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Malingering and Associated Syndromes

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Webster's new world dictionary gives a very limited definition of "malinger" as "to pretend to be ill or otherwise incapacitated in order to escape duty or work; shirk." Dejong in *The Neurologic Examination* defines "malingering" as "a willful, deliberate, and fraudulent imitation or exaggeration of illness, usually intended to deceive others, and under most circumstances, conceived for the purpose of gaining a consciously desired end." Present-day historical and psychiatric works tend to neglect the subject. The *Encyclopedia Britannica* contains no article pertaining to it. Garrison's *An Introduction to the History of Medicine* contains no reference to malingering in its index of thirty pages. Nor does the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association list the term, and no standard modern psychiatric textbook includes any comprehensive survey. Yet, almost every physician, almost every psychiatrist, can relate some experience with patients presenting a problem in this area, and personnel in the armed services, the courts, the prisons, and the large hospitals, find it a behavioral manifestation of concern and mystery.

Nevertheless, there are a great many articles in the literature related to malingering and associated syndromes, and numerous authors have devised

complicated classifications of these phenomena based on a variety of dimensions. Such parameters include (1) the kind of organ system supposedly involved, (2) the nature of secondary gain, (3) the degree of suffering involved, (4) whether the symptoms are invented, exaggerated, based on genuine disorder or injury which has ceased but is alleged to continue, or genuine symptoms are attributed to a cause other than the cause in fact, (5) the psychological setting in which the malingering occurs, and (6) basic motives, and whether these motives and the production of symptoms are conscious or unconscious. Such taxonomic systems are theoretically intriguing but seem to have little practical application in clinical psychiatry. The basic common behavioral pattern subsumed under the term "malingering and related syndromes" may be conveniently assigned to not more than five or six categories.

Definitions

A number of terms relating to the concept of malingering are commonly found in the literature. "Imitation" is used in a good or indifferent sense as the general term meaning "copy." "Simulation" is used most often in a pejorative sense as a specific form of imitation in which the person acts or appears to be what he really is not (e.g., the simulation of poverty). Simulation of disease is considered as factitious illness or malingering. "Factitious illness" occurs when the person knows that he is acting out a disability, yet is unable to stop.

Spiro described what he termed “chronic factitious disease,” in which there is simulation of a disorder with the subject allowing painful and dangerous diagnostic procedures to be carried out on himself.

“Malingering” is the simulation of disease or disability, in which a measure of conscious control is exercised, and the subject knows that he is acting and can stop. This is a specific form of simulation. Malingering or factitious illness occurs usually to avoid responsibility, to avoid punishment, to avoid difficult or dangerous duties, or to receive compensation. The term “malingering” appeared first in Grose’s *Classical Dictionary of the Vulgar Tongue* in 1785, originating from the French *malingre* meaning sickly or ailing, and from the Latin *malus aeger,* meaning an evil or base disposition.[1] Szasz holds that malingering does not meet the usual criteria of diagnoses and is considered more as the violation of a set of social rules, akin to cheating, with the term really expressing the physician’s moral condemnation of a patient and his behavior, and therefore without rational meaning as a psychopathological syndrome.

Some special forms of malingering include self-inflicted injury, Munchausen’s Syndrome (which involves the usually elaborate simulation of disease by persons who tend to wander from hospital to hospital), and the Ganser Syndrome of absurd or approximate answers.

Use of the Term "Malingering"

According to Schroeder, many doctors refuse to use the term "malingering" because it tends to alienate the patient, since its use does not convey a proper diagnostic impression; (2) physicians seem to be naturally cautious insofar as there is only one thing more painful than failing to discover apparent deceit, and that is to deny the existence of disease in a patient in whom a better informed physician would have diagnosed it; and (3) the fear that the patient may bring a defamation suit. Physicians who have used the term may have done so consciously to punish the patient for a perceived antisocial act, under the guise of establishing a "diagnosis" or in attempting to demonstrate lack of ill health. The same malingering behaviors, however, at one instance may be regarded with condemnation, and at another with praise (for example, in the feigning of illness to escape from a prisoner of war camp). The term "malingering" has tended to involve an emotionally loaded connotation implying that the doctor is being duped by the patient, his time being wasted, and his diagnostic and therapeutic skills being ridiculed. Many articles on the subject in the medical literature have included such pejorative words as liar, scoundrel, wretch, knave, rascal, unscrupulous, and cowardly. This probably represents a general social attitude, at least in part, since Weiss and Perry found that lying and deception are regarded as fairly serious crimes in a variety of cultural loci.

Historical Aspects

The idea that people would feign or produce illness or disability to avoid duty, or for gain, has been noted since antiquity. The Greeks ranked malingering in military service with forgery, a crime punishable by death. (The punishment was later mitigated to exposure to the public gaze in female attire for three days.)

Galen, in the second century, wrote a treatise entitled "On Feigned Diseases and the Detection of Them," describing Roman conscripts who cut off thumbs or fingers to render themselves unfit for military service, and a servant who inflamed his knee by application of juice of thapsia. Galen coined the term "pathomimes" for such people.

Montaigne gave an account of the avoidance of military service by the Romans in an essay entitled "Of Thumbs," and in "How A Man Should Not Counterfeit To Be Sick" discussed the possible consequences of malingering. Temkin described the imitation of epileptic attacks as originally detailed by Ambroise Pare in which beggars would put soap into their mouths in order to produce foam, and Mayhew described in detail methods used to simulate illness for the purpose of begging in nineteenth-century London.

However, in general there has been a relative paucity of historical information concerning malingering. Murphy pointed out that up until one

hundred fifty years ago there was a lack of medical journals (initial description of diseases was usually published in book form), that in England there were no physicians of commissioned rank in the Royal Navy until well into the nineteenth century, and that at that time there seemed to be a fear of publishing works on malingering since it was associated with the shirking of military service and thus might have an adverse effect on morale. He noticed the tendency to ascribe socially undesirable conditions to other than one's own national source; syphilis was known in Italy as "the French evil," while in France, the sufferers were assumed to be afflicted with the "Italian pox." In the case of malingering, Jones and Llewellyn wrote in 1917 that the German literature stressed that Poles, Alsatians, and Lorrainers were addicted to simulation more than Germans proper, and Austrian military surgeons found that most of their malingerers hailed from Bohemia. Gavin in 1845 " marked that the Irish seemed to be most numerous and expert in counterfeiting disease, with lowland Scotchmen being next.

Interest in malingering has usually been kindled by wars, the introduction of social reforms (e.g., the medieval religious interest in the sick), and by the introduction of medical and social insurance, as in France, Germany, and Great Britain in the latter half of the nineteenth and the earlier part of the twentieth centuries.

Hutchison, who was surgeon to the Royal Naval Hospital in England,

wrote “Some Observations on Simulated or Feigned Diseases” in 1824 and 1825, stimulated by the Revolutionary War of 1793-1815 which involved long, dreary naval voyages resulting in extremely poor morale. Cheyne, a military physician, in 1827 wrote his “Medical Report on the Feigned Diseases of Soldiers” (which he called “The English Malady”), published in the *Dublin Hospital Reports.*

Later French and German works around the turn of the century, as well as those of Collie in 1913 and Jones and Llewellyn in 1917, were stimulated by Employer’s Liability, Workmen’s Compensation, and National Insurance Acts in their respective countries. In 1894, for example, studies on malingering formed the major content of the *Monatschrift für Unfallheilkunde,* and about this time the journal *La Medicine des Accidents du Travail* began publication.

