although they acknowledge that he has a legitimate need. On the other hand, abusive relationships, debilitating anxiety, and loneliness are the sorts of problems for which psychiatry confidently claims to provide solutions. In many cases, accurately assessing the patients' needs and channeling patients to appropriate social service agencies or nonemergent medical or psychiatric care might reduce their excessive and inappropriate use of the ED, thereby helping both the patient and the hospital.

A further point about the complexity of malingering presentations is raised by Dr Berlin’s third case presentation (page 25). In this case, there was a complex blend of apparent exaggeration of distress in the context of strong and pressing motives to malingering but with a history of unambiguous suicidal behavior. Despite its complexity, this case may represent the rule rather than the exception--namely that most cases of medical or psychiatric deception reflect a combination of internal and external motivations, of which the patient may be more or less aware. Experiences with genuine illness can introduce patients to the adventitious reinforcement associated with the sick role, which might lead to other strategic sick-role enactments. The existence of such cases reinforces the need for a thorough assessment of suspected cases of malingering.

Most patients who are suspected of malingering probably do not fit the stereotype of the malingerer as a con artist or drug seeker but rather are simply desperate people who are doing their best to cope with difficult life situations and have nowhere left to turn for help. As we have alluded, both patients and hospital staff are victims of a social system that has made the hospital ED the de facto provider of a wide range of social welfare services. Realizing this may go a long way toward redirecting angry and hostile feelings away from the patient. Recognizing that the patient probably has legitimate basic human needs, perhaps emergent ones, should help mobilize an empathic response to patients who are often perceived simply as cheats. SAVING FACE IN THE ED

The obvious complication that arises in suspected cases of malingering is that the malingerer gives the impression that he is not being honest with the evaluator about the exact nature of his problem, making it impossible to evaluate the patient's real needs. Why are they not being honest with the evaluator? Dr Berlin focuses his attention on psychological barriers, such as a "defensive need to dehumanize the image of the clinician" and a lack of trust that limits self-disclosure. We suggest that there is another psychological obstacle to honesty, one that may be present in all but the most nefarious cases: the need to save face.

Sociologist Erving Goffman observed that most social interactions have a bit of dishonesty built into them. According to this dramaturgic analysis, the rules of social engagement specify that we each are entitled to small lies, boasts, and excuses and, in return, we are obligated to honor the lies, boasts, and excuses of others. For example, a physician arrives late for an important social engagement, telling her husband she had to answer a page; the husband accepts the excuse, knowing that in all likelihood it is not true; the physician knows that her husband doubts the excuse; and domestic tranquility is maintained--at least for the time being. Goffman's genius was in seeing this type of subterfuge as a normative and necessary part of human interaction and not as a form of psychopathology.

We believe that in many cases in which malingering is suspected, the patients' specific needs are accompanied by a second, universal need to maintain a sense of basic human dignity. In these
cases, it is the desire to save face, not the desire to cheat the system, that explains why the malingering patient is not honest with the evaluator. The patient who is seeking refuge from an abusive spouse is lying about being ill for 2 reasons: one is to gain access to the safety of the hospital; the other is to avoid admitting to a total stranger that she has been too weak, afraid, or emotionally needy to break away from a man who treats her worse than he treats his dog. The economically disadvantaged African American mother brings her child to the ED with exaggerated reports of respiratory distress because she cannot afford primary pediatric care and because she wishes to avoid the indignity of being judged by yet another white social security administrator from whom she must beg for charity. Even in Dr Berlin's second case presentation, the patient was seeking relief from the pressures of his home life without having to suffer the humiliation of admitting to the physician that he has been abused by his girlfriend's children and is so angry over this fact that he is afraid he will hurt someone. Dr Berlin suggests a number of approaches for breaking out of the dishonest communication patterns in which clinicians and suspected malingering patients often find themselves. Many of his suggestions involve direct confrontation of the dishonesty. Although there may be some cases in which confrontation is necessary and advisable, we suspect that less direct strategies that are attentive to the issue of saving face may ultimately produce a better result in most cases.

