

“I just saw Big Bird. He was 100 feet tall!” Malingering in the emergency room

Four instruments can help you make a rapid assessment of a patient feigning symptoms

The economic downturn in the United States has prompted numerous state and county budget cuts, in turn forcing many patients to receive their mental health care in the emergency room (ER). Most patients evaluated in the ER for mental health-related reasons have a legitimate psychiatric crisis—but that isn’t always the case. And as the number of people seeking care in the ER has increased, it appears that so too has the number of those who feign symptoms for secondary gain—that is, who are malingering.

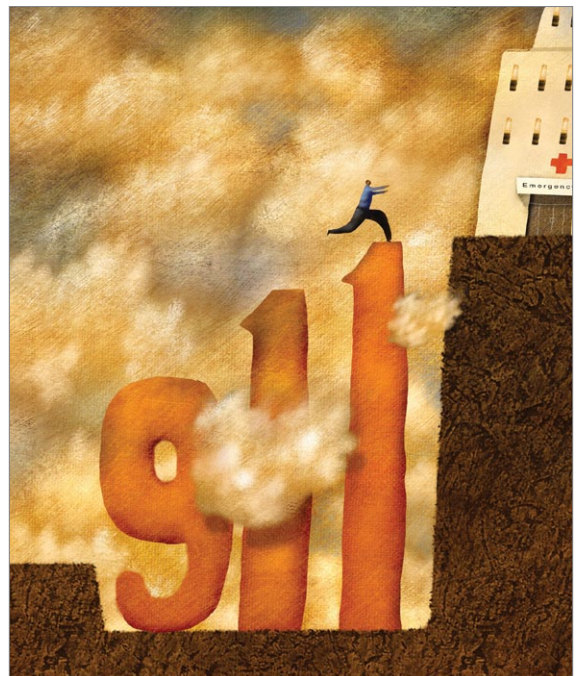
This article highlights several red flags for malingered behavior; emphasizes typical (compared with atypical) symptoms of psychosis; and provides an overview of four instruments that you can use to help assess for malingering in the ED.

A difficult diagnosis

No single factor is indicative of malingering, and no objective tests exist to diagnose malingering definitively. Rather, the tests we discuss provide additional information that can help formulate a clinical impression.

According to DSM-5, malingering is “...the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives...”¹ Despite a relatively straightforward definition, the diagnosis is difficult to make because it is a diagnosis of exclusion.

Even with sufficient evidence, many clinicians are reluctant to diagnose malingering because they fear retaliation and diagnostic uncertainty. Psychiatrists also might be reluctant to diagnose malingering because the negative connotation that the label carries risks stigmatizing a patient who might, in fact, be suffering. This is true especially when there is suspicion of



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Malingering

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Research suggests that as many as 13% of patients in the ER feign illness



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Table 1

Red-flag behaviors that raise suspicion of malingering

- Giving vague responses (eg, numerous “I don’t know” responses)
- Using overly technical terminology (eg, “command auditory hallucinations”)
- Demanding certain medications
- Divulging symptoms too eagerly or dramatically
- Describing mental illness that develops overnight or psychotic symptoms that develop later in life (eg, in the 5th, 6th, and 7th decades of life)
- Making dependent or conditional threats of self-harm, violence, or litigation
- Attempting to take control of the interview
- Endorsing or demonstrating both psychiatric symptoms (eg, psychosis) and cognitive deficits (eg, impaired memory)

Source: References 3,4

partial malingering, the conscious exaggeration of existing symptoms.

Despite physicians’ reluctance to diagnose malingering, it is a real problem, especially in the ER. Research suggests that as many as 13% of patients in the ER feign illness, and that their secondary gain most often includes food, shelter, prescription drugs, financial gain, and avoidance of jail, work, or family responsibilities.²

CASE REPORT

‘The voices are telling me to kill myself’

Mr. K, a 36-year-old white man, walks into the ER on a late December day. He tells the triage nurse that he suicidal; she escorts him to the psychiatric pod of the ER. Nursing staff provide line-of-sight care, monitor his vital signs, and draw blood for testing.

Within hours, Mr. K is deemed “medically cleared” and ready for assessment by the psychiatric social worker.

Interview and assessment. During the interview with the social worker, Mr. K reports that he has been depressed, adamantly maintaining that he is suicidal, with a plan to “walk in traffic” or “eat the end of a gun.” The social worker places him on a 72-hour involuntary psychiatric hold. ER physicians order psychiatric consultation.

Mr. K is well-known to the psychiatrist on call, from prior ER visits and psychiatric hospital admissions. In fact, two days earlier, he put a psychiatric nurse in a headlock while being escorted from the psychiatric inpatient unit under protest.

On assessment by the psychiatrist, Mr. K continues to endorse feeling suicidal; he adds: “If I don’t get some help, I’m gonna kill somebody else!”