Punton provided an interesting example of deception of insurance and railroad companies. A man named Moffett described his “cane and screw” racket, in which he used a specially prepared cane to loosen the floor screws on streetcars and railroad cars, over which he would then pretend to stumble and then institute a claim for injuries sustained. He stated that he made it a universal rule to employ the very best doctors, as he found, by experience, that they were the most easily fooled, while the companies he fleeced were better satisfied with their opinions. In this connection, he noted that he paid

the doctors' bills promptly and willingly, even though at times he thought they were exorbitant, but this was done, he said, in order to impress them with the honesty of his actions.

Normal Occurrences

Complaints of illness without a physical basis are not uncommon in some children as an attempt to avoid a potentially unpleasant situation, such as school. These are more in the nature of hypochondriacal desires, which are usually easily dispelled by firm action on the part of the parent.

Simulation can be seen as a means of self-preservation in animals that may feign death, for example, and Shapiro has pointed out that people may malinger as a "protective reflex" as a result of anxiety. Malingering may also occur in a normal situation in the prison camp, where one may feign illness or injury as a means to effect escape. Flicker has estimated that about one-tenth of the malingering he has seen in the military has been in men without any other display of psychopathology.

Prevalence and Epidemiology

Sund in a study of prognoses of psychiatric disorders in Norwegian men who had been in compulsory military service between 1949-1959 found an incidence of malingering of 3 percent. During World War II, the incidence

among American soldiers was variously estimated at between 2 and 7 percent. Flicker, for example, estimated that about 5 percent of all inductees malingered. He stated, however, that in apparent refutation of this concept, in one station hospital, at a time when sixty thousand patients were listed in the registrar's office, there were but seventeen who were diagnosed as malingerers, which is 0.028 percent. On intensive questioning of the medical officers it was revealed that they believed there were more cases than were diagnosed, but they were deterred from making such a diagnosis because of the administrative difficulties of proving it at a court martial.

Brussell and Hitch reported that 2 to 7 percent of the cases referred for military neuropsychiatric consultation were diagnosed as malingering. It has been noticed that the less psychiatric knowledge the doctor has, the greater the proclivity for making the diagnosis of malingering, and the greater the doctor's psychiatric experience, the less he is ready to use the diagnosis.

Jung, for example, reported that malingering was diagnosed in only 0.13 percent of 8,430 admissions to the Swiss Mental Hospital of Burgholzli. In general, estimates of prevalence or epidemiology of malingering are extremely difficult to achieve because the diagnosis of the condition depends on the knowledge and experience of the physician, his attitude towards the person he is examining, and whether he accepts the use of the term as a diagnostic entity. Apparently, however, malingering is not concentrated in

any particular age group and may occur equally among males and females.

Etiology and Psychodynamics

It is clear from the literature that malingering is not a single entity and is not independent of the underlying personality. Indeed, Flicker noted that most instances of feigned psychosis occur in persons who are already of unsound mind and that it is most frequently the oligophrenic who feigns feeblemindedness. It is presumed to occur where there is danger of an examination, criminal charges, or imprisonment, or associated with military conscription, especially when morale is low or during an unpopular war, and particularly with the danger of becoming a front-line soldier. Other reasons postulated include monetary gain in association with insurance and compensation, the need to be the center of interest and attention, a grudge against doctors and hospitals related to revenge, the desire for free board and lodging in hospital, the need for a haven from the police, as a method of obtaining drugs, and as a result of prolonged idleness leading to introspection.

Taylor described what he calls “disease-rewarding situations,” which are situations that are unpleasant, threatening, or stressful, and which may be avoided, terminated, or mitigated by falling ill. This allows a member in a family to avoid responsibilities, escape disliked duties, claim the special

privileges accorded to invalids, and perhaps achieve the emotional subjugation of relatives. These also occur outside the family as in insurance claims, the military, and in prison. Taylor points out that "hypochondriacal desires," that is, the desires to be ill, are distinguished by the common characteristic of being disease-rewarding. The hypochondriacal desire may lead at most to a malingered disease or to the particular form known as Munchausen's Syndrome. If, however, there is an auto-suggestive capacity of sufficient strength, then the hypochondriacal desire may be converted into a "hypochondriacal conviction" of being ill, which may lead to classical hypochondriasis. Hypochondriacal patients are so convinced auto-suggestively that they are ill, that they succeed in repressing all knowledge of their hypochondriacal desires. Their illness is a reality for which they feel in no sense responsible, and yet the subjective suffering of the typical hypochondriac is not confirmed by evidence of objective symptoms. In this way, they differ from malingerers who often go to great lengths to simulate objective symptoms.

Taylor further goes on to state that people who are not only strongly autosuggestible but also have a strong dissociative capacity may succeed in transforming the hypochondriacal desires into hypochondriacal convictions which are self-verifying, both subjectively and objectively. They then suffer from a "hysterical illness." They are like malingerers, because they exhibit both subjective and objective symptoms, and are like hypochondriacs,

because they have no memory of their hypochondriacal desires. In such cases, however, the auto-suggestive and dissociative capacities of most people are insufficient to maintain a hysterical illness for a long time. As a result, the patient may become conscious of his hypochondriacal desires and may then deliberately aggravate whatever hysterical symptoms he still has, and thus may resort to the tricks of the malingerer. The whole malingered-hysterical mixture is then exhibited with histrionic ostentation, so that it becomes difficult if not impossible for the psychiatrist to decide where hysteria ends and where malingering begins (see Figure 13-1). Hawkings et al. have interestingly drawn attention to the similarity between some cases of anorexia nervosa and malingering.

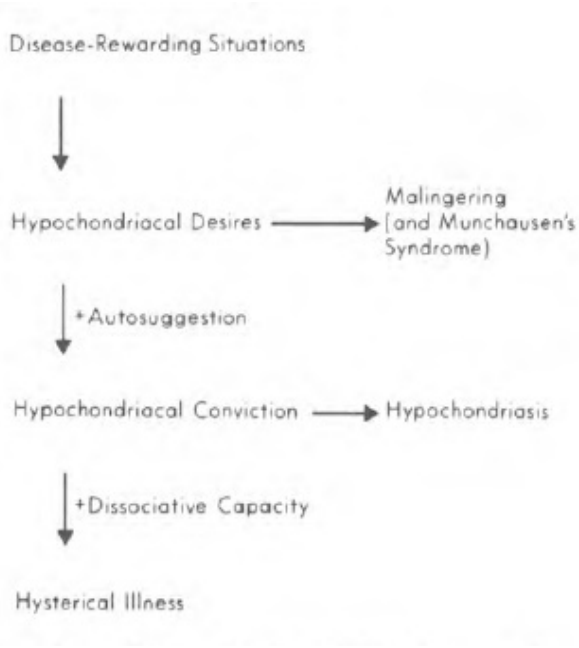

Figure 13-1.
Psychosocial development of "malingering" and related behavior (after F. KraüpI Taylor).

Rome took the point of view that like suicide and imposture, malingering is an attempt to cancel out the self, specifically through loss of ability or responsibility. In the extended sense of the term, all instances of malingering are also instances of crypto-suicide, that is, of hidden self-destructive action. Rome pointed to the malingerer's remarkable tolerance for pain, the singular absence of such affects as guilt and depression, and suggested that an undifferentiated ego lying at the base of repeated self-injury, with the plea for help based on a symbolic confusion that is the result

of a failure in communication, is an essential part of the condition. He further noted the necessity of the reaction of the examiner, one usually constituted of both revulsion and compassion, and described as the primary site of psychopathology the area of interpersonal relationships between the patient and the parent with whom his identification had been hostile. Rome's data demonstrated that such patients often have experienced repeated brutality which resulted in actual physical injury. Weiss has also described cases of suicidal attempts that indicate that an element of malingering may be involved.

