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PERSONALITY AND IMPULSE CONTROL DISORDERS (R LEE, SECTION EDITOR)

Antisocial and Borderline Personality Disorders in the Emergency Department: Conceptualizing and Managing "Malingered" or "Exaggerated" Symptoms

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Abstract

Purpose of Review Patients with antisocial personality disorder (ASPD) and borderline personality disorder (BPD) are often suspected of malingering or exaggerating symptoms, though there is no clear evidence that they do so more than other patients. We review the manifestations, etiology, and management of seemingly feigned symptoms in these disorders, particularly related to their presentation in the emergency department (ED).

Recent Findings It is dangerous to assume that all patients with ASPD and BPD are intentionally feigning symptoms in the ED. However, when ASPD patients are known to be malingering, the focus should be shifted to addressing the motivation behind malingering and the patient's true goals, ideally done with a curious rather than confrontational approach. BPD patients also may appear to be malingering or exaggerating symptoms, but their presentation often is more accurately attributed to the lack of ability to mentalize and effectively communicate their needs, as well as emotional hypochondriasis.

Summary Education of ED staff, demonstrating genuine concern, and attempting to find a common goal with patients will aid in keeping an objective view of the patient's distress, minimizing escalation, and optimizing patient outcomes.

Keywords Antisocial personality disorder · Borderline personality disorder · Malingering · Emergency department · Factitious disorder

Introduction

Individuals with antisocial personality disorder (ASPD) and/or borderline personality disorder (BPD) visit the emergency department (ED) often and, while there, create unique challenges for staff and providers [1, 2]. Individuals with ASPD utilize emergency departments and inpatient hospitals more than those with other diagnoses and represent a significant subset of ED patients [2–4]. Likewise, individuals with BPD also are frequent visitors to the ED (~9% of all patients in a psychiatric ED) and, given their emotional dysregulation, impulsive behaviors, and elevated risk for suicide, create high levels of stress among staff [5, 6••]. Those with personality disorders also tend to visit the ED more recurrently and have longer lengths of stay in the ED, factors which can engender and exacerbate staff frustration [7].

The emphasis of this article is the common and often perplexing challenge of managing individuals with ASPD and/or BPD who are, or are perceived to be, malingering or exaggerating their symptoms in the ED. We will explore what underlies this phenomenon for these two disorders, how cases may present, inherent challenges for treatment, and potential approaches to managing these situations in the ED setting. Considerable stigma associated with ASPD and/or BPD may relate to this issue, as emergency clinicians regularly perceive individuals as "faking" their symptoms to achieve a desired goal. As a result, providers may seek to avoid interactions with such patients or treat them with hostility, which creates iatrogenic problems. If a provider fails to skillfully manage these situations, ED visits may be protracted and poor clinical outcomes can ensue.

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Considerations Related to Antisocial Personality Disorder

Case Vignette

R.M. is a 31-year-old male with a reported history of schizophrenia, depression, and substance use disorder, who presents to the ED in the evening. When triaged by a nurse, he is irritable and does not answer many questions, instead repeating that he needs to be in the hospital. When pushed to explain further, he yells "I'm depressed and suicidal!"

The social worker on duty is consulted and recognizes the patient's name as he has been a recurrent visitor to the ED. He is not very forthcoming about whether he has a suicidal plan, but does say that he is hearing voices telling him to kill himself, and repeats that he needs to be admitted to the hospital. The social worker attempts to ask about his social supports, his living situation, employment status, substance use history, and his current and past treatment. He says he has nobody who cares for him, he receives disability payments, and he is currently homeless. He admits to using marijuana daily but denies any other substances, although his medical record indicates cocaine and alcohol use in the past. After a few minutes, he says in a loud voice, "I'm done answering your questions!"

Before the physician evaluates the patient, the nurse pulls him aside and asks what they are going to do about "the malingerer" and says that he has shown no active signs of psychosis and has been sleeping off and on, glaring at other patients, and refusing to engage in conversation, other than to repeatedly ask for food. The nurse says, "can we get him out of here quickly?" The physician already feels stressed about the impending interaction and anxious about how best to proceed.

