

Detection and Management of Malingering in a Clinical Setting

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Focus Points

- Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms.
- Malingering differs from somatoform disorder in its intentionality of symptom generation, and is similar in terms of external incentive.
- Malingering is similar to factitious disorder in its intentionality of symptom production, but differs in that in factitious disorder there is no palpable external reward.
- Malingering is a diagnosis of exclusion. The patient must be thoroughly evaluated by taking detailed history, mental status examination, relevant laboratory investigations and, if necessary, psychometric evaluations.
- Malingering may coexist with genuine psychosocial problems.
- When a patient is found to be a malingerer, clinicians should tactfully and nonjudgmentally present inconsistencies to the patient and offer a face-saving way out of the interaction.

Abstract

Malingering is the deliberate production of false, (or gross exaggeration of), physical or psychologic symptoms for a known external reward. It is not considered a form of mental illness or psychopathology, although it can occur in the context of other mental illnesses. Even though it is easy to define, clinicians still find making the diagnosis very challenging. Although clinicians face malingered symptoms regularly in the emergency room and on the general psychiatric wards, they are most likely reluctant to diagnose it for fear of being sued or so as not to stigmatize the patient. Identifying a malingerer will help focus resources toward patients with genuine symptoms. However, there is the perception by the typical patient who exhibits symptoms suggestive of malingering that he or she is being called a liar. This review presents two case scenarios and discusses how clinicians can diagnose malingering as well as the tactical approach towards its management.

Introduction

[AU: PLEASE PROVIDE A SHORT INTRODUCTION]

Case Scenario 1

Ms. X is a 35-year-old African American woman with a history of Graves' disease and migraine. She was admitted to the psychiatric unit as a result of a possible suicide attempt via medication overdose. However, when interviewed, the patient denied deliberate overdose. She denied depressive or psychotic symptoms. She eagerly reminded the clinical team that she was an attorney, and that her adopted father was a physician, hence she knew about medico-legal cases and how doctors withhold vital treatments from the patients. Self-reported medications on admission included trimethobenzamide hydrochloride for diarrhea, propranolol for tremors and anxiety, morphine for her migraine, and **Tiptazole** **[AU: IS THIS A NEW DRUG? CANNOT FIND REFERENCE TO IT. PLEASE CHECK THAT YOU HAVE CORRECT SPELLING]** for the hyperthyroidism. Ms. X denied any past psychiatric and substance abuse history. She had no knowledge of her biological parents and she is unmarried with no children. Mental status examination revealed a disheveled lady without psychomotor agitation or retardation. Her speech

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was normal in rate but low in tone and volume. She described her mood as "fine." Her affect was reactive, and her thought process was logical and goal directed. There were no depressive or psychotic cognitions in the thought content. Ms. X also denied suicide or homicide ideas or any perceptual abnormalities. She was cognitively intact, and her insight and judgment were deemed to be fair. Pertinent physical examinations revealed a pulse rate of 124, blood pressure of 155/95, exophthalmos, and thyroid enlargement.

The clinical team made an axis I diagnosis of anxiety disorder secondary to Graves' disease and migraine. While in the hospital, Ms. X demanded to be served food almost every hour because of a hypermetabolic state. She frequently requested for her medications, and especially morphine which she said she needed for her migraine. With her consent, the clinical team contacted her brother, who confirmed that she needed high dose of morphine and that she has had multiple previous psychiatric hospitalizations for similar presentations. Liaison work to Ms. X's endocrinologist, however, revealed that she has a drug-seeking behavior, and has always refused adequate control of her thyrotoxicosis in order to seek benzodiazepines and morphine. The clinical team became more vigilant. The nursing staff noticed that when given the medications, Ms. X would separate morphine from the others. Her urine drug screen result returned as positive for benzodiazepines but not morphine, which she claimed to have used the day prior to admission. After a steady state, morphine should stay in the system for several days and should still be detectable in the urine after 24 hours of intake. This reflected an inconsistency in her story. The clinical team concluded that even though Ms. X has hyperthyroidism and migraine, she deliberately refused proper control of these and also exaggerated her headache and anxiety in order to obtain benzodiazepines and morphine. She was tactfully confronted about this and was told that the morphine would be tapered off, after which the patient discharged herself.

Case Scenario 2

Ms. Y was a 48-year-old illegal immigrant who was transferred from the

immigration detention center to the psychiatric inpatient unit after complaining of depression and suicidal thoughts. These started a few days after she learned that the UK Immigration adjudicator ruled that she should be deported. Along with the depressed mood, she also complained of poor sleep, appetite, and loss of enjoyment in life. History revealed that the patient had never had any psychiatric hospitalizations in the past. There was no significant medical history. There was no family history of psychiatric illness. Physical examination was normal. Mental status examination revealed a middle-aged woman who was calm and cooperative despite her reported level of distress. Her speech was normal, and even though she subjectively reported depression, her objective affect was euthymic. She admitted to suicidal thoughts with plans to jump into "the river." She also had command auditory hallucination telling her to "jump into the river," if she was deported. She was uncertain whether the voices belonged to males or females. She endorsed the interviewer's suggestion that the voices may take on a life of their own and give her headaches and body aches. The voices also bothered her during sleep. Apart from the voices, there were no other psychotic features. Due to her immigration status, the clinical team could not obtain any collateral information from any family member. The patient was placed on suicide watch pending diagnostic clarification and certitude. She was also placed under discreet clinical observations in a variety of settings. Over the subsequent days, it was noticed that contrary to the patient's subjective complaint, she was usually the first in line for food. She was sleeping well and was fully interactive and energetic as observed by her participation in all the ward based activities and games. She also informed the other patients that she was told at the immigration detention center that no airline will carry a mentally ill patient, hence the unlikelihood that she would be deported. After a week, it was quite clear that patient was deliberately malingering depressive symptoms in order to avoid deportation. The avoidance of deportation served as the secondary gain. Based on this, the clinical team gently confronted the patient that her reported symptoms were not

