

A Clinical Approach to the Malingering Patient

Ricky D. Malone and Christopher L. Lange

Abstract: Malingering presents special challenges to the practicing clinician, including diagnostic uncertainty, the confrontation of potentially criminal conduct, and countertransference and personal reactions. Maintaining a traditional clinical approach to the patient suspected of malingering enables the therapist to draw analogies to other disorders and utilize customary diagnostic and therapeutic skills.

Malingering has long been recognized in the military, and has predictably come to the forefront of clinical practice during a time of war. The art in military medicine is to find a way to make our ethical and fiduciary responsibility to act in the best interest of the patient coincide with the needs of the system. In this context, malingering can also be viewed as an immature or primitive defense in a very stressful situation, and approached accordingly. This article discusses key elements of the history and mental status examination in the clinical assessment of malingering, and therapeutic analogies that offer the possibility of a positive outcome for an otherwise potentially negative encounter.

Malingering has always presented special challenges to the practicing clinician, which is not unexpected since it places one immediately at odds with the patient, given opposing goals for the clinical encounter. Although malingering may be listed on Axis I as a focus of clinical attention in the multiaxial assessment, many clinicians may not even conceptualize it as a mental disorder or diagnosis, but rather as a type of antisocial behavior. Indeed, malingering may be the basis for civil or criminal litigation as a form of fraud, and in the armed forces it can be a specific criminal offense under the Uniformed Code of Military Justice.

Professionals are reluctant to label patients as malingerers for many reasons, not the least of which is this perception that it is tantamount to accusing the individual of fraud and deceit. As clinicians we are accustomed to using our skills to diagnose and treat those who seek help for their problems, and often feel out of our element when confronted with a patient who seeks not therapeutic assistance to improve his or her

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well-being, but rather "official" corroboration of an attempted deception. Nevertheless, approaching the patient suspected of malingering from a traditional clinical perspective allows the therapist to draw analogies to other disorders and bring to bear our customary diagnostic and therapeutic skills, albeit with a different set of expectations.

We should also bear in mind that reluctance to diagnose an obvious case of malingering or, even worse, taking the perceived path of least resistance and treating the patient as if he or she had the feigned illness anyway, will likely violate the maxim of "*primum non nocere*" (first do no harm). It may be tempting to insulate the patient from the natural consequences of this behavior with the shortsighted view that either the benefits accrued by a successful deception or avoiding the penalties associated with fraud would be in the patient's best interest. However, this would inevitably promote a dysfunctional psychosocial developmental process and foster longer-term negative effects. The art in military medicine is to find a way to make our ethical and fiduciary responsibility to act in the best interest of the patient coincide with the needs of the system. Such dual agency issues, of course, are not limited to the military, since therapeutic practice often requires balancing the individual needs of the patient with broader social obligations.

The *Diagnostic and Statistical Manual, 4th Edition*, defines malingering as "the intentional production of false or grossly exaggerated physical or psychological problems, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs" (American Psychiatric Association, 2000, p. 739). It also points out that it may be viewed as adaptive behavior under extreme circumstances, for example when a prisoner of war feigns illness to escape maltreatment. Malingering has a longstanding history of recognition in the military, highlighting the avoidance of military duty at the top of the list of external incentives in its description (Lipian & Mills, 2000). This issue has predictably come to the forefront of clinical practice during a time of war. Malingering has increasingly surfaced as an attempt to avoid combat duty by soldiers who otherwise lack the antisocial tendencies we usually associate with this behavior. In this context, malingering can also be seen as a maladaptive or primitive defense in a very stressful situation (Blair, Jones, Clark, & Smith, 1997).

The initial clinical suspicion of malingering is often intuitive, suggesting a definition more akin to Justice Potter Stewart's oft-quoted description of pornography, paraphrased, "I cannot define it, but I know it when I see it" (*Jacobellis v. Ohio*, 1964). This seemingly intuitive suspicion with an apparent lack of objective data adds to the reluctance to definitively document the clinical impression of malingering. However,

this initial subjective impression of deception often results from the subconscious processing of nonverbal cues. As described by Lande in 1989, "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 intuitively is due to this leakage" (Lande, 1989, p. 484)

The first step in the clinical approach to malingering requires bringing this subconscious processing into conscious awareness and verbalizing those nonverbal cues in a more objective fashion. The clinical skills involved in this process are similar to those required to recognize one's own countertransference reactions and to treat them as clinical data rather than obstacles to therapy. This adaptation of familiar clinical skills also begins the process of drawing clinical analogies and placing the therapist back in more comfortable territory.

