MALINGERING DISORDERS

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Psychiatrists will encounter patients who willfully deceive physicians, family, and friends for ulterior motives. Unfortunately, this behavior, called malingering, is common across psychiatric care settings and poses clinical and professional challenges for treating physicians. It is natural for clinicians to feel frustrated by patients who are malingering; most physicians pursue their careers out of a sense of compassion and altruism. Being lied to can feel like a betrayal of the doctor-patient relationship.

The antidote to that frustration and sense of betrayal is developing an aptitude for recognizing malingering, understanding why that behavior occurs, and working with the patient toward mutual treatment goals. In this way, malingering patients may remain challenging to treat, but psychiatrists may nonetheless ally with patients and address their needs. This review describes the phenomenon and epidemiology of malingering and provides guidance on identifying and managing the malingering patient.

Definition and Types of Malingering

In the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), malingering is defined as the “intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.” This definition highlights two fundamental elements of malingering:

- Symptoms are produced intentionally
- Symptoms are produced to obtain an external incentive of some kind

Since the third edition of the DSM (DSM-III), malingering has been listed as a “focus of attention” that is “not attributable to a mental disorder.” The DSM does not list diagnostic criteria for malingering; rather, the DSM identifies several situations in which the clinician might have a heightened suspicion for malingering. These situations are described here [see Table 1].

The DSM-5 does classify deceptive behaviors conducted to procure controlled substances as malingering. Ultimately, malingering is a diagnosis of exclusion: short of the patient admitting to deception, there is no definitive way to diagnose malingering, and its presence is best judged by an informed practitioner’s careful and thorough assessment.

Malingering may be classified based on the nature of symptom exaggeration. Pure malingering occurs when patients endorse or create entirely new symptoms. For example, a homeless patient may complain of chest pain to shelter overnight in the emergency department while a coronary syndrome is excluded. Alternatively, a patient may surreptitiously self-administer laxatives to produce diarrhea and extend the hospital stay. Partial malingering describes a situation in which a patient exaggerates true underlying symptoms. For example, a patient with chronic pain from a work-related accident may exaggerate the degree of pain that is present to obtain a larger financial settlement.

With both pure and partial malingering, the patient presents the clinician with greater symptom burden than is present. However, patients may also intentionally deceive physicians by presenting as healthier than they are—a presentation known as dissimulation. For example, a psychotic patient may deny auditory hallucinations out of fear that endorsing those symptoms will increase the likelihood of involuntary hospitalization. The demographics and clinical characteristics of patients who dissimulate appear similar to those who partially or purely malingering.

Another form of malingering is false imputation. False imputation occurs when patients have a true symptom burden but try to mislead clinicians as to their origins. An example of false imputation is a patient who presents with a cellulitis but declines to disclose the source of infection as intravenous drug use so as not to be denied opioid pain medications. The different forms of malingering are presented here [see Figure 1].

Although the extent and type of symptom exaggerations vary among malingers, a clear external incentive for a psychiatrist to diagnose malingering must also be present. External incentives are any kind of benefit to be made by misleading clinicians as to the symptom presentation. There are limitless such incentives, some of which are described here [see Table 2].

An external incentive is sometimes called secondary gain. Although secondary gain is no longer used in the DSM-5, the concepts of primary and secondary gain continue to commonly arise in discussions of malingering. Primary gain is the unconscious “reduction in intrapsychic conflict” and “partial drive gratification” accomplished by use of a defense mechanism. Primary gain is often confused with the benefits gained by patients’ adopting the sick role, including being excused from work or school, or being cared for by others. Those benefits are secondary gain, and malingering is present when patients intentionally feign illness to obtain them.

Malingering is not considered a mental illness. Both the DSM-5 and the 10th revision of the International Classification of Diseases (ICD-10) consider malingering a focus of clinical concern that is not itself a disease state. This classification hardly makes malingering any less of a challenge for clinicians.

Malingering by Proxy

The DSM-5 recognizes that factitious disorder may be imposed on another person, a condition also named factitious disorder by proxy or Munchausen’s by proxy. In factitious disorder imposed on another, illness is falsified in a victim so that

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The perpetrator may fulfill an unconscious need [see Differential Diagnosis, below]. Malingering by proxy occurs when a perpetrator falsifies or exaggerates illness in another person for an external incentive. This condition has been described in several case reports but is not a DSM-5 diagnosis. Most cases of physical illness induced as a result of malingering by proxy are among children who are intentionally injured by parents for financial gain. Malingering by proxy is a form of child abuse, and its perpetration is a crime.

A variant of malingering by proxy is the attempt to convince another that he or she has a primary psychiatric illness. This form of malingering is colloquially described as “gaslighting,” after a play in which the protagonist attempts to convince his wife that she is insane. Gaslighting is a form of emotional abuse. Most often the perpetrator is an adult spouse, family member, or friend who is attempting to have a family member involuntarily institutionalized. Motivations for perpetrators include to avoid providing care for a family member, to maintain a substance use disorder, or to obtain financial rewards.

Epidemiology

It is difficult to ascertain the prevalence of a disorder in which persons are by definition trying to elude detection. Estimated rates of malingering are derived from the use of neuropsychological tests, clinician evaluations, and fraud claims data. The difficulty of identifying malingering has made it difficult, if not impossible, to develop an epidemiologic evidence base. Nonetheless, all physicians will encounter malingering in practice.

Malingered medical disability exacts a financial toll on our society. As many as 60% of adult Social Security Disability applicants are suspected to be malingering, at a cost of over $20 billion a year. A study of U.S. Veterans Affairs disability payments found that 25% of awardees—receiving $19.8 billion of payments—lacked compelling evidence of combat exposure. The presence of financial reward or greater external incentives increases the likelihood of malingering.