Without prompting, the patient states that “the voices are telling me to kill myself.” He says that those voices have been relentless since he left the hospital two days earlier. According to Mr. K, nothing he did helped quiet the voices, although previous prescriptions for quetiapine have been helpful.

Mr. K says that he is unable to recall the clinic or name of his prior psychiatrist. He claims that he was hospitalized four months ago, (despite the psychiatrist’s knowledge that he had been discharged two days ago) and estimates that his psychotic symptoms began one year ago. He explains that he is homeless and does not have social support. He is unable to provide a telephone number or a name to contact family for collateral information.

Mental status exam. The mental status examination reveals a tall, thin, disheveled man who has poor dentition. He is now calm and cooperative despite his reported level of distress. His speech is unremarkable and his eye contact is appropriate. His thought process is linear, organized, and coherent.

Mr. K does not endorse additional symptoms, but is quick to agree with the psychiatrist’s follow-up questions about hallucinations: “Yeah! I’ve been seeing all kinds of crazy stuff.” When prompted for details, he says, “I just saw Big Bird... He was 100 feet tall!”

Lab testing. Mr. K’s blood work is remarkable for positive urine toxicology for amphetamines.

Nursing notes indicate that Mr. K slept overnight and ate 100% of the food on his dinner and breakfast trays.

Red flags flying

Mr. K’s case highlights several red flags that should raise suspicion of malingering (Table 1)^{3,4}:

- A conditional statement by which a patient threatens to harm himself or others, contingent upon a demand—for example, “If I don’t get A, I’ll do B.”

- An overly dramatic presentation, in which the patient is quick to endorse distressing symptoms. Consider Mr. K: He was quick to report that he saw Big Bird, and that this Sesame Street character “was 100 feet tall.” Patients who have been experiencing true psychotic symptoms might be reluctant to speak of their distressing symptoms, especially if they have not experienced such symptoms in the past (the first psychotic break). Mr. K, however, volunteered and called attention to particularly dramatic psychotic symptoms.

- A subjective report of distress that is inconsistent with the objective presentation. Mr. K’s report of depression—a diagnosis that typically includes insomnia and poor appetite—was inconsistent with his behavior: He slept and he ate all of his meals.

Atypical (vs typical) psychosis

Malingering can occur in various arenas and take many different forms. In forensic settings, such as prison, malingered conditions more often present as posttraumatic stress disorder or cognitive impairment.⁵ In non-forensic settings, such as the ER, the most commonly malingered conditions include suicidality and psychosis.

To detect malingered psychosis, one must first understand how true psychotic symptoms manifest. The following discussion describes and compares typical and atypical symptoms of psychosis; examples are given in *Table 2 (page 36)*.^{6,7} *No single atypical psychotic symptom is indicative of malingering.* Rather, a collection of atypical symptoms, when considered in clinical context, should raise suspicion of malingering and prompt you to seek additional collateral information or perform appropriate testing for malingering.

Hallucinations

Typically, hallucinations take three forms: auditory, visual, and tactile. In primary

psychiatric conditions, auditory hallucinations are the most common of those three.

Tactile hallucinations can be present during episodes of substance intoxication or withdrawal (eg, so-called coke bugs).

Auditory hallucinations. Patients who malingering psychosis are often unaware of the nuances of hallucinations. For example, they might report the atypical symptom of continuous voices; in fact, most patients who have schizophrenia hear voices intermittently. Keep in mind, too, that 75% of patients who have schizophrenia hear male *and* female voices, and that 70% have some type of coping strategy to minimize their internal stimuli (eg, listening to music).^{6,7}

Visual hallucinations are most often associated with neurologic disease, but also occur often in primary psychotic disorders, such as schizophrenia.

Patients who malingering psychotic symptoms often are open to suggestion, and are quick to endorse visual hallucinations. When asked to describe their hallucinations, however, they often respond without details (“I don’t know”). Other times, they overcompensate with wild exaggeration of atypical visions—recall Mr. K’s description of a towering Big Bird. Asked if the visions are in black and white, they might eagerly agree. Research suggests, however, that patients who have schizophrenia more often experience life-sized hallucinations of vivid scenes with family members, religious figures, or animals.⁸ Furthermore, genuine visual hallucinations typically are in color.

