Differentiating Genuine from Feigned Suicidality in Corrections

A Necessary but Perilous Task

Joseph H. Obegi, PsyD

Suicide Summit: October 28, 2020

Agenda

1. Necessity and Peril
2. Suicidality
3. Feigned Suicidality
4. Understanding
5. Assessing

During a medication pass, a nurse observes that a patient has covered the window of his cell door. The patient is not visible and does not respond to verbal overtures. Within minutes, an extraction team assembles. Through the food port, staff see the patient lying on his bunk and covered with a blanket. Rise and fall of the patient's chest is noted, but the patient remains "unresponsive." The team enters the cell, and upon removing the blanket, they observe that the patient has wrapped a white t-shirt tightly around his neck. Using a specialized cutting tool, the staff remove the ligature. The responding nurse describes the patient as pale but breathing. No cardiopulmonary resuscitation is indicated. Minutes later, oxygen saturation is 100%. Upon his return from the emergency room, the patient is seen joking with officers and inquiring about the status of his in-transit property. He reports to a psychiatrist that he intended to die.

Obegi (2020)

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Obegi (2020)

What to Call it?

manipulation
secondary gain
suicide/al gestures
suicide threats
contingency-based suicidality
contingent suicidal intent
contingent suicide threats
conditional threats of suicide

blackmail
manipulative suicide attempt
allegedly suicidal
feigned attempt/ideation
“suicide attempt”
iatrogenic malingering
contraintentioned

Obegi (2020)

feigned suicidality

Rogers (2008a); Obegi (2020)

feigned suicidality

Deliberately exaggerating or fabricating symptoms but leaves the question of motive open

Rogers (2008a); Obegi (2020)

feigned suicidality

Deliberately exaggerating or fabricating symptoms but leaves the question of motive open

The phenomenology of individuals who consider suicide, inclusive of all cognitive, emotional, and behavioral aspects not just suicidal ideation and behavior

Rogers (2008a); Obegi (2020)

Necessity and Peril

Necessity and Peril

Necessities
Use finite clinical resources (staff, beds)
Protect unit programming
Prevent overutilization of medical services
Treat psychiatric conditions and rehabilitate
Make clinically informed decisions

Obegi (2020)

Necessity and Peril

Necessities	Perils
Use finite clinical resources (staff, beds)	Stigma
Protect unit programming	Bias future treaters
Prevent overutilization of medical services	Denials of care
Treat psychiatric conditions and rehabilitate	Injury or death
Make clinically informed decisions	Liability fears

Obegi (2020)

Challenges in Differential Diagnosis

- Not possible nor useful?
- No psychological tests
- No comparison condition
- Paucity of literature

Research Findings

- About 10 percent of inpatient samples report feigning suicidality
- No association between motive (categorized as manipulative, escape, or psychological relief) and either suicidal intent or medical seriousness of self-injury
- Patients making “conditional threats” not more likely to die by suicide at 6 months and 7 years post-discharge.
- “Allegedly suicidal” patients less likely to present with depression
- Correctional clinicians frequently suspect feigned suicidality

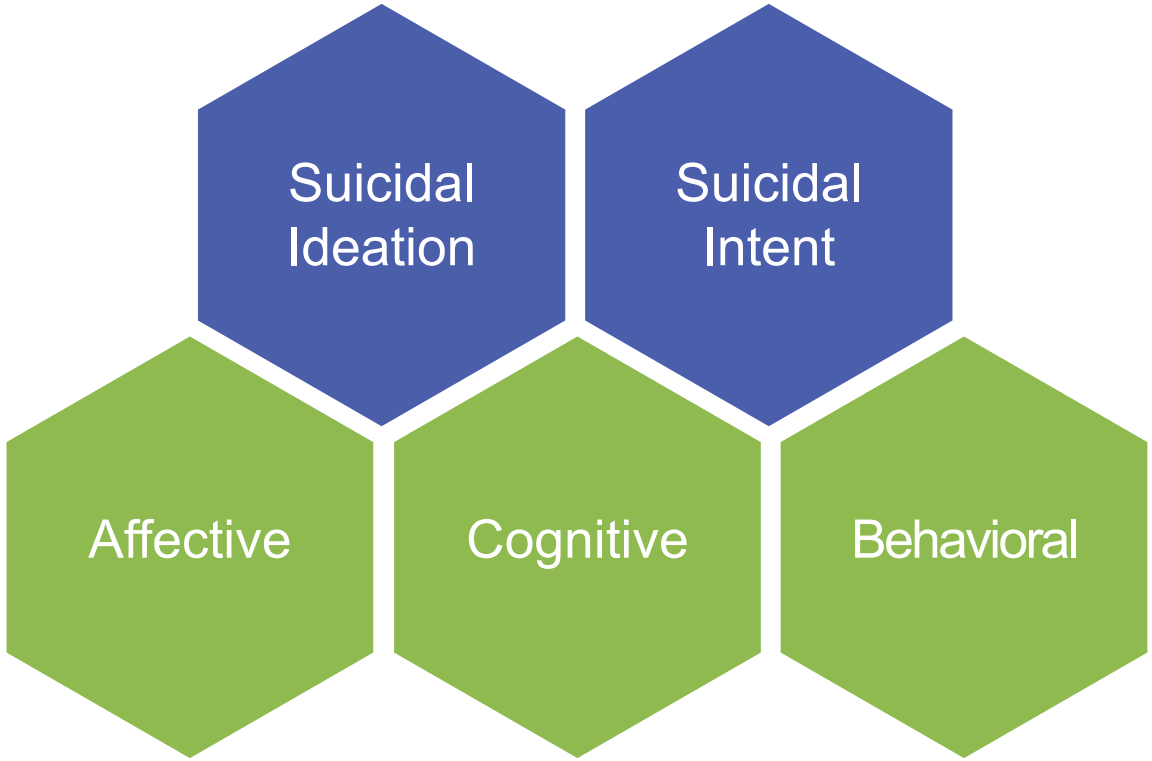
Dear et al. (2000); Lambert (2002); Lambert & Bonner, (1996); McDermott et al. (2013); McDermott & Sokolov (2009); Pinsker (1981); Rissmiller et al. (1998); Rismiller et al. (1999)

Suicidality

Suicidality as a Condition

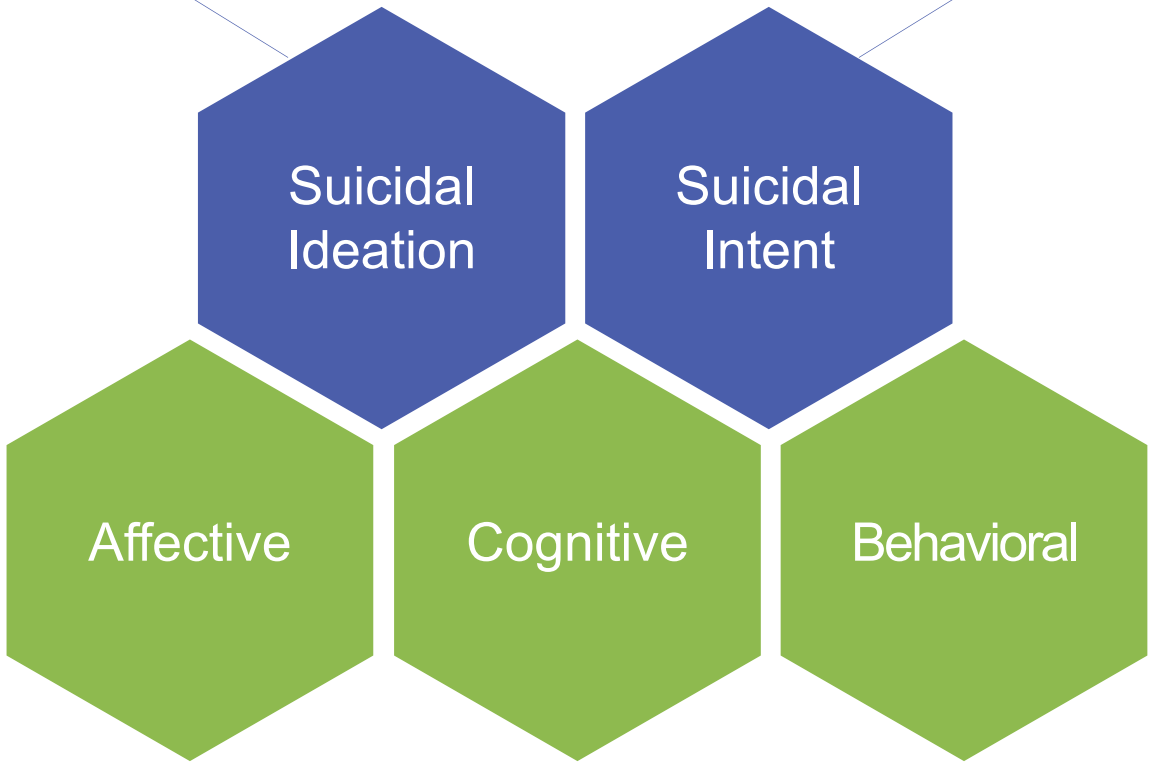
- Collection of signs and symptoms: affective, cognitive, behavioral (not just suicidal ideation and behavior)
- Cause significant distress and disability
- Not an expectable reaction to stressors
- Psychobiological dysfunction
- An episodic condition with state-like symptoms, a progressive course, and an onset that can be gradual or rapid

Obegi (2019a, 2019b)


Suicidal Ideation
Suicidal Intent
Affective
Cognitive
Behavioral

Obegi (2019a)

Recurring:
Wishes to be dead
Thoughts of suicide
Internal debates



Self-reported intent
Communications
Time spent planning
Selecting a method
Worked out plan
Preparations for death
Preparations for SA
Suicide attempt

Obegi (2019a)

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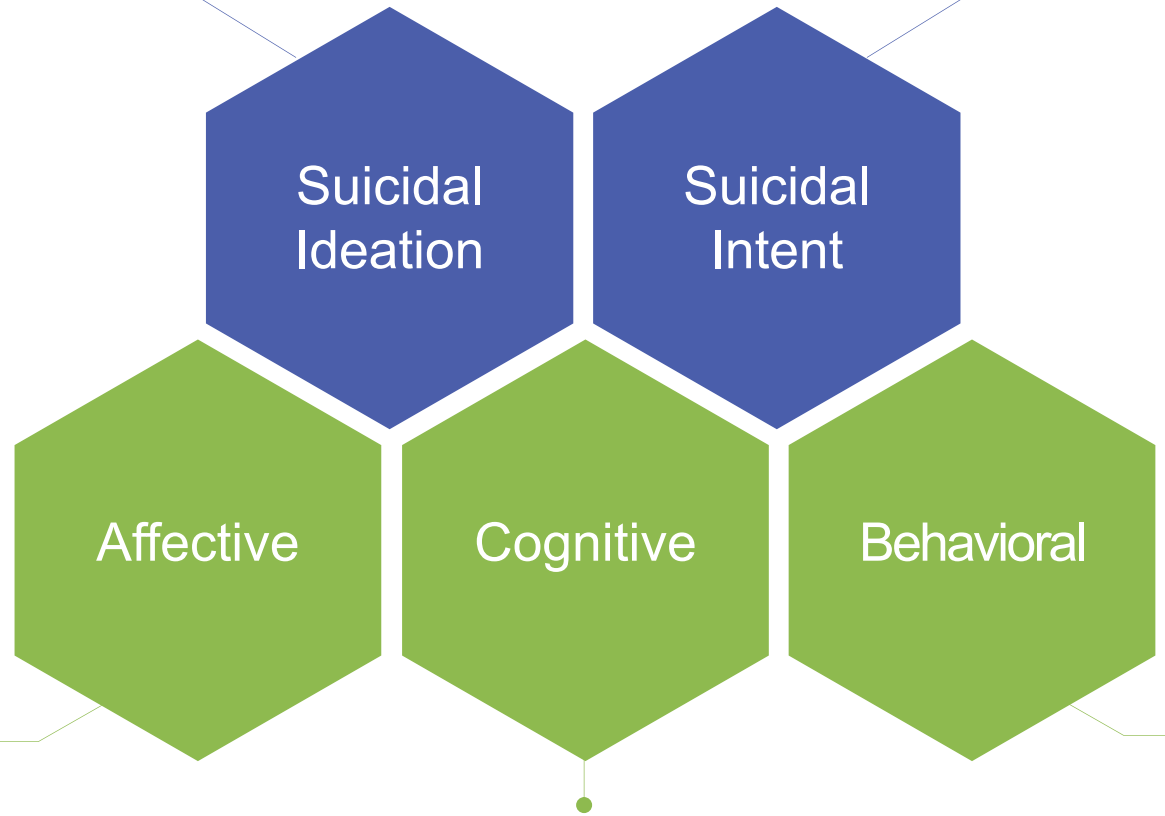


