Malingering Clinical Presentation

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Disclosure: lilly Honoraria Speaking and teaching; Sunovion Honoraria Speaking and teaching; Otsuke Grant/research funds reseach; Merck Honoraria Speaking and teaching

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Background

Malingering is not considered a mental illness. In the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, malingering receives a V code as one of the other conditions that may be a focus of clinical attention. The *DSM-IV-TR* describes malingering as follows:

"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."[1]

Proposed revisions in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* will not alter this approach.[2]

Case study

Mr. A is a 21-year-old man who recently volunteered for the Marines. In boot camp, he comes to the medical officer complaining of "depression." He says he sees Satan every night, telling him to kill himself and his commanding officer. He says he has been visited by Satan every night since he was a child, and that he is convinced he has supernatural powers. He has no history of psychiatric or behavioral problems prior to his enlistment.

On examination, he often bursts into gibberish. When asked what year it is, he says, "1352." When asked what city he is in, he says, "I don't know." The nurse informs the examining physician that this young man was perfectly relaxed and sociable in the waiting room.

Pathophysiology

Malingering is deliberate behavior for a known external purpose. It is not considered a form of mental illness or psychopathology, although it can occur in the context of other mental illnesses.

Epidemiology

Mortality/Morbidity

The total cost of health insurance fraud in the United States (including untruthful claims by patients and medical personnel) was more than $59 billion in 1995, resulting in a cost of $1050 in added premiums for the average American family.[3]

History

- Strongly suspect malingering in the presence of any combination of the following:
  - Medicolegal presentation (eg, an attorney refers patient, a patient is seeking compensation for injury)
  - Marked discrepancy between the claimed distress and the objective findings
  - Lack of cooperation during evaluation and in complying with prescribed treatment
  - Presence of an antisocial personality disorder[4]
- Malingering often is associated with an antisocial personality disorder and a histrionic personality style.
- Prolonged direct observation can reveal evidence of malingering because it is difficult for the person who is malingering to maintain consistency with the false or exaggerated claims for extended periods.
- The person who is malingering usually lacks knowledge of the nuances of the feigned disorder. For example, someone complaining of carpal tunnel syndrome may be referred to occupational therapy, where the person who is malingering would be unable to predict the effect of true carpal tunnel syndrome on tasks in the wood shop.
- Prolonged interview and examination of a person suspected of a malingering disorder may induce fatigue and diminish the ability of the person who is malingering to maintain the deception. Rapid firing of questions increases the likelihood of contradictory or inconsistent responses. Asking leading questions may induce the person to endorse symptoms of a different illness. Questions about improbable symptoms may yield positive responses. However, because some of these techniques may induce similar responses in some patients with genuine psychiatric disorders, exercise caution in reaching a conclusion of malingering.
- Persons malingering psychotic disorders often exaggerate hallucinations and delusions but cannot mimic formal thought disorders. They usually cannot feign blunted affect, concrete thinking, or impaired interpersonal relatedness. They frequently assume that dense amnesia and disorientation are features of psychosis. It should be noted that these descriptions also may apply to some patients with genuine psychiatric disorders. For example, individuals with a delusional disorder can have unshakable beliefs and bizarre ideas without formal thought disorder or affective blunting.[5]
- The most common goals of people who malinger in the emergency department are obtaining drugs and shelter. In the clinic or office, the most common goal is financial compensation.[6]

Physical

Typically, deficits on physical examination do not follow known anatomical distributions. Otherwise, there are no specific techniques of physical examination that reliably detect malingering.[7]

The following can be found on a Mental Status Examination:[8, 9]

- A patient's attitude toward the examining physician is often vague or evasive.
- Mood may be irritable or hostile.
- Thought processes are generally cogent. Thought content is marked by preoccupation with the claimed illness or injury.
- Threats of suicide may follow any challenge to the veracity of the claim, or a response deemed by the malingerer to be inadequate.
- As noted under History, persons with malingering psychotic disorders often exaggerate hallucinations and delusions but cannot mimic formal thought disorders. They usually cannot feign blunted affect, concrete thinking, or impaired interpersonal relatedness. They frequently assume that dense amnesia and disorientation are features of psychosis. These descriptions may also apply to some patients with genuine psychiatric disorders. For example, individuals with a delusional disorder can have unshakable beliefs and bizarre ideas without formal thought disorder or affective blunting.[5]
- Individuals with malingering may attempt to feign any other type of mental status abnormality, but usually do so in a manner that is erroneous or grossly exaggerated.