CLINICAL ASSESSMENT

The clinical assessment of suspected malingering begins, as always, with a careful history and comprehensive mental status examination. When possible, the history should rely more heavily on collateral contacts than the usual clinical assessment, much the same as we would approach a forensic examination. This is an apt analogy, since we may anticipate that our diagnostic conclusions will be objectionable in the eyes of the patient and likely challenged, and may eventually serve as the basis for legal or administrative action, either by or against the patient. The initial history obtained from the patient should include a detailed description of the phenomenology associated with the illness (e.g., the nature and characteristics of the hallucinations in feigned psychosis), which will provide objective data to support the contentious diagnosis.

Besides the obvious exaggeration of the severity of symptoms, the history provided by the malingerer is usually replete with inconsistencies. Careful documentation of these inconsistencies provides further objective data to definitively establish the diagnosis. They include the internal inconsistencies in the patient's account of his or her symptoms, inconsistencies between reported signs and symptoms and those that we may observe, and inconsistencies with the typical signs and symptoms of the feigned illness.

When practical, a prolonged interview makes it difficult for the patient to sustain the deception, much like the strategy employed by police interrogators, leading to inconsistent reporting over time. Careful attention to these inconsistencies helps to confirm the diagnosis, and may provide clues to the patient's motivation and areas to explore if confron-

tation is required. Reported claims of symptoms may also be inconsistent with clinical observations, for example when a patient reports extreme cognitive deficits yet managed to negotiate the public transportation system without assistance and show up for his or her appointment punctually.

Perhaps the most important observations, though, are the simple inconsistencies with known features of the feigned illness that a malingerer may be unaware of (depending on how well they have prepared) or be unable to reproduce. These generally fall into two categories, which may be thought of as errors of omission and errors of commission. The latter involves the reporting of signs or symptoms that are rarely if ever seen in the truly ill, for example, describing visual hallucinations in schizophrenia as black-and-white when questioned in detail, when in fact a minority of true schizophrenics report visual hallucinations and they almost universally describe them as being in color when they do. Historical inconsistencies represented by errors of omission involve a failure to exhibit signs and symptoms that are commonly seen in the truly ill, for example, disorganization or the negative symptoms of schizophrenia. Thorough familiarity with the phenomenology of the feigned illness and knowledge of the prevalence of such specific characteristics are indispensable in this aspect of the history. Resnick (1999) provided an excellent description of this approach to the assessment of feigned psychosis, which may be readily adapted to other illnesses after a quick review of the pertinent characteristics.

The mental status examination in the assessment and documentation of malingering focuses on the nonverbal cues to deception resulting from the "leakage" mentioned earlier. Special vigilance is required if one suspects the presence of an antisocial, borderline, or narcissistic personality disorder or traits, as is often the case, since there may be less anxiety or guilt associated with deception in these individuals. Studies of the detection of deception have demonstrated that eye contact and facial expressions are unreliable indicators in spite of popular beliefs to the contrary. This holds true for experienced clinicians and interrogators as well as for lay people. Instead, we are advised to pay attention to the voice rather than visual clues (Depaulo, Stone, & Lassiter, 1985). Indeed, visual cues may be more distracting than helpful. Vocal clues to deception include elements of prosody and speech content. The speech of malingerers often sounds rehearsed, with fewer pauses than genuine patients, precisely because they have rehearsed many times, at least mentally. When led away from these prepared scripts with specific questions, their speech shows more hesitation, grammatical errors, and parapraxes. At this point, they tend to make overgeneralized and vague statements, avoiding details because of uncertainty of the "correct" re-

sponse, a characteristic seldom seen in patients who have truly experienced the feigned illness. Perhaps related to underlying feelings of guilt, it has also been observed that most people when lying tend to make more negative statements, while using fewer contractions in their speech (e.g., "I do not" instead of the more conversational "I don't"; DePaulo et al., 1982). Elucidation of these observations in the mental status examination provides further objective evidence to support the diagnosis of malingering.

