Malingering

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Malingering adds to the cost of medicine. Unnecessary tests, exhaustive evaluations, and repeated referrals are part of the cost. In noneconomic terms, malingering erodes trust and confidence in the physician-patient relationship. This article explores means whereby the physician can detect the malingerer. Once the physician is convinced of the disingenuous nature of the symptoms, intervention is indicated. Suggestions for confronting the malingerer are reviewed.

The laity's increasing sophistication in this scientific, literate, and litigious world has amplified the difficulty of identifying the malingerer, characterized as "an actor." Because the possibility that an individual would even feign illness runs contrary to the empathic, trusting nature of the physician, the issue often never reaches the threshold of consideration.

The skill of the malingerer and the traditional caring and concerned nature of the physician work in tandem, allowing the actor to perpetrate his fraud. As this curious relationship develops, it becomes apparent, often subliminally, that the request for "help" actually is perverse. The malingerer pursues a carefully charted path not subject to major deviations, while the physician just as doggedly pursues the proper regimen to eventuate in full recovery. The actor, aware of the role he is playing, is able to subtly sidestep the physician. The illness continues to the silent delight of the actor, and much to the chagrin of the physician.

The physician's mounting frustration produces hostility, overtly or covertly expressed. For the experienced physician, this feeling should serve as a warning sign to pursue further investigation. Unfortunately, the physician rarely focuses skills to alleviate the impasse but institutes unnecessary interventions and reinforces subsequent behavior.

In the general population, malingering adds to the economic cost of medicine, both in tort actions and unnecessary interventions. The erosion of trust between the physician and patient is perhaps the greatest cost of malingering.

Identifying the actor in his role requires an organized approach, tempered with patience. Sensi-

tivity to the issue and consideration of malingering as a differential diagnosis are paramount. Only then can the curtain fall on the actor's performance.

Definition

Is malingering a specific mental illness replete with psychopathologic aberrations, or merely a conscious, voluntary act? A body of literature that defines malingering as a mental illness^{1(P88)} supports the former concept.

With World War II came numerous combat stress casualties and psychiatric theories that proposed that only a mentally ill person would malingering. Psychological tests have demonstrated that while malingerers respond differently, patently unusual responses are rare.

The Diagnostic and Statistical Manual of Mental Disorders, edition 3, revised (DSM-III-R)² supports the nonmental illness aspect and describes the prevailing concept of malingering.

It categorizes malingering as a "condition not attributable to a mental disorder," and concludes:

The essential feature of malingering is intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military conscription or duty, avoiding work, obtaining financial compensation, evading criminal prosecution, obtaining drugs, or securing better living conditions.^{2(P360)}

Etymologically, "malingering" has both French roots, *malingre*, to be sick, and Latin roots, *malus aeger*, an evil disposition.^{3(P401)} A common dictionary definition is "the willful, deliberate, and fraudulent feigning or exaggeration of the symptoms of illness or injury, done for the purpose of a consciously desired end."⁴

Conflicts of values

Viewed in this manner, malingering is not an illness with attendant disability and discomfort, but instead the manifestation of a conflict between personal and social values.⁵ Society rarely approves of faking an illness as a means of avoiding unpleasant work or achieving compensation, yet willfully exploits illness. We wink at that day of "sick leave," or "not tonight...I have a headache" but not at the same behavior if it aims to exact a price higher than society will accept.

The draftee who feigns an illness to avoid military duty "costs too much." If malingering goes unchecked, contagion develops and vast resources are lost. In World War I, an enterprising entrepreneur opened a "school of malingering."^{6(P160)} The participants were as carefully coached as any drama student is, and embarked on what for many were successful acting careers.

