EDITORIAL

MALINGERING IN CLINICAL PRACTICE WITH SPECIFIC REFERENCE TO PSYCHIATRY AND PSYCHOLOGY

Malingering is the intentional simulation of illness for an external gain.[1] It can occur in any medical illness and most clinicians will encounter this problem at some point in their clinical practice. Malingering occurs most often in a medico-legal setting where the external gain is monetary compensation for disability. However, in day-to-day practice most clinicians will probably be confronted with simulation in the context of avoiding work due to illness. Many clinicians may also experience the opposite situation, namely where patients try to hide illness or diminish the degree of symptoms in order to return to work or to qualify for an insurance policy.

The prevalence of malingering in mental health may be higher than commonly expected. In 1996, Coetzer and Emsley[2] formulated guidelines for disability assessment in psychiatry. They pointed out that psychiatric disorders were, at that time, the second most common reason for permanent disability due to medical illness. Hugo *et al.*[3] established that simulation occurred commonly in the context of disability assessments. Twenty-five per cent of patients showed malingering with a threshold scale and 31 - 72% with screening tests for malingering. The authors highlighted that these results should be cautiously interpreted as many contributing factors may play a role.

There are many reasons why individuals may want to malinger. Understanding the underlying theories may limit the intolerance that clinicians tend to experience when confronted with simulation. The most widely accepted theory for malingering focuses on a conscious or unconscious cost-benefit analysis on the part of patients. Patients may think that they can benefit financially from an assessment, so 'it wouldn't hurt' to perform below par in the evaluation. Rogers calls this scenario the adaptational model where patients may be attempting to meet their objectives in adversarial circumstances.[4] In our experience there is often an exaggeration of symptoms or perpetuation of symptoms in situations where settlement has been pending for some time. In long drawn out cases with constant reiteration of symptoms to different experts, symptoms may become entrenched.

Most clinicians believe that they would be able to rely on their clinical skills and experience for the diagnosis of malingering. However, it has been shown that these are unreliable.[4] On the other hand, malingerers overestimate their ability to simulate without detection. Iverson[5] provides some qualitative descriptions of methods used for simulating. He points out that persons with malingering may show poor co-operation, aggravation and frustration, slow response times and frequent hesitations, and general confusion during the testing process. These clinical pointers could be missed in a psychiatric or psychological setting unless clinicians use objective assessment techniques. Many mental disorders do not have clear objective signs and it becomes difficult to judge the veracity of symptoms. Special tests, designed to measure simulation, will aid the clinician's clinical skills.[3,6,7]

Theron *et al.*[6] and De Villiers *et al.*[7] provide standardisation data for screening tests of malingering in a South African sample. It is important that cut scores on these tests are not viewed as definitive for the diagnosis of malingering. Clinical experience and judgement must complement these screening measures.

The presence of simulation complicates clinical diagnosis and management. Many authors argue that it is impossible to diagnose an underlying disorder or be certain of the degree of impairment in the presence of simulation; an example is simulated memory impairment in the presence of head injury. Direct confrontation does not help and a way needs to be found for the patient to improve co-operation and save face.

Malingering in psychiatric and psychological practice presents many challenges to clinicians. It is important to be aware of possible simulation, especially in a medico-legal context. However, before finally diagnosing malingering one should exclude genuine illness, factitious disorder, or conversion disorders. In factitious disorder, symptoms are feigned to assume the sick role, and in conversion disorder symptoms appear in relation to conflict or stressors. Collateral information is important in determining the diagnosis and the degree of disability actually present.

Frans J Hugo

Department of Psychiatry
University of Stellenbosch
W Cape

Frances Hemp

Department of Psychiatry
University of Cape Town

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. APA, 1994.
2. Coetzer P, Emsley RA. Guidelines to the management of disability claims on psychiatric grounds. *S Afr Med J* 1996; **86** (6): Insert, 1-8.
3. Hugo FJ, Theron FH, de Villiers N, Hemp F, Thornton HB, Emsley RA. The prevalence of malingering in persons seeking compensation on the basis of neuropsychiatric symptoms. *South African Journal of Psychiatry* 2001; **7**: 110-114.
4. Rogers R. *Clinical Assessment of Malingering and Deception*. 2nd ed. London: The Guilford Press, 1997.
5. Iverson GL. Qualitative aspects of malingered memory deficits. *Brain Inj* 1995; **9**(1): 35-40.
6. Theron FH, Hugo FJ, Spangenberg JJ, Hemp F, Maritz JS, Emsley RA. Validation of psychometric scales for malingering in a student sample. *South African Journal of Psychiatry* 2001; **7**: 96-102.
7. De Villiers N, Hugo FJ, Theron FH, Hemp F, Spangenberg JJ, Emsley RA. Psychometric tests for malingering in persons with a diagnosis of depression. *South African Journal of Psychiatry* 2001; **7**: 103-109.