CASE REPORT

Suicidal Ideation on Day of Discharge

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Major depressive disorder (MDD) is one of the most prevalent psychiatric disorders in the adolescent population (1). Treatment for MDD is multidisciplinary and includes elements of psychoeducation, supportive management, psychotherapy, family involvement, school involvement, and pharmacotherapy (2). Furthermore, treating comorbid conditions in MDD is essential, because they can influence the ability to achieve complete response (2). Comorbid conditions can increase the risk of suicide and functional impairment for patients with MDD (2). Comorbid factitious disorder (FD) can be a barrier to proper treatment and safe discharge planning (3).

FD is a psychiatric condition in which patients deliberately produce or falsify signs and symptoms of an illness. Patients are motivated by internal factors, such as the psychological drive for attention, rather than external factors, such as financial gain (4). Despite growing evidence of FD among pediatric patients, it remains underdiagnosed and misunderstood. A 2008 article by Ehrlich et al. (5) cited the prevalence of FD as 0.7% among pediatric patients. Given the rarity of FD, much of the research is focused on adult populations. Moreover, even the limited research on pediatric FD focuses primarily on presentations with physical rather than psychiatric symptoms (5).

In this case, we add to the literature on pediatric presentations of FD by describing a case report of an adolescent who reported suicidal ideation despite her readiness for discharge. Some details have been altered to protect patient confidentiality, but key points of the case have been preserved. Consent was obtained from the patient's guardian.

CASE

A 14-year-old female with a history of recurrent MDD, posttraumatic stress disorder, and generalized anxiety disorder was admitted to the inpatient psychiatric unit for suicidal ideation. Before admission, the patient had more than five previous inpatient psychiatric admissions and two prior suicide attempts: one by overdose and another by cutting her wrists in front of her mother. She was recently at a residential treatment center for 6 months because of poor functioning at home and school. After her stay at the residential center, she went home with her grandparents. She normally lived with her parents; however, the relationship was strained and likely contributed to her symptoms. One month after discharge, she ran away after an argument with her grandmother. The same day, she was found near a bridge with intention to jump and was brought to the hospital.

On admission, the patient endorsed depressive symptoms and active thoughts of suicide. She was engaging in nonsuicidal self-injury during and prior to admission by cutting and burning her arms. The patient reported that a trigger for suicidal ideation was an upcoming forensic interview regarding a sexual assault. She reported a variety of trauma-related symptoms and ongoing, daily generalized anxiety. She endorsed nonspecific auditory hallucinations, which were suspected to be negative self-talk and flashbacks, rather than psychosis.

During her inpatient stay, the patient underwent individualized therapy and medication adjustments. Sertraline and quetiapine were past medications and were restarted. Prazosin was started for trauma-related nightmares. The patient was initially engaged in programming and sociable with peers. During the first 3 days of admission, her anxiety and depression consistently improved. The patient denied suicidal ideation, and discharge planning began. However, after a call with her guardian, the patient again reported suicidal ideation to staff and then refused to speak to the treatment team. This pattern repeated each time she had a phone conference or pending discharge over the next 2 weeks. Discussion with the patient's mother revealed that a similar pattern had occurred during her stay in the residential treatment center. The team began to suspect a factitious element to this patient's suicidality.

Throughout the patient's admission, she gradually became less cooperative with the psychiatric team and disinterested in unit programming. She remained highly social with peers. After multiple team discussions, she was placed on individual programming aimed to reduce peer distraction and encourage focus on treatment. The patient gradually opened up to the unit therapist. Her anxiety and negative self-image had been driving her suicidal ideation and nonsuicidal self-injury, which were exacerbated by tension with her grandmother rather than the forensic interview alone. The team scheduled mediated calls with her grandmother to address communication. After multiple days of sustained improvement, the patient was informed of discharge only after her family arrived on the final day. The patient was discharged home and has not had a repeat psychiatric admission in more than a year since discharge.

DISCUSSION

This case raises various complex topics, but the discussion focuses on factitious elements. Despite readiness for discharge, patients may refuse to leave the hospital for multiple reasons. When a patient wishes to stay against medical advice to obtain an obvious secondary gain, malingering can be diagnosed (3). Malingering is the feigning or gross exaggeration of a physical or psychological symptom for external gain (such as financial reward) (3). FD can be diag-

TABLE 1. Reasons patients may desire to remain in the hospital against medical advice and associated diagnoses