Putting malingering in the differential

Regardless of the number of atypical symptoms a patient exhibits, malingering will be missed if you do not include it in the differential diagnosis. This fact was made evident in a 1973 study.⁹

In that study, Rosenhan and seven of his colleagues—a psychology graduate student, three psychologists, a pediatrician, a psychiatrist, a painter, and a housewife—presented to various ERs and intake units, and, as they

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One red flag of malingering is an overly dramatic presentation, in which the patient is quick to endorse distressing symptoms



Malingering

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You might discover pertinent information in ambulance and police reports and a review of prior ER visits

Table 2

Some typical and atypical characteristics of hallucinations

<i>Is the voice male, female, or both?</i>	75% of people with true schizophrenia hear voices of both sexes
<i>Does the voice originate inside or outside your head?</i>	88% of patients with schizophrenia report that the voices originate outside their head
<i>Do you ever hear voices in another language?</i>	98% of real hallucinations are spoken in a person's native language
<i>Does anything make the voices less acute?</i>	70% of people with schizophrenia are able to use a coping strategy to minimize auditory hallucinations
<i>Are the voices clear or difficult to understand?</i>	93% of true auditory hallucinations are clear and coherent
Source: References 6,7	

had been instructed, endorsed vague auditory hallucinations of “empty,” “hollow,” or “thud” sounds—but nothing more. All were admitted to psychiatric hospitals. Once admitted, they refrained (again, as instructed) from endorsing or exhibiting any psychotic symptoms.

Despite the vague nature of the reported auditory hallucinations and how rapidly symptoms resolved on admission, seven of these pseudo-patients were given a diagnosis of schizophrenia, and one was given a diagnosis of manic-depressive psychosis. Duration of admission ranged from 7 to 52 days (average, 19 days). None of the study participants were suspected of feigning symptoms.

It's fortunate that, since then, mental health professionals have developed more structured techniques of assessment to detect malingering in inpatient and triage settings.

Testing to identify and assess malingering

The ER is a fast-paced environment, in which treatment teams are challenged to make rapid clinical assessments. With the overwhelming number of patients seek-

ing mental health care in the ER, however, overall wait times are increasing; in some regions, it is common to write, then to re-write, involuntary psychiatric holds for patients awaiting transfer to a psychiatric hospital. This extended duration presents an opportunity to serially evaluate patients suspected of malingering.

Even in environments that allow for a more comprehensive evaluation (eg, jail or inpatient psychiatric wards), few psychometric tests have been validated to detect malingering. The most validated tests include the Structured Interview of Reported Symptoms (SIRS), distributed now as the Structured Interview of Reported Symptoms, 2nd edition (SIRS-2), and the Minnesota Multiphasic Personality Inventory Revised (MMPI-2). These tests typically require ≥30 minutes to administer and generally are not feasible in the fast-paced ER.

Despite the high prevalence of malingered behaviors in the ER, no single test has been validated in such a setting. Furthermore, there is no test designed to specifically assess for malingered suicidality or homicidality. The results of one test do not, in isolation, represent a comprehensive neuropsychological examination; rather, those results provide additional data to formulate a clinical impression. The instruments discussed below are administered and scored in a defined, objective manner.

When evaluating a patient whom you suspect of malingering, gathering collateral information—from family members, friends, nurses, social workers, emergency medicine physicians, and others—becomes important. You might discover pertinent information in ambulance and police reports and a review of the patient's prior ER visits.

During the initial interview, ask open-ended questions; do not lead the patient by listing clusters of symptoms associated with a particular diagnosis. Because it is often difficult for a patient to malingering symptoms for a prolonged period, serial observations of a patient's behavior and interview responses over time can provide additional information to make a clinical diagnosis of malingering.⁴

What testing is feasible in the ER?

Miller Forensic Assessment of Symptoms Test. The M-FAST measures rare symptom combinations, excessive reporting, and atypical symptoms of psychosis, using the same principles as the SIRS-2.

The 25-item screen begins by advising the examinee that he (she) will be asked questions about his psychological symptoms and that the questions that follow might or might not apply to his specific symptoms.

After that brief introduction, the examinee is asked if he hears ringing in his ears. Based on his response, the examiner reads one of two responses—both of which suggest the false notion that patients with true mental illness will suffer from ringing in their ears.

The examinee is then asked a series of Yes or No questions. Some pertain to legitimate symptoms a person with a psychotic illness might suffer (such as, “Do voices tell you to do things? Yes or No?”). Conversely, other questions screen for improbable symptoms that are atypical of patients who have a true psychotic disorder (such as “On many days I feel so bad that I can’t even remember my full name: Yes or No?”).

The exam concludes with a question about a ringing in the examinee’s ear. Affirmative responses are tallied; a score of ≥ 6 in a clinical setting is 83% specific and 93% sensitive for malingering.¹⁰

Visual Memory Test. Rey’s 15-Item Visual Memory Test capitalizes on the false belief that intellectual deficits, in addition to psychotic symptoms, make a claim of mental illness more believable.

In this simple test, the provider tells the examinee, “I am going to show you a card with 15 things on it that I want you to remember. When I take the card away, I want you to write down as many of the 15 things as you can remember.”¹³ The examinee is shown 15 common symbols (eg, 1, 2, 3; A, B, C; I, II, III, a, b, c; and the geometrics \circ , \square , \triangle).