The diagnostic criteria of ASPD includes "repeated lying, use of aliases, or conning others for personal profit or pleasure" [8]. Similar to DSM-IV-TR, DSM-5 lists malingering with a V-Code, rather than in the diagnostic portion on the manual, thus not defining it as a formal mental disorder. It describes malingering as "the intentional production of false or grossly exaggerated physical or psychological problems. Motivation for malingering is usually external (e.g., avoiding military duty or work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs)." DSM-5 also proposes that malingering should be suspected if ASPD is present in combination with other cues [8]. The prevalence of malingering in an ED setting is difficult to ascertain, but one study indicated that malingering was suspected in one-third of patients presenting to a psychiatric ED [9•]. Despite the correlation between ASPD and malingering, if emergency clinicians assume that those with ASPD are always malingerers, then their evaluation of safety and risk—an essential function in the ED—is more likely to be unreliable. Furthermore, it is important not to ignore the adaptive nature of malingering whereby individuals may feign symptoms in the context of negative life circumstances to recruit support and subsequently improve their lives [10]. Whether or not reported symptoms are accurate indications of a patient's mental state is further complicated by the actual increased suicide risk in patients with ASPD, as well as the frequent psychiatric comorbidities that occur with ASPD [11].

Although it is unclear if patients with ASPD are more likely to malinger than those with other disorders, or are more skillful at it, they do at times present to the ED with feigned illnesses or complaints. Patients with ASPD can present in the custody of law enforcement, feigning psychosis or suicidal ideation in an attempt to avoid going to jail. At other times, they may threaten suicide or homicide if they are denied access to narcotics or a hospital bed. Understanding the motivations behind the issue of malingering in ASPD and how to best detect and manage it in the ED is critical.

Over- and Under-diagnosis

Some patients are assumed to have ASPD because of criminal history, homelessness, substance use, difficulties with anger control, impulsivity, provoking negative emotions in staff, or simply being unpleasant. It is important to recognize that this "labeling" may subsequently lead to a lower threshold in suspecting malingering. In turn, this may result in an inadequate safety evaluation and substandard referrals for mental health treatment. On the other hand, failure to recognize or under-diagnose ASPD and thus, malingering, may result in unnecessary medication administration and inappropriate exhaustion of mental health resources.

How to Recognize Malingering

A primary task is for clinicians to determine whether symptoms are real or feigned. While clinical experience is helpful in this process, it is best to adhere to some guiding principles. Generally with malingering, a motive exists, such as needing shelter, drug-seeking, avoiding obligations, or desiring a mental health diagnosis for legal or financial reasons. When feigned, symptoms tend to be overly advertised, absurd, blatant, overly intense, or in an uncommon combination [10, 12, 13]. Individuals who malinger will sometimes use clinical terms to describe their experiences such as "auditory hallucinations" or "I am homicidal" or may provide vague or repetitive "I don't know" answers when asked about details of their complaints [13]. There are typically discrepancies between the patient's report of symptoms and other sources of information such as their medical record, prescription drug monitoring systems, family, friends, other providers, or law enforcement

officers. In the ED, providers may find incongruities between what the patient endorses and their direct clinical observations, mental status examinations, and staff reports. Often, those who malinger are reluctant to engage in discussing options alternative to their pre-determined plan, being more focused on achieving their goals rather than addressing their symptoms. An example is a patient demanding to be hospitalized for psychotic symptoms but refusing antipsychotic medications.

Recommendations for Management

When providers suspect symptoms may be feigned or exaggerated, it is nonetheless important to acknowledge the patient's distress and need for assistance. Such a stance may provide a framework for transitioning to a more collaborative interaction, whereas staff or clinician hostility will likely preclude the development of a therapeutic alliance and complicate and lengthen the ED stay. The focus here should be on the general distress expressed by the patient rather than complete agreement with all of their reports. Given the prevalence of psychiatric comorbidities with ASPD, screening for other potential mental health disorders is important. Certainly, if the complaints are physical in nature, medical workup is indicated to rule out life-threatening conditions.