CASE MANAGEMENT OF THE SUSPECTED MALINGERER

Effective management of suspected malingering should begin with the working assumptions that the patient has a legitimate need and that the ED visit is probably the patient's last best hope for getting that need met. The evaluator should communicate to the patient that people turn to the ED for help with a variety of legitimate problems, some of which can be dealt with at the hospital and some of which cannot, and that the evaluator is committed to doing everything possible to ensure that the patient's needs are met.

Also, the evaluator should set a tone of acceptance and respect that will foster open and honest responses on the part of the patient. Patients who sense a positive and accepting attitude in the evaluator may feel comfortable in confiding their true need to the clinician. In larger urban settings, it might be advisable to have around-the-clock coverage by a clinical social worker who can help assess the patient's broader needs and make appropriate referrals to public and private social service agencies, such as shelters, safe houses for abused women, and free clinics. For persistent malingerers, the sorts of assessments that would provide useful insights into the causes of their malingering are certainly not compatible with the limited time and resources of clinicians in the ED setting. In these especially difficult cases, we believe the clinician should support, whenever possible, a brief hospitalization. The chief objective of the admission would be to conduct a thorough functional analysis of the patient's health care use. Such an analysis functions to help clinicians understand the patient's health care use in the context of a broad range of ongoing and acute stressors, as well as the resources available to the patient to cope with these challenges. Unlike an ED workup, the evaluation of inpatients can be more deliberate and wide-ranging. Whereas a focus on broad psychosocial concerns in the ED might strike the patient as invalidating their acute complaint, that sort of broad approach is expected in the inpatient context and may communicate to the patient that he is being taken seriously. Moreover, an inpatient evaluation would provide the opportunity for nonphysician health care professionals to evaluate the patient and perhaps match some of their nonemergent medical and psychosocial needs with available resources in the community. An inpatient evaluation also would provide an opportunity for a definitive evaluation of the patient's presenting complaint, helping protect the patient in cases of difficult-to-diagnose medical or psychiatric conditions and the hospital from future claims of negligence.

There are 3 possible outcomes of a brief inpatient evaluation of a suspected malingerer. First, the patient might fail to cooperate in an honest and forthcoming manner despite the best efforts of staff to treat him in a nonjudgmental and dignifying manner. If this occurs, the hospital has a medical record of the concerted efforts that have been made to help the patient and his unwillingness to accept that help. These data would be valuable to ED personnel should the patient return to the ED with suspicious complaints, providing evidence to support a denial of services. Second, the patient may cooperate with the evaluation, revealing that he has legitimate needs that fall outside the purview of medicine or psychiatry. Hospital team members who are aware of programs through which the patient's needs could be met can help educate the patient, assist him with paperwork, and make appropriate referrals. Third, the cooperative patient might reveal that the problem with which he has been using the sick role to cope may be amenable to psychiatric or psychological intervention. Each of these outcomes ultimately enhances the ability of hospital staff to gauge the fit between the patient's needs and the
hospital's resources and, therefore, maximizes the likelihood that the patient will receive the help he needs. **FINAL THOUGHTS**

Anyone who has been to a busy ED in the late hours of the night can attest that it is not a pleasant place to be. Long waits are punctuated by brief interactions with busy staff who simply have no time and energy for pleasantries with the patients. The idea that anyone would freely and willingly subject himself to the experience flies in the face of common sense. Most persons with genuine illness visit the ED as a last resort, and we believe that most suspected malingerers who visit the ED do so as well.

The challenge to ED psychiatrists and clinicians is to uncover the patient's need, to understand the nature of his inability to satisfy it in more adaptive ways, and to do all this in a manner that preserves the patient's basic human dignity. Achieving this will require that the clinician redirect hostile feelings away from needy patients and onto the systems that have forced both themselves and their patients to play this mutually humiliating game of cat and mouse. In the end, the system is destined to fail. The EDs of the world cannot provide food, clothes, protection, and kindness to all those in need.

**References: REFERENCES**

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