

4 Putting It Together

And now is the time to put together all the material you have gathered for your patient and create a diagnosis that will guide treatment and predict outcome. The chapters of Part III focus on specific areas of diagnostic interest; this chapter covers the basics of how you can weave together the various threads of information to create an initial diagnosis. The first big issue is judging the relative value of the pieces of information you have assembled.

Sometimes, of course, everything points in the same direction:

Nedra is a 78-year-old widow whose daughter-in-law and son relate that over the past 2 years her memory has gradually worsened. At first, she seemed only to misplace things; with time, she began forgetting conversations she had just had, could not remember how to prepare certain favorite foods, and several times neglected to turn off a burner on the stove. Lifelong a cheerful, positive person who never says a word against anyone, now she appears morose and angry. Her only family history of mental disorder is in her own mother, who, after a lengthy period of decline, had been diagnosed as “senile” by the family doctor the year before she died in a nursing home.

When examined, Nedra refuses to shake hands and will respond only with the phrase “damned foolishness” when asked to identify her son. When a nursing aide walks into the room, Nedra curses and mutters racial epithets.

Nedra’s diagnosis of Alzheimer’s is suggested powerfully by three data sources: the recent history, the family history, and the current MSE. There’s nothing that would support a different diagnosis, though data from a routine physical exam and laboratory screening should be obtained.

Such unanimity among sources isn’t always the case. Consider the history of Rusty.

When he was 23, and again at 28, Rusty had been clinically depressed. His father had suffered depression off and on with his drinking—“He was a hopeless alcoholic,” Rusty testified—but Rusty swore alcohol had never been a problem for him. With each episode he had responded rapidly and completely to treatment with antidepressant medication, and for several years between episodes, he had required no medication.

Now 36, he has just remarried and for the third time has become depressed. This time, however, there is a difference: Whereas during his two previous episodes he complained of rather severe terminal insomnia, now he feels “forever tired” and sleeps 12 hours a day. His clinician refers Rusty to an internist, who finds that his thyroid is severely underperforming. Within a week of starting thyroid replacement hormone as his only medication, Rusty is on his way back to normal.

Rusty’s past history tells one story; his family history tells another. And then along comes a third episode—with a subtle difference in symptoms. When one line of information contradicts another, determining what weight to give the various lines of evidence can pose problems.

When Information Sources Conflict

Fortunately, a number of diagnostic principles can help sort out the confusion that can result from conflicting information sources.

History Beats Current Appearance

We clinicians need to keep reminding ourselves that accurate diagnosis depends heavily on the previous history of mental illness. Take delusions as an example: What does it really mean when Jerome says that a scanning radio has been implanted in his brain? Of course, he could have schizophrenia, which is what we often (and often mistakenly) think of first when considering any psychotic symptom. But delusions can also take place in the context of a substance use disorder, a physical disease, dementia, or even antisocial personality disorder. Or, they may characterize severe mood disorder.

Five years earlier, Dick was hospitalized when he became acutely excited and psychotic. Believing that he possessed the divine power

of healing, he had wandered the streets, praying and placing his hands on the head of anyone using a wheelchair he met. For several weeks he was hospitalized and treated with antipsychotic drugs. Subsequent to his discharge, he developed what was called a “postpsychotic depression”; in its depths, he left his position at work and isolated himself almost completely from his family life. He later reported that several times during this period, he had nearly killed himself.

Eventually, however, Dick recovered completely and took a job even better than the one from which he had resigned. Reunited with his family, he prospered for 3 years until, while once again attending an out-of-town convention, he became acutely confused. This time, he would enter strangers’ homes, where he would inform the startled residents that he was the “literal brother of Christ.” Again he was hospitalized; this time, a new mental health team diagnosed him as having bipolar I disorder and treated him with antipsychotics and lithium. He recovered within 10 days and has subsequently remained well on lithium alone.

Dick’s MSE suggested schizophrenia, but the historical information conveys a far different picture: abrupt onset (schizophrenia usually begins gradually) and complete recovery (schizophrenia often leaves behind some residual symptoms). Patients with schizophrenia sometimes have extremely severe and long-lasting depressions, but these are far more typical of bipolar I disorder. In other words, for Dick, as for many mental health patients, the longitudinal history shouting “bipolar I disorder” far outweighs the MSE that seems to whisper “schizophrenia.” Using the course of illness as the basis for diagnosis was first described in 1852 by French psychiatrist

Benedict Morel (who also coined the term *dementia praecox*, an early name for schizophrenia).