consistent with clinical observation. She was urged to tell the full story. Thereafter, she confessed to trying to avoid deportation and asked for further immigration options. She was referred to the hospital social worker that would provide her with legal options. She was not commenced on any psychotropic medications.

Clinical Review

Based on the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition-Revised (*DSM-IV-TR*)¹ malingering is the intentional production of false or grossly exaggerated physical or psychologic symptoms. It can be further differentiated into "pure malingering" (for a disorder that does not exist at all), "partial malingering" (for exaggeration of existing symptoms), or "false imputation" (when symptoms are attributed to a totally unrelated etiology).^{2,3} Table 1 summarizes the setting that should arouse the suspicion of malingering. Table 2 gives examples of possible external gains, which include but are not limited to avoidance of military duty, avoidance of work, criminal prosecution, getting financial compensation, or obtaining drugs. The diagnosis of malingering is stigmatizing, and some harsh terms have been used in cross-section of literature and notable medical textbooks. These terms include "dubious," "fraudulent," "voluntary," or "clinical lying."^{4,5,6} It may be difficult to differentiate malingering from somatoform disorders, and there should always be a full physical (including thorough neurologic) examination before making the diagnosis.

In 1973, Rosenhan⁷ carried out an interesting study on simulated psychosis. Eight volunteers, including a psychology student, three psychologists, a pediatrician, a psychiatrist, a painter, and a housewife, became pseudo-patients and gained admission to psychiatric hospitals by claiming that they were "hearing voices." The voices were stopped on admission. Each of these pseudo-patients was diagnosed as schizophrenic with a hospital stay of 7–52 days. Based on this, Rosenhan concluded that "we cannot distinguish sane from insane in psychiatric hospitals." He was largely criticized, one of the strongest criticisms provided by Spitzer,⁸ who claimed it unsurprising that psychiatrists fail to diagnose pseu-

do-patients when they are not looking for them.

In nonforensic settings, malingered conditions are more likely to include dissociative identity disorder, psychosis, suicidality, posttraumatic stress disorder (PTSD), amnesia, acute dystonias, and sleep disorders, whereas in forensic settings, malingered conditions are more likely to include malingered PTSD, malingered amnesia, and malingered cognitive deficits.² General psychiatrists are usually reluctant to make the diagnosis, as it portrays the patient as a liar and may damage the therapeutic relationship.¹⁰ These psychiatrists are also wary of being sued in this era of medical malpractice claims.¹¹ Forensic psychiatrists, on the other hand, work from the premise that many examinees cherish covert goals called "secondary gain."⁶ Even though it is a form of abnormal illness behavior put on by the patient in order to achieve external gains, it may still coexist with genuine physical or mental illness. For example, a patient with chronic schizophrenia may malingering suicide ideation in order to seek hospital admission.¹⁰

Epidemiology

While the exact prevalence is unknown, studies have shown that malingering may be more common in some specific settings, such as the military, prison, factories, or criminal prosecutions.⁵ It can occur at any age and has been reported in a child as young as 9 years of age.¹² Yates and colleagues¹¹ found that 13% of emergency room attendees feigned illness, and that their suspected secondary gains includ-

ed food, shelter, medications, financial gains, and avoidance of jail, work, or family responsibilities. Some studies have reported malingering in 10% to 12% of psychiatric inpatients.¹³ Thirty-two percent of referrals to a medium secure forensic unit could be classified as fabricating or exaggerating symptoms of mental illness.¹⁴

Clinical Features

Clinicians should be strongly suspicious of malingering whenever there is a marked discrepancy or symptom inconsistency between subjective complaints and objective findings. For example, a depressed patient who complains of poor appetite and sleep may be discreetly observed to always finish his meal, have the desserts, sleep soundly, and interact appropriately with others. Clinicians should also look out for bizarre presentation in the presence of external incentives, like seeking prescription drugs.¹⁵ Another example of bizarre or unusual presentation is when someone hears voices while asleep or hears voices continuously rather than intermittently. Further signs of malingering include circumstances where there is lack of cooperation during evaluation, medico-legal context, and antisocial personality disorder, or when patients complain bitterly and describe the distress they are facing with their symptoms.