Rates of malingering vary based on clinical practice setting. Consistent with the DSM-5, rates are suspected to be the highest in medicolegal and correctional settings. A survey of forensic neuropsychologists found that malingering rates among persons referred by the court for an evaluation varied based on the injury and reason for referral. For example, about 30% of personal injury and disability claimants were found to be malingering; mild head injury, chronic fatigue, and chronic pain were the diagnoses most likely to be exaggerated. In another study of claimants that applied different neuropsychological tests to estimate prevalence, between 20 and 50% of persons seeking compensation for chronic pain were found to be malingering. Malingering is suspected in 32 to 65% of prison inmates seeking psychiatric services.

Malingering is less common but still prevalent in routine practice settings. A study (and replication) of psychiatric inpatients with suicidal ideation found that about 10% were malingering, based on neuropsychological testing and patients’ anonymous self-reports. A similar number of emergency department patients are suspected by providers to be malingering. A survey of psychiatric outpatients in therapy found that a sizable minority (42%) expected some secondary gain, and only very few disclosed this gain to the therapist. Outpatient malingering appears more likely in the presence of greater financial incentives. In one investigation, most patients seeking outpatient mental health care were found to be concurrently seeking disability payments. Once a full disability payment was obtained, patients accessed services much less frequently. This pattern suggests that patients were in part accessing services to bolster a case for disability payments rather than out of psychiatric need. Malingering probably presents similarly in telepsychiatry practices, even as no epidemiologic data have yet been collected. The prevalence of malingering across clinical settings is summarized here [see Table 3].

### Table 2: Common External Incentives for Malingering

<table>
<thead>
<tr>
<th>Incentive</th>
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<tbody>
<tr>
<td>Housing</td>
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<tr>
<td>Controlled substances</td>
</tr>
<tr>
<td>Financial gain through disability or court settlements</td>
</tr>
<tr>
<td>Jail diversion</td>
</tr>
<tr>
<td>Absence from work or school</td>
</tr>
<tr>
<td>Solicitation of care from others</td>
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It is unknown how the frequency of malingering varies across countries and cultures. Pain behavior in particular is quite variable over time and across cultures, and it may be difficult to discern behaviors suspicious for malingering without a cultural context. That one study of predominantly Hispanic patients with chronic pain found quite low rates of malingering suggests that further study is necessary to ascertain cultural aspects of malingering.\textsuperscript{18}

### Pathophysiology

Malingering is not a mental illness. And given how many different motivations exist to mangle, it is unlikely that all malingering arises from a common pathophysiology. However, there are commonalities among malingering behaviors that can inform a clinical approach to malingering behavior. By definition, malingering is the product of a premeditated, conscious effort to deceive. This choice suggests the presence of higher-order cognitive functions that consider the likely consequences and rewards for those actions.\textsuperscript{19} Indeed, functional neuroimaging demonstrates that the frontal cortex appears more activated among subjects who are intentionally feigning memory impairment than among normal controls.\textsuperscript{20,21} These neural pathways use the neurotransmitters serotonin and dopamine; abnormalities of metabolism and transmission of these neurotransmitters are associated with predatory behavior and increased aggression in both animal models and patient cases.\textsuperscript{22,23} These associations are particularly salient for malingering associated with antisocial traits and aggressive behaviors. Although studies can correlate these abnormalities with malingering, it is unclear that acquiring these abnormalities induces malingered behaviors.\textsuperscript{19}

Several psychological models of malingering have been described. A pathogenic model formulated malingering to be the conscious manifestation of the patient’s desire to control an unconscious psychological conflict.\textsuperscript{24} In this model, the patient attempts to manage anxiety by producing overt, identifiable, conscious symptoms that could thereby be recognized and treated by the psychiatrist. This description helped differentiate malingering from conversion disorder, in which observable symptoms are unconsciously produced by the patient, but were not ultimately consistent with patients’ observed behaviors, where the presence of symptoms was dependent on the presence of external incentives.

Although this pathogenic model has not been borne out, its development imparted the value of an explanatory model by providing clinicians with a less pejorative and more empathetic understanding of why patients mangle. In the absence of any such understanding, clinicians are more likely to advance a prejudice toward the patient or even act out of an aggressive countertransference position by applying the malingering diagnosis. Such an adversarial approach was only reinforced by the DSM-III’s description of malingering as correlated with medicolegal evaluations and antisocial personality disorder. The DSM description provides some clues to identification of malingering but leaves clinicians without an understanding of psychopathology or identifiable symptoms around which to structure treatment.

Thus, both the pathogenic model and the DSM’s diagnostic model have shortcomings. An adaptational model has been posited that both addresses the need to identify malingering and provides a framework for clinical management.\textsuperscript{25} In the adaptational model, the patient selects malingering as the choice most likely to obtain maximal reward with minimal risk.\textsuperscript{24} In this sense, malingering behavior reflects the patient’s rational balancing of reward and risk. The lack of viable alternatives to malingering increases the appeal of malingering. The decision to mangle becomes still more appealing in situations where the patient perceives a greater personal stake or more adversarial tone to the evaluation. These concepts of the adaptational model are demonstrated here [see Figure 2].

This adaptational model is consistent with contemporary evidence in which higher potential rewards of malingering are correlated with higher suspected rates of malingering.\textsuperscript{11,12,25} Furthermore, this model reminds clinicians that the patient’s behaviors are enacted to achieve a particular goal—a goal on which a therapeutic alliance may be formed. The management approach described in this review most closely reflects the adaptational description of malingering.

