Malingering

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An understanding of malingering behaviour and indeed malingering as a concept is, so far as it is available, important to psychiatrists and to psychiatry more generally. Even if one restricts the application of the term to 'symptoms invented or exaggerated for external gain' then the subject remains relevant in so far as it presents an impediment to diagnosis and thus to the appropriate apportioning of resources. The literature indicates that such behaviour, at least in its pure form, is relatively uncommon and it is rather the overlap between malingering and the related diagnostic categories of hysteria, factitious disorder and antisocial personality disorder which underlies continuing interest in malingering and makes it the worthy object of continuing academic attention. This article is based on a review of both historical and contemporary work in the area and although orthodox in its approach to malingering is particularly concerned to highlight definitional, classificatory and nosological problems.

HISTORY AND ETYMOLOGY

The Oxford English Dictionary (1991) indicates that 'malingering' is derived from the French *malingre* meaning 'sickly or ailing'. It is perhaps worth noting, however, that the Latin adjective *malignus* meaning 'of an evil nature or disposition . . . ' (Lewis & Short, 1945) is perhaps the origin of the term, an origin which 'malingering', if this is correct, shares with the word 'malignant'.

According to Bassett-Jones & Llewelyn (1917) who reviewed the development of the concept up to the date of the publication of their book in 1917, both Galen and Paré gave attention to the subject. The term, however, did not find its way into the English language until its inclusion in Grose's *A Classical Dictionary of the Vulgar Tongue*, compiled in 1785. The first systematic treatment of malingering published in the English language was Hector Gavin's *On Feigned and Factitious Diseases Chiefly of Soldiers and Seamen*, published in 1843.

Towards the end of the 19th century and in the early part of the 20th century, industrial expansion coupled with the introduction of workers' compensation and the broadening of Tort law led to a greatly increased concern about the socio-economic implications of malingering behaviour and a consequent surge in interest in it, and particularly in its detection, by civilian medical practitioners. In 1912 Collie wrote *Malingering and Feigned Sickness* and in 1917, as mentioned above, Bassett-Jones & Llewelyn's scholarly work entitled *Malingering or the Simulation of Disease* was published. These books focused almost exclusively on the detection of malingering by physical examination and various supplementary and often ingenious tricks and were written in language which betrayed an attitude of moral condemnation towards individuals exhibiting such behaviour. Subsequent work in the area has tended to deal with malingering in relation to compensation litigation (Trimble, 1981) and/or its detection (Rogers, 1988).

DEFINITIONS

Definitions of malingering always contain reference to two components, firstly that symptoms must be invented or exaggerated and secondly that this is done deliberately for the purposes of gain. *Butterworth's Medical Dictionary* (1978), for example, defines malingering as "the feigning of illness or disease or pretending inability to undertake work or service". Legal and military definitions incorporating the same components are available, but restrict the application of the term by context. DSM–IV (American Psychiatric Association, 1994) 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 military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs". But ICD–10 (World Health Organization, 1992) and DSM–IV choose to list it under Z76.5 'person encountering health services in other circumstances' and V65.2 'additional conditions that may be a focus of clinical attention' respectively. These placements indicate that malingering is to be conceptualised as a behaviour (not as a diagnosis or illness) which can be manifest in any individual whether or not he is ill, and if he is ill whether or not the malingered symptoms relate to the illness from which he is 'genuinely' suffering. This standpoint entails that malingering can coexist with any illness and some authors have even gone so far as to suggest it can do so with hysteria (Gorman, 1982) and with factitious disorder (Cramer *et al*, 1971). As a corollary the difficulty with this view is that it appears to have the consequence that an individual can malinger hysteria or a factitious disorder.