Malingering may present as a mental fog during commitment of a crime, and vigilant clinician may notice a lack of consistency between a patient's verbal complaint and physical observations. Just as in hysteria, malingering may

reflect the patient's perception of psychopathology. Clinically, malingering may be detected if emphasis is placed on forms as well as the contents of psychopathology. The form of a psychic experience is the description of the experience in phenomenologic terms. For example, while the content of an auditory hallucination might be "you are worthless," the form would be in terms of clarity of the voice and its location within the head or in external space. While it may be easier for a malingerer to fake the "content" of psychotic experiences, without direct questioning by the examiner it would be much more difficult to feign the "form" of such psychotic experience. Taking cognizance of the form would also allow the clinician to be able to contrast the egodytonic auditory hallucination in schizophrenia from the egosyntonic auditory hallucination in mood disorder. Malingers also volunteer more visual hallucinations than the genuinely psychotic patients.¹⁶ The behavior of someone with malingered psychosis may not conform to the content of his delusion. Stutts and colleagues¹⁷ reported a case of pediatric condition falsification referred to as malingering by proxy. Unlike factitious disorder by proxy, which occurs without external motivation, the child was made to feign an immobile upper extremity for the purpose of a legal settlement. Malingering by animal proxy¹⁸ has also been described, whereby pet owners were strongly suspected or confirmed to have been engaging in malingering to obtain controlled medications for their personal use. These cases bear a striking resemblance to malingering in the general medical setting for drugs to abuse.

Making a Diagnosis

No studies have given consistent result, and clinicians should mostly use open-ended questions. Inquiries should be phrased without giving clues, and the more prolonged the interview the more difficult it is for the malingerer to maintain a counterfeit account.²⁰ Table 3 gives some pointers to malingering during history taking and mental state examination. Because malingers are unaware of detailed psychopathology, the symptoms they describe often appear too "mad" or too exaggerated. Someone malingering schizophrenia

Table 1
Possible Settings that Should Arouse Suspicion of Malingering

Suspect malingering if there is:

- Lack of cooperation with diagnostic evaluation and lack of compliance with prescribed treatment regimen
- Presentation within a medico-legal context
- Palpable external gain like avoidance of military duty, financial compensation, etc.
- Presence of antisocial personality disorder
- Drug seeking behavior

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Table 2
Possible External Gains¹⁹

- Food
- Shelter, especially during winter periods
- Narcotic medications
- Financial gain in the context of compensation, social security benefit
- Avoidance of jail, work, military, or family responsibility
- Damages for alleged psychological injury
- Transfer to psychiatric hospital to avoid arrest
- Criminal setting to avoid standing trial or to mitigate sentence

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may claim global confusion under the impression that mentally disordered individuals appear confused. They are more often flamboyant in the description of their symptoms, unlike schizophrenics who may be reluctant to share odd or bizarre experiences. In malingers, symptoms are presented early and they add other things to it as the interview progresses, especially when closed question format is used. Malingers are easily suggestible and can be induced to add contradictory or absurd symptoms to their story. If you ask questions about improbable symptoms, they are likely to be endorsed. For example, a malingeringer may answer affirmatively to this question: "Do you sometimes see these voices, as they enter mostly through the right ear and twist in the brain and spread through the whole of your body?" A malingeringer may also attempt to provide an answer to an absurd question like "Why do helicopters eat their young?", whereas a genuinely ill person may point out the absurdity. Note however, that some successful malingers may not endorse bizarre symptoms or give

answers to absurd questions.²¹

Examiners' perceived ability in their skill to detect malingering may bear no relationship with their actual ability.²² Thus, it is important for clinicians to be aware of the characteristics of genuine psychiatric symptoms as this would be relevant when they are compared to malingered symptoms. Taking the suspicion of malingered auditory hallucination as an example, clinicians should, in an open-ended way, gear the questions towards the content, clarity, and location of the voices, ie, do the voice originate in the head or in external space? Genuine auditory hallucinations are usually clear, intermittent, outside the head, and associated with delusions.²³ Additionally, when auditory hallucination is of the command type, patients do not always obey the voices as they know that doing so may be dangerous.²⁴ Malingered "voices," on the other hand, usually occur continuously rather than intermittent, and within the head rather than from the external space.²⁵ They may also be in stilted language and there are usually no efforts by the patients to ameliorate it.²³ Genuine visual hallucinations are of normal sized people, seen in color, and do not typically change whether or not the eyes are closed.²⁵ This should be contrasted with malingered visual hallucinations which usually occur in black and white and may be the only schizophrenic symptom.²³ Malingered visual hallucination may also be in the form of bizarre elements like aliens, space ships, and winged dogs.

Since malingering is a diagnosis of exclusion, clinicians should be wary of labeling a patient as a malingeringer when the patient might actually have a genuine complaint, especially if the patient is from a different subculture. Witzum and colleagues²⁶ described the difficulties in diagnosing individuals from different cultures as malingers. During 1 year, 24 inductees diagnosed as malingers by several army psychiatrists were reexamined by the authors of the article and subsequently re-diagnosed as psychotic, suffering from a personality disorder, or mentally retarded. In a case report by Thimineur and colleagues,²⁷ a patient on worker's compensation was repeatedly identified as a malingeringer by six different physicians who had evaluated her for chronic complaints. Ultimately,

she was found to have a lesion that explained all of her subjective complaints. Malingering should not be confused with somatoform disorders. In somatoform disorders, symptoms are unconsciously generated, whereas there is conscious generation or exaggeration of symptoms in typical of malingering. Both, however, do this for palpable external gains. Malingering should also be differentiated from factitious disorder (in which the motive is not external gain but rather a desire to occupy a sick role).