Sorting out a delusion’s true meaning requires us to focus on many elements from

Diagnostic Principle: A patient’s history often provides better guidance for diagnosis than does the cross-sectional appearance (MSE).

the patient’s history, including the presence of physical health problems, severe depression or mania, and family history of mental illness. How long have symptoms been present? Do drugs or alcohol seemingly cause them to appear? Do they regress only with medication, or do they come and go spontaneously? These historical considerations, of course, apply to hallucinations and to many other symptoms that the patient presents. We’ll discuss them more fully in Parts II and III.

Recent History Beats Ancient History

Here we pay homage to the fact that symptoms reported early in the course of a patient's illness may carry far less diagnostic information than does later evidence.

When I first saw Nancy as an office patient, she was just 16 and none too delighted to be there. Her mother had insisted on the appointment, however, because of Nancy's problem with appetite. "Her weight just keeps going down," Mom said, "and she picks at her food. I'm so afraid that she has anorexia, like Julie down the street." But Nancy denied thinking that she was too fat. "I guess I do look kinda skinny," she confided, in what was just about the last complete sentence she would speak before dropping out of treatment. She told her mother that she'd try to eat more and not to bug her, and that seemed to be the end of it.

At the time, I realized that Nancy could have anorexia nervosa or another eating disorder, but that depression and substance use were also possibilities. It could even turn out that her symptom was just an expression of the problems nearly all adolescents experience while becoming adults. I didn't learn the answer until one afternoon 8 years later, when Nancy returned on her own, again with loss of appetite—and a 15-pound weight loss. This time, she admitted that her mood was so low she was having trouble performing on her job as a bank junior officer. To the consternation of her fiancé, her sex interest had dropped to near zero and she was even having thoughts about suicide. Her problem this time was clearly severe depression; I suspected that, in attenuated form, this had also been her problem as a teenager.

Diagnostic Principle: A patient's recent history often more accurately indicates diagnosis than does older history.

Clinicians of long experience have had similar encounters with anxiety symptoms (will they become generalized anxiety disorder [GAD], panic disorder, or a mood disorder?) and depression (will it become bipolar I or II disorder, dysthymia, or an adjustment disorder?). When older symptoms are clarified, newer ones can change diagnosis and inform treatment.

Collateral History Sometimes Beats the Patient's Own

Let's not go overboard here. Of course, diagnosis is largely driven by what your patient tells you. But some patients lack perspective on their own dif-

faculties. An elderly widow who lives alone may not realize how forgetful she has become; a teenage boy may grow up unaware that his gang affiliations have been so troublesome. Occasionally, someone just plain lies. Even patients who try their best to provide accurate, complete information may lack access to family history or early social history, either of which can help determine a diagnosis.

A biology student at a local college, Jack complains about “indecision and lack of direction.” He tells me that he fears he is developing schizophrenia, the diagnosis for which his father was institutionalized years ago. When later (with Jack’s permission) I meet with his mother, she tells me in confidence that Jack is not her biological child, but the product of a brief relationship a younger sister had with her boss. Jack had been adopted at birth and never learned the truth about his origins. His legal father’s diagnosis has no biological bearing on Jack’s own illness.

Diagnostic Principle: Obtain collateral history whenever possible; it is sometimes more accurate than the patient’s own.

Signs Beat Symptoms

Here we need to insist on the technical definitions of signs (what you observe about the patient) and symptoms (what the patient has noticed and can tell you). The trouble with symptoms is that they can carry two different interpretations—yours and the patient’s. Some patients may not understand your interpretation; others may even misconstrue your meaning as they report it to others. In other words, the objectivity of signs may point the way to a correct diagnosis.

You’ve probably encountered the phenomenon yourself—perhaps when an office patient, with eyes filling quietly with tears, denies feeling hurt by a lover’s abandonment. More striking denials are those of the gaunt patient with anorexia nervosa who claims to look fat, or the patient with schizophrenia who denies hallucinations but keeps glancing uneasily around the room.

Diagnostic Principle: Signs (what you observe about a patient) can be a better guide to diagnosis than symptoms (what the patient tells you).

Imogene, a patient with somatization disorder (see Chapter 9 for my discussion of this condition), lies on a gurney in the urgent care center. Though

immobilized by “complete paralysis” from the waist down, she nonchalantly chews gum and discusses with a nurse the just-played Super Bowl game. The disconnect between the sign of her emotional detachment and her physical symptom of paralysis is a classic example of *la belle indifférence*, or paradoxical lack of distress.

Be Wary of Crisis-Generated Data

When people are acutely troubled, it can affect how they view the world and their place in it. If your patient has just been jilted by a lover, fired, or bereaved, the resulting mood can color the tone of the story you hear, even to the point of affecting the patient’s perspective on experiences that occurred long ago.

