Malingering

Utility and Measurement

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Schedule

- Introduction
- Types of malingering
  - Cognitive, Psychopathology, & Medical
- Measures of malingering
  - Direct & Indirect
- Clinical interview & collateral information
- Diagnoses & documentation
- Ethical & legal issues
- Q&A

What is Malingering?

- Lying about an illness?
- Exaggerating symptoms?
- Lying about being well?
- Omission or commission?
- Is it different than deception?

Introduction

- Malum - Latin for 'bad'
  - Not to be confused with mālum - Latin for 'apple'
    - Explains the etymology for the phrase 'bad seed' and an apple being used to tempt Eve in the Biblical story
- Malingering has been documented throughout history (Tracy & Rix, 2017)
  - To avoid fighting in the Trojan War, Odysseus planted salt instead of seed to convince Agamemnon he was mad (Lund, 1941)
  - Galen, a Roman physician, described a patient who malingered colic to avoid going to a meeting (Lund, 1941)
  - Railway accidents which resulted in 'post-traumatic neurosis' (a precursor to PTSD) were recorded to have cases which were malingered (Erichsen, 1882)

Definition

- DSM-5
  - "**The essential feature of malingering is 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, evading criminal prosecution, or obtaining drugs. Under some circumstances, malingering may represent adaptive behavior – for example, feigning illness while a captive of the enemy during wartime" (APA, 2013, p. 726-727).

Where Malingering Occurs

(Adetunji et al., 2006)

- Occurs in civil, criminal, & other settings
  - **Civil**: A plaintiff who appears emotionally or physically injured by a defendant may be more likely to win and receive a larger settlement
    - E.g., workers compensation claims, social security disability insurance
  - **Non-Forensic Settings:** A patient who appears to be in pain may be more likely to obtain medication and an individual who meets criteria for a learning disorder may receive more services

Where Malingering Occurs

(Adetunji et al., 2006)

- Occurs in civil and criminal settings
  - **Criminal**: A defendant who meets the criteria for insanity or incompetency may face a less harsh sentence or be entitled to a different type of incarceration (hospital vs. prison)
    - E.g., NGRI or Death Penalty (malingering of psychotic symptoms more common), Incompetency (malingering of cognitive deficits more common)

Why People Malinger

(Adetunji et al., 2006; Resnick & Knoll, 2005)

- **Avoidance**
  - Pain
  - Arrest
  - Criminal prosecution
  - Conscription into the military
  - Work complaints or conflicts
- **Obtaining or Pleasure**
  - Financial
  - Controlled substances
  - Free room and board
  - Workers' compensation or disability benefits
  - Insurance Fraud
  - Early retirement
  - Policy requirements

Prevalence

- Malingering may be more common in certain settings (Sadock & Sadock, 2003)
  - **Prisons & courts - 32 to 65%** (Pollock, Quigley, Worley, & Bashford, 1997; Yates, Nordquist, & Schultz-Ross, 1996)
  - Outpatient Therapy - 42% (Van Egmond, & Kummeling, 2002)
  - Emergency Rooms - 13% (Yates, Nordquist, & Schultz, 1996)
  - Psychiatric Settings - 10-12% (Rissmiller, Steer, Friedman, & DeMercurio, 1998)
  - Military - 10% (Townsend, 2016)

Prevalence cont.

- Malingering Assessments (Rogers, 2008)
  - 15-17% Forensic referrals
  - 7% Non-forensic referrals
- Malingering within specific litigation (Mittenberg, Patton, Canyock, & Condit, 2002)
  - 39% - individuals with mild closed head injuries
  - 30% - disability claimants
  - 29% - personal injury claimants
  - 19% - criminal defendants

When to be on high alert

(Adetunji et al., 2006)

- **Legal** or medical setting
- Discernible discrepancy between patient's claimed symptoms and the objective findings
- Lack of cooperation during evaluation or with treatment compliance
- Diagnosis of Antisocial Personality Disorder

Terminology

(Rogers, 2008)

- **Deception**
  - Any attempt to distort or misrepresent facts
- **Dissimulation**
  - Deliberate distortions or misrepresentations of psychological symptoms
- **Feigning**
  - Exaggeration or fabrication of symptoms (psychological or physical)

Terminology cont.

(Rogers, 2008)

- **Distortions**
  - Non-deliberate distortions
    - Omission - unintentionally leaving information out
    - Confabulation - gaps in memory are filled in by the patient's beliefs
  - Deliberate distortions: intentional attempt to misrepresent reality
    - Secrecy - deliberately withholding information
    - Lying - fabrication or denial of a story

Terminology cont.

(Rogers, 2008)

- **Defensiveness**
  - Minimizing maladjustment by masking psychological, cognitive or medical difficulties
- **Impression management**
  - Deliberate efforts to control others' perception of individual
- **Social desirability**
  - Denying negative characteristics and adopting positive role intended to create a favorable image

Terminology cont.

