Malingering?

Part I

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PGYIII

Disclosures

None

Disclaimer

- This presentation incudes references to studies citing symptom prevalence
- These figures are not necessarily applicable unless subject being evaluated is comparable to subject/circumstance tested in cited study
- Compare apple to apples

Case Study

The individual is a 44 year old Caucasian male with unknown PPHx and a claim of no significant PMH. Until recently he was working for a moving company as a furniture mover. He reported he was injured while working. A disability claim was filed citing a back injury incurred from an accident at work. He stated he can no longer perform the work required at his employer moving heavy items all day. Physical exam and radiological evidence were not conclusive. The insurance company handling the claim pursued video surveillance for concern of fraud.

G. Brown, personal communication, November 6, 2013

Southern Professional Investigations, Inc., (March 9, 2011). Worker's Comp Fraud Investigation Sample #2. Retrieved from /http://www.youtube.com/watch?v=A2Mufn2SF6c

***This video is not related to the fictional case study presented and is used only for educational purposes.**

Case Study

The surveillance tape shows the individual at his residence lifting what appears to be a somewhat heavy item. The insurance company claimed the defendant was malingering in order to receive financial compensation. The video was cited as proof the subject was not disabled and could perform similar tasks as he previously did at the moving company he worked for.

G. Brown, personal communication, November 6, 2013

Who believes the individual's claim of disability is bona fide?

Who believes the individual is malingering?

Who needs more history before deciding?

Case Study

Information and evidence that was not reported by the insurance company included:

1. The subject was working on damage to his house after a storm and did not have insurance/funds to hire help.

2. Before subject lifted the object he took “heavy duty” opiate medication in order to tolerate the pain.

3. For the next 3 days subject had to rest in bed due to the incapacitating pain that resulted from his physical efforts.

G. Brown, personal communication, November 6, 2013

Has anyone's opinion changed?

What may initially appear as malingering can have alternate explanations.

Malingering
DSM-5 V65.2

- Intentional production of false or grossly exaggerated physical or psychological symptoms

- Motivated by external incentives such as:
  1. Avoiding military duty or work
  2. Obtaining financial compensation
  3. Evading criminal prosecution
  4. Obtaining drugs

DSM-5 p726-727;
Images from film "Fight Club". (1999)

DSM-5
Strongly suspected if…?

- Medicolegal context of presentation (attorney)
- Marked discrepancy between claimed stress/disability and objective findings
- Lack of cooperation during evaluation and complying with treatment
- Antisocial personality disorder

DSM-5 p. 727

Expanded Definitions

- Since DSMIII (1980), there has been a stable definition of malingering continuing to the current DSM-5 (2013)
- In addition to false/exaggerated production of symptoms, depending on the scenario, denial of symptoms or denial/alteration of previous history could be construed as malingering

Why Are Clinicians Hesitant To Diagnose Malingering?

1. Must rule out many other disorders [1]
2. Mistaking malingering can stigmatize patient and lead to poor care in the future [2]
3. Legal action for defamation of character (which some courts have ruled for [4]) or being assaulted by essentially calling someone a liar [3]

Rogers, R. (Resnick, P. J., 1997) 2008, p. 112; Burgess & McMillan, 2001 [1]; Pollack, 1982 [2]; Kropp & Rogers, 1993 [3]; Resnick, P. 2008 (2) [4];

History

- Malingering was initially believed by some to be a form of mental illness during the psychoanalytic peak, there was dissention from others. [1]
- **Pseudo malingering** (unsubstantiated) true psychosis preceded by malingering as a prodromal symptom of psychosis [1]
- DSM-5 states malingering is not a mental disorder (V-codes) [2]

Rogers, R. 2008 [1]; DSM-5, 52 p. 715 [2]

Misconceptions

- Malingering is rare- belief may lead to neglect
- Malingering is a static response style –once a malingerer always a malingerer
- Deception equates malingering- malingerers lie so liars malinger

Rogers, R. 2008, p.7-8

Misconceptions

- Malingering always an antisocial act by people with antisocial PD
- Any noted malingering represents pervasive pattern and the tip of the iceberg
- Stable trait like base rates- can depend on the circumstance (insanity vs custody)
- Clinicians can easily detect- may lead to inadequate evaluations

Antisocial PD & DSM?

- DSM-5 suggest APD should arouse suspicion for malingering- studies have failed to show this relationship
- Psychopathic traits can be associated with malingering [1], most with APD do not meet criteria for psychopathy [2]
- Other studies report APD and psychopaths are no more skilled at malingering than others
- However, adaptational model suggests APD and Medicolegal context should increase malingering prevalence

Rogers, R. 2008, p. 8-9; Edens, Buffington, & Tomicic, 2000 [1]; Poythress, Edens, & Watkins, 2001; Rogers & Cruise, 2000 [2];

