

Review Article

Malingering of Psychiatric Disorders: A Review

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Abstract

Malingering is conceptualized in contemporary clinical practice as a condition requiring clinical attention. The malingering of psychiatric disorders is perhaps more prevalent than previously thought and is associated with considerable cost to the society. There is no fool-proof method to identify malingerers and its detection and management raise complex methodological, ethical and legal questions. The current review aims to highlight these issues and; where possible; suggestions to deal with the same. For this purpose an electronic search of MEDLINE and EmBase databases were done. In addition cross-references were hand searched. Research publications dealing with various aspects of malingering of psychiatric disorders were included. The current literature suggests that this condition is difficult to detect. The actual prevalence may be more than current estimates because of various reasons and its detection needs inputs from multiple sources including clinical as well as psychometric methods. There appears to be greater need to give attention to this condition with a view to making clinical care and resources available to those in genuine need for the same (German J Psychiatry 2007; 10: 126-132).

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Introduction

Malingering is defined in DSM-IV^{TR} as the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining principal compensation, evading criminal prosecution or obtaining drugs (American Psychiatric Association, 2000). It further mentions that, under some circumstances, it may represent adaptive behaviour. It is not considered to be a medical or psychiatric diagnosis. However, physicians or psychiatrists may encounter such subjects in their routine practice or may be called upon to evaluate them as part of medico legal proceedings. It is estimated that the prevalence of malingering among mental health patients is around 1% in civilian clinical practice and 5% is the military context. The rates of malingering psychological symptoms following personal injury vary from 1-50%. As expected, in a medico legal setting, the prevalence is reported to be be-

tween 10-20%, which is higher than in other conditions and may be spuriously inflated due to the adversarial nature of such evaluation (Hickling et al, 1999). Malingering has been reported across all age groups including children (Peebles et al, 2005). Although any disorder may be simulated, malingerers particularly favour psychiatric disorders as these are difficult to identify objectively. The commonly seen malingered psychiatric symptoms are mental retardation or mental deficiency, dementia or cognitive disorders, amnesia, psychosis which may include hallucinations or delusions or both, post-traumatic residual symptoms. Besides the motivations of feigning as discussed above, the motive behind feigning of psychiatric symptoms can be getting disability or social benefits, claim compensation after any accidental injury, settle scores with hated employer etc (Mills & Lipian, 2000; Knoll & Resnick, 2005).

Malingering has been said to be synonymous with faking, lying and fraud (Lo Piccolo et al, 1999) and these have been integral parts of human behaviour since the earliest times. Lying seems to extend across a spectrum with normal behav-

behaviour at one end, malingering at the other end and personality disorders, somatoform disorders and factitious disorders in between. Descriptions of feigned madness appear in the Bible (Lipian & Mills, 2005). The Greeks punished malingering in military services by death. Ulysses feigned insanity to avoid duty during the Trojan War. The earliest scientific reference to malingering; however, can be found in "On Feigned Disease and the detection of them" by Galen in 2nd century AD and the first notable American text on the subject was Theodore Beck's 'Elements of Medical Jurisprudence' (Beck, 1823). One of the earliest landmark studies in this field was by Rosenhan (1973), entitled "On being sane in an insane place" which highlighted the difficulties in detecting malingering of mental illness. Thereafter, over the past two decades, there has been a renewed interest in this area, which may be due to an increasing awareness and proliferation of knowledge about various psychiatric disorders. It makes the job of a malingeringer easier and that of a psychiatrist, increasingly difficult.

Concept and nosology

Malingering has been conceptualized over the years, as follows:

1) Malingering as a disease (the pathogenic concept): Many authors, especially those of the psychoanalytic fold, labelled 'malingering' as a form of mental disease (Resnick, 1999). Hay (1983) has opined that the simulation of schizophrenia is the prodromal phase of genuine illness, and that this diagnosis should be made with great caution. This phenomenon has also been referred to as "pseudo-malingering" i.e. it is a temporary ego supporting device. In keeping with the pathogenic concept, it was opined that malingering concerns arrest of development at an early phase and it reflects an ineffectual attempt to keep other symptoms under control. Some studies also showed that those malingering an illness actually turned out to be ill, when followed over a course of time (Waschspress et al, 1953).

However, such studies are few and contemporary literature has pointed out that the pathogenic model is flawed because it perceives a breakdown between conscious and unconscious psychological defence mechanisms, which is not evident in all cases (Lo Piccolo et al, 1999). Moreover, most of these subjects miraculously recover from their symptoms after termination of litigation. So, currently malingering is not considered to be either a disease or indicative of a disease. However, an overlap between psychopathology and malingering may still occur, and is important to identify (Pollock, 1998).