Avoiding frank confrontation is generally recommended, but often, some exploration of discrepancy or doubt is needed. This is a sensitive discussion and should be managed wisely and with caution. A provider may explain that the patient's complaints are inconsistent with observations, previous reports, or collateral information and may ask for the patient's help to better understand the situation. It is valuable to provide the patient with possible explanations for their distress, giving them an opportunity to "save face" to relieve some of the tension that may develop during this discussion, and to open the door for them to admit they may be seeking pain control, shelter, or other assistance [14••]. The provider can attempt to team with the patient and help them understand the ED staff indeed want to help with their actual concrete needs.

If the patient continues to focus on their symptoms or "doubles down" by complaining of even more intense symptoms, it is recommended that clinicians bypass further exploration of the complaints and shift the focus to genuine needs and how to move the plan forward. At times, specific resources the patient requests are not available, and the patient can, in a frank but supportive manner, be tactfully educated that the exact services or interventions they are seeking are beyond what can be offered in the ED. In many of these cases, the patient will at this point seek to leave the ED of their own accord, angrily at times, and the staff should be prepared for this possibility.

It is often difficult to reach a satisfactory disposition in cases of frank malingering. This is particularly true for patients with ASPD who are reluctant to engage in outpatient treatment. While this is frustrating for ED clinicians and staff, it is important to keep focused on the abilities and limitations of the ED setting. As malingering is not a mental illness and there is no specific treatment for it, referring such individuals to social service agencies for housing and financial needs and outpatient mental health treatment may be the best that can be provided.

A universal rule in the ED and certainly when evaluating those with ASPD is to always consider "safety first." Retaliation with impulsive or planned aggression is a serious concern when requests are declined and demands are not met, particularly when treating those with a history of violence. Aggressive and/or violent patients also tend to provoke significant negative emotions in staff who may in turn accommodate unreasonable requests or conversely avoid the patient and dismiss their symptoms [15]. If there are indications that violence or threats of violence are likely to be forthcoming, such as observable signs of increasing agitation, providers may need to set clear boundaries about the rules of the unit and what is deemed unacceptable behavior. If possible, this part of the conversation should be conducted with security personnel present.

Considerations Related to Borderline Personality Disorder

Case Vignette

A.R. presents to the ED with police after a friend called 9-1-1 to report safety concerns. He reportedly texted several people that he was thinking about killing himself. When interviewed, he says that he has been experiencing "significant anguish" and he feels that he is "unlovable." When asked to explain further, he says that his girlfriend has been more distant recently and he fears that she is going to leave him. He thinks he has made efforts to maintain a close connection (by constantly texting and calling her) but he does not "feel the love." He is tearful and sobbing throughout the interview, gasping for air, such that it is difficult for the ED clinician to hear what he is saying. He asks "if I can't be with her, why would I want to keep living?"

When discussing the case with other ED staff, the clinician says "He is sooo borderline, just very dramatic. He's going to have to calm down before I can talk to him more." After some time, the clinician attempts to further engage the patient about his safety risk, to which he replies that he thought about overdosing on pills but did not take any action. He has been trying to text his girlfriend but has not heard back, and now he feels even more intensely suicidal and does not think he can keep himself safe. He has no reported history of suicide attempts. When the clinician moves towards attempting to work

on a discharge safety plan, he becomes more upset, saying, "So you don't care about me either!" and bursts into tears.

When patients with BPD present to the ED with recurrent suicidal ideation and behaviors, clinicians may feel helpless, frustrated, and unable to maintain control of sober decision-making processes [16]. A common perception in these instances is that individuals with BPD are being overly dramatic, demanding gratuitous medications and high levels of care. The concepts of malingering, intentionally producing feigned symptoms to gain an external incentive, and/or factitious disorder, intentionally feigning symptoms in order to maintain a sick role, are often applied to these cases [8]. However, these concepts do not always explain the presentation of a decompensated individual with BPD, nor help with their clinical management.

A key component to understanding this issue has to do with the word "intentional." Patients with BPD may not be intentionally producing these seemingly malingered or exaggerated symptoms, but rather are likely experiencing a more nuanced, complex process.