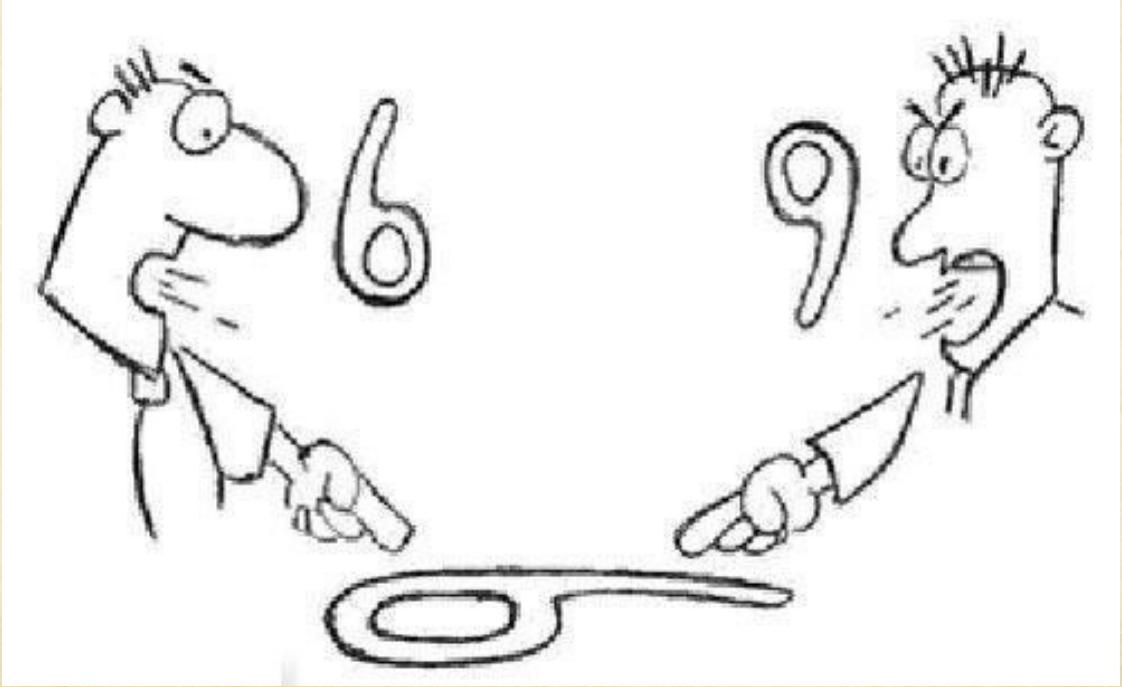
Rule out Factitious Disorder

- Falsification of physical or psychological signs or symptoms, or induction of injury/disease
- Presents self as ill, impaired, or injured
- Obvious external rewards for behavior is absent
- Motivation for behavior is to assume the sick role

DSM-5 p. 324-325

Terminology

For effective communication across providers, terminology describing how patients respond should be clear with the same meaning.



Rogers, R. 2008, p. 6; Image retrieved from http://web.horizondisplay.com/Portals/204021/images/cartoon%20picture%202%20for%20blog.png

Response Styles

- The way in which responses are given to questions and physical exam tasks
- Conscious decision to disclose or deceive
- Not trait-like characteristics, can be flexible
- Modified by circumstances and motivations
- Inconsequential responses may not be relevant

Rogers, R. 2008, p. 3-8

Response Styles
Non-specific Terms

- **Unreliability**- accuracy of information reported is questionable; intent not assumed
- **Nondisclosure**- information is withheld without assumption of intent; voluntary or involuntary
- **Self-disclosure**- how open a person is to share self information; withholding does not imply lying, only unwillingness to share
- **Deception**- any consequential attempt to distort or misrepresent self reporting
- **Dissimulation**- intentional distortion/misrepresentation of psychological sx

Rogers, R. 2008, p.4- 5

Response Styles

Avoid due to multiple/conflicting definitions:

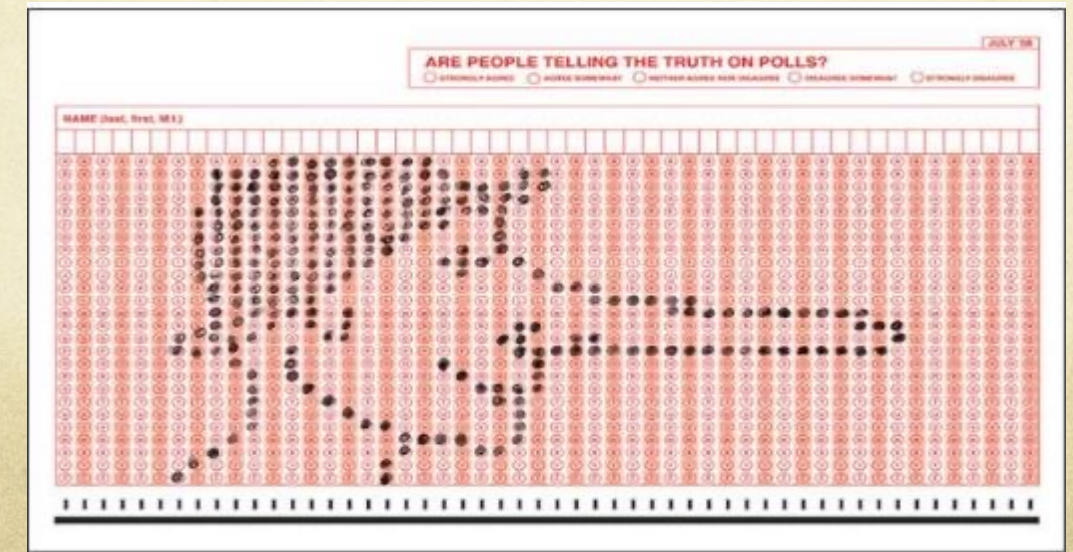
- **Suboptimal effort**- can be applied to almost anyone, can be affected by a number of reasons (internal/external factors)
- **Over reporting**- high level of endorsement, unclear as can be deliberate or unintentional, mistaken for feigning

Rogers, R. 2008, p. 6

Response Styles
Overstated Pathology

Malingering

- Consider magnitude of dishonesty
- Minor exaggerations or isolated symptoms do not qualify (partial malingering) (depends on what pt believes gain will be)
- Can co-occur with internal motivations



Rogers, R. 2008, p. 5

Response Styles
Malingering Subclassification

- **Pure malingering**- feigning a nonexistent disorder
- **Partial malingering**- consciously exaggerating actual symptoms
- **False imputation**- assigning actual symptoms to unrelated cause

Rogers, R. (Resnick, P. J., 1997) 2008, p. 112

Response Styles
Overstated Pathology

Factitious

- Exclusion (external) may be difficult due to frequent dual roles of family and work related issues

Feigning

- Psychological tests can determine feigned symptoms
- Do not reveal motivation, can not establish malingering

Rogers, R. 2008, p. 5-6

Response Styles
Simulated Adjustment

Defensiveness

- Opposite of malingering, masking of symptoms
- Denial or gross minimization of symptoms

(Can have consequences equal to malingering)

Social Desirability

- Present self in most favorable way relative to social norms, concealment of symptoms
- Denial of negative, endorsement of positive characteristics

Response Styles
Simulated Adjustment

Impression Management (concealment)

- Effort to control others' perceptions
- Stronger relation to situation than social desirability is
- May stem from a desired outcome or identity

What about DSM Criteria?