B) Malingering as an adaptive response (the adaptational concept): This model proposes that malingering represents an adaptation to hostile circumstances. According to this model there are two broad dimensions in malingering i.e. cost-benefit analysis and adversarial setting. Malingeringers perceive the environment in 'adversarial and risky' terms and malingering is seen as a behaviour, which maximizes the chances for success in such a situation (Rogers et al, 1998).

Although this model may account for a small percentage of malingeringers, it has been criticized for its failure to account for those who malingering purely for profit. On the other hand, this model is preferred by some, as it seems to be minimally pejorative (Yates et al, 1998).

C) Criteria based DSM Concept: The DSM concept of malingering is in stark contrast to the other two models. It relies on specific objective criteria for its definition rather than theoretical constructs. Malingering is listed here as an additional condition that may be a focus of clinical attention. It is suggested that malingering should be suspected when there is a medico-legal context of presentation; discrepancy between subjective complaints and objective findings; lack of co-operation during diagnostic evaluation and treatment; and antisocial personality disorder.

The second criteria been suggested as being the most reliable of all four criteria with empirical support. According to one study, discrepancies between subjective complaints and objective findings were absent only in 6.0% of malingeringers and in 74.5% of control subjects (non-malingering, psychiatric inpatients) (Lo Piccolo et al, 1999). The DSM concept of malingering is the most recently proposed one and is widely accepted as being the ultimate among the above concepts. However, Rogers et al (1998) argues that the DSM approach to malingering is an example of a "criminological" model of malingering and that it is vague, binary, unsupported by research, moralistic and should be abandoned.

Malingering may be pure or partial and positive or negative. Pure malingering implies false production of non-existent symptoms while partial malingering implies exaggeration of pre-existing symptoms. Positive malingering implies that the subject is feigning the symptoms of an illness while negative malingering implies that the subject is hiding or misreporting the symptoms. Data tampering, staging of false events, false imputation and misattribution of symptoms are also mentioned as being subtypes of malingering varying in the degree of intentionality, symptom exaggeration and actual impairment (Lipian & Mills, 2000). Staging events means carefully planning, orchestrating and executing events, which might result later in an injury or an explanation for a feigned disability. Data tampering involves altering diagnostic instruments, data or record, so as to influence the results of an examination or test. False imputation involves ascribing actual symptoms to a cause consciously understood to have no relation to the symptoms and misattribution implies ascribing actual symptom to a cause erroneously believed to have given rise to them. It may, however, involve unconscious processes and may not always be a part of malingering.

The assessment of malingering

The difficulties in detecting malingering were aptly demonstrated by Rosenhan's (1973) famous study. Psychiatrists are frequently reluctant to consider the possibility of malingering (Yates et al, 1996). Perhaps, it is because of the ethical and legal implications of labelling a subject as malingeringer. However, in a time when treatment resources are scarce and information about psychiatric illnesses is widely available to

the public, identification of a malingerer may not only save time and money, but make services available to those with legitimate needs.

Three types of research methods have been most commonly used in studying malingering i.e. simulation designs; known-group comparisons and differential prevalence designs (Guriel et al, 2003). Simulation designs consist of an analogue setting in which subjects are offered small incentives to respond to assessment material in a particular manner and their responses are compared to control participants or clinical criterion groups. The results do not have a high degree of generalizability to clinical settings. Known-group comparisons involve comparing the malingerers with actual patients. Although difficult; as it involves identifying the known group; this design offers high generalizability to clinical settings. Differential prevalence designs involve comparison of groups assumed to be different in their response styles.

Malingering should be suspected in situations involving atypical, bizarre or absurd presentation in the context of external motives (Cunnen, 1997); subjects who have been referred from an attorney for evaluation of disability or work compensation; criminal cases related to competency or criminal responsibility; a marked discrepancy between subjective complaints and objective findings; lack of co-operation during diagnostic evaluation and presence of anti-social personality disorder. DSM-IV particularly cautions clinicians and researchers to rule out malingering when issues of compensation apply in order to prevent a false rise in the post traumatic stress disorder database (Rosen, 2006). As there is no single test, which can confirm that a subject is malingering, once it is suspected, a systematic approach incorporating all the clues should be employed.