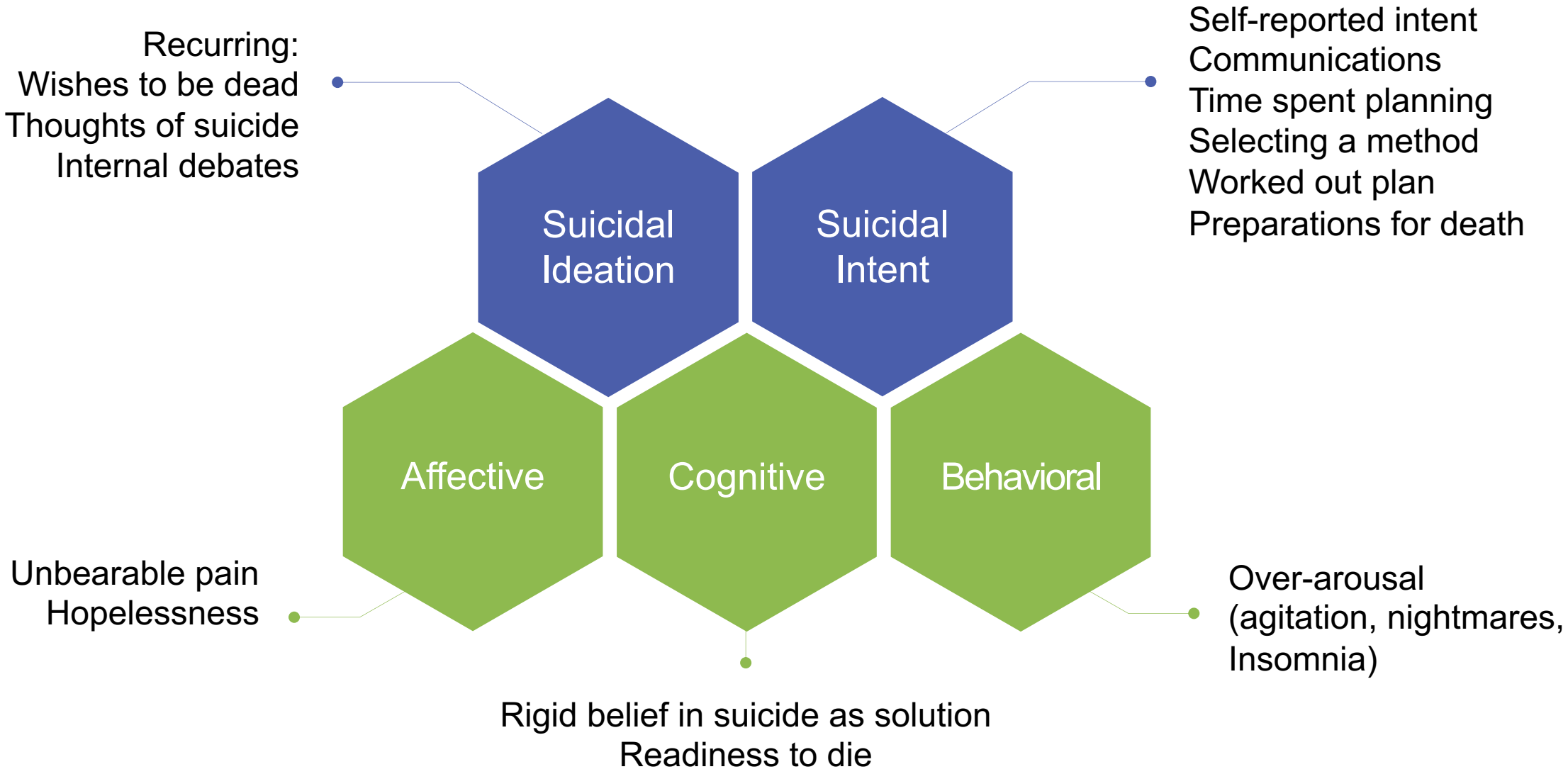
Unbearable pain
Hopelessness

Over-arousal
(agitation, nightmares,
Insomnia, severe anxiety)

Rigid belief in suicide as solution
Readiness to die

Obegi (2019a)

