Deception and Malingering

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INTRODUCTION

This chapter describes the evaluation of the possibility of malingering in neuropsychological assessment. Cases with financial incentives will be emphasized—e.g. workers compensation, personal injury litigation, and Social Security disability. Although malingering in criminal forensic and military settings will not be discussed, this material is relevant to those settings. Assessment of the patient who is attempting to feign mental health will not be examined.

Malingering is defined as the intentional production of symptoms for the purpose of obtaining an external incentive such as financial compensation, dodging of military duty, or avoidance of punishment for criminal behavior (American Psychiatric Association, 1987). Malingering is not considered a mental disorder although it frequently coexists with mental disorders. Unlike malingering, in Munchhausen syndrome and other factitious disorders the incentive is to play the patient role rather than to obtain an external incentive (Pankratz, 1981).

Historically, observations of malingering were first recorded in biblical times. The development of the legal concepts of the tort and negligence in medieval times, followed by development of workers compensation systems in Europe and the United States in the 19th century, brought monetary gain into prominence as incentive for malingering. The advent of the railroads led to numerous high-velocity accidents and the industrialization of the workplace led to both more dangerous workplaces and less self-employment. Contemporary debates about malingering are parallel to those of the 19th century (Trimble, 1981). According to Trimble (1981), the work of Erichsen (1882) was enormously...
influential in providing credence to the notion that an injury did not have to be visible to be compensable. Erichsen (1882) introduced the concept of "spinal concussion," which he viewed as pathology at the molecular level. Shortly afterward, Page (1885) argued that the origin of much of the disability associated with the entity of "spinal concussion" was psychological and criticized Erichsen for the lack of evidence of neuropathological damage.

Clearly, in the past many clinicians felt poorly equipped to make the diagnosis and to distinguish between hysterical reactions and malingering (McMahon & Satz, 1981). Research reviewed in this chapter showed that the average clinician generated unacceptable error rates when attempting to diagnose malingering, at least in the past. More recently, our understanding of both clinical manifestations of poor motivation and diagnostic accuracy have improved substantially.

The actual incidence of malingering is unknown because past research has been hampered by difficulty in ascertaining that all cases have been identified. Opinions in the literature state that it is rare after head injury (Bigler, 1986; Cartlidge & Shaw, 1981), common and virtually synonymous with accident neurosis (Miller, 1961), and probably common in neuropsychological examinations of compensable head trauma (Heaton, Smith, Lehman, & Vogt, 1978). In a sample of 2500 industrial accident cases of all types of injuries (Braverman, 1978), 38% were judged by unspecified criteria to be malingerers. The incidence differs across settings and populations. A literature review of malingering cited incidence estimates ranging from 1 to 50% (Resnick, 1988). It may be less common in severe traumatic brain injury patients who have no trouble proving disability than in minor head trauma patients. A review of 33 cases of financially compensable mild head injuries evaluated in the author's independent practice revealed that 5 patients generated results on forced choice memory testing (described later) that were diagnostic of malingering while an additional patient confessed to malingering. By these conservative diagnostic criteria the incidence rate was 18%. By less conservative criteria the incidence of poor motivation was 26% in an extension of the same series (Binder & Willis, 1991).

Clinician Attitudes and the Need for Differential Diagnosis

Psychologists and psychiatrists sometimes seem reluctant to make the diagnosis that implies that symptoms are exaggerated or totally factitious and induced by a desire to obtain money or other incentive. Yet, a recent survey revealed that most psychologists and neurosurgeons felt that financial incentives played some role in the postconcussive syndrome (McMordie, 1988). Many clinicians fail to appreciate the reinforcing value of money and all too quickly dismiss the possibility of malingering. Society pays people to perform honest tasks that, in some ways, are more disagreeable than simulating illness. Although mental health professionals tend to regard work highly, not all people share these values. Some people do things for money that are more unpleasant than malingering. Why shouldn't some patients malinger?