

Malingering

WILLIAM H. REID, MD, MPH

Malingering is a forensic topic that is also relevant to most nonforensic clinicians. Almost every experienced psychiatrist, psychologist, or therapist has wrestled with, or wondered about, patients who appear to be faking symptoms in order to gain something of obvious value (or avoid something obviously painful). In this column, I will focus on malingered psychiatric or neuropsychiatric symptoms, but the definitions given below apply to malingered general medical symptoms as well.

It's Not Munchausen's or "Psychosomatic"

Take out a copy of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*¹ and look at the small, but very important, differences among malingering, factitious syndromes, and somatoform syndromes (Table 1). Although these concepts are often confused, it's easy to separate them once you understand that **malingering** refers to feigning or significantly exaggerating symptoms for a *conscious gain or purpose*,^{*} **factitious** refers to feigning symptoms for a largely or wholly *unconscious purpose*, and **somatoform** ("psychosomatic" as used here) refers to any of several syndromes that do not involve feigning at all, but rather the largely or wholly unconscious creation of symptoms for an *unconscious purpose*. Note that the definition of malingering includes exaggeration as well as complete fabrication of symptoms.

Presentations of Malingered Psychiatric Symptoms

The malingering attempts I see in my practice have three main purposes, which lend themselves to several broad kinds of malingered or exaggerated symptoms.

People trying **to avoid responsibility or punishment** for something, such as criminal behavior, generally feign psychosis. Symptoms of dementia may also be faked by criminal defendants (who often limit such complaints to "amnesia" or memory "blackouts").

Individuals who are feigning disability or damage in order **to get money** or something valuable from a government, insurance company, or lawsuit often fake symp-

toms of brain damage, but sometimes allege (or exaggerate) anxiety, depression, or psychotic symptoms.

People trying **to get drugs** don't want to appear psychotic or demented, but rather feign symptoms that are likely to get them a narcotic or stimulant. In psychiatry, this usually means severe anxiety, but it also includes sleeplessness, adult attention-deficit/hyperactivity disorder (ADHD), narcolepsy, pain, and the ever-popular "I ran out of my medication and my regular doctor won't be back until next week."

You Usually Can't Tell By Interviewing

Some psychiatrists and psychologists believe that a good interview and a sensitive clinician can see through malingering most of the time. That's just not true. I hate it when psychiatrists or psychologists answer a lawyer's trial or deposition question such as "How do you know he wasn't faking, doctor?" with something like "Psychiatrists are trained to know these things." Lots of people can fool us for an hour or so.

A few years ago, I produced a DSM-III-R training video with nine "patient" interviews depicting various diagnoses. The participants were all neighbors or hospital employees who had briefly reviewed their chosen "diagnoses," with no rehearsal, before filming. As months and years passed, many colleagues and clinical teachers have referred to the "patients" as genuine, in spite of a brief "these-are-actors" disclaimer in the video. Several viewers thought they were classic examples of their respective "diagnoses."

While there are some fairly effective ways to reveal, for example, malingered psychosis (see below), most of the commonly held axioms about separating real from bogus patients don't hold up under scrutiny. Liars don't reliably

Dr. Reid is a forensic and clinical psychiatrist in Horseshoe Bay, Texas, and a past president of the American Academy of Psychiatry and the Law. He maintains an educational website, *Psychiatry and Law Updates*, at <www.reidpsychiatry.com> and his most recent book, *A Clinician's Guide to Legal Issues in Psychotherapy*, is available from Zeig, Tucker & Co, Phoenix, AZ. This column contains general clinical and clinical-forensic opinions which should not be construed as applying to any specific case, nor as any form of legal advice.

^{*}Many reasons, of course, are more personal or clinical than legal or monetary. For purposes of this column, deceptions such as lying about one's suicidal thoughts in order to leave the hospital are not considered "malingering."

