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Malingering Psychosis: Guidelines for Assessment and Management

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PURPOSE: The purposes of this paper are to (a) identify theoretical underpinnings of malingering, (b) to discuss interview and intervention techniques based on pertinent literature, and (c) to offer an organized mnemonic to help clinicians easily identify possible malingered psychosis presentations.
CONCLUSION: Detecting the malingering of psychotic symptoms is a challenging task for Advanced Practice Psychiatric Nurses. Diagnosing a patient of malingering requires caution on the clinician's part.
PRACTICE IMPLICATIONS: A thorough understanding of potential signs of malingering vs. genuine psychosis is needed as well as knowledge of legal ramifications.

Detecting malingering in a patient who presents with symptoms of psychosis is one of the most challenging tasks for an advanced practice psychiatric nurse (APPN). Some of the reasons for difficulties are the subjective nature of some of the symptoms of psychosis, the rapid pace of the clinical interview in most treatment settings, and the necessity to maintain a clear understanding of the definition of malingering compared to other conditions of falsely reporting of symptoms. The *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association [APA], 2000) lists malingering not as a diagnosis but as "Additional Conditions That May Be a Focus of Clinical Attention" (APA, 2000, p. 739). In the DSM-IV-TR, malingering is defined as: ". . . intentional production of false or grossly exaggerated physical or psychological symptoms, moved by external incentives such as military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs" (APA, 2000, p. 739). Although malingering is not considered a psychiatric diagnosis, it can be associated with psychiatric disorders (Murdach, 2006). Malingering is frequently mistaken for factitious disorder. Compared to malingering, patients with factitious disorder primarily wish to be in a patient role and receive medical care (APA, 2000; Murdach, 2006). Understanding the scope of the occurrence of malingering can also be helpful to providers. The exact prevalence of malingering is unknown but there have been some attempts at identifying occurrence rates among treatment settings (Resnick & Knoll, 2008).

The DSM-IV-TR (APA, 2000) definition of malingering gives credence to a common misconception that malingering is an activity by those with antisocial personality disorder and thus is more commonly found in criminal forensic settings (Rogers, 2008). However, Mittenberg, Patton, Canyock, and Condit (2002) reported findings that malingering occurred more often in the public service setting than in the forensic setting. For example, they found that malingering comprised of 30% of disability evaluations, 29% of personal injury evaluations, only 19% of criminal evaluations, and 8% of medical cases. LeBourgeois (2007) remarked that this finding is consistent with studies of base rates of malingering during mental health evaluations. Yates, Nordquist, and Schultz-Ross (1996) noted that 13% of patients presenting to the emergency room for psychiatric symptoms were found to be feigning symptoms but none were diagnosed as malingering. Of these 59 patients, almost half were identified as feigning symptoms in order to obtain food or shelter. Rogers (2008) suggested that malinger-

ing rates have been overreported due to the inclusion of behaviors similar to malingering, like false imputation, which is the attribution of real symptoms to a false cause. Others have reported that malingering is underdiagnosed because providers ". . . fear being sued, assaulted—or wrong . . ." (Adetunji et al., 2006; Resnick & Knoll, 2005, p. 1). Not only is malingering a challenge for providers to identify and researchers to track, but it is also costly to the healthcare environment. Garriga (2007) reported that malingering costs the United States insurance industry approximately $150 billion a year. These factors suggest that providers need to be adept at assessing for malingering as part of any differential diagnosis when evaluating patients during the clinical interview.

The purposes of this paper are to (a) identify theoretical underpinnings of malingering, (b) discuss interview and intervention techniques based on pertinent literature, and (c) offer an organized mnemonic to help clinicians easily identify possible malingered psychosis presentations.

Theoretical Models

The DSM-IV-TR definition of malingering implies that this deceptive process is a malicious act. However, understanding the motivation to malinger as an adaptive mechanism could be the key to developing better interventions. Rogers (1990, 2008), one of the foremost experts in malingering, describes the most comprehensive models for understanding the motivation behind malingering. Throughout his research, he identified three distinct concepts of malingering: pathogenic, criminological, and adaptational. Understanding the motivation to malinger can assist the clinician in maintaining a balanced perspective of the patient (Rogers, 2008).

