

Medical and Nonmedical Fainting: Separating the Sheep from the Goats

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Abstract

In recent times, the Nigerian public space has been awash with various incidences of “fainting” during investigations seeking to unravel issues surrounding alleged financial mismanagement in public institutions. A critical question is, to what extent do these apparent fainting behaviors represent a true illness-related event? Feigning of medical symptoms for external gains is well-described phenomenon with enormous cost to both forensic and nonforensic settings. Separating the sheep from the goats in these situations is a task many clinicians are not familiar with. This article aims to articulate the current models of malingering and to highlight the various ways of detecting deception in clinical settings. The authors opine that an integrative strategy, which involves the combination of various approaches with emphasis on the verbal and nonverbal signals during clinical interviews coupled with psychological testing and perhaps neuroimaging techniques, may improve the detection of deception in the clinical setting. We recommend that clinicians should not shy away from employing any of these “malingering diagnostic” approaches when there is a reasonable suspicion to the veracity of patients’ symptoms such as fainting during a panel inquiry.

Keywords: Fainting, malingering, medical, Nigeria, nonmedical

INTRODUCTION

Feigning of disabling symptoms or diseases for external gains is common in both forensic and nonforensic settings.^[1] According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), malingering is defined as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.”^[2] Though, malingering is not recognized as a psychiatric disorder in the current diagnostic manuals, the cost is enormous especially in the criminal justice system.^[1,3]

Despite the clarity of its definition as stated above, detecting malingers in real life has remained elusive. For example, one study using DSM criteria found that malingering was identified in 13.6% - 20.1% (i.e., true positives) and misclassified in 79.9% - 86.4% (i.e., false positives).^[4] This finding is understandable considering the difficulties in correctly recognizing real malingering. For example, Halligan *et al.*^[5] observed that the core question in the evaluation of malingering is: “To what extent the individual’s reported symptoms are a product of free will or related to a known pathology/psychopathology or psychosocial influences beyond his/her volitional control.” This

arduous task of inferring the level of conscious awareness, the extent of consciously mediated intention, and the motivations that accompany the symptoms presented by the patients could explain the high rates of false positives. In addition, the traditional clinician–patient relationship is based on trust, so clinicians may feel uneasy about labeling a patient as malingering. Apart from the uneasiness on the part of clinicians, there are real issues of stigma arising from labeling a patient as a malingeringer and fears of potential lawsuits from patients who may be alleging malpractice or defamation.^[6] There is also the problem of personal threats or actual violence on the clinician by the patient.^[6]

In Nigeria, where the authors practice, the public space in recent times is awash with various incidences of “fainting”

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among civil and public servants, in many instances, at public inquiries.^[7] These public hearings tend to seek for the truth, especially regarding the possible misappropriation of public funds. In these scenarios, a challenging aspect is detecting deception. Do these “faintings” have a real underlying pathological basis for which medical treatments are needed or are they feigned? In this paper, our aim is to update clinicians in sub-Saharan Africa on the phenomenon of malingering and highlight some of the ways of separating the sheep from the goats in clinical circumstances.

HISTORICAL PERSPECTIVE

Deception by feigning illness appears to be as old as humankind with numerous examples in the Biblical and classical writings, especially in political and military settings.^[8] For example, David “feigned insanity and acted like a mad man” to avoid the king’s wrath (1 Samuel 21:11–16). The history of malingering was shaped by landmark events in the history of the world. For example, World War I brought a new dimension to professionalization of malingering.^[9] Bourke^[8] wrote in his book thus: “some men went to great lengths of bodily mutilation to escape the war.” Similarly, the move from the judiciary or disciplinary settings to medical spheres has been argued to be hinged on the enactment of some social legislations.^[10] The introduction of progressive social legislations in Germany and Workman’s Compensation Act and the National Insurance Act in the United Kingdom at the end of the 19th century and early 20th century engineered the transition to the medical settings.^[10–12] These legislations gave the clinicians the unfamiliar task of determining who should be the beneficiaries of these social securities or compensations. The above events have implications; for example, in Germany, the floodgate of malingering was opened and clinicians were now seemingly doing the job of detectives.^[11,12]