- DSM only list guidelines, no actual criteria
- Rogers and Vitacco (2002) state DSMIV-TR suggestions should not be used citing "ineffectiveness and limited conceptualization of malingering".
- Claim misclassification rate of over 80% using DSM guidelines (criteria vs differential dx)
- DSM concept may be too limited compared to richer explanatory models

Rogers, R. 2008, p. 39

Malingering Explanatory Models

- **Adaptational** (prevailing model)- individual employs a cost-benefit analysis to choose which symptoms to feign
- **Pathogenic**– an underlying disorder is the motivation or means for malingering (BPD)
- **Criminological**- malingering is an antisocial act committed by antisocial people

Roger, R. 2008, p. 9

Malingering Explanatory Models

- Using a purely criminological model can increase countertransference and negative perceptions

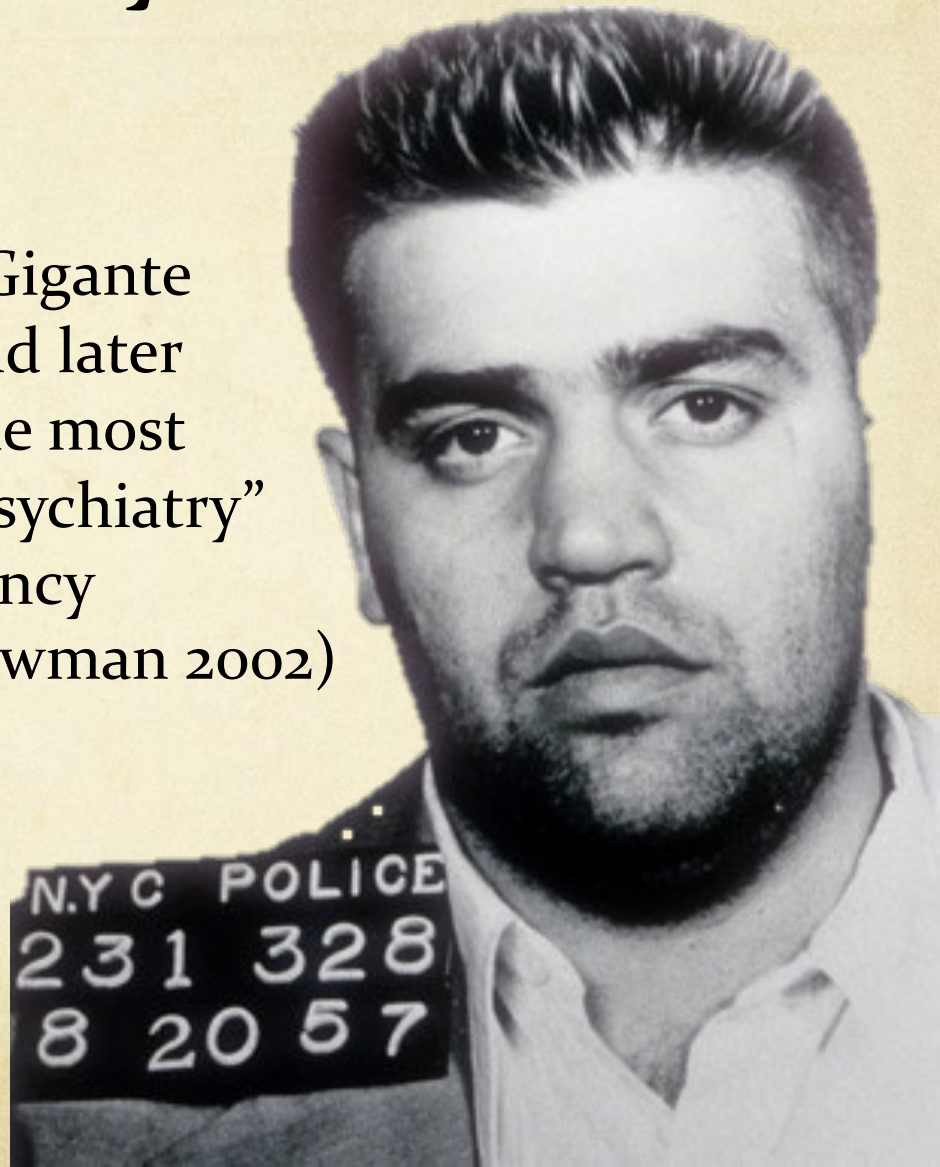
Rogers, R. 2008, p. 50

Genuine vs Feigned Symptoms?

Image retrieved from http://napervilledemocrats.org/ntdo/wp-

Malingered Psychosis

- Mobster Vincent "The Chin" Gigante malingered schizophrenia (and later dementia [1]) had deceived "the most respected minds in forensic psychiatry" during 1990-1997 for competency evaluations to stand trial (Newman 2002)



Rogers, R. (Resnick & Knoll) 2008, p. 51; Reid, W. 2003 [1];
Image retrieved from
http://mafiapage.nl/Vincent%20Gigante%2001.jpg

Auditory Hallucinations
Ask About

- Source: inside/outside, above/behind head, one or both ears
- Gender: male or female
- Age: child or adult
- Vocal Characteristics: single/multiple voices, clear/vague/inaudible, loudness
- Frequency: continuous/intermittent, time of day, during sleep

Rogers, R. (Resnick & Knoll) 2008, p. 55

Auditory Hallucinations
Ask About

- Familiarity: known/unknown, familiar/unfamiliar
- Type of Language: commands, formal, 2nd or 3rd person
- Response: ability to disregard, emotional response, has conversation with them
- Associated Characteristics: hallucinations in other sensory modalities or delusions, other psychotic symptoms

Rogers, R. (Resnick & Knoll) 2008, p. 55

Goodwin & Colleagues (1971)

Auditory Hallucinations

- Classic study of 116 hallucinating patients
- 75% heard both genders
- 88% heard both familiar and unfamiliar voices
- 7% heard vague, inaudible, or unclear messages

Rogers, R. (Resnick & Knoll) 2008, p. 55. ; Image retrieved on 11/15/13 from http://www.trulygraphics.com/wp-content/uploads/2010/10/i-hear-voices-in-my-

Auditory Hallucinations
Inside or Outside the Head?

- Goodwin and colleagues (1971) most AH are perceived outside the head (88%)
- Junginger and Frame (1985) only 50% of schizophrenics have AH outside the head
- Copoloy and colleagues (2004) many psychotic patients hear AH inside and outside the head

Auditory Hallucinations
Inside or Outside the Head?

- Daalmann and colleagues (2012) found "healthy" individuals with auditory verbal hallucinations and did not meet criteria for any DSM-IV dx perceive varied AH localization
- Psychotic individuals(>60% Schizophrenic) in same study had similar results in regard to localization
- Both groups heard voices "outside head, close to ears, and inside head"

Daalman, Verkooijen, Derks, Aleman, Sommer, 2012;

Auditory Hallucinations
Inside or Outside the Head?

