**Malingering**

Malingering occurs along a spectrum ranging from deliberate embellishment or exaggeration of symptoms to consciously lying about a condition. The best available evidence indicates that the latter type of faking, while significant, is small in comparison to those who present themselves genuinely. There is little agreement about actual proportions - estimates vary from about 7% to 30% of claims.

The DSM-V states that the essential feature of malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding work, obtaining financial compensation, evading criminal prosecution or obtaining drugs.

In a work environment, some people mildly or even moderately exaggerate their symptoms, either consciously or unconsciously, because they feel their problems have been summarily dismissed by their employer. Further, litigation can result in endless visits to various assessors for each 'side', and lead to feelings of being invalidated. These people feel growing pressure to 'prove' the reality of their symptoms and increasingly emphasise their sufferings to assessors. This group does not fit the DSM-V definition of malingering because there is not an intentional production of false or grossly exaggerated symptoms.

Deception is usually suspected when the individual’s symptoms are vague, ill defined, overdramatised, inconsistent, or not in conformity with signs and symptoms known to occur in the particular condition. In this regard, the history, mental status and physical examinations, records, and other available collateral information may demonstrate inconsistencies in the nature and intensity of the person’s complaints. Under ordinary circumstances, the health provider rarely gets a sufficient insight into patient illness behaviours to obtain evidence for such definitive labelling.

It can be argued that the question of whether or not a person is lying, is not a psychiatric issue but a legal one. Stating that a person is a malingerer has the potential to cause psychological distress, and many deem it inadvisable to use the term 'malingering' in a psychiatric report. Any exaggerations and inconsistencies in symptom patterns should be reported, and the often complex reasons behind them explored. The Court can then make a judgement about the presence of malingering.

Tests: An increasing number of valid and reliable tests to determine whether an injured person is responding truthfully during psychological testing have been developed. However, as with all psychometric tests, they must not be taken simply at face value.

Many factors, often interacting, can influence the results of standard psychometric tests of malingering. Depression, fatigue, anger, loss of concentration, dissociation, chronic physiological arousal, pain, environmental factors such as sub-optimal testing conditions, are just some of the influencing factors.

The ability of neuropsychologists to detect “faking” on neuropsychological test batteries remains controversial. Tests such as the MMPI, which was designed with internal validity scales, were not primarily designed to detect malingering. It is suffice to say that the tests are most useful in assessing strengths and weaknesses in cognitive functioning of impaired *cooperative* patients, rather than as a barometer of who is “faking” and who is giving their best effort. The history, records, and clinical interview of the patient offer more guidance in this last regard.

Reference:
American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV)

American Medical Association, Guides to the Evaluation of Permanent Impairment, 6th EditionAPS Newsletter December 2002, Susan Ballinger MAPS, Past Chair, APS College of Clinical Psychologists