A Case of Factitious Homicidal Ideation

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Homicidal ideation is often fabricated or embellished by psychiatric patients in both the emergency room and inpatient settings. Typically, this symptom is malingered to achieve short-term hospital admission and temporary relief from complications of substance abuse, homelessness, and illicit activities. Very rarely, a patient may feign homicidal intent for the primary purpose of remaining in the role of patient (factitious disorder). Although factitious disorder with psychological symptoms has been described in a variety of circumstances, the psychiatric literature lacks any reports of factitious homicidal ideation. This is a report on the case of a patient who was civilly committed on numerous occasions for protracted periods based solely on his self-professed homicidal ideation. The case raises both forensic and clinical questions and reinforces the authors' belief that further investigation is needed to develop more sophisticated methods of detection, evaluation, and treatment of factitious disorder with psychological symptoms.

J Am Acad Psychiatry Law 32:277–81, 2004

"Danger to others due to a mental illness" is a characteristic criterion for civil commitment in the United States. California state law provides for an initial involuntary 72-hour evaluation, an involuntary 14-day certification, and ultimately an involuntary 180-day certification for continued dangerousness.[1] However, retrospective analysis has demonstrated that individuals are rarely committed for 180 days, especially when verbal threats are the sole rationale.[2] The evaluation of dangerousness is complex and is reviewed extensively elsewhere.[3]

Often, clinicians use the presence or absence of homicidal ideation as a major part of their assessment of dangerousness in the emergency room or inpatient settings. Because it is subjectively reported by the patient, homicidal ideation is easily fabricated. Fabrication or embellishment of symptoms for secondary gain (e.g., obtaining money, avoiding jail) characterizes malingering, while doing so for primary gain (e.g., maintaining the role of patient) characterizes factitious illness.[4]

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Not uncommonly, homicidal ideation is malingered to obtain short-term hospital admission and, consequently, temporary relief from complications of substance abuse, homelessness, and illicit activities. Rarely, a patient may feign homicidal intent for the primary purpose of remaining a patient. We report the case of a male patient who was committed numerous times based only on his self-professed homicidal ideation toward unidentified individuals.

Case History

A middle-aged male was admitted involuntarily to a private psychiatric hospital for a 72-hour evaluation for "danger to others." Prior to admission, he had informed his outpatient psychiatrist that he intended to murder four unnamed physicians who he believed had provided him inappropriate or incomplete medical and psychiatric treatment in the remote past. His plan to kill these individuals incorporated such details as the length of time it would take to drive to the necessary target locations and the specific firearms he would use to carry out the "mass murder." In consecutive examinations, the patient vowed to follow through with his plan if released. Therefore, he was committed to the hospital.

Further psychiatric history was gleaned from interviews with the patient and review of available treatment records. A limited number of records, namely discharge summaries less than five years old,

were available through a centralized patient database linking the medical records systems of multiple hospitals in a particular health care system. However, the patient refused to divulge where he had received medical or psychiatric treatment prior to this time and, in any case, did not give us permission to contact these unknown facilities. He also did not allow us to contact his family or friends, stating that he had been estranged from his family for many years and that he had "no friends."

He eventually found work as a skilled laborer. The patient suffered a knee injury at work that led to chronic pain and disability. Since that accident, he had been alienated from his family, had had no close friends, and had not been involved in any meaningful romantic relationships (he reported that he was heterosexual).

Approximately 10 years prior to the current admission, the patient had seen a psychiatrist and complained of stress, pain, and severe anger. As a result, he was hospitalized for several weeks for a diagnosis of adjustment disorder with depressed mood. A few months later, he was rehospitalized for a similar presentation. He reported ongoing bitterness toward "injustices" he had suffered both at work and in his medical and psychiatric treatment. Over the next four to five years, the patient had frequent contact with the mental health system and multiple psychiatric hospitalizations, generally precipitated by "stress and anger" related to his aforementioned treatment.