Grinker described imposture as a form of mastery over early traumata. There is usually a history of early deprivation and a discrepancy between the ego ideal and the self-image. He suggested that by imposturing, the impostor seeks love and approval from new objects, and in addition seeks revenge for past disappointments through the superiority and hostility expressed in his own secret knowledge of his deceit, thus avoiding conscious shame and the feeling of ego incompleteness.

Spiro found that impostors, functional pain patients, wanderers, and masochists show phenomenologic and psychodynamic similarities to patients with chronic factitious symptoms. Early childhood deprivation and difficult relationships with aloof, absent, or sadistic parents may have sensitized the latter patients to distorted learning stemming from traumatic early illness or

hospitalization. Spiro emphasized that the concept of mastery as applied by Grinker to impostors offers the most useful explanation for the subject's subsequent behavior.

Role-Playing and Szasz's Point of View

Szasz in a thoughtful and provocative paper discussed the relationship of the term "malingering" to diagnosis and its social connotation. He pointed out the communicative aspect of diagnosis between the physician and other physicians, and in military life between the physician and his military superiors, and suggested that the diagnosis of malingering implies the covert command from the physician to the military judicial authorities to punish the patient.

Szasz viewed malingering as part of life as a game, implying to the observer that the malingerer is getting away with something and, therefore, malingering is the same as cheating. The term "malingering" is reserved for those actions that result in the avoidance of an unpleasant duty by some motor behavior expressly disallowed by society, and the physician acts as an expert arbiter who must decide whether a person is ill within the rules that society sets for illness.

Szasz added that psychiatrists have accepted "malingering" as an entity and therefore have proceeded to describe its characteristic

psychopathological features, but by so doing have substituted the concept of mental illness for other problems, and thus as a self-fulfilling prophecy find that which they are most interested in finding. He drew attention to the social context in which malingering may occur and wrote that the notion of malingering does not and cannot serve as a description of either a psychopathological syndrome or a particular psychological mechanism, in view of the fact that the term is used only in connection with a person's intention of getting out of the service or some similar aim, whereas there are many persons, for example, who enlist in the armed forces in order to get away from painful situations in their civilian and home life. This latter form of malingering called "fraudulent enlistment" is not known or regarded as true malingering, and the feigning of health by applicants for life insurance or victims of Nazi concentration camps, although termed dissimulation, may still be considered healthy, if the psychiatrist happens to side with the patient's value judgment. From the point of view of the Nazis, however, it would be considered malingering and, therefore, "the notion of malingering tells more about the observer's agreement or disagreement with the value of the social structure in which he and the patient live than it does about the latter's behavior." Thus, wrote Szasz, one can distinguish malingering as (1) a diagnosis, (2) a violation of a set of social rules, and (3) a psychopathological syndrome characterized by special psychological features. To Szasz, malingering is not a diagnosis in the usual sense of the word, but rather it

expresses the physician's condemnation of behavior, and no rational meaning can be given to malingering as an alleged psychopathological syndrome; the phenomenon is best viewed in the framework of the sociopsychology of games.

Symptomatology

The signs and symptoms of malingering obviously depend on the clinical picture chosen by the patient, and such clinical pictures can involve almost any system in the body. When Asher originally classified Munchausen's Syndrome, he described the acute abdominal form, the hemorrhagic form with self-inflicted wounds, cranial trauma, hematuria, hematemesis, and hemoptysis, and a neurological form with headaches, syncope, meningitis, or seizures. Chapman added a dermatological form involving contact dermatitis, and Cookson subsequently added pulmonary edema, produced by aspirating water. More commonly, one encounters those who have ingested oral anticoagulants (known as the dicourmarol eaters), those producing anemia due to voluntarily induced hemorrhage, those with orthopedic problems involving low back pain,'' those with ophthalmological conditions seen sufficiently frequently for the term "Oedipism" to be coined for self-inflicted injury to the eye, those with metabolic conditions produced by the use of insulin or thyroid extract, and those with complaints of hearing difficulties.

In a short article entitled “Artifices of War,” Liddle described the various methods used to simulate illness, including castor oil dysentery and the use of digitalis to produce cardiac arrhythmias. He quoted three general principles which were offered by the Germans who during World War II dropped leaflets containing advice on how to feign illness on the United States soldiers in Italy. It was suggested that the subject give the impression the feigned illness was hated, that the subject should stick to one kind of disease, and that the doctor should not be told too much. Blinder has described characteristics that he considers typical of the malingerer, such as an overriding preoccupation with “cash rather than cure” and ability to “know the law and the precedents pertinent to the patient’s claim”; constant complaints about feeling miserable, with no accompanying signs or symptoms of depressive illness; symptoms that come and go; a long history of drifting about with spotty employment, as well as a history of alcoholism, drug abuse, desertion, or a criminal record. As there are many symptoms that can be produced using a variety of noxious agents, so there are methods for detecting the malingered act. These have varied from Wagner’s use of ether to detect feigned insanity, to the testing of urine temperature as an indication of factitial fever (as described occurring in the military forces in Vietnam by Ellenbogen and Nord). In regard to using medication to verify malingering, President John Quincy Adams commented, “A medicine of violent operation, administered by a physician to a man whom he believes to be in full health but who is taking

his professional advice, is a very improper test of the sincerity of the patient's complaints, and the avowal of it as a transaction justifiable in itself discloses a mind warped by ill-will."

Thus, the symptomatology varies with the method employed and the literature is replete with methods for detection. One should be aware of the dictum of Charcot who said, "I am forced to say and repeat that in my opinion the idea of malingering is only too often based upon the ignorance of the doctor." At an earlier time, Marines who complained of dull pains in the chest on exercise were dubbed malingerers if no signs were found by stethoscope, at another time, night blindness was regarded as a cause for dishonorable discharge, and at yet another time, it was thought that if stammerers could sing easily they must be malingering. As conditions have improved and more diagnostic tools have become available, the diagnosis of malingering has tended to decrease. "Goldbricking," a U.S. Army slang term which originally referred to simulation of minor disability or illness with the purpose of obtaining relief from arduous or unpleasant duties for a short period, is found in almost every variety of military service (and where there is gross exaggeration of genuine minor symptoms, British soldiers call it "scrimshanking"). The American term has now come to be in common usage for any shirking of responsibility.

The differential diagnosis of malingering must include such conditions

as hypochondriasis, hysteria, sociopathy, compensation neurosis, and true psychosis, as well as the self-mutilator and the polysurgical patient. In terms of differentiation from hysteria, Layden has stated that the hysterical person's unconscious goal is to salvage his self-esteem. The malingerer's self-esteem is of sufficient proportion that he can tolerate a reduction consequent to the act of malingering. The hysteric is seen to be not consciously simulating illness, is usually honest about his symptoms, and has a marked degree of inferiority. He deceives himself and makes no conscious efforts to produce the symptoms. However, differences between malingerers and hysterics are not absolute, and one often finds many hysterical traits in malingerers, and some near-conscious dramatic play-acting in the hysterical patient.