Feigned Suicidality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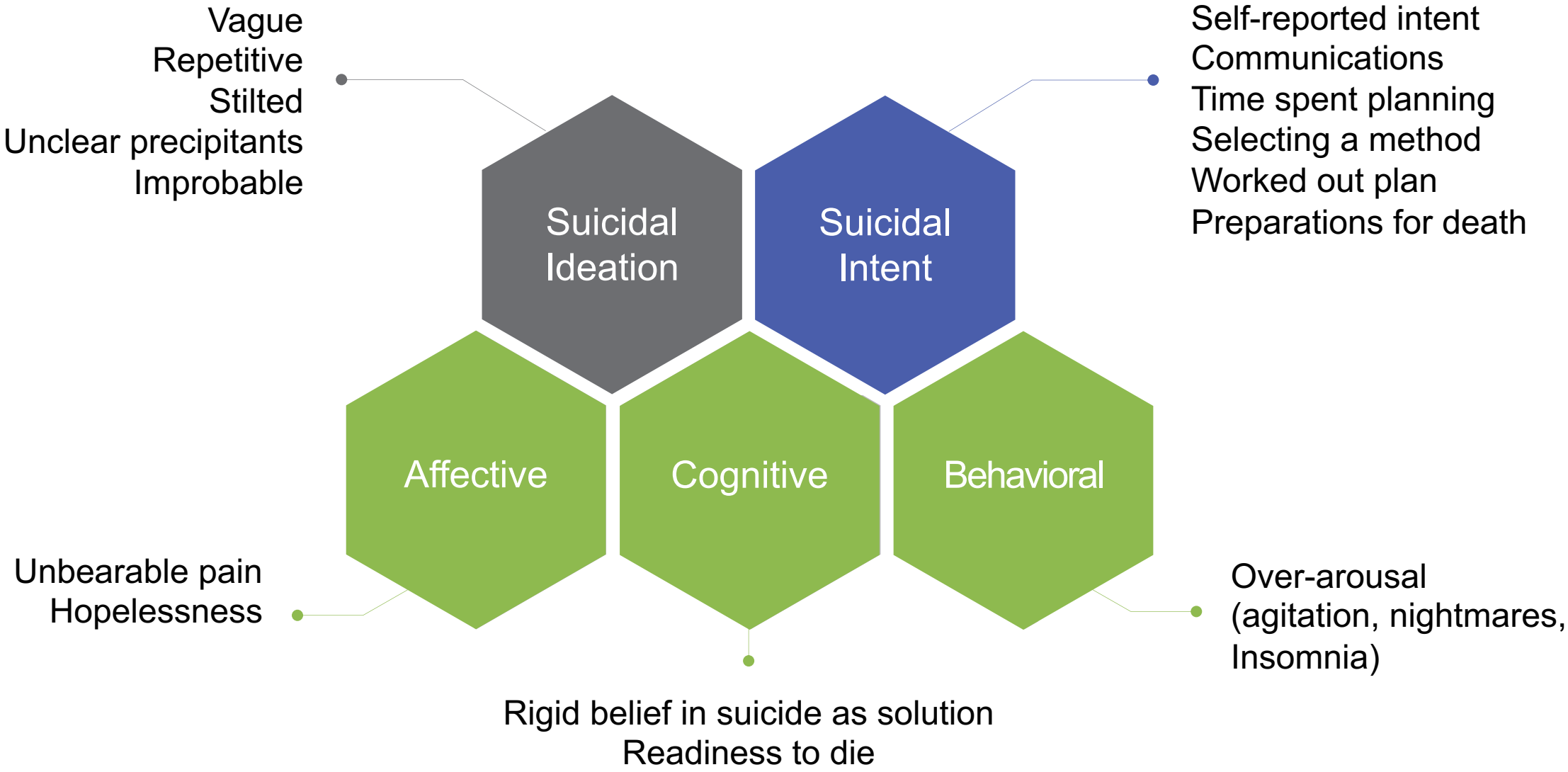
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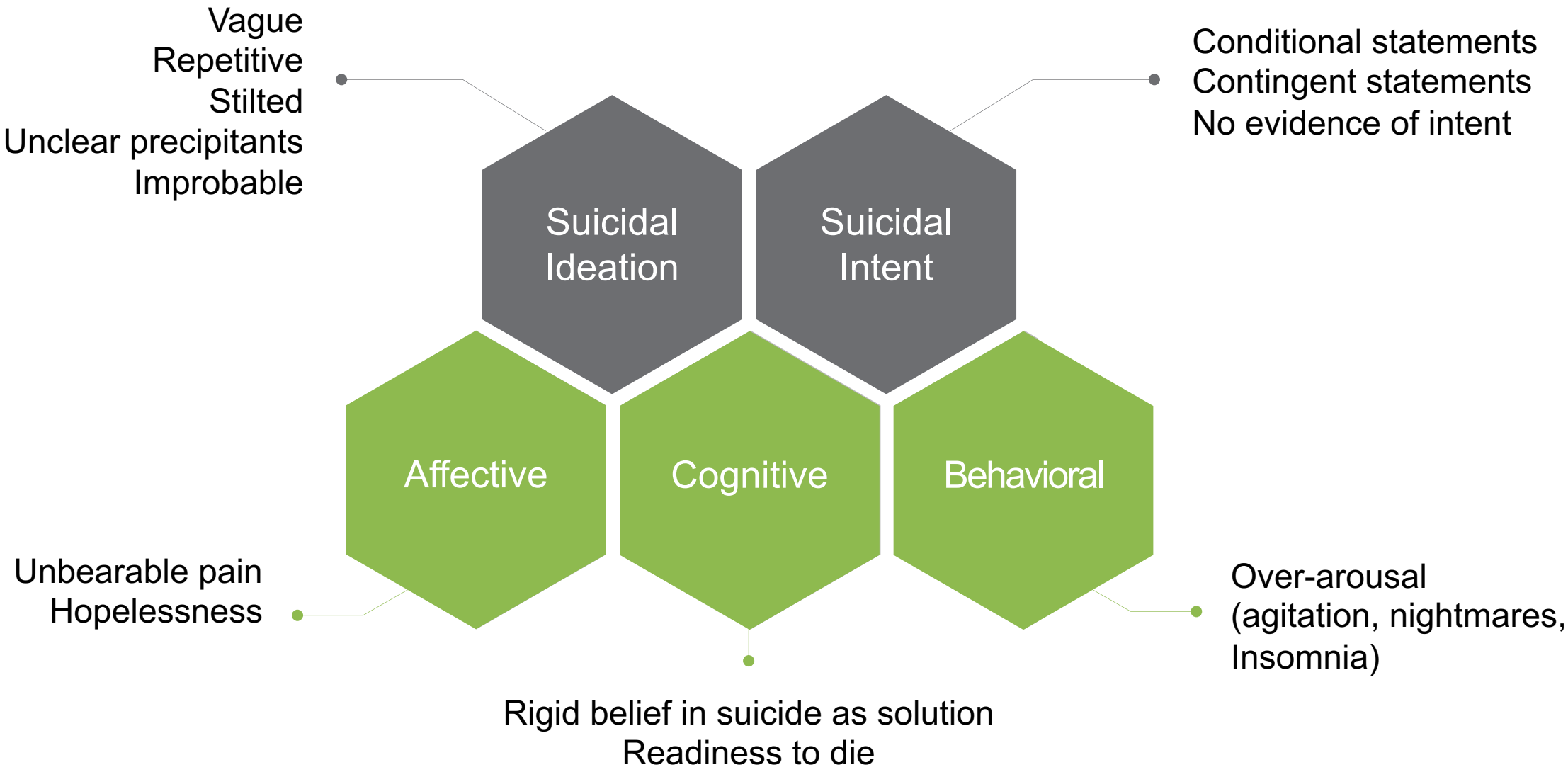
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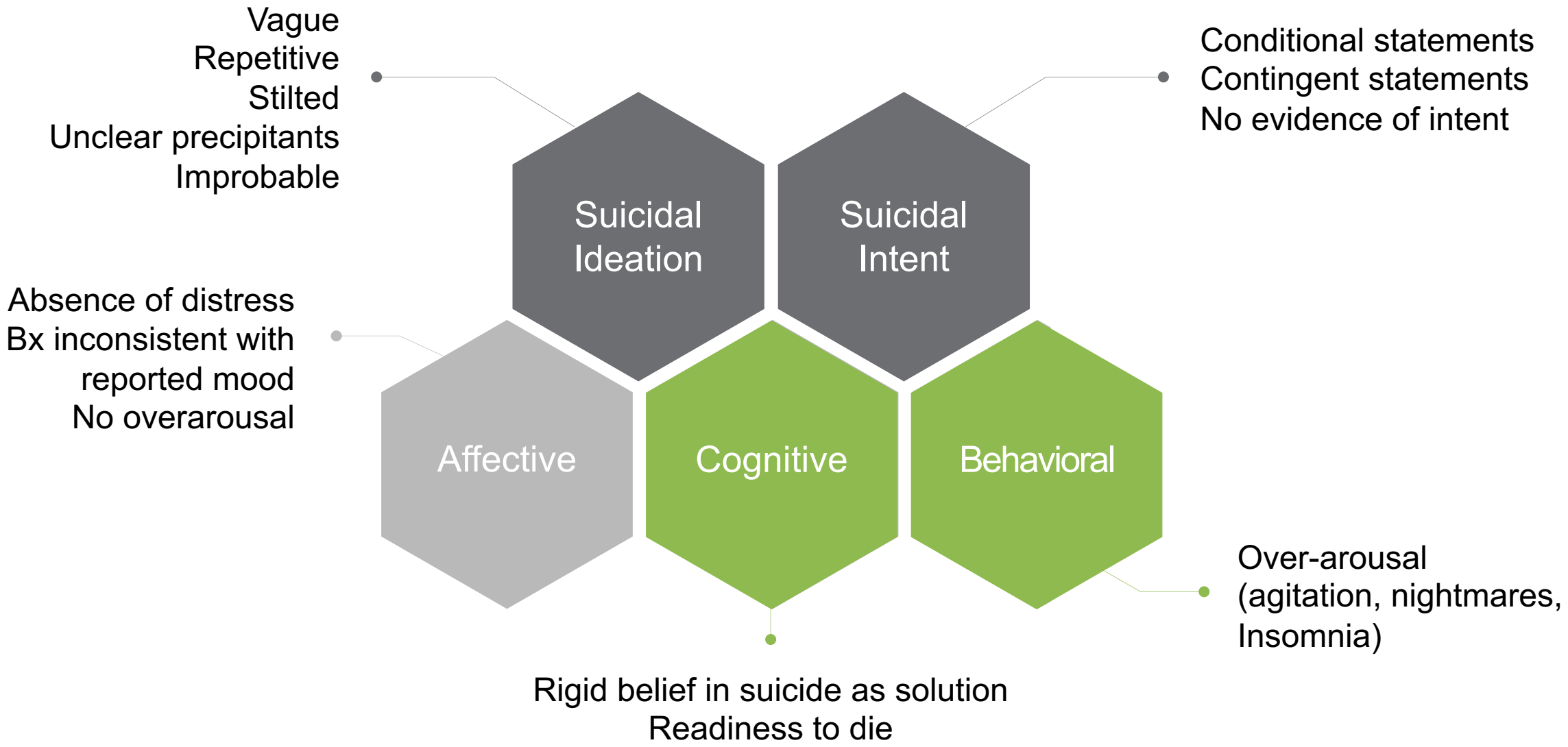
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Bx inconsistent with reported mood
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Rigid belief in suicide as solution
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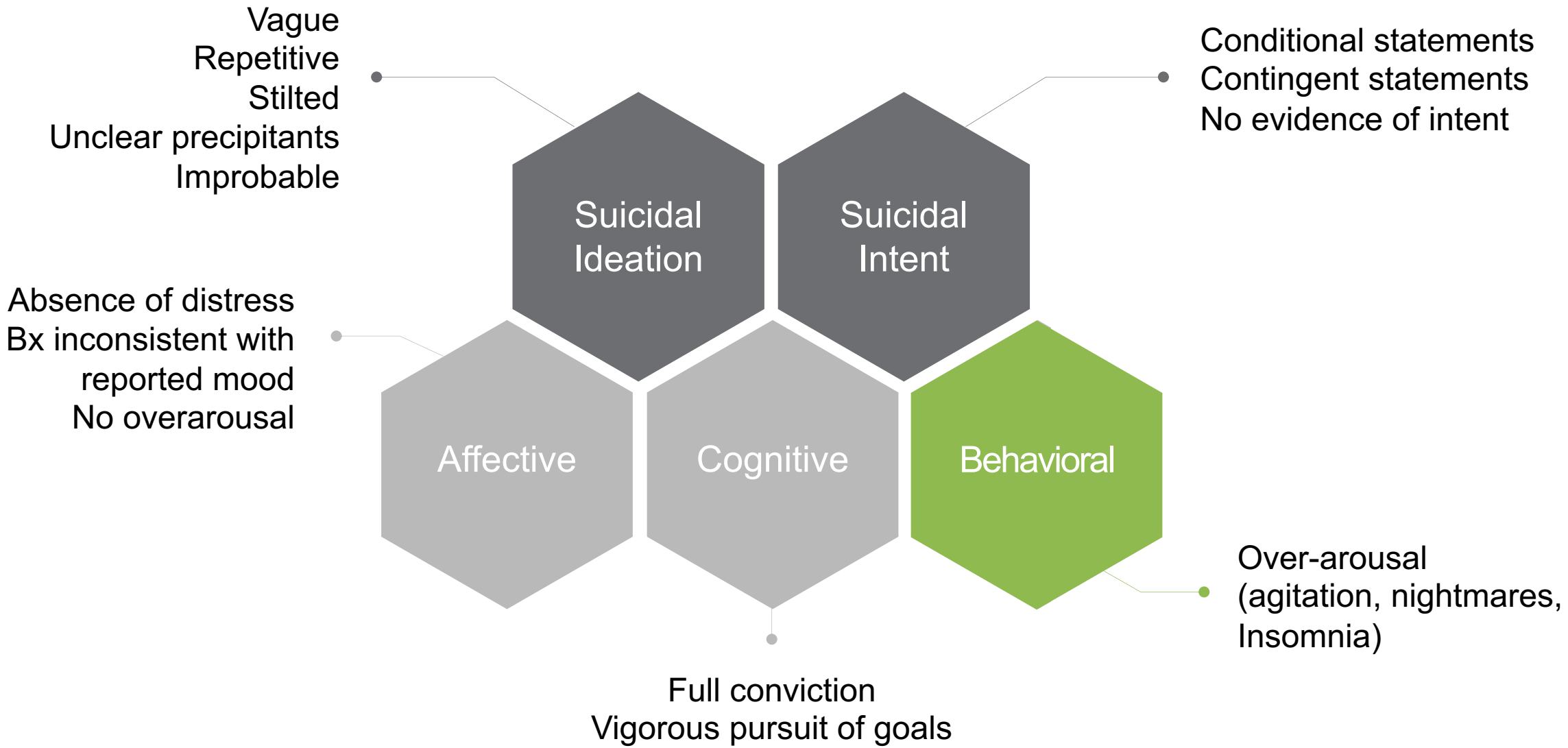
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Affective
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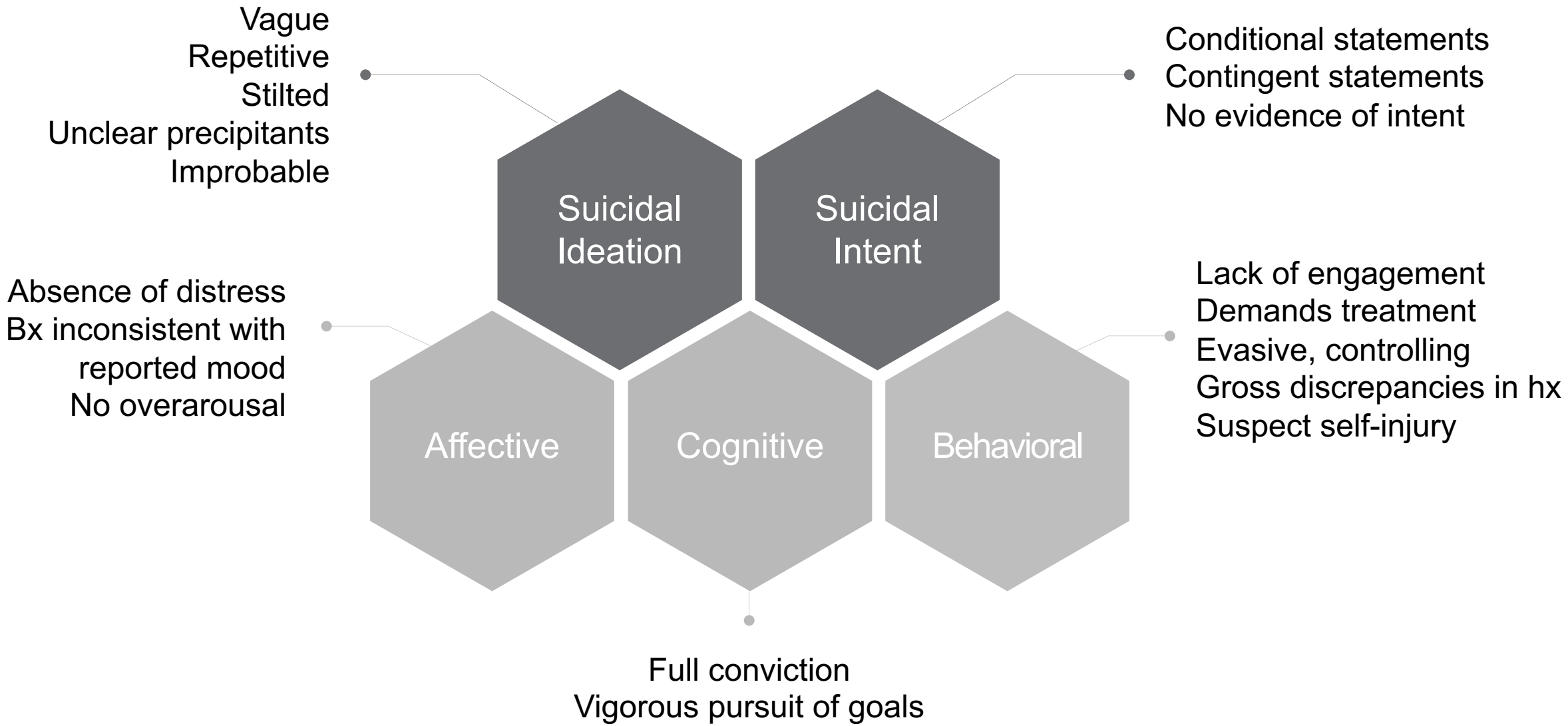
Full conviction
Vigorous pursuit of goals