At 5 seconds, the examinee is prompted, “Be sure to remember all of them.” After 10 seconds, the stimulus is removed, and the examinee is asked to recreate the figure.

Normative data indicate that even a patient who has a severe traumatic brain injury is able to recreate at least eight of the

symbols. Although controversial, research indicates that a score of < 9 symbols is predictive of malingering with 40% sensitivity and 100% specificity.¹¹

Critics argued that confounding variables (IQ, memory disorder, age) might skew the quantitative score. For that reason, the same group developed the Rey’s II Test, which includes a supplementary qualitative scoring system that emphasizes embellishment errors (eg, the wrong symbol) and ordering errors (eg, wrong row). The Rey’s II Test proved to be more sensitive (accurate classification of malingerers): A cut-off score of ≥ 2 qualitative errors is predictive of malingering with 86% sensitivity and 100% specificity.¹²

Coin-in-the-Hand Test. Perhaps the simplest test to administer is the Coin-in-the-Hand, designed to seem—superficially—to be a challenging memory test.

The patient must guess in which hand the examiner is holding a coin. The patient is shown the coin for two seconds, and then asked to close his eyes and count back from 10. The patient then points to one of the two clenched hands.

This task is repeated 10 times; each time, the provider gives verbal feedback about the accuracy or inaccuracy of that attempt. Studies indicate that a patient who has a severe traumatic brain injury is able to score 85% correct. A score $< 85\%$, however, suggests feigning of symptoms (sensitivity, 92.5%; specificity 87.5%).¹³ Hanley and co-workers demonstrated that people who are simulating cognitive impairment had a mean accurate response of 4.1, whereas people who had true amnesia had a mean accurate response of 9.65.¹⁴

Persons who feign psychosis or mood symptoms often inaccurately believe that people with mental illness also have cognitive impairment. Both Rey’s test and the Coin-in-the-Hand Test capitalize on this misconception.

Mini-Mental State Examination. Research also has shown that the Folstein Mini-Mental State Examination (MMSE) can screen for malingered cognitive impairment. Powell compared 40 mental health clinicians who were instructed to feign

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Persons who feign psychosis or mood symptoms often have the inaccurate notion that mentally ill people also have cognitive impairment



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When you suspect a patient of malingering, you should avoid accusing him of faking symptoms

Related Resources

- Miller Forensic Assessment of Symptoms Test (M-FAST). Psychological Assessment Resources, Inc. www4.parinc.com (enter "M-FAST" in search field).
- Duffy S. Malingering psychological symptoms: An empirical review. Illinois State University, Department of Psychology. <http://psychology.illinoisstate.edu/cc/Comps/Duffy%20-%20Malingering.pdf>. Accessed September 10, 2013.

Drug Brand Name

Quetiapine • Seroquel

psychosis and 40 patients with schizophrenia. Using the MMSE, the researchers found that the malingers more often gave approximate answers.¹⁵ Moreover, Myers argued that, when compared with Rey's Test, the MMSE is superior for assessing malingered cognitive impairment because it has a higher positive predictive value (67%, compared with 43% for Rey's Test) and a higher negative predictive value (93% and 89%).¹⁶

What can you do for these patients after diagnosis?

Malingering is not considered a psychiatric diagnosis; there are no indicated therapies with which to manage it—only guidelines. When you suspect a patient of malingering, you should avoid accusing him (her) of faking symptoms. Rather, when feasible, gently confront the person and provide the opportunity for him to explain his current behaviors. For example, you might say: "I've treated many patients with the symptoms that you're reporting, but the details you provide are different, and don't ring completely true. Is there anything else that could explain this?"¹⁷

Regardless of a patient's challenging behaviors, it is important to remember that people who feign illness—whether partial malingering or pure malingering—often do need help. The assistance they require, however, might be best obtained from a housing agency, a chemical dependency program, or another social service—not from the ER. Identifying malingered behaviors saves time and money and shifts limited resources to people who have a legitimate mental health condition.

Last, despite an empathetic approach, some malingering patients continue to feign symptoms—as Mr. K did.

CASE CONTINUED

Although the psychiatrist on call considered forsaking the police to escort Mr. K out of the ER, he eventually agreed to leave the hospital on his own, stating, "My death is going to be on your hands."

Eight days later, Mr. K visited the ER at a different hospital, endorsing chronic pain and demanding narcotics.

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Bottom Line

As the number of people seeking care in the emergency room (ER) has increased, so has the number of those who feign symptoms for secondary gain. No single factor is indicative of malingering, and no objective tests exist to diagnose it definitively. Furthermore, there are no indicated therapies with which to manage malingering—only guidelines. Keep in mind that people who feign illness, whether partial or pure malingering, often do need help—although not the services of an ER.

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