For example, in Munchausen's syndrome (a factitious disorder), the secondary gain is receiving the medical treatment itself, ie, being placed in a sick role. Affected patients go to extreme lengths to produce clinically convincing physical and laboratory signs of disease. Occasionally, patients with Munchausen's syndrome inject their knees to produce swelling and may ingest agents to distort their laboratory findings. Conscious generation of symptoms unifies malingering and factitious disorder whereas the discriminating factor is either the presence of a palpable external gain (malingering) or just the desire to fulfill a sick role (factitious disorder). (Figure)

Investigations

Clinicians should take a full history, mental status, and detailed physical (including neurologic) examination. History taking is best achieved with open-ended questions whereby symptoms may be found to be vague, ill-defined, and overexaggerated. They may not conform to identifiable or known clinical conditions. Mental state examination may reveal inconsistent symptoms, which negates established phenomenologic standards. (Table 3)

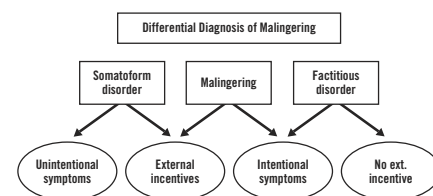
Since the complaints in malingers

Table 3
Pointers to a Malingeringer During History and Mental State Examination^{2,9,23}

- Exaggerated story
- Flamboyant presentation
- Incongruity between a patient's claimed distress and objective findings
- Vague answers to questions when the answers should be clear but when the patient is unsure which of the answers would signify psychopathology
- Easy suggestibility and induction to add absurd or bizarre elements to the story
- Non-conformity with orthodox psychopathologic experiences, eg, continuous rather than intermittent hallucination
- Lack of knowledge about whether extraneous events like sleep or noise could affect symptoms, eg, voices that persist even during sleep
- Tendency to favor command hallucinations, which in the forensic setting may be exculpatory, or in the emergency room may facilitate hospitalization.
- Hostility and intimidation of the clinician, especially when the clinician displays obvious skepticism

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Figure
Differential Diagnosis of Malingering



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can rarely be sustained continuously, observation by healthcare professionals, especially the nurses, is essential. Vital signs, sleep log, appetite, as well as the interaction with staff and other patients on the ward may be revealing. Observation may also reveal drug-seeking behavior, lack of cooperation with treatment plans, etc. It is also essential to conduct psychosocial investigations, collecting collateral information from relatives, and past records from primary care physicians, psychiatrists, and case managers. Physical investigations, including full blood count, blood biochemistry, urine drug screen, electrocardiograph, and electroencephalograph, may also be revealing.

In routine ward-based evaluations, malingering is mostly diagnosed with the aid of clinical history, mental state examination, physical and neurological examination, appropriate investigations, collateral information, discreet observation of the patient during the assessment period, and repeated clarification of inconsistencies.

In medico-legal settings, however, psychometric evaluations may provide a more objective measure of inconsistencies in a patient's presentation. These psychometric evaluations include validity scales that enable the evaluator to determine tendencies like exaggeration, defensiveness, untruthfulness, consistency in responding over time, and tendency to excessively respond in either positive (true) or negative (false) manner.⁹ These psychometric evaluations are based on the idea that individuals who malingering, in an attempt to magnify symptoms, will perform less adequately than predicted on a simple measure of cognitive functioning. A variety of tests are actually objective tests of cognition that could detect inadequate effort or exaggeration. Specific examples of useful psychometric tests are as follows:

Minnesota Multiphasic Personality Inventory

The largest body of research on detection of feigning using self-report inventories has focused on the Minnesota Multiphasic Personality Inventory (MMPI) and its successor, the MMPI-2. Meta-analyses on the detection of feigned symptoms have indicated that validity scales from the

MMPI and the MMPI-2 are quite sensitive to "faking bad" at the group level.²⁸ Bagby and colleagues²⁹ found that the Backpage Infrequency subscale was optimal for identifying feigned depression and that the infrequency and infrequency psychopathology subscales were superior for detecting feigned schizophrenia. Some studies further found that the optimal scales for detection of faking are the dissimulation subscales.³⁰ A specialized validity scale on MMPI-2, referred to as the malingered depression scale, consists of 32 items that detected malingered symptoms of depression.³¹ Elhai and colleagues³² compared 64 adult PTSD outpatients at a child sexual abuse survivor treatment program with 85 adult college students instructed and trained to malingering PTSD. They found that MMPI-2 contains indices that adequately predicted malingering with strong cross-validation. Bagby and colleagues³³ further found that trained mental health experts are unable to feign major depressive disorder successfully on the MMPI-2.