The Pathogenic Model

The pathogenic model developed from the early work of Menninger (1935). This model identifies the motivation for malingering as a state in which a person feigns symptoms in an effort to control his experience of illness that is occurring and report the symptoms to gain secondary incentives (Rogers, 2008). This type of malingering is sometimes considered "partial malingering" because there is an actual disorder occurring. An example of this is an individual who has been diagnosed with schizophrenia, who has been stabilized on a specific treatment plan, and presents with much more severe symptoms in order to procure more medication or an alternate. Rogers (1990) noted that this model has been disregarded due to lack of replication of the original findings.

The Criminological Model

The DSM-IV-TR description of malingering suggests that it is likely to occur when individuals are faced with criminal charges and are seeking reprieve from legal consequences (APA, 2000). The DSM-IV-TR also suggests a connection between malingering and individuals who have co-occurring antisocial issues (APA, 2000). Researchers identified that understanding the motivation to malinger only when in conjunction with criminality is a limited viewpoint (Ford, King, & Hollender, 1988; Rogers, 2008). Rogers described this motivation for malingering as the "criminological" model which does not accurately reflect all cases of malingering according to the epidemiological research Rogers reviewed.

The Adaptational Model

Rogers's (1990, 2008) model includes the perspective of malingering as an adaptive process. Rogers observes the malingering act as an individual's attempt to cope with extreme stressors. Rogers proposed three assumptions with this model. They include the following: (a) the patient will perceive the interview as either involuntary or adversarial; (b) the patient does not see other alternatives to achieve his/her goal; and (c) the patient believes there are no other means to achieve his goal.

Viewing the motivation to malinger through the lens of the adaptational model suggests that the patient is in need of services despite that they are falsifying their presentation. This could be an act of desperation or an indication of poor coping skills. Maintaining this perspective allows the clinician to function in the widest role possible while preserving the integrity of their role.

Interviewing Techniques

The clinical research of the presentation of malingering is extensive with results concluding in the development of valid psychometric scales used for detection of malingering (Rogers, Gillis, & Bagby, 1990; Schretlen, 1988). This literature evaluates malingering of a wide variety of conditions and diagnoses. Numerous authors reviewed cases of malingering of traumatic head injuries, physical disabilities, and pain syndromes (McDermott & Feldman, 2007; Mendelson & Mendelson, 2004). The body of research regarding malingering psychiatric illness is growing (Chesterman, Terbeck, & Vaughan, 2008).

Resnick and Knoll (2008) note the growth in the clinical research literature on the topic of detecting malingering vs. other psychiatric diagnoses in daily practice, and also literature specifically discussing the malingering of psychosis. Having an arsenal of interviewing techniques allows the clinician to make a better, more complete, and valid assessment during the clinical interview (Resnick & Knoll, 2008). This is especially important when obtaining collateral data or specific comprehensive psychometric assessments are not possible.

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Identifying specific interviewing skills that can detect suspected malingered symptoms is valuable to the clinician both for differentiating the primary diagnosis and for saving time. Carefully structuring the clinical interview is essential for developing a standardized approach to initially assessing patients (Rogers, 2008). The initial stages of the clinical interview may be unstructured for the purposes of establishing rapport. Resnick (2007) identified three specific interviewing techniques that can assist the clinician. These include (a) asking about specific details of symptoms, (b) asking patients if they experience identified malingering symptoms, and (c) confronting paranoid ideations. For example, asking specific details of psychotic symptoms being presented allows the provider to make some comparisons to symptoms of genuine psychosis.

When clinicians suspect malingering, they must be ". . . more critical and less accepting . . ." of their impressions (Resnick & Knoll, 2005, p. 1). Subjective assessment of psychotic symptoms generally begins with the patient's description of his experience. The clinician supports the patient in this process by offering open-ended questions. It can be difficult to remember the varied symptoms of potential malingering, which will be presented in the following section, while also connecting with the patient and asking interview questions.