Bachelor wrote that the differentiation of hysteria and simulation is in fact arbitrary. Simulation is a voluntary production of symptoms by an individual who has full knowledge of their voluntary origin; in hysteria there is typically no such knowledge and the production of symptoms is the result of processes that are not fully conscious. He said that Kretschmer rightly pointed out, however, that the criterion of conscious or unconscious will not serve to distinguish simulation from hysteria, for not all motives of the healthy mind are conscious and not all hysterical ones are unconscious, and there appear to be gradations between hysteria and simulation. Schroeder stated that the basic difference between neurosis and malingering is the degree to which the mental mechanisms of the deception are unconscious and

not within the patient's awareness. The malingerer may be unaware of his motives but conscious of his deception and his pretense of symptoms. The neurotic, on the other hand, consciously believes the existence of what he feels to be his afflictions. Spaeth described a variety of difficulties of differential diagnosis between neurosis and malingering and pointed out that in many cases only by confession can the differential diagnosis finally be made.

The Malingering of Mental Illness

The kinds of psychiatric disorders that are likely to be malingered are amnesias, psychotic-like symptoms or behavior, neurotic-like symptoms or behavior, and mental defect. There are certain general principles to be followed in considering malingered psychiatric illness. The first step should be to consider the possibility of its existence. The second should be to pay attention to the setting and life history of the patient. Finally, one must determine the clinical diagnosis and the positive aspects thereof.

Jones and Llewellyn pointed out that the malingerer tends to overact his part and is likely to believe that the more bizarre his behavior, the more psychotic he will be considered. It is apparently difficult for a subject to maintain a pretended symptom or behavior for a long period of time, so that hospital observation for a month or so may aid in establishing the diagnosis.

In the case of amnesia, Davidson considered the following as explanations to be taken into account in the differential diagnosis: hysteria, psychosis, alcoholism, head injury, epilepsy, and malingering. Amnesia is thought to be the most common malingered psychiatric symptom, but the cause cannot be determined until all possibilities have been seriously considered and appropriate investigations performed. As good a history as possible is essential. A malingered amnesia tends to be somewhat patchy and self-selective. According to Davidson, a defendant who is pretending amnesia rarely alleges loss of his own identity. There are often inconsistencies in the memories which are claimed but, as McDonald has pointed out, clear-cut amnesia which does not expand or contract from day to day may also be seen in malingering. However, in genuine amnesia, the beginning and the end of the amnesia are usually found to be somewhat blurred. The differentiation between hysterical and malingered amnesia is still a difficult one to make.

McDonald also noted that although narcoanalysis is frequently successful in resolving hysterical amnesia, it is less likely to be of value and should not be employed in suspected malingered amnesia. A simulated restoration of memory under narcoanalysis may later form a basis, however unjustified, for an insanity plea, and introduce difficult medical-legal complications at a subsequent court trial. Davidson, on the other hand, did point out that because it tends to have little effect on the defendant's responsibility, the appraisal of genuineness of an amnesia is forensically less

important than it might seem, and even though the emotional trauma of committing a crime might induce a hysterical amnesia, it does not necessarily absolve the defendant. This probably would be true also of the amnesia of pathologic intoxication.

With malingered psychosis, one certainly must consider the clinical picture and correlation between that and known clinical pictures and natural history of the illness. In both malingerers and genuine psychotics, the reasons given for delusions of persecution seem to be common. However, the malingerer does often find it necessary to remind the examiner that he does have delusions. Usually, well-organized delusional systems develop over a period of time, and if the malingerer has committed a crime and had no delusions prior to that crime, he may need to develop them rapidly. As Davidson wrote, a malingered persecutory delusion has no historical roots. He also pointed out that delusions of unworthiness are seldom malingered, and that since genuine delusions of unworthiness are found chiefly in depression, the accompanying signs and symptoms should establish the diagnosis. Delusions as an isolated symptom without consistent behavioral and affective changes are rare in genuine psychosis.

Ossipov, in discussing the malingering of psychosis in the military, pointed out that a good objective history is basic. Also, the behavior of the malingerer after the case is settled is of significance. It is important as well to

know the setting in which the malingering begins and the time of onset. Malingerers, he wrote, tend to portray a "state" or an episode but not a disease, and so one has to evaluate the whole clinical picture.

The malingered grandiose delusion seems to be either an isolated symptom or part of a bizarre overdramatized constellation of behavior that does not fit any psychosis. When excitement occurs, it is rather difficult for a sane person to keep up the hyperactivity which, therefore, usually occurs only when the subject believes that he is being observed. It is unlikely to be accompanied by elated mood and flight of ideas. Repeating the same phrase or gesture over and over is not likely to occur as an isolated symptom; when it does, one should be suspicious of malingering. Usually, very bizarre behavior in general tends to reflect a certain amount of malingering, as do ideas or behavior which conform to the subject's idea of psychosis but do not conform to the usual picture that one sees in psychiatric illness. However, Eissler pointed out that malingering may be a defense against the onset of loss of ego control and that where there is such a threat of personality disintegration, the patient may feel, "I am not submitting to it but performing it." Where hallucinations and delusions are put forward, the malingerer often becomes very evasive, as he thinks that the examination is for the purpose of testing the genuineness of the symptoms.

Psychotic depression is perhaps more difficult to simulate insofar as the

self-reproachful ideas are not often exhibited and the signs of insomnia and constipation may also be very difficult to simulate. Signs of lowered metabolism, subnormal temperature, lowered red blood count, and the general attitude of the depressed patient, are also rather difficult for the malingerer to keep up consistently. In the case of mutism, one has to consider the other possible causes, such as depression, mania, catatonia, epilepsy, and delirium, and again to review the history obtained from others that may suggest an alternate diagnosis. It may be difficult for the subject to maintain consistent mutism and he may slip up if awakened out of a sound sleep, or during narcoanalysis.

Davidson has noted that psychosis malingered in personal injury claims differs from that feigned in criminal actions in two ways, namely, motivation and opportunities for observation. Motivation tends to be weaker in injury claimants, so they generally confine their psychotic symptoms to the kinds of feigned dementia, "harmless" delusions, and depression that would not result in their being committed to a mental hospital. A Ganser type of reaction is not uncommon in this kind of malingering. The fraudulent injury claimant is seldom under twenty-four-hour observation, so that the malingering of psychosis in this instance tends to be relatively rare with more frequency of feigning neurosis or some kind of "organic" symptom.

Since neurosis does not impair responsibility, it is not often malingered

in criminal cases. Baro suggested that malingering is the most common picture seen after industrial injuries. Davidson listed ten criteria by which one may be able to differentiate a true psychoneurosis from a malingered one:

1. Inability to work combined with retention of the capacity for play suggests the possibility of malingering.

2. Faithfulness in swallowing medicines, submitting to prescribed injections and other treatments, and attending clinics is common in neurotics but rare in malingerers.

3. If the patient fits into the responsible-honest-adequate class he is probably not a malingerer.

4. If the content of the patient's thinking, dreaming, and talking involves details of the (frightening) accident, he is probably neurotic.

5. Evidence that the patient carries on allegedly lost functions when he thinks he is not being observed may point to malingering; neurotics frequently are unable to carry out certain functions under emotional stress.

6. Malingerers, in contrast to neurotics, are not likely to copy symptoms they have seen in others during hospitalization.

7. Psychological testing may help discriminate.

8. Willingness to submit to surgical operation or to mental hospitalization may indicate that the patient is not

malingering.

