# Challenges in Assessing and Managing Malingering, Factitious Disorder, and Related Somatic Disorders

October 30, 2015 | Special Reports [1], Forensic Psychiatry [2], Munchausen Syndrome [3], Somatoform Disorder [4]
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Reporting of symptoms that are beyond available medical evidence is a central feature of malingering and related conditions, making the clinical differentiation of these disorders a challenge.

Malingering, factitious disorder, and related somatic disorders present with unique diagnostic and treatment challenges. Reporting of symptoms that are excessive, nonexistent, or exaggerated beyond available medical evidence is a central feature of each condition, and this can make the clinical differentiation of these disorders a daunting task. Treatment is similarly difficult because, by the very nature of these conditions, a patient's self-report cannot be relied upon prima facie and traditional treatment approaches often do not address the underlying impetus for the reported symptoms. Management of such patients is an unwelcome undertaking for many mental health providers, and many non-psychiatric physicians prefer to avoid it altogether. Psychiatry and other mental health services, therefore, may provide a unique role by recognizing and addressing these conditions in their own patients and by providing useful consultation to providers of other specialties in instances of noncredible symptom report.

**Malingering**

*Criteria*. As documented in DSM-5, malingering is not a mental disorder but is, instead, a condition that may be a focus of clinical attention. While listed under a general heading of "Nonadherence to Medical Treatment," malingering is not simply nonadherence. Rather, malingering is defined as an intentional production of grossly exaggerated or feigned symptoms motivated by an external incentive, such as obtaining financial compensation or evading criminal prosecution. Thus, while malingering should be considered whenever the veracity of a patient's self-report is called into question, a dubious symptom report, in and of itself, is not sufficient to diagnose malingering. Similarly, attempts to obstruct or derail evaluation or treatment due to poor participation, nonadherence, or vague or inconsistent reporting are not enough to determine the presence of malingering. To determine that a patient is malingering, the following conditions must be met:

- Symptoms are feigned or grossly exaggerated
- Excessive symptom production must be intentional
- The symptom production is motivated by an external incentive (eg, avoiding work or military duty or criminal prosecution, or obtaining financial compensation or drugs)

*DSM-5 supportive indicators*. Both DSM-IV-TR and DSM-5 provide 4 conditions under which malingering "should be strongly suspected." These include medicolegal context, discrepancy between self-report and medical findings, poor patient cooperation, and antisocial personality disorder. While these conditions are included to potentially aid clinicians in flagging cases in which malingering should be considered, it is important to be aware that these supportive features are neither necessary nor sufficient to determine malingering.

Some argue that the previously listed indicators—particularly antisocial personality disorder and uncooperativeness during an evaluation—should be ignored because they do not adequately distinguish malingerers from nonmalingerers.[1,2] For example, many malingerers are not uncooperative; indeed, they may appear very cooperative and compliant if they believe that such behavior will help to manipulate their providers into believing their symptoms.[3] Thus, these proposed indicators should not be viewed as diagnostic criteria or central features of malingering.

*Is it really malingering?* Caution is recommended when you are unsure whether a determination of malingering is actually appropriate. It is not uncommon for patients with depression, anxiety, or chronic pain to report symptoms or to demonstrate signs that exceed those expected for their medical or psychiatric conditions. In some patients, such displays are unintentional and may reflect a transfer of psychological symptoms to physical symptoms, a heightened preoccupation and concern

with physical or psychological symptoms, or an increased perception of symptom intensity relative to other patients with similar afflictions.