Following steps may be undertaken:

(1) Obtaining Historical Data

Interview with the patient: This should be long, detailed, gruelling and as early as possible after the event in question. It is difficult for the malingerer to maintain guard for protracted periods of time (Lo Piccolo et al, 1999). The subject may be asked leading questions about a different illness to see how they respond to it. An elaborate 5-step 'Cross Examination Clinical Interview' for suspected malingerers has been given by Othmer and Othmer (2000). These 5 steps are: listen, tag, confront, solve and approve. The first step involves asking open-ended questions and encouraging elaboration, not giving any clues to the suspicion held by the examiner. Tagging implies double-checking the subject's story for accuracy, clarification and identifying rehearsed statements, inconsistencies, excessive details and attitude. In the confrontation phase, the subject's inconsistencies are pointed out by juxtaposing contradictions in a questioning but non-threatening manner. Thereafter, a process of yes or no questioning is initiated and kept up despite resistance by the patient. Finally, disclosure is greeted by approval of the subject's decision to take steps towards recovery. The central emphasis during the whole interview is on maintaining an alliance with the subject while taking the position of an adversary to his lie but not to him.

Interview of Collateral Sources: This may serve to refute or confirm the patient's information or provide additional information (Hall & Pritchard, 2000).

Review of records of prior functioning: Records of prior functioning at the work place may be reviewed to confirm or refute any evidence of claimed disability. Any history of substance abuse, psychiatric illness or antisocial acts will increase the suspicion of malingering.

(2) Observation

Important points need to be noted both during the interview with the subject and across time and situations.

(a) Observation during interview situation

Verbal behaviour, facial expressions and bodily gestures may provide important clues.

Subjects who are lying tend to speak in high-pitched voices; make frequent grammatical errors and also hesitate and pause during interviews more than genuine subjects. Their pauses may be filled with non-informative fillers such as "uh, er. Ah". However, changes in pitch and volume are less reliable indicators of deception (Wiley, 1998). Gestures and facial expression are less apt to be rehearsed since facial muscles are under both voluntary and involuntary control. In addition, false affects are 'deliberate'; 'prolonged' and lack the usual 'crescendo-decrescendo' of natural affects (Othmer & Othmer, 2000). The quality of a false smile also differs from a genuine one as it is asymmetric, usually involving only the lower face (Ekman, 2000). With respect to specific emotions, "anger" & "surprise" can be more readily feigned as compared to the other emotions. The timing of affective display may be either early or late as compared to normal subjects. Some changes associated with emotions viz. "blanching" or "flushing" are difficult to feign for obvious reasons. Body movements are less frequently monitored by a malingerer and are a good source of leakage. In a malingerer, illustrators i.e. gestures that accompany speech are used less frequently; emblems i.e. gestures that communicate a specific meaning in a specific culture, may be discordant with the spoken language, and manipulators i.e. movements involving self-grooming, scratching, pulling, rubbing another body part and use of props viz. a pen, are distinctly prolonged and frequently repeated by the subject (Wiley, 1998).

(b) Observation across time and situations

Observational methods to confirm suspicion of malingering may involve controlled environment observation i.e. clinical observation of behaviours in an in-patient unit and real world surveillance. This is most advantageous when physical disabilities are claimed and involves covert observations and video recordings of the claimant. Due to inherent stress in attempting to maintain deception for 24 hrs a day; there is often a breakdown of the discipline required, thus providing an opportunity for detection of the same.

Psychological Tests

In a quest to ensure objectivity, various psychological tests have been used as an aid to detect malingering. These are not necessary; as none has been found to be definitive⁴, but can be a useful adjunct to support this diagnosis. Research shows varying efficacy, false positive as well as false negative rates (Leng & Parkin, 1995). Coaching of subjects with regard to strategies on avoiding detection viz. avoidance of endorsing bizarre symptoms has been seen to help them and make detection difficult (Baer et al, 1995). Nevertheless, an examiner is likely to detect malingering on these tests because malingerers do not know when to start faking; they fail on simple items but may pass the difficult ones; they have patterns of error different from those with a genuine impairment and cannot gear their responses to the reported level of impairment (Gudjonsson & Shackleton, 1986).

Two instruments are widely utilized for studying malingering. These are Minnesota Multiphasic Personality Inventory (Butcher et al, 1989) and Structured Interview of Reported Symptoms (Rogers et al, 1992). These instruments have been developed with particular attention to the response style of the subjects and this constitutes their strength in detecting fake responses.