- Dissociative Identity Disorder- third most commonly documented dissociative symptom is hearing voices "in the head" [1]
- Rape Victims- Shevlin and colleagues (2007) 21% of women raped < age 16 heard voices, primarily inside the head (most likely dissociative)
- Varied results suggest location should not be used to determine genuineness [3]

Dell, P. 2006 [1]; Rogers, R. (Resnick & Knoll) 2008, p. 55 [3];

Auditory Hallucinations

- Most (81%) are worried or upset by AH [1]
- Themes in schizophrenia are usually instructive or persecutory [2]
- Voices often threatening, obscene, accusatory, or insulting [3]

Rogers, R. (Resnick & Knoll) 2008, p. 56; Carter, Mackinnon, & Copoloy, 1996; Pollock, 1998 [1] ; Small, Small, & Anderson, 1966 [2]; Sadock & Sadock, 2003 [3]; Goodwin et al., 1971; Leudar, Thomas, McNally, & Glininski, 1997; Oulis, Mavres, Mamounas, & Stefanis, 1995 [4];

Auditory Hallucinations

- Questions usually chastising rather than only information seeking
- May focus on sexuality with derogatory nature with men described as gay and women as immoral (unlikely faked/ stigmatizing) [1]
- Music is rare unless organic brain pathology present

Rogers, R. 2008, p. 56; Nayani & David, 1996 [1]; Fischer, Marchie, & Norris, 2004 [2]; Berrios, 1991 [3];

Musical Hallucinations

- Oliver Sacks & Musicophilia (MH w/o psychosis)
- Can be associated epilepsy, vascular, cerebral tumors, dementia, alcohol withdrawal states, depression [2] and psychoses [3]

Aizenberg, Modai, Roitman [2]; Duncan, Mitchell, Critchley [3];

Auditory Hallucinations

- Most report negative effects from hallucinations, some report positive effects as well
- Intensity range is variable, possibly in the same patient (whispers to shouting)
- Rhythm of speech usually normal
- Malingers may claim speech is formal or has implausible or far fetched language (ex. “Go commit a sex offense” or “Stick up, stick up, stick up!”) [1]

Rogers, R. (Resnick & Knoll) 2008, p. 57; Pollock, 1998
[1];

Command Hallucinations

- Easy to fabricate and often claimed to be exculpatory (insanity defense)
- True command hallucinations often associated with delusions (75%) and non-command hallucinations (85%) [1]
- Compliance is related to beliefs about voices and how delusions interplay [2]
- Isolated command hallucinations without additional psychotic sx should raise suspicions [3]

Rogers, R. (Resnick & Knoll) 2008, p.56; Thompson, Stuart, & Holden, 1992 [1]; Braham, Tower, & Birchwood, 2004 [2]; Pollock, 1998 [3];

Command Hallucinations
How likely to obey?

- Conflicting data
- Various studies range from 22%-84%
- Patients with genuine hallucinations do not <u>always</u> obey them [2]
- Dangerous commands are less likely to be followed [1]

Rogers, R. (Resnick & Knoll) 2008, p.56; Juninger, 1995 [1]; Kasper et al., 1996 [1]; Resnick & Knoll 2005 [2];

Visual Hallucinations

- Usually of normal sized people and in color [1]
- Do not typically change with eyes open or closed [2]
- Lilliputian hallucinations are rare and associated with alcohol use, organic disease [3], or toxic psychosis (anticholinergic toxicity) [4]; uncommon in schizophrenia [5]

Rogers, R. (Resnick & Knoll) 2008, p. 57; Goodwin et al., 1971 [1]; Assad & Shapiro, 1986 [2]; Cohen, Alfonso, & Haque, 1994 [3]; Lewis, 1961 [4]; Assad, 1990 [4]; Leroy, 1922 [5] ; Image, top right, retrieved from http://www.fanpop.com/clubs/invader-zim/images/12898179/title/gir-hallucinating-photo; Image, bottom, retrieved from http://www .cinemapera estudiants.cat /activitats/Activitats2011/GULLIVER

Visual Hallucinations

- Evidence does exist for monochromatic and black and white hallucinations in the following
- Focal epilepsy- brief, stereotyped, fragmentary, figures unlikely identifiable [1]
- Orthographic hallucinations- 25% pts w/VH secondary to eye disease (letters, words, nonsense letter strings) [2]
- Migraines- B&W patterns during visual aura [3]

Manford & Andermann, 1998 [1]; Ffytche, Lappin, Philpot, 2004 [2]; Panayiotopoulos, 1999 [3];

Visual Hallucinations

- Drug induced VH associated when eyes closed or in the dark [1]
- Shadows, flashes of light, moving objects associated with substance use and neurologic disease [2]
- VH in those over 60 years old suggestive of eye pathology [3] (Charles Bonnet Syndrome & Lilliputian)

Rogers, R. (Resnick & Knoll) 2008, p. 58; Assad & Shapiro, 1986 [1]; Cummings & Miller,; Mitchell & Vierkant, 1991 [2]; Beck & Harris, 1994 [3];

Dramatic or atypical VH concerning for malingering [1]

(especially with incongruent behavior)

Rogers, R. (Resnick & Knoll) 2008, p. 58 Powell, 1994 [1].
Tool. Vicarious. Image retrieved on 11/17/13 from http://www.youtube.com/watch?v=Mq1Qb2rGQEs

General Medical Disorders vs. Schizophrenic Spectrum

- General medical or neuro disorders usually have more prominent visual hallucinations [1]
- Less prevalence of thought disorder, bizarre behavior or negative symptoms[1]
- Neurological disorders can create complex visual hallucinations with bright colors and dramatic settings [1]

Rogers, R. (Resnick & Knoll) 2008, p. 58 ; Fringe Movie Series, Retrieved on 11/15/13 from : http://s716.photobucket.com/user/cytherians/media/fringe/fringe-tinfoil-hat2.jpg.html; Cornelius et al., 1991 [1];

Cenesthetic Hallucinations

- Sensation of an altered state in an organ or bodily distortion
- Examples: burning sensation in brain, pushing sensation in blood vessels or cutting sensation in bone marrow
- Unlikely to be feigned due to bizarre and obscure nature of hallucination

Rogers, R. (Resnick & Knoll) 2008, p. 58; Sadock & Sadock, 2003;