The length of the clinical interview is another way in which the clinician may identify malingering. According to literature (LeBourgeois, 2007; Resnick & Knoll, 2008), the malingering patients will tire in their attempt to maintain their symptomatology; therefore, as the time in the clinical interview is extended patients will relent in their presentation. While a specific amount of time varies among clinicians and facilities, what is important is to allow time to ask the same question in varying contexts. Finally, the clinician should always consider any collateral information that is available (Resnick & Knoll, 2008; Waite & Geddes, 2006). Sources of information might include family and friends presenting with the patient, other medical records, case workers, or other evaluations that may have occurred for social benefits.

Harris (2003) emphasizes "No foolproof method exists for identifying malingerers" (p. 1). Disturbing findings highlight this fact. For example, researchers (Hay, 1983; Humphreys & Ogilvie, 1996) discovered that a number of patients who were diagnosed with malingering psychosis later developed schizophrenia or other serious psychiatric illnesses, such as bipolar disorder. Hay (1983) followed up on six patients 10 years after initial interview during which malingering was "identified." All but one patient became permanently afflicted with schizophrenia. Humphreys and Ogilvie (1996) followed up with 10 "malingering" patients 20 years after initial interview. They identified 3 of the 10 patients who met full criteria for schizophrenia at the 20-year follow-up, one of which required long-term inpatient hospitalization for management. Although these reports might not be of statistical significance, they do exemplify the importance of remaining cautious in labeling a patient as malingering.

Assessment of Malingered Psychosis

In order to help remember the potential symptoms of malingering psychosis to better structure the clinical interview, simplified mnemonics were developed based the literature reviewed: "FACING IT," "HELPS," and "IDEA." "FACING IT" represents the potential symptoms of malingering auditory hallucinations, "HELPS" identifies potential malingering symptoms of visual hallucinations, and "IDEA" represents the suspected malingering symptoms of delusions (Table 1).

Auditory Hallucinations

The "F" in "FACING IT" stands for frequency of the auditory hallucinations. Researchers found that genuine auditory hallucinations are intermittent, not continual, and are typically heard in complete sentences instead of stilted language (Resnick & Knoll, 2005). However, Harris (2003) mentions that during the early stages of psychosis, some patients may hear single words or phrases. An example of stilted language was presented by Resnick and Knoll in which a man accused of robbery alleged voices that said, "Stick-up, stick-up, stick-up" (Resnick & Knoll, 2005, p. 4). It is also important to know that the voices heard during genuine auditory hallucinations are usually clear and audible and, 88% of the time, the voices appear to originate outside the head (Resnick & Knoll, 2005).

"A" stands for absent association to delusions. Auditory hallucinations experienced by persons with genuine psychosis are frequently associated with delusions (Resnick & Knoll, 2005). For example, patients who hear voices saying they are a "bad person" and they are "going to pay for it" would most likely also experience paranoid delusions such as the belief that they are being followed or watched. "C" represents command hallucinations in which the client feels compelled to follow. In fact, some patients are able to engage in certain activities to help them cope with commands. Resnick and Knoll (2005) found that patients with genuine command hallucinations "do not always obey the voices, especially if doing

Table 1. Probable Symptoms of Malingering of Auditory Hallucinations

F	FREQUENCY constant and in stilted language
A	ASSOCIATION with delusions is missing
C	COMMAND hallucinations are irresistible
I	INSUFFICIENT attempts to cope or manage
N	NEGATIVITY lacking in voices
G	GENDER of voices is specific
I	IDENTITY of voices unknown
T	TIMING of treatment response is rapid

so would be dangerous" (p. 3). They state that the clinician should become suspicious when a patient complains of command hallucinations but is free of other types of psychotic symptoms. Resnick and Knoll add that 85% of hallucinations are non-command and 75% are associated with delusions. The major themes of the voices in patients who suffer from paranoid schizophrenia are typically persecutory or include instructions. Junginger (1990) found, however, that 39% of patients who reported command hallucinations obey them. There is noted to be a higher incidence of patients responding to command hallucinations if the voice is familiar to the patient (APA, 2003). Therefore, interventions need to be taken with patients who are voicing command hallucinations in order to make sure patients are safe. It is always better to err on the side of caution.