Structured Interview of Reported Symptoms

The Structured Interview of Reported Symptoms (SIRS) consists of 172 items organized along a number of scales. It permits symptom phenomena to be judged as exaggerated, over-reported, atypical, or absurd. It demonstrated solid sensitivity and specificity.³⁴ In 1992, Rogers and colleague³⁵ tested the effectiveness of the SIRS to detect feigning of three diagnostic groupings, schizophrenia, mood disorders, and PTSD, on 45 psychologically knowledgeable correctional residents. They found that the SIRS maintained its powers of discrimination with respect to clinical samples. There is an abbreviated version adapted as a screening measure of malingering in a correctional setting.³⁶

Miller Forensic Assessment of Symptoms Test

The Miller Forensic Assessment of Symptoms Test (M-FAST) was developed as a brief, reliable, and valid screen for malingered mental illness. In 2004, Miller examined the initial validity of the M-FAST in a sample of 50 criminal defendants found incompetent to stand trial because of a men-

tal illness. The M-FAST total score and items were compared with the SIRS and the fake-bad indicators of the MMPI-2. Results indicated good evidence of construct and criterion validity as well as high correlations between the M-FAST, SIRS, and the fake-bad indices on the MMPI-2.

The Victoria Symptom Validity Test

The Victoria Symptom Validity Test (VSVT) is computerized and consists of 48 trials, subdivided into 3 blocks of 16 trials apiece. Each block contains 8 "easy" and 8 "difficult" items. The VSVT analysis provides details of the total errors, errors on easy versus difficult items, and reaction times on easy versus difficult items. The test requires approximately 15 minutes to administer. The computer program performs all relevant calculations, determines the relationship of this performance to chance levels, and organizes this information into a printed report.

Personality Inventory for Youth

The Personality Inventory for Youth (PIY) has four validity scales, namely, the validity scale, made up of six highly improbable statements; inconsistency scale, consisting of pairs of highly correlated statements; dissimulation scale, which would expose intentional distortion; and defensiveness scale, an extension of the Lie scale of the parent-report Personality Inventory for Children. This inventory could point towards minimization, malingering, and random response sets on the PIY validity scales.

Structured Inventory of Malingered Symptomatology

The Structured Inventory of Malingered Symptomatology (SIMS) was introduced in 1997 to evaluate feigned symptoms. It is a brief self-report inventory written at a 5th-grade reading level to identify feigning of specific conditions. Although it has demonstrated adequate test-retest reliability, internal consistency, and high accuracy in terms of detecting malingered symptoms, a major limitation is that it has not been systematically validated in forensic settings. It was found to strongly detect manipulative and antisocial personality features.⁴¹

Test of Memory Malingering⁴²

The Test of Memory Malingering (TOMM) is a well-validated and widely used forced-choice symptom validity test. It consists of 50 “targets” (line drawings of common objects), which are presented individually from a stimulus booklet or on the computer screen, followed by a 50-item forced-choice recognition trial. This is further followed by a second learning, and then a second recognition trial. Correct identification of 45 or more targets on both trials 1 and 2, indicates that the patient is unlikely to be malingering. The TOMM has proven success in identifying poor effort level or malingering, and have been shown to be remarkably unaffected by variables like mental disorders, language disorders, dementia, or mild intellectual impairment. The TOMM has also been validated in the forensic psychiatric population with excellent specificity and modest sensitivity.⁴³

Rey Auditory Verbal Learning Test⁴⁴

The Rey Auditory Verbal Learning Test was employed by Powell and colleagues⁴⁵ in 2004, in an effort to detect symptom exaggeration. They used the concept of serial position patterns during word recall, as an indicator of poor effort. The better quality of recall for early (primacy) and recent (recency) material defines what is termed the serial position effect. The serial position effect was then examined in four groups: normal controls, symptom-coached simulators, test-coached simulators, and a group of moderate to severe sub-acute traumatic brain injury (TBI) patients. The result showed that normal control participants and TBI patients demonstrated the expected serial position effect, while the simulators clearly suppressed the primacy effect. The authors concluded that the test might not be sensitive or specific enough to be used independently to detect sub-optimal efforts, especially in clients with sophisticated styles of exaggeration.

Wisconsin Card Sorting Test⁴⁶

The Wisconsin Card Sorting Test (WCST) is a concept-identification task designed to measure abstraction and planning abilities, as well as the tendency to perseverate to a given response pattern. The current WCST

consists of four stimulus cards and 128 response cards. The task is to sort the response cards according to color, form, and number. The examiner is allowed to give only positive or negative feedback after the examinee places each response card beneath one of the stimulus cards. On the basis of this information, the participant must derive the correct sorting principle. After 10 consecutive, correctly sorted cards, the sorting category changes without warning from color, to form, to number, and then to each category again in the same order. Measures of performance on the WCST have been shown to be sensitive both to brain damage as well as to increased age.⁴⁷ A study⁴⁸ was carried out in 1999 using the WCST to detect malingering in student simulator and patient samples. Logistic regression analysis of the number of categories and failure to maintain set distinguished malingering and normal undergraduates with 70.7% sensitivity, and 87.1% specificity.

