CASE REPORT

Malingering: A Result of Trauma or Litigation?

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Malingering, which is defined in DSM-5 as the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives," is easy to define, yet difficult to diagnose (1). Studies have shown that approximately 13% of patients who present to the emergency department for psychiatric symptoms are malingering (2). Not only is this time-consuming for health care providers and facilities, it is reported to cost the U.S. health care system approximately $150 billion annually (3). Furthermore, an estimated 32% of forensic psychiatry referrals are considered to involve cases of malingering (4). While it is imperative to know how to accurately assess for malingering, it is equally important to understand an individual's motive to malinger.

The following three theoretical models have been proposed by Dr. Richard Rogers, one of the leading forensic psychologists in the phenomenon of malingering (5): the pathogenic model, also known as "partial malingering," which involves a patient exaggerating preexisting symptoms in an effort to control his or her experience of a physical illness or other psychiatric disorder that is simultaneously co-occurring; the criminological model, which involves individuals seeking reprieve from legal consequences; and lastly, the adaptation model, which suggests that malingering is an adaptive process for individuals attempting to cope with extreme stressors and could be an act of desperation or an indication of poor coping skills.

The case report below exemplifies a combination of the three theoretical models of malingering and suggests that the underlying motive may change over a patient's lifetime. Additionally, the following original theory is hypothesized: once a patient is involved in the criminal justice system, he or she may exhibit malingering behaviors consciously or even subconsciously. Furthermore, this case theorizes that malingering may be acquired throughout the litigation process.

CASE

"Joey" was a 9-year-old boy who was in an accident while riding a motorbike. He sustained multiple injuries, including a moderate traumatic brain injury (TBI). He was hospitalized for 2 weeks and was initially noted to have spastic quadriparesis, dysarthria, and cognitive impairment. The patient underwent extensive rehabilitation, resulting in a nearly complete recovery from the deficits he sustained in the accident and was left only with a residual, left upper-extremity contracture.

Two years after the accident, the patient's mother filed a product liability lawsuit against the manufacturer of the motorbike due to the bike's small size and lack of a safety flag. The lawsuit claimed that the manufacturer negligently failed to warn consumers of the dangerousness of the bike. The case went to trial and resulted in a $4.5 million verdict in favor of the plaintiff. However, 3 years after the initial lawsuit was filed, the patient was found to be partly at fault, which reduced the awarded amount to $2.5 million.

During the ensuing lawsuit, the patient underwent extensive psychological evaluation. He was diagnosed with oppositional defiant disorder, and mild neurocognitive disorder was ruled out. The patient, who routinely disrespected his caregivers with racist remarks and indecent behavior, exhibited worrisome signs of underlying and evolving character pathology. The forensic examiner believed that much of this behavior was secondary to the patient's preexisting oppositional defiant disorder. Clinical examination, neuropsychiatric testing, and head imaging indicated that there was little to no evidence that his behavior was a result of frontal lobe damage or lingering effects of a TBI. However, both his family and caretakers felt that the behavior was due to his history of TBI.

The patient was later lost to follow-up. Years later, he was found panhandling in the streets by a local television news station. Although his left arm remained contracted, the rest of his body was completely capable and ambulatory. However, he would sit in a wheelchair and masterfully imitate his previous deficits. He spoke in a slurred and muffled tone, despite his speech being clear and concise at baseline. He boasted about receiving $60,000–$100,000 each year by panhandling, thereby exposing his fraudulent behavior. He had accumulated a myriad of criminal charges over the course of his life. A timeline of these legal charges, starting at age 18, is presented in Figure 1. The timeline highlights the development of antisocial personality disorder over the ensuing years. Antisocial personality disorder is a common comorbid disorder among individuals who malinger.

At age 33, he was released from jail after being charged with trespassing. From the jail, he went directly to an emergency department and requested narcotics for chronic pain. The emergency department refused to give him these medications. Upon discharge from the emergency department, he suddenly reported suicidal ideation and command auditory hallucinations telling him to "blow" his brains out. He was then discharged to the state psychiatric hospital, where he was admitted for further evaluation. On arrival, he spoke in a slurred manner in front of clinicians but was later witnessed to be speaking clearly and coherently with other hospital staff

and patients. His records revealed that he had been hospitalized at least 20 times at various facilities for similar complaints. He had been given multiple diagnoses and tried on numerous medications, although he was never compliant with any treatment plan. He reported that he was stressed about pending legal charges and had nowhere to live, and he requested a letter stating that his disability should be restarted. During the admission process, he bragged about manipulating the system via his use of multiple hospital admissions, both to evade legal charges and to avoid homelessness.

Neuropsychological testing was performed, and the results supported the diagnoses of antisocial personality disorder and malingering. While it is known that TBI may increase the risk of comorbid psychiatric disorders later in life, no evidence of any mood or neurocognitive disorder was found in this patient. The team withheld initiation of medication given the numerous inconsistencies in the patient's presentation and results of his psychological examinations. Discharge planning was discussed; however, the patient became physically aggressive and threatening when confronted with such plans. Although patient placement was difficult in this case, the patient was ultimately discharged, without medication, from the psychiatric facility to a local homeless shelter.

DISCUSSION

In the above case, the patient repeatedly feigned his neurological and psychiatric deficits for secondary gain. While there was an interplay between the three proposed models of malingering as the patient aged, one could conclude that underling all of these was the 5-year-long trial during which his alleged deficits were under constant scrutiny in a product liability lawsuit, in which a large sum of money was at stake.

Initially, the patient fit the pathogenic model, as he learned to cope with his traumatic injuries. He likely learned to exaggerate his underlying deficits, since the legal verdict was largely determined by the severity of damages. At that time, when the patient was a young child and vulnerable, the subtle message toward him was likely that he must "look his worst" in order to be rewarded additional damages. This may have subliminally reinforced any preexisting maladaptive and pathological behaviors.

The patient later fit into the adaptation model, with his efforts to acclimate not only to his injuries but to his new status as a "disabled victim." As a child, "performing" for a jury was an incentive that may have exacerbated any underlying character abnormalities during formative years of brain development. The adaptation model also encompasses the patient using his deficits, by exaggerating his impairment, to obtain his needs and desires during the litigation period. Ultimately, and paradoxically, this resulted in an adult who was neurologically recovered but one who had an acquired antisocial personality disorder and malingering behavior.

The patient started to have many legal encounters once he turned 18 years old (as shown in Figure 1). He was charged with "theft by deception" on numerous occasions. Additionally, he was seen carrying his wheelchair up three flights of stairs before raping a woman with disabilities. However, he continued to exaggerate his impairments when charged with such crimes in order to avoid criminal convictions.

Although criminal charges were not pressed by the state psychiatric hospital when the patient became physically aggressive after he was confronted with discharge plans, this was considered as an option. According to the U.S. Department of Justice National Crime Victimization Survey conducted from 1993 to 1999, the annual rate of nonfatal, job-related violent crime was 12.6 per 1,000 workers in all occupations; however, that rate increased to 68.2 per 1,000 when surveying psychiatrists and other mental health professionals (6). Further literature suggests that 40%–50% of psychiatry residents might be physically assaulted by a patient during their years of residency training (7). Although criminal charges pressed by medical professionals against patients are rare, filing charges should be considered as a recourse.

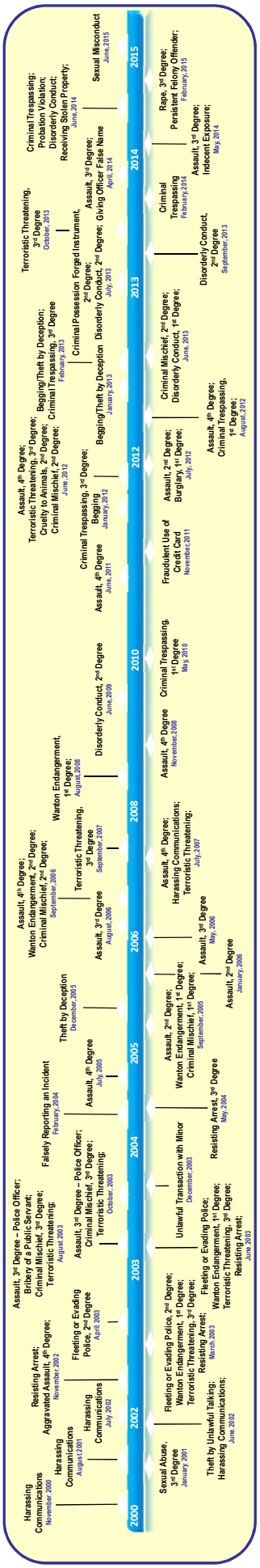

FIGURE 1. Timeline of the Patient's Criminal Charges From Age 18

KEY POINTS/CLINICAL PEARLS

- Malingering is defined in DSM-5 as the "intentional production of false or grossly exaggerated physical or psychological symptoms" motivated by secondary gain.
- Accurately assessing malingering is of utmost importance, since approximately 13% of all psychiatric emergency department visits and 32% of forensic psychiatry patients are thought to be malingering.
- The three theoretical models proposed in the development of malingering are pathogenic, criminological, and adaptation.

CONCLUSIONS

Assessment of malingering is important for all psychiatrists. It is also crucial to consider why individuals may adopt the malingering role. For example, when a substantial legal verdict is at stake, it is possible that the litigation process itself may reinforce maladaptive and pathological behaviors, and the individual may learn to rely on or magnify preexisting impairments for known secondary gain.

In the case presented here, the patient's preexisting oppositional defiant disorder was intensified during a legal trial, since his family and caregivers continuously excused his behavior due to his history of a TBI. The ensuing trial ultimately reinforced the progression of his antisocial personality disorder, since he was never held accountable for his behavior. Ultimately, the lawsuit overemphasized his impairments and prior brain injury and deemphasized any responsibility that he had over his actions. Further studies are needed to determine how litigation may affect an individual's long-term mental health.

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Details in this case report have been altered to protect the patient's privacy.

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