Obegi (2019a)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Improbable
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Contingent statements
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Suicidal Ideation
Suicidal Intent
Absence of distress
Bx inconsistent with reported mood
No overarousal
Lack of engagement
Demands treatment
Evasive, controlling
Gross discrepancies in hx
Suspect self-injury
Affective
Cognitive
Behavioral
Full conviction
Vigorous pursuit of goals

Obegi (2019a)

Other Suggestive Behaviors I

- Makes indirect threats and dares
  - *“Fine. Send me back to my cell and see what happens.”*
- Blames staff for their future death
  - *“If I kill myself, it’s going to be on you.”*
- Makes ominous and vague statements
  - *“I don’t feel safe with clothes/without a sitter.”*
- Reports “voices” commanding suicide
  - In the absence of a mood or psychotic disorder; reports being unable to resist the commands despite evidence to the contrary

Obegi (2020)

Other Suggestive Behaviors II

- Sudden remission of SI
  - SI quickly remits after admission; abruptly drops suicidal statements upon learning that the treatment team will not comply with demands
- Regresses as discharge approaches
  - Upon learning of discharge, and after a period of denying SI, the patient reports new SI, engages in minor self-injurious behavior, or, citing fears or suicidal behavior, voluntarily gives up clothing or requests constant observation
- Collateral reports suggesting the inmate planned to “go suicidal”
- Disconfirming evidence

Obegi (2020)

Distortions in Treatment

- Long stints of 1:1 without a rationale
- Suspect petitions for involuntary medications
- Documentation gaps
- Feeling “held hostage”
- Stagnating treatment
- Prevent defense, waiting out the patient

Obegi (2020)

“Nobby Harris says he’ll kill himself if I don’t lend him three dollars.”

Behaviors should always be considered in the larger clinical context. Any one behavior, by itself, is **never** sufficient to confirm feigning and in some cases may indicate high suicide risk.

Suicidal ideation and behavior should **never** be dismissed and always require careful evaluation and explanation.

- Employ safeguards
- Brave vs. reckless
- Cumulative evidence
- Time is your ally
- Beware of the “inconsistency trap”

Kontos et al (2018); Rogers (2008b)

Understanding Feigned Suicidality

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

“…no one lies about SI because things are going wonderfully.”

Kontos et al.. (2018)

Adaptational Model of Malingering I

Rogers (1990); figure adapted from Simpson & Sharp (2017)

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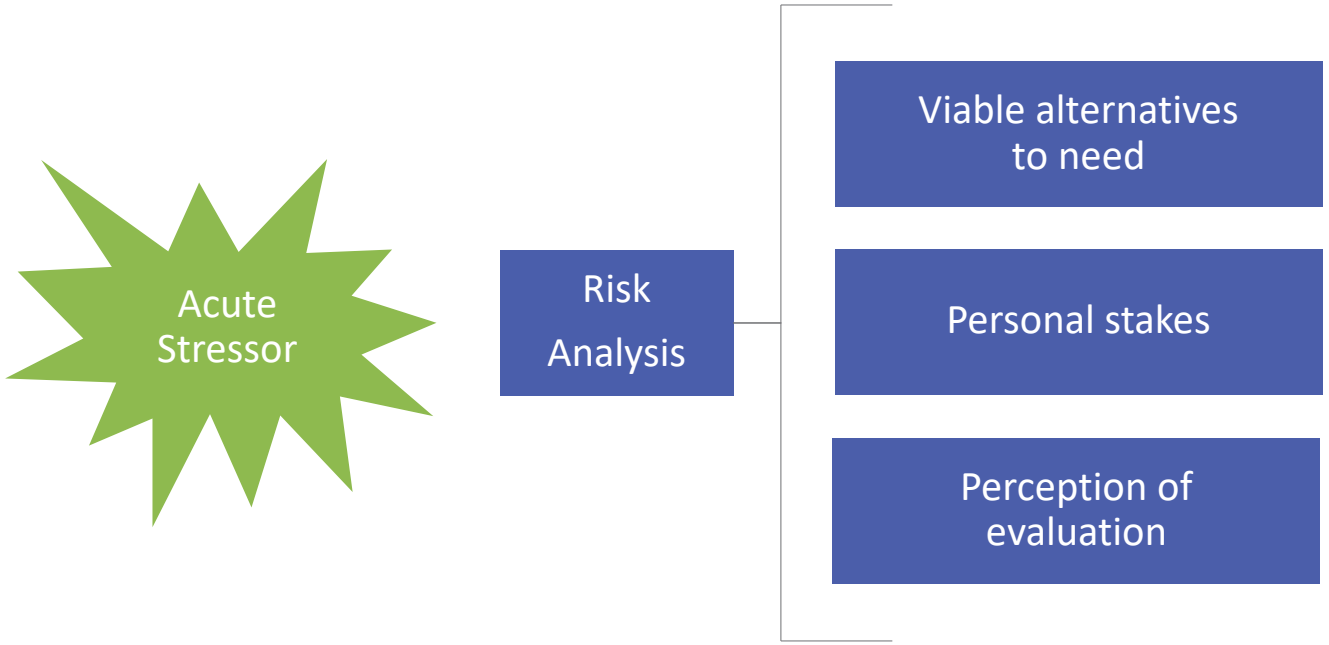

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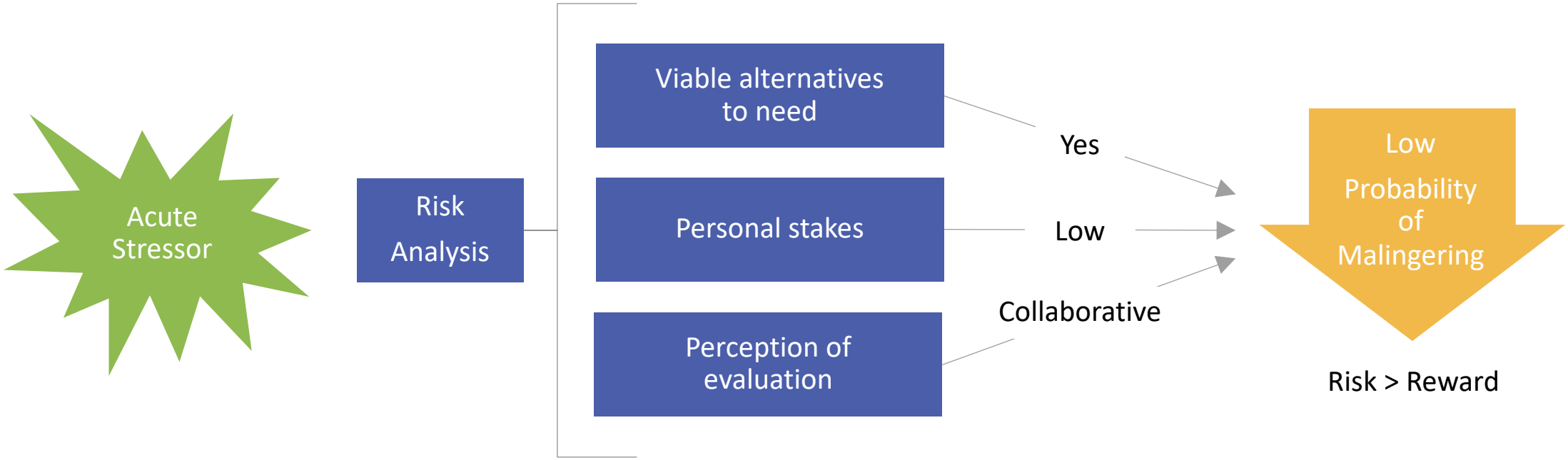

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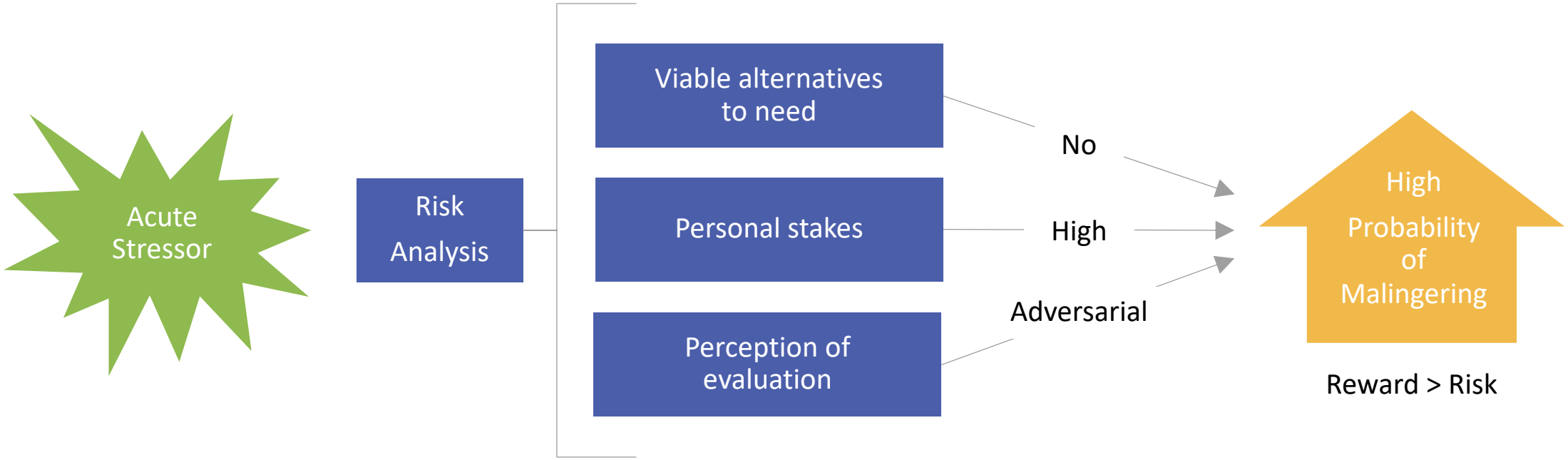

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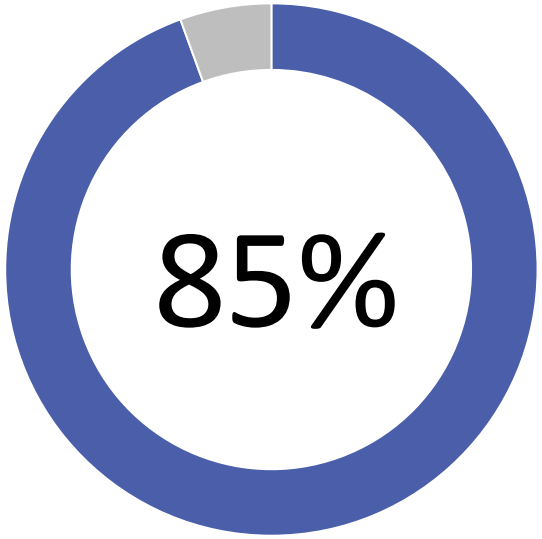
Motives in CDCR: Crisis Patients