Unlike the observable external gratification that motivates a malingerer, patients with factitious disorder, especially Munchausen’s syndrome (Table 4), has the need to fulfill nonobservable intrapsychic needs. Simply put, factitious disorder patients just want to maintain a sick role. As such, patients with factitious disorder go to extreme lengths to produce clinically convincing physical and laboratory signs of disease. They may inject their knees to produce swelling or ingest agents to distort their laboratory findings. With regards to somatoform disorder, they differ from malingering in that even though both are motivated by external gains, symptoms production in somatoform disorder are unconscious. According to literature, suggestions or hypnosis do not influence the symptoms in malingering unlike in conversion disorder.⁵

Comorbid Disorders

Common comorbid disorders in patients who malingering include personality disorders, schizophrenia, and substance abuse and dependence. Of the personality disorders, the antisocial and borderline varieties often appear comorbid with malingering. Clinicians should be on the lookout for hostility, criminality, manipulation and substance abuse. In the case of schizo-

phrenia, diagnosis may be made by the history of delusions, hallucinations, and thought disorder.

Management

There is no specific treatment for malingering other than a tactful and empathic approach. However, any underlying psychiatric or medical dis-

Table 4
Differential Diagnosis

- Factitious disorder: Symptom production is intentional and the basic motivation is to assume a sick role rather than a palpable external gain. Examples⁴⁹ include:
 - Munchausen’s syndrome (intentionally seeking multiple hospital admission for no external gain)
 - Munchausen’s by proxy (intentionally inducing illness in another for no palpable external gain)
 - Laparotimophilia migrans (intentional multiple hospital admissions looking for laparotomy)
 - Cardiopathia fantastica (false heart attacks)
 - Hemorrhagica histrionica (presents with deliberate alarming bleeding)
 - Neurologica diabolica (curious fits)
 - Factitious homicidal ideation⁵⁰ (feigning of homicidal intent in order to remain in a sick role.)
 - Factitious hemoptysis^{51,52}
- Somatoform and Conversion disorder: Symptom production is not intentional even though external gain may be apparent. Symptom relief may be obtained by suggestion or hypnosis
- Ganser syndrome: This term is used to describe any behavior, which simulates psychosis or dementia. Described by Ganser⁵³ in 1898 among three prisoners awaiting execution, it was mainly characterized by giving approximate or absurd answers to questions, which are straightforward. In 1979, Enoch and Trethowan⁵⁴ further described it, as having four main features: the use of approximate answers, (hence responding to simple questions with absurdly incorrect answer), clouding of consciousness, somatic conversion features, and sometimes pseudo-hallucinations. There has been considerable argument whether the condition is primarily dissociative or organic, or a variant of malingering.⁵⁵

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order should be addressed. Patients should not be labeled as a liar. Rather, it should be documented in the chart as inconsistencies that needed to be clarified with the patient. In terms of appropriate documentation, it could be framed thus: "Detailed evaluation could not find a clear underlying psycho-physiologic cause for the patient's symptoms. The clinical team will discuss with the patient to clarify these inconsistencies.." This approach is important because as mentioned earlier, malingering may coexist with genuine psychosocial problems. The process of empathic clarification may unravel that a female patient, attempting to escape from a physically abusive husband, is trying to ensure hospitalization by mixing genuine and malingered symptoms. Empathy and tactical approach may make such patients give up the feigned symptoms in response to treatment. Similarly, physicians need to remember that patients may actually have other psychiatric disorders which they may not bring to attention due to poor expression, cultural differences, or language barrier. Where possible, an interpreter should be utilized and a referral made for appropriate interventions, such as drug and alcohol counseling or individual therapy, depending on the unraveled comorbidity.

Conclusion

In various settings, clinicians will encounter patients who feign or exaggerate symptoms, especially when there is a demonstrable external incentive. Despite this, the authors of this article are hesitant to make such diagnoses of malingering, most likely because of the need to be viewed as clinicians as opposed to as police detectives. However, since it is important for resources to be focused on genuine presentations, clinicians should be aware of this possibility and be competent enough to identify a malingerer. To acquire such competence, clinicians should be conversant with basic psychopathologic concepts. It is also crucial for psychiatrists to be able to explore forms as well as content of symptoms. While there are batteries of neuropsychologic instruments specific enough to make a diagnosis of malingering, clinicians must not forget that malingering could coexist with genu-

ine psychiatric illnesses. Based on this, when a patient malingeres suicidality, they should be given the benefit of doubt pending clinical observations. When the diagnosis is clear, clinicians should avoid blatantly calling the patient a liar.² Rather, clinicians should tactfully and nonjudgmentally present inconsistencies to the patient and offer a face-saving way out of the interaction. **PP**