Diagnostic Principle: The stress of crisis can color how a patient perceives life’s experiences.

The day after her apartment was burglarized, Jill complains that she is the unluckiest person in the world: “I never catch a break!” she moans. Her therapist, who has known her for years, decides it’s time to institute a course of cognitive-behavioral therapy, in an effort to help her deal with the negative stereotypes she holds of herself.

The flip side is that a positive experience like the joy of new love can also distort a person’s understanding of reality.

Objective Findings Beat Subjective Judgments

Here’s a reminder that clinicians’ intuitions, while sometimes uncannily accurate, should never outrank verifiable information. The “schizophrenic feel” you might experience when talking to a new patient should only prompt due diligence in your hunt for signs and symptoms. My own favorite *bête noire*, borderline personality disorder, is a diagnosis that clinicians may be tempted to make without a full evaluation.

Or take 19-year-old Jordan, whose slow, quiet speech, level gaze, and sad smile create instant sympathy in his interviewer. Although he claims not to know what triggers his anxiety attacks, just a few minutes’ conversation made it seem likely that he has panic disorder. Perhaps it covers a pretty severe major depressive episode. These predictions are shattered when more history is obtained from his older sister,

who has accompanied him to his appointment. She reports that he has been increasingly distressed by his feelings about his own sexual orientation. Confusion, shame, and fears that his homophobic father would become enraged have caused him to confide only in her. With the sister's additional

Diagnostic Principle: Resist the allure of the hunch—embrace objective data as the bedrock of diagnosis.

information, adjustment disorder moves closer to the top of the differential diagnosis.

Consider Family History

For decades, we've known that mental disorders run in families. Indeed, during the last half of the 20th century, a great deal of work established the fact that many (perhaps most) of the syndromes we confront every day have a strong genetic component. In Chapter 8 we'll consider the issues surrounding family history in greater detail, but for now we'll just note an example:

Grant has always been a quiet, thoughtful boy, but not long after his 15th birthday his behavior turns erratic. For several months his family endures verbal outbursts over minor disappointments. He becomes belligerent, several times accosting total strangers on the street who he thinks “look funny” at him. One afternoon after school, he actually picks a fight with a policeman, who escorts him to the emergency room. There he talks to himself in apparent response to auditory hallucinations. After admission, he masturbates openly in the ward dayroom—twice. After a week on antipsychotic medication, he isn't much better, and the staff wonders whether he has schizophrenia. However, a consultant notes that years ago Grant's uncle (his mother's brother) had an acute psychosis and was subsequently successfully maintained on lithium. With the addition of a mood stabilizer, Grant's psychosis rapidly resolves.

Of course, it would be unwise to base your entire therapeutic strategy on a single data point, but family history can erect a useful signpost on your diagnostic path. I will qualify this assertion somewhat (and will provide a revised version of the following diagnostic principle) at the end of Chapter 8, but for the moment let us state the principle as it is given here.

Diagnostic Principle: Family history can help guide diagnosis.

Simplify with Occam's Razor

William of Occam, a 14th-century English philosopher, stated a law that applies in many fields beyond health care. Now a mainstay of medical diagnosis (and many other areas of problem solving), it advises that if something has two possible explanations, you should choose the simpler one. Because it “shaves away” unneeded detail, it has come to be known as *Occam's razor*, or the principle of parsimony.

At age 47, Jakob appears at the emergency room complaining of two problems: He feels terribly depressed, and he hears voices. The depression has plagued him for several months; he is “at the end of [his] tether.” He fears he is close to committing suicide—the fate of his older brother, Hans, only 2 years ago. Jakob admits that his appetite has been off, and he’s lost weight; he sleeps poorly; he has little interest in his usual activities (he is an avid collector of old guns and usually haunts antique shows); and his concentration at work is so poor that his boss has ordered him to take time off to “get straightened out.” Jakob believes he has let everyone down, including his boss and his family, and he feels enormously guilty, deserving of death.

The voices have troubled him for only a few days. He hears them just behind his left ear and, though he doesn’t know their cause, they seem terribly real. At all hours of the day and through much of the night, two strangers, a man and a woman, shout that he is “a real bum” and tell him that he should use one of his weapons “for the purpose God intended them”—that is, to kill himself. Tears well in his eyes and his lip trembles as he stammers, “I feel really terrified.”