BURDEN OF MALINGERING

Deception is not peculiar to those who engage in malingering and has been described by some authors as an essential part of everyday social interaction.^[13] It has been estimated that malingering occurs in 45.8%–59.7% of adults presenting for disability examinations.^[1] The prevalence rates of malingering differ across various populations; for example, about 3% and 19.0%, respectively, among injured workers and disability claimants in the United States of America (USA) were reported to be malingering.^[14,15] An opinion-based survey by a forensic psychologist in the USA reported prevalence rates of 17.4% and 7.4%, respectively, in the forensic and nonforensic settings.^[16] Mittenberg *et al.*^[17] estimated the base rates (i.e., rates when the influence of the source of referral is statistically adjusted for) and found a prevalence of 29% in personal injury, 30% in disability and compensation claims, 19% in criminal cases, and 8% in the medical or psychiatric settings. Despite modest efforts by the researchers, especially from the USA, the phenomenon of malingering is largely underinvestigated.^[4] This may be due to several factors including but not limited to

methodological challenges. Important methodological issues are the absence of largely acceptable measures or difficulty defining the behavior, problem with identifying suitable subjects and establishing reliable base rates, and a general reluctance on the part of researchers to explore the topic.^[4] In sub-Saharan Africa, there is a dearth of data on the burden of malingering in the region. However, one case report in Nigeria described a behavior suggestive of malingering in a neurology clinic.^[18] As previously stated in Nigeria, many public and civil servants have been reported in the media to have “fainted” during judicial and parliamentary inquiries about issues of public funds. We cannot say if some or all of these “faintings” are medical or nonmedical because we have not been involved in assessment of those cases. At this point in time, we do not have figures for properly documented scientific studies of malingering in Nigeria.

EXPLANATORY MODELS OF MALINGERING

Malingering in the clinical setting may present in various forms, namely^[19] invention (i.e., where a patient without actual symptoms claim to have), perseveration (i.e., where genuine symptoms previously experienced are alleged to be present), exaggeration (i.e., where symptoms or their effect are magnified), and transference (i.e., where genuine symptoms currently present are falsely attributed to previous or unrelated injuries). Similarly, Resnick^[20] described three potential subtypes of malingering: pure (i.e., involves complete fabrication), partial (i.e., involves exaggeration of existing symptoms), and false imputation (i.e., when the evaluator intentionally attributes symptoms to a cause that has little or no relationship to the development of symptoms).

To better understand the concept of malingering, explanatory models were proposed to elucidate the primary motivations for various individuals who malingering.^[21] Based on motivations, Rogers^[21] proposed three models that are nonmutually exclusive in clinical settings, namely pathogenic, criminological, and adaptational models of malingering. The pathogenic model is similar to the biomedical concept of malingering. In this model, malingering is considered a product of underlying psychopathology/disease conditions. Critics of this model argue that the inclusion of malingering within the medical framework is reductionism because it ignores the fundamental notions of responsibility, free will, and the patient’s capacity to choose.^[22] The criminological model, otherwise called a naturalistic sociolegal model of malingering, was proposed by the critics of the biomedical model. This model conceptualizes malingering as an antisocial behavior or attitude. Proponents of this model argue that it is a reasonable and legitimate alternative to explain illness deception because it takes its central root on the concept of free will.^[4,22] The criminological model was first articulated in DSM-III and the same tradition continued in DSM-5 with four indices, diagnostic (i.e., presence of antisocial personality disorder), contextual (i.e., medico-legal examination), and two presentational variables (i.e., uncooperativeness and discrepancies with objective findings).^[2] The third model (i.e.,

adaptational model) was proposed by Rogers and Shuman^[4] to avoid the monistic explanations of malingering, namely insane (pathogenic model) and bad (criminological model). This model is likened to the biopsychosocial model, where feigning of symptoms is considered an adaptive effort to deal with difficult life circumstances. According to this model, malingerers engage in a cost–benefit analysis during assessments, especially when the context of evaluation is perceived as adversarial; the personal stakes are very high, and no other alternative appears to be viable.^[4] Similarly, Velsor and colleague^[23] proposed four models, three of which are similar to the Roger’s pathogenic, criminological, and adaptational models. In addition, they introduced the nurturance model. In this model, persons feigning symptoms attempt to use their relationship with the treating clinician to fulfill their unmet psychological needs.