References

1. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed rev. Washington, DC: American Psychiatric Association; 2000.
2. Thompson J, LeBourgeois III H, Black F. Malingering. In: Simon RI, Gold LH, eds. *The American Psychiatric Publishing Textbook of Forensic Psychiatry: The Clinician's Guide*. Washington, DC: American Psychiatric Association; 2004:427-448.
3. Resnick PJ. Malingering of posttraumatic stress disorder. In: *Clinical Assessment of Malingering and Deception*. 2nd ed. Rogers R, ed. New York, NY: Guilford Press; 1997:130-152
4. Gelder M, Gath D, Mayou R, Cowen P. *Oxford Textbook of Psychiatry*. 3rd ed. New York, NY: Oxford University Press; 1998.
5. Sadock BJ, Sadock VA, eds. *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry*. 9th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2003.
6. Gutheil TG, Appelbaum PS. *Clinical Handbook of Psychiatry and the Law*. 3rd ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2000.
7. Rosenhan DL. On being sane in insane places. *Science*. 1973;179(70):250-258.
8. Spitzer RL. On pseudoscience in science, logic in remission, and psychiatric diagnosis: a critique of Rosenhan's "On being sane in insane places". *J Abnorm Psychol*. 1975;84(5):442-52.
9. Gunn J, Taylor P. *Forensic Psychiatry: Clinical, Legal and Ethical Issues*. Oxford, England: Butterworth-Heinemann; 1998.
10. **Harris MR, Resnick PJ. Suspected Malingering: Guidelines for Clinicians. *Psychiatric Times*. 2003;20(13):68-71. [AU: I COULD NOT FIND THIS REFERENCE IN THE DECEMBER 2003 ISSUE. DO YOU HAVE THE EXACT VOLUME AND ISSUE NUMBERS?]**
11. Yates BD, Nordquist CR, Schultz-Ross RA. Feigned psychiatric symptoms in the emergency room. *Psychiatr Serv*. 1996;47(9):998-1000.
12. Lu PH, Boone KB. Suspect cognitive symptoms in a 9-year-old child: malingering by proxy? *Clin Neuropsychol*. 2002;16(1):90-96.
13. Rissmiller DA, Steer RA, Friedman M, DeMercurio R. Prevalence of malingering in suicidal psychiatric inpatients: a replication. *Psychol Rep*. 1999;84(3 Pt 1):726-730.
14. Pollock PH, Quigley B, Worley KO, Bashford C. Feigned mental disorder in prisoners referred to forensic mental health services. *J Psychiatr Ment Health Nurs*. 1997;4(1):9-15.
15. Cunien AJ. Psychiatric and medical syndromes associated with deception: In *Clinical Assessment of Malingering and Deception*. 2nd ed. Rogers R, ed. New York, Guilford Press 1997
16. **Cornell DG, Hawk GL. Clinical presentations of malingerers diagnosed by experienced forensic psychologist. *Law Hum Behav*. 13:375-383. [AU: I COULD NOT FIND THIS REFERENCE. PLEASE VERIFY AND SUPPLY YEAR AND ISSUE NUMBER]**
17. Stutts JT, Hickey SE, Kasdan ML. Malingering

- by proxy: a form of pediatric condition falsification. *J Dev Behav Pediatr*. 2003;24(4):276-278.
18. LeBourgeois HW 3rd, Foreman TA, Thompson JW Jr. Novel cases: malingering by animal proxy. *J Am Acad Psychiatry Law*. 2002;30(4):520-524.
 19. Resnick PJ. The detection of malingered psychosis. *Psychiatr Clin North Am*. 1999;22(1):159-172.
 20. Anderson EW, Trethowan WH, Kenna JC. An experimental investigation of simulation and pseudo-dementia. *Acta Psychiatr Scand*. 1959;34(suppl 132):1-42.
 21. Edens JF, Buffington JK, Otto RK, Buffington JK, Tomicic TL, Poythress NG. Factors differentiating successful versus unsuccessful malingerers. *J Pers Assess*. 2001;77(2):333-338.
 22. Ekman P. *Telling Lies: Clues to Deceit in the Marketplace, Politics, and Marriage*. New York, NY: Norton; 1985
 23. Resnick PJ, Knoll J. Faking it. How to detect malingered psychosis. *Current Psychiatry*. 2005;4(11):13-25.
 24. Kasper ME, Rogers R, Adams PA. Dangerous and command hallucinations: an investigation of psychotic inpatients. *Bull Am Acad Psychiatry Law*. 1996;24(2):219-224.
 25. Goodwin DW, Alderson P, Rosenthal R. Clinical significance of hallucinations in psychiatric disorders. A study of 116 hallucinatory patients. *Arch Gen Psychiatry*. 1971;24(1):76-80.
 26. Witztum E, Grinshpoon A, Margolin J, Kron S. The erroneous diagnosis of malingering in a military setting. *Mil Med*. 1996;161(4):225-229.
 27. Thimineur M, Kaliszewski T, Sood P. Malingering and symptom magnification: a case report illustrating the limitations of clinical judgment. *Conn Med*. 2000;64(7):399-401.
 28. Berry DT, Baer RA, Harris MJ. Detection of malingering on the MMPI: A meta-analytic review. *Clin Psychol Rev*. 1991;11:585-598.
 29. Bagby RM, Rogers R, Buis T, et al. Detecting feigned depression and schizophrenia on the MMPI-2. *J Pers Assess*. 1997;68(3):650-664.
 30. Berry DT, Cimino CR, Chong NK, LaVelle SN, Ho IK, Morse TL, Thacker SR. MMPI-2 fake-bad scales: an attempted cross-validation of proposed cutting scores for outpatients. *J Pers Assess*. 2001;76(2):296-314.
 31. Steffan JS, Clopton JR, Morgan RD. An MMPI-2 scale to detect malingered depression (Md scale). *Assessment*. 10(4):382-392.
 32. Elhai JD, Gold SN, Sellers AH, Dorfman WI. The detection of malingered posttraumatic stress disorder with MMPI-2 fake bad indices. *Assessment*. 2001;8(2):221-236.
 33. Bagby RM, Nicholson RA, Buis T, Bacchiochi JR. Can the MMPI-2 validity scales detect depression feigned by experts? *Assessment*. 2000;7(1): 55-62.
 34. Rogers R. Structured interviews and dissimulation. In: Rogers R, ed. *Clinical Assessment of Malingering and Deception*. 2nd ed. New York, NY: Guilford Press; 1997.
 35. Rogers R, Kropp PR, Bagby RM, Dickens SE. Faking specific disorders: a study of the Structured Interview of Reported Symptoms (SIRS). *J Clin Psychol*. 1992;48(5):643-648.
 36. Norris MP, May MC. Screening for malingering in a correctional setting. *Law Hum Behav*. 1998;22(3):315-323.
 37. Miller HA. Examining the use of the M-FAST with criminal defendants incompetent to stand trial. *Int J Offender Ther Comp Criminol*. 2004;48(3):268-280.
 38. Thompson G. Victoria Symptom Validity Test: an enhanced test of symptom validity. *J Forensic Neuropsychol*. 2002;2:43-67.
 39. Wrobel TA, Lachar D, Wrobel NH, Morgan ST, Gruber CP. Performance of the Personality

