

Malingering



in apparently psychotic patients: Detecting it and dealing with it

Look for external incentives, atypical hallucinatory symptoms described by the patient

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Imagine you're on call in a busy emergency department (ED) overnight. Things are tough. The consults are piling up, no one is returning your calls for collateral information, and you're dealing with a myriad of emergencies.

In walks Mr. D, age 45, complaining of hearing voices, feeling unsafe, and asking for admission. It's now 2 AM. What would you do?

Of course, like all qualified psychiatrists, you will dig a little deeper, and in doing so you learn that Mr. D has visited this hospital before and has been admitted to the psychiatry unit. Now you go from having a dearth of information to having more records than you can count.

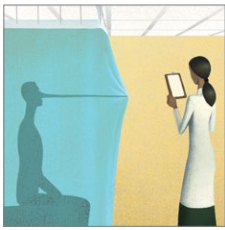
You discover that Mr. D has a history of coming to the ED during precarious hours, with similar complaints, demanding admission.

Mr. D, you learn, is unemployed, single, and homeless. Your meticulous search through his hospital records and previous admission and discharge notes reveal that once he has slept for a night, eaten a hot meal, and received narcotics for his back pain and benzodiazepines for his "symptoms" he demands to leave the hospital. His psychotic symptoms disappear despite his consistent refusal to take antipsychotics throughout his stay.

Now, what would you do?

As earnest medical students and psychiatrists, we enjoy helping patients on their path toward recovery. We want to advocate for our patients and give them the benefit of the doubt. We're taught in medical school to be non-judgmental and invite patients to share their narrative. But through experience, we start to become aware of malingering.

Suspecting malingering, diagnosed as a condition, often is avoided by psychiatrists.¹ This makes sense—it goes against the essence of



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It is important to remember that malingering can coexist with a serious mental illness



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Table 1

Signs of true psychosis

Hallucinations (auditory, visual, olfactory, somatic)
Delusions (bizarre vs non-bizarre)
Disorganized speech
Disorganized behavior
Negative symptoms (flat affect, avolition)

Table 2

Common reasons for feigning illness

Obtain money
Enhance a disability application
Receive drugs (controlled substances)
Evade criminal responsibility
Obtain free shelter or housing in the form of a hospital admission
Avoid military service
Source: References 4,6

our training and imposes a pejorative label on someone who has reached out for help.

Often persons with mental illness will suffer for years until they to receive help.² That's exactly why, when patients like Mr. D come to the ED and report hearing voices, we're not likely to shout, "Liar!" and invite them to leave.

However, malingering is a real problem, especially because the number of psychiatric hospital beds have dwindled to record lows, thereby overcrowding EDs. Resources are skimpy, and clinicians want to help those who need it the most and not waste resources on someone who is "faking it" for secondary gain.

To navigate this diagnostic challenge, psychiatrists need the skills to detect malingering and the confidence to deal with it appropriately. This article aims to:

- define psychosis and malingering
- review the prevalence and historical considerations of malingering
- offer practical strategies to deal with malingering.

Know the real thing

Clinicians first must have the clinical acumen and expertise to identify a true mental illness such as psychosis² (Table 1). The differential diagnosis for psychotic symptoms is broad. The astute clinician might suspect that untreated bipolar disorder or depression led to the emergence of perceptual disturbances or disordered thinking. Transient psychotic symptoms can be associated with trauma disorders, borderline personality disorder, and acute intoxication. Psychotic spectrum disorders range from brief psychosis to schizophreniform to schizoaffective disorder or schizophrenia.

Malingering—which is a condition, not a diagnosis—is characterized by the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives.^{3,4} The presence of external incentives differentiates malingering from true psychiatric disorders, including factitious disorder, somatoform disorder, and dissociative disorder, and specific medical conditions.¹ In those disorders, there is no external incentive.

Malingering was first described as a means to avoid military service. In today's clinical practice, malingering can occur in circumstances where the person wishes to avoid legal responsibility or when compensation or some other benefit might be obtained.⁵ There are many reasons why one would feign an illness (Table 2).^{4,6}

It is important to remember that malingering can coexist with a serious mental illness. For example, a truly psychotic person might malingering, feign, or exaggerate symptoms to try to receive much needed help. Individuals with true psychosis might have become disenchanted with the mental health system, and thereby have a tendency to over-report or exaggerate symptoms in an effort to obtain treatment. This also could explain why many clinicians intuitively are reluctant to make the determination that someone is malingering. Malingering also can be present in an individual who has antisocial personality disorder, factitious disorder, Ganser syndrome, and Munchausen syndrome.⁴ When symptoms or diseases that either are thought to be exaggerated or do not exist, consider a diagnosis of malingering.