Although Jakob resists talking about it, he admits to drinking “a little too much, now and again.” Close questioning reveals the following: Whereas for 20 years he has consumed nearly three fifths of hard liquor a week, over the past 6 months his alcohol intake had nearly doubled. A week ago, “stomach flu” caused him to vomit so often that he couldn’t keep anything down, not even alcohol. It was shortly afterward that the voices began their insistent clamor.

A novice diagnostician might consider Jakob to be suffering from three different mental conditions: major depression, an acute psychotic disorder, and severe alcohol abuse. Occam’s razor, however, pares the problem to its essentials: As is quite common in alcohol use disorder, Jakob’s heavy alcohol use eventually induced a severe depression. When he became physically ill (was it really flu, or did his system finally rebel at so much alcohol?), he went into alcohol withdrawal and heard voices. The auditory hallucina-

tions a person can experience in alcohol withdrawal closely mimic those of schizophrenia. Occam's razor directs us to propose that Jakob has one basic illness that has caused many symptoms and at least three mental disorders.

Such parsimonious thinking is important in part because it helps us understand what not to do. For example, Jakob's depression will probably abate once he stops drinking. Antidepressant medication would both burden his system with yet more chemicals and reinforce the idea that his depression was an independent illness that could be addressed with pills, without facing the issues of his alcohol use. The diagnosis of a psychosis due to alcohol use militates against the long-term use of antipsychotic agents: Once Jakob stops drinking, his hallucinations will surely disappear.

Diagnostic Principle: Use Occam's razor—prefer the diagnosis that provides the simplest explanation for your data.

Zebras and Horses

The healing professions have a saying, taught to generations of students: "If you hear hoofbeats in the street, think of horses, not zebras." In other words, keep in mind the not-too-surprising fact that you are more likely to encounter common disorders than uncommon ones and adjust your diagnostic thinking accordingly. This highly useful adage is also a diagnostic principle, but it can be used in a wrong way or a right way.

The wrong way is to make it the mainstay of your diagnostic strategy, as I've seen happen, especially in regard to depression. We so often encounter what appears to be major depressive disorder that it tends to crowd out competing possibilities. Perhaps because it is readily reimbursed by insurance, clinicians often feel pressured to use this term instead of other, less well-compensated diagnoses, such as personality or adjustment disorders. Some writers have quite seriously suggested that a purely statistical approach to diagnosis (that is, always diagnose major depression, which is encountered in over 50% of mental health patients, especially in the clinic) could be a winning strategy more than half the time. Of course, what we want for our patients is to be right all the time, or as nearly so as possible.

The apparent rarity of any condition depends on the population you typically work with. If you are employed in a mental hospital, psychotic patients with schizophrenia and bipolar disorders may constitute the bulk of your practice. If you see only outpatients, you'll probably encounter many who have anxiety disorders or mild to moderate depression. Similarly (no

surprise), you'll find a lot of people with drug-induced disorders in substance use treatment facilities, and patients with PTSD in Department of Veterans Affairs (VA) hospitals. It's seductive, isn't it, to think that if you see a regressed patient in a nursing home, Alzheimer's dementia will be the diagnosis? Alas, you can't rely for your diagnosis on the popularity of a given condition in your own patient population. I've encountered depression in veterans (who may also have PTSD); bipolar disorders in schoolboys (who typically have attention-deficit/hyperactivity disorder [ADHD]); and many, many instances of depression (and mania, too) in geriatric patients.

A better way to use the "horses, not zebras" principle is always to consider common diagnoses, but not to the point of ignoring other possibilities. For example (as we'll discuss in Chapter 10), when formulating a differential diagnosis I often include mood disorders, though they may not make the final cut.

When Irwin comes to the mental health clinic, he has felt depressed for nearly 6 months. His symptoms are pretty typical, his clinician thinks—trouble sleeping, loss of appetite (though his weight had actually increased a few pounds), feelings that he is a failure, and inability to focus on his work as a kitchen remodel designer. He emphatically denies any thoughts about suicide. His boss suggested the appointment because Irwin seemed to be suffering so much. At age 38, he has never had previous emotional difficulties; he neither drinks nor uses drugs.

The recent weight gain puzzles his clinician, who wonders whether, in the face of reduced appetite, the depression could have a physical cause (such as hypothyroidism or some other endocrine disorder). To be on the safe side, Irwin agrees to a checkup from his family practitioner, whom he hasn't seen for "almost longer than I can remember." In the meantime, recognizing that a physical cause for a mood disorder like Irwin's is a long shot, his clinician initiates a course of cognitive-behavioral therapy.