DETECTING MALINGERING

Detecting malingering in clinical settings is a challenging task for clinicians.^[24,25] Critics have argued that the role of clinicians in determining illness deception is unclear and sometimes raises ethical concerns.^[24,25] The ethical challenge is hinged on the clinicians’ duty to the patient versus his duty to the society.^[24] Nevertheless, the DSM-5 gave the criteria for suspicion of malingering in the presence of any combination of the following: (1) medicolegal presentation (e.g., referral from an attorney, patient seeking compensation), (2) marked discrepancy between the claimed damage and the objective findings, (3) lack of cooperation during evaluation and in complying with the prescribed treatment and follow-up, and (4) the presence of antisocial personality disorder.^[2] Despite its usefulness, the DSM-5 criteria have been criticized; Rogers and Shuman^[4] and Ensalada^[25] argued that the criteria are insufficient and offer little guidance for determining consciousness of actions (voluntariness) or consciousness of motivation. However, emerging research in forensic settings has described some verbal (i.e., from history) and nonverbal signals (i.e., from mental status examination) for detecting deception in various settings.^[26-29]

CLINICAL HISTORY

The clinical history taking is an important process in detecting malingering. One important factor is the ability of the clinician to observe inconsistencies. These inconsistencies could be in any of the following areas: within the history, between the history and observed behavior, between patient’s symptoms and published diagnostic criteria, between history from the patient and collateral information, between patient’s history and the medical records, and over time (between intervals of assessments or examination).^[30] Other interviewing techniques that have been proposed to be useful in detecting malingering include: first, the use of prolonged interview and examination, which may induce fatigue and diminish the ability of the malingerer to maintain deception; second, rapid firing of questions, which may increase the likelihood of contradictory or inconsistent responses; third, the use of leading questions,

which may induce the person malingering to endorse symptoms from a different illness; and fourth, questions about improbable symptoms, which may yield positive responses. Rogers^[21] encouraged clinicians to be wary of unusually high number of rare symptoms (i.e., valid symptoms that are infrequently reported by other patients), blatant symptoms (i.e., symptoms immediately recognized by nonprofessionals as indicative of severe disease e.g., patient reporting he is suicidal or homicidal), absurd or improbable symptoms (i.e., symptoms that are almost never reported even in the most severe disease), and nonselective endorsement of symptoms (i.e., a strategy used by malingerers based on the belief that the more symptoms they endorse, the more likely they are to be adjudged ill). However, a major drawback of the above techniques is that similar responses may be found in real patients; hence, clinicians should be cautious in reaching conclusions about malingering based on them alone.

DETECTING POSSIBLE DECEPTION USING VERBAL SIGNALS DURING CLINICAL INTERVIEW

The use of verbal signals in lie detection has grown considerably in the past decades.^[26] The reality monitoring theory posits that truthful memories of actual events originate in perceptual experiences and are embedded in the context of time and space.^[26] In other words, the recall of a truthful event is expected to be rich in spatial and temporal contextual attributes. Based on this theory, the “richness in detail hypothesis” to explain some verbal attributes of deception was described.^[26] The use of the richness in detail concept as a predictor of deception is based on the diversity of perceptual and contextual details in the evaluatee’s account of their symptomatology. It is therefore expected that people speaking the truth are more likely to be rich in their account of an event they experienced. However, a major drawback to this concept is that liars may frequently attempt to manipulate their fabricated accounts to make them appear truthful by intentionally adding false perceptual and contextual details.^[27,31,32] This ability of liars to increase the quantity of their accounts to mimic truthful accounts minimizes the diagnostic efficacy of the richness in detail concept. To overcome this limitation, some authors have postulated that the richness in detail concept can be optimized using the quality of account variables in addition to the quantity of the account variables.^[32] A helpful approach suggested is the “Verifiability Approach.”^[28] The use of the later approach to detect deception is based on the understanding that lies, by nature, are based on strategies.^[28] Specifically, liars perceive that by giving vivid details, they portray themselves as being truthful^[33]. Hence, they are motivated to provide or exaggerate details to make an impression of honesty.^[34] On the other hand, provision or exaggeration of details also puts liars at risk, as the veracity of their account could easily be checked. Aware of this danger,^[35] liars are cautious about giving details to avoid being caught. These two opposing motivations, that is, for and against, put liars in a dilemma. To resolve this, liars may present details that cannot be checked or not verifiable.

