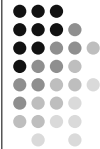


Treating Malingering in an Acute Care Setting

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Treating Malingering in an Acute Care Setting



- Rule of Thumb

- If it doesn't add up...
- It doesn't add up.

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- Malingering

- DSM-IV-TR Definition: the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.
- Can vary from full fabrication of symptomatology (*pure malingering*) to conscious exaggeration of actual symptoms (*partial malingering*).
- Some individuals may downplay or deny symptomatology for secondary gain, which can also serve as malingering.

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- Malingering

- Factors associated with malingering include:
 - history of legal problems
 - substance dependence
 - antisocial personality disorder
 - homelessness and
 - being single.

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- Factors that increase suspicion for malingering include:

- A thorough knowledge of symptoms as they present in a 'genuine' illness goes a long way in helping diagnose malingering.
- Display of illness only in selective settings or at certain times, particularly when the patients knows that he/she is being observed.
- Symptoms relayed in an overly zealous or scripted manner; conversely, answers provided in an evasive, fairly vague manner.

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- Factors that increase suspicion for malingering include:

- Positive endorsement of virtually all symptoms inquired about, particularly ones which are uncharacteristic for a given disorder.
- Discrepancy between what is reported, observed, learned from testing, and what is known about the typical presentation for a disorder (i.e.: in psychosis, the presence of isolated hallucinations (particularly visual) or command hallucinations that are always obeyed; in severe depression, absence of psychomotor retardation or other neurovegetative symptoms).

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- **Factors that increase suspicion for malingering include:**
 - Inconsistency in history provided or patient presentation over time.
 - Contradictory collateral information.
 - Prior history of malingering.
 - Patient refusal to comply with recommended testing or treatment.
 - Patient refusal to accept that no diagnosis is present.
 - Patient insistence on receiving only a certain medication or class of medications.
 - Atypical treatment response (overly rapid improvement, absence of improvement, unusual side effects).

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- **If you suspect malingering:**
 - Consider possible reasons for secondary gain:
 - seek collateral information
 - evaluate over several sessions
 - consider ordering psychological or physiological testing and
 - Consider obtaining a second opinion or consultation.
 - Psychological testing can be employed in the detection of malingering.
 - Keep in mind that a patient can mangle certain symptoms but still suffer from psychiatric illness.

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- **If it is determined that a patient is malingering, one may, and should, still be able to intervene therapeutically.**
 - Consider the underlying reason for the malingering (i.e.: for a patient who is feigning suicidality out of fear that he will be attacked by his cell mate, attempting to arrange for a transfer to another cell).
 - Treat the underlying condition, skill deficit or cognitive distortion.

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- **Malingering is distinguished from factitious disorder in its motivation:**
 - Malingering is prompted by a conscious desire to obtain external rewards or environmental outcomes.
 - Factitious disorder is motivated by a combination of intrapsychic needs manifesting themselves as a nearly irresistible desire to assume the sick role.

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- **Differentiating malingering from the somatoform disorders (e.g., conversion disorder)**
 - Somatoform disorders lack the volitional component of malingering.
 - In the somatoform disorders, an underlying emotional conflict is thought to be unconsciously transformed into a physical manifestation of some kind.
 - No external environmental outcome or reward is consciously sought.

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- **If malingering occurs in association with such mental disorders as antisocial personality disorder, factitious disorder, or a somatoform disorder, the diagnostician is enjoined to consider those diagnoses primary.**

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- **Diagnosis and Clinical Features**
 - **Diseases are usually feigned to accomplish:**
 - Avoidance of Criminal Responsibility, Trial, and Punishment
 - Avoidance of Military Service or of Particularly Hazardous Duties
 - Financial Gain
 - Avoidance of Work, Social Responsibility, and Social Consequences
 - Facilitation of Transfer from Prison to Hospital
 - Admission to a Hospital
 - Drug-Seeking
 - Child Custody

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- **The psychiatric conditions most likely to be malingered are:**
 - Mental retardation
 - Organic impairment
 - Amnesia
 - Psychosis and
 - Posttraumatic residua, including depression and posttraumatic stress disorder (PTSD).

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- **Features of Malingered Delusions**
 - Abrupt onset and termination rather than gradual development and hesitant abandonment
 - Eagerness to call attention to delusions and symptoms rather than reluctance to acknowledge them
 - Behavior inconsistent with delusional content rather than reflective of delusional content
 - Thought content grossly disturbed in the face of conventional and goal-directed thought process

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- **Features of Malingered Auditory Hallucinations**
 - Continuous rather than intermittent
 - Vague, inaudible, or unintelligible rather than distinct
 - Free-standing rather than associated with delusions
 - Stilted in language and specific in tone rather than basic and general
 - Reported in the first person rather than in the third person
 - Uncontrollable rather than susceptible to strategies for containment
 - Irresistible rather than susceptible to indifference