"I" stands for ineffective attempts to cope with the auditory hallucinations. Harris (2003) points out that patients who are suspected of malingering auditory hallucinations should be asked what actions they find useful to decrease the voices as, often, patients have found ways to manage some of their symptoms. Patients who suffer from genuine hallucinations find that distracting activities can help diminish voices. Activities such as working, listening to the radio, or watching TV can be useful. However, Harris (2003) cautions that watching TV and listening to the radio can sometimes worsen hallucinations. Both Harris (2003) and Resnick and Knoll (2005) find that changing positions, such as lying down or walking, as well as seeking interpersonal contact and taking medications can also decrease auditory hallucinations. Harris (2003) also advocates asking patients what increases voices. Patients with genuine auditory hallucinations typically find that being alone worsens hallucinations whereas patients suspected of malingering may not (Nayani & David, 1996).

The "N" in "FACING IT" indicates the lack of negativity of the auditory hallucinations. The majority of genuinely psychotic patients who experience auditory hallucinations consistently report that the voices are demeaning or negative (Nayani & David, 1996). These voices make derogatory comments about the patients, their activities, and the activities of others. In women, these remarks may include derogatory comments about sexual activities (Nayani & David, 1996). In men, the voices may make negative comments about their sexual orientation (Harris, 2003).

The "G" in "Facing It" refers to the gender of voices. In other words, are the voices male or female? The genders of genuine auditory hallucinations typically include both male and female voices whereas malingerers may only identify one gender (Goodwin, Anderson, & Rosenthal, 1971).

"I" in "It" refers to identity unknown. Genuinely psychotic patients can identify the voice they are hearing 66% of the time (Harris, 2003). The identity of the voice(s) is usually associated with someone they know or are related to. Lastly, "T" in "Facing It" refers to timing of response to treatment. Typically, response to treatment is delayed. Resnick and Knoll (2008) state, "the median number of days for hallucinations to clear after the first initiation of antipsychotic medication is 27" (p. 55) (Table 2).

Visual Hallucinations

The mnemonic "HELPS" refers to the suspected malingering symptoms associated with visual hallucinations. Cornell and Hawk (1989) found that subjective reports of visual hallucination occur at the rate of approximately 4% of patients in a genuine psychotic episode vs. 46% of those believed to be malingering. Harris (2003) further differentiated between the types of hallucinations seen based on the underlying cause. For example, patients who are withdrawing from alcohol are more likely to see animals while patients with genuine psychosis typically report seeing. Genuinely psychotic patients frequently report that the visual hallucinations appear suddenly and without prodromal symptoms. Asaad and Shapiro (1986) discovered that patients who suffered from drug-induced hallucinations experienced visual perceptual abnormalities when their eyes were closed and/or in darkened areas. Resnick and Knoll (2005) add that images of flashes of lights, tracers, or moving objects are more associated with neurological disease and/or substance use.

The genuinely psychotic patients experience visual hallucinations in color whereas suspected malingerers may report these types of hallucination in black and white (Goodwin et al., 1971). Therefore, the "H" stands for hue to prompt the provider to ask specifically about the color of the reported visual hallucination. The genuinely psychotic patient will see the visual hallucinations when their eyes are opened or closed. "E" refers to the finding that suspected malingering patients report that their visual hallucinations cease when they close their eyes (Harris, 2003; Resnick & Knoll, 2005).