9. If the patient refuses an offer of employment in which he would have to use abilities or skills associated with unimpaired areas, he probably is malingering.

10. Obvious satisfaction with and eagerness for re-examination particularly by groups of doctors is more consistent with neurosis.

The Ganser Syndrome

In 1898, Ganser described a condition, the chief characteristic of which he called *"vorbeigehen,"* meaning to pass by. The essence of this was to reply to a question with an answer that would be absurd in content (or *"vorbeireden,"* meaning talking past or beside the point at which an approximately correct answer might be given). The symptom of *"vorbeireden"* was first described by Moeli in 1888. Because of this characteristic, the condition has also been referred to as "the syndrome of approximate answers." The original description included not only such peculiar verbal responses but also visual and auditory hallucinations, clouding of consciousness, disturbed sensory perception, and occasional confused-anxious-perplexed state, changing from day to day and with total disappearance in a few days, leaving the patient with amnesia for the episode. Since the original observations were made in four criminals awaiting trial, the

Ganser Syndrome has often been associated with such circumstances, although the condition has also been shown to occur in a civilian population under conditions of anxiety or stress. There is no real agreement as to whether the syndrome is in fact a neurosis or a psychosis or a manifestation of malingering. Wertham considers it to be hysterical pseudo-stupidity occurring almost exclusively in jails and old-fashioned German textbooks. Other authors have suggested that there is a resemblance between *vorbeireden* and schizophrenic thought disorder, and have noted that some cases of Ganser Syndrome later are diagnosed as chronic schizophrenia.

A useful summary of *vorbeireden* is to be found in the papers by Anderson, Trethowan, and Kenna. The main feature of the Ganser Syndrome is inconsistency, the subject failing to answer simple questions, and yet answering difficult questions with ease. Sometimes random answers are given rather than approximate or absurd replies. Tasks may be handled in the same way. Another feature is that no matter how idiotic the question asked, the subject most often seems to struggle to arrive at a correct answer, only to give an absurd kind of reply. Physical or conversion-like symptoms, such as headache, paralysis, disturbances in gait, rigidity, anesthesia, tremor, and convulsions, may also be present.

Davidson suggested that it is unwise and unnecessary for the examiner of a prisoner to cite a Ganser reaction as evidence of malingering, since it is

considered by some to be a genuine psychosis and since it may well be the result of the defendant's confinement. In any case, the distinction between simulation and the Ganser Syndrome may be difficult to make, but it is seldom important with regard to the question of criminal responsibility at the time of a crime.

Munchausen's Syndrome

This is the name generally applied to the disorder manifested by the person who in the absence of appropriate medical or surgical need tends to wander from hospital to hospital, to which he is admitted putatively with what appears to be an acute illness supported by a plausible, dramatic, and often elaborate history which turns out to be untrue, after which he discharges himself against advice (usually after quarreling with the doctors and nurses). Such patients were perhaps first described by Menninger' who drew attention to their masochism, but it was Asher who coined the term "Munchausen's Syndrome" to describe the characteristic behavior of such wanderers and often polysurgical addicts. The name of the syndrome is derived from the book of fanciful and absurd adventures and travels attributed to Baron Hieronymous Karl Friedrich Munchausen. The real Baron Munchausen (1720-1791) of Hanover, Germany, enjoyed an established reputation as a teller of exaggerated tales related to his experiences as a cavalry officer in the German-Turkish campaigns of 1737 to 1739. In 1785,

Rudolph Eric Raspe published a book in London entitled *Singular Travels, Campaigns, and Adventures of Baron Munchausen.* The book, however, was a hoax derived from Raspe's imagination. He had met the Baron only briefly and did considerable elaboration upon his stories which rapidly established the Baron as a preposterous liar. It was because of the fanciful stories, which were both dramatic and untrue, that Asher decided to choose the name "Munchausen" for the patients who traveled from hospital to hospital as described, although the original character never submitted to any surgical operation. Other names given to this syndrome include *Maladie de Lucy* (after a poem by Wordsworth) and *Pathomimie de Dieulafoy.*

The characteristic features of the syndrome originally described by Asher included (1) feigned severe illness of a dramatic and emergency nature, the symptoms of which may or may not be corroborated by signs on physical examination; (2) evidence of many previous hospital procedures, particularly laparotomy scars and cranial burr holes; (3) aggressive, unruly behavior and a mixture of truculence and evasiveness in manner; and (4) a background of multiple hospitalizations and extensive travel, evidenced by "a wallet or handbag stuffed with hospital attendance cards, insurance claim forms and litigious correspondence."

Ireland et al., after an extensive review of the literature, added the following four characteristics: (1) factitious evidence of disease

surreptitiously produced by interference with diagnostic procedures or by self-mutilation; (2) departure from the hospital against medical advice; (3) pathological lying; and (4) the absence of any readily discernible ulterior motive.

Barker, Chapman, and Ireland et al. further described such patients as follows: They tend to be aggressive in their relationships, indulging in frequent arguments with hospital staff and other patients; they are flamboyant and elaborate falsely on their past (pseudologia); they often seem to have considerable medical knowledge, are egocentric, and attempt to gain sympathy for their condition.

Barker also observed wide fluctuations of mood in these patients and pointed out that they often show considerable confidence towards physicians, although they tend to be wary with psychiatrists, and if admitted to psychiatric wards tend to leave against advice or to escape if committed. If confronted with knowledge of their past or if the validity of their condition is at all questioned, they will attempt to leave the hospital. Barker has found, however, that such confrontation tends to result in a depressive reaction and that such patients are prone to suicidal attempts. They usually tend to be socially isolated, and may have a history of petty theft or disorderly conduct. Considerable travel is a characteristic feature and they have the ability to withstand great amounts of discomfort associated with diagnostic procedures

that may be initiated.

Impostorship is not uncommon among such patients, with claims of being a war hero or a member of a profession. In some instances, they may have a medically related background with a sibling or parent who was a physician or nurse. They may have a conspicuous physical appearance, such as being obese or tattooed. They also tend to be young and to appear more frequently in countries where hospitalization is free. There are many reviews of the syndrome in the literature, with those by Ireland et al., Spiro, and Barker being of special interest.

Psychological Tests

A useful review of psychological tests in relation to malingering is included in McDonald's book, *Psychiatry and the Criminal.* Some work has been done in an attempt to distinguish the person who appears to be less intelligent on his test scores than he may in fact be. Hunt described a predictable test pattern for the mental defective, which is different from that of the malingerer. An example was found in responses to the question, "If eight boys clubbed together and paid two dollars for the use of a room, how much should each boy pay?" Apparently, the two most common answers given by retarded persons are four dollars and sixteen dollars. This seemingly occurs because the defective is unable to manipulate the numbers

appropriately and might either divide or multiply eight by two. The malingerer, however, works the problem correctly, but then deliberately distorts the results by a small amount, to produce an answer such as twenty-three or twenty-six cents.

Davidson pointed out that malingering should be suspected when the subject can do all the nine-year-old tests, but consistently fails at the six-year level, or where a wild and wide scatter of passed and failed tests occurs without the pattern of normal age-grade development. Crowley, using the Kent EGY, attempted to distinguish differences between the test performance of truly feebleminded women and women who were asked to feign mental deficiency. The mean scores of the malingering groups were significantly lower than those of the truly feebleminded group, although it was impossible to identify individual malingerers from the total scores unless they were extremely low.