Table 1. Comparison of malingering, factitious, and somatoform syndromes

	Purpose	Voluntary/Involuntary
Malingering	Conscious gain or avoidance	Voluntary (entirely within person's conscious control)
Factitious	Unconscious	Voluntary (entirely within person's conscious control)
"Psychosomatic"	Unconscious	Involuntary (outside conscious control)

idget or blink more, avoid eye contact, or use less detail in their explanations. And when someone *does* exhibit one or more of those behaviors, there are many possible reasons besides malingering.

Detecting Malingering Isn't Hopeless

On the other hand, it's not accurate to say that there's *no* reliable way to assess whether or not someone is faking significant psychiatric or memory symptoms. A great deal of study has been done in this area, and there has been no small amount of success when it comes to evaluating complaints of brain injury, memory problems, and psychosis. (On-the-spot assessment of anxiety, depression, or pain, however, is much more difficult.)

The first level of assessment is suspicion. Is the patient's presentation or the circumstance of the evaluation unusual? Do the person's symptoms promote any obvious advantage? Even if no advantage seems obvious, is there a suggestion, for example, that the patient wants to be diagnosed and treated to avoid arrest, or to mitigate responsibility for something? Are the symptoms particularly subjective and difficult to corroborate? Does the patient, even subtly, steer you away from your usual diagnostic and corroborative methods (e.g., laboratory testing, contacting past doctors, or getting hospital records)?

Most clinicians are trusting souls. We want to believe that patients come to us for relief, and that they thus have little reason to lie (or shade the truth). But patients *do* lie to us from time to time. I'm not suggesting that professionals in ordinary clinical practice always assume a jaded posture or go into every interview with a bias against the patient, but you should be alert for *reasons* the patient may not be telling the truth.

Routine Psychological Testing. Many commonly used psychological and neuropsychological tests can raise one's index of suspicion, although they should not be used alone to make a "diagnosis" of malingering. For a few standard neuropsychological instruments, such as the Recognition Memory Test (RMT),² cutoff scores below which malingering may reasonably be suspected have been tentatively established. Fairly complex personality and symptom assessments, such as the Minnesota Multiphasic Personality Inventory (MMPI),³ have validi-

ty scales, some of which are very well "normed" with large and diverse populations. Psychometric instruments that lack specific deception scales (e.g., many neuropsychological batteries and intelligence tests) often have interpretation guidelines for atypical performance or uncommon answer patterns. Computer interpretation provides statistical comments; the psychologist's or neuropsychologist's experience with the population being tested is even more valuable.

Tests for Malingering Itself. There are several tests specifically designed to detect deception, generally using an "actuarial" approach. These instruments, mostly used for revealing malingered memory problems or brain injury, generally do not rely on clinical nuances. They use the power of statistics against a backdrop of extensive test validation. The most common (e.g., the Pritchard tests,⁴ Hiscock test,⁵ and Portland Digit Recognition Test [PDRT]⁶) present the evaluatee with a series of very simple tasks, such as remembering word or number pairs or comparing lists of things. Some involve increasing levels of apparent difficulty (but none is very hard). Most can be given in a short time, using oral, written, or computerized techniques. For example, the Pritchard tests⁴ can be easily given in a clinician's office or clinic. They present the evaluatee with one or more of three kinds of simple neuropsychological tasks involving detecting an auditory signal, recognizing differences between recently seen numbers, and detecting a bright shape in a visual field. The test is available as inexpensive software for a desktop or laptop computer. Administration is easy and highly reliable because of the computer-based presentation. Interpretation of the results is based on well-validated "rules" that are applied in the office.

When nonmalingered populations are given these and similar tests, even moderately brain-damaged patients routinely answer 80%–95% of the questions correctly (depending on the instrument). Malingerer's efforts to look amnesic or brain-damaged are usually exaggerated, resulting in far more wrong answers than would be predicted in a truly damaged person, or even by chance. When the difference between the evaluatee's results and the damaged population's norm is highly significant, the presence of deception can be reliably inferred.

Sometimes such testing can be informally created, though one must be cautious about overestimating the validity of the result.