### Diagnosis

Malingering is best identified through an informed, thorough clinical assessment. There is no gold standard for the diagnosis of malingering; the best standard is probably the patient who self-admits to malingering. This section guides the clinician through common presentations in which malingering should be suspected. Clues to the identification of malingering are summarized here [see Table 4].

#### Social and Clinical Context

Consideration of the context for clinical evaluation is the first clue to the possible presence of malingering. Malingering is more common in medicolegal and forensic settings, such that practice in those areas was highlighted in the DSM as a risk factor for malingering.\textsuperscript{26} However, clinicians must be alert to potential external incentives present in more typical clinical settings; these gains include excuses from work or school, diversion from jail, or grounds for obtaining compensatory payment through a disability evaluation.

Potential incentives are best elucidated through obtaining a social history. A homeless patient may need a safe respite for one night in the emergency department; a divorced parent may be participating in care to prove that he or she is “receiving treatment” for the purposes of a custody evaluation.

### History of Present Illness

Several clues in the patient’s history of present illness may point to an increased likelihood of malingering. Malingers

<table>
<thead>
<tr>
<th>Table 3 Prevalence of Malingering by Clinical Setting</th>
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<tbody>
<tr>
<td><strong>Setting</strong></td>
</tr>
<tr>
<td>Disability claimants</td>
</tr>
<tr>
<td>Outpatient therapy</td>
</tr>
<tr>
<td>Chronic pain clinic</td>
</tr>
<tr>
<td>Inpatient psychiatry</td>
</tr>
<tr>
<td>Emergency department</td>
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<tr>
<td>Prison</td>
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often present with unusual or atypical symptoms. A malingering patient may use highly technical language suggesting familiarity with medical writing or diagnosis (eg, “I’m having suicidal ideation to overdose”) yet nonetheless leave the evaluator with an unclear sense of symptoms’ onset, duration, or modifying factors. Atypical onset of symptoms—for example, new-onset psychosis in one’s fifties—warrants increased scrutiny, perhaps for malingering, although also for a medical etiology of illness. A psychiatrist is more likely to obtain sufficient detail to evaluate for malingering by using open-ended questions.

Clinicians should not interpret the quantity of endorsed symptoms as a sign of malingering. Nor should “textbook cases” be considered more likely malingered than cases with unusual or atypical presentations.

Although wholly atypical symptoms are likely to be purely malingered, patients may also exaggerate or embellish existing symptoms as a form of partial malingering or false imputation. These patients can usually well describe their symptoms, and identifying malingering in these cases is particularly difficult. Clinicians should be suspicious of patients who appear preoccupied with, but not distressed by, peculiar symptoms.

When malingering psychosis is suspected, the description of psychotic symptoms needs to be carefully explored. Psychotic symptoms are easy for the malingering patient to endorse, but it is difficult to accurately mimic a primary
Psychotic disorder, such as schizophrenia. Overly divulged delusions and hallucinations should raise one’s suspicion for malingering. Psychiatrists can leverage their knowledge of hallucinations as described by patients with schizophrenia to identify atypical symptoms reported by malingerers. Common descriptions of psychotic descriptions compared with atypical descriptions that are more concerning for partial or pure malingering are provided here [see Table 5]. Feigning thought process disorganization for even a short period of time is extraordinarily difficult, and disorganization is unlikely to be malingered.

Malingering patients may also make conditional threats as part of their presentation: “If you don’t admit me, then I’ll kill myself.” These patients will often try to control the psychiatric part of their presentation: “If you don’t admit me, then I’ll kill myself.” Malingering patients also make exerted efforts to deny that they are lying. However, these observations are based on clinical experience and have not been rigorously validated.

Many malingering patients also equate psychiatric illness with memory and cognitive impairment. Psychiatrists can leverage their knowledge of delusions and hallucinations to identify atypical symptoms reported by malingerers. Com- hallucinations as described by patients with schizophrenia to malingering. Psychiatrists can leverage their knowledge of delusions and hallucinations to identify atypical symptoms reported by malingerers. Common descriptions of psychotic descriptions compared with atypical descriptions that are more concerning for partial or pure malingering are provided here [see Table 5].

Table 5: Typical versus Atypical psychotic Symptoms

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Typical</th>
<th>Atypical—suspect malingering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory hallucinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>Intermittent</td>
<td>Constant</td>
</tr>
<tr>
<td>Commands</td>
<td>Can resist commands</td>
<td>Must obey commands</td>
</tr>
<tr>
<td>Coping strategies</td>
<td>Effective</td>
<td>Ineffective</td>
</tr>
<tr>
<td>Gender</td>
<td>Male and female</td>
<td>Single gender</td>
</tr>
<tr>
<td>Identity</td>
<td>Able to identify</td>
<td>Unable to identify</td>
</tr>
<tr>
<td>Behavior</td>
<td>Consistent with delusions</td>
<td>Inconsistent</td>
</tr>
<tr>
<td>Delusions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorganization</td>
<td>Delusions and thought disorganization</td>
<td>Dramatic delusions with organized thoughts</td>
</tr>
<tr>
<td>Details</td>
<td>Reluctant to share</td>
<td>Eager to share</td>
</tr>
<tr>
<td>Onset</td>
<td>Gradual</td>
<td>Rapid</td>
</tr>
<tr>
<td>Treatment response</td>
<td>Delayed</td>
<td>Rapid</td>
</tr>
</tbody>
</table>
LAbORATORY TESTING

Currently, biologic and laboratory measurements are of minimal utility in the evaluation of malingering. In the evaluation of malingering, laboratory testing is most commonly used to evaluate for underlying medical illness. There are instances in which laboratory testing may inform discrepancies with the patient’s reported history, as when a patient denies substance use but has a positive urine toxicology screen. Because it is difficult, and sometimes impossible, to entirely exclude the presence of somatic pathophysiology, malingering patients warrant an appropriate medical examination and evaluation for potential underlying illnesses. This evaluation may include laboratory, radiologic, neuropsychological, or other cognitive and occupational functioning tests.

