Psychiatric Malingering - Detection and Management

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PURPOSE
These guidelines provide direction to NSW Mental Health clinicians and Emergency Department staff on the standards for the detection and management of psychiatric malingering.

Malingering is the conscious feigning, exaggeration or self induction of illness for personal gain, other than merely gaining the status of a patient.

In the context of the psychiatric assessment in the emergency department, it may involve a patient who presents with a range of symptoms and signs, who may seek to achieve gains diverse as accommodation, financial assistance, avoidance of criminal charges, or prescription medications.

Background
There are no evidence based guidelines for the management of suspected malingering, and few statements in literature to guide the clinician who suspects a patient may be feigning psychiatric symptoms.

The Mental Health and Drug & Alcohol Office consulted the NSW branch of Royal Australian & New Zealand College of Psychiatrists (RANZCP) in relation to advice on the development of training guidelines for the diagnosis and management of psychiatric malingering. This request arose from a recommendation in the NSW Mental Health Sentinel Events Review Committee’s third Tracking Tragedy report.

The RANZCP advice (copy attached) relates to the diagnosis and management of malingering in the emergency department situation, however the authors comment that the guidance provided in their paper is largely relevant to acute psychiatric settings.

Mental Health Services and emergency departments should consider the information provided by the RANZCP (appendix 1) to assist in the management of suspected psychiatric malingering.

KEY PRINCIPLES
• Malingering is a rare and extremely difficult diagnosis to accurately detect; and
• Apparent malingering of psychiatric symptoms is almost invariably associated with the presence of another concurrent psychiatric diagnosis.
• Decisions about the diagnosis and management of psychiatric malingering must be made in consultation with a senior mental health colleague.

Recommended Standards
Because clinicians are unlikely to be able to successfully identify psychiatric malingering in all but extraordinary circumstances:
• Mechanisms must be in place for clinicians to consult with more senior mental health clinicians (generally the Consultant Psychiatrist on call)
• Junior clinicians should not make this diagnosis without careful review by a senior colleague.
Senior clinicians should only make a provisional diagnosis of malingering.
All clinicians making a provisional diagnosis of malingering, should then make, and record, any other provisional diagnoses apparent.

In relation to management of this diagnosis:
- Patient management decisions should be based on a holistic formulation, and
- Consideration should be given to the patient’s risk profile for harm to self or others.
- Management strategies should provide options for safe management with a significant margin for error, given the tentative nature of the formulation for these patients.
- The decision to discharge from ED on diagnosis of malingering should only be made in consultation with Consultant Psychiatrist on call.

USE OF THE GUIDELINE

These guidelines should be used in conjunction with Area Health Service or facility protocols, as appropriate.

Area Directors of Mental Health should:
- Bring the attached RANZCP advice to the attention of medical staff and other clinicians providing mental health consultation and care in the Area; and
- Ensure that relevant Area mental health service protocols are reviewed to include the RANZCP paper’s key points as practice standards for the diagnosis and management of malingering.

Area Directors of Emergency Medicine should:
- Alert relevant medical and nursing staff to the principles and standards for the management of suspected psychiatric malingering in emergency departments as outlined in this Guideline.

REVISION HISTORY

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<td>September 2009 (GL2009_016)</td>
<td>Deputy Director-General Strategic Development</td>
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ASSOCIATED DOCUMENTS

THE DETECTION AND MANAGEMENT OF
PSYCHIATRIC MALINGERING IN THE EMERGENCY
DEPARTMENT

Robert Gribble, Chris Ryan and Ralf Ilchef, NSW Section of Consultation-Liaison Psychiatry, on behalf
of NSW Branch RANZCP

Though this be madness yet there is method in't.

Polonius, Hamlet II ii

The Tracking Tragedy Report reviews and makes recommendations regarding
sentinel events involving patients seen by mental health services in New South
Wales. The 2007 report commented on a case where a patient was assessed by a
mental health service as having a provisional diagnosis of malingering and was
discharged from hospital. Subsequently the patient committed homicide. The Report
recommended that training guidelines be developed and implemented regarding the
diagnosis of malingering and the application of the diagnosis (1).

This report, an expert analysis of the literature, is the Section of Consultation-Liaison
Psychiatry's response to this recommendation. We have limited ourselves to the
assessment and management of malingering in the emergency department, which is
our area of expertise, though obviously much, indeed most of the report, likely
applies well to other acute psychiatric settings.

