Malingering: Faking it Till it's Real

"Deception occupies a central and privileged place in forensic psychiatry"
(Gunn et al., 2014)

Marc Roffey MBChB FCPsych(SA)[1]

Malingering is a vast topic, and overlaps with other important psychiatric conditions, including factitious, dissociative and somatoform disorders (somatic symptom disorder in DSM-5). It occurs in both criminal and civil forensic settings, because of the powerful gains that may arise from successfully feigning mental illness. It is also common in prison populations and the military.

In DSM-5 malingering is found under the section on V-codes, because it is not a disorder but a condition that could be a focus of attention (APA, 2013). The manual states that "the essential feature of malingering is 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" (p.726).

When assessing patients, forensic mental health professionals need to adopt a uniquely different stance to those working in general psychiatry, where it can usually and reasonably be assumed that people give truthful accounts of their illnesses, so that they can be successfully treated. A low threshold of suspicion for malingering should occur in the following contexts:

- Medicolegal proceedings
- Significant discrepancy between the individual's claimed impairment and objective findings
- Lack of cooperation during evaluation and compliance with treatment
- Diagnosis of antisocial personality disorder (APA, 2013)

Resnick (1999) classified malingering into 3 types:

- *Pure malingering*: the complete fabrication of symptoms, in that the examinee actually has no symptoms.

[1] Dr. Roffey is a forensic psychiatrist with more than 15 years of experience, during which he was a consultant in the Forensic Mental Health Service based at Valkenburg Hospital.

- *Partial malingering*: the amplification of existing symptoms, where the examinee may fulfil criteria for a diagnosis but feigns severity
- *False imputation*: the inappropriate, or false, assignation of causality of symptoms. This is common in civil litigation where the claimant falsely insists that her disorder was caused by the defendant.

The motivations for malingering may not be overt and therefore difficult to understand. Rogers and Neumann (2003) have proposed three explanatory models:

- *Pathogenic*: the motivation for malingering appears to be insufficient and therefore must arise from intrapsychic needs. Their course tends to be deteriorative whereby the original intention becomes overwhelmed by psychopathological processes. This can explain why some who initially are assessed as malingering but with time become worse.
- *Criminological*: the definition in DSM-5 (above) hews to this explanation in which the individual and her presentation are characteristically labelled as "bad".
- *Adaptational*: the individual tries to deal with a difficult situation via some sort of "cost-benefit analysis". For example, a prisoner may feign illness to escape bullying.

Cautionary Notes

Determining the presence of malingering, especially in marginal cases, is more complicated than is generally supposed, because

1. Psychiatric diagnoses are not discrete categories, easily distinguished from normally occurring phenomena. Succeeding editions of the DSM have loosened these boundaries, not only as a recognition that disorders are mostly extreme versions of normality, especially as with personality disorders, but also that atypical presentations are relatively common (Frances, 2013). Consequently, confident pronouncements that an examinee is feigning can be disputed by other experts, who may ultimately be correct. MacDonald (1976) relates an anecdote of "a physician who, walking into his ward one day with his intern, remarked, "Well, how are they all this morning". "All doing excellently" said the intern, "except the malingerer in the corner who died last night" (p.278)
2. Add to this the precaution about the weakness of how we make diagnoses. As Thompson et al. (2004) warn "..the diagnosis of psychiatric disorders is based largely on self-reported subjective symptoms that may be learned and feigned" (p.427).

3. Outcomes of malingering are typically poor, even after the successful conclusion of whatever initiated the behaviour (Bass and Wade, 2019). There are surprisingly few data on how many diagnosed with malingering ultimately are diagnosed with a genuine disorder.
4. Consequently, the base rates of malingering are not known. Estimates vary for about 10% of criminal cases and up to 50% in personal injury litigation (McDermott, 2018).
5. Malingering does not always involve "feigning bad" (simulation) but can be "feigning good" (dissimulation). The latter typically occurs when someone with a mental illness must be declared well, such as to be released as a state patient or to gain control over her affairs (Feuerstein et al., 2005).
6. It is not uncommon that an examinee who has a serious mental illness also obviously malingers during an assessment. His lack of insight prevents him from realising that he is actually ill, but does know that he needs to avoid the consequences of the evaluation. Many anecdotes come to mind, such as the young man who rolled around on the floor during an interview, and described seeing a group of ghouls waving and shouting at him. Later nursing staff reported that he was mostly quiet and withdrawn in the ward, was objectively hallucinating and was intermittently thought disordered.
7. Occasionally an examinee was given an incorrect diagnosis by a treating clinician and persists in using it in good faith (Faust, 2023).