Percent Involving DTS

- QM emails to supervisors re: “secondary gain”
- Sample of 117 emails (1-2017 to 7-2018)

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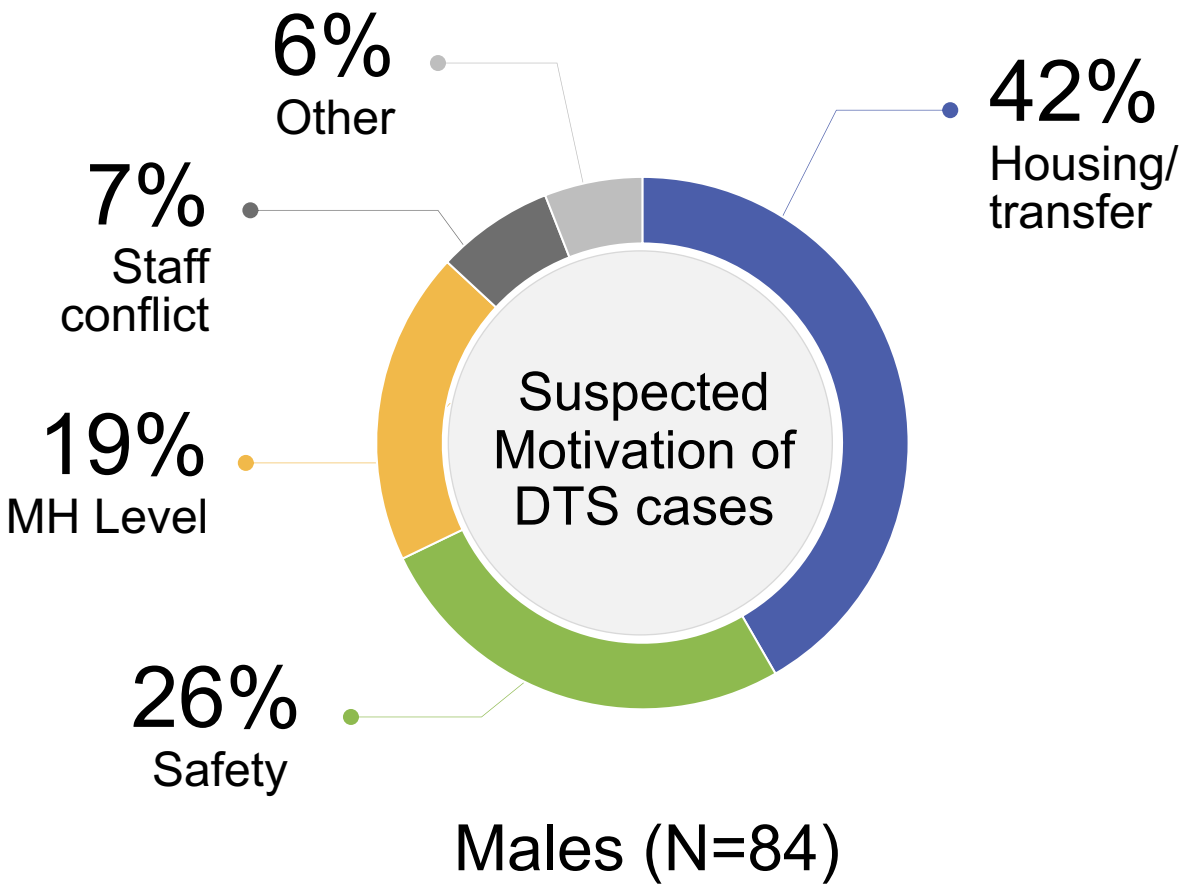
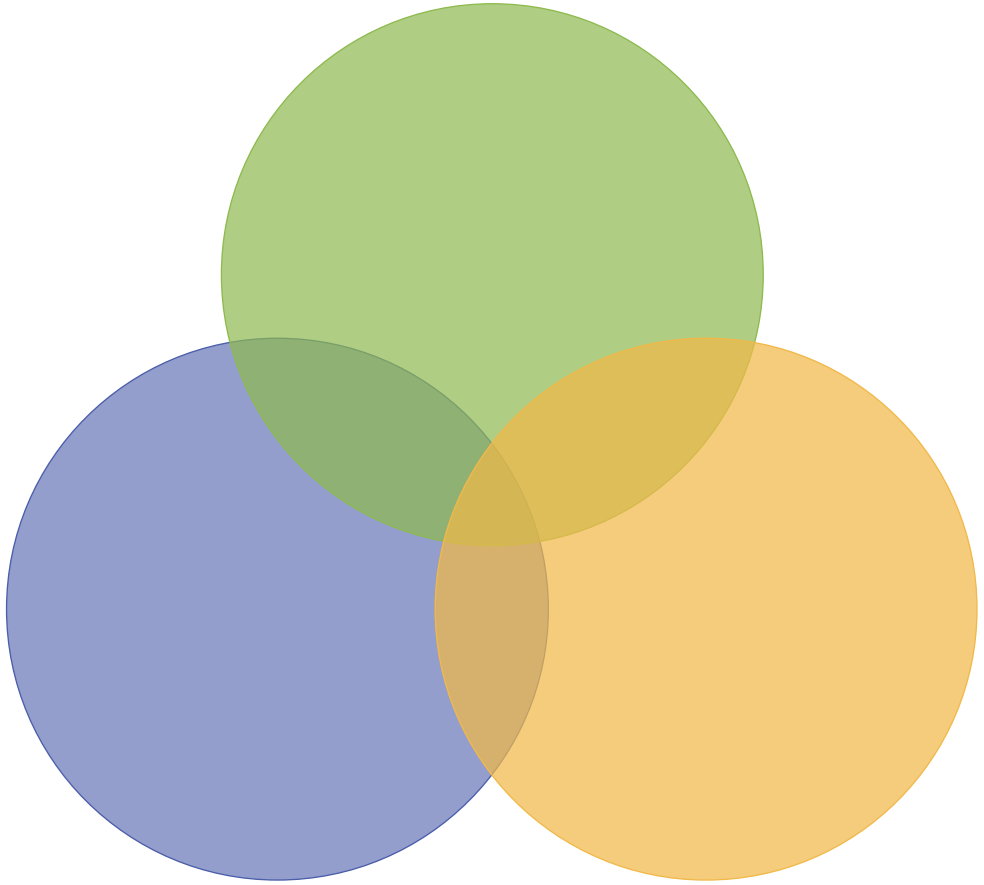


- QM emails to supervisors re: “secondary gain”
- Sample of 117 emails (1-2017 to 7-2018)

Motive

- There may be multiple motives
- Not suicidal intent OR manipulation
- Due to deception, motives can rarely be established with high confidence
- The presence of motive, by itself, does **not** confirm feigning or malingering

Groups of Self-Injuring Inmates



Inspired by Bonner (2001)

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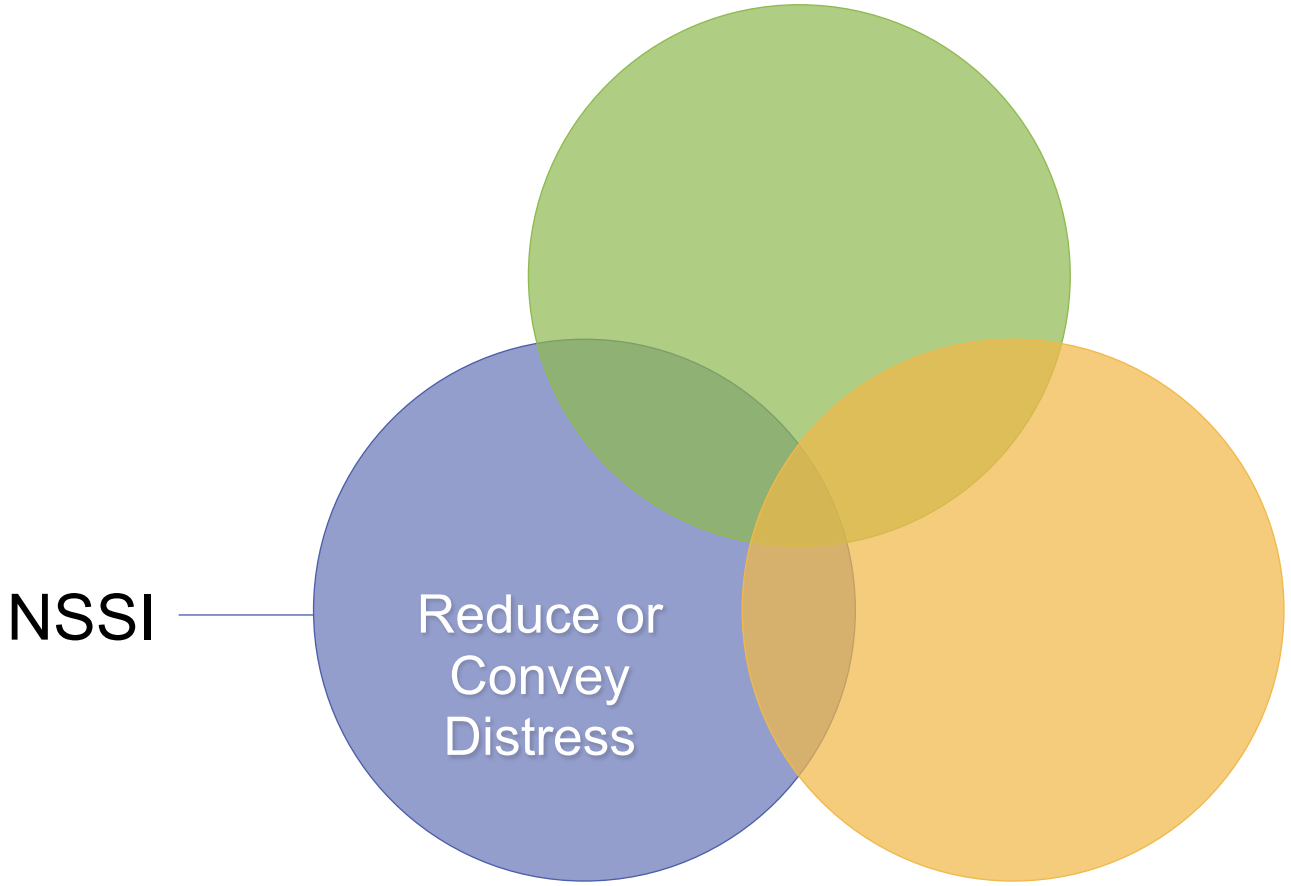