The diagnosis of a rare disorder is so attractive that it can seduce you into ignoring more common causes for whatever mental symptoms the patient has. Making (and reporting) such a finding is a coup; the clinician achieves instant hero status. Whereas it is vital always to keep in mind that such a thing is possible, a measured approach that also employs Occam's razor melds the benefits of accurate

Diagnostic Principle: Horses are more common than zebras; prefer the more frequently encountered diagnosis.

diagnosis with speedy treatment. (In the event, the concerns of Irwin's clinician were set to rest when a workup revealed no evidence of a physical cause for depression. In other words, no zebras, just an ordinary horse.)

Evaluating Your Data for a Differential Diagnosis

Putting the foregoing principles to work every day in the service of our patients may seem daunting. However, if we follow these steps for the following case histories, we'll end up with viable differential lists that lead to working diagnoses, which in each case will help us formulate a prognosis and recommend treatment. I've never met a patient whose condition required that I use all the diagnostic principles at once, but the somewhat more detailed case vignette that follows will serve to illustrate several of them.

Edna

Edna has recently become engaged, yet she has begun having anxiety episodes that she fears could make her lose her scholarship. "Could I just have a few Valiums to get me through finals?" she begs her counselor. "Maybe we should try to understand the whole picture first," comes the reply. Her story turns out to be more complicated than a few tablets can fix.

Edna had been a cheerful, somewhat roly-poly baby born to first-time parents when they were in their 40s. Her mother juggled a professional career and obsessive-compulsive disorder (OCD), which limited the time she spent with baby Edna. Her father traveled on business; when home, he spent much of his free time attending Alcoholics Anonymous (AA) meetings to maintain his rather tenuous sobriety. As a result, Edna was reared by a succession of housekeepers whose principal duties weren't child care. Left largely to her own devices, she grew up with books and television for friends, and not much in the way of social graces. A moody child to begin with, her disposition didn't improve when her menstrual periods started at age 13.

Edna had been "unnaturally shy." In fact, throughout high school she had had only one date, and that was with a second-string football player who had tried to have sex with her after the movies. "He got me down to my underwear before good judgment grabbed hold, and I got dressed." Throughout high school and her first 3 years of college, she immersed herself in study and not much else. By the fall of her senior

year, she was on track to graduate a semester early, *summa cum laude* in political science.

Near Christmas, she met a young man. Always persuaded that she would never marry, she hadn't bothered much with her looks, but a roommate recently had taught her how to fix her hair and had burned the tacky pair of jeans Edna wore to class nearly every day. Perhaps the new clothes and lipstick did the trick; her young man, himself a perpetual wallflower, had pursued her vigorously and proposed on the second date. On the spot, she accepted him. "I guess I was so grateful that I just said 'Yes,'" she comments to her clinician. "It was the happiest night of my life, to coin a cliché." It was also the last truly happy day she'd enjoyed.

In the week since her engagement, Edna has spent many anxious hours. "I feel afraid—though of what, God knows—and I get short of breath and my heart beats too fast. It makes my chest hurt." In 2 days she will introduce Geoffrey to her parents, and she feels nauseated at the prospect. Now she stays up at night, trying to study, worrying that she will fail her final exams and have to remain in school an extra year. She also worries about how her parents will regard Geoffrey. Most of all, she agonizes over the prospect of getting married and perhaps having the responsibility of a family.

Edna's facial expression is lively and pleasant, though appropriately concerned; once or twice she becomes tearful, but mostly she speaks logically and in complete sentences, showing good command of her facts. Toward the end of the evaluation, Edna mentions that her roommate wants to speak with the clinician. Ann's information is brief, but telling: Edna seems just fine when she is with Ann. It's only when she is with Geoffrey, or is about to see him, or sometimes is even talking about him, that she seems flooded with anxiety.

Analysis

Here's how I'd go about mining Edna's history to create a broad-ranging differential diagnosis:

1. As in any differential diagnosis, I would first question whether there was a medical or substance use problem (two diagnostic principles that I've already mentioned, and that we'll cover further in Chapter 9). Of course, I consider medical disorder causes first—not because they are so terribly common, but because of their considerable potential for causing harm to the patient and because, often, they can be readily treated. Either the current use of a substance or withdrawal from substance use commonly

causes anxiety, and Edna had requested Valium; so a possible substance use etiology also earns its place on my list.

2. Edna's chief complaint is anxiety, so I'd then review the full spectrum of anxiety disorders, summarized in Table 12.1. She could have an incipient panic disorder or GAD, though the course of her symptoms had been very brief. The history of her present illness informs many of the choices in our differential diagnosis.

