Book Review

Reviewed in This Issue: Richard Rogers, (ed.), Clinical Assessment of Malingering and Deception (2nd ed.). New York: Guilford Press, 1997. 525 pp., $47.95.

Is the detection of malingering an art, a science, or simply speculation? In the past, malingerers were mainly described by colorful anecdotes attributed to the grouses of military doctors looking at a long sick call line before an overseas deployment. This volume, like its predecessor, attempts to provide some objective standards for the evaluation of suspected malingerers. It does not give us a litmus test, but has many sophisticated tools for detecting deception. Many chapters also warn us of the limitations of certain commonly used "lie detector" tests.

Edited by Richard Rogers and published in 1988, the first edition of Clinical Assessment of Malingering and Deception made impressive additions to the then-scanty literature about malingering. At that time, malingering was a subject often ignored by mental health providers, unless they were forensic psychiatrists, military medical officers, or those involved in assessing disability claims. In the nine years between the publication of the first and second editions, the fields of forensic psychiatry and psychology have exploded as has the literature discussing malingering and other forms of deception.

This second edition of Clinical Assessment of Malingering and Deception, published in 1997, should be viewed as a sophisticated textbook or reference source. The two introductory chapters are general and useful for any mental health practitioner. The remainder of the volume is geared toward subspecialists. It cannot be read in one sitting, but is a convenient source with numerous references. It is geared for those who deal with the courts or disability ratings. Clinicians should be aware that this volume is in the library, but it is less relevant for their daily practice. Forensic psychiatrists and psychologists will want to own the book.

Under section headings of "Diagnostic Issues," "Psychometric Assessment," and "Specialized Methods" are 19 chapters. Most of the titles are the same as the original text (although some have different authors), including "Malingered Psychosis," "Children and Deception," and "Hypnosis and Dissimulation." Existing chapters expand on topics such as recovered childhood memories and integrity testing. New and revised psychological testing has been included. Two chapter titles, "Denial and Misrepresenting of Substance Abuse" and "Assessment of Malingering with Self-Report Measures," are new. While the first edition is 370 pages long, the new one is 525. Almost all of the original chapters have been made longer with more comprehensive references. There are 64 pages of references.

The introduction by the editor, Richard Rogers, opens with a discussion of assumptions of honesty and self-disclosure. Given the demands of managed care, the desire for confidentiality, and other questions of autonomy and involvement the accuracy of self-report by any patient may be suspect.

Rogers outlines the primary motives for malingering in three explanatory models. Malingerers are either mentally disordered, bad,
or adapting to bad circumstances. The first model, the pathogenic, postulates that the underlying force behind malingering is a mental disorder. The criminological model assumes a bad person in bad circumstances who is performing badly. According to the adaptational model, malingering is “more likely to occur when (1) the context of the evaluation is perceived as adversarial; (2) the personal stakes are very high; and (3) no other alternatives appear to be viable.” This latter model is best supported by descriptive data and is also the broadest and least pejorative explanation.

Most psychiatrists and psychologists view malingering on a continuum with conversion disorders and factitious disorders. As outlined in the DSM-IV, conversion disorders are characterized by unconscious conflicts without obvious conscious gain. Factitious disorders have people deliberately injuring themselves for unconscious primary gain. Malingers injure themselves or complain of illness for secondary or conscious gain (American Psychological Association 1994). This rather simplistic categorization fails to take into account the difficulty in distinguishing between primary and secondary gain or conscious and unconscious symptoms, and the lack of empiric evidence for these concepts.

In the excellent second chapter, “Psychiatric and Medical Symptoms Associated with Deception,” Alan Cunnien provides a much more sophisticated discussion of factitious disorders (FDs) and malingering. His extensive categorization of factitious disorders emphasizes the multilevel nature of behavior: “the mere presence of external gains cannot negate in every sense the primacy of psychological motives.” Cunnien distinguishes factitious disorders from malingering in a more clinically useful way: “malingering is more often time-limited and environmentally opportunistic, while FDs are more likely to demonstrate chronicity, history of prior feigned illness, and insistence on aggressive pursuit of treatment.” He also describes disorders commonly accompanied by deceptive behavior, such as eating disorders and substance abuse. He provides tables of threshold criteria for consideration of FD and malingering, as do most of the chapters.

The third chapter, “Malingered Psychosis” by Dr. Philip Resnick, is an update of a classic chapter. Dr. Resnick outlines why persons usually malinger psychosis: (1) to avoid or mitigate punishment; (2) to avoid conscription or combat; (3) to seek financial gain; (4) prisoners who may seek to escape; and (5) to seek psychiatric admission to obtain services or avoid charges. He characterizes hallucinations, delusions, and mutism documented in patients with severe mental disorders to contrast them with fabricated symptoms. He also provides a threshold model for the evaluation of malingering in psychosis in defendants pleading insanity, including criteria such as a report of a sudden irresistible impulse and the presence of a partner in the crime.

Three chapters discuss psychometric assessment in great detail. The first, on multi-scale personality inventories, summarizes the scales that can be used to assess item omissions, consistency of item endorsement, and accuracy of item endorsement on the MMPI-2. The second, “Dissimulations on the Rorschach,” agrees that there is no “signature” that reliably distinguishes faked protocols. However, threshold indicators for the suspicion of malingering include a marked paucity of “popular” responses and numerous responses with dramatic, morbid, or bizarre contacts, particularly when they involve ordinary form quality.

The final psychometric chapter focuses on detection of patients with exaggerated deficits following mild head trauma. Like so many chapters in this volume, it could be a book in itself. Threshold indicators include marked inconsistencies between present diagnosis and neuropsychological findings and between reported and observed symptoms.

