

"... AND NOTHING BUT THE TRUTH," A LOOK AT MALINGERING

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Malingering Defined: DSM-IV¹ defines malingering as the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty ... avoiding work, obtaining financial compensation or obtaining drugs." When a person makes personal injury claims for an external compensation, what he or she seeks is money. So, questions about whether a person is "telling the truth" or whether the person is consciously and deliberately "lying" to get financial benefit become highly relevant.

Citing Carroll et al.,² Putnam, Scott and Adams³ report that "35% to 42% of medical costs in 1993 claimed by individuals in auto accidents were related to staged or non-existent accidents or the inflation of claims for actual injuries." False claims for personal injuries are monies stolen from insurance carriers and from people, like us, who pay insurance premiums. Also, claims judged to be false when they are not cost the injured party dearly.

Salient Modifications Regarding Malingering: DSM-IV's definition stresses that malingering means straightforward, conscious, deliberate lying, or marked symptom exaggerations for external gain. DSM-IV⁴ defines *fictitious disorder* as

1. "Intentional production or feigning of physical signs or symptoms."
2. "The motivation for the behavior is to assume the sick role."
3. "External incentives, such as economic gain, avoiding legal responsibility ... (as in malingering) are absent."

Persons experiencing factitious disorders have strong incentives to understand themselves as harmed by sickness and are powerfully invested in seeking treatment even when that treatment may be harmful to them. Such persons will probably be highly resistant to psychological explanations of their troubles. Understanding how aware they are of the signs and symptoms they create is not easy. Nor is assessing their motivations for creating the stories they tell through complaints and behaviors directed at health service providers.

DSM-IV⁵ reports that somatoform disorders differ from malingering and factitious disorders because the person does not consciously and deliberately create the symptoms and signs that they present to health service providers. DSM-IV diagnostic criteria makers also suggest that persons experiencing somatoform disorders are showing long standing adjustive patterns to stress. One aspect of somatization disorder is "a history of many physical complaints beginning before age 30 years that occurs over a period of several years."⁶ DSM-IV criteria makers also review a longstanding hypothesis regarding somatoform disorders overall and conversion

symptoms in particular.⁷ Clinicians can believe that conversion symptoms can represent unconscious translation of anxiety about life issues into physical ailment-like symptoms. Sometimes people understand and accept these seemingly physical symptoms more easily than they might emotional issues that they could not clarify.

Malingering is not a well-defined factitious or somatoform disorder. Malingering is a conscious effort to get something to which we are not entitled by creating or exaggerating symptoms we know are not real, or not very real.

Malingering Prevalence: Reynolds,⁸ citing other authors in his book reports that malingering prevalence can range from one to fifty percent. According to Reynolds, Binder and Rohlings⁹ could show that 23% of head injury litigants are malingering. Reynolds reports that Youngjohn et al.¹⁰ report that 48% of claimants complaining of persistent postconcussive symptoms are malingering. Binder asserts that patients with mild head injuries are more likely to litigate than patients with moderate complaints. He asserts that mild head injury patients may find monetary incentives more compelling than do patients with moderate or severe injuries. Still, clients with moderate or severe injuries may present more obvious physical trauma that leads to quicker legal settlements.

We may find broad ranges of estimates of malingering prevalence for the following kinds of reasons:

1. People who are malingering do not tell us that this is what they are doing.
2. As clinicians we need to be careful about the kinds of criteria that we use to decide potential malingering. Spreen and Strauss¹¹ point to Tombaugh.¹² They write that "... diagnosis of malingering should not be made on the basis of the test score itself. The TOMM only addresses whether the results reflect the patient's optimal performance."

A psychiatrist, we think Allen Stone, worried that psychiatric hospitalization criteria stressing danger to self and others allowed mental patients to go free who could clearly benefit from treatment and defied voluntary hospitalization. The psychiatrist proposed a reasonable man test. According to this test, the recalcitrant involuntarily hospitalized patient could come to his senses and realize that the hospitalization, voluntary or not, was in his best interest.

Sometimes psychologists long for the cooperative patient. This patient knows that his full cooperation and his best effort will create a strong psychological evaluation with fewer uncertainties. The cooperative patient will know that by doing his consistent best he will diminish the number of confusions and dilemmas that the testifying health expert will face when reporting the claimant's situation. This patient will both appreciate and know the steps he must take to provide the best evaluation possible. Still, claimants may not always do these things. Also, they may not be malingering when they do not.

Bernad¹³ provides the following kinds of guidelines for considering malingering in forensically toned client evaluations.