A defendant with no history of severe mental illness and no current psychiatric symptoms was accused of breaking into a house and assaulting the occupants. He alleged that he was unusually intoxicated that night and did not remember the event at all. With his attorney's permission, he was given a list of 20 items in the house and asked to search his memory as hard as he could to try to remember any of them. He was told to answer either "present" or "absent" for every item, even if he had only a very subtle impression rather than a clear memory (a "forced-choice" technique). The instruction was not so related to whether or not he remembered, but to asking him to try very hard and answer one way or the other.

The items were things such as "torn screen where the assailant broke through the back door," "kitchen knives left scattered on the counter and floor," and "table overturned while fleeing in the dark." He was not told, but would have been able to discern if he remembered, that only half the items on the list had actually been present, while the other half were fictitious.

Had the defendant answered randomly, he would have been expected to answer about 10 of the 20 items correctly. If he had simply answered "absent" to every item, the test would have been invalid (remember that he was asked to give some answer, even if merely from a subtle mental impression). Had he remembered and answered honestly, he would have been expected to be correct for some number much greater than 10. Instead, he answered 19 of the 20 items incorrectly. This strongly suggested that he remembered the house and his actions but was trying to deceive the evaluator.

Structured Interview Instruments. Many standardized clinical interviews have been used to try to differentiate feigned psychiatric (especially psychotic) symptoms from real ones, usually on the basis of very uncommon answers. Some efforts use existing clinical interview formats, such as specialized interpretations of Spitzer and Endicott's *Schedule for Affective Disorders and Schizophrenia (SADS)*^{7, 8} Others, such as Rogers' *Structured Interview of Reported Symptoms (SIRS)*,⁹ were created specifically to reveal malingering and deception.

The SIRS is the most validated and reliable instrument that has thus far been developed for assessing the feigning of psychosis. It is administered orally, in less than an hour, and includes interpretation instructions. It has several different scales that are designed to address different kinds of malingering, all related to severe psychiatric

symptoms rather than memory or neuropsychological deficits.

Hypnosis, Polygraphs, and Chemically-Augmented Interviews

You know that "black pill" the CIA uses to get spies to tell the truth? The scopolamine cocktail that makes even James Bond spill his guts unless he's gotten an antidote from "M"? The amytal interview that helps patients explain their emotional woes? The hypnotic technique that shows the world how you really are (and maybe makes you bark like a dog whenever you see a bagel)? They're all extremely overblown, misunderstood, and generally useless for our anti-malingering purposes. Not only that, but those that do exist[†] tamper with the memory in such a way that real memories (if memory or dissociation is the malingering issue) may become unreliable.

Polygraphs and polygraphy are interesting, but outside the realm of this column. Both the procedures and the issues surrounding them are complex, and they are rarely used in clinical settings.

The Final Word

Malingering is neither as easy nor as hard to uncover as many clinicians believe. Consult a colleague who uses modern detection techniques and be careful not to confuse malingering, factitious, and somatoform syndromes.

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fourth edition. Washington, DC: American Psychiatric Association; 1994.
2. Millis SR. The Recognition Memory Test in the detection of malingered and exaggerated memory deficits. *Clinical Neuropsychologist* 1992;6:405-13.
3. Butcher JN, Dahlstrom WG, Graham JR, et al. Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual for administration and scoring. Minneapolis, MN: University of Minnesota Press; 1989.
4. Pritchard DA. Tests of Neuropsychological Malingering, Version 2.0 (computer software). New York: CRC Press, 1998.
5. Hiscock M, Hiscock CK. Refining the forced-choice method for the detection of malingering. *J Clin Exp Neuropsychol* 1989;11:967-74.
6. Binder LM. Malingering following minor head trauma. *Clinical Neuropsychologist* 1990;4:25-36.
7. Spitzer RL, Endicott J. Schedule for Affective Disorders and Schizophrenia (SADS). New York: Biometric Research, 1978.
8. Rogers R, ed. Clinical assessment of malingering and deception, second edition. New York: Guilford, 1997.
9. Rogers R. Structured Interview of Reported Symptoms (SIRS). Odessa, FL: Psychological Assessment Resources, 1992.

[†]The "black pill" doesn't exist, and I'm not allowed to say one way or the other about the scopolamine cocktail.