Pollaczek studied the possibility of detecting malingering on the CVS abbreviated intelligence scale, consisting of the comprehension and similarities subtests of the WAIS, together with a vocabulary test selected from items of the Stanford-Binet, in which experimental groups were requested to simulate mental deficiency on the test, while genuine mental defectives were given the test in the usual manner. Although it was again not possible to detect malingering using the total test scores, there were enough

significant differences between the experimental and control groups on individual items to make a key for malingering. Using this key, it was possible to distinguish about 90 percent of the malingerers, with only 10 percent of the mental defectives being falsely identified as malingerers.

Goldstein also developed a key for the detection of malingering of mental deficiency. On the basis of experiments involving the use of a good group who passed the examination, a failure group who failed the examination, and a simulated malingerer group, he developed an instrument specifically adapted to the Army's Visual Classification Test. The key which he evolved was successful in identifying 97 percent of simulated malingerers and 85 percent of presumed genuine failures. He suggested that for optimum results such a test should probably have the following characteristics: (1) a liberal sprinkling of easy items, (2) items of varying difficulty, and (3) a scrambled sequence.

Davidson noted the importance of the life history in relating the genuineness of alleged mental defect. If the subject is a high school graduate, genuine defect is unlikely. He suggested adding five to the last successfully completed school grade to obtain a quick approximation of true mental age (i.e., if the subject successfully completed the ninth grade and dropped out of school in the tenth, one would expect to find a mental age of about fourteen). Davidson stated that this formula is seldom more than two or three years out

of line.

Rosenberg and Feldman used the Rorschach to study 93 malingering soldiers, and described eleven Rorschach signs and four behavioral signs produced as a result of evasion due to the subjects' conscious fear that the test might be too revealing. The Rorschach signs included (1) few responses, less than five or six, mostly of the nature of "I don't know" or "It's an inkblot"; (2) mostly popular responses; (3) other responses of vague indefinite form, such as maps or clouds; (4) inconsistencies of response with recognition of difficult forms and rejection of easy forms, and refusal to see new responses on testing limits; (5) perseveration with the same response being given on ten different cards; (6) description and color-naming which is usually an explanation of how the inkblots are formed; (7) delayed responses and excessive turnings of the cards; (8) partial rejection of responses, usually asked as a question or qualified by "It might be," etc.; (9) rejections in inquiry; (xo) marked lack of additional responses; and (11) often one response per card. The behavioral patterns involved misunderstanding of directions, attempts to impress the examiner with exaggerated furrowing of the brow and overconcentration on the cards, frequent questions, such as "What's all this for?" and increased complaints such as pains, headaches, and dizziness during testing (as compared to neurotics who usually do not complain during the test). They also observed that malingering subjects were more likely to describe animals as dead than alive when the subject was pushed. In general,

the unstructured nature of the Rorschach Test appeared to be helpful in differentiating malingerers from non-malingerers. The Thematic Apperception Test has also been used in an effort to detect malingering, but it appears that because of the more obvious nature of the stimuli, deception is more easily possible.

The Minnesota Multiphasic Personality Inventory has been studied extensively in this regard. An excellent review of the relevant MMPI literature appears in a paper by Exner et al., in which they discuss the value of four validity scales on the MMPI. Cofer et al. found that college students attempting to fake "normal" performance could be detected by an additive combination of the L and K scores. Calvin and McDonnell noted eight studies in which faking on the MMPI could be detected at a statistically significant level, again using the validity scales. Recently, however, other studies have suggested that a high score on a single validity scale does not necessarily invalidate the diagnostic patterning.

Gough also found that there are 74 items in the MMPI to which persons attempting to malinger respond significantly differently than do diagnosed psychoneurotics. Gough termed this group of items a "Dissimulation Scale" (DS). Exner et al. pointed to the usefulness of Gough's DS and the F-K dissimulation index as valid methods for detecting malingering. He also supported Cofer's original findings that the F scale taken alone can be useful

for the detection of malingered records.

Management of Malingering

The physician is likely to come into contact with the malingerer either in the military, in prison, in the general or mental hospital, or in connection with compensation. It is not unusual for the response of the physician to the malingerer to be a hostile one. The physician usually sees the role of the patient carrying with it certain built-in expectations, including the motivation to accept therapeutic help. When he suspects that a patient may not fit the traditional mold, he attempts to resolve his shaken professional role by controlling the situation in which he feels he has been controlled or duped, by attempting to expose the individual. The diagnostic procedure in such instances becomes confused with the management of the case, and may become more of a punishment than actual diagnostic aide. In this connection, Layden has described the necessity for the physician to understand the dynamics of how he and the patient may become hostile in order to avoid the tendency to blame. He suggested that the malingerer may reduce his deception as an unconscious means of insuring the continuance of the physician's esteem, and that attempts through therapy to reduce the malingerer's hostility to significant persons in his environment may induce him to give up his symptoms.

Hollender and Hersh described a situation where the psychiatrist as consultant is asked to see a patient suspected of or known to be inducing a medical illness by ingesting pills or injecting pathogens. They noted the paradox of the psychiatrist behaving first as detective or prosecutor to determine whether the patient is in fact malingering, and then expecting to be accepted as ally or helper by the patient to resolve the dilemma. They suggested that the psychiatrist meet first with the referring physician and persuade him to confront the patient with the facts. Once this has been done, then psychiatric help can be offered, and when the patient can acknowledge that he is not medically ill and will redefine himself as being psychiatrically ill, it may be possible to institute psychiatric treatment. In this way, the psychiatrist is seen as a helper rather than as an adversary. The variables involved in the management obviously are dependent on the examiner's skill and knowledge and time available, the type of malingerer and his skill and knowledge, and the injury or illness feigned. Where compensation is involved, it is probably wiser to settle all compensation claims either by their outright rejection or by a lump sum payment.

Earlier, Shaw also found that confrontation by the physician was not effective because of the threat of disgrace for the patient. He, therefore, allowed the malingerer to save face by employing an intensive therapeutic regimen that would have been used if the patient's pain, for example, had been real. Group therapy was used with some success by Brody, mainly for

the treatment of so-called polysurgery addicts, and Ireland et al. suggested that some patients with Munchausen's Syndrome might be committed to a mental hospital, where long-term psychotherapy to eliminate the expressed motive may be the best approach.

Brussel and Hitch suggested that in dealing with the military malingerer, the examiner maintain himself on the alert, refrain from asking leading questions or showing his own suspicious attitude, and avoid any display of surprise or sarcasm. They pointed out that while the diagnosis of malingering may be the first one contemplated, it should be the last one to be accepted. They suggested that persons who malinger rarely do well in military service and should be returned to civilian status. This concept was substantiated by the work of Weiss et al., who found in a blind follow-up study that "pathological personality types" (in which category most malingerers were placed) were among the poorest adjustment risks in Army service.

Cheyne in 1827 detailed his prescription for dealing with malingerers in the military. He wrote:

> The medical officer must not allow even flagrant imposition to deprive him of the command of his temper; he must listen to the most contradictory statement, not really with patience, but without evincing the slightest distrust; in short, his manner must be the same to a soldier laboring under strong suspicion of fraud, as it would be to the best man in the regiment, and he will in general find that complete ignorance of his sentiments will,

more than anything, disconcert the malingerer. Secondly, if the case is evidently feigned, he ought to take the malingerer aside, mildly expostulate with him on his folly, or if necessary, threaten to report him to the commanding officer if he should persist in his misconduct, or again attempt to feign sickness. By such means, many a good soldier has been reclaimed, who had he been exposed to shame, would have become a callous profligate.