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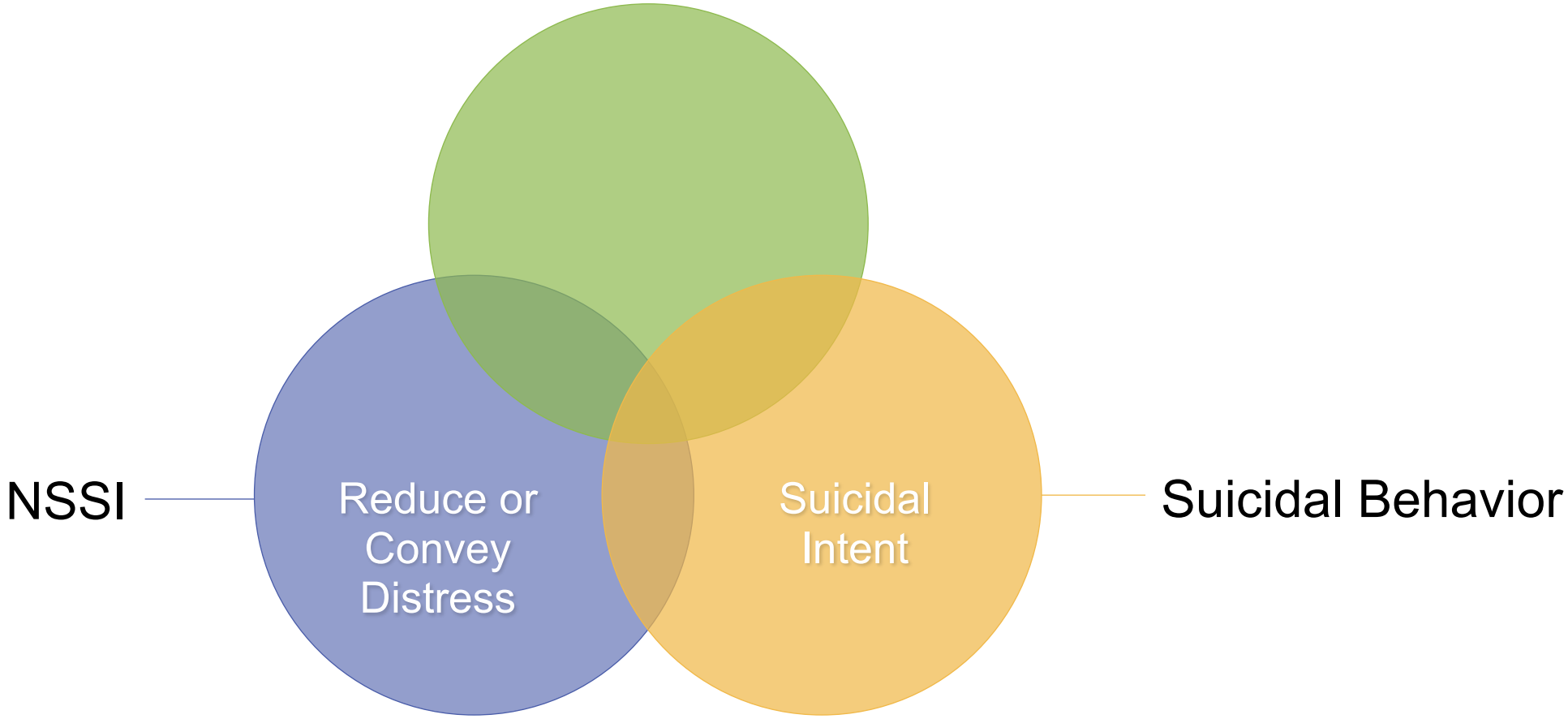

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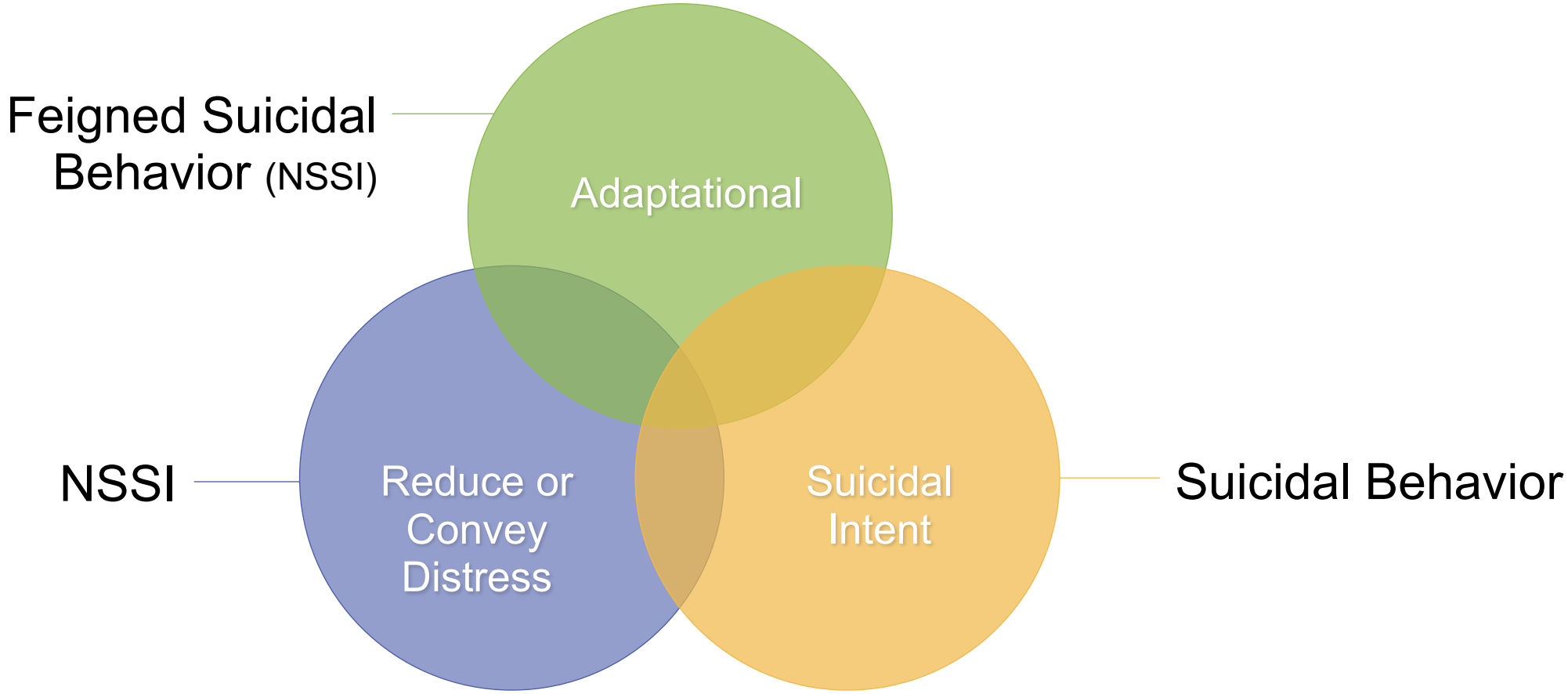

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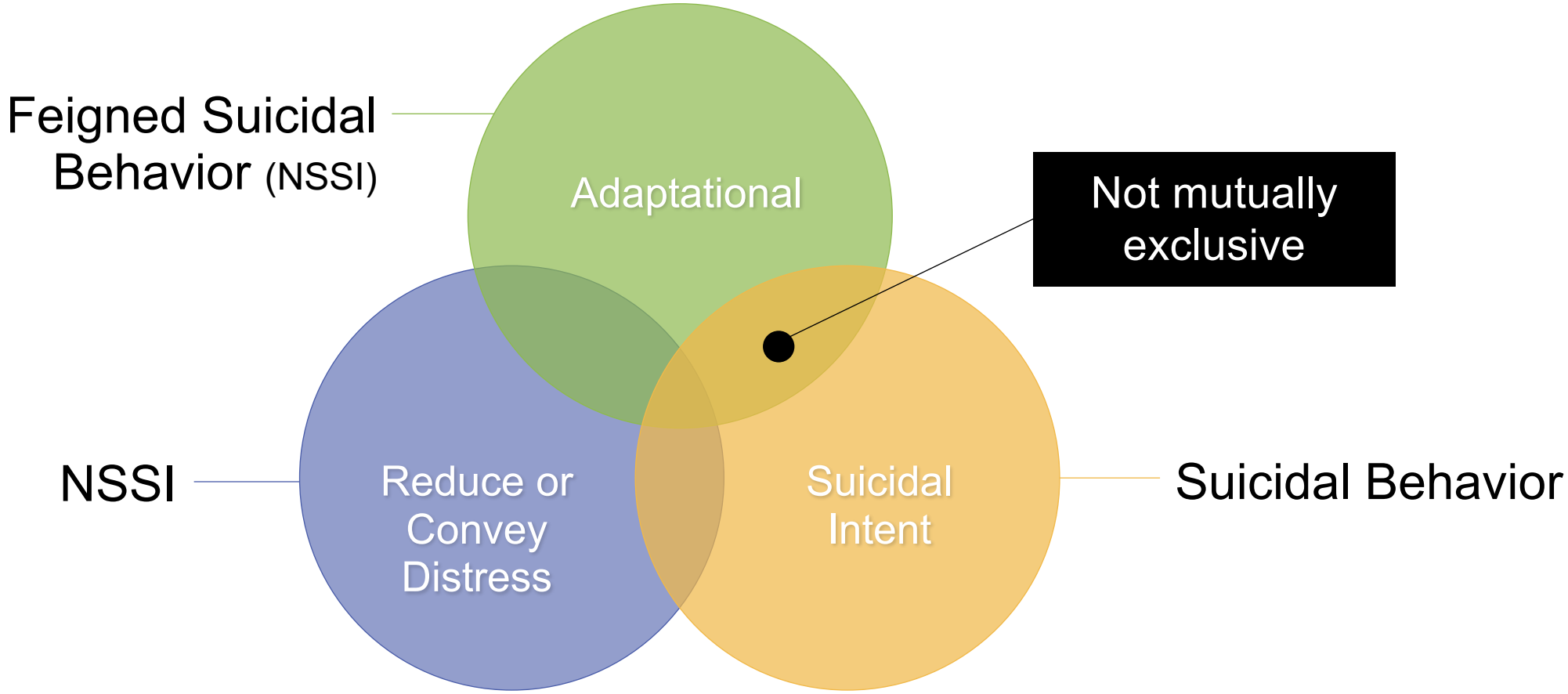

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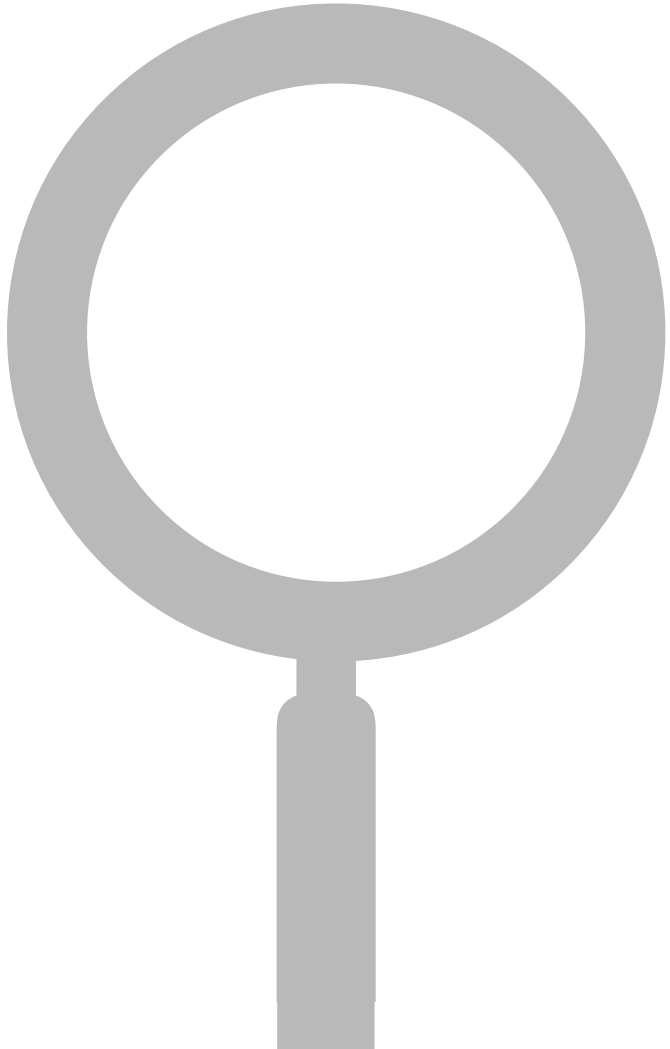
Assessing Suspected Feigned Suicidality