3. The family history diagnostic principle rears its head! Edna's mother had been treated for OCD, which runs in families. Genetic studies tell us that a patient with an anxiety disorder is likely to have relatives with a variety of other anxiety disorders, not just the one. (DSM-5-TR places OCD in a separate chapter, but it carries with it loads of anxiety.)

4. What wouldn't I include from the anxiety disorders list? I'd agree there's no evidence for agoraphobia, and Edna said nothing about phobias, other than whatever might be implied by the prospect of growing old without a mate. Although Geoffrey's sudden proposal preceded Edna's symptoms, it would be a real stretch to frame her story as PTSD (another former anxiety disorder that DSM-5-TR places in its own chapter).

5. Among the other items of information from the initial assessment, we note Edna's somewhat isolated childhood, which suggests the possibility of avoidant personality disorder. (However, later on we'll note a diagnostic principle that cautions us to be wary of diagnosing a personality disorder in the face of any major mental disorder.) And by the way, I'd certainly want to rule out somatizing disorders for any young person.

6. I don't mean to slight the MSE; however, rather than providing closure, its components often serve best to suggest other fields for inquiry. Edna's tearfulness does show some evidence of depression, which I nearly always include in a differential diagnosis, anyway. And yes, that is another of my diagnostic principles.

7. This vignette also demonstrates the important yet often ignored principle that collateral history can help frame the discussion of diagnosis. The information from Edna's roommate provides something that Edna seemingly cannot—perspective on timing and precipitating events. The “horses, not zebras” diagnostic principle reminds us that we should especially consider those diagnoses that occur commonly in the general population, among which are situational problems (also known as problems of living).

Considering all of the points made above, I'll propose the following differential diagnosis in evaluating Edna's problem (and leave it as an exercise to arrange these items in a safety hierarchy and determine the best diagnosis overall):

- Adjustment disorder with anxiety symptoms (problems of living)
- Anxiety disorder due to medical problem
- Avoidant personality disorder
- Depressive disorder
- GAD
- OCD
- Panic disorder
- Somatic symptom disorder
- Substance-related anxiety disorder

Dealing with Contradictory Information

When clinicians with years of experience face contradictory information, the appropriate diagnosis often seems to emerge almost by instinct. As I'll try to show with another detailed vignette, this apparent intuition is usually just a matter of noticing when clues from the history conflict with one another, or when cues from the MSE don't match up with the usual course of a mental disorder. Resolving contradictory information is not a matter of spiritualism but of practice. I feel strongly enough about this to call it a diagnostic principle.

Diagnostic Principle: Watch for contradictory information, such as affect that doesn't fit the content of thought, or symptoms that don't match the usual history of a disorder.

Tony

Tony is only 45, but as he relates his complicated history, he looks a good 10 years older. Homeless and severely depressed, he suffers from poor concentration and appetite, punishing insomnia, inability to work, and recurrent death wishes and suicidal attempts. During one such attempt, he parked his car in a remote area and ran a hose from the exhaust into the passenger compartment, started the engine, then

settled down to die. That attempt failed when the gas tank ran dry before he even lost consciousness. More recently, he pointed a borrowed pistol at his head. Because several friends intervened to take it away from him, he fired all five shots into the ceiling. "It only harmed the plaster."

That episode prompted his admission to a VA hospital, where he was treated with medications. (Of all the antidepressants he has tried over the years, Prozac seemed to help the most.) While in the hospital, Tony applied for housing assistance, which was ultimately denied—he doesn't know why. Subsequently, he apparently checked himself out of the hospital; 4 days later, he found himself 200 miles away, in yet another VA hospital. He doesn't know how he traveled from one city to the other, and he cannot recall what happened during the lost time. At first, he can't even dredge up personal information such as his Social Security number, though he always knows his own name.

Tony states that besides his depression, for many years he has intermittently heard several different voices. There is his mother's voice, which laughs at him, and the voice of his dead brother. A stranger he knows only as "Cathy" pronounces his name so clearly that every time he hears it, he turns to see who might be there. He has heard none of these voices for several days prior to the current evaluation. From time to time he also has visual hallucinations of a man who stands about 12 inches tall, whom he encountered for the first time many years ago on Okinawa when serving in the Army. He also sometimes sees his mother (who is still alive) in a scene "so real I could touch her." From time to time he believes that she and other people are "laughing behind my back."

During his interview, Tony's mood appears to be about medium in quality and appropriate to the content of his thought. His affect, which is of normal lability, becomes tearful when he discusses his failed marriage. This story is that two decades ago he married a woman from Colombia, taking pains to ensure that she, her children, and her mother all became legal U.S. residents. As the result of his wife's unfounded accusations and legal chicanery, he ended up living in a hotel room while she and her relatives continued to occupy his house. He eventually abandoned all his property and moved on to become a security guard at a casino. He claims never to have used alcohol or street drugs intemperately.