Thirdly, if he should fail by means of persuasion, and if the thought be palpable, he ought to take the malingerer into hospital and without prescribing for his pretended complaints, lay the case before the commanding officer.

Fourthly, but if the grounds of his suspicion cannot be convincingly stated, he must cautiously conceal his sentiments, until by patient investigation, his doubts are removed, and a satisfactory report of the case can be prepared.

Fifthly, in this stage of the inquiry, he must employ no means but such as would be applicable to the case were it genuine. He must not, on his own authority, employ any coercive or penal measures, or even irritating applications or nauseating medicines, nor spare diet unless such would be proper if the disease were real.

Sixthly, when after the calmest inquiry, he is convinced that the complaint is unfounded, or the disease fabricated, and shall have reported accordingly to the commanding officer, the case is no longer in his hands; he ought not to prescribe for the malingerer, but ought to pass him in going through the wards. Neglect will often bring him to resume his duty. . . .

Because of sociocultural taboos about lying and deception, especially to achieve unfair or undeserved gains or to escape duty or punishment, and because of the physician's own self-image and fears of being manipulated,

malingering has been a phenomenon of medical, legal, penal, military, and general social interest for centuries. It is now clear, however, that this and related behaviors do not represent a disease per se, but rather a mode of adaptation influenced by environmental and developmental patterns, as well as being an immediate and sometimes ongoing reaction to stress. Such behavior may be related to a variety of psychiatric disorders, including personality disorder, neurosis, psychosis, and mental retardation. Obviously, it is important for the psychiatrist to establish the fact that malingering may be present, but more important is the investigation of the relevant etiologic and dynamic factors involved, and the diagnosis and treatment of the basic disorder in which malingering, imposture, factitious illness, or even the Ganser or Munchausen Syndromes may occur.

Bibliography

Adams, F. *The Seven Books of Paulus Aegineta*. London: Sydenham Society, 1846.

Anderson, E. W. "An Experimental Approach to the Problem of Simulation in Mental Disorders," *Proceedings of the Royal Society of Medicine*, 49 (1956), 513-515.

Asher, R. "Munchausen's Syndrome," *Lancet*, 1 (1951), 339-341.

Bachelor, I. R. C., ed. *Henderson and Gillespie's Textbook of Psychiatry*, 10th ed. New York: Oxford University Press, 1969.

Barker, J. C. "The Syndrome of Hospital Addiction (Munchausen Syndrome)," *Journal of Mental Science*, 108 (1962), 167-182.

Baro, W. Z. “Industrial Head and Back Injuries,” *Indust. Med*., 19 (1950) 69-71.

Bernard, J., et al. “Hypochromic Anemias Due to Voluntarily Induced Hemorrhages (*L’Asthénie de Ferjol’s Syndrome*),” *Press Med*., 75 (1967), 2087-2090.

Blinder, M. “Composite Picture of the Malingering Patient,” *Medical World News*, 1970.

Brody, S. “Value of Group Psychotherapy in Patients with ‘Polysurgery Addiction,’ ” *Psychiatric Quarterly*, 33 (1959), 260-283.

Brussell, J. A., and K. S. Hitch. “Military Malingerer,” *Military Surgeon*, 93 (1953), 33-44.

Calvin, A., and J. E. McDonnell. “Ellis on Personality Inventories,” *Journal of Consulting Psychology*, 17 (1953), 462-464.

Chapman, J. S. “Peregrinating Problem Patients—Munchausen’s Syndrome,” *Journal of the AMA*, 165 (1957), 927-933.

Charcot, J-M. Quoted in Jones and Llewellyn, Ref. #47.

Cheyne, J. “Medical Report on the Feigned Diseases of Soldiers,” *Dublin Hospital Reports*, 4 (1827), 123-181.

Cofer, C., J. Chance, and A. Judson. “A Study of Malingering on the MMPI,” *Journal of Psychology*, 27 (1949), 491-499.

Collie, Sir J. “Malingering,” in W. R. Bett, ed., *Short History of Some Common Diseases*. London: Oxford University Press, 1934.

----. *Malingering and Feigned Sickness*. London: Edward Arnold, 1913.

Cookson, H. “Correspondence,” *British Medical Journal*, 2 (1955), 1330.

Crowley, M. E. “The Use of the Kent EGY for the Detection of Malingering,” *Journal of Clinical Psychology*, 8 (1952), 332-337.

Davidson, H. A. *Forensic Psychiatry*, 2nd. ed. New York: The Ronald Press, 1965.

Davis, D. "The Physician-Patient Relationship: Involvement Versus Insight," *Missouri Medicine*, 58 (1961), 569-571.

----. "They Were Fain to Feign," in preparation.

DeJong, R. N. *The Neurologic Examination*, 3rd ed. New York: Hoeber-Harper, 1967.

Deutsch, A. R. "Malingering and Conversion Reactions in Ophthalmology," *Journal of Tennessee Medical Association*, 61 (1968), 694-698.

Diagnostic and Statistical Manual of Mental Disorders, 2nd ed. (DSM II). Washington: American Psychiatric Association, 1968.

Eissler, K. R. "Malingering," in G. B. Wilbur, and W. Muenstenberger, eds., *Psychoanalysis and Culture*. New York: International Universities Press, 1951.

Ellenbogen, C., and B. M. Nord. "Freshly Voided Urine Temperature: A Test for Factitial Fever," *Journal of the AMA*, 219 (1972), 912.

Exner, J. E., Jr., et al. "On the Detection of Willful Falsifications in the MMPI," *Journal of Counseling Psychology*, 27 (1963), 91-94.

Flexner, J. T. *Doctors on Horseback—Pioneers of American Medicine*. New York: Dover Publications Inc., 1969.

Flicker, D. "Malingering, a Symptom," *Journal of Nervous and Mental Disease*, 123 (1956), 23-31.

Ganser, S. J. *"Über einen eigenartigen Dämmerzustand," Arch, für Psychiat. Nerventk*., 30 (1898), 633.

Gardner, R. C. "Malingering Test for Low Back Pain," *New England Journal of Medicine*, 282 (1970), 1050.

Garrison, F. H. *An Introduction to the History of Medicine*, 4th. ed. Philadelphia: W. B. Saunders,

1929.

Gavin, H. *On the Feigned and Factitious Diseases of Soldiers and Seamen*. Edinburg: University Press, 1838.

Goldstein, H. "A Malingering Key for Mental Tests," *Psychology Bulletin*, 42 (1945), 104-118.

Gorman, C. A., et al. "Metabolic Malingerers," *American Journal of Medicine*, 48 (1970), 708-714.

Gough, H. "The F Minus K Dissimulation Index for the MMPI," *Journal of Consulting Psychology*, 14 (1950), 408-413.

Greidanhus, T. H., et al. "Surreptitious Ingestion of Oral Anticoagulants," *Henry Ford Hospital Medical Journal*, 18 (1970), 99-106.

Grinker, R., Jr. "Imposture as a Form of Mastery," *Archives of General Psychiatry*, 5 (1961), 449-452.

Grose F. *Classical Dictionary of the Vulgar Tongue*. London: Printed for S. Hooper, 1785.

Guttmacher, M. S. "Lie Detection and Narcoinvestigation," in *The Role of Psychiatry in Law*. Springfield, Ill.: Charles C. Thomas, 1968.

Hawkings, J. R., et al. "Deliberate Disability," *Brit. Med. J.*, 1 (1956), 361-367.