The use of laboratory markers in classifying psychiatric illness may hold promise for better identifying malingering. One study attempted to differentiate patients with schizophrenia from a group of patients suspected of malingering psychosis. In that study, patients with schizophrenia demonstrated typical abnormalities in neuronal firing based on standardized evoked potential, whereas patients with malingered psychosis did not demonstrate the expected abnormality. These biologic measures correlated with scores on the Structured Interview of Reported Symptoms (SIRS), a common neuropsychological test used to evaluate for malingering. The clinical application of biologic markers for depression, anxiety, and suicidal ideation may similarly contribute to the assessment of malingering. At present, these markers remain insufficiently specific to be used in the such an assessment.

Psychiatric consultants must be prepared to recommend laboratory, radiologic, and other testing for medical patients suspected of malingering. It is not uncommon for treating physicians to feel frustrated by malingering patients. Some treatment teams manifest this frustration by not completing a full medical evaluation of the patient’s complaints. For example, a clinician may not investigate possible causes of pain in a patient suspected to be malingering for opioids. In these situations, the consulting psychiatrist should recognize the problematic dynamic and advocate for the patient to receive an appropriate medical assessment.

Malingering patients may also attempt to falsify laboratory tests. One common scenario is the patient who dilutes a urine sample to minimize the possibility of a positive drug screen. Other patients may attempt to present as hypoxic (by holding their breath) or add blood to urine (to simulate hematuria). A physician’s suspicion and medical workup are usually sufficient to identify these behaviors. For example, an observed specimen collection or a urinalysis added to a urine toxicology test can exclude intentional dilution as the source of a negative test.

There are techniques for identifying deception based on the body’s physiologic response to high stress situations. Polygraphy, or the lie detector test, is frequently used in law enforcement settings. Polygraph testing is administered by a trained investigator who uses scripted questions and describes the subject’s autonomic variability on truthful versus deceptive answers. Subjects may exhibit changes in temperature, heart rate, and respiration rate when lying. Clearly, there are serious limitations as to the use of polygraphy for a clinician who wants to preserve a therapeutic alliance. Moreover, polygraphy requires a highly standardized administration environment, unavailable in clinical settings, and may not be valid among medically or psychiatrically ill patients.

Similar objective tests have been studied for identifying deception. Functional magnetic resonance imaging and computerized voice stress analysis are two potential alternatives that have not been found valid for clinical use.

NEUROPSYCHOLOGICAL TESTING

Neuropsychological testing can inform an assessment of the likelihood of malingering. Some tests are appropriate for bedside use.

Neuropsychological tests for malingering use one or more of several strategies to identify malingering. One strategy is inviting patients to endorse atypical or unusual symptom clusters. Tests will ask patients to endorse the symptoms they are experiencing, and a high rate of endorsement of unusual symptoms may signal malingering. This strategy is similar to that employed by an astute clinician in soliciting the history of present illness. The most frequently used test in forensic settings, the SIRS, employs this strategy. A neuropsychological test may also employ a forced-choice format, in which malingering patients respond in a nonrandom pattern. For example, in the Test of Memory Malingering (TOMM), a patient is shown a series of objects. The patient is then shown two objects, one of which was part of the series and one that is completely new. The patient is asked to pick the object just shown. A patient with true memory impairment will randomly pick one object, thereby answering correctly 50% of the time. A subject feigning memory impairment will intentionally answer incorrectly, leading to poor scores (<50%) that would not occur by random chance. The TOMM appears valid even in patients with severe depression.

Other tests present apparently challenging questions to patients. However, the task is simpler than patients perceive. This discrepancy in face validity plays on the malingering patient’s desire to incorrectly answer challenging questions. One example of this test is the Rey 15-Item Memory Test (RMT), in which a patient is asked to copy 15 symbols as a test of memory. This test appears difficult at first glance, but most patients can complete the test easily. As with other tests listed here, questions have been raised as to the validity of the RMT among patients with significant psychiatric illness.

Most neuropsychological tests should be administered by a clinician with specialized training. However, several tests are short and appropriate for bedside use or screening in situations where clinicians are likely to encounter malingering. The Miller Forensic Assessment of Symptoms Test (M-FAST) is a 25-question instrument that may be administered in 5 to 10 minutes in outpatient and emergency department settings. The RMT takes only 1 to 2 minutes to administer at the bedside.

Several neuropsychological tests commonly used to evaluate for malingering and the methods they employ are listed here.