Factitious disorders

There is a range, then, of conscious behavior that is judged by social values. At the least disruptive level are those who have the aforementioned "sick day" or marital headache. At the extreme are those who consciously manipulate for even greater gains. Somewhere in the continuum lie those with factitious disorders. Of specific note is the tendency of some individuals, frequently criminals, to provide the most ludicrous response to a simple question. For example, when asked how many months in a year, they may say 13. Josef Ganer^{3(P403)} was first to describe this *vorbeireden*, or approximation of answers. Such persons have a tenaciousness in presentation that differs from that of the malingerer. In addition, no clearly observable goal is manifest. Ganer syndrome, as it has been known historically, is defined in the DSM-III-R under the title, "factitious disorder with psychological symptoms."²

A more dramatic factitious disorder is the Münchausen syndrome, or "factitious disorder with physical symptoms," characterized by Paul Bunyon-like stories, frequent hospital admissions, vague history, medical noncompliance, and a lack of family visits. The only goal of the person who consciously perpetrates this disorder is hospitalization. Unnecessary medical interventions are even more likely to occur for this disorder than for malingering.

Another form of malingering appears as an extension of a present or previously diagnosed disability. An unrelenting pain following a minor injury or fabrication of new symptoms to preclude hospital discharge is characteristic. Exploitation of the handicap is recognized as a vehicle carrying anger, revenge, and greed.^{3(P404)}

Complicating the distinction between what is conscious and unconscious is the recognition of both a primary and secondary gain in certain psychiatric disorders. Primary gain refers to the unconscious conflict resolution that the neurosis addresses, while secondary gain refers to more consciously derived advantages from the neurosis, such as money, work changes, help, or even attention.⁷ The interplay between the two can tax even the most astute psychiatrist.

Malingering, then, is a willful act with many permutations. For a performance to be successful,

the actor must have some confidence in his ability to deceive. Another prerequisite is a diminution of the inhibiting force in most people—guilt. The more closely the actor bridges the gap between deception and detection, the more likely he will succeed. The space between deception and detection is filled with anxiety, guilt, embarrassment, and even danger. These are potent factors that, when incompletely suppressed, lead to leakage. Often the first impression the physician has that something is amiss, usually subsumed intuitively, is due to this leakage.

Associated personality disorders

Certain personality disorders are associated with malingering,^{8(P318)} and the more adaptive the act in different situations, the higher the correlation with the personality.^{1(P86)} Individuals with personality disorders characterized by a disregard for social convention are prone to using manipulative tactics.

Environmental situations can provoke malingering. During periods of overwhelming social upheaval, often associated with imminent death, the incidence will increase. For example, "Cases of malingering in the USSR during the Civil War when banditry was being eliminated [were common]. In days before the revolution there was malingering to avoid military services; at present time one hardly ever finds this...."^{9(P944)}

Historical perspective

Malingering has been observed to be more common in institutional settings. Prisoners and soldiers have such a predilection. Whether this represents a true increase, a concentration of individuals so predisposed, factors promoting this behavior, or simply heightened sensitivity by the clinician^{10(PP855-856)} is clarified by examining the act historically.

Biblical and classical times

Malingering has been recognized from Biblical times:

And David arose, and fled that day for fear of Saul, and went to Achish the King of Gath. And the servants of Achish said unto him. Is not this David the King of the land? Did they not sing one to another of him in dances, saying Saul hath slain his thousands, and David his ten thousands? And David laid up these words in his heart, and was sore afraid of Achish the King of Gath. And he changed his behavior before them, and feigned himself mad in their hands, and scrabbled on doors of the gate, and let his spittle fall down upon his beard. Then said Achish unto his servants. Lo, ye see the man is mad: wherefore then have ye brought him to me? Have

I need of mad men, that ye have brought this fellow to play the mad man in my presence? Shall this fellow come into my house.¹¹

To avoid military service, Ulysses malingered a psychosis. By yoking a bull and horse together and plowing the seashore with salt, Ulysses had hoped to portray himself as a most unbalanced individual. His ruse was detected, however, when he maneuvered the plow around an infant placed in his path.¹²

The reigns of Henry VIII and Victoria

In 1542 during the reign of Henry VIII, the English adopted a statute that addressed the issue of malingering.^{6(P159)} Although the statute was in effect only until 1547, the judiciary sidestepped the issue of malingering versus a real illness and proceeded with sentencing regardless of the etiology.

A look at Victorian prison life not only helps illustrate the harshness of the penal system, but also explores the inmates responses. At sick call, for example, "the queues were swollen by the powers of the surgeon, almost miraculous in the circumstance, to transform the daily life of the convict."^{13(P169)}

The drudgery, danger, and disease rampant in the prison system were sufficient motive for many to fake an illness. The hospital ward offered rest, attention, and, most importantly, an improved diet.