The Client's History: We need to know the claimant's symptom presentation and whether they make sense in at least two ways. First, we want to know how congruent symptoms are with the facts. Sometimes, as in automobile accidents, we can turn to police reports and early health service provider reports. Maybe we will know from these documents whether the client experienced loss of consciousness and posttraumatic amnesia. Still, the client's recall and early medical documentation may not fully answer our questions concerning these matters.

Also, we need to know salient aspects of the client's history. Peck¹⁴ describes claimants who reported they lost strong cognitive or vocational competencies because of trauma. Still, past school and work reports did not support their accounts. Peck¹⁵ reports a list of documents to review, if available, concerning a client's history. With no intent to deceive, clients may report symptoms and show evaluation findings that seem to bear on the matter being litigated. Still, other processes may contribute. Reports from others, family members, co-workers, and work supervisors, can help to clarify the onset and development of troubles that claimants may report.

The Client's Evaluation Conduct: Reitan and Wolfson¹⁶ describe a case where test battery inconsistencies suggested that the claimant was not giving his best effort. The client told Reitan of a past avocation he

could no longer do and sorely missed. Reitan spoke to the defense attorney about the evaluation inconsistencies the claimant showed. Later videotapes showed the claimant happily and effectively engaging in his lost avocation.

During his internship one of the writers learned that three sexual responses on a patient's Rorschach pointed to schizophrenia. The writer waited long to see those three on one patient protocol. Pathognomonic signs are those that establish, as clearly as signs can, a particular condition. Still, they may not often come.

Suspect Intratest Discrepancies: Sometimes variable test scores within a specific battery can point to efforts to dissemble. Heaton et al.¹⁷ did a study with the WAIS-R, the Halstead Reitan Battery (HRB) and the MMPI, three major tests in psychological assessment regarding neuropsychological diagnosis. The researchers instructed "volunteer malingerers" to dissemble severe neuropsychological disabilities. Researchers also gave volunteers information about organic impairment. Furthermore, they offered an additional bonus if they faked successfully. Researchers showed these test results along with genuine neuropsychological test batteries to 10 neuropsychologists. The judges ranged from chance to proficiency levels 20% above chance in differentiating the two sets of batteries. Reitan countered asserting that judges could have improved their proficiency had they attended to "malingerers" performance on HRB "sub tests" assessing comprehensive tasks

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with tasks assessing more specific skills. Berry and Butcher¹⁸ also responded to Heaton's study. They reported that researchers did a discriminate functioning analysis of Heaton's results. Researchers using these guidelines could successfully differentiate all but two of the 32 MMPI protocols submitted to the 10 neuropsychologists for evaluation.

Because of the similarities of the processes they assess, "sub tests" of different comprehensive batteries — like the Wechsler Adult Intelligence Scales, the HRB and the Wechsler Memory Scales (WMS) — should "go together" with other tests in that battery. Hartlage¹⁹ reports a study conducted by Mittenberg et al.²⁰ The researchers matched 67 head injured patients with 67 simulators for full scale I.Q. and age. They found that the head injured patients presented congruent results on a sub test for crystallized knowledge with a test of working memory. Simulators produced grossly discrepant scores between the two tests. Mittenberg et al.²¹ used 39 brain-injured subjects, and 39 simulators to assess deceptive test taking on the WMS-R. They found that simulators did significantly worse with one measure of memory compared with another. The two measures of memory were similar enough that they should have covaried. Mittenberg found this difference incongruous.

These studies show both strengths and weaknesses. Heaton and Mittenberg used simulators, often college students, to simulate brain damage.

Reitan²² writes "normal subjects pretending to be brain damaged show none of the stresses, anxieties, guilt, depression, and desperation experienced by many litigants whose future financial stability may depend on the outcome of the neuropsychological evaluation." We might add whether the claimants are faking or not.

Test-Retest Comparisons:

Reitan asserts that most personal injury litigants will experience more than one neuropsychological evaluation. As he has done with other neuropsychological assessment questions, Reitan proposes using the claimant as his own control. Litigants are likely to receive the same tests, e.g., the WAIS-R, WAIS-III, HRB, more than once.

Employing the sub test scores of the Wechsler batteries and HRB sub tests, he created a Retest Consistency Index. He compared the client's score with each sub test during the first administration with the second. He created a second measure, a Response Consistency Index. If a person answered a sub test item correctly on the first administration then, absent clear new pathology, she or he could probably do as well or better the second time.

Using these indices Reitan compared 20 claimants undergoing litigation with 20 head injured patients not undergoing litigation. He reported that he could not match people in the two groups for severity of damage. On both his indices he found that claimants did more poorly during the second evaluation than they had during the first. He identified cutoff scores that differentiated between claimants and non-claimants.

Reitan²³ describes examiner influences that he felt may have influenced his results. He asserts that psychological examiners retained by the defense, who are often the second evaluators, would be predisposed to see less pathology.