- Inventory for Youth validity scales. *Assessment*. 1999;6(4):367-380.
40. Smith GP, Burger GK. Detection of malingering: Validation of the Structured Inventory of Malingered Symptomatology (SIMS). *J Am Acad Psychiatry Law*. 1997;25(2):183-189.
 41. Cima M, Hollnack S, Kremer K, et al. The German version of the Structured Inventory of Malingered Symptomatology: SIMS. *Nervenarzt*. 2003;74(11):977-986.
 42. Tombaugh TN. *The Test of Memory Malingering: TOMM*. Toronto, Canada: Multy Health Systems; 1996.
 43. Weinborn M, Orr T, Woods SP, Conover E, Feix J. A validation of the test of memory malingering in a forensic psychiatric setting. *J Clin Exp Neuropsychol*. 2003;25(7):979-990.
 44. **Rey A. *Lexaneen clinique en psychologie [Clinical examinations in psychology]*. Paris, France: Presses Universitaires de France; 1964. [AU: I COULD NOT FIND THIS SOURCE. PLEASE VERIFY]**
 45. Powell MR, Gfeller JD, Oliveri MV, Stanton S, Hendricks B. The Rey AVLT Serial Position Effect: a useful indicator of symptom exaggeration? *Clin Neuropsychol*. 2004;18(3):465-476.
 46. **Grant DA, Berg EA. A behavioral analysis of reinforcement and ease of shifting to new responses in a Weiggl-type card-sorting problem. *J Exp Psychol*. 1948;38:404-411. [AU: COULD NOT FIND THIS SOURCE. PLEASE VERIFY AND SUPPLY ISSUE NUMBER]**
 47. Fristoe NM, Salthouse TA, Woodard JL. Examination of age-related deficits on the Wisconsin Card Sorting Test. *Neuropsychology*. 1997;11(3):428-436.
 48. Suhr JA, Boyer D. Use of the Wisconsin Card Sorting Test in the detection of malingering in student simulator and patient samples. *J Clin Exp Neuropsychol*. 1999;21(5):701-708.
 49. Hope RA, Longmore JM, Hodgetts TJ, Ranrakha PS. *Oxford Handbook of Clinical Medicine*. 3rd ed. New York, NY: Oxford University Press; 1993.
 50. Thompson CR, Beckson M. A case of factitious homicidal ideation. *J Am Acad Psychiatry Law*. 2004;32(3):277-281.
 51. Saed G, Potalivo S, Panzini L, Bisetti A. Munchausen's syndrome. A case of factitious hemoptysis. *Panminerva Medica*. 1999;41(1):62-67.
 52. Ozden A, Canat S. Factitious hemoptysis. *J Am Acad Child Adolesc Psychiatry*. 1999;38(4):356-357.
 53. **Ganser SJ (1898): Ueber einen eigenartigen hysterischen Daemmerrzustand. *Archi fur Psychiatrie und Nervenkrankheiten*. 1898;30:633. (Translated by Shorter CE. *Br J Criminol*. 1965;5:120). [AU: COULD NOT FIND ON PUBMED. PLEASE VERIFY AND SUPPLY ISSUE NUMBERS]**
 54. Enoch MD, Trethowan WH. *Uncommon Psychiatric Syndromes*. 2nd ed. Bristol, England: John Wright and Sons Ltd; 1979.
 55. **Latham RW, White AC, Sims ACP. Ganser syndrome: The etiological argument. *Journal of Neurology, Neurosurgery and Psychiatry*. 1978;41:851-854. [I COULD NOT FIND THIS SOURCE. PLEASE VERIFY AND SUPPLY ISSUE NUMBER.]**