Manifestations

Malingered psychiatric conditions that have been well-documented in the literature include psychosis, depression, suicidality, PTSD, dissociative identity disorder (previously known as "multiple personality disorder), amnesia and cognitive defects/disorders.

Neuro-psychiatric conditions that are commonly malingered include seizures, acute dystonia, chronic pain, sleep disorders, amnesia and cognitive defects/disorders.

The most common malingered psychiatric conditions in our unit include amnesia and psychosis (specifically auditory hallucinations, including command hallucinations, as these have exculpatory significance for the malingerer, and visual hallucinations). Amnesia is an important topic in its own right and will be dealt with in a separate section. With respect to hallucinations, it is useful for assessing psychiatrists to know their 'normal' phenomenology, and to contrast this with the characteristics of atypical hallucinations that are often described by malingerers. Note that it is these positive features of psychosis that are commonly malingered – thought disorder and negative symptoms are much harder to imitate (as is mania). Malingered *mutism* is also encountered. Knowledge of the causes of true mutism helps in establishing whether it is being malingered or not.

It is important to be aware of conditions that mimic malingering but where there is not a specific *external* gain to be achieved. These include factitious disorders, where symptoms are consciously fabricated, and somatic symptom disorders, where the production of symptoms is unconscious – in both of these conditions the *motivation* for the behaviours is unconscious.

Teasing out the Various Manifestations of Illness Deception

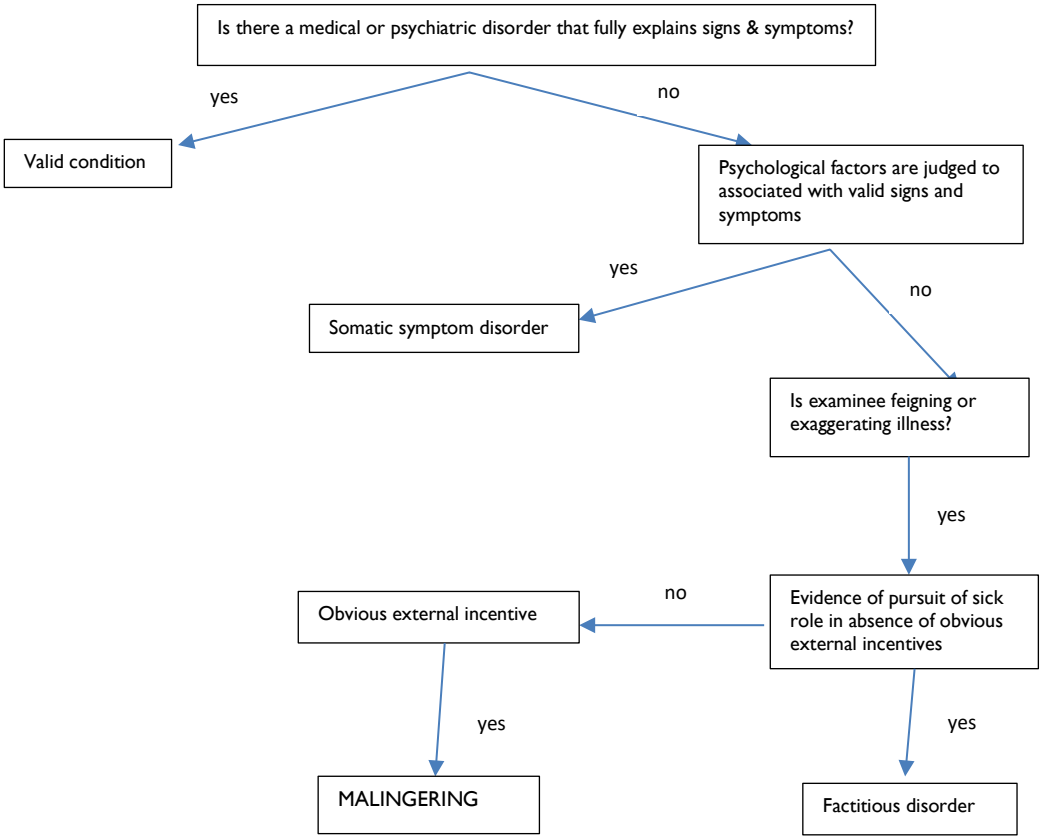
Abnormal illness behaviour bestows the privileges of the "sick role" onto the pretender. Not surprisingly, many in need, ordinary people, criminals and litigants do try to enjoy its benefits. Discerning between them depends on whether the symptoms are consciously produced, what they intend to gain and on the contexts in which they occur.