Hollender, M. H., and S. P. Hersh. "Impossible Consultation Made Possible," *Archives of General Psychiatry*, 23 (1970), 343-345-

Hunt, W. A. "The Uses and Abuses of Psychometric Tests," *Kentucky Law Journal*, 35 (1946), 38.

----, and H. J. Older. "Detection of Malingering Through Psychometric Tests," *U.S. Naval Medicine Bulletin*, 41 (i943). 1318-1323.

Hutchison, A. C. "Some Observations on Simulated or Feigned Diseases," *London Med. & Phys. J.,* 51 (1824), 87-99.

----. “On Simulated or Feigned Diseases,” *London Med. & Phys. J.,* 54 (1825), 87-93.

Ireland, P., J. D. Sapira, and B. Templeton. “Munchausen’s Syndrome: Review and Report of an Additional Case,” *American Journal of Medicine*, 43 (1967), 579-592.

Istre, C. O., et al. “Automatic Audiometry for Detecting Malingering,” *Arch. Otolaryng*., 90 (1969), 326-333.

Jones, A. Bassett, and J. L. Llewellyn. *Malingering or the Simulation of Disease*. Philadelphia: P. Blakison’s Son and Co., 1917.

Jung, C. G. “On Simulated Insanity (1903),” in *Collected Works*. London: Routledge and Kegan Paul, 1 (1959). 159.

Kenna, J. C. “An Experimental Approach to the Problem of Simulation in Mental Disorders: III. Psychological Aspects,” *Proceedings of the Royal Society of Medicine*, 49 (1956), 519-520.

Keynes, G., ed. *The Apologie and Treatise of Ambroise Pare*. London: Falcon Educational Books, 1951.

Kingsley, H. J. “Peculiarities in Dermatology: A Case of Dermatitis Artefacta,” *Central African Journal of Medicine*, 13 (1967), 264.

Layden, M. “Psychiatric Aspects of Malingering,” *Southern Medical Journal*, 60 (1967), 1237-1239.

Liddle, G. G. “An Artifice of War,” *Journal of the AMA*, 212 (1970), 785.

Mayhew, H. *London’s Underworld: Selections from London Labor and the London Poor*. London: William Kimber, 1950.

McDonald, J. M. *Psychiatry and the Criminal*. Springfield, Ill.: Charles C. Thomas, 1958.

Mehra, K. S., and B. B. Khare. “Sub-conjunctival Saline as Test and Treatment for Ocular Malingering,” *Journal of All-India Ophthalmologic Society*, 15 (1967), 77.

Menninger, K. A. *Man Against Himself*. New York: Harcourt, Brace and Co., 1938.

----. "Psychology of a Certain Type of Malingering," *Archives of Neurology and Psychiatry*, 33 (1935), 507-515.

Moeli, C. *Über irre Verbrecher*. Berlin, 1888.

Montaigne, M. de. *The Essays of Montaigne*, J. Florio, transl. New York: Random House, 1933.

Murphy, E. L. "Malingering," in W. R. Bett, ed., *The History and Conquest of Common Diseases*. Normans: University of Oklahoma Press, 1954.

----. "Skulkers Unveiled: Or Further Notes on Malingering," *Irish Medical Association Journal*, 32 (1953), 9-17.

Ossipov, V. P. "Malingering, the Simulation of Psychosis," *Bulletin of the Menninger Clinic*, 8 (1944), 39-42.

Packard, A. J., Jr. "Orthopedic Detection of Malingering," *Southern Medical Journal*, 60 (1967), 1233-1237.

Pinel, P., "Feigned Mania: The Method of Ascertaining It," in *A Treatise on Insanity*. New York: Hafner Publishing Co., 1962.

Pollaczek, P. P. "A Study of Malingering on the CVS Abbreviated Individual Intelligence Scale," *Journal of Clinical Psychology*, 8 (1952), 77-81.

Punton, J. "Medical Malingering and International Fraud," *Kansas City Medical Index-Lancet*, 24 (1903), 273-280.

Raspe, R. E., et al. *Singular Travels, Campaigns, and Adventures of Baron Munchausen*. New York: Dover Publications, Inc., 1960.

Redlich, F. C., and D. X. Freedman, *The Theory and Practice of Psychiatry*. New York: Basic Books, Inc., 1966.

Rome, H. P. "Malingering as Crypto-Suicide," in A. W. R. Sipe, ed., *Hope, Psychiatry's Commitment*. New York: Brunner/Mazel, 1970.

Rosenberg, S. J., and T. M. Feldman. "Rorschach Characteristics of a Group of Malingerers," *Rorschach Research Exchange*, 8 (1944), 141-158.

Schroeder, O. D., Jr., et al. "Malingering: Fact or Fiction," *Post-Graduate Medicine*, 40 (1966), A22-A28, A58-A64.

Segarra, J. M. "Test for Malingering," *New England Journal of Medicine*, 283 (1970), 375.

Shapiro, S. L. "Malingering with Reference to the Eye, Ear, Nose, and Throat," *Industrial Medicine and Surgery*, 22 (1953), 65-68.

Shaw, R. S. "Pathologic Malingering. The Painful Disabled Extremity," *New England Journal of Medicine*, 271 (1964), 22-26.

Spaeth, E. B. "The Differentiation of the Ocular Manifestations of Hysteria and of Ocular Malingering," *Archives of Ophthalmology*, 4 (1939), 911.

Spiro, H. R. "Chronic Factitious Illness: Munchausen's Syndrome," *Archives of General Psychiatry*, 18 (1968), 569-579.

Sund, A. "Prognosis of Psychiatric Disorders in Norwegian Men in Military Service," *Norwegian Medicine*, 84 (1970), 843-849.

Szasz, T. S. "Malingering: 'Diagnosis' or Social Condemnation?" *Archives of Neurology and Psychiatry*, 195 (1957), 432-443.

Taylor, F. Kraüpl. *Psychopathology*. Washington: Butterworths, 1966.

Temkin, O. *The Falling Sickness: A History of Epilepsy from the Greeks to the Beginning of Modern Neurology*. Baltimore: Johns Hopkins Press, 1945.

Trethowan, W. H. "An Experimental Approach to the Problem of Simulations in Mental Disorders: II. Experimental Data," *Proceedings of the Royal Society of Medicine*, 49 (1956), 515-

519.

Wagner, C. G. “Feigned Insanity: Malingering Revealed by the Use of Ether,” *American Journal of Insanity*, 61 (1904), 193-198.

Weiss, J. M. A. “The Gamble With Death in Attempted Suicide,” *Psychiatry*, 20 (1957), 17-25.

----. “The Role of the Psychotherapist in Military Training Centers,” *Military Medicine*, 118 (1956), 95-108.

----, W. G. Hill, and J. L. Boyer. “Subsequent Military Performance of Soldiers Treated at a Mental Hygiene Consultation Service,” *Mental Hygiene*, 38 (1954), 604-612.

----, and M. E. Perry. “Transcultural Attitudes toward Crime,” in preparation.

Wertham, F. *The Show of Violence*. New York: Doubleday and Co., Inc., 1949.

Whitlock, F. A. “The Ganser Syndrome,” *British Journal of Psychiatry*, 113 (1967), 19-29.

Wilson, W. A. “Oedipism,” *American Journal of Ophthalmology*, 40 (1955), 563-567

Notes

1 “Malinger” is pronounced with a hard “g” sound to rhyme with “singer.”