(Rogers, 2008)

- **Factitious Presentations**
  - Intentionally feigning or assuming the "sick role"
- **Factitious Disorder**
  - Incentive to take on the sick role
  - Malingering is differentiated by external incentives

Common Myths

(Rogers, 2008)

- *False:* Malingering is a static response style
  - ***Malingering is related to specific objectives in particular context***
    - E.g., avoiding military duty, obtaining financial compensation, evading criminal prosecution, or obtaining drug
- False: Malingering and genuine disorders are mutually exclusive
  - ***Once malingering is detected do not dismiss all symptoms***

Common Myths

(Rogers, 2008)

- False: Any observable sign of feigning represents a pattern of malingering
  - ***Feigning is not necessarily malingering***
- False: Only those with Antisocial Personality Disorder (ASPD) malinger
  - ***ASPD and malingering are NOT mutually exclusive***

Common Myths cont.

(Rogers, 2008)

- False: Deception is evidence of malingering
  - ***Defensiveness and positive impression management are forms of deception and are not necessarily evidence of malingering***
- False: Malingering should be diagnosed if deception and dissimulation are present
  - ***Deception and dissimulation are associated with various disorders***
    - Conduct d/o, oppositional defiant d/o, personality d/o's, psychopathy, substance use d/o, eating d/o, and factitious d/o

Types of Malingering

(Resnick,& Knoll, 2005)

- Attributing symptoms to an etiologically unrelated cause (False Imputation)
  - E.g., attributing problems with concentration to a learning disorder rather than daily substance use
- Describing past symptoms no longer present or exaggerating current symptoms (Partial Malingering)
  - E.g., describing past symptoms of pain as current in an effort to obtain medication
- Fabrication and gross exaggeration of a mental disorder for external purposes (Full Malingering)

Domains of Malingering

(Rogers, 2008)

- Three broad domains
  - **Neurocognitive Abilities**
  - **Mental Health Disorders**
  - **Medical Complaints**

Neurocognitive Malingering

- Feigned issues with neurocognitive abilities
  - Concentration & Attention
  - Memory
  - Executive Functioning & Judgment

Detecting Malingered Neurocognitive Impairment cont. (Larrabee, 2012)

- Malingering can occur in one of three patterns:
  - False or exaggerated reporting of symptoms
  - Intentionally poor performance on tests
  - A combination of symptom of exaggeration and intentional performance deficit

Detecting Malingered Neurocognitive Impairment (Rogers, 2008)

- Detection strategies for feigned cognitive impairment form two general categories
  - **Unlikely Presentations**
    - Presence of unusual or atypical characteristics not generally observed in normative samples
  - **Excessive Impairments**
    - Evaluation of frequency and intensity of characteristics generally observed in normative samples

Unlikely Presentation

(Rogers, 2008; Larrabee, 2012; Widows & Smith, 2005)

- **Symptoms Exaggeration**
  - Structured Inventory of Malingering Symptoms (SIMS)
    - Low Intelligence Domain
    - Neurological Impairment Domain
    - Amnestic Disorders Domain
- **Magnitude of error**
  - Choosing incorrect errors unlikely among genuine patients
    - WMS-R Visual Reproduction and Logical Memory subtests
    - Test of Cognitive Abilities (TOCA) Magnitude of Error scale
- **Performance Curve**
  - Genuine patients produce more errors with increased item difficulty
    - Rate of Decay Raven Standard Progressive Matrices
    - TOCA Performance Curve (PC) scale

Unlikely Presentation

(Rogers, 2008; Larrabee, 2012; Widows & Smith, 2005)

- **Violation of learning principles**
  - WMT Immediate Recognition vs. Delayed Recognition
  - WMT Delayed Recall vs. Delayed Recognition
  - WTM Paired Associations vs. Immediate Recognition
  - RAVLT (Rey Auditory Verbal learning Test)

Excessive Impairment

- **Floor Effect**
  - Simple cognitive tasks can be completed by most impaired persons
    - Rey-15
    - Dot-Counting Test
    - TOMM
    - WMT
    - Letter Memory Test
    - RBANS EI (Effort Index) and ES (Effort Scale)

Excessive Impairment

- **Symptom Validity Testing**
  - Using force choice to test failure rate, most impaired individuals succeed approx. 50%
    - Portland Digit Recognition Test (PDRT)
    - Computerized Assessment of Response Bias (CARB)
    - Victoria Symptom Validity Test (VSVT)

Excessive Impairment

- **Forced Choice Testing**
  - Malingerers evidence greater deficits than genuine patients
    - PDTR
    - 21-Item Test
    - WMT
    - TOMM

Excessive Impairment

- **Remember inconsistencies and poor test performance can also be related to secondary factors outside an individuals conscious intent or control:**
  - E.g., depression, lack of sleep, visual and auditory impairment, anxiety, medical problems, prescriptions, conversion disorder, factitious and somatization disorders, etc.

Determing Neurocognitive Malingering Using Standard Test Measures (Larrabee, 2012)

- Inconsistencies between:
  - **Neurocognitive domains**
  - E.g., a patient with impaired