Intentional Exaggeration Versus Extreme Emotional Dysregulation

Patients with BPD often utilize a defense termed "emotional hypochondriasis," defined by Zanarini and Frankenburg as the "transformation of unbearable feelings of rage, sorrow, shame, and/or terror into unremitting attempts to get others to pay attention to the enormity of the emotional pain that one feels" [17]. For patients with BPD, interpersonal crises can exacerbate this tendency to "exaggerate" or use hyperbole [17]. The emergency clinician, who by definition is treating patients in crisis, will likely encounter individuals with BPD whose affect and behavior do not match their reported mental state. Terms such as "manipulative" may be used to describe these patients, as they are perceived to be exaggerating their distress and not attempting to hide it [18]. Adding to the impact of emotional dysregulation in patients with BPD is the prevalent issue of alexithymia [19•]. If the individual has difficulty controlling and also accurately identifying and describing their emotions, it can make it even more likely that over-reporting of symptoms can occur [20]. Reframing these behaviors as symptoms of the illness is helpful here to guard against excessive countertransference reactions.

Suicide "Gestures"

Aborted or seemingly half-hearted suicide attempts and displays of self-injury in direct observation of others are often seen as obvious bids for attention rather than representing true suicidality. Here again, these behaviors are frequently intended to communicate with those they perceive as "abandoners," in order to induce them to stay, to hold, and to love. Those in the BPD patient's personal circle may think "why didn't they just say they were upset?" while clinicians may feel they are dealing with someone who is not in grave distress and who is taking time away from "truly ill" patients. Providers responding to these behaviors with a dismissive or hostile attitude as opposed to genuine concern will only serve to further the patient's emotional dysregulation and undermine the likelihood of an expeditious and safe disposition [6••]. This is particularly salient when considering the increased suicidal behaviors in individuals with BPD, in one study accounting for nearly 20% of all suicide attempts [21].

Lying Versus the Inability to Mentalize

Individuals with BPD often have significant difficulties in mentalizing, understanding what others may be thinking or feeling [22]. They sometimes do not hone the ability to integrate their internal world with external reality during early stages of development. This can lead to them presenting their feelings as facts, using subjective interpretations or minimal evidence, and inferring how they feel events occurred and the reasons for others' behaviors, rather than using more objective data. When coping with acute interpersonal stress, patients with BPD may perceive minimally negative, neutral, or even positive signals from others as evidence of mistreatment, and this can be misinterpreted by ED personnel as direct and intentional lying.

Recommendations for Management

When emergency clinicians interpret patients' reports of symptoms as intentionally distorted or hyperbolic and when they suspect self-endangerment efforts are a mere tool to manipulate others, they may struggle to adequately assess and manage patient risk. The provider will be well-served to frame these behaviors and symptoms as indirect communication of the need for support, validation, and emotional containment. Conceptualizing the patient with BPD in this way helps decrease the clinician's feeling of being coerced or manipulated and increases the likelihood of a therapeutic alliance. Furthermore, if providers understand that with BPD, suicidal threats and self-harming behaviors may be an unsophisticated and maladaptive attempt at interpersonal communication, they may avoid some common ED treatment pitfalls, including inadequate safety evaluations, unnecessary hospitalizations, and excessive medication administration.

When the BPD patient has experienced multiple hospitalizations and yet a lack of significant clinical progress persists,

recurrent visits to the ED may become more fraught for providers and patients. In these instances, it may be useful for ED clinicians to express doubt that further hospitalizations or additional medications will be helpful and rather to redirect the discussion to alternative interventions and strategies. Care should be taken to always assess for acute risks above and beyond chronic baseline risk, which may necessitate short-term hospitalization. While brainstorming with the patient about alternative options, one should be mindful not to express doubt of the seriousness or veracity of the patient's distress, as this often leads to a further escalation of reported symptoms and increased risk of self-harm [23]. It behooves clinicians to take an authentically curious stance of "not knowing," rather than rushing to judgment about the ideal disposition, and to always validate the patient's distress, no matter how recurrently they have visited the ED [24]. As always when a patient with BPD is in crisis, focused attention should be paid to likely interpersonal stressors central to their distress [6••].