DEFINITION AND PREVALENCE IN THE EMERGENCY DEPARTMENT

Malingering is the conscious feigning, exaggeration or self induction of illness for a
personal gain, other than merely gaining the status of a patient. In the context of the
psychiatric assessment in the emergency department, it may involve a patient
pretending to have a range of symptoms and signs, to achieve gains diverse as
accommodation, financial assistance, avoidance of criminal charges, or prescription
medications.

Perhaps due to the difficulties in reliably recognising malingering discussed below
there is only one published study giving any indication on the prevalence of
psychiatric malingering in the emergency department. Yates and coworkers asked
psychiatric trainees providing emergency services at a general hospital in Honolulu to
complete questionnaires on 227 patients evaluated over a two-month period to
assess whether they suspected the patient of malingering, and whether the patient
was confronted about the suspicions. Though the trainees were supervised by an
experienced emergency psychiatrist, it is not clear how often this psychiatrist saw the
patients concerned. Thirteen percent of patients were strongly or definitely suspected
of feigning symptoms. Six patients received a secondary diagnosis of malingering, none a primary diagnosis of malingering, and less than half were confronted (2).

In an Australian context, an unpublished review of 4525 psychiatric consultations to the emergency department at Westmead Hospital in Sydney found that the diagnosis of "malingering" was recorded in only six cases. These cases were seen within working hours, and most were seen by an experienced consultation-liaison psychiatrist. All patients who received a diagnosis of malingering also received at least one other psychiatric diagnosis.

Taken together these findings suggest that while psychiatric trainees, at least, may suspect at a degree of malingering relatively frequently, a diagnosis of malingering is made extremely rarely and essentially never made without making an additional psychiatric diagnosis.

DIFFICULTIES IN DETECTION OF MALINGERING IN THE EMERGENCY DEPARTMENT

Numerous studies suggest that the average person has little or no ability to accurately detect a lie. Among the general population, and even among most law enforcement officers, rates of successful detection are generally at what would be expected by chance. While some studies have suggested that some subgroups within some professions, such as some Secret Service agents, may be genuinely expert lie detectors, even these "truth wizards" rarely achieve accuracy scores above about 70% (3).

There are no studies suggesting that health professionals have any particular expertise in lie detection. Indeed, it is possible that health professionals are worse at detecting liars than the general population. One famous study, that examined the experiences of normal individuals who were admitted to psychiatric hospitals after feigning hallucinations, noted that the psychiatrically unwell inpatients were more likely to detect those feigning psychiatric symptoms than their psychiatrists were (4).

The only reliable way of determining whether or not an individual has told an untruth is to compare their claim with the evidence that supports their claim. If you say that you did not eat the Mars Bar, but the Mars Bar is gone, the empty wrapper is beside you, and you have chocolate on your lips, you are probably lying.

Many of the claims made by people presenting to the emergency department with psychiatric symptoms will be about the nature of their own mental or bodily states and therefore "the facts" will not be available for verification or contradiction. If you say you do not want a Mars Bar, there is no external evidence that can be used to determine the veracity or otherwise of your claim. Claims regarding internal states such as mood, hallucinations and delusions are similarly inaccessible for verification or contradiction.

Our inability to detect the act of lying coupled with the inaccessible nature of mental state claims has lead some authors to search for indicators in people's descriptions of their internal mental states that might indicate that they are lying. Resnick, for
example, a recognised expert in the field, suggests that a claim that an auditory hallucination is "vague or inaudible" should raise suspicion that the claim is false (5). He bases this advice on the results of a 1971 study of 116 people with hallucinations and a variety of diagnoses that found that only 7% of auditory hallucinations had this quality (6). Resnick works primarily in the forensic setting. While the presence of statistically unusual features in a person's presentation may be of use to a jury trying to weigh a person's innocence or guilt in the context of all the other trial evidence presented, this sort of analysis will be of no real use in the emergency department.

There is no evidence that any particular feature or combination of features of a person's reports of his mental state can be used to reliably determine whether that person is lying about his auditory hallucinations, delusions or mood. Even if it were possible to design a scheme for the detection of malingered mental illness with a reasonably high sensitivity and specificity, the low base rate of malingered mental illness in the emergency department would necessarily mean that such a test would identify many false positives (7).