Reason or motivation to stay	Associated diagnosis	Description
Primary gain: a desire to play the sick role in the hospital; no obvious external gain	Factitious disorder imposed on self	Psychiatric condition in which patients deliberately produce or falsify signs and symptoms of illness (4)
Secondary gain: to obtain meals, shelter, financial benefits, or attention; to avoid legal problems; or to obtain medications; obvious external gain	Malingering	Patient feigns or grossly exaggerates a physical or psychological symptom for external (secondary) gain (3)
Patient disagrees with the opinion of the medical team: attempt to stay longer until a better solution to the patient's problems can be identified and applied	Functional neurological disorder (conversion disorder)	Psychiatric condition in which a particular symptom affects motor or sensory functioning, causing significant distress or deficit to normal everyday functioning, with no organic cause, and the symptom cannot explained by another psychological or physiological condition (6)
Fear of leaving the hospital: feeling of safety while in the hospital; overwhelmed and incapable of functioning outside the hospital	Somatic symptom disorder	Psychiatric condition in which one or more somatic symptoms are associated with excessive worry, which causes a loss of opportunity in personal and social life (7)

nosed when the patient's motivation is a primary gain (with no obvious external gain) (3). FD imposed on self is an intentional falsification of illness, including feigning illness, self-induced illness, or exacerbation of preexisting illness, motivated by internal factors. In both malingering and FD, patients are conscious of their intention to deceive (3). When the motivation to stay is unconscious, then somatic symptom disorder or conversion disorder is more likely (6, 7). Table 1 summarizes some of the most common reasons that patients may desire to remain in the hospital (3, 4, 6, 7).

When factitious elements are suspected, the patient should not be immediately confronted. Such interaction can damage the therapeutic alliance (8, 9). FD is often secondary to another emotional disorder, and treatment of that psychopathology can help decrease factitious behaviors (8). Early recognition of factious elements is important to prevent unnecessary and invasive procedures and expenses (10). Accurate diagnosis is also important. A retrospective study by Krahn et al. (9) showed that physicians are reluctant to include FD in the differential diagnosis without definitive proof. The lack of an appropriate diagnosis is detrimental to the patient, because suspicion of fabrication of illness can lead to countertransference that interferes with compassionate medical care (9). Treatment involves connecting with patients empathetically and helping them act out their distress in a healthy manner (10).

The patient's treatment and discharge are complicated when the patient feigns thoughts about and plans for suicide in an attempt to remain hospitalized against medical advice (3). Strategies for the physician in such cases include first determining the patient's gain and then attempting to make the patient aware of his or her motivations (3). Knowing what the patient's motivations are allows the physician to discuss the reasons for staying in a nonjudgmental manner, with a focus on finding alternate ways to meet the patient's needs outside the hospital (3).

For the patient described here, the treatment approach for factitious elements included empathetic listening, unconditional acceptance, and attempts to help the patient act out distress in a healthy manner. With such an extended residential stay and prior assault, the patient was reluctant to return to school and normal life. To encourage the patient to connect with peers and family outside the hospital rather than relying on support from the inpatient unit, the patient's treatment plan focused on individual programming. An additional barrier arose when the patient reported difficulties creating a safety plan at the family home. She participated in family therapy with her grandmother and slowly built confidence to develop a reasonable safety plan.

According to Moran et al. (3), forming the discharge plan for a patient with factitious elements of disease includes three stages: planning, the encounter, and follow-up. The planning phase involves a multidisciplinary team with doctors, nurses, social workers, legal guardians, and security officers (3). The medical team may refrain from telling the patient about discharge until the encounter phase—when the patient is informed of impending discharge. During this phase, the physician should use empathy and compassion to inform the patient. If the patient is agitated or threatens staff, security may need to intervene (3). In the follow-up phase, documentation is critical for discharge, including any further factitious behaviors, as is follow-up with an outpatient provider (3).

As described by Moran et al. (3), discharge for this patient first involved a planning stage to contact the patient's extended family, followed by improved symptomatology and close collaboration with social workers to ensure a safe home environment (3). The encounter phase for this patient had to occur multi-

KEY POINTS/CLINICAL PEARLS

- Factitious disorder is a condition in which patients deliberately falsify illness, motivated by internal gain (to play the sick role).
- Malingering should be diagnosed when patients' deliberate falsification of illness is motivated by external gain (e.g., financial).
- Clinicians should identify the motivation for factitious elements of disease and attempt to meet those needs outside the hospital.

ple times, but the treatment team aimed to inform the patient of discharge with the utmost empathy and compassion. Eventually, the encounter phase had to occur very close to the time of discharge. The follow-up phase involved careful documentation of the patient's discharge process and a careful outpatient care plan formed in collaboration with the patient and family.

CONCLUSIONS

Adolescents with recurrent MDD and factitious elements require special consideration for both treatment and discharge. These patients require a multidisciplinary approach. Difficult financial situations, a challenging home life, and lack of social connection outside the hospital can be barriers to discharge. Clinicians should attempt to understand a patient's motivations for staying hospitalized. Discharge of patients with factitious elements requires exceptional compassion and support during all three phases of discharge—planning, encounter, and follow-up. Care teams may need to perform multiple or abrupt encounter phases while preparing for safe discharge. Finally, successful discharge relies on appropriate maintenance treatment with follow-up psychotherapy and medication management.

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