Malingering in the Clinical Setting

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Psychiatry is the go-to specialty for determining whether a patient in need of inpatient hospitalization or has an alternative motivation?

Psychiatrists frequently find themselves in situations in which they have to determine whether patients' psychiatric signs and symptoms are legitimate or feigned. In the emergency department, physicians are asked to determine whether patients are in need of inpatient hospitalization or whether there is an alternative motivation. Disability cases, workers' compensation, and civil liability cases are often influenced by treating psychiatrists' diagnoses and treatment recommendations.

The assessment of malingering can be difficult, because it challenges the trust inherent in the doctor-patient relationship. Nonetheless, in this column I hope to assist clinicians in understanding, detecting, and handling the disposition of patients who present with forged or exaggerated symptoms. With an outline of the types, motivations, and presentations of feigned mental illness, a physician can gather the relevant information to determine whether a diagnosis of malingering can be made.

The consequences of undetected malingering are extensive. The cost to society can be measured in dollars, safety, and health care availability. The Texas Department of Insurance reports that fraud that broadly includes malingering costs the insurance industry $150 billion annually, increasing the cost of insurance by $1800 per family. Malingering has obvious consequences for public safety when it causes bottlenecks in the criminal courts. In addition, in many parts of the country there are a limited number of psychiatric inpatient beds. It is not unheard of for a seriously mentally ill patient to spend days in an emergency department awaiting admission to an inpatient psychiatric facility. With the current resources, not including malingering in a differential diagnosis frequently blocks other, truly ill patients from receiving care. Last, it can be argued that the physician has an obligation to the malingerer, at least when in a therapeutic relationship, not to perpetuate and reinforce maladaptive behavior.

Malingering, however, is not always maladaptive. There are times when malingering is quite adaptive. Admission to a psychiatric ward may be a life or death matter in the cold of winter. A patient who is in danger from his or her cocaine dealer would find it incredibly adaptive to hide in a locked, guarded hospital for several days. Less dramatically, many well-adjusted, productive members of society can attest to calling in "sick" on a beautiful day as crucial to their mental health. The DSM-IV TR defines malingering 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 financial compensation, evading criminal prosecution, or obtaining drugs." Resnick goes further to provide us with more descriptive subcategories: pure malingering, partial malingering, and false imputation. Pure malingering is feigning a disorder that does not exist; exaggeration of existing symptoms is partial malingering; and attributing symptoms to an alternative cause defines false imputation.

Assessing malingering

When assessing for malingered psychosis, Resnick's categories are particularly helpful. A patient feigning psychosis as described by pure malingering will often think that the more fantastic and bizarre the claim (eg, describing little people or Martians), the "crazier" he will seem. Because he has never experienced an actual hallucination, he may keep descriptions of the voices vague. He may not give the number of voices, sex, or exactly what is being said in the hallucinations. Among suspicious auditory hallucinations, Resnick lists commands that are always obeyed, are unassociated with delusions, are continuous rather than intermittent, occur in stilted language, or are voices seeking information.

Real delusions have an insidious onset and the patient is often hesitant to call attention to them. Malingering should be suspected in a delusion that presents acutely, is spotlighted by the patient, or is particularly bizarre without associated thought disorganization. Resnick describes suspicious visual
hallucinations as those reported in black and white, miniature or giant, and again, bizarre without disorganization. Visions that change when the eyes are closed or those that occur alone are also suspect.

In partial malingering, thought disorganization becomes the most useful clue. A patient with a psychotic illness can often convincingly describe hallucinations and may actually have negative symptoms or be able to fake them, but disorganized thought processes are difficult to fake and are even more difficult to maintain.

For the same reason, mania is infrequently feigned. Pressured speech is a unique phenomenon, which for those not suffering from an affective disorder is nearly impossible to keep up. Merely extending the interview will expose a patient who is faking a manic episode, because the patient will tire. The pretense of mania is more often manifested in a reported history of past manic episodes in the context of a current presentation of depression. Again, the clinician must look for the lesser-known and atypical symptoms of depression. Hypersomnolence and hyperphagia are portrayed in popular culture as the usual presentation of depression. Most people do not realize that, more frequently, those suffering from depression lose weight and have difficulty in sleeping and that the former symptoms occur more in atypical depression. Malingerers who claim to be depressed may report having difficulty in falling asleep instead of the usual early morning awakening or frequent awakening. Open-ended questions provide security against giving the malingerer the clues he needs to be successful.