A clinical approach also requires the systematic consideration of a differential diagnosis. When malingering is suspected, this differential diagnosis often includes unfeigned illness, conversion disorder, and factitious disorder. Ruling out the illness suspected of being feigned requires the usual diagnostic work-up for that illness, with particular attention to the signs, symptoms, and the typical characteristics of the specific phenomenology associated with it. The decision to use invasive or costly procedures judiciously requires balancing an assessment of the risks and benefits of the procedures with the likelihood and consequences of an erroneous diagnosis, either false positive or false negative. The consequences of not treating a relatively minor illness are obviously different than for a more serious illness; similarly, the legal or financial consequences of an erroneous diagnosis of malingering may vary widely depending upon the circumstances. Ruling out a conversion disorder may be more difficult, since a key factor in distinguishing it from malingering is whether the symptom production is conscious or unconscious. This elaboration may become even more complicated in the patient whose feigned symptoms are done out of "habit," which may be seen as arising within a preconscious awareness. Such patients may feign a symptom, but can only conjure the motivation, or even an awareness of the falsity of their symptoms, with a conscious act of focusing attention. This maintenance of a repressive barrier censors the unacceptable desire to lie outright, a primitive method to gain relief from suffering, from interfacing with the conscious region of the mind.

In this case, associated features are helpful; for example, malingerers are more likely to be suspicious, uncooperative, and avoidant of diagnostic evaluation, whereas patients with conversion disorder tend to be friendly, cooperative, and readily engage in diagnostic procedures (Lipian & Mills, 2000). Although the deliberate production or feigning of symptoms may be obvious in some cases, distinguishing between malingering and factitious disorder based on the conscious awareness of the motivation is still often unclear. A combination of primary and secondary psychological gain is often present, and the attribution of which factor is most significant may still involve a certain degree of subjective clinical judgment.

When there is clinical doubt about the diagnosis, or reluctance to definitively state it without more objective evidence, psychological testing may sometimes provide further support. The validity scales of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) are widely used and often provide useful information (Butcher et al., 1989). There are also some instruments designed specifically for the detection of malingering, for example, the Structured Interview of Reported Symptoms (SIRS; Rogers, 1992) or the Test of Memory Malingering (TOMM; Tombaugh, 1997), which are frequently used in forensic settings where it is much more prevalent.

COUNTERTRANSFERENCE

As clinicians, we are trained to accept our patients' word when reporting their symptoms. From their descriptions of illness, one guides their treatment into productive avenues. When it becomes clear that a patient has been dishonest about his or her symptoms for the purpose of an external motivator, the therapist may well become plagued with a sense of betrayal. A frequent thought endorsed is, "I should have known." However, studies have found that therapists are poor lie detectors, despite our skill in the human psyche. Only 12% of psychiatrists reach a significant level of accuracy in detection of lies (Ekman & O'Sullivan, 1991). In this same study, it was found that the general population could detect lying only slightly greater than chance. Of the groups studied, only Secret Service Agents were of greater accuracy (29%) in the detection of deception than psychiatrists. Objectivity about our own limitations in this regard should help dispel any sense of personal failure, which should remind us to examine why we empathized with the patient in the first place and perhaps identify unconscious motivations underlying the deceit.

Mark Twain once said that "None of us could live with a habitual truth teller; but thank goodness, none of us has to" (Twain, 1882, p. 1). This anecdote implies the bold assertion that everybody lies. To be judgmental in our approach is paradoxical in light of our mixed societal messages about deceit, where we condone "white lies" to protect the self-esteem or status of another person or group. It is a more useful approach, instead, to work with the patient to determine the reason they have lied. Countertransference reactions need not be limited to the negative aspects of the patient's presentation and behavior. They also offer the best opportunity for us to explore what in ourselves has agreed with the story, had it been accurate. By delving into this aspect of our own subconscious, we can begin to understand what were the patient's unspoken, and potentially unconscious, reasons for the deception.

Anger at the patient generally stems from a belief that they are "putting something over" on us as therapists. This deception attacks the core of our sense of power, because the lie serves as a reminder of our personal, narcissistic sense of powerlessness. However, every lie told may be seen as an attempt to support the liar's sense of self-esteem, power, and individuality. This holds true for the malingering patient as well. The primitive nature of this technique to acquire psychological protection is a legitimate focus that warrants treatment.