Conclusion

Managing the issue of malingering or exaggeration of symptoms in ASPD and BPD is a unique challenge, as clinicians are often unsure about the veracity of the patient's presentation and how to move forward in reaching a disposition. Given the significantly increased risk of suicide in those with these disorders, even symptoms which may be perceived to be feigned or exaggerated should not be categorically dismissed [25–27]. By discounting the very real safety risks associated with these patients, appropriate treatment interventions may not be recommended or pursued, and liability risk is likely to be raised. Difficulties with impulse control are common in patients with ASPD and BPD, and harsh confrontations, hostility, and rejection can trigger overwhelming negative emotions and, in turn, dangerous behaviors.

Furthermore, the idea that all symptoms in these individuals are exaggerated or feigned assumes that the individual with ASPD or BPD is in control of their behaviors and/or is engaging in them intentionally to harm, disturb, or gain an advantage over others. While in some situations this may certainly be the case, it is important to recall that neurobiological and psychological factors also influence their reactions and behaviors, and these patients may merely be doing what they feel they must to navigate their crisis.

Ideally, ED staff can avoid using terms such as "antisocial" or "borderline" to describe a patient based on the perception of feigned or exaggerated symptoms, and seek to only use such terms when discussing a clinical diagnosis. Education of staff is crucial, so that knowledge of the clinical characteristics of ASPD and BPD is standard and not based on myths or stigma.

Recognition of excessive countertransference reactions is critical in managing individuals with these disorders. Clinician behaviors compelled by feelings of fear, hostility, or frustration are rarely helpful and often harmful. Adverse events, insufficient risk assessments, and poor decision-making are no doubt more likely to occur when providers are emotionally dysregulated and their clinical judgment is clouded. Seeking consultation with colleagues and/or supervisors about challenging cases is an important stress and risk management intervention to help providers cultivate a more rational and dispassionate perspective.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflicts of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

References

Papers of particular interest, published recently, have been highlighted as:
- • Of importance
- •• Of major importance

1. Boggild AK, Heisel MJ, Links PS. Social, demographic, and clinical factors related to disruptive behaviour in hospital. Can J Psychiatr. 2004;49(2):114–8.
2. Goldstein RB, Dawson DA, Chou SP, Ruan WJ, Saha TD, Pickering RP, et al. Antisocial behavioral syndromes and past-year physical health among adults in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. J Clin Psychiatry. 2008;69(3):368–80.
3. Goodwin RD, Hamilton SP. Lifetime comorbidity of antisocial personality disorder and anxiety disorders among adults in the community. Psychiatry Res. 2003;117(2):159–66.
4. Compton WM, Conway KP, Stinson FS, Colliver JD, Grant BF. Prevalence, correlates, and comorbidity of DSM-IV antisocial personality syndromes and alcohol and specific drug use disorders in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. J Clin Psychiatry. 2005;66(6):677–85.
5. Pascual JC, Corcoles D, Castano J, Gines JM, Gurrea A, Martin-Santos R, et al. Hospitalization and pharmacotherapy for borderline personality disorder in a psychiatric emergency service. Psychiatr Serv. 2007;58(9):1199–204.
6. •• Hong V. Borderline personality disorder in the emergency department: good psychiatric management. Harv Rev Psychiatry. 2016;24(5):357–66. https://doi.org/10.1097/HRP.0000000000000112. **This article offers guidelines for how to optimally manage individuals with borderline personality disorder in the emergency setting, utilizing the Good Psychiatric Management framework.**
7. Penfold S, Groll D, Mauer-Vakil D, Pikard J, Yang M, Mazhar MN. A retrospective analysis of personality disorder presentations in a