False imputation often manifests as pretended depression, posttraumatic stress disorder (PTSD), or other anxiety disorders. All these diagnoses are frequently the focus of disability claims, workers' compensation claims, or other civil litigation scenarios. Here, collateral information and detective work are essential. A thorough evaluation includes searching for past trauma and past symptomatology to determine the most likely cause of symptoms. The above disorders are particularly vulnerable to malingering because of the importance of patient-reported symptoms in the diagnosis.

Again, the length of the interview can wear down the deceptive patient. Asking the same question repeatedly in different contexts will often expose inconsistencies in the account of a patient who is malingering. Look for divergence in self-reported symptoms and behavior. It is not logical that a patient with PTSD reports avoidance of situations or things relating to an accident to an evaluating clinician but will repeatedly rehash the accident when the purpose is to direct blame or liability.

Tests for malingering
When time permits, there are psychometric tests that can assist in the detection of malingering. For example, the Minnesota Multiphasic Personality Inventory-2 is the most validated test for detecting malingering in the psychiatric setting. The Structured Interview of Reported Symptoms was specifically designed for the detection of mangled psychiatric symptoms. The Test of Memory Malingering is used to detect faked memory deficits. The Rey 15-Item Memory Test is used as a screening test; it has low sensitivity but high specificity. When psychological testing is not an option, unobtrusive observation is crucial in detecting malingering because the fallacy is often revealed when the physician is out of sight. Ancillary staff can be crucial in the detection of inconsistent behavior. The patient who is tearful and suicidal may expose himself by joking with staff when believed to be out of view of the physician. A patient demonstrating what appears to be psychomotor retardation in the interview might move rapidly to a smoking break. Winning at card games is inconsistent with the distractibility of psychosis or other cognitive impairments.

Course of action
The contradictions inherent in the malingerer can manifest in an unlimited number of ways, but what should clinicians do once malingering has been confidently diagnosed? A framework for formulating a disposition is needed. Rogers and colleagues describe 3 motivational models of malingering: pathogenic, criminological, and adaptational. These models can be used to assist in formulating a reasonable disposition. The pathogenic model contradicts our current conceptualization of malingering because it attributes malingering to an underlying mental illness that will eventually become apparent and has fallen out of favor. The criminological model addresses malingering in the context of personality traits, such as antisocial personality disorder, and is more frequently applicable or useful in the forensic setting. Finally, the adaptational model proposes that the malingerer is using cost-benefit analysis. The malingerer has weighed the benefits and risks and decided that "being sick" can yield what he wants or needs.

Case Vignette
Mr M, a 41 year old, presented to the VA Medical Center stating that he was going to kill
himself by walking in front of a car. He had been seen 5 times in 4 days. He went to the mental health walk-in clinic once and the rest of the visits were to the emergency department. Each time, he claimed to be suicidal. He was admitted to the inpatient unit twice but each time spent only one night before being discharged. There were multiple notes from the nursing staff reporting that he was laughing and joking with them and other patients once in the ward.

For most clinicians outside the forensic setting, the motivational model that is most useful is the adaptational model. The adaptational model can uncover the tools needed to successfully create a disposition that is safe and satisfactory to both the malingering patient and the clinician. After Mr M’s chart was reviewed, collateral information was received from previous on-call physicians, and the assessment itself was complete, malingering was at the top of the differential diagnosis. However, this is still a patient who is homeless and clearly verbalizing that he will attempt suicide if not admitted to the hospital. The key to a successful disposition is not proving that this patient is lying. It can be accomplished by asking him what he really wants or feels he needs—that is, what are the components of his adaptational model?

After discussing the information gathered with the patient, Mr M admitted that he understood from a social worker in another city that the only way to get the specific benefits he wanted was to be admitted to the inpatient psychiatric facility. Once the inaccuracy of this information was conveyed, the patient was happy to be directed toward more appropriate services. He then readily admitted that he had never been suicidal and expressed his irritation that he had to waste so much time at the VA Medical Center pretending to be depressed.

Although the criminological model first comes to mind, viewing this case through the adaptational model allows physicians to understand the patient and give him a means of fulfilling at least some of his needs while saving face. This method allows the clinician to avoid a more confrontational approach in situations that are already volatile. It is usually much more productive to give a malingerer a way out than to confront him directly about the deception.

There are many incentives for malingering in different psychiatric settings. Clinicians must balance a desire to treat with a low threshold for suspicion of feigned symptoms. A malingering assessment must be comprehensive, including a thorough clinical interview, a review of all records, examination of collateral information, and psychological testing when available. A diagnosis of malingering delivers a powerful stigma, so psychiatrists must carefully weigh all the evidence before drawing that conclusion. By understanding the types, motivations, and presentations of malingering, a clinician can systematically and empathetically diagnose and respond to the intentional feigning of psychiatric symptoms.

References:
