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REVIEW ARTICLE **OPEN ACCESS**

Mapping the Feigned Psychotic Illness: An Overview of Malingering

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ABSTRACT

Through an analysis of the literature that is currently available, the concept of malingered psychosis is investigated.Clinical signs of fabricated psychotic symptoms are reviewed, along with potential malingering motives.The approaches covered centre on the inpatient assessment of suspected malingerers and cover topics like interviewing strategies and psychometric tests to support clinical perceptions.
Keywords: *Malingering, feigning psychotic symptoms*

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INTRODUCTION

According to American Psychiatric association (2020), Malingering is the purposeful impersonation of a disease or incapacity in order to attain a specific goal. For instance, it could appear as fabricating a mental illness as a legal defense, fabricating a physical disease to obtain compensation, fabricating an injury or misleading others about one's level of recovery to avoid engaging in physical activity [1].

HISTORICAL BACKGROUND

Biblical records include instances of malingering. To appease a king, David "acted crazy and pretended to be insane".Malingering first appeared in English medical literature in 1843.A French surgeon detailed the usage of ether to discern between fake and actual sickness, four years later. The emergence of workman's compensation in the nineteenth and twentieth centuries gave rise to many derogatory words, such as compensation neurosis, to characterize potential malingering [2]. German troops were given booklets during World War II by the British that explained how to pretend to be injured in order to get a leave of absence. A German CD-ROM addressed as the "Sickness Simulator" was lately offered for sale online; the program taught staff members how to feign illness in order to request sick time [2, 3].

DEFINITION AND SUBTYPES

Malingered psychosis entails the deliberate fabrication of psychiatric symptoms with an aim of attaining noticeable external benefits for the patient who is presenting [4]. Due to the fact that the term "psychosis" covers a wide spectrum of clinical manifestations, malingering affected patients choose to fabricate psychotic symptoms instead of another category of disorder in order to obtain external benefits[5] and pose a diagnostic challenge for medical professionals who, when giving the benefit of the doubt, incline to bundle malingering in with factitious diseases and related clinical manifestations [6-8].

Malingering, according to the DSM-IV-TR, is the "intentional production of false or grossly inflated physically or mentally manifestations, inspired by extrinsic reward like wanting to avoid service in the military, avoiding employment, acquiring monetary compensation, seeking to avoid criminal indictment, or acquiring drugs." Malingering is listed in the section "Other Conditions That May Be a Focus of Clinical Attention" in the DSM-IV-TR even though it is not a psychiatric disease [2].

According to Resnick, malingering may entail fabricating symptoms as pure malingering, deliberately exaggerating pre-existing psychopathology as partial malingering, falsely imputed symptoms as false imputation, or a combination of the three. Psychosis, mood disorders, suicidal ideation, and PTSD are a few examples of malingering psychiatric diseases[9].

REASONS FOR MALINGERING

There are many reasons why a patient might pretend to have a psychiatric illness, but clinicians working

in non-clinical settings probably observe patients doing so for one of the following three factors:

1. Obtaining a psychiatric diagnosis in order to receive financial benefits from worker's compensation or disability insurance;
2. Posing illness in order to obtain prescription drugs; or
3. Attempting to get into a mental hospital for meals, housing, or safety from the law[10].

WHAT MALINGERING LOOKS LIKE? [11-13]

Malingering's general presentation is usually characterized by the following:

1. As exhaustion sets in, answers become less crazy. This is one justification for setting up in-depth interviews when malingering is suspected.
2. Manifesting positive symptoms. Negative symptoms of schizophrenia are hardly presented. While it is possible to simulate hallucinations & delusions, it is uncommon to replicate catatonic conduct or flattened affect.
3. Repeating and overplaying. The likelihood of malingerers drawing attention to their illusions is higher.
4. They usually are inconsistent with their presenting symptoms. Malingers may pretend to forget imperative information like their date of birth.
5. Malingers fail to fabricate disorders of form of thought which is most common presentation of psychotic illness.
6. They become highly uncooperative during interviewing. They pretend to show aggression, show improvement in symptoms in very less time of duration which is not possible in case of psychotropic drugs.
7. As affirmed by collection of history and collateral information, their present manifestations of symptom will not match with their current gross psycho-social functioning.

COLLATERAL INFORMATION

Collateral information, which identifies secondary gains or reveals contradictory derailment in psychiatry history, is frequently crucial in detection of malingering. Patients who refuse to disclose such information must be noted because these behaviours further confirms malingering. Complete documentation can serve as both a litigation defense and tool for physicians conducting subsequent evaluation.

It is essential that an assessor look for alternative sources of information when self-report information is dubious. The defendant's academic transcripts, criminal records, records of psychiatric treatment, general health or hospital records, and interaction with others who have interacted with the patient are among the important sources of information that may be used[14].

THE ASSESSMENT OF MALINGERING

A systematic strategy that takes into account all the evidence should be used since there is no one test that can definitively prove that a subject is faking an illness. The following actions could be taken:

1. History taking: This needs to be lengthy, tedious, and written as soon as possible following the incident in concern. This needs to be lengthy, tedious, and written as soon as possible following the incident in issue. The malingerer finds it challenging to keep their guard up for long durations (Lo Piccolo et al, 1999) [15]. To gauge their reaction, the individual could be beginning questions concerning a different illness.

Othmer and Othmer have provided a complex 5-step "Cross Examination Clinical Interview" for alleged malingerers (2000). These are the 5 steps: to hear, tag, confront, resolve, and nod. The first step entails offering open-ended questions, fostering explanation, and withholding any hints as to the examiner's suspicions. Tagging entails verifying the story's correctness, seeking clarification, and spotting rehearsed claims, contradictions, excessive detail, and attitude. In the confrontation stage, the subject's contradictions are brought to light by contrasting them in a challenging but non-threatening way. Following then, a procedure of yes-or-no inquiry is started and continued despite the patient's resistance. Finally, the subject's decision to start the process of healing is welcomed after disclosure. The main focus of the entire conversation is on remaining allies with the subject [16].

Interviewing collateral sources could be used to support or deny the patient's claims or to learn further information [17].

Review of earlier functioning records: Prior functioning records from the workplace may be examined to support or contradict any evidence of a disability claim. The likelihood that someone is faking an illness will rise if they have a history of substance misuse, mental illness, or antisocial behaviour.

2. Observation: It needs to be done both during the interview and across all situations.

During the interview: Important cues may be given by verbal behaviour, facial expressions, and physical movements. Higher-pitched voices, frequent grammatical errors, as well as increased hesitation and pausing during interviews, are all characteristics of liars. They may utilize fillers, such as "oh, er. Ah," to fill in their silences. Pitch and loudness shifts, however, are less dependable signs of dishonesty. In a malingerer, manipulators, or movements involving self-grooming, scratching, pulling, touching another body part and using a prop like a pen, are noticeably extended and repeatedly repeated by the patient. Emblems, or gestures that express a specific meaning in a given culture, are gestures that are used less frequently than illustrators, or gestures that accompany speech [18].

Across all situations: Clinical behaviour observation in the clinical setting as well as outside monitoring are two examples of observational approaches that can be used to confirm a suspicion of malingering in a controlled environment. When physical infirmities are alleged and covert observations and videotaping of the claimant are involved, this is most favourable. Important cues may be given by verbal behaviour, facial expressions, and physical movements. Speaking in a high-pitched voice, making numerous grammatical mistakes, and pausing and hesitating more than truthful people during interviews are all signs that a subject is lying. Given that facial muscles are controlled by both intentional and involuntary processes, gestures and facial expressions are less likely to be practiced. False affects also lack the typical "crescendo-decrescendo" of natural affects and are "planned," "prolonged," and other characteristics [16, 18].

3. Psychological testing: Various psychological tests have been employed as a tool to help identify malingering in an effort to assure objectivity. These can be a helpful adjunct to support the diagnosis but are not necessary because none have been proven to be absolutely certain4. Research demonstrates that efficacy, false positive, and false negative rates can differ [19]. For research on malingering, two tools are frequently used. These are the Structured Interview of Reported Symptoms and the Minnesota Multiphasic Personality Inventory (Butcher et al., 1989)[20].These tools' process in spotting phone responses stems from their development, which paid close attention to the participants' preferred modes of response.

Minnesota Multiphasic Personality Inventory:

This instrument has 568 items and 20 fundamental scales. Some of them, such as any attempts to exaggerate one's symptoms, have been proven to be helpful in assessing the validity of the test-attitude. taker's Malingering is indicated by a low L scale, a high F scale, and a low K scale.[21]

Personality Assessment Inventory:

Another multiscale, objective personality test is the PAI, which also includes validity and clinical measures. It comprises 344 elements and 22 separate scales. There are six different response distortion indicators, and it has been proven that they are all helpful. It has been described as fairly effective, with discriminant analysis producing a hit rate of more than 80% despite psychology students fabricating the disorder using a one-week preparation period to give false answers on the exam [21].

Structured Interview of Reported Symptoms:

This structured interview has indeed been evaluated for its effectiveness in identifying post-traumatic stress disorder, mood disorders, and schizophrenia deception [22]. It is made up of eight scales and is intended to evaluate dishonest responding [22]. In terms of identifying malingerers, this interview looks competent but not flawless. It has been observed to mistakenly label real patients as whiners.[22]

MANAGEMENT

Malingering is not regarded as a diagnosis; hence management does not refer to the techniques used to treat psychiatric conditions. Therefore, it seems sense that there are no recognized non-pharmacological or pharmaceutical treatments created specifically for malingerers. However, some recommendations have been made for the doctor or psychiatrist who believes the patient they are looking at is faking a disease. The diagnosis of malingering should be supported by careful and thorough documentation, as doing so carries with it clear consequences for the practitioner[18]. Avoid consulting with additional medical specialists because doing so just encourages malingering. Directly accusing a patient of fabricating a disease should never be done since it may lead to resentment, a breakdown in the doctor-patient relationship, a lawsuit against the doctor, and, very infrequently, violence [22].

CONCLUSION

Instead of viewing malingering as a distinct psychopathological disorder, it is appropriate to think of it as a concentrate of clinical attention. Though any medical diagnosis can be fabricated, malingering of psychiatric problems may be more prevalent than previously thought and is particularly challenging to spot. The identification of malingering is very challenging and comes with clear hazards for the doctor. A

systematic strategy with inputs from multiple sources is a beneficial way to confirm this condition because there is no industry-accepted best practice investigative tool for malingering.

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