Canadian university-affiliated hospital's emergency department. BJPsych Open. 2016;2(6):394–9.
8. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington: American Psychiatric Publishing; 2013.
9.• Rumschik SM, Appel JM. Malingering in the psychiatric emergency department: prevalence, predictors, and outcomes. Psychiatr Serv. 2019;70(2):115–22. https://doi.org/10.1176/appi.ps.201800140. **This study analyzed a survey completed by attending psychiatrists in a psychiatric emergency room regarding patient visits ($N = 405$) to learn about the prevalence of malingering in this setting and its primary characteristics. It found that about one-third of the patients were suspected of malingering and suspecting of malingering influenced disposition.**
10. Rogers R. Development of a new classificatory model of malingering. Bull Am Acad Psychiatry Law. 1990;18(3):323–33.
11. Black DW, Gunter T, Loveless P, Allen J, Sieleni B. Antisocial personality disorder in incarcerated offenders: psychiatric comorbidity and quality of life. Ann Clin Psychiatry. 2010;22(2):113–20.
12. McDermott BE, Sokolov G. Malingering in a correctional setting: the use of the structured interview of reported symptoms in a jail sample. Behav Sci Law. 2009;27(5):753–65. https://doi.org/10.1002/bsl.892.
13. Brady MC, Scher LM, Newman W. "I just saw Big Bird. He was 100 feet tall!" Malingering in the emergency room. Curr Psychiatr Ther. 2013;12(10):33–40.
14.•• Simpson SA, Sharp CS. Malingering disorders. 2017. **This article is a comprehensive analysis of the issue of malingering and how to detect and manage it.**
15. Simon JR, Dwyer J, Goldfrank LR. The difficult patient. Emerg Med Clin North Am. 1999;17(2):353–70 x.
16. Gabbard GO. An overview of countertransference with borderline patients. J Psychother Pract Res. 1993;2(1):7–18.
17. Zanarini MC, Frankenburg FR. Emotional hypochondriasis, hyperbole, and the borderline patient. J Psychother Pract Res. 1994;3(1):25–36.
18. Deans C, Meocevic E. Attitudes of registered psychiatric nurses towards patients diagnosed with borderline personality disorder. Contemp Nurse. 2006;21(1):43–9.
19.• Derks Y, Westerhof GJ, Bohlmeijer ET. A meta-analysis on the association between emotional awareness and borderline personality pathology. J Personal Disord. 2017;31(3):362–84. https://doi.org/10.1521/pedi_2016_30_257. **This meta-analysis is aimed at exploring the evidence that the BPD characteristic of emotional dysregulation is due to low levels of emotional awareness. A moderately positive correlation was found after analyzing 39 studies that met their criteria.**
20. Merckelbach H, Prins C, Boskovic I, Niesten I, À Campo J. Alexithymia as a potential source of symptom over-reporting: an exploratory study in forensic patients and non-forensic participants. Scand J Psychol. 2018;59(2):192–7. https://doi.org/10.1111/sjop.12427.
21. Bolton JM, Robinson J. Population-attributable fractions of Axis I and Axis II mental disorders for suicide attempts: findings from a representative sample of the adult, noninstitutionalized US population. Am J Public Health. 2010;100(12):2473–80. https://doi.org/10.2105/AJPH.2010.192252.
22. Fonagy P, Bateman A. The development of borderline personality disorder–a mentalizing model. J Personal Disord. 2008;22(1):4–21. https://doi.org/10.1521/pedi.2008.22.1.4.
23. Gunderson JG. Borderline personality disorder: a clinical guide. American Psychiatric Pub; 2009.
24. Fonagy P, Bateman AW. Mechanisms of change in mentalization-based treatment of BPD. J Clin Psychol. 2006;62(4):411–30.
25. Beautrais AL, Joyce PR, Mulder RT, Fergusson DM, Deavoll BJ, Nightingale SK. Prevalence and comorbidity of mental disorders in persons making serious suicide attempts: a case-control study. Am J Psychiatry. 1996;153(8):1009–14.
26. Oldham JM. Borderline personality disorder and suicidality. Am J Psychiatry. 2006;163(1):20–6.
27. Zanarini MC, Frankenburg FR, Hennen J, Reich DB, Silk KR. Prediction of the 10-year course of borderline personality disorder. Am J Psychiatry. 2006;163(5):827–32.