A few years prior to the current admission, he had been placed on his first 180-day certification at a psychiatric facility for expressing homicidal ideation toward unnamed prior treating physicians. He was rehospitalized at another hospital within the same year for a similar presentation and remained hospitalized involuntarily, on four consecutive 180-day certifications, for a period of two years. During that hospitalization, he reported experiencing auditory hallucinations (the quality of which is unclear from the records), paranoia, and depressive symptoms. However, the treatment records from this facility did not indicate that clinicians had documented objective evidence supporting the patient's reported symptoms. Nevertheless, he was subsequently diagnosed with schizoaffective disorder, depressed type, and began to receive social security disability for this mental illness. Less than one year following discharge from the hospital, he presented again with the same chief complaint, leading to the present civil commitment.

The patient reported numerous psychiatric hospitalizations in his lifetime and estimated having spent almost 50 percent of the past decade in psychiatric facilities. During that time, he reported receiving a variety of psychiatric diagnoses including affective disorders (major depressive disorder, bipolar disorder, dysthymia), anxiety disorders (obsessive-compulsive disorder, posttraumatic stress disorder), a psychotic disorder (schizoaffective disorder, depressed type), and personality disorders (narcissistic, borderline). However, it was unclear from the available medical records how these conclusions were reached. He had also had multiple trials of psychotropic medications including antidepressants, mood stabilizers, and antipsychotic drugs (both typical and atypical). The patient noted that no medication had alleviated his homicidal ideation, but had only caused distressing side effects, for which he blamed his physicians. The patient denied any suicide attempts or substance abuse. He claimed to have committed several homicides in the past, but refused to provide details.

Hospital Course

Findings in physical and neurological examinations at admission were normal. Bedside cognitive testing revealed no deficits. Routine laboratory tests were unremarkable. Electroencephalograms (EEGs) were normal in awake and drowsy states. Brain magnetic resonance imaging (MRI) showed diffuse cortical atrophy, predominantly along the cerebral convexities and in the temporal lobes bilaterally. The significance and etiology of the atrophy was unclear. The ventricles, basal ganglia, and other brain structures were normal, and the patient did not demonstrate any cognitive deficits, was not particularly impulsive or disinhibited, and had experienced no significant personality change over the past decade (according to the patient and review of available records).

Neuropsychological testing showed highly variable attention, concentration, and executive functioning, as well as borderline verbal memory and hypothesis formulation. However, the patient's full-scale IQ was 132 (verbal IQ 135, performance IQ 120). His Beck Depression Inventory score was 39, consistent with severe depressive symptomatology. The Millon Clinical Multiaxial Inventory (MCMI)

was consistent with narcissistic personality characteristics. The neuropsychological impression was of "conscious symptom exaggeration for primary or secondary gain."

Sequential examinations and ongoing close observation of the patient in the ward milieu revealed no evidence of formal thought disorder, hallucinations, or delusions. Although the patient reported feeling depressed, he was often observed to laugh and joke with other patients on the ward and did not display psychomotor agitation or retardation. His appetite, sleep, and energy were excellent. The patient's antipsychotic medication was discontinued without complication. He was eventually treated with gabapentin for chronic knee pain and a selective serotonin reuptake inhibitor for possible dysthymia, with modest responses to both. His physical complaints were unchanged, despite consultation and treatment by the orthopaedic, physical medicine, and pain management services.

The patient repeatedly launched into accusatory tirades about his mistreatment and made a specific demand to "rectify" this mistreatment: government subsidization of his "permanent hospitalization" at a private community psychiatric facility. When informed that this request was unrealistic, the patient indirectly threatened his treating psychiatrists. Because the patient's threats did not appear to be due to an Axis I disorder, the treatment team contemplated referring the matter to the police for possible criminal prosecution. However, although the patient alluded to the desire to kill four physicians who had treated him in the past, he never named anyone specifically. Under the laws of the state of California, prosecution for making terrorist threats requires the victim to "fear for his life," which was not true in this case. We also considered attempting to warn the individuals whom this patient had threatened to kill. However, the patient was uncooperative in releasing older records of his prior psychiatric and medical treatment to us. Therefore, we were unable to identify any potential victims. We contacted law enforcement officials about the possibility of issuing subpoenas to obtain all of his past treatment records but they were not interested in pursuing this course of action.