Table: A comparison of common abnormal illness behaviours

TYPE	SYMPTOM PRODUCTION	MOTIVATION	CLINICAL FEATURES
MALINGERING	Conscious	Conscious	Symptoms are feigned, or denied, to avoid or gain an obvious objective[2].
FACTITIOUS DISORDER (Munchausen's syndrome)	Conscious	Unconscious	Other than desiring the benefits of assuming the "sick role" (i.e. secondary gain) the person's objective is not clear. The person can go to extraordinary lengths to manipulate investigations, falsify records etc. Commonly they have histories of wandering and '*pseudologica fantastica*". When the individual presents another (victim) as being ill, such as a child, criminal charges can result.
SOMATIC SYMPTOM AND RELATED DISORDERS	Unconscious	Unconscious	The person is excessively distressed and preoccupied with (usually) somatic symptoms despite a seeming lack of evidence for any disorder. Commonly this co-occurs with a valid somatic disorder. Subtypes include: ⇒ Chronic pain ⇒ Illness Anxiety Disorder ⇒ Conversion Disorder (Functional Neurological Symptom Disorder)

[2] This includes confidence tricksters who pretend to be ill to solicit donations from unsuspecting strangers. The internet has amplified its occurrence.

Figure: Flow diagram to distinguish between abnormal illness presentations



(Thompson et al., 2004)

The Detection of Malingering

In forensic settings, clinical suspicion of malingering should arise under the following circumstances:

- When there is a strong external incentive e.g. a violent offence has occurred which will likely result in a custodial sentence. In civil cases (e.g. disability claims) financial incentives have been positively correlated with malingering.
- In the presence of antisocial personality disorder and/or psychopathy.
- When there is an endorsement of symptoms that are *rare, blatant, absurd and preposterous*, sometimes referred to as 'overcrowding of the canvas' (MacDonald, 1976, Rogers, 1997).
- Where symptoms are not consistent with observed behaviours (e.g. the patient who complains of constantly hearing voices but does not seem distracted by them).
- Poor adherence to treatment, and/or unusual response to treatment.
- When during the administration of cognitive and other psychological tests, there is:
    - Inadequate or variable levels of effort. Faust (2023) cautions that assessing effort may be complicated by medication, cognitive impairment or intense anxiety.
    - Unusual or implausible behaviour and test responses (e.g. approximate answers).

- Inconsistency in test responses *over time*, and across similar tests of functioning.
- Inconsistencies between test performance and observed behaviour or expected levels of functioning (e.g. a patient who claims to be innumerate but plays dominoes on the ward).

All methods for exposing malingering are flawed, but inaccuracies can be minimised by checking for inconsistencies over several testing domains. Generally the 3 components of assessment consist of:

1. Clinical assessments and interviews

2. Collateral sources of information, and

3. Psychological testing (McDermott, 2018).

Clinical Assessment Of Malingering:

It is generally a good technique to start the forensic clinical interview by asking about the patient's background. There are several reasons for this, and in this context such an approach reveals, early on, any hesitancy or unwillingness to engage in an honest and cooperative manner with the interviewer.

When psychiatric symptoms are enquired after, and malingering is suspected, it is important to ask open-ended questions, so as not to provide the patient with a check-list of symptoms that they may have learned, and that they can respond affirmatively or not to. Questions can then be refined to narrow down on features with a view to determining whether they are atypical or not. e.g. does the patient have a strategy to diminish troublesome voices, and if so what are they?