Genuine Hallucinations

- Hallucinations (88%) commonly co- occur with delusions [1]
- More likely intermittent than continuous [2]
- Olfactory/tactile rare unless medical cause or late schizophrenia after age 45 [3]
- One study reported a 27 day average for hallucinations to clear after initiating antipsychotic [4]

Rogers, R. (Resnick & Knoll) 2008, p. 55; Lewinsohn, 1970; Pollock, 1998 [1]; Goodwin & Colleagues, 1971; Nayani & David, 1996; Pollack, 1998 [2]; Pearlson, et al., 1989 [3]; Gundez-Bruce et al., 2005 [4];

Atypical Hallucinations

- Continuous
- Vague or inaudible
- Not associated with delusions
- No strategies to reduce malevolent AH
- Formal language
- Unbearably distressing
- Unpredictable
- All commands obeyed
- Black and white VH
- VH without AH in Schizophrenia

Rogers, R. (Resnick & Knoll) 2008, p. 59;


ANY
QUESTIONS
?

Malingering?

Part II

Dan Nicolau, MD
PGYIII

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Coping Strategies

- Coping strategies to deal with true hallucinations often devised (ask)
- Examples: activities, changing posture, interpersonal contact, medications [1]
- Schizophrenic hallucinations tend to diminish when involved in activities [2]
- Likely to develop strategies with malevolent voices

Rogers, R. (Resnick & Knoll) 2008, p. 57; Falloon & Talbot, 1981 [1,2]; Goodwin et al., 1979 [2]; Kanas & Barr, 1984 [1];

Coping Strategies

- Talking with voices and incorporating them into their life [1]
- Use voices as a type of advisor in certain situations [1]
- When commands not carried out, voices can rephrase question, speak louder, or curse at patient
- Malingerers more likely to say they were compelled and action was carried out without any discussion

Rogers, R. (Resnick & Knoll) 2008, p. 57; Leudar et al., 1997 [1];

Delusions

- Genuine delusions vary in content, theme, degree of systemization, and relevance to person's life [1]
- Complexity and sophistication of delusions generally reflect person's intelligence [2]
- Persecutory delusions more likely to be acted on [3]
- Technical content (computer chips, phones) are 7X more frequent in men vs. women [4]

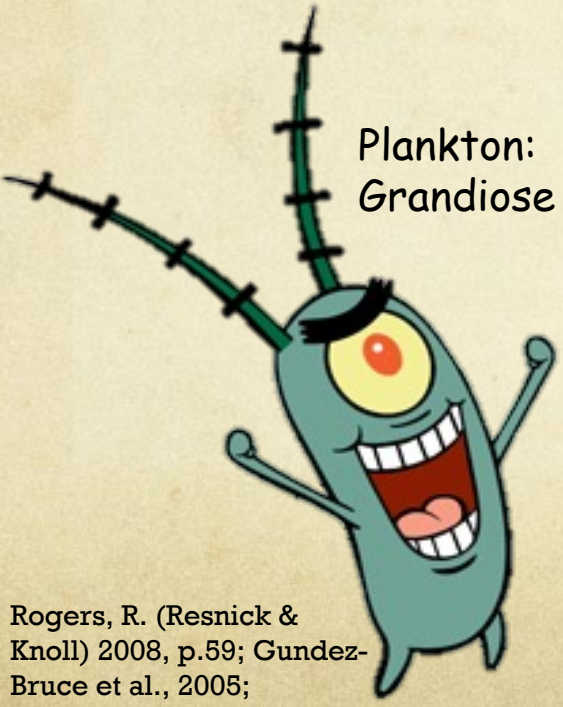
Rogers, R. (Resnick & Knoll) 2008, p. 58-59; Spitzer, 1992 [1]; Thakur, Hays, Ranga, & Krishnan, 1999 [2]; Wesley et al., 1993 [3]; Kraus, 1994 [4]; The Shining. 1980. Image retrieved on 11/15/13 from http://www. huffingtonpost .com /gregg-hurwitz/anxiety-of-influence_b_217638.html

Delusions

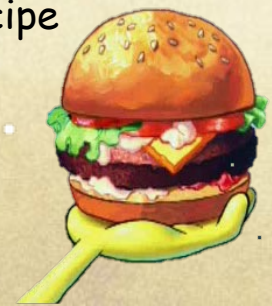
Time Frame

- Usually take weeks or longer to fully develop and even longer to clear
- One study found it takes on average 73 days for delusions to clear after starting antipsychotics

3. World domination !



Plankton:
Grandiose delusions?



1. Get Krabby Patty recipe

2. Destroy Krusty Krab

Rogers, R. (Resnick & Knoll) 2008, p.59; Gundez-Bruce et al., 2005;

Malingered Delusions

- Malingers may claim sudden onset or cessation of delusions [1]
- Feigned delusions are usually persecutory, sometimes grandiose, and rarely self-deprecatory [2]
- Genuine delusions with bizarre content often present with disorganized thinking
- Behavior of patient often conforms to content in true delusions

Rogers, R. (Resnick & Knoll) 2008, p. 59; Gundez-Bruce et al., 2005 [1]; Davidson, 1952a; East, 1927 [2];

Assessment of Suspect Delusions

- Compare behavior and speech patterns to content of delusions
- Persecutory delusions without paranoid behavior is suspect
- Exception to above is long history of schizophrenia where the delusions get used to
- If reported belief in delusion is strong, assess work and community functioning which should be affected

Rogers, R. (Resnick & Knoll) 2008, p. 59

Signs of Malingered Psychosis

- Psychosis is overacted [1]
- Malingerers think more bizarre presentations are more believable [2]
- More likely to volunteer symptoms [3], take control of interview, or act hostile and intimidating

Rogers, R. (Resnick & Knoll) 2008, p. 60-62;
Wachpress, Berenberg, & Jacobson, 1953 [1];
Lowensteien, 2001 [2]; Powell, 1991; Ritson & Forest,
1970 [3];

Signs of Malingered Psychosis

- Malingered cognitive impairment often co-occurs with malingered psychosis [1]
- Frequent selective evasive answers [2]
- Repeating questions or answering slowly to think about responses to simple questions
- Vague responses to straightforward questions

Rogers, R. (Resnick & Knoll) 2008 p. 61; Bash & Alpert, 1980; Lowensteien, 2001; Schretlen, 1988 [1]; Powell, 1991 [1,2];