Causes

Malingering often occurs in the context of antisocial personality disorder. Common contexts that may precipitate malingering behavior include the following:

- Criminal prosecution
- Military service
- Workers' compensation claims
- Desire for drugs[1, 10]

Differential Diagnoses

- Conversion Disorders
- Factitious Disorder
- Hypochondriasis
- Somatoform Disorders

Other Tests

- The Minnesota Multiphasic Personality Inventory (MMPI) can detect inconsistent or atypical response patterns associated with malingering (see image below). The F scale and the F-K index are the most valuable indicators. Several subscales, such as the Fake Bad Scale, have been extracted from MMPI profiles.
- Multiple other psychological tests have been validated for detection of malingering, including the Test of Memory Malingering, the Negative Impression Management Scale, and the Rey 15-Item Test.[10]

Medical Care

- Do not accuse the patient directly of faking an illness. 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. Allow the person who is malingering the opportunity to save face.
- Alternatively, the physician may inform people who are malingering that they are required to undergo invasive testing and uncomfortable treatments (provided, of course, that such warning is true).
- Invasive diagnostic maneuvers do more harm than good. Hospitalization is almost never indicated since individuals intend no harm to themselves and a hospital stay rewards the undesirable behavior.
- The likelihood of success with such approaches is inversely related to the rewards for the malingering behavior.[11, 12, 13, 9]

Consultations

People who malinger almost never accept psychiatric referral, and the success of such consultations is minimal. Avoid consultations to other medical specialists because such referrals only perpetuate malingering. However, in cases of serious uncertainty about the presence of genuine psychiatric illness, suggest psychiatric consultation.

Psychiatric consultation may be suggested as an augmentation to dealing with an acknowledged symptom. For example, the primary physician might propose, "Your pain has to be causing your system a great deal of stress, and we know that only makes the pain worse. Consultation from a psychiatrist might help us with your pain by reducing the stress." Without being confrontational, the physician must remain honest.[3, 13, 9]

Complications

Hostile or threatening behavior may ensue if the malingerer's claims are challenged, or if the physician fails to respond to his/her demands for disability certification, medications, etc.

References

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. Washington DC: American Psychiatric Press Inc; 2000:683.
2. American Psychiatric Association. DSM 5 Development: J 03 Functional Neurological Disorder (Conversion Disorder). American Psychaitric Association DSM 5 Development. Available at http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=8. Accessed March 22, 2012.
3. LoPiccolo CJ, Goodkin K, Baldewicz TT. Current issues in the diagnosis and management of malingering. *Ann Med*. Jun 1999;31(3):166-74. [Medline].
4. Faust D. The detection of deception. *Neurol Clin*. May 1995;13(2):255-65. [Medline].
5. Resnick PJ. Defrocking the fraud: the detection of malingering. *Isr J Psychiatry Relat Sci*. 1993;30(2):93-101. [Medline].
6. Purcell TB. The somatic patient. *Emerg Med Clin North Am*. Feb 1991;9(1):137-59. [Medline].
7. Samuel RZ, Mittenberg W. Determination of Malingering in Disability Evaluations. *Primary Psychiatry*. 2005;12(12):60-68. [Full Text].
8. Donaghy M. Symptoms and the perception of disease. *Clin Med*. Nov-Dec 2004;4(6):541-4. [Medline].
9. Malone RD, Lange CL. A clinical approach to the malingering patient. *J Am Acad Psychoanal Dyn Psychiatry*. Spring 2007;35(1):13-21. [Medline].
10. Anderson JM. Malingering: A constant challenge in disability arenas. *J Controversial Med Claims*. May 2008;15(2):1-9.

11. Udell ET. Malingering behavior in private medical practice. *Clin Podiatr Med Surg*. Jan 1994;11(1):65-72. [Medline].

12. Voiss DV. Occupational injury. Fact, fantasy, or fraud?. *Neurol Clin*. May 1995;13(2):431-46. [Medline].

13. McDermott BE, Feldman MD. Malingering in the medical setting. *Psychiatr Clin North Am*. Dec 2007;30(4):645-62. [Medline].

14. Ziegler SJ. Pain, patients, and prosecution: who is deceiving whom?. *Pain Med*. Jul-Aug 2007;8(5):445-6; author reply 447-8. [Medline].