"L" stands for lone visual hallucinations. Patients who suffer from schizophrenia are more likely to experience auditory hallucinations and less likely to experience or report visual hallucinations (Resnick & Knoll, 2005). Suspected malingerers, however, are more likely to only describe visual hallucinations without the presence of other hallucinations, delusions, or other symptoms of psychosis (Resnick & Knoll, 2005). This is due to their limited knowledge of the hallmark symptoms of genuine psychosis.

Table 2. Probable Symptoms of Malingering Visual Hallucinations

H	HUE is black and white
E	EYES closed stops the visual hallucinations
L	LONE visual hallucinations without delusions in patients with schizophrenia
P	PROVIDES specific details eagerly when asked to describe visual hallucinations
S	SIZE abnormal and unusual details

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The genuinely psychotic patients lack specificity when describing visual hallucinations. Additionally, psychotic patients are reluctant to discuss their hallucinations. Most clinicians become suspicious when they encounter a patient who willingly discusses his hallucinations and describes them in detail. Therefore, "P" stands for "provides specific details eagerly" when asked to describe visual hallucinations (Cornell & Hawk, 1989).

In conjunction with an eagerness to talk about their hallucinations, malingerers also add strange details and odd characteristics about the visual hallucinations. The "S" in this mnemonic stands for "size of people is abnormal," meaning reports of seeing giants or unusually small people suggest malingering (Resnick & Knoll, 2005). One cautionary note is that this symptom needs to be considered with other objective data as this could indicate a toxicity or organic cause to the individual's presentation (Cohen, Alfonso, & Haque, 1994; Lewis, 1961) (Table 3).

Table 3. Probable Symptoms of Malingering Delusions

I	INCONSISTENT behavior to delusional description
D	DRAMATIC or bizarre content without disorganized presentation.
E	EAGER to talk about delusion and are specific in the details.
A	ABRUPT onset or termination

Delusions

In the mnemonic "IDEA," clinicians are reminded of the types of presentations of delusions that indicate possible malingering. For instance, the "I" corresponds to the inconsistencies in the person's behavior and the content of the delusion (Harris, 2003). An example is a person describing a persecutory delusion such as a belief that he/she is being followed by the Federal Bureau of Investigation, but does not engage in paranoid behavior like being suspicious of the interview.

Next, the actual content of the delusion is examined. The "D" stands for dramatic or bizarre content without disorganization. Persons malingering psychosis are attempting to be convincing with their knowledge of psychotic presentations. By doing so, they often provide elaborate details of the delusional belief system and the descriptions are provided in an organized fashion (Resnick & Knoll, 2005). People with true psychosis are illogical in their reasoning about the delusional belief as well as demonstrate disorganized thought patterns when presenting (APA, 2000).

As with visual hallucinations, the genuinely psychotic patients are reluctant to share the details of their delusional contents (McClellan & McCurry, 1999). When clinicians encounter psychotic patients who freely share details of their delusions, this could indicate suspected malingering. Therefore, the "E" in the mnemonic represents eager to share details (Resnick & Knoll, 2005).

The "A" indicates the abruptness of the feigned delusion. Malingerers may report or present sudden onset or rapid discontinuation of delusions (Harris, 2003). In actuality, delusions develop over time (weeks to months) and, with treatment, fade in importance in persons with a genuine psychotic illness. Patients with psychotic illness may continue to have beliefs consistent with delusions but they are less preoccupied by them (Resnick & Knoll, 2005).

Overall, this mnemonic could be useful to providers as they organize their clinical interview, specifically if they are beginning to identify inconsistencies suggesting false reporting of symptoms of psychosis. Once a provider begins collecting evidence of malingering psychosis, they may then question how to manage this individual therapeutically throughout the remainder of the clinical interview.