People are anxious about taking neuropsychological tests. They are anxious the first time. They may be more anxious the second time when evaluated by an expert for the defense. People take these examinations while being evaluated by other experts. It is probably clear to the claimant that, through all these evaluations, somebody is bringing their credibility into question. Not feeling uncertain when confronting an unfolding series of evaluations is hard for the client.

Specific Tests for Dissembling and Test Taking Motivation: Spreen and Strauss²⁴ present a series of tests for "Malingering and Symptom Validity Testing" which go from basic to moderately complex. We will follow their path from "floor tests" that should capture naive attempts to dissemble through more complex assessment tasks.

Rey²⁵ created a very simple test of symbol recall and reproduction. Clinicians hoped that it would be a good floor test that was easy to pass. Spreen and Strauss²⁶ dash this hope. They cite Bernard²⁷ who shows the test did not distinguish between controls and dissemblers. The latter group passed the test. Spreen and Strauss also cite Schrectlen et al.,²⁸ who gave the test to 148 patients with neurologically toned disorders, 76 patients instructed to fake amnesia, and 80 normal controls. Twenty seven percent of the patients scored in the

malingering range, and 15% of the subjects instructed to fake brain damage scored in the malingering range.

Spreeen and Strauss also described the 21 item test by Iverson.²⁹ The test "looks like" other tests that a person might encounter in a neuropsychological evaluation. Test developers created at least three measures of less than optimal performance. Iverson et al.³⁰ gave their test to a group of community volunteers and a group of psychiatric patients. They told half of each group to simulate organic intellectual impairment. They achieved 90% accuracy in differentiating between the two groups. So, this test shows promise as a baseline estimate of less than optimal test-taking performance.

Symptom Validity Tests: In a coin toss, the coin will come up either heads or tails and the odds are 50/50. Over time the coin toss can go either way. Statisticians, however, can calculate 90% confidence intervals to show that our hypothetical coin is sticking to "heads or tails" rules of chance. Tests of symptom validity rest on this simple premise.

In these tests the psychologist reads a stimulus prompt to the client. After different time periods, the psychologist shows the prompt to the test taker. Test developers match the prompt with information that is like the prompt, yet saliently different.

If the claimant consistently recognizes the psychologist-given prompt, then the person is doing right and trying hard. If the claimant consistently does not call the prompt, then the

claimant may well know the correct prompt, and give us the incorrect information to show their terrible memory. If the claimant follows the rules of chance then two things may be happening. The claimant may have severe troubles with concentration and memory, or the claimant may be "stiffing" us.

The Victoria Symptom Validity Test (VSVT)³¹ rests on these premises. Evaluators give stimuli to test takers. Intervals of immediate presentation, ten seconds, and then fifteen seconds are employed. Spreeen and Strauss³² report that Slick³³ gave the VSCL to these groups:

1. Normal Adults (N=42)
2. Normal Adults asked to feign brain damage (N=42)
3. Compensation Seeking Patients (N=121)
4. Patients not seeking compensation (N=26)

They divided VSVT test scores into three categories: (1) significantly above chance; (2) questionable; (3) significantly below chance. The researchers found:

1. All controls and non compensation seeking patients performed above chance.
2. 83% of the Compensation seeking patients got scores above chance.
3. 83% of the simulators fell in the questionable or below chance category.

Spreeen and Strauss³⁴ and these test developers still caution: "Even in causes where financial and other incentives exist, and the patient's performance is suspect, the patient

may be legitimately impaired and/or acting without conscious intent. For example patients with impaired judgment, (perhaps reflecting executive dysfunction) may exhibit chance level performance."

Several Symptom Validity Tests contain instructions that these are memory tests and become more difficult as the time between stimulus presentation and recognition are increased. By suggesting increasing difficulty, test developers can hope to foster greater prospects for deception. Prigatano and Amin,³⁵ as reported in Adams and Rankin,³⁶ provide examination instructions that stress the time between presentation and recognition rather than difficulty.

Conclusion: Malingering, as defined by the APA diagnostic criteria, means deliberate falsification of the truth. We may not easily know it when we encounter it. Like it or not, malingering is like any other diagnostic question we encounter. We deal with other diagnostic issues by looking to evidence in patient history, patient behavior, and patient evaluation performance to see where they point, and whether they converge. Spreeen and Strauss³⁷ present an excellent table of potential inconsistencies in patient history, patient behavior, and patient responses to evaluation tasks. As with many other diagnostic questions, we can use these leads and their consistencies to point us to answers about the patient's evaluation performance. They give us two other important guiding prompts. First, we may do better identifying inconsistencies than to affirmatively declare the claimant's intent

in producing them. Second, we may sometimes learn the client's reasons for these performances and may respond with help.

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