As a child, Tony says, he was always depressed. Nearly friendless, he played with a rubber lizard he called "Tonto" and a number of imaginary playmates. He had a clubbed foot that was treated with a cast, which he remembers kicking through the boards of his crib when he was just a small baby.

Analysis

Some of Tony's data conflict either with one another or with common sense. For example, the repeated suicide attempts that went badly (though fortunately) awry seem exaggerated, possibly invented. In answer to his devastating marriage, he stoically abandoned his property and moved on. The visual hallucinations of his mother were more vivid than is usual for psychosis. Seeing Lilliputian people is characteristic of delirium tremens, yet he denies the use of alcohol. He gave a name to one of the voices he heard, which is unusual in psychosis. Whereas genuinely psychotic people try to ignore the hallucinations that torment them, he invariably turned to see who was talking. While in a purported fugue-like state, he traveled with apparent purpose to another VA hospital, where he was not known. Although he could have been recounting what others had told him, some statements about his own childhood seem wildly extravagant: He has "always" been depressed; he can recall kicking his crib. Finally, despite his many afflictions and sorrowful history, his mood on interview is comfortable, not depressed.

Taken one at a time, these characteristics might seem unimpressive, but in aggregate they create a reasonable suspicion of someone trying to present himself as sick and needy. This clinical picture, which also fits with a motivation for the secondary gain of being housed, places a duty upon the clinician to reject the story's face value and to investigate further before making a diagnosis and recommending treatment.

Malingering

I hate it when I'm faced with the need to diagnose malingering. Of course, if I refuse, I can't fulfill my duty as a diagnostician—but once someone's been labeled "malingerer," the cat's among the pigeons and it's hard ever again to regard that individual as anything but a manipulator and a liar. If someone admits to inventing a story, and if I can be absolutely sure of my ground, I will limit my statement to that one piece of behavior: "History of fugue state was fabricated." In other words, I label the behavior as "malingered" rather than the person as a "malingerer."

My reluctance to use these terms stems from the twin facts that, especially for mental events, malingering is terribly hard to prove, and there are no reliable criteria. A patient series that demonstrates my concern was reported from Israel by Witztum and colleagues in the journal *Military Medicine* in 1996. Of 24 individuals diagnosed as "malingerers" in the course of a year, the authors rediagnosed nearly all as having serious psy-

chopathology, including psychosis, mental retardation, and mood disorders. All but 3 of the 24 were judged unfit to serve in the military.

The manufacture of physical symptoms is relatively easy to spot: Careful observation will reveal that the patient claiming to have kidney stones drops grains of sand into a urine specimen, or that an apparently persistent fever is the result of using the thermometer to stir coffee. Much more difficult to detect is the manufacture of mental symptoms and syndromes, which can include amnesia, PTSD, psychosis, eating disorders, bereavement, depression, mania, and even reports of stalking. I've discussed some of the warning signs in the sidebar "Recognizing Red Flag Information."

Besides the prospect of obtaining money—think insurance fraud—a variety of motives can encourage the reporting of false symptoms. Some patients want to avoid social responsibilities (such as work or child support) or dangerous assignments, especially in the military. Many clinicians have encountered patients who fake pain to obtain prescription drugs they can sell or misuse. An occasional person may minimize actual mental symptoms, "faking good" to win release from a mental hospital or regain custody of a child. And a well-known motive is to avoid punishment for a crime, through a plea of reduced capacity or insanity.

A notorious (and nearly successful) instance of blatant malingering is that of Kenneth Bianchi, one of two men who carried out the Hillside Strangler murders in the 1970s in Los Angeles and Washington State. A charming, lifelong chronic liar, Bianchi had previously set himself up as a psychotherapist with a fake diploma from Columbia University and a "doctor of psychiatry" degree from a nonexistent institution. When caught, Bianchi produced a second personality, Steven, who brazenly claimed responsibility for the murders ("Killing a broad doesn't make any difference to me"). So persuasive was this performance that several experts in multiple personality disorder (MPD, now referred to as dissociative identity disorder) pronounced him psychotic and therefore not accountable for his crimes. But Bianchi met his match when the prosecution brought in psychiatrist Martin Orne, who told him (falsely) that all cases of MPD have more than two made-up personalities. Within hours, a third personality obligingly emerged. One of the clinicians who had been taken in, after becoming a prison psychiatrist and learning that he had "no reason to believe anything they said," later recanted belief in Bianchi's MPD.