Despite the patient's ongoing complaints, he appeared comfortable and relaxed on the ward at all times. He remained focused on his perceived victimization and stated that those involved in his suffering must ultimately die. He repeatedly alluded to his murderous plans and testified to his homicidal ideation in mental health court on several occasions. After more than three months in the hospital, he renounced any imminent homicidal intent, though he implied that he would "probably do something in the future." The treatment team concluded that the patient was not a danger to others due to a mental disorder. Consequently, a recommendation was made to the court to discontinue his 180-day certification. The court agreed and the patient's involuntary hold was terminated. After the hearing, the patient was confronted with our suspicions that he was embellishing or fabricating psychiatric symptoms (namely homicidal ideation and depression). However, he denied this. He was offered continued voluntary hospitalization on a different ward, but declined and left the hospital the same day that his hold was discontinued.

Discussion

After more than three months of evaluation while the patient was involuntarily hospitalized, it was concluded that he was not a danger to others due to a mental disorder. For over five years of having reportedly similar thoughts, he had not acted on them. He showed good impulse control on the ward. He had no history of making direct threats or attacks against those he blamed for his problems. He did not exhibit a formal thought disorder or any other signs of psychosis or agitation while hospitalized. Although the patient reported feeling depressed, he was often observed to laugh and joke with other patients on the ward. He did not appear anxious or agitated and showed no psychomotor retardation. His appetite, sleep, and energy were excellent. Therefore, it became evident that his overall presentation was inconsistent with any of the major mental disorders necessary for civil commitment. The treatment team's clinical impression was conscious embellishment, if not total fabrication, of homicidal ideation and depression, motivated by his desire to remain in the role of patient. Consequently, factitious disorder with psychological symptoms was the final diagnosis.

We reached this conclusion after careful consideration of multiple factors. As mentioned previously, the patient did not demonstrate signs of a psychotic, mood, anxiety, or substance abuse disorder. Therefore, if the patient's homicidal ideation were genuine, the only psychiatric diagnostic category that could be responsible for this continued symptom

would be a personality disorder. We considered the possibility that the patient had a paranoid personality disorder, the presence of which may have made genuine homicidal ideation more likely. However, we decided this was improbable for several reasons:

1. This patient actively sought out psychiatric treatment and was quite forthcoming with his reported homicidal ideation. Individuals with paranoid personality disorder do not generally seek out mental health treatment and tend to be reluctant to confide in others, because they fear that information will be used maliciously against them.[4]

2. This individual seemed quite comfortable in the role of a psychiatric patient and did not appear to think it was stigmatizing in any way. In contrast, individuals with paranoid personality disorder are quite sensitive to perceived attacks on their character or reputation (e.g., being characterized as mentally ill) and are quick to react angrily or to counterattack.[4]

3. This patient's MCMI was inconsistent with a diagnosis of paranoid personality disorder.

Although we concluded that this patient did not have a paranoid personality disorder, we thought it extremely likely that he had a narcissistic personality disorder and dependent traits. However, we strongly doubted that these were responsible for producing genuine homicidal ideation. Rather, we thought that his narcissistic personality disorder and dependent traits fueled his desire to remain well cared for in the patient role and his fabrication or embellishment of homicidal ideation helped him achieve that end. The following observations led us to this conclusion:

1. The patient's MCMI was consistent with a narcissistic personality disorder. The patient's history and clinical observations were indicative of a narcissistic personality disorder and dependent personality traits. This combination of personality characteristics is generally not consistent with prolonged genuine homicidal ideation, but is consistent with factitious disorder.[5]

2. The patient's behavior was not characterized by the planning and execution of a homicide but rather by the repetitive pattern of communicating a symptom (i.e., homicidal ideation), being rehospitalized, and sabotaging interventions designed to resolve that symptom. This indicates that the patient's main goal was to be cared for continuously.