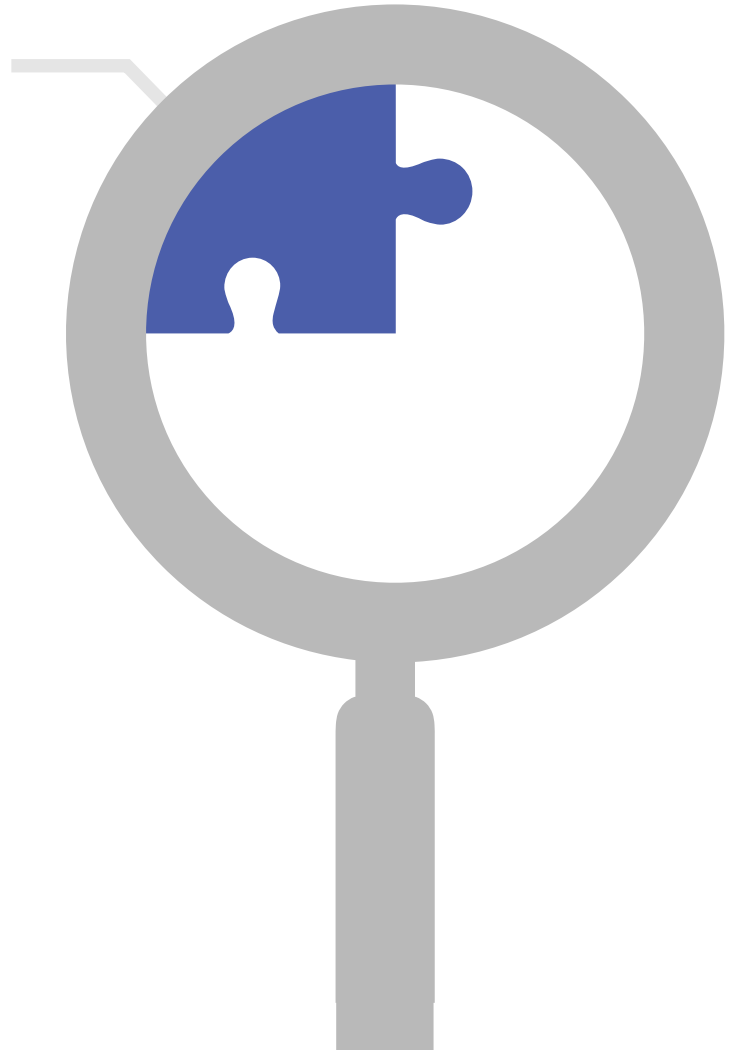
Assessment Steps



Assessment Steps

DIFFERENTIAL DIAGNOSIS

Are there signs of feigning?
Are there signs of suicidality?
Is there consensus?



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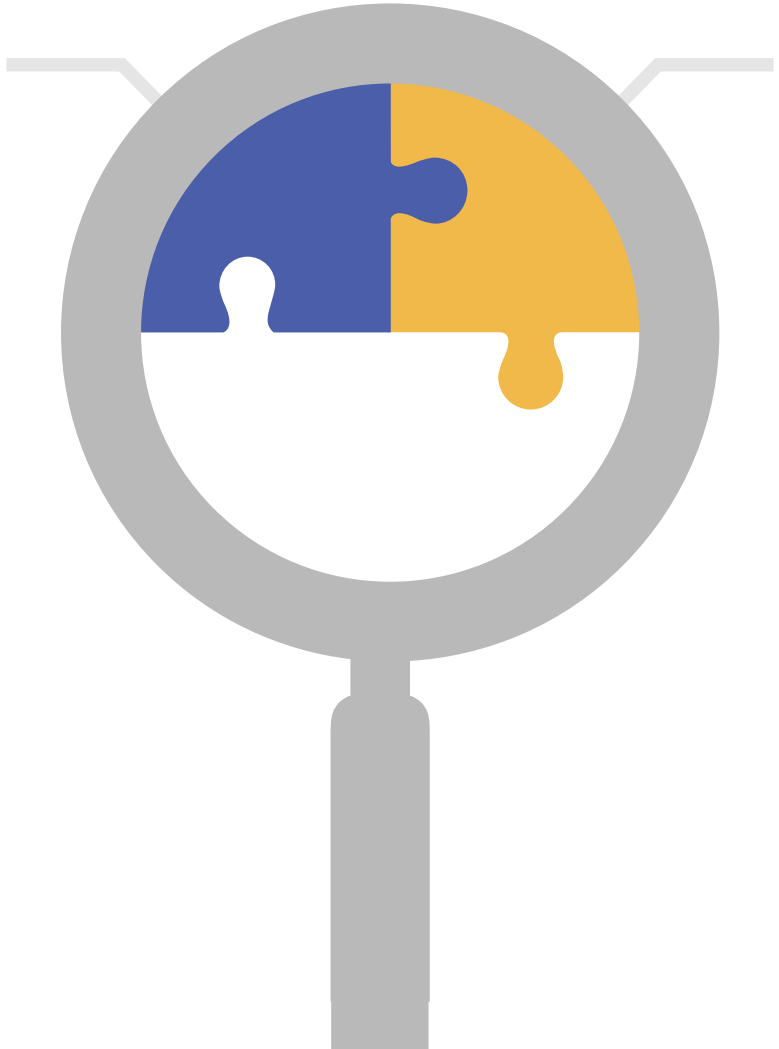

MOTIVES

What are the circumstances?
What is the motive, if any?
Is there consensus?

Assessment Steps

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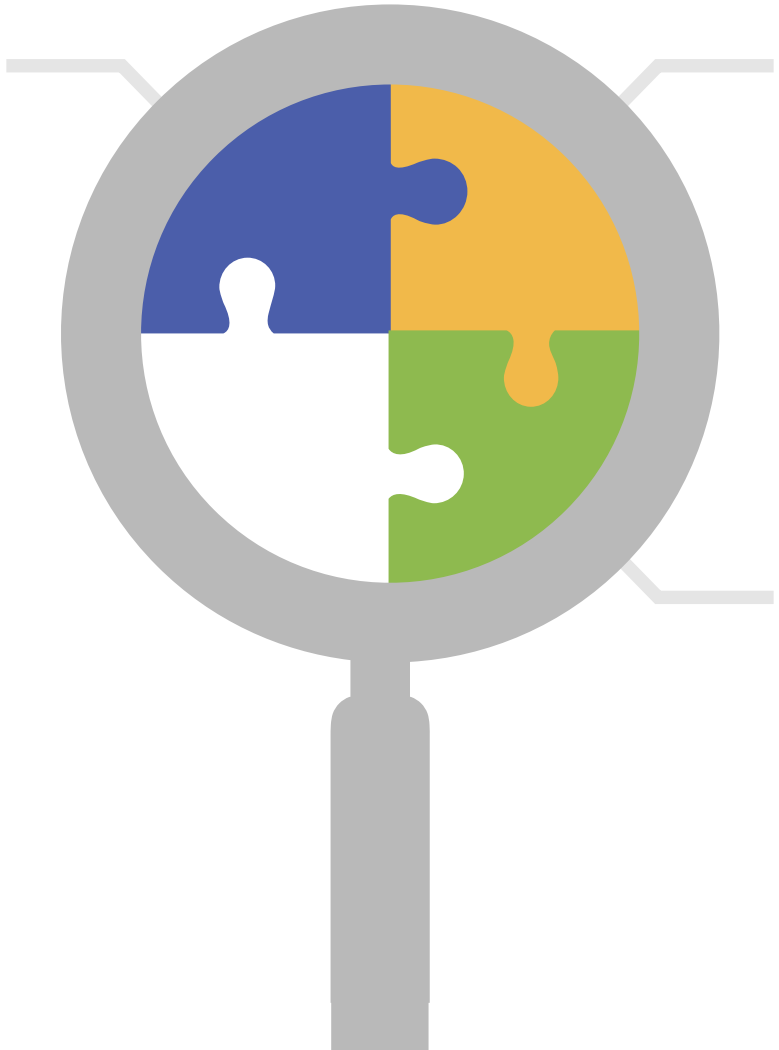

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SUICIDE RISK ASSESSMENT

What is the acute risk level?
Is there suicidal intent?
Is there consensus?

Assessment Steps

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Are there signs of feigning?
Are there signs of suicidality?
Is there consensus?

MOTIVES

What are the circumstances?
What is the motive, if any?
Is there consensus?

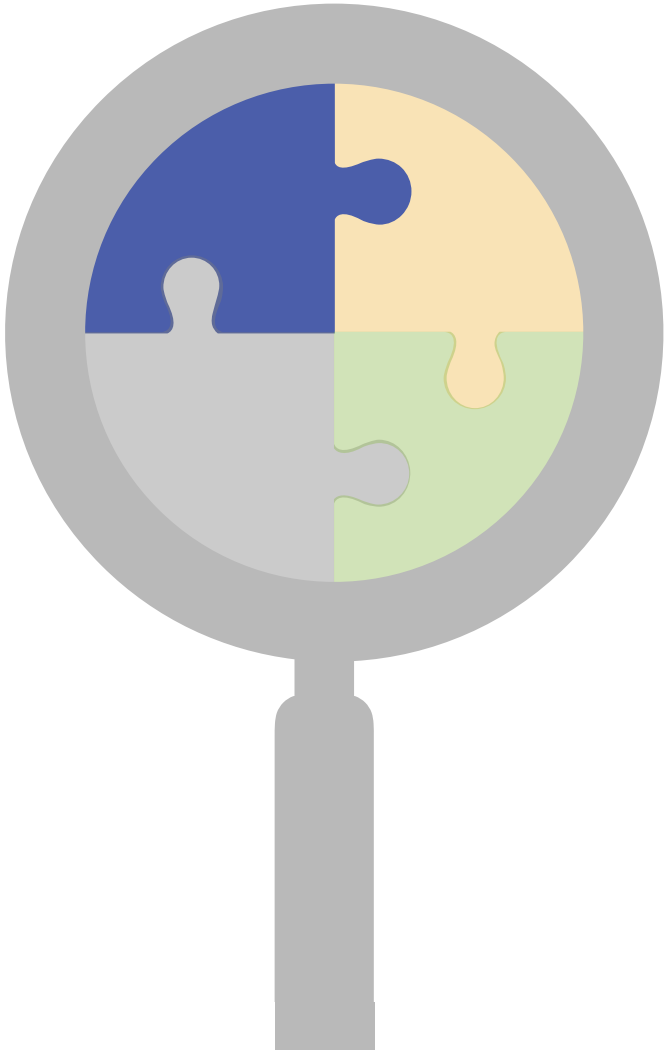
TREATMENT

If feigning and motive are established and suicidal intent is ruled out, what is the appropriate level of care?
What is the treatment plan?