Doctors Sewell and Salekin author the chapter “Understanding and Detecting Disimulation in Sex Offenders.” Sex offenders are characterized as denying or minimizing their sexual behavior. The authors begin the chapter with a useful typology of distinction
developed by Kennedy and Grubin (1992), which characterizes specific offense types and related denial patterns. Pattern 1 was composed of men who admitted their offenses, but denied causing any harm to the victims (usually young boys). They believed that the problem was with society, rather than with themselves, and had the highest rate of recidivists. In pattern 2, the offenders blamed the victims (usually spouses or young girls) for the offense. Those in pattern 3, which included many heterosexual incest offenders, attributed their actions to a temporary altered mental state. Pattern 4 offenders were characterized by total denial of the offense, usually against adult females.

A useful discussion of physiological assessment of sex offenders, using phallometric assessment, delineates the limitations of these methods. Penile plethysmography (PPG) is the assessment of sexual arousal via direct measurement of penile volume or circumference changes. However limitations include the ease with which PPG assessments can be faked, the need for standardization of test protocols/stimuli, and the lack of cumulative findings on subgroups of sex offenders.

“Polygraphy and Integrity Testing,” by Doctors Iacono and Patrick, also highlights the pitfalls of hoping for an accurate lie detector test. Both defense and trial attorneys should be familiar with the methods and limitations of these tests. The authors conclude: “psychologists should be wary of the polygraph testing . . . many problems include: (1) inadequate research addressing their validity, (2) the lack of polygraphy training forcing psychologists to rely on the opinions of polygraphers who were inadequately trained in psychophysiology and psychometrics, and (3) the dearth of information available on the use of these procedures with clinical populations.”

Another chapter by Doctors Rogers and Stava, “Drug-Assisted Interviews,” outlines similar caveats to the use of sodium amytal and other “truth serums.” Certainly clinicians, attorneys, and our professional organizations should peruse these chapters carefully before evidence is proffered in court.

Overall, this second addition of Clinical Assessment of Malingering and Deception is a very impressive volume. The wide array of authors includes a wealth of experience in the field. The tables at the end of each chapter help summarize reasons for suspicion of each condition. The references are extensive, and there are two indexes, one by author and one by subject.

However, I have some concerns about the book. Psychologist researchers wrote many chapters, and sometimes the importance of the statistics is not clearly explained for the clinician. The numerous references are included by author’s name and date in the middle of the sentence, rather than referred to numerically at the end, which makes it hard to read. Readers who do not have time to study an entire chapter would benefit from clear introductions and summaries highlighting the key conclusions. However, the tables of threshold criteria do provide the information in a convenient form.

Despite the length of the book, there are areas that are barely mentioned, especially the knowledge base about malingering in the military and the Veteran’s Administration (VA) system. The book is focused on assessment, but some historical and current clinical experience could have been highlighted.

For example, both war and peace have brought forth examples of military malingerers: some Russian and Austro-Hungarian conscripts rubbed infected trachomatus cloths into their eyes to induce disqualifying infections; pilots suddenly developed a fear of flying before bombing runs; sailors cut their wrists to get out of the brig; and soldiers shot themselves in the foot to return from Somalia. Readers interested in that subject can review my chapter in Principles and Practice of Military Forensic Psychiatry (Ritchie 1997). Most of the military examples seem to fit into the adaptational model described above.

Other organizations, especially those who process disability claims like the VA, also tell stories of exaggerated claims. The VA is the largest medical system in the United States and their experience is relevant to this volume.
In addition, although different chapters mention that prisoners may dissimulate for many reasons, there is not a specific chapter for the prisoner psychiatrist. Perhaps sections on the correctional, military, and VA systems could be included in the next edition.

Ethical issues arise in any discussion of deception by either patients or their physicians. In this era of managed care, is deception justified? Given current attitudes towards managed-care organizations, it seems that patients should not believe everything their physicians tell them. Since many doctors might be acting to increase managed care profits, should patients be acting to limit their risk and in some cases behave in a way that misinform their doctors to obtain the care the patients want? On the other hand, some physicians report lying to obtain appropriate authorization of care from HMOs for their patients. If it is ethical for the doctor to write a deceptive medical record, why is it unlawful for a patient to provide a deceptive medical record? Isn’t this assigned change from traditional medical ethic to the ethic of the marketplace? If such changes are occurring, do they have implications for understanding of malingering and deception? Unfortunately, this volume only briefly mentions this topic in a single paragraph in the introduction by Rogers: “these (managed care) changes are likely to affect fundamentally how patients perceive practitioners and their consequent willingness to be open and honest.”

In conclusion, there is no easy litmus test for malingering. Claims to the contrary should be treated according to the principle of caveat emptor. Clinical Assessment of Malingering and Deception provides an useful and organized approach to detection of dissimulation and deception. The forensic specialist and attorney specializing in mental health law will want to have the book readily available. Clinicians seeing patients without legal issues may not find it to be worth the price unless they have a special personal interest in the topic.

REFERENCES

AMERICAN PSYCHOLOGICAL ASSOCIATION. Diagnostic and Statistical Manual of Mental Disorders (4th ed.). American Psychological Association Press, 1994.

KENNEDY, H. G., and GRUBIN, D. H. Patterns of denial in sex offenders. Psychological Medicine (1992) 22:191–6.

RITCHIE, E. C. Malingering and the United States Military. In R. G. Lande and D. T. Armitage, eds., Principles and Practice of Military Forensic Psychiatry. Charles C Thomas, 1997.