Beyond keeping in mind that some displays of symptom magnification may be unintentional or not motivated by external incentives (and, therefore, not malingering), remember that a diagnosis of malingering can have serious negative consequences for patients. Malingering is not just a clinical term used by physicians; it is also a forensic term used by attorneys and it can have legal implications. As such, some forensic clinicians have indicated that the term malingering be reserved for cases where the evidence for the diagnosis is incontrovertible.[2,4] In cases where it is unclear whether a patient is malingering, it may be more appropriate to describe the patient's behavior with terms such as unreliability (presentation of inaccurate information), nondisclosure (withholding of information), deception (attempts to distort or misrepresent information), or atypical (presentation of unusual information).[1]

**Factitious disorder**

Similar to malingering, a diagnosis of factitious disorder also requires conscious and intentional falsification of physical or psychological symptoms. Thus, both etiologies should be considered in any case where a volitional attempt to deceive medical providers via exaggeration or feigning of symptoms is suspected. Despite these similarities, the 2 conditions differ in regards to patients' motivation to deceive. Malingering requires that deception be motivated by an external incentive. A diagnosis of factitious disorder requires that the deception occur even in the absence of an external incentive. This suggests that individuals with factitious disorder are motivated by an internal incentive, where deceptive behaviors might serve the purpose of gaining nurturance, attention, or sympathy from family, friends, or medical providers.

While the main tenets of factitious disorder remain fairly similar across DSM-IV-TR and DSM-5, a prior criterion that required that the motivation for deceptive behavior be "to assume the sick role" is now absent from DSM-5. This change is likely a reflection of the challenges in determining the presence or absence of specific internal incentives. Importantly, clinicians may now make the diagnosis without needing to make inferences regarding a patient's internal motivation to deceive (eg, assuming a sick role) so long as an external incentive is not apparent and malingering has been excluded as a cause of the deception.

**Factitious disorder imposed on another**

Factitious disorder imposed on another (formerly factitious disorder by proxy) occurs when one volitionally falsifies the psychological or physical signs or symptoms of another person in the absence of an external incentive. In some instances this may take the form of an individual falsely reporting or exaggerating another's symptoms to receive sympathy or attention. In more deleterious instances, individuals may actually induce physical or psychological harm or injury to another.

For example, in Munchausen syndrome by proxy, a parent might surreptitiously cause medical issues in a child (such as poisoning the child to the point of sickness) and then repeatedly take the child to a pediatrician for evaluation of the symptoms to gain professional attention and personal nurturance from the issue.

Certainly ethical and legal issues can arise due to this type of behavior, and it is essential that clinicians be aware of relevant state laws and institutional policies, as both may vary by location. When the victim is a child, mandatory reporting laws are likely applicable and efforts should be made to protect the child from further harm.

**Differentiating malingering and factitious disorder from related somatic disorders**

A number of substantive changes to the diagnostic labels and criteria for somatoform disorders appear in DSM-5. These disorders are now referred to as somatic symptom and related disorders. This DSM diagnostic category includes factitious disorder as well as conditions such as somatic symptom disorder, illness anxiety disorder, and conversion disorder (functional neurological symptom disorder). The latter disorders can be difficult to clinically differentiate from malingering and factitious disorder because patients with these disorders also report symptoms that are in excess of, inconsistent with, or incompatible with known manifestations of true medical illness.

For example, patients with somatic symptom disorder—the condition that most closely resembles the condition previously referred to as somatization disorder—may express concern, report disruption of daily life, or seek out medical intervention for their somatic symptoms to an extent that is excessive given the actual severity of any true medical condition. However, such patients differ from those with malingering or factitious disorder in that they do not intentionally exaggerate or falsify their symptoms for the purpose of an external or internal incentive (**Figure**). Rather, patients with somatic symptom disorder truly believe that their symptoms are real, are genuinely distressed by their purported symptoms, and often lack insight into the psychological processes underlying

their symptoms.

Similarly, a diagnosis of conversion disorder is appropriate when patients present with a clearly neurologically incompatible loss or alteration in motor or sensory function that cannot be attributed to an intentional act of deception. DSM-5 does not require clinicians to determine that symptoms are unintentionally produced to diagnose conversion disorder. This seems to imply that when discriminating between conversion disorder, malingering, and factitious disorder, a greater degree of confirmatory evidence is required for malingering/factitious disorder, and that in the absence of such evidence (ie, evidence of feigning), conversion disorder is likely a more appropriate diagnosis in cases of medically unexplained neurological symptoms.