There are degrees of malingering. In the most blatant cases, patients simply make stuff up; some exaggerate actual symptoms. Still others may

Recognizing Red Flag Information

A variety of characteristics raise the red flag of warning that a patient's data cannot be accepted at face value. Before fully trusting this information, you must compare it with interview data from informants, with previous medical records, with laboratory tests—or perhaps you should test it by the simple means of further frank discussion. Especially revealing among such items of history and behavior are the following, listed in no particular order:

Memory loss in the absence of cognitive disorder. A poor memory, readily fabricated and difficult to verify, can prove irresistible for patients who have something to hide or to gain.

Spotty amnesia. Someone claims not to remember personal information but converses about contemporary issues of the day.

Use of extreme language to describe symptoms. Examples include “I lost 20 pounds in 3 days,” “I sometimes go a whole week without a wink of sleep.”

A patient who engages in criminal behavior while hospitalized. This may include assaults, sex with staff or other patients, and dealing drugs.

Repeated unsuccessful suicide attempts. Although many patients make multiple, sincere efforts to end their lives, others seem to be play-acting in an effort to attract attention or sympathy. The danger is that it can be hard to gauge the level of sincerity.

Unusual symptoms. Here we'd include symptoms that are excessively dramatic, rare, or severe—beyond the usual range of psychopathology. One example is Tony's behavior on hearing voices (he turned to confront them every time he heard them). Others would be claims to have schizophrenia characterized by delusions that begin or end suddenly, visual hallucinations of doll-sized people, or hallucinations that are continuous rather than intermittent. The onset of symptoms may be more sudden than is usual for the given diagnosis (full-blown delusions that develop overnight). Symptoms of many disorders beginning at the same time can sometimes be a tip-off. Of course, an especially crafty patient may have consulted textbooks to learn how mental illness typically presents.

Absence of typical symptoms. For example, most depressed people will have problems with sleep and appetite; the absence of such problems should raise suspicions.

A story that keeps changing. People who make up or exaggerate material may find it hard to keep their stories straight.

(cont.)

Recognizing Red Flag Information (cont.)

Multiple personalities. Genuine dissociative identity disorder has been well documented for decades, but so has the fabrication of “alternates” by some people to avoid detection or punishment for criminal or otherwise unwelcome behavior.

Secondary gain. Symptoms that help a person gain money or avert loss require thoughtful evaluation.

Course of illness atypical for a given mental disorder. A patient who has worked steadily for a decade yet claims a long history of schizophrenia would arouse my suspicions.

Poor cooperation. Patients who evade or outright refuse to answer questions during testing or the interview may have something to hide. I’d also worry about someone who refuses to allow consultation with informants.

Incongruous affect. Bland or even cheerful affect that doesn’t match a person’s serious circumstances, such as paralysis or blindness, is sometimes called *la belle indifférence*; it is often encountered in patients with somatizing disorders. (However, you may encounter a silly or otherwise incongruous affect in other disorders.)

Interpersonal manner. Research has documented clinicians’ tendency to believe an assertive individual who has a pleasant facial expression and dominates the conversation. We need to be alert lest such characteristics of normalcy overwhelm our judgment of a patient’s essential truthfulness.

Performance below chance on standard tests of memory, cognition, or intellect. Even random answers should be right some of the time; to score worse than chance requires planning. Some patients give blatantly false answers: “2 times 2 is 5,” “Santa’s suit is green,” “There are 30 hours in a day.”

Hospitalization in many locations. In what was classically called Münchhausen syndrome (now, factitious disorder), patients move from one caregiving institution to another.

Failure of multiple normally adequate treatments. Patients who remain depressed after treatment with various antidepressants, cognitive-behavioral therapy, and a course of electroconvulsive therapy deserve a complete reevaluation rather than yet another course of therapy.

Internal inconsistencies in the patient’s history. For example, a patient on welfare who talks about business deals should prompt more careful examination of other aspects of the history.

falsely attribute their symptoms to something they know is not actually the cause; for example, a patient may claim that anxiety symptoms, actually of long standing, arose after a minor industrial accident.

Whether history and behaviors are tailored from whole cloth or merely embroidered, there's more to the differential diagnosis than just malingering. One possibility is factitious disorder (most famously, persons with Münchausen syndrome who obtain admission to a succession of hospitals); another, which seems possible in the case of Kenneth Bianchi, antisocial personality disorder. You may also encounter unconsciously augmented or made up symptoms in patients with various somatizing and dissociative disorders.

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