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- **Factors Suggesting Malingering of Psychological Distress after Trauma**
 - Assertion of inability to work in the face of unimpaired capacity for pleasurable activity (recreation, social interaction)
 - Subscription to more obvious symptoms of widely publicized disorders in the face of denial of more subtle features
 - Spotty, questionable vocational history; tendency to drift; fringe member of society
 - Evasiveness during interview; unwillingness to concretely address a return to work, responsibility, and social expectation
 - General presentation of sullenness, suspicious guardedness, uncooperativeness, or resentment

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- **Factors Suggesting Malingering of Psychological Distress after Trauma**
 - Refusal to comply with recommended diagnostic or treatment procedures; avoidance of direct examination
 - History of disabling injuries and unusually frequent absences from work
 - Traits common to antisocial, narcissistic, borderline, or histrionic personality disorders
 - Energetic and concerted pursuit of legal claim in the face of alleged debility caused by depression and posttraumatic stress disorder
 - Refusal of employment suggested as plausible despite alleged disability
 - Self-depiction in excessively favorable and capable terms before alleged trauma and behavioral collapse

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- **Other Possible Indications of Malingering**
 - Malingers tend to overact their part, often mistakenly believing that the more bizarre they appear, the more convincing they are.
 - Unsophisticated malingers often confuse madness with dumbness, supposing that silly or childlike responses go hand in hand with bizarre, delusional experiences.
 - Schizophrenic thinking (a formal thought disorder) is far more difficult for malingers to imitate than is its content. Thus, it is much less likely that malingers will mimic loose associations or tangential or circumstantial reasoning than that they will describe or act out odd beliefs.
 - The lack of a family history of the disorder or of prior incidents is suspicious.

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- **Other Possible Indications of Malingering**
 - Psychotic individuals experiencing an acute episode are likely to act in direct accordance with their delusional system, whereas malingers claim to have done so only when such concordance is opportunistic.
 - Malingers are unlikely to successfully imitate the subtle signs of residual schizophrenia. Blunted affect, concreteness, and odd, schizoid relatedness are presentations familiar only to the most talented malingers.
 - They are likely to repeat questions or answer questions slowly, working to give themselves more time to fabricate convincing responses.

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- **Other Possible Indications of Malingering**
 - Malingers are likely to contradict themselves in their accounts of the illness, and those contradictions may multiply as the interview progresses.
 - They may be led astray by leading questions that the examiner knows are psychologically absurd, and they may make mistakes when questioned rapidly or directly confronted.
 - Malingers' symptoms may fit no diagnostic entity, and, when caught in such a discrepancy, they may sulk or laugh from embarrassment.
 - Malingers sometimes attempt to take control of the interview, behaving in an intimidating and blustery manner.

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- **Other Possible Indications of Malingering**
 - In Depression, the absence of diurnal variation, of specifically early-morning awakening (as opposed to vague, generalized insomnia), of angry irritability, and of diminished sexual interest may suggest imitation.
 - Bona-fide depression is evident in the client's facial expression and cognitive slowing. Malingered depression often lacks the typical furrowed brow and a slowed rate of speech.
 - Possibly most revealing of all is a lack of depressive withdrawal from enjoyable domains, such as social and recreational activities, in the face of apparent total incapacity in aversive domains, such as work.

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- **Other Possible Indications of Malingering**
 - The PTSD malingers may be more impressed by (and, therefore, hopes to impress more with) the expressionistic symptoms of nightmares and flashbacks.
 - In true PTSD victims, the nightmares tend to vary in content while hewing to the constant themes of terror and helplessness; malingers are more likely to report re-experiencing "exactly the same dream."
 - A textbook-perfect presentation should raise greater suspicion than a presentation characterized by a vague, more approximate symptom cluster.
 - Malingers typically "wear out" over time. Prolong the interview.

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- **Where self-report information is suspect, it is crucial that an evaluator seek alternate sources of information. Key sources of information might include, but are not limited to:**
 - school transcripts
 - mental health treatment and evaluation records
 - medical records
 - arrest records
 - correctional records (particularly those relating to grievances and disciplinary infractions)
 - interviews with people who have had contact with the client/defendant/patient

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• Assessment Techniques

- *Rare Symptoms* - Endorsement of symptoms infrequently seen in a clinical population is a common technique used to distinguish malingers from genuine patients. This is one of the most robust detection strategies.
- *Indiscriminant symptom endorsement* - When given the opportunity, malingers tend to endorse a wide variety of symptoms. The over-endorsement of symptoms continues to be a hallmark of malingering.
- *Obvious symptoms* - Those symptoms that are clearly indicative of mental illness are more often endorsed than those that might not be so obviously associated with psychopathology.

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• Assessment Techniques

- *Improbable symptoms* - When an examinee endorses symptoms that have a fantastic or outrageous quality the credibility of their report should be questioned.
- *Extreme or unusual severity* - Even severely impaired patients experience only a discrete number of symptoms as intolerable. Malingers are often unable to estimate how many severe symptoms should be reported or endorsed. They also tend to report that most of their symptoms are extremely severe.
- *Unlikely symptom combinations* - Unless the malingers has advanced knowledge of psychopathology, s/he would probably be unaware of the fact that some symptoms that are common alone are not found together.