The methods prisoners used to foist an illness were legion. The result was a pitched battle between the physicians and patients. Common tactics^{13(P1730)} included ingesting soap to induce a foamy diarrhea, or pressing the big toe firmly on the ground then alternately relaxing. The latter action had the most remarkable effect on cardiac auscultation: it affected an irregular heart beat. Faking paralysis was common also.

Since all illness raised the specter of malingering, prison doctors developed an appropriate armament. "The first defense of the Doctor against these minor impositions was the threat of report and disciplinary action."^{13(P173)} More stringent measures were reserved for the more recalcitrant. Operating on the premise that faking was always primal, the doctors subjected an inmate with paralysis to a typical evaluation:

On Thursday they applied a large blister to the nape of his neck, Friday a huge mustard plaister about the size of a small bed pillow was placed on the pit of the stomach, Saturday and Sunday they left him to enjoy the delights of these practical jokes, and on Monday, I believe, they started at him with the stomach pump.^{13(PP175-176)}

American Civil War

During the same time period, yet a continent away,

a Confederate surgeon wrote to his wife:

Cpt McFall and Lieutenant Mike Bowers came back looking for stragglers, and found four young men who were known to be cowards, but who were always great braggarts after a battle was over. They all pretended to be sick, but I could see no indications of it, and they were marched off, but, before reaching the works, one of them slipped away, although the fighting had ended.¹⁴

The north also had its share of malingerers. A Union officer noted in his diary:

Long roll was beat about 11 o'clock p.m. The Regt turned out to a man and were in line of Battle in 7 minutes, and ready for the enemy. Yet there was a number who were suddenly taken with a pain in the stomach and felt like going back to their tents.¹⁵

Detecting the deception

Historically, then, one practices deception in the service of a desirable end. However, since many actors are not so well versed, their audience may become vaguely aware of the deception. Although difficult for the physician to verbalize, this awareness is probably related to the concept of leaking.¹⁶

The malingerer, consciously aware of his charade, is battling his anxiety in varying degrees. His attempt to suppress anxiety by controlling facial muscles, voice, or posture is not always successful. As a result, the anxiety leaks out and betrays the actor. In a blatant form of deception, the individual who smiles, yet has an angry voice, perplexes his audience and raises questions of veracity.

Apparently conversation falls within a range of expectations which, when exceeded, provokes an internal review.¹⁷ Such aberrations might include: messages that are too good or too negative, a furtive glance, an awkward stare, a rigid posture, and other behavioral extremes. "The lady doth protest too much, me thinks" *Hamlet* III, ii, 242) is the Shakespearean recognition of this phenomenon.

Yet, just how effective can an examiner be in detecting deception? Of 16 studies reviewed by DePaulo and colleagues,^{17(P130)} all but two concluded that lie detection by examiners is more accurate than may occur by mere chance. Common sense indicates that perception and interpretation of the covert signs of deception will enhance accuracy.

In another study¹⁸ comparing the modalities of reading, listening, and observing for accuracy in detecting deception, it was found that visual cues are mostly distractors that diminish accuracy. Listening and reading (ie, a deposition) provide a better approach. This is consistent with another observation that whenever an examiner suspects deception, he or she minimizes visual cues while attending more closely to the nature and quality of

the voice.^{17(P137)} Perhaps, in some respects, this accounts for the psychoanalyst's posture.

Careful attention, then, to the voice will provide valuable clues. In general, the examiner should note both latency and length of response. When a person is practicing deception, he pauses long before answering a question.^{17(P136)} The additional time allows for tailoring the subsequent response, which then becomes either quite brief or exhaustive.^{17(P136)} Again, what falls outside the expected range is suggestive. Additional clues include: grammatical errors, "Freudian slips" (or parapraxes), a change in pitch, and periods of prolonged silence.

The examiner needs to understand any change in behavior. The actor is playing to a select audience, and, at times, the assumption of the role is recognizable. In the waiting room, for example, one may observe the actor in animated conversation with others, or perhaps engaged in serious reading. When the actor enters the physician's office, his behavior changes, often most dramatically.

The malingerer also overacts:

In imitating the behavior of a psychotic patient, the malingerer goes to extremes. If he is told to shut his eyes, he does not close his lids, but uses his fingers to bring the lids together. When someone shakes hands with him, he uses his left hand instead of his right. Another malingerer, when going to sleep, puts on his glasses and lights his pipe. Such conduct is due to the fact that the malingerer thinks that the stranger he behaves, the more psychotic he will be assumed to be.^{9(P41)}

Although most actors are more accomplished than this, the principle remains the same. The actor is basing his performance on his own preconceived notions. The best means of detection, then, is a thorough history and physical examination. The physician's experience, medical knowledge, and judgment combined lead to discovery of symptom contradictions.

In the initial evaluation, the examiner gauges the degree of cooperation. The actor often will call attention to his symptoms, yet take umbrage at an in-depth evaluation.^{12(P270)} Such hostility can effectively intimidate the physician and preclude an evaluation. Those particularly adept at evasion produce an aura of pseudocooperation. Persons with certain personality disorders are particularly skillful, so that the examiner may be embarrassed at the conclusion of such an interview to be aware of the paucity of information garnered. The actor's ability to turn a question, nimbly sidestep it, and still satisfy the interviewer is incredulous at times. The examiner should suspect this maneuver when the actor resists clarification.

The other posture of the actor is to adopt an ingratiating attitude. Absolute statements, such as "I never lie" or "You can always trust me," often are a prelude to a mendacious monologue.

The onset of the illness and the premorbid history are important. Is the history compatible with the diagnosis under consideration? In persons with severe mental illness, the chronology generally is punctuated by hospitalizations. One should examine the origins of the illness, particularly in relation to external events such as a criminal indictment.

Persons affected with severe pain, depression, or major illness will have varying degrees of cognitive impairment. A clear, concise account of the disability argues for a more intact mental status.¹⁹ In addition, a claim of major impairment must be weighed against the tenaciousness with which the actor pursues many claims.²⁰ Disability is also nonselective so that work inhibition should coexist with recreational impairment. An individual overwhelmed with pain will find it difficult to enjoy any pleasurable activity.

Hearing voices

An interesting tactic of the actor is to assert a simple declarative statement forcefully: "I hear voices." The actor assumes such a position is unassailable. A subjective experience is difficult, but certainly not impossible, to verify. A thorough history combined with discriminating diagnostic details is sufficient.

Hallucinations

The physician should probe any hallucination in-depth, beginning with open-ended questions that provide little structure: By saying, "Tell me more about your voices," the examiner indicates to the malingerer that additional details will be required.

As the interviewer gathers information, he or she should vary the pace of the interview to look for latency. Leading questions are helpful to gauge consistency. An individual suffering a true disability has specific signs and symptoms. Suggesting alternative symptoms is confusing to the malingerer.

There is often a sense that the actor takes his cues from the examiner and tailors his responses as appropriate. The examiner should explore this area with both structured and open-ended questions: "Do the voices affect your life? Are they worse at night or during the day? Are the voices more noticeable during meals or after meals?" The gamut of answers can run from the sublime to the ridiculous.

Often the hallucinations exist in an isolated form that defies the typical presentation. Normally, hallucinations coexist with a delusional process. In the major depression, a profound sense of worthlessness is reinforced by self-deprecating voices.

Hallucinations alone do not a psychosis make. Without the associated thought disorder, ambivalence, disturbed affect, or organic etiology, hallucinations should be suspect. These latter elements of a psychosis are more difficult to portray, leaving the examiner with an advantage. If the actor attempts simulation, he will find maintenance difficult. A prolonged interview or hospitalization will fatigue all but the most stalwart.

Since the malingerer often chooses to feign hallucinations, discriminating diagnostic details gleaned from a literature review are useful. One often-quoted study²¹ notes that auditory hallucinations are the most common form; however, visual hallucinations predominate in persons with the organic brain syndrome.

Hallucinations in more than one of the senses are common. Nearly 75% of patients with either an affective disorder with psychosis or chronic schizophrenia report visual hallucinations at least one time in their life. Fifty percent of the schizophrenics reported an incidence of tactile hallucinations. Half of the affective disorder and schizophrenic patients had concurrent auditory and visual hallucinations. An important differential is the presence of hallucinations when other people are present. Ninety-four percent of schizophrenics had hallucinations regardless, while 43% of patients with affective disorders never hallucinated when other people were around.

Excepting the chronic schizophrenic, 67% of patients with affective disorders and 79% of schizophrenics experience hallucinations for six months or less. Hallucinations occur intermittently, not continuously. Seventy-five percent reported hallucinations of less than one hour's duration. The majority described the voices as originating "outside their head." Only 8% endorsed confidence in removing hallucinations through distraction. In the study by Goodwin and colleagues²¹ and a subsequent one by Hellerstein and colleagues,²² the patients generally ignored command hallucinations. None submitted to specific acts. Ninety-three percent described clear auditory hallucinations—not muffled, indistinct sounds.

Visual hallucinations in the patients with non-organic etiology are colored representations of normal-sized people. In addition, there is no change in the hallucinations according to whether the eyes are open or closed. This point differentiates drug-

induced hallucinations where closed eyes intensify the experience.²³

Medical records and psychologic tests

Finally, a review of medical records and a battery of psychologic tests also can help identify the malingerer.

A relatively new diagnosis subject to the malingerer's exploitation is the posttraumatic stress disorder (PTSD). Because the disorder consists of mostly subjective symptoms, verification can be elusive; thorough evaluation is foremost.

An exhaustive review of military records that disclosed several discrepancies was no doubt decisive in the guilty verdict reached in *Arizona v. Jensen*.²⁴ Citing PTSD, the defendant sought to overturn a prior conviction for murder. As the new 1985 trial unfolded, the defendant's claim of extensive combat exposure was refuted. Since PTSD is becoming entrenched in both criminal and civil litigation, elucidating discriminating diagnostic details requires collateral contacts with employers, family, and friends. Only then can one reasonably establish cause and effect.

Another malingered diagnosis is the seizure. Foisted as exculpatory for misfeasance, goal-directed violence is rare as an epileptic phenomenon.²⁵

Management approaches

Having identified a potential malingerer, the examiner shifts the focus toward clarification. Direct confrontation is rarely necessary. It is preferable to challenge the malingerer indirectly. Discussing the differences between the malingerer's presentation and established medical knowledge can begin with, "Your illness doesn't quite fit with my experience."

Allowing the individual to consider the consequences of continued acting also can be useful. Explaining the predicted outcome of the disability in terms of extensive hospitalization, job impairment, and the attendant social stigma sometimes is sufficient. In many instances, the malingerer will abandon the role if the cost is too great.

Other management approaches borrow from lessons learned in military psychiatry. On the battlefield, rapid triage is necessary. Separating the combat stress casualties, the malingerers, and those with true psychiatric disorders requires a systematic approach. The acronym PIES (proximity, immediacy, expectancy, and simplicity) is used to describe the basic modality: The soldier is evaluated in close proximity to the battleground as immediately as conditions allow. If treatment is necessary,

it is kept simple, with the clear expectation that a return to duty will follow.

In a situation or setting where there is a high incidence of malingering, one should evaluate the suspected malingerer as soon as possible.¹ Early determination of the malingerer is quite relevant in forensic psychiatry, where a substantial delay between alleged offense and examination allows the actor both to learn and rehearse his role.

The evaluation should not convey the expectation that a major psychiatric diagnosis is forthcoming.

As Ossipov notes, "There is also the danger that if a definite diagnosis is made there will be a certain fixed prejudicial attitude on the part of the hospital personnel because of the specific diagnosis assigned."⁹(P42) The examiner must select the methods of evaluation judiciously, opting for simplicity. Unnecessary medical interventions not only reinforce the patient role, but normal variances leave room for later manipulation.

Summary

Physicians should include malingering in the differential diagnosis particularly in certain institutional settings. Factors such as litigation and social chaos increase the prevalence.

Malingering is viewed properly as a willful act directed toward a specific goal. Such goals might include: monetary gain, relief from onerous duty, revenge, avoiding responsibility, and ensuring dependence. The practice of malingering is common and exists as a continuum. Certain types of feigning are condoned, while others bring sanctions, with the threshold between the two being indistinct. For the physician to determine this distinction requires careful assessment of the potential impact on the patient and society.

Detecting deception is difficult, but not impossible. The concept of leaking provides some legitimacy to intuition when the examiner notices that the actor is disingenuous. Whenever malingering is added to the differential diagnosis, a thorough evaluation, discriminating diagnostic details, and certain interview techniques will provide a degree of objective verification.

Once the physician identifies malingering, he or she focuses on management. Indirectly confronting the individual, the preferred method, allows the malingerer to abandon the role and retain dignity. Ultimately, malingering remains a difficult issue for both the patient and the physician. Proper management, however, can produce beneficial results that preserve the integrity of the physician-patient relationship. The judgement and skill of the physician will, as always, shape the outcome.

1. Bash IY, Alpert M: The determination of malingering. *Ann NY Acad Sci* 1980;347:86-89.
2. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders DSM-III-R*, ed 3, revised. Washington, DC, American Psychiatric Press, Inc, 1987, p 360.
3. Gorman WF: Defining malingering. *J Forensic Sci* 1982;27:401-407.
4. *Dorland's Illustrated Medical Dictionary*, ed 27. Philadelphia, WB Saunders Co, 1988, p 975.
5. Szasa TS: Malingering: 'Diagnosis' or social condemnation. *Arch Neurol Psychiatry* 1956;76:432-433.
6. Diamond BL: The simulation of sanity. *Journal of Social Therapy* 1956;3(2):158-165.
7. Fenichel O: *Psychoanalytic Theory of Neurosis*. New York, WW Norton & Co, Inc, 1945, pp 126-127.
8. Garner NN: Malingering. *IMJ* 1965;128:318-319.
9. Ossipov VP: Malingering: The simulation of psychosis. *Bull Mennings Clin* 1944;8:39-42.
10. Kaplan HI, Sadock BJ: *Modern Synopsis of Psychiatry IV*. Baltimore, Williams & Wilkins, 1985, pp 855-856.
11. I Samuel 21:10-15 (King James Version).
12. Macdonald JM: *Psychiatry and the Criminal: A Guide to Psychiatric Examination for the Criminal Court*, ed 3. Springfield, Ill, Charles C Thomas Publisher, 1976, p 267.
13. Priestly P: *Victorian Prison Lives*. New York, Routledge, Chapman & Hall, Inc, 1985, p 169.
14. Welch S: *A Confederate Surgeon's Letter to His Wife*. New York, Neale Publishing Co, 1911, p 53.
15. Wiley BL: *The Life of Billy Yank*. Baton Rouge, La, Louisiana State University Press, 1971, p 86.
16. Audio Digest Foundation: *Malingering*, vol 14, No. 24. Glendale, Calif, California Medical Association, 1985.
17. DePaulo BM, Zuckerman M, Rosenthal R: Humans as lie detectors. *Journal of Communication* 1980;30(2):129-139.
18. Maier N, Thurber J: Accuracy of judgements of deception when an interview is watched, heard, and read. *Personnel Psychology* 1968;21:23-30.
19. Lees-Haley P, Lawton M: Guard yourself against the menace of malingerers. *Medical Malpractice Prevention* January-February 1987, pp 22-24.
20. Resnick P: The detection of malingered mental illness. *Behavioral Sciences and the Law* 1984;2(1):21-37.
21. Goodwin DW, Alderson P, Rosenthal R: Clinical significance of hallucinations in psychiatric disorders: A study of 116 hallucinatory patients. *Arch Gen Psychiatry* 1971;24(1):76-80.
22. Hellerstein D, Frosch W, Koenigsberg HW: The clinical significance of command hallucinations. *Am J Psychiatry* 1987;144:219-221.
23. Asaad G, Shapiro B: Hallucinations: Theoretical and clinical overview. *Am J Psychiatry* 1986;143:1088-1097.
24. Sparr LF, Atkinson RM: Posttraumatic stress disorder as an insanity defense: Medicolegal quicksand. *Am J Psychiatry* 1986;143:608-613.
25. Riley TL, Brannon WL Jr: Recognition of pseudoseizures. *J Fam Pract* 1980;10:213-220.

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