3. The patient offered a concrete solution to his perceived unfair treatment, namely remaining hospitalized indefinitely at a particular private inpatient psychiatric facility. This indicates that the patient believed "justice would be served" more fully by his receiving continuous caretaking rather than by his acting on his reported homicidal thoughts.

4. Other features of the patient's presentation are consistent with prior cases of factitious disorder. These include:

- The patient presented to multiple hospitals in different areas of the country. Peregrination is common in factitious disorder.
- The patient left the hospital after being confronted with our suspicions that he was embellishing or fabricating symptoms.
- The patient has not returned to our facility.

Obviously, another major diagnostic consideration was malingering, especially given this patient's history of manipulation for secondary gain (e.g., disability income). However, this possibility seemed much less likely than factitious disorder for the following reasons:

1. The patient spent two consecutive years under civil commitment based merely on his self-reported homicidal ideation. He could have recanted this at any time to be released. However, he appeared to find pleasure in the role of patient and in being "institutionalized." In fact, the patient's expressed desire was to be able to remain hospitalized indefinitely at a particular private inpatient psychiatric facility. Extended civil commitment would probably be seen as a negative consequence by most malingerers (especially those with ample income) and something to be avoided rather than sought after.

2. Obtaining disability income did not lead to resolution of his reported homicidal ideation, which continued despite the lack of any realistic additional secondary gain. In addition, the patient probably realized that ongoing contact with the mental health system (i.e., hospitalization) would only jeopardize his disability income if his behavior were eventually diagnosed correctly. Therefore, he was risking previously acquired secondary gain to remain in the role of patient.

3. The patient's life appeared to be organized consistently and continuously around his homicidal ideation and perceived victimization. This would be unusual for true malingerers, who generally feign symptoms intermittently at opportune times.

4. The patient was savvy about psychiatric symptoms and diagnoses. Extensive knowledge of medical or psychiatric terminology is quite common in factitious disorder.[6]

5. The patient's MCMI was consistent with a severe narcissistic personality disorder, but showed little evidence of antisocial traits. This profile would be more consistent with factitious disorder than malingering.

Although factitious disorder with psychological symptoms has been described in a variety of contexts (post-traumatic stress disorder,[7] mourning,[8] sexual harassment,[9] and stalking[10]), review of the psychiatric literature revealed no reports of factitious homicidal ideation. The difference between factitious disorder with psychological symptoms and malingering is often subtle, and the continuum between unconscious and conscious motivations (for symptom production) makes distinguishing the two quite difficult at times, even for the experienced clinician. Several researchers have even questioned whether factitious disorder with psychological symptoms is a mental illness.[11]

Little is known about the incidence of factitious psychological disorders, but three different studies estimated that 0.14 percent,[12] 0.5 percent,[13] and 5.0 percent[5] of psychiatric hospital admissions are factitious in nature. Many authors contend that these patients are largely undiagnosed and hence are undertreated.[14]

Our understanding of the etiology of the disorder is based primarily on case reports. Generally, those who feign psychological symptoms for primary gain come from distant, emotionally depriving families and suffer from severe psychological dysfunction.[15] Cluster B personality disorders (particularly Borderline and Narcissistic types) and substance abuse are common.[5]

Despite the fact that patients who present with psychological symptoms are presumptively "closer to treatment" (having initially come to a psychiatric facility), there are few, if any, reports of successful treatment.[5] In fact, research suggests that patients with factitious disorder have a worse prognosis than those with other major mental disorders. As one study concluded quite succinctly, "It appears that acting crazy may bode more ill than being crazy."[5] Ironically, these patients may have, in addition to their factitious psychiatric illness, another psychiatric disorder that may be responsive to psychotherapeutic or psychopharmacologic intervention. Unfortunately, this idea is largely speculative, since most of these patients leave the hospital abruptly once confronted and are lost to follow-up. More investigation is certainly needed to develop more sophisticated methods of detection, evaluation, and treatment of factitious disorder with psychological symptoms to minimize unnecessary psychiatric hospitalizations and civil commitments.

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