Signs of Malingered Psychosis

- More difficult to replicate form/process of psychotic thinking than content [1]
- Derailment, neologisms, loose associations, and word salad rarely malingered
- Perseveration rarely malingered
- Can repeat ideas without becoming tangential, as schizophrenics can not
- Disorganized/confused with Psychiatrist, plays great chess with patients on ward [2]

Rogers, R. (Resnick & Knoll) 2008, p. 61; Sherman et al., 1975 [1]; Resnick & Knoll 2005 [2];

Signs of Malingered Psychosis

- Negative symptoms- flat affect, alogia, avolition, or impaired interactions rarely replicated
- Positive symptoms are easier to fake
- Alleges AVH but not distracted [1]
- Reports VH in black and white [1]
- Ticks and fleas may be present, genuine schizophrenics can also malinger (adaptational model)

Rogers, R. (Resnick & Knoll) 2008, p. 61; Resnick & Knoll 2005 [1];

Suggested Criteria for Malingered Psychosis

A. Clear external incentive (established, not inferred)

B. Marked variability by at least one:

1. Marked discrepancy of interview and non-interview behavior
2. Gross inconsistencies in reported psychotic symptoms
3. Blatant contradictions between reported prior episodes and documented history

Rogers, R. (Resnick & Knoll) 2008, p. 64

Suggested Criteria for Malingered Psychosis

C. Unlikely symptoms as evidenced by one or more:

1. Elaborate psychotic symptoms that lack common paranoid, grandiose, or religious themes
2. Sudden emergence of psychotic symptoms to explain exclusively criminal behavior
3. Atypical hallucinations or delusions

Rogers, R. (Resnick & Knoll) 2008, p. 64

Suggested Criteria for Malingered Psychosis

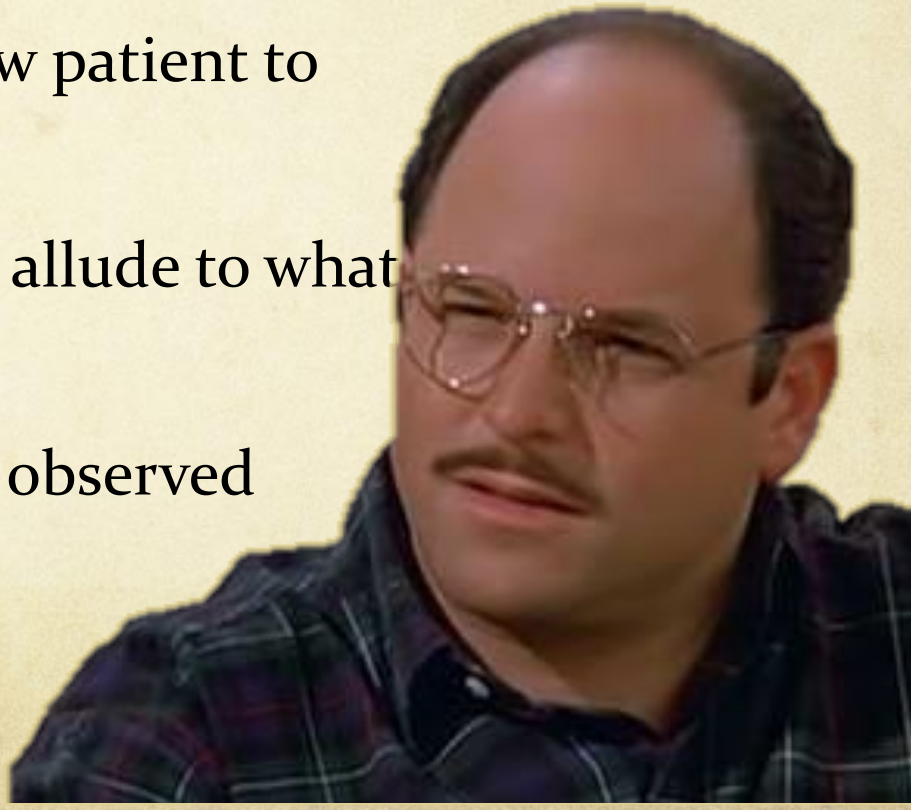
D. Confirmation of malingered psychosis by either:

1. Admission of malingering
2. Strong corroborative data (e.g., findings from psychological measures with very low false positive rate)

Rogers, R. (Resnick & Knoll) 2008, p. 64

Interview Approach

- Try not to appear suspicious, annoyed, or incredulous [1]
- Begin with open ended questions
- Avoid leading questions, allow patient to answer in their own words
- Ask questions in a way to not allude to what true psychotic symptoms are
- Ask if patient has previously observed psychosis



Rogers, R. (Resnick & Knoll) 2008, p. 62; Sadock & Sadock, 2003 [1]; Seinfeld, UD. Image retrieved on 11/17/13 from http://thewhiskywoman. files.wordpress. com /2012/12/george-costanza.jpg?w=480;

Interview Approach

- Review collateral information before interview if possible
- Ask about rare/improbable symptoms that are almost never reported
- Examples: upside down vision, do cars have organized religion, do you see words spelled out when people speak
- Ask a relevant question when patients have their guard down, during break or when first awakening (used in Gigante case)

Rogers, R. (Resnick & Knoll) 2008, p. 62-63

Interview Approach

- Be aware of inconsistencies such as:
- Clear description of severe confusion or memory loss
- Conflicting versions of their history to same examiner
- Reporting active hallucinations without distractions
- Deteriorated functioning with interviewer not displayed in other environments (on unit with other patients)

Rogers, R. (Resnick & Knoll) 2008, p. 63

Lying and Facial Expressions?