A key challenge in any discussion of abnormal health care-seeking behavior is the extent to which a person's reported symptoms are considered to be a product of choice, psychopathology beyond volitional control, or perhaps both. Clinical skills alone typically are not sufficient for diagnosing or detecting malingering. Medical education needs to provide doctors with the conceptual, developmental, and management frameworks to understand and manage patients whose symptoms appear to be simulated. Central to understanding factitious disorders and malingering are the explanatory models and beliefs used to provide meaning for both patients and doctors.⁷

When considering malingered psychosis, the suspecting physician must stay alert to possible motives. Also, the patient's presentation might provide some clues when there is marked variability, such as discrepancies in the history, gross inconsistencies, or blatant contradictions. Hallucinations are a heterogeneous experience, and discerning between true vs feigned symptoms can be challenging for even the seasoned clinician. It can be helpful to study the phenomenology of typical vs atypical hallucinatory symptoms.⁸ Examples of atypical symptoms include:

- vague hallucinations
- experiencing hallucinations of only 1 sensory modality (such as voices alone, visual images in black and white only)
- delusions that have an abrupt onset
- bizarre content without disordered thinking.^{2,6,9,10}

Malingers might describe an overly simplistic or vague hallucination, such as a single repetitive, unidentifiable voice with little variability in attempt to avoid detection¹¹ (Table 3).

The truth about an untruthful condition

Although the exact prevalence of malingering varies by circumstance, Rissmiller et al^{12,13} demonstrated—and later replicated—a prevalence of approximately 10% among patients hospitalized for suicidal ideation or suicide attempts. Studies have demonstrated even higher prevalence

Table 3

Common characteristics of feigned hallucinations

Hallucinations that occur in 1 sensory modality only (typically only voices)
Visual hallucinations in black and white only
Voices that are vague, simplistic, inaudible, or unintelligible
Unable to identify or describe the voice
Stilted or implausible language
Command voices related to an offense or external motivation
All commands must be followed and/or no attempt to diminish the hallucination

within forensic populations, which seems reasonable because evading criminal responsibility is a large incentive to feign symptoms. Studies also have shown that 5% of military recruits will feign symptoms to avoid service. Moreover, 1% of psychiatric patients, such as Mr. D, feign symptoms for secondary gain.¹³

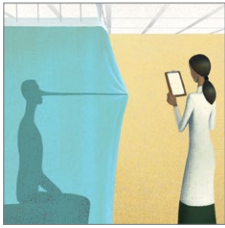
Although there are no psychometrically validated assessment tools to distinguish between real vs feigned hallucinations, several standardized tests can help tease out the truth.⁹ The preferred personality test used in forensic settings is the Minnesota Multiphasic Personality Inventory,¹⁴ which consists of 567 items, with 10 clinical scales and several validity scales. The F scale, "faking good" or "faking bad," detects people who are answering questions with the goal of appearing better or worse than they actually are. In studies of patients hospitalized for being at risk for suicide who were administered tests of self-reported malingering, approximately 10% of people admitted to psychiatric units were "faking" their symptoms.¹⁴

It is important to identify malingering from a professional and public health standpoint. Society incurs incremental costs when a person uses dwindling mental health resources for their own reward, leaving others to suffer without treatment. The number of psychiatric hospital beds has fallen from half a million in the 1950s to approximately 100,000 today.¹⁵

Clinical Point

Hallucinations are a heterogeneous experience, and discerning between true vs feigned symptoms can be challenging

continued



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It has been suggested that malingering could be viewed as an immature or primitive defense

Related Resources

- Brady MC, Scher LM, Newman W. "I just saw Big Bird. He was 100 feet tall!" Malingering in the emergency room. *Current Psychiatry*. 2013;12(10):33-38,40.
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Practical guidelines

Malingering presents specific challenges to clinicians, such as:

- diagnostic uncertainty
- inaccurately branding one a liar
- countertransference
- personal reactions.

Our ethical and fiduciary responsibility is to our patient. In examining the art in medicine, it has been suggested that malingering could be viewed as an immature or primitive defense.¹⁶

Although there often is suspicion that a person is malingering, a definitive statement of such must be confirmed. Without clarity, labeling an individual as a malingerer could have detrimental effects to his (her) future care, defames his character, and places a thoughtless examiner at risk of a lawsuit. Confirmation can be achieved by observation or psychological testing methods.

Observation. When in doubt of what to do with someone such as Mr. D, there is little harm in acting prudently by holding him in a controlled setting—whether keeping him overnight in an ED or admitting him for a brief psychiatric stay. By observing some-

one in a controlled environment, where there are multiple professional watchful eyes, inferences will be more accurate.¹

Structured assessments have been developed to help detect malingering—one example is the Test of Memory Malingering—however, in daily practice, the physician generally should suspect malingering when there are tangible incentives and when reported symptoms do not match the physical examination or there is no organic basis for the physical complaints.¹⁷ Detecting illness deception relies on converging evidence sources, including detailed interview assessments, clinical notes, and consultations.⁷

When you feel certain that you are encountering someone who is malingering, the final step is to get a consult. Malingering is a serious label and warrants due diligence by the provider, rather than a haphazard guess that a patient is lying. Once you receive confirmatory opinions, great care should be taken in documenting a clear and accurate note that will benefit your clinical counterpart who might encounter a patient such as Mr. D when he (she) shows up again, and will go a long way toward appropriately directing his care.

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Bottom Line

Clinicians often don't want to suspect malingering in a patient presenting with psychotic illness because they fear wrongly labeling a patient who needs treatment. The presence of external incentives differentiates malingering from true psychiatric disorders. Close observation and obtaining a consult are key. Although there are no psychometrically validated assessment tools to distinguish real vs feigned hallucinations, several standardized tests, such as the Minnesota Multiphasic Personality Inventory, can help tease out the truth.

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