Screening

Efforts to screen for malingering among clinical populations typically aim to apply neuropsychological tests that are adapted or appropriate to the care setting. Shorter psychological tests...
may be useful for emergency departments, whereas longer structured interviews and more complex testing may be useful for an outpatient posttraumatic stress disorder (PTSD) clinic with more time and greater uniformity of presenting diagnosis.50 Efforts to implement screening more widely have also wrought negative publicity for health care systems.51 Ultimately, with more time and greater uniformity of presenting diagnosis, they consider inadequate.52 Just like patients with factitious disorder for medical care, and have difficulty accepting treatments that they perceive are not intentionally produced by the patient. Physicians must be continually alert to the possibility that symptoms considered malingered may represent a treatable, underlying illness. Over time, with the advancement of medical technology and expertise, many presentations once thought to be the result of somatic, conversion, or deceptive disorders have been discovered to be the production of another biological process—for example, epilepsy, movement disorders, and multiple sclerosis.53

Psychiatric illness must also be considered whenever malingering is suspected. Illness behaviors may reflect the limited coping skills available to a patient impaired by a psychotic illness or developmental disability.54 Patients experiencing intense anxiety also present with pronounced illness behaviors. These patients may be experiencing a crisis in which their available coping skills are inadequate to resolving a life stressor.55 Clinicians may feel frustrated that the patient is not managing apparently straightforward dilemmas and instead using the medical system to enhance their social network or obtain important material needs (eg, housing). However, patients in crisis will engage in and benefit from a discussion of treatment options; this response contrasts with that of malingering patients, who perceive a discussion of treatment options to be an obstacle in obtaining an external goal. The malingerer then responds with anxiety or anger. Malingering is compared with other somatic and anxiety disorders here [see Table 7].

Malingering may also be confused with poor effort in evaluation, particularly on psychological tests. Poor effort may reflect anergy, depression, fatigue, or cognitive impairment that results from major depression, traumatic brain injury, or cognitive disorders.56,57 Neuropsychological tests may be particularly helpful in instances where depression is suspected to either complicate the presentation or itself be the malingered symptom. The TOMM’s validity has been demonstrated in the presence of severe concurrent depression and anxiety, and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) identifies depression as feigned even by psychiatric experts.58

Patients who produce illness behaviors for the purposes of obtaining controlled substances are, by definition in the DSM-5, malingering.1 This definition includes patients who are attempting to obtain substances to alleviate physical symptoms of withdrawal. Patients malingering for drugs of abuse are typically unwilling to entertain alternative options for the treatment of anxiety, pain, or another condition for which they are seeking prescription medications. For example, a patient malingering for benzodiazepines may well have an underlying anxiety disorder. The malingering patient would be less likely to participate in a discussion of serotonergic agents or nonpharmacologic treatments for anxiety. False imputation may be present when

### Differential Diagnosis

Malingering must be differentiated from other deceptive behaviors. Psychiatrists must remain aware that malingering typically co-occurs with other mental illnesses. Malingering is often contrasted with factitious disorder. As in malingering, patients with factitious disorder intentionally exaggerate or create symptoms. However, factitious disorder differs from malingering in that the patient’s desire to enact these behaviors is not driven by external incentives.1 Rather, it is thought that these patients enact behaviors out of an unconscious need to mitigate the anxiety of an underlying psychic conflict.1 It can be difficult to differentiate the underlying reason for a patient’s behavior, particularly when a malingering patient may be reluctant to engage in a discussion of treatment goals. Most patients with factitious disorder are female and simulate medical illness.55

The intentionality of behaviors in malingering and factitious disorders contrasts with somatic symptom disorders, which are characterized by the unintentional exaggeration or production of illness. In DSM-5 somatic symptom disorder, patients are preoccupied with physical symptoms, perseverate on the need for medical care, and have difficulty accepting treatments that they consider inadequate.59 Just like patients with factitious disorder or malingering, patients with somatic symptom disorder may also have concurrent underlying illness. Patients with conversion disorder unconsciously manifest physical disability, including paralysis and seizures. Conversion disorder is most often precipitated by an acute stressor and may result from abnormalities of neurocircuitry that link volition, movement, and perception.50 Patients may present with minimal distress related to even profound incapacity. Conversion symptoms are differentiated from malingering in that they are not intentionally produced by the patient. Physicians must be continually alert to the possibility that symptoms considered malingered may represent a treatable, underlying illness. Over time, with the advancement of medical technology and expertise, many presentations once thought to be the result of somatic, conversion, or deceptive disorders have been discovered to be the production of another biological process—for example, epilepsy, movement disorders, and multiple sclerosis.53 Even in contemporary practice, medically unexplained symptoms continue to comprise a significant proportion of patient presentations.50,59

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### Table 6

<table>
<thead>
<tr>
<th>Test</th>
<th>Length</th>
<th>Strategies used to detect malingering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rey 15-Item Memory Test13</td>
<td>15 items, 1-2 min</td>
<td>Misleading face validity</td>
</tr>
<tr>
<td>Miller Forensic Assessment of Symptoms Test (M-FAST)90</td>
<td>25 items, 5-10 min</td>
<td>Atypical symptom endorsement</td>
</tr>
<tr>
<td>Test of Malingered Memory (TOMM)14</td>
<td>100 items, 15-20 min</td>
<td>Misleading face validity, forced-choice testing</td>
</tr>
<tr>
<td>Structured Interview of Reported Symptoms (SIRS)80</td>
<td>172 items, 30-40 min</td>
<td>Atypical symptom endorsement, forced-choice testing</td>
</tr>
<tr>
<td>Minnesota Multiphasic Personality Inventory-2 (MMPI-2)57</td>
<td>567 items, 60-90 min</td>
<td>Atypical symptom endorsement, forced-choice testing</td>
</tr>
</tbody>
</table>
Table 7  Malingering Compared with Psychiatric Illnesses