CLASSIFICATION

It is possible to classify malingering in a variety of ways. Classifications based on context, that is whether it occurs in a military setting or against the background of a compensation claim, or of criminal charges, are of limited value. An alternative is to classify by the choice of symptom. Now although an individual's choice of symptom raises interesting questions, and notwithstanding the contribution of psychodynamic theory, we appear to be quite some way from even beginning to answer the questions thus raised. Norris (1943) proposed a similarly pragmatic, but perhaps more useful, classification in which he said symptoms were either invented, exaggerated, perseverated or transferred (that is from an earlier injury or illness and attributed to the injury which is the subject of ongoing litigation). Pure invention aside, it seems likely that psychosomatic research will continue to work towards collapsing these seemingly artificial distinctions, unless of course one is willing to sanction their use by explaining just how an individual can deliberately set about perseverating his exaggerated symptoms without collapsing the distinction in his own mind.

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Having reviewed the more pragmatic schemes of classification, only the traditional approach, which is best viewed as a more fundamental attempt to classify malingerers rather than acts of malingering, remains. The repeated concern of writers for most of this century has been to argue that malingering is a symptom of personality disorder and/or to differentiate it from similar presentations of the neuroses and, in particular, hysteria. In keeping with this, Mock (1930) spoke of 'liars', 'neurotics' and 'mixed-types' and Travin & Protter (1984) similar separated the group into the three overlapping types of 'other-deceivers', 'self-deceivers' and lastly 'mixed deceivers'. Nippe (1927) had previously introduced the term 'teleophrenia' to cover the intermediate cases. Reflection reveals that the cornerstone of this approach is deceit, which according to these classificatory systems, straddles the gap between the personality disorders and the neuroses. Deceit of others, indicating personality problems of the antisocial type, and of oneself, indicating hysterical tendencies.

Although it seems that closing the gap between malingering and psychopathology is an appropriate way of approaching the subject, one continuum based on deceit is not enough for the task. In the first instance, pure malingering quite clearly serves an adaptive function in certain circumstances (Rogers, 1988) and therefore cannot directly be identified with personality disorder, even if it is more likely to be exhibited by individuals thus classified (see below). Secondly, the continuum described above, which is based on the direction of deceit, conflates the act of deceit with the motive for deceiving, with the consequence that if an individual is in a situation where he obviously stands to gain something, then he automatically falls into the category of 'other-deceiver' irrespective of whether or not his symptoms are consciously fabricated. Thirdly, leading on from this, it is important to separate the motive for deceit from the act of conscious symptom fabrication, because a clinician faced with a patient with a factitious disorder would, because of the absence of obvious gain, be forced, on pain of contradiction, to categorise him as a 'self-deceiver'.

As a preliminary conclusion, then, malingering cannot be explicated in terms of any one continuum which bridges the gap between personality disorder and hysteria. In the first instance it is a behaviour which can be manifest in individuals who are normal, along a continuum to those who have been traditionally categorised as suffering from antisocial personality disorder. But also, ignoring for a second this first continuum, malingering is separated from, but related to, the factitious disorders because of the progressive absence of obvious goals as one moves from the former to the latter; furthermore, and irrespective of these two relationships, any individual whose presentation falls into this area may be aware of his deceit or alternatively his symptoms may be unconsciously determined. An attempt to classify malingering is thus to approach the problem from the wrong direction; what is needed is a clearer explanation of the relationship between malingering apart from, and as part of, these conditions.

NOSOLOGY

To take antisocial behaviour first, Szasz (1956) said that "no examination of malingering seems possible without touching on certain aspects of the socio-psychology of antisocial action". Now while the pure invention of symptoms for gain is prima facie antisocial, the two World Wars taught us unequivocally that malingering can serve an adaptive function and it is surely possible to view the pursuit of financial reward similarly. The literature, however, supports the clinical intuition that there is an association between antisocial personality disorder and malingering behaviour. Sierles (1984) showed a significant correlation between self-report measures of malingering and sociopathy, and so DSM–IV is perhaps correct in suggesting the relevance of this association to clinical practice. It must be emphasised, however, that there is a general consensus that pure malingering is rare (Braverman, 1978) and it is clearly prudent to assess carefully the advantage of such behaviour to an individual and indeed the individual's personality more broadly, before taking it to indicate psychopathology of the antisocial type.