COMORBIDITY AND MALINGERING

The judgement that it is possible that a patient is malingering, or even that a patient is definitely malingering, does not exclude the possibility that the patient also suffers genuine complaints that may need clinical attention. Indeed, apparent malingering of psychiatric symptoms seems almost invariably related to the presence of another concurrent psychiatric diagnosis. This was the finding in both the Westmead and Honolulu series discussed above.

Instrumental psychosis or the Good Soldier Svejk syndrome, is a useful term, proposed by Tyrer and colleagues, where patients who may, at times, mangle psychosis also have a valid psychotic diagnosis (8). The authors note that "the falsity of simulated psychiatric symptoms is difficult to prove and the relative contribution of conscious and unconscious motives virtually impossible to assess", but propose this syndrome as a way of better understanding patients with psychosis who may, at least in part, manufacture or exaggerate symptoms.

Even in those cases where a concurrent psychiatric diagnosis is not present it seems likely that one will eventually become apparent. Two studies have followed patients originally diagnosed as malingering for up to 20 years. Hay found that five of six patients originally thought to have been feigning a schizophrenic psychosis eventually developed some form of genuine disorder (9). Humphreys and Ogilvie found that all seven patients described as having a personality problem or disorder and feigning psychotic symptoms in a 1970 publication had developed a genuine psychosis by 1996 (10).

THE MANAGEMENT OF SUSPECTED MALINGERING

There are no evidence-based guidelines on the management of suspected malingering. While lists of potential indicators of malingering have been proposed, their reliability and validity is untested (11). Indeed there are very few statements of
any sort in the literature to guide the clinician who suspects that the patient before her may be feigning some psychiatric symptoms.

Clinicians in the emergency department should acknowledge that they lack the ability to successfully identify malingered mental illness in all but extraordinary circumstances. Junior clinicians should not make this diagnosis without careful review of their decision by a senior colleague. Even a senior clinician should generally only make a provisional diagnosis of malingering in the emergency department. A firm diagnosis of malingering in this context will be vanishingly rare.

Having made a provisional diagnosis of malingering, all clinicians should go onto to make and record any other provisional diagnoses that are apparent. They should then incorporate these diagnostic findings into a formulation, drawing on the patient’s personality style and social circumstances, that describes a proposal for how this patient got to be in this predicament at this moment. Decisions about the patient’s management should be based on this holistic formulation. Given that, in such patients, the formulation will likely be tentative, management strategies will tend to take this uncertainty into account and provide options for safe management with a significant margin of error.

In developing management plans clinicians should also guard against the possibility that their decisions are being inappropriately biased by the countertransference issues referred to below.

COUNTERTRANSFERENCE AND THE SUSPECTED MALINGERER

In much the same way as the vast majority of drivers believe themselves to be of better than average driving skill, so it seems the majority of people in certain professional groups – police, judges etc – falsely believe themselves to be good at detecting lies. While there is no direct evidence that psychiatrists or psychiatric trainees regard themselves as good lie detectors, it is possible that they do. If they do, it is likely that they are wrong.

Clinicians should guard against any impulse to believe that they have any special aptitude in the detection of deception. Similarly, junior clinicians should be wary of similar claims made by senior clinicians and inquire as to the evidence they have for their superior ability.

The discovery that one has been hoodwinked, or even the feeling that another is trying to pull the wool over one’s eyes, naturally evokes feelings of antipathy to the actual or suspected perpetrator. Clinicians should take care to ensure that such feelings do not prevent the person in front of them from receiving the best available care.

Generally the feigning of psychiatric symptoms is impossible to reliably to identify. Even when definitely present deception in this context is usually a simple marker of the patient’s distress and perceived inability to legitimately obtain the care that the patient feels is needed. In these circumstances, the decision to discharge a person
from the emergency department should not be made lightly, and only in consultation with a very experienced mental health clinician.

Reference List


(2) Yates BD, Nordquist CR, Schultz-Ross RA. Feigned psychiatric symptoms in the emergency room. Psychiatric Services 47, 998-1000. 1996. Ref Type: Journal (Full)


(9) Hay GG. Feigned psychosis - a review of the simulation of mental illness. British Journal of Psychiatry 143, 8-10. 1983. Ref Type: Journal (Full)