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Key features</th>
<th>Example</th>
<th>Difference from malingering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factitious disorder</td>
<td>Conscious symptom creation to resolve unconscious conflict</td>
<td>Surrupitious injection of insulin</td>
<td>Internal rather than external incentive</td>
</tr>
<tr>
<td>Somatic symptom disorder</td>
<td>Severe anxiety and excessive preoccupation with physical symptoms</td>
<td>Repeated emergency department visits for somatic symptoms without underlying medical illness</td>
<td>Unintentional and without external incentive</td>
</tr>
<tr>
<td>Illness anxiety disorder</td>
<td>Preoccupation with and fear of having serious medical illness</td>
<td>Persistent belief that cancer is present despite reassuring medical workup</td>
<td>Unintentional and without external incentive</td>
</tr>
<tr>
<td>Conversion disorder (functional neurologic disorder)</td>
<td>Neurologic symptoms that cannot be explained by medical workup; typically preceded by acute stressor</td>
<td>Sudden blindness after the death of a spouse</td>
<td>Unintentional and without external incentive</td>
</tr>
<tr>
<td>Acute anxiety and crisis</td>
<td>Inability to control worry; impaired problem solving and inability to resolve life stressor</td>
<td>Newly homeless and unable to use coping strategies to solve problem</td>
<td>Unintentional; patient engagement in discussion of treatment options</td>
</tr>
</tbody>
</table>

this anxious patient attributes his or her anxiety to benzodiazepine withdrawal to convince the physician to prescribe more benzodiazepines.

Although malingering patients are behaving deceptively, addiction is a biological and genetic illness in which patient’s behaviors may be altered by cravings, reinforcing stimuli, and a drive to use substances. For patients with addiction, malingering is maladaptive in that it reinforces the substance use disorder. On identifying malingering for substance use, psychiatrists should begin an assessment of the patient’s use disorder and consider providing appropriate treatment, including motivational interviewing or pharmacotherapy.

The identification of substance use disorders and malingering among chronic nonmalignant pain patients on opioids is a challenging and controversial topic. Pseudoaddiction describes the situation in which a patient continually requests higher medication doses to address underlying pain; these requests may be accompanied by problematic behaviors, including deception. Pseudoaddiction differs from malingering in that the patient’s motivation is for pain or anxiety relief as opposed to attainment of addictive substances. As a concept, pseudoaddiction reminds clinicians to continually address the presence of true underlying medical illness. However, pseudoaddiction lacks any biological basis and has not proven to be distinguishable in presentation or outcomes from primary substance use disorders.

Increasingly, pseudoaddiction is discounted as a way for clinicians to rationalize problematic behaviors and avoid the difficult work of talking with patients about their often iatrogenic substance use disorder.

Malingering and personality pathology, including maladaptive decision making, may often be conflated. Psychiatrists have strong and characteristic countertransference reactions to patients with personality disorders. These reactions include feeling unappreciated, mistreated, helpless, or annoyed. Clinicians cannot help but experience these emotional reactions, yet they must be careful that this countertransference does not mislead them to overconsider the likelihood of malingering.

That said, the presence of antisocial personality disorder should heighten psychiatrists’ suspicion for malingering behaviors. Antisocial personality is characterized by a lack of empathy and regard for others’ safety or well-being as well as repeated deceitfulness and manipulation. Even though antisocial patients will narcissistically prioritize themselves, in fact, antisocial personality is associated with poor outcomes, including high mortality from medical illness, accidents, and suicide. As for other psychiatric diseases, substance use disorders substantially worsen the prognosis of antisocial patients.

Management

There are no clinical trials and few scientific data comparing approaches to malingering. Based on the available literature and clinical experience, we present an approach to help clinicians manage the complications of malingering and engage the patient in treatment. This approach comprises identifying malingering, treating comorbid conditions, containing countertransference reactions, acknowledging the patient’s distress and goals, and partnering with the patient to treat those goals while maintaining appropriate therapeutic boundaries. This management strategy and some potential complications for the treating clinician are summarized here [see Figure 3].

Identification

The first step to managing malingering is evaluating the likelihood of its presence. The preceding section provides a framework for the clinician to evaluate potential malingering. Recognizing that the patient is falsifying or exaggerating a presentation is a prerequisite to recognizing the complications of malingering, including intense countertransference and the disrupted therapeutic alliance with malingering patients.

Treatment of comorbid conditions

As discussed, malingering is not itself a mental illness and often occurs in the presence of other illnesses. The identification of malingering should not stop—and indeed should encourage—the
Figure 3  Clinical management of the malingering patient and potential complications.
ongoing assessment of psychological, psychiatric, and medical morbidity. Especially in the case of partial malingering, patients will exaggerate some symptoms that are already or have recently been present. For example, patients may emphasize the presence of hallucinations, a symptom with which they are familiar because they have schizophrenia.

The adaptational model emphasizes that malingered behaviors result from a patient’s rational choices in which the potential benefits to be gained by those behaviors outweigh the consequences of being caught. Providers should recognize that, for patients, malingering is often an effective means of acquiring medical care, shelter, and social support. Untreated psychiatric illness may be one obstacle to otherwise obtaining these goals. Thus, treatment of comorbid illness reduces the patient’s need to mangle. For instance, patients with substance use or severe psychosis may be unable to find adequate shelter and therefore seek emergency care for exaggerated somatic or psychiatric complaints. Because emergency department care takes so long, this strategy often provides the patient with overnight shelter. Reducing barriers to care and connecting these patients with outpatient treatment may reduce the frequency of emergency department presentations.

ACKNOWLEDGMENT OF NECESSARY GAIN

Secondary gain has a pejorative connotation for treating physicians. However, for patients who are seeking a safe place to stay or medications they perceive as critical to their well-being, secondary gain is a necessary gain. At the least, malingering reflects a deficiency in coping and life management that has resulted in an untenable and distressing situation.