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• Assessment Techniques

- *Erroneous stereotypes* - If an examinee subscribes to common misconceptions of mental illness and the associated symptoms, malingering may be suspected. For example, a person relying on stereotypes might describe his schizophrenic condition as "having two personalities."
- *Reported versus observed symptoms* - Potential malingers often report symptoms that do not correspond with their actual behavior. An evaluator should be aware of any inconsistencies between self-report and either clinical observation or observations from the record. Marked discrepancies may be useful in the detection of malingering. One downfall of this detection strategy is that sometimes genuine patients lack insight into their symptoms.

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• Malingering Assessment Tools

- **Structured Interview of Reported Symptoms (SIRS)** This was developed by Richard Rogers and his colleagues in 1992. It is a structured interview designed to assess functional malingering. It is very well researched and takes about 35-40 minutes to administer. It is designed to assess someone presenting psychotic-like symptoms as opposed to cognitive deficits.
- **Miller Forensic Assessment of Symptoms Test (M-FAST)** This instrument was developed to function as a screening device for malingered mental illness. The M-FAST, which can be completed in 5-10 minutes, is a 25-item structured interview that yields a total score that corresponds with seven strategies identified as being commonly employed among malingers.

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• Malingering Assessment Tools

- **Structured Inventory of Malingered Symptomology (SIMS)** This is a 75-item true-false test designed to detect the presence of malingering of specific neurological conditions. It is recommended primarily as a screening device to determine if further assessment is warranted. Research data is still somewhat limited. The validation sample was primarily white females and did not employ an actual clinical population.
- **Test of Malingered Memory (TOMM)** As the title suggests, this test was specifically designed to detect feigned memory impairment. It is a 50-item recognition test for adults. It relies on the premise that malingers will score less than expected, but not necessarily below chance.

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• Malingering Assessment Tools

- **Minnesota Multiphasic Personality Inventory (MMPI-2)** This test of 567 true/false items is the most widely used and widely researched test of adult psychopathology and supports classification, treatment, and management decisions in criminal justice and correctional settings. Professionals who are trained in MMPI-2 interpretation however can utilize the validity indicators, particularly the family of F scales (F, Fb, Fp), to generate hypotheses regarding the potential for dissimulation. Consistency scales (VRIN and TRIN) can be helpful in separating random responding and reading problems from other types of invalid profiles.

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- **Vignette-A 45 year old male inmate of European descent suffers from a delusional disorder. He states that he walks in his sleep and requests a lower bunk chrono.**
- **What would you do?**

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- **Issue the Chrono.**
- **Refer him to medical for a neurological consult.**
- **Tell him to get lost.**
- **Refer him to the Psychiatrist for a medication consult.**

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- **Call Officers in building and ask about problem.**
- **Ask officers to monitor and note unusual behavior in log.**
- **If no problems are reported (most likely scenario is you would have probably have been informed by custody if a problem did exist) follow up with inmate/patient.**
- **Explain that since sleepwalking does not seem to be causing him any problems, he does not really need a lower bunk chrono.**

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- **Malingering is a disorder requiring an intervention or treatment.**
- **It is not an excuse to ignore or dismiss legitimate needs.**

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- **The Goals of Treating Malingering**
 - Extinguish malingering
 - Address legitimate needs
 - Reinforce alternative coping mechanisms

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- **Treatment depends on the motivation for malingering.**
 - What is the secondary gain that the inmate/patient is seeking.

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- **Motivation for Malingering**
 - Pathogenic Motivation
 - Criminological Motivation
 - Functional Motivation

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- **Pathogenic Motivation-When a patient is suffering from mental illness and can not manage some aspect of his/her life, he/she will exaggerate symptoms because he/she does not have other means of managing life.**

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- **Criminological Motivation-When an inmate is trying to avoid some sort of consequences for a rules violation.**
 - Claim behavior was the result of mental illness.
 - To avoid segregated housing
- **When an inmate is attempting to achieve financial gain.**
 - Qualifying for Social Security disability

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- **Adaptation Motivation-When the inmate sees that his/her stakes are high, and his/her options are limited he/she will engage in malingering to increase options.**
 - Usually related to safety concerns.

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- **Treatment for Pathogenic Motivation**
 - Try to avoid the use of acute care setting.
 - Medication consultation
 - Reevaluate level of care
 - Increase clinical contact for a period of time
 - In acute care setting
 - Medication consultation
 - Explore features of situation creating stress.
 - Restructure situation to make it more manageable
 - Help inmate develop plan for handling future stress.

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- **Treatment for Criminological Motivation**
 - Try to avoid acute care treatment
 - Explain consequences of acute care treatment.
 - Offer alternatives
 - In acute care setting
 - Treat as if symptoms real.
 - Continue to confirm to that criminological goals will not be met.
 - Minimize stay to avoid inmate becoming comfortable

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- **Treatment for Adaptation Motivation**
 - Try to avoid the use of acute care setting
 - Do careful interview to assess true need.
 - Respond to true need.
 - In acute care setting
 - Continue to assess true need
 - Use multidisciplinary team to develop options for addressing true need
 - Implement options and minimize stay in acute care setting

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Reference

Rogers, R (1997). *Clinical assessment of malingering and deception*. New York, The Guilford Press.