Turning to hysteria. A situation in which there is much to be gained from illness does not preclude a lack of conscious awareness of symptom production and vice versa. As mentioned, clinicians have too often conflated the act of deceit with the motive for that deceit, and attributed 'other-deceit' to individuals purely on the basis of the presence of obvious gains. The pursuit of understandable gains must be allowed to vary independently of the conscious element in symptom production. By way of illustration, in the context of compensation litigation one is often left wondering how a minor injury with the prospect of only a trivial compensation pay-out can result in an individual presenting as significantly disabled. The answer is not always that such people regard money more highly than the rest of us do, but rather that the prospect of such gains often does not provide enough of a motive for the malingering which is thereby attributed. Now in the absence of sufficient motivation the way is open for one to argue that the element of the presentation not attributable to the pursuit of obvious goals is, at least possibly, unconsciously produced. This is one reason why the distinction between hysterical reactions and all but the purest of malingering is of limited clinical usefulness.

Having separated the direction of deceit from motivation *per se*, it remains to look more closely at obvious gains and in particular their presence or absence. Over and above the issue of clinicians leaning towards a diagnosis of malingering as opposed to hysteria if obvious gains are available, attention should be given to what such clinicians would say about malingering if such gains are not available. They would diagnose factitious disorder. And in connection with this problem, DSM–IV talks about requirement of "evidence of an intrapsychic need to maintain the sick role" in these cases, cases which are clearly at the end of a continuum along which motivation becomes increasingly difficult to understand.

As for the 'evidence' in question it is interesting that any individual fabricating symptoms could be said to have such a need and it would appear that it is introduced as an explanation only in the factitious disorders because of the absence of the usual types of gain. Indeed, the term 'intrapsychic' is used pecisely to preempt this objection. If the "need to maintain the sick role" were 'extrapsychic', we would presumably be dealing with a case of malingering. With this in mind it seems somehow illegitimate to introduce the 'sick role' as a motive at the end of this continuum of behaviour. One can argue that either individuals or their desires, at the end of such a continuum, are very different from those of their purely malingering counterparts, but then the common-sense understanding of motivation generally used to explain human behaviour must, at some point along the continuum, be arbitrarily replaced with circular explanations that invoke the consequences of any

given behaviour to explain that behaviour. Furthermore, and ignoring this arbitrariness, such a strategy has the unacceptable implication that all behaviour is psychologically determined.

The whole area is extremely complex and the above is little more than an attempt to highlight the fact that malingering is related to antisocial personality disorder but also merges with factitious disorder along a different continuum on account of the lack of gain to satisfactorily explain behaviour in many cases. As for the question of hysteria, an individual whose symptoms are, so to speak, not attributable to an acceptable illness may lie anywhere along a continuum from conscious fabrication of symptoms to the unconscious production of symptoms. It is recognised that this last suggestion raises a number of complex issues in the area of psychosomatic medicine, but it none the less embodies the traditional assumption that, leaving aside experiential symptoms such as pain, there is a distinction to be made between, for example, genuine paralysis and paralysis of psychological origin. Perhaps the best way of understanding the subject is to see any individual as having a value on three intersecting continua.

CONCLUSION

There is a vast literature on the subject of malingering, but other than a consensus on the fact that pure malingering is rare, there is little agreement on how to define and understand the behaviour, particularly given the fact that it appears to straddle the distinction between illness and health, and also overlap with other difficult-to-define illness categories. It is suggested that over and above the superficial problems of the type of symptom and the context in which the malingering occurs, a better understanding of the subject can be gained by looking at the inter-relationships between deceit, gain, personality disorder, hysteria and factitious disorders. Greater appreciation of these relationships may shift the emphasis from one of detection to one of assessment, a fact which is particularly important given that the current strategies for detection are largely unsuccessful.

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