Psychiatrists can build an alliance with malingering patients by acknowledging their genuine needs and considering alternatives to achieve those goals. According to the adaptational model, the psychiatrist aims to lower the stakes of the evaluation for the patient by providing the patient with viable alternatives. For example, an emergency department patient seeking housing may be unaware of overnight shelters or how to access case management. The patient may prefer hospitalization to being in the shelter, but a clinician will have a more satisfying and successful patient interaction by problem solving with the patient rather than dismissing the patient’s concerns immediately. Moreover, in such cases, a patient leaving invalidated and upset is more likely to immediately go to another emergency department, or the same department on the next shift, with the same, albeit ineffective, strategy.

REPEATED OBSERVATIONS

Particularly in consultation and emergency settings, malingering symptoms can be difficult to identify after a single encounter. Repeated interactions with the patient can help both identify malingering and provide more opportunities for treatment.

Prolonged observation allows the psychiatrist to use a multidisciplinary team and therapeutic milieu to understand the patient’s presentation. Malingering patients often interact differently with physicians than with other team members, such as behavioral health technicians and nurses, whom they perceive as being less important for achieving their goals. In inpatient psychiatric settings, patients may present differently in groups and the milieu than during individual sessions. The psychiatrist should obtain reports from other treating providers and attempt to resolve these discrepancies as part of the broader treatment formulation. Regular team meetings are an invaluable method for obtaining these reports and studying other team members’ reactions to a patient.

Repeated evaluations also allow greater time in which to understand the patient’s secondary gains for malingering. The psychiatrist may then help the patient pursue those goals through alternative means. For instance, over the course of a long emergency department stay, a patient who presented requesting opioids for malingered pain begins to go into opioid withdrawal. This development informs the treatment team of the patient’s sense of urgency to acquire opioids. The treatment discussion may then proceed to options for acute detoxification with pharmacotherapy and helping the patient access substance treatment. Motivational interviewing may be conducted with patients who are resistant to appropriate substance treatment. In this example, the psychiatrist has successfully reframed the presentation around treatment of a comorbid substance use disorder.

For patients presenting with malingered suicidal or violent ideation, prolonged observation provides the psychiatrist with greater information about current safety risk. Longer observation offers the team time to better evaluate the patient’s degree of agitation, anxiety or panic, or sleeplessness—all symptoms that herald greater risks of suicide, violence, and coercive treatment.

CONFRONTATION

There is no utility to outright confrontation with the malingering patient. Malingering is exhausting and anxiety provoking for the patient, and being labeled a liar only serves to make the patient feel isolated and powerless. The challenge for the provider is to alleviate the anxiety of deception by letting the patient know that there is no value to further deception while simultaneously not belittling or demeaning the patient. To do this, the psychiatrist may raise the question of discrepancies using concrete examples and invite the patient’s explanation. It is beneficial to provide malingering patients with a “face-saving way out of the interaction.” For example, ask if any other factors may be contributing to symptoms. There should be continual acknowledgment that the patient is in distress and requires help. Avoid accusatory language.

Having alleviated the pressure to continue malingering, the psychiatrist should proceed to reinforce for the patient the benefits of continuing to work together. These benefits include addressing genuine material needs (e.g., housing, legal assistance, care of medical conditions) and treating comorbid physical or mental illness, including through pharmacotherapy. As the adaptational model suggests, a collaborative relationship will be more effective than an adversarial relationship for reducing malingered behaviors.

REACTION TO THE MALINGERING PATIENT

Malingering provokes strong reactions among physicians. Physicians expect patients to be truthful and often feel angry, frustrated, or even vengeful on learning that they have been intentionally lied to. A physician must recognize and acknowledge these reactions to successfully manage a malingering patient.

These strong emotional reactions may be manifested through unprofessional or inappropriate responses to the patient. Clinicians
may act rudely or dismissively toward the patient’s concerns. Such dismissals result in underinvestigation of symptoms and a failure to recognize underlying physical and psychiatric illness that may require treatment. Anxiety or a sense of helplessness among providers may lead to unnecessary or even counterproductive care. How certain patient postures may evoke strong, particular reactions that then result in poor treatment decisions is illustrated here [see Figure 4]. Finally, strong countertransference may prevent the provider from recognizing malingering behaviors as a reflection of the patient’s inadequacy in resolving life stressors [see Pathophysiology, above]. In this sense, understanding malingering as an adaptive behavior for the patient reframes the therapeutic relationship from a more adversarial context.

Practitioners should be mindful of their higher propensity for burnout when working with suspected malingers.73 Outpatient providers report feeling exhausted, cynical, and ineffective when working with malingering patients. This sense only increases when comorbid personality disorders and substance use disorders are being treated.

Psychiatrists receive extensive training in managing their emotional reactions, including countertransference, and how to use those reactions diagnostically.65 As consultants working in outpatient and hospital settings, psychiatrists must support nonpsychiatric colleagues in containing their strong reactions. The consulting psychiatrist may be invaluable to the primary team by simply pointing out the strong feelings harbored toward the patient and normalizing them as common. Then the psychiatrist may help the team realize appropriate boundaries and responsibilities toward the patient who is malingering. These responsibilities include the appropriate workup of medical issues. To this end, the consulting psychiatrist may encourage an inquisitive and curious stance from the treatment team. Psychiatrists can advocate for social work assistance commensurate with the patient’s needs. However, psychiatrists should also ensure that the treatment team does not overindulge a patient by providing unnecessary or inappropriate assistance, perhaps out of a fear of confrontation or a sense of failure instilled by the patient’s behaviors.