SUICIDE RISK ASSESSMENT

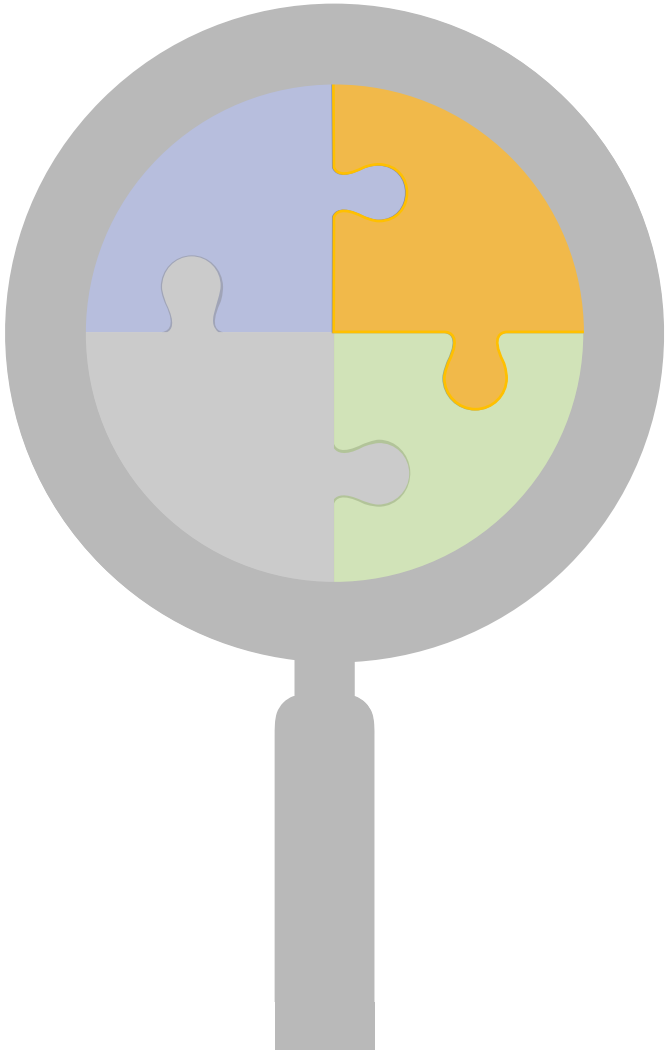
What is the acute risk level?
Is there suicidal intent?
Is there consensus?

Differential Diagnosis



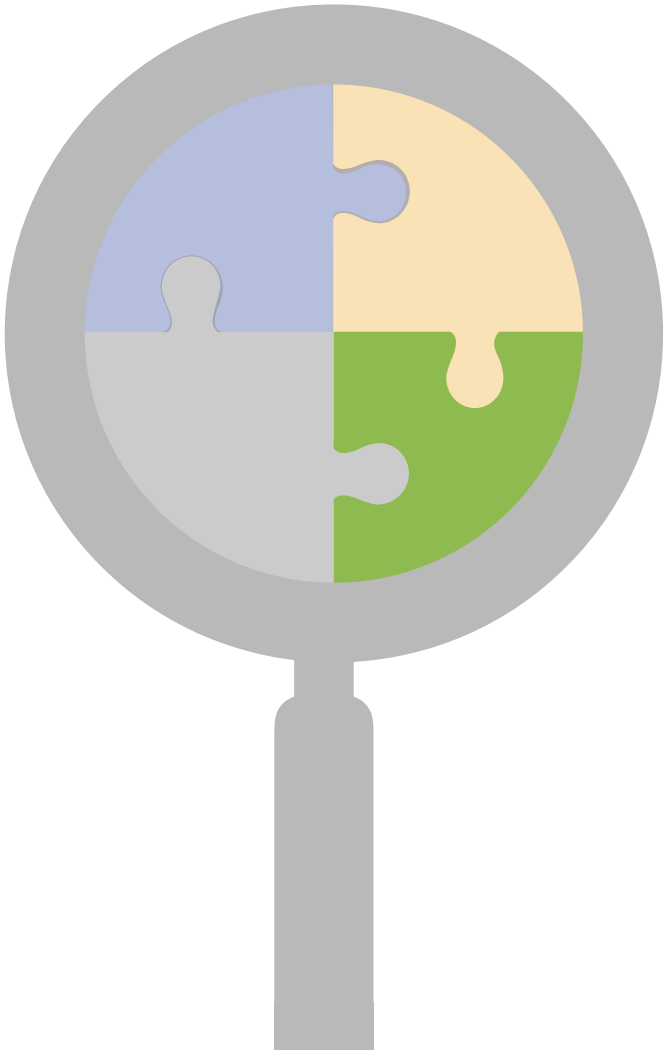
- Compare the current presentation to the conventional presentation
- Complete a chart review
- Interview collaterals
- Look for discrepancies
- Use a thorough and lengthy clinical interview
- Rule out alternative hypotheses

Motive



- No assessment is complete until there is a consensus on a motive
- Motives are highly varied, but in CDCR escape motives are the most common
- There may be multiple motives or unclear motives
- The presence of motive, by itself, does not confirm feigned suicidality

Suicide Risk Assessment

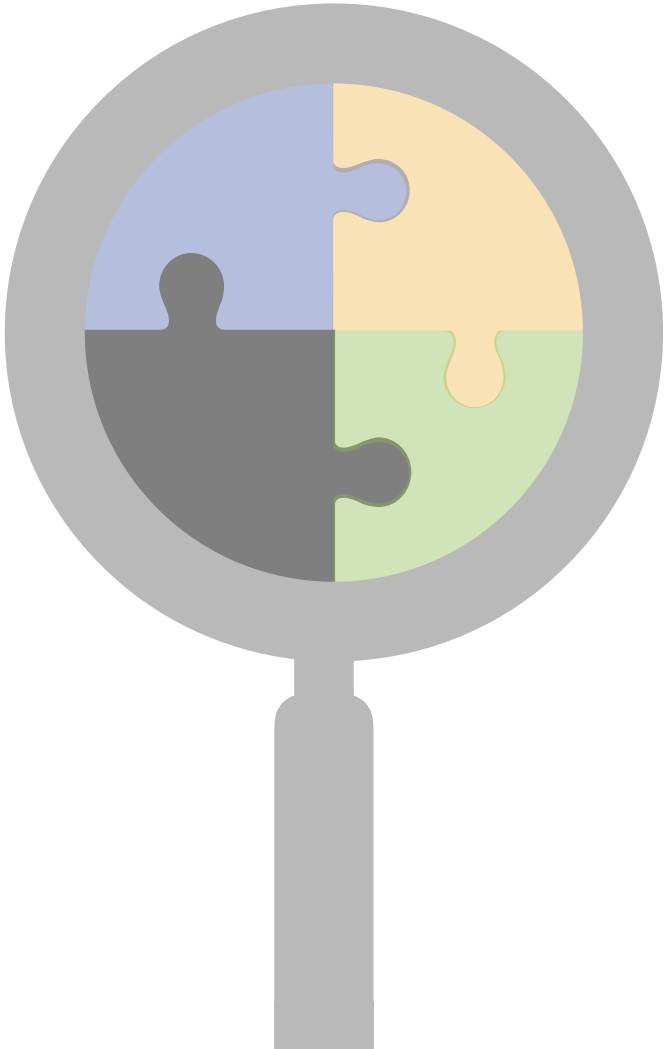


- A suicide risk assessment is always necessary
- Do not overrely on self-report; gather clinical evidence of suicidal intent
- Ask yourself: Why is the patient presenting with suicidality now?
- Clearly document your rationale for the acute risk level

“That through suicidal behavior someone may seek, among other things, attention or some benefit does not help much in predicting how great a danger they represent.”

Haycock, (1992)

Treatment



- Should the level of care change? Why or why not?
- Take a problem-solving approach
  - Address motive
  - Develop safer, adaptive alternatives
  - Use gentle confrontation
- Not all patients feigning suicidality will be receptive
- Consider “therapeutic discharge”

Exercise

Part 1

DIFFERENTIAL DIAGNOSIS

Are there signs of feigning?
Are there signs of suicidality?
Is there consensus?

MOTIVES

What are the circumstances?
What is the motive, if any?
Is there consensus?

SUICIDE RISK ASSESSMENT

What is the acute risk level?
Is there suicidal intent?
Is there consensus?

TREATMENT

If feigning and motive are established and suicidal intent is ruled out, what is the appropriate level of care?
What is the treatment plan?

Part 1

1100 *You learn via phone that an inmate has boarded up in ASU. There is no visual contact and custody is engaged in de-escalation.*

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1110 The LPT calls you, reports that the inmate threatened self-harm, and requests your immediate assistance. Custody opened the food port and found that the inmate barricaded the door with a mattress.

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1115 Update from the LPT: The window paper partially peeled away. Officers briefly saw the inmate. Around the inmate's neck was a tied piece of white fabric. The inmate immediately re-affixed the paper. Custody initiated an emergency extraction. Upon entering, the inmate was standing in the back of the cell in a bladed stance. The white fabric was on the floor.

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1120 The extraction is completed. The inmate has minor injuries as a result of the extraction. You are on-call.

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Part 2

Your chart review reveals: 25 y.o. Hispanic inmate, adjustment disorder, prescribed Celexa and med compliant. Patient placement history shows no other LOCs. No SREs. Last clinical contact at CSP Anywhere was unremarkable.

Your criminal file review reveals: First termer, down 2 years of a 3-year term. SNY from CSP Anywhere. Arrived yesterday on an out-to-court-basis. Court order to appear shows a charge of drug possession.

LPT and ASU officers say the inmate looked "fine" last night and this AM.

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LPT and ASU officers say the inmate looked "fine" last night and this AM.

You interview the patient in a non-confidential setting with an officer present. The patient insists, "I can't be at this prison", but refuses to elaborate. "If you send me back to AdSeg, I'll kill myself." There is no acute distress. The patient is minimally cooperative. The C-SSRS Ideation section is positive to all 5 questions regarding the past month.

A confidential space becomes available and you continue your interview. You probe for safety concerns. The patient discloses being at your prison 6 months ago where the charge for drug possession occurred. After lockup, the patient dropped out and was transferred to CSP Anywhere.

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Part 3

Your supervisor calls and asks for an update. You communicate that the patient is contingently suicidal but is experiencing some distress. You indicate that MHCB admission is not warranted, but to decrease the risk of further acting out you suggest a Warden-to-Warden transfer of the patient to a sister institution. The supervisor agrees and begins making the necessary phone calls.

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You return to interviewing the patient. Upon arriving yesterday, the patient describes becoming overwhelmed by a fear of being assaulted by gang members. The patient's voice trembles and tears appear.

You ask the patient to recount the events in ASU that morning. The patient describes a sense of hopelessness and desperation that lead to boarding up. When you inquire about the patient's state of mind and plan for the torn fabric before the window covering peeled away, the patient states, "I wanted to die. But then the paper came off and the officers saw me." The patient described being stunned in the moment then removed the fabric and prepared for the impending extraction.

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Part 4

Pausing the interview, you call your supervisor who informs you that the Warden-to-Warden transfer has been approved and the transportation team is ready.

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Part 4

Pausing the interview, you call your supervisor who informs you that the Warden-to-Warden transfer has been approved and the transportation team is ready.

You relay your updated findings, namely, that there was an interrupted suicide attempt, and request consultation.

After a review of the clinical findings, the two of you agree that feigned suicidality is unlikely and acute risk for suicide is high. Moreover, given the seriousness of the attempt, the Warden-to-Warden transfer should be cancelled and the patient referred to an MHCB.

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Summary

- Feigned suicidality is a common presentation in corrections
- Differential diagnosis is a necessary task
- Be familiar with a typical presentation of feigned suicidality
- Exercise caution but don’t panic
- Attempt to understand motives
- Exaggeration vs. fabrication
- A finding of feigned suicidality is not the end of assessment or treatment

Contact

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