When liars use this strategy, the inflation of false nonverifiable details increases the quantity of speech and mimics the reality monitoring prototype of truthfulness. However, this strategy by liars also leaves ambiguity in the quality of their accounts. Therefore, the use of quality of verbal signals rather than the quantity of details provided may be helpful in detecting deception in clinical settings. A recent article by Burgoon^[29] highlighted the various linguistic indicators of deception as follows: quantity and specificity (i.e., deceivers tend toward shorter sentences and are less specific), diversity (i.e., richness in description of symptoms is an index of truthfulness, liars are less likely to broaden their lexicon), ambiguity/hedging/uncertainty (i.e., vagueness, equivocation, and hedging are suggestive of deception), personalism (i.e., ownership of thoughts using personal pronouns may be seen in truth tellers), and immediacy (i.e., responding in the “here and now” is often associated with truthfulness whereas nonimmediacy, may be associated with deceit).

PHYSICAL EXAMINATION

Physical examination findings in most cases should support the historical findings in clinical settings. In other words, deficits in physical examination that do not follow known anatomical distributions may raise suspicions about malingering.^[36]

MENTAL STATUS EXAMINATION

A careful observation of what is said, not said, and how it is said both verbally and nonverbally may raise the clinician’s suspicions about the veracity of patient’s symptoms. Some authors have identified some nonverbal signals that may be indicative of deception. First, the expression of emotions and arousal activation may be the first telltale signs of deception.^[37] Looking for signs of anxiety, fear, shame, and other negative emotions may raise suspicions about deception.^[37] Microexpressions such as leaked feigned sadness and inappropriately expressed happiness should also be looked for.^[38,39] Furthermore, behavioral indicators of hyperarousal such as restive leg movements, postural shifts, vocal tension, more hesitations, and speech errors may be a pointer to deception. However, a major drawback of the above is that real patients may also experience these things, whereas a malingerer may have been coached/or taken time to rehearse as to be judged truthful. The second nonverbal signal is a cognitive difficulty. This is based on the assumption that lying is harder than speaking the truth and may produce outward signs of this difficulty. This may manifest as behavioral indicators such as excessive blinking, gaze avoidance, reduction or cessation of illustrative gestures, etc. In addition, it may also present with some vocal indicators such as hesitancy in answering questions, shorter responses, and more speech errors. Other nonverbal signals include behavioral control and self-presentation. In the latter, the evaluatee presents himself/herself as honest and believable. Furthermore, patients’ attitudes toward the examining physician that is vague and evasive, irritable mood, or even threats of suicide, especially

when symptoms are challenged and preoccupation with the claimed injury or disease, should raise the clinician’s suspicion of deception.

COLLATERAL INFORMATION

There is a need to search for collateral information that supports or refutes the evaluatee’s self-report. Such data may include previous medical or forensic records, interviews of collateral informants familiar with the evaluatee, personal files, insurance agencies records, surveillance tapes, and police reports. The clinician should endeavor to document records reviewed, records requested but not received, as well as records that the evaluatee or other agencies refused to submit for scrutiny.

PSYCHOLOGICAL TESTING

A number of psychological test instruments have been used in collaboration with clinical interviews to detect malingering. Commission of uncommon mistakes, performance across varying levels of difficulty, inconsistency of scores across multiple examinations that measure comparable functions, and comparison of results from the available scores of known malingerers may be helpful in identification of deception in clinical settings. Common instruments used in the assessment of malingering include the Minnesota Multiphasic Personality Inventory-2 Restructured Form, Structured Interview of Reported Symptoms, Portland Digit Recognition Test, arousal-based approaches (e.g., the polygraph), cognitive loading approaches (e.g., asking a surprise question), and cognitive malingering approaches (e.g., tests of memory malingering). A recent review^[3] described these measures in detail. Modern lie detection techniques also use neuroimaging (e.g., functional magnetic resonance imaging) and other neuropsychological processes (e.g., p300 event-related potential).

CONCLUSION

There is a dearth of published data on malingering in Nigeria; however, this phenomenon may be more common than it appears. A high index of suspicion is required on the part of clinicians to avoid giving sick roles to persons who are not actually sick. Careful history, physical and mental status examination, psychometric, and other supporting neuroimaging assessments may be useful in detecting malingering in clinical settings.

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