TREATMENT

Having established the diagnosis of malingering, the next step in a clinical approach obviously entails an attempt to treat the "disorder." From the viewpoint that this represents a maladaptive or primitive defense in a misguided attempt to resolve a problem or conflict, therapeutic efforts focus on the promotion of more socially acceptable and mature coping strategies while tactfully confronting the deception. This requires a degree of clinical neutrality combined with eventual firm but nonadversarial confrontation of inconsistencies and diagnostic conclusions. Such an approach is often difficult, since countertransference and personal reactions are common and frequently complicate diagnosis and treatment. Therapists, as a group, tend to believe a patient's historical account, even while recognizing the possibility of unconscious distortion, reflecting an empathic response based on the assumption that the patient is there in a genuine effort to receive help from us and alleviate distress. This empathic response is diametrically opposed to the personal emotional reaction experienced when we believe we are being manipulated in a direction we do not wish to travel. However, this is also true in the case of diagnosing and treating many personality disorders, again allowing us to draw upon a clinical analogy and adapt our usual approach to this challenge.

It may be helpful to elicit underlying reasons for the deception and then explore alternate "face-saving" pathways if possible. By avoiding collusion in the deception, establishing an expectation of recovery, and perhaps offering an opportunity to give up the deception without necessarily admitting to it overtly, the patient may be guided to a more adaptive outcome. Once again, this indirect confrontation and "face-saving" alternative approach may be viewed as analogous to therapeutic methods used in the treatment of conversion or factitious disorders.

The approach to the malingering patient in combat is complicated by dual agency and ethical considerations. Although the motivation may appear to be no more than a superficial attempt to return home, it is often predicated by a legitimate primal fear for personal safety. In either

sense, it creates a concern for an "epidemic" of malingering within the unit. Furthermore, the malingerers' actions create a danger to the lives of the peers with whom they stand side-by-side in arms. This introduces the military psychiatrist's third-party duty to protect those comrades and involve the military commanders, derived from our dual role as officers in the Armed Forces. These commanders may demand that disciplinary action be pursued when such deception has been detected, which may or may not be in the patient's best interest from a purely clinical perspective. The military psychiatrist is challenged with balancing these considerations and the investment of therapeutic resources, including his or her own time and energies. Often the adage of "greatest good for the greatest number" influences the type of treatment that can be offered in the combat zone, where there may be substantial pressures to treat "bona fide" combat stress reactions, rather than "misconduct stress behavior." If we must succumb to the pressure to forgo treatment of the latter group, we may miss a genuine opportunity to effect not only a long-lasting change in the patient, but also an opportunity to return a more functional troop back to the unit.

Symptoms frequently abate only after the desired outcome has been achieved, or the effort is clearly seen as futile by the patient. It may therefore become necessary to point out the negative consequences of persisting in an unsuccessful attempt to deceive and to offer the patient an opportunity to avoid them. Obviously, the more the behavior has been reinforced, either earlier in the current episode or in prior episodes, the more likely it is to persist or recur. If despite these efforts the patient is unwilling to abandon attempts to feign illness, at some point we must also abandon the hope of a short-term positive therapeutic outcome. Instead, we may be forced to adopt the view that the ensuing negative consequences are necessary if the individual's longer-term psychosocial development is ever to be realized.

SUMMARY

The reluctance to diagnose malingering in spite of strong suspicions stems from both conscious and unconscious processes on the therapist's part, but it can be overcome with an informed clinical approach that provides us some hope of a truly positive therapeutic outcome. Approaching the deception as a maladaptive attempt on the patient's part to resolve a problem or conflict, and drawing analogies to other clinical situations involving more primitive defenses, allows us to use our familiar clinical skills of diagnosis and treatment to resolve our own and the patient's conflicts in what is often an uncomfortable encounter for both. This clinical approach requires a careful history that illuminates incon-

sistencies and a mental status examination that describes the nonverbal cues to deception. It may also include the judicious use of indicated ancillary studies to provide objective data to support a definitive diagnosis, regardless of the comfort level. Therapeutic efforts may then focus on the promotion of more socially acceptable and mature coping strategies to resolve the patient's problem, avoiding the complications of incurring further negative consequences. If these interventions fail, such negative consequences may eventually prove necessary to overcome the maladaptive behavior.

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