- Gross facial expressions offer least reliable cues for detecting lies (micro expressions?)
- Facial pleasantness incorrectly rated by observers to be associated with honesty
- Feigned smile more likely to be asymmetric; attention to voice rather than to visual clues improves detection of lies

Resnick, P. 2008b;

Lying

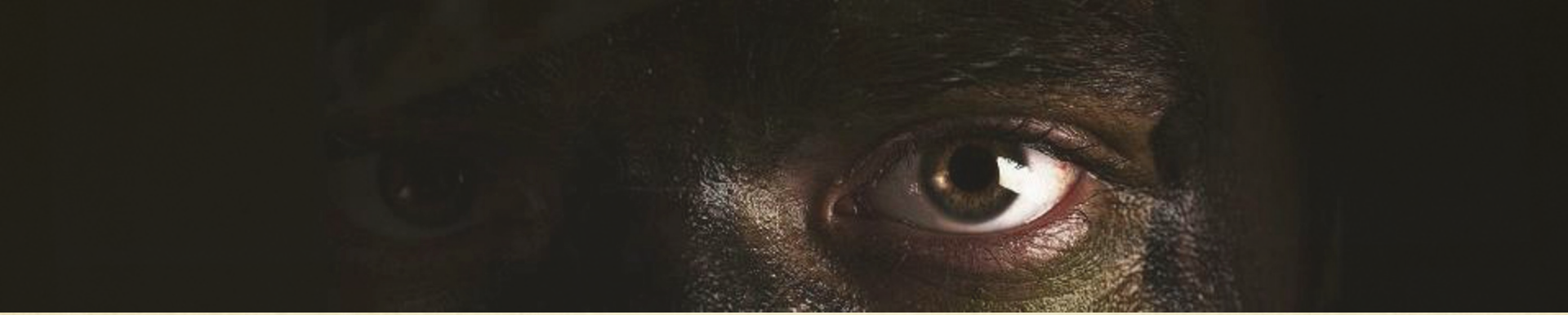
- The average adult tells 1 lie per day
- The average college student, 2 lies per day
- When talking to their mothers, 50% of what college students say is a lie

Resnick, P. 2008b

PTSD

- Easy to malinger, difficult to detect malingering
- Symptoms virtually all subjective, difficult to verify independently, widely available to the public
- 86-94% of people naive to PTSD can meet dx from a checklist [1]
- Trauma exposure leads to PTSD in minority of cases [2]

Rogers, R. (Resnick, P. J., 1997) 2008, p. 112-113;
Burgess & McMillan, 2001; Lees-Haley & Dunn, 1994;
Slovenko, 1994 [1]; Davidson, 1993 [2];



Traumatic Event Exposure Risk Factors

- Low Education
- Male
- Early conduct problems
- Extraversion
- Family hx of mental disorder or SA
- Occupation

Rogers, R. (Resnick, P. J., 1997) 2008, p. 110; Breslau, Davis, Andreski, & Peterson, 1991; ; Image retrieved on 11/17/13 from http://admh13-cura.wikispaces.com/file/view/PTSD.jpeg

Pre-trauma Characteristics Increasing Chances of PTSD

- Female
- Hx psych illness 1st degree relative
- Parental poverty
- Separation/divorce of parents before age 10
- Childhood trauma
- Childhood/adolescent behavior disorder
- Low adolescent self esteem
- Prior psych disorder
- Introversion
- Life stress prior and following trauma
- Neuroticism

Rogers, R. (Resnick, P. J., 1997) 2008, p. 110-111;
Davidson, 1993;

Other PTSD Predictors

- 2003 meta-analysis of 476 studies found peri-traumatic dissociation single best predictor [1]
- Previous trauma
- Previous psychological maladjustment
- Believing their life is threatened during trauma
- Lack post trauma social support
- Peri-traumatic emotional response

Rogers, R. (Resnick, P. J., 1997) 2008 p. 111 ; Ozer, Best, Lipsey, & Weiss, 2003 [1];

PTSD

- Prevalence varies depending on type of trauma experienced
- Sexual trauma has higher rates of developing PTSD [1], 80% of rape victims vs. 15-30% in car accidents [2]

Rogers, R. (Resnick, P. J., 1997) 2008, p. 111; Hapke,, Schumann, Rumpf, John, & Meyer, 2006 [1]; Hall, Hall, & Chapman, 2006 [2]; Amir, Kaplan, & Kotler, 1996 [3];

PTSD
Feigned Memory Deficits

- Overemphasizing memory deficits
- Can't remember overlearned data (name, gender, etc.) [1]
- Procedural memory impairment (driving, tying shoes)
- Poor score on tests labeled "Memory Testing"
- Memory testing worse than chance
- Clear recollection of trauma with reported memory loss

Rogers, R. (Resnick, P. J., 1997) 2008, p. 116; Brandt, 1992; Levin, Lilly, Papanicolau, & Eisenberg, 1992 [1];

PTSD Interview

- Avoid revealing criteria through questions
- Ask open ended questions, avoid leading
- Bias may lead to exaggeration of sx to justify impairment
- Ask for a detailed account of symptoms
- Follow up generic sx with details of circumstance, degree, frequency, context

Rogers, R. (Resnick, P. J., 1997) 2008, p 117

PTSD Malingering Indicators

- Symptoms described are vague [1]
- Stating DSM criteria alone not sufficient
- Fails at describing nuances and details that come with personally experiencing event

Rogers, R. (Resnick, P. J., 1997) 2008, p. 117; Pitman, Sparr, & Saunders, 1996 [1];

PTSD Malingering Indicators

- Absence of irritability, poor focus, exaggerated startle response or other associated behaviors during interview
- Minimizing other possible causes for symptoms
- Pre-trauma functioning portrayed in overly complimentary light
- Incapable to work while participating in hobbies, recreational events, and socializing

Rogers, R. (Resnick, P. J., 1997) 2008, p. 117

Identifying Malingered PTSD

- Performing an activity claimed as causing incapacity
- Individual confesses to malingering
- Confession provides strong evidence with considerable certainty but infrequently encountered
- A thorough investigation with multiple pieces of evidence usually needed

Rogers, R. (Resnick, P. J., 1997) 2008, p. 112

Psychophysiological Measurements

- One of few objective measures available
- Various studies have played combat sounds with measurements of HR, BP, and forehead EMG with mixed results
- Mixed results ranging from 95.5% of PTSD/controls correctly classified [1] to 25% undetected feigning physical symptoms[2]
- May be due to specific traumas being triggers (machinegun fire for medic not as significant as helicopter noise)

Rogers, R. (Resnick, P. J., 1997) 2008, p. 122 ;
Blanchard, et. al., 1982 [1]; Pittman, et al., 1994 [2];

Psychophysiological measurements

- Largest study, Kean and colleagues (1998), tested HR, skin conduction, and muscle tension in Vietnam vets to autobiographical and neutral scripts
- 1/3 patients with current PTSD (n=778) did not react physiologically
- Claimed alien abductees not meeting Criterion A responded equal to or more than PTSD patients in above study [1]

Rogers, R. (Resnick, P. J., 1997) 2008, p. 122; McNally 2006 [1]

What About Standardized Measures?