Therapeutic Interventions and Management

There are no published standards of practice for how to intervene if malingered psychosis is suspected during the interview. Opinions vary about what to do and are based on perceptions of practice and not research-driven guidelines. The responsibility of the provider includes not only accurately documenting the findings as well as treatment planning but also remaining therapeutic. The literature was collected through keyword searches in EBSCO, CINAHL, and PsycINFO databases; additionally, the reference lists of key articles were reviewed for further literature focusing on interventions with malingering patients. The articles were selected from keywords of malingering and interventions or malingering and management strategies. Thus, the following is an accumulation of the commonly reported strategies from this literature that describe techniques, which the advanced practice provider should consider. The authors of this paper developed the guideline from interventions and/or management strategies from the selected articles:

Management techniques at a practice level:

- Clear documentation and access to consultation for psychometric testing (LeBourgeois, 2007; Murdach, 2006)
- Obtaining comprehensive psychological testing using reliable and valid instruments whenever possible (Chesterman et al., 2008; LeBourgeois, 2007; LoPiccolo, Goodkin, & Baldewicz, 1999; Resnick & Knoll, 2005)
- Have a mechanism for obtaining collateral information if available (Harris, 2003; LeBourgeois, 2007; LoPiccolo et al., 1999)

Management techniques while with the patient:

- Promoting a safe and supportive relationship to assist in eliciting possible underlying motivations (Harris, 2003; Murdach, 2006)

- Explore the client's knowledge of psychosis and symptoms of psychotic illnesses (Resnick & Knoll, 2005; Waite & Geddes, 2006)
- Determine the nature of the secondary gain that is being sought (Waite & Geddes, 2006)
- "Accept the deceiver but not the deception" (Murdach, 2006, p. 157)
- Provide clear explanation of possible realistic options for services (Garriga, 2007)
- Follow the "ABCs" to presenting to the patient the findings of malingering as documented by LeBourgeois (2007). "Avoid accusations of lying, beware of countertransference, clarify not confront, security measures" (p. 3)
- Give patients an out by gently presenting inconsistencies to real diagnostic features. Asking them "Can you think of any other factors that might be causing these symptoms?" allows the patients to reveal their true need (Garriga, 2007; Harris, 2003; Resnick & Knoll, 2005).

These management techniques and interventions were accumulated from the literature reviewed; however, these techniques have not been tested or validated. These strategies should undergo testing for their appropriateness and feasibility. Hopefully, these will be used as a beginning discussion to develop rigorous research.

Implications for Nursing Practice

Malingering psychotic behavior is a complex phenomenon which requires advanced skills by APPNs as well as other advanced psychiatric providers in the assessment, diagnosis, and treatment of such a condition. However, anecdotal evidence suggests advanced practice nursing programs do not provide specific training on how to differentiate genuine psychotic symptoms from possible malingered psychotic symptoms during the clinical interview nor do they coach students on how to manage these findings when discovered. This could lead the nurse clinician to misdiagnosing a patient, as well as prescribing treatments that would be inconsistent and potentially harmful to the patient. Simon and Shuman (2007) point out that 33% of all malpractice claims against psychiatrists are a result of incorrect treatment, and 8% are for misdiagnosing.

Advanced practice nurses need to use their time efficiently and cost effectively. Malingered psychosis is costly to practices, facilities, and organizations (Garriga, 2007). Identifying potential signs of malingering and implementing therapeutic interventions can save clinicians' valued time and expense. While psychometric testing is the best practice for conclusively identifying malingering, the structured clinical interview occurs first and can be a valuable opportunity for collecting important subjective data. The intervention and management techniques provided in this article need rigorous testing to evaluate their effectiveness objectively but provide a basis for APPNs to practice.

As mentioned in this paper, identifying a patient as malingering requires caution on the clinician's part. Therefore, a thorough understanding of potential signs of malingering vs. genuine psychosis is needed. Hasty interpretations of malingering without adequate grounding and observation can result in bias toward the patient by the clinician, and other healthcare providers. Additionally, this may result in the patient not receiving optimal care or being discharged from care. This could lead to a missed opportunity to engage the patient in a therapeutic dialog and further exploration of his/her motivations and fears. Even worse, a malingering diagnosis may be incorrect, which could result in a patient who is suffering from psychosis not receiving needed treatment, leading to further long-term suffering of that patient.

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