Consultation with colleagues

Because deceptive patients can be clinically and emotionally challenging, the physicians treating them benefit from routine and ad hoc consultation with colleagues. Discussing a difficult case with a peer colleague provides space to voice frustration before it impacts either the larger team or the patient’s care. This consultation helps providers ensure that an appropriate standard of care has been provided despite the difficult circumstances. Using peer consultation in this manner also provides medicolegal protection when trying to manage high-risk malingered behaviors—for instance, the patient overtly threatening suicide on discharge.

Clear limits

Sometimes, despite the psychiatrist’s best efforts, a patient is unwilling to partner on a mutually agreeable care plan. This situation can be aggravating for the provider (who has done as much as possible for the patient) and the patient (who continues to have his request refused). At worst, these conflicts result in agitation, aggression, or other coercive treatments. At best, they result in an unsatisfying therapeutic encounter.

Nonetheless, it is crucial for psychiatrists and other treatment providers to maintain appropriate boundaries. To do so, it is necessary to set clear limits for the patient. For example, the provider might say, “I will not prescribe opioid pain medications” or “You cannot stay in the hospital.” Removing any ambiguity by setting limits in a concise statement may seem difficult but often has the effect of deescalating the patient.74 Such limit-setting statements provide the opportunity to “reset” the encounter as the patient may decide to stop malingering for an unobtainable goal and instead focus on a new, realistic goal. To continue the example of a patient who has been told he or she cannot stay in the hospital, the patient may stop trying to obtain an admission and instead focus on alternatives for shelter.

![Figure 4](https://example.com/figure4.png)

Figure 4  Examples of clinical pitfalls after unmanaged countertransference.
PERSONAL SAFETY

It is important to take proper precautions in patients with known risk factors for violence. During an evaluation, the risk of agitation is higher among patients with disruptive behaviors, severe psychosis, and impaired insight. Staff should have adequate training and confidence in verbal deescalation skills and physical safety. For example, the emergency psychiatrist assessing a malingering patient with a history of assault may request security to stand by outside the room. The physician must feel safe in order to effectively build a therapeutic alliance with the patient.

DOCUMENTATION

The final step in the management of malingering is documenting thoroughly. The psychiatrist’s note should review observed inconsistencies and collateral information obtained as part of the assessment. The description of direct observations is particularly important when there is concern that a patient’s history may be unreliable. These direct observations include how the patient interacts with nonphysician staff and the degree of observed distress or physical impairment. The assessment should describe other conditions that were considered and excluded as part of the medical and psychiatric evaluation. The presence, status, and treatment of concurrent psychiatric illnesses should be noted. These illnesses should be diagnosed in addition to the presence of malingering. A thorough assessment should enumerate the reasons the clinician suspects malingering contributes to the presentation.

The suicide and violence risk assessment for the malingering patient models that of other psychiatric notes. For patients with malingering, the note might include particular mention of how the psychiatrists have modified suicide risk. A clinical encounter with a malingering patient and the elements that should be documented are summarized here [see Figure 5].

Quality of Care Measures

Quality of care measures have not been frequently applied to the identification and management of malingering. There are

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Figure 5  Sample malingering encounter and assessment.
several barriers to the use of measures for malingering. One is the difficulty of identifying malingering. Also, because malingering may occur in so many different settings, there is unlikely to be an effective universal approach to identification.26

A more helpful approach may be to evaluate the impact of malingering on achievement of quality measurements for other illnesses. Similarly, processes for improving care might be based on comorbidities that are related to malingering. For example, a standardized approach to pain management in one emergency department resulted in greater satisfaction among both patients and providers.77 Establishing clear boundaries and expectations for the doctor-patient relationship removes much of the conflict and intense countertransference produced by treating malingering patients.

Prognosis and Outcomes

According to the adaptational model, malingering is contingent on the patient’s perception of risks and rewards. An acute episode of malingering is likely to persist as long as this cost-benefit paradigm remains unchanged. For example, patients with somatic symptoms who are undergoing related litigation have been recognized as unlikely to improve until resolution of the legal proceedings, a phenomenon sometimes called “compensation neurosis.”27 Similar patterns of persisting illness have been identified among patients seeking disability payments.9

Unfortunately, few longitudinal studies evaluate outcomes on patients who mali-ger. In one study, therapy outpatients who endorsed seeking secondary gain for treatment were more likely to have poor results in therapy.16 Another long-term study of emergency department patients found that suicide rates among patients with contingent suicidal ideation were zero, compared with 11% for patients with noncontingent suicidality.28 However, although contingent threats are often correlated with malingering, this study did not necessarily identify malingering patients. The suicide and violence risk among patients who mali-ger has not been quantified. For instances in which malingering is closely associated with major mental illnesses, including antisocial personality disorder and substance use disorders, prognosis are likely defined by those co-occurring illnesses. It is unclear if malingering behaviors are further correlated with positive or negative outcomes.

Conclusion

Malingering is a complex and frustrating clinical issue for physicians. Although malingering occurs across all clinical settings, the difficulty in detecting malingering has hindered description of its prevalence, scientific tests of its management, and an understanding of its implications for patients and providers. The most effective strategy for managing a malingering patient includes identifying the malingering, clarifying the patient’s needs, adopting an empathetic and nonconfrontational approach, and collaborating with the patient to reach a common goal. Understanding malingering as a patient’s inability to otherwise resolve an acute stressor enables providers to maintain a compassionate stance and minimize negative outcomes.

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SOMATIC SYMPTOM DISORDERS