- Instrument should have norms for PTSD
- CAPS gold standard for PTSD assessment
- MMPI-2 >SIRS> PAI for PTSD feigning
- Trauma population heterogeneity may contribute to dissimilar clinical profiles [1]
- Leads to atypical profile configurations with elevations on psychological tests [2]
- Multiple data sources/collateral info should be evaluated rather than relying only on scales

Rogers, R. (Resnick, P. J., 1997) 2008, p. 118; Elhai, Frueh, Gold, Gold & Hamner, 2000 [1]; Wilson, 2004 [2];

Psychophysiological Measurements

- Genuine physiologic response can not confirm or disconfirm presence of PTSD
- Psychophysiological testing is an objective method however can be flawed to detect genuine versus malingered PTSD
- Significant minority of patients with PTSD can have false + for malingering as well as false -

Rogers, R., (Resnick, P. J., 1997) 2008

Suggested Criteria for Malingered PTSD

A. Understandable motive to malinger PTSD

B. At least two of the following:

1. Irregular employment/job dissatisfaction
2. Prior injury claims
3. Capacity for recreation and not work
4. No nightmares/exact repetitions civilian trauma
5. Antisocial Personality traits
6. Evasiveness/contradictions
7. Non-cooperation

Rogers, R. (Resnick, P. J., 1997) 2008, p. 123

Suggested Criteria for Malingered PTSD

C. Confirmation by one of the following:

1. Confession
2. Unambiguous psychometric evidence
3. Strong corroborative evidence (e.g., video)

Rogers, R. (Resnick, P. J., 1997) 2008, p. 123

What is the Significance of Approximate Answers?

Ganser's Syndrome

- DSM III: Factitious Disorder with Psychological Symptoms
- Essential feature is voluntary production of severe psychological(often psychotic) symptoms
- This has also been referred to as, pseudopsychosis, or pseudodementia.

DSM-III, p. 286

Ganser's Syndrome

- DSM-5 lists as "other specified dissociative disorder" [1]
- Defined as the giving of approximate and vague answers (2+2 =5) [1]
- Form of malingering? Refer to Anderson & Colleagues (1959) study of simulated dementia [2]
- Occurs most frequently in prison inmates, may be attempt to gain leniency from prison or court officials [3]

DSM-5, p 292 [1]; Rogers, R. 2008, p. 54 [2]; Cocores, Schlesinger, Gold, 1986 [3];

Simulated Dementia

- Anderson & Colleagues (1959) study comparing simulators vs. organic/pseudo dementia
- Simulators believed they should not give right answers- thus gave approximate answers (link to Ganser's syndrome)
- True demented pts answers more obviously wrong
- Perseveration was substantial with organic dementia and absent with simulators

Rogers, R. 2008, p. 54

Successful vs. Unsuccessful Malingerers

- Successful: Endorse fewer symptoms [2]
- Successful: Avoid overly bizarre or unusual symptoms [2]
- Unsuccessful: Faking psychotic symptoms in addition to intellectual sx (college grad not knowing colors of American flag) [1]
- Unsuccessful: Inadequate or incomplete knowledge of illness being faked [2]

Resnick & Knoll, 2005 [1] (Edens & Otto, 2001) [2];

What else to Use?
Psychometric Testing

- Validated and multiple independent sources for confirmation, psychometric tests [1]
- Many psychometric tests are available, few have been validated for this purpose [2]
- SIRS, MMPI-2, M-FAST considered the more reliable tests [2]
- Clinical screening: M-test, SIMS, ADI, M-FAST [3]
- Comprehensive: SIRS, MMPI-2, PAI[3]

Rogers, R. 2008, p. 7-8 [1]; Resnick & Knoll, 2005 2;
Duffy, S. 2001 [3];

Prevalence?

- The true prevalence of malingering is not known
- Only those who get caught are included in statistics, the malingerers that get away with it are not reported
- Cornell and Hawk (1989) found up to 8% of pretrial defendants tried to fake psychosis
- Survey of clinicians reported suspected malingering in 29% personal injury and 30% disability cases [1]

Rogers, R. (Resnick & Knoll) 2008, p. 51-52; Rogers, R. (Resnick, P. J., 1997) 2008, p. 112; Mittenberg, Patton, Canyock, & Condit, 2002 [1];

Prevalence?

- Other factors contributing to issue with knowing prevalence rates include large entities such as SSA and VA not systematically testing for malingering
- The SSA programs operation manual as of 7/23/2013 states “Do not purchase symptom validity tests (SVT) to address issues of credibility or malingering as part of a CE.”

Documentation

- Almost always need to consider data outside of clinical interview [1]
- List evidence objectively suggesting malingering, do not reach definitive conclusion unless evidence is overwhelming

Resnick, P. 2006; Resnick & Knoll 2005 [1];

You Suspect Malingering What next?

- If you decide to confront, avoid accusations of lying [1]

Resnick & Knoll, 2005; Thompson, LeBourgeois, & Black,

You Suspect Malingering What next?

- Give patient every opportunity to save face
- Asking to "clarify inconsistencies" may be more productive and safer for examiner
- If patient has history of violence or aggression have security personnel present

Resnick & Knoll, 2005

Costs to Society

- Evidence of malingering exist in 76% adult claims and 67% child claims for Social Security Disability Income in 2004 in one state [1]
- In 2011 SSDI program paid out $132.3 billion [2]

Duffy, S. 2011; Chafetz & Abrahams, 2005; Portman, R. 2013 2;

Ethical Concerns

- A survey of neuropsychologists indicated 54.2% rarely or never used the term due to ethical dilemma [1]
- More than 80% referred to invalid test results, inconsistencies, or indications of exaggeration [1]
- Providing unnecessary treatment to a strongly suspected malingerer may be harmful with possible permanent effects (psychotropics) [2]

Brink, K. 2007 (Slick, Tan, Strauss, & Hultsch, 2004) [1];
Seward & Connor, 2008 [2]

Considerations

Labeling someone a malingerer could have significant consequences to that persons future including:

- Stigmatization
- Denial future insurance claims
- Biased future treatment even for legitimate needs
- Adverse consequences in the criminal justice system

Duffy, S. 2011; LoPiccolo, Goodkin, & Baldewicz, 1999 [1]; Seward & Connor, 2008 [2];


ANY
QUESTIONS
?

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