Confronting patients about malingered symptoms is not a useful strategy, as it creates anger and resentment in the patient, who may respond by becoming uncooperative, or by escalating their symptoms or behaviours to justify their self-reports, or by acting out with aggression or violence.

Seeking clarification from the patient works better, and is done by avoiding words like 'lying'. Inconsistencies can be pointed out in a calm and non-judgemental manner, with a request for commentary on these inconsistencies.

The 'ABCs' of assessing malingering is a useful aid:

- **A**void accusations of lying
- **B**eware of countertransference
- **C**larification is being sought, not confrontation

- **S**ecurity measures should be available

In forensic settings, malingering patients should know that the assessing clinicians are 'onto them'; also telling them that if they are really ill they will be detained indefinitely in a psychiatric hospital as 'state patients' can be a useful deterrent against ongoing malingering.

Collateral information

A deeper assessment of malingering would include obtaining collateral information from the usual sources, including family members, employer, medical records etc. These sources allow for triangulation of information such that important inconsistencies can be revealed

Psychological testing

In addition formal psychological tests can be administered, despite their lack of evidence for their validity (Faust, 2023)[3]. Nevertheless the following tests have been recommended ((Thompson et al., 2004, Erlacher and Reid, 2006, McDermott, 2018):

- The MMPI-2 (Minnesota Multiphasic Personality Inventory
- MMCI-3 (Millon Clinical Multiaxial Inventory)
- PAI (Personality Assessment Inventory) all contain validity scales which detect responses which may reflect patterns which negatively affect response validity, as well as flagging the possibility of malingering.
- Rey 15 item test
- Forced Choice test
- Portland Digit Recognition test
- Structured Interview of Reported Symptoms
- Miller Forensic Assessment of Symptoms Test (M-FAST).
- Word Memory Test
- Fake Bad Scale (FBS)
- Response Bias Scale
- Malingering Index

Locally, these tests are not routinely administered, although they are used on occasion, for particularly challenging cases. Most of these tests rely on the "Floor Effect" by which examinees are asked very

[3] Almost all psychological tests have been developed using volunteers (usually students) who were instructed to malinger symptoms. Unfortunately it has not been possible to use genuine malingerers as a comparator group.

simple questions, such as 2+2=, their own birth date, how many legs a cat has etc. Often the malingerer will provide approximate answers, that is, nearly correct but wrong.

An additional useful strategy when dealing with difficult cases of malingering is to extend the period of observation. This allows for observation of inconsistencies in reported symptoms, inconsistent behaviour, and more time to collect collateral and administer psychological tests.

Disclosure of Findings

Finally, when writing reports, it is important to avoid using the term 'malingering', which is seen as highly pejorative. It is better to use phrases such as 'the reported symptoms are not due to mental illness', or 'there is no psychiatric cause for (them)' (Gunn et al., 2014). This also allows the examiner the flexibility to change her assessment should new information emerge.

Case Vignettes For Reflection And Discussion

1. During a private practice session, a patient, new to psychiatric services, was referred for urgent admission as he was depressed and suicidal. His common-law wife was well-known to the referring psychologist, who had been treating her for longstanding depression. He was assessed by a psychiatrist who admitted him to a private psychiatric hospital, after giving an apparently convincing history of symptoms of depression. He was admitted at about 5pm in the evening, and started on antidepressant medication. At about 3am the following day, SAPS arrived at the hospital, charged him with conspiracy to commit murder (of his business partner), and he was taken into custody.

2. During an observation ward-round, a physically healthy patient suddenly stopped talking to the interviewing psychiatrist, turned around and started talking to the empty chair next to him. When asked what he was doing, he said he was talking to a tokoloshe. Upon direct questioning he stated that the tokoloshe's name was 'Peter', and he gave increasing elaborate responses to enquiries about the tokoloshe's appearance. There were no other features of psychosis present, a complete absence of distress, and the patient was able to give a lucid account of his experiences. The rest of the interview was interrupted by the patient periodically addressing 'Peter' in a dramatic manner.

Recommended Reading

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The last two articles provide useful information about the characteristic features of the visual hallucinations that are rarely seen in schizophrenia. Knowing these features (e.g. that they are typically Lilliputian in nature, and almost always in colour), is useful when assessing malingered positive symptoms of psychosis.

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