MMPI-2 (Minnesota Multiphasic Personality Inventory)

This is a 568-item instrument with 20 primary scales. Some of these have been found to be useful in evaluating the validity of the test-taker's attitude, including any attempts to exaggerate one's symptoms. The triad of a low L scale, a high F scale and a low K scale indicates malingering. A short form of the MMPI-2 has been validated using these scales. The F-scale, called the malingering index, addresses symptoms that are stereotypically associated with serious psychopathology but are rarely found in patients. Fake bad scale (Fb), which is a unique combination of MMPI test items has been investigated specifically for the purpose of identifying faking of physical complaints among personal injury claimants. However, it has not been found to be useful and not recommended for use in clinical settings (Butcher et al, 2003). Malingered depression scale (Md) has 32 items that can detect malingered symptoms of depression. The O-S scale, F-Fb 1scale and Ds2 scales have also been used to identify fake responses. A meta-analysis found that the Ds scale has minimal false positive rates while the Fb has cut-off scores that are most consistent (Rogers et al, 2003). MMPI-2 may even detect malingering by experts (Bagby et al, 2000) and despite the subjects having information about the symptoms of a disorder. Overall, MMPI-2 appears to be helpful but not infallible in identifying malingerers. For example, the scores on F-scale are found to be high among victims of sexual abuse in childhood (Klotz Flitter et al, 2003). Cautious responses (Vigilione et al, 2001), higher intelligence and knowledge of MMPI-2 have been seen to produce more realistic patterns which are difficult to detect (Pelfrey, 2004).

Subjects malingering depression have been reported to be able to evade detection (Walters & Clopton, 2000).

SIRS (Structured Interview of Reported Symptoms)

This structured interview has been tested for its utility in detecting feigning of schizophrenia, mood disorders and post traumatic stress disorder (Rogers et al, 1992). It consists of eight scales and is specifically designed to assess deceptive responding (Rogers, 1997). This interview seems adequate but not perfect in detecting malingerers. It has been seen to misclassify true patients as malingerers (Calhoun et al, 2000).

PAI (Personality Assessment Inventory)

The PAI (Morey, 1991) is another multiscale, objective personality inventory containing clinical, personality and validity scales. It has 344 items with 22 non-overlapping scales. There are six response distortion indicators, all of which have been found to be useful (Morey & Lanier, 1998). It has been termed as moderately effective (Rogers et al, 1996) with discriminant analysis yielding a hit rate above 80% irrespective of the disorder being faked among psychology students with one-week preparation to give fake responses on the test.

SIMS (Structured Inventory of Malingered Symptomatology)

This recently developed instrument (Smith & Burgen, 1997) contains items constructed from combination of revised validity questions from existing instruments and known characteristics of malingerers. It has a high sensitivity for detection of malingerers and superior discriminant validity to the F and K scales of the MMPI. However, it has low specificity with high false positive rates (Edens et al, 1999). Its use as a screening instrument for malingering has been suggested.

Other Scales

M-Test (Beaber et al, 2000); Wildman symptom checklist (Wildman & Wildman, 1999); Trauma Symptom Inventory (Briere, 1995); Mississippi Scale for Combat- Related PTSD (Dalton et al, 1989); Morel Emotional Numbing Test for PTSD (Morel, 1998) have been investigated for the detection of malingered PTSD. However, results have not been encouraging. Thus, psychological testing must be considered as a supportive indicator that can be put up as corroborating evidence to establishing the diagnosis of malingering (Lo Piccolo et al, 1999).

Rorschach Test

Rorschach is a widely utilized projective technique that has also been tested for clinical utility in detection of malingering. However, studies till date are inconclusive about the utility of this test in detecting malingering. In a critical review, Perry and Kinder (1990) reported that no specific malingering pattern has been found across the studies reviewed by them. However, Ganellan et al (1996) reported that malingers give less emotion laden and more dramatic responses on Rorschach. They also recommended the combined use of MMPI-2 and Rorschach as a powerful psychometric technique.