**Standardized assessment of excessive illness behavior**

In many cases, psychiatric providers can determine that symptoms are excessive, exaggerated, or feigned based on clinical history and examination findings. When feigning or exaggeration of symptoms is suspected but not confirmed or in cases where differential diagnosis of these conditions is still questionable, psychiatric providers may consider referring patients to a clinical neuropsychologist or psychologist for additional workup. Clinical neuropsychologists assess cognitive functioning to detect true cognitive changes. At the same time they often employ standardized and well- validated tests that are sensitive to patient attempts to exaggerate or feign cognitive impairment.

Common validity tests administered by neuropsychologists include Test of Memory Malingering, Word Memory Test, Medical Symptom Validity Test, and Rey 15 Item Test. These tests were designed to appear challenging to an examinee but, in actuality, are easily performed even by individuals with rather severe cognitive impairment. Similarly, both neuropsychologists and clinical psychologists commonly utilize emotional and personality measures such as the Minnesota Multiphasic Personality Inventory – 2nd edition and the Personality Assessment Inventory to identify invalid reporting of both psychological and somatic symptoms. These measures often include validity scales that directly assess for honest and accurate responding as well as clinical scales that assess for underlying personality characteristics that might be linked to or directly causing the exaggerated symptoms. Such standardized assessment provides an objective approach for helping to determine the veracity and nature of a patient's reported symptoms.

**Treatment and management**

A major hurdle in diagnosing and treating patients with disorders characterized by medical and psychiatric deception is that key distinguishing features of the disorders––those relating to intent and motivation––are not readily observed in most clinical settings.[5] Determining whether a patient's deception is motivated by external versus internal factors can be difficult even in the presence of secondary gain, as external incentives (eg, financial gain, avoidance of work) may not always be the primary operant or may work alongside internal motivators (eg, sympathy from a spouse or co-workers). Even when psychological or neuropsychological testing unequivocally documents that a patient is presenting excessive or exaggerated symptoms, testing might not provide full insight into the motivation behind the documented exaggeration. Thus, testing should be viewed as an empirical method to determine whether a patient's complaints are valid (ie, are the complaints accurately reported and not exaggerated?), but testing should not be viewed as a means to solely or specifically diagnose malingering.

Because differential diagnosis of malingering, factitious disorder, and related somatic disorders is often difficult even when there is documentation of symptom exaggeration, it is recommended that clinicians try to extend beyond categorical thinking about the conditions and instead try to understand the function of the deceptive behavior (eg, avoiding work to avoid stress caused by a difficult co-worker) when treating and managing individuals with such presentations.[5] This approach may allow for a bridge to treatment in patients whose deception is rooted in poor coping or potentially remediable psychological problems.

Patients may find discussions regarding stress and coping strategies to be more palatable than confrontations about their deception or assertions that "it's all in your head." In cases where illness deception is potentially affected by stress, depression, or anxiety, both psychotherapeutic and pharmacological interventions may be warranted and helpful. Documentation of both true and falsified symptoms can be beneficial in justifying clinicians' diagnosis and treatment, and in providing information to other providers who work with the deceptive patient.

When a patient's excessive report or falsification of symptoms is likely to result in overuse of medical services (eg, over-prescribing of medications, repeated surgeries), it is often helpful for mental health clinicians to recommend that other providers adopt relatively conservative treatment approaches to minimize iatrogenic effects and unnecessary health care expenditures. When you

suspect malingering, true symptoms may sometimes exist. If falsified symptoms can be disentangled from non-falsified symptoms, treatment of true symptoms may be possible in some cases.

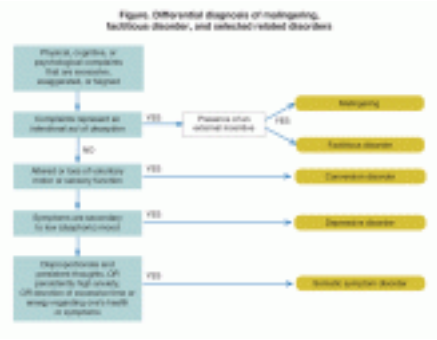

Figure. Differential diagnosis of malingering, factitious disorder, an...

**Disclosures:**

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