Differential Diagnosis

There are other disorders in psychiatry where a patient might have complaints, which do not seem to have an underlying physical or a clear psychological basis. These need to be carefully excluded before a diagnosis of malingering can be made and at times it becomes difficult to distinguish these disorders because of lack of clear demarcating line. One of the most important differential diagnoses of malingering is factitious disorder. Though, similar to malingering in terms of conscious intentional production of signs and symptoms of a disease, factitious disorder differs from malingering in term of motivation to produce symptoms, which is adoption of the 'sick-role' rather than the attainment of a tangible external gain. Usually, the patient's primary goal is to receive medical, surgical, or psychiatric care to gratify some unconscious psychological needs (Feldman & Ford, 2000). The symptom production in factitious disorder may involve simulation, exaggeration, aggravation or induction of physical or psychological signs and symptoms (Feldman & Ford, 2000). Asher (1951) used the term Munchausen's (Munchausen's) syndrome for the first time to describe the category of patients who chronically use fabricated symptoms to gain hospital admissions. For many years, the terms Munchausen's syndrome and factitious disorder were used interchangeably, but now Munchausen's syndrome is considered to represent the most severe form of the factitious disorder and constitutes only a small percentage of all factitious disorders. Factitious disorders with symptoms of depression (Phillips et al., 1983), bereavement (Snowden et al., 1978), post-traumatic stress disorder (Sparr & Pankratz, 1983), alcohol dependence (Caradoc-Davies G, 1988) and feigned psychosis (Ritson & Forrest, 1970; Cheng & Hummel, 1978; Pope et al, 1982; Grover et al, 2005) have been described. Compared to malingering, patients with factitious disorder would be cooperative for diagnostic evaluation and in complying with the prescribed treatment. Another important aspect of factitious disorders is "Munchausen's by proxy", in which feigning extends beyond the individual to the fabrication/induction of symptoms in another person who is under the individual's care. The perpetrator's motive is to assume the sick role by proxy. However, it is to be remembered that factitious or Munchausen's by proxy should be a diagnosis of exclusion. Somatoform and dissociative disorders are charac-

terized by the presence of somatic complaints or dissociative symptoms that have no demonstrable peripheral organ disorder; psychological disturbances and magnified health concerns not under the conscious control of the patient. In contrast with malingering, these disorders have a distinctive symptom profile and absence of a clear external incentive. In conversion disorder, as in malingering, objective signs cannot account for the subjective experience and differentiation between the two can be very arduous. However, certain factors which may point towards malingering are that malingerers are more likely to be suspicious and uncooperative; they may try to avoid diagnostic evaluations and refuse treatment; they may refuse employment opportunities designed to circumvent their disabilities and are less likely to have historical gaps and inaccuracies in their account. Rather, they may provide detailed descriptions of the events, which reportedly precipitated their symptoms. Further patients with malingering often have associated antisocial traits, like history of acting out, previous lawsuits, difficulty with law enforcement agencies (Wiley, 1998). Observing patients when they think they are not being observed gives a clue to the diagnosis (e.g. the conversion patient with paralysis will remain paralyzed whereas a patient with malingering may move their limbs). However it is also important to remember that some of the patients with somatisation or dissociative disorders are often suspected to be malingerers, not only by their relatives or their workmates, but also by doctors who are not familiar with psychiatric disorders. When such is the case, the clinician should address the relatives and workmates and should try to explain the underlying issues as part of the clinical management of the case.

Apart from the above, malingering of a certain disorder or symptoms might co-exist with another actual disorder, which should not be ignored. Cases of partial malingering, where underlying symptoms are exaggerated also need to be differentiated from cases of pure malingering.

Management

As malingering is not considered to be a diagnosis, management does not imply the kind of measures utilized for the treatment of psychiatric illnesses. Understandably then, there are no known pharmacological or non-pharmacological therapies designed for a malingerer. However, certain guidelines have been suggested for the physician or psychiatrist who is convinced that the subject examined by him is malingering a disorder (Lo Piccolo et al, 1999). Careful and detailed documentation supporting the diagnosis should be done, as the diagnosis of malingering carries with it definitive risks for the clinician. Consultations to other medical specialists should be avoided because such referrals only perpetuate malingering. The patient should not be accused directly of faking an illness as hostility, breakdown of the doctor-patient relationship, lawsuit against the doctor, and, rarely, violence may result. The more advisable approach is to confront the person indirectly by remarking that the objective findings do not meet the physician's objective criteria for diagnosis and the person who is malingering should be

given the opportunity to save face. Despite all this, the subject may still continue to mangle the symptoms and the likelihood of success with such approaches is inversely related to the rewards for the malingering behaviour.

Conclusion

Malingering can best be conceptualized a focus of clinical attention rather than as a psychopathological condition in itself. Although any medical condition may be faked, malingering of psychiatric disorders is perhaps commoner than previously considered and is particularly difficult to detect. Therefore, diagnosis of malingering is difficult and carries with it definitive risks for the clinician. As there is no gold standard investigative tool for malingering, in cases where it is suspected, a systematic approach with inputs from multiple sources is a useful means to confirm this condition. Given the considerable cost of malingering to society, it is vital that mental health professionals pay due attention to the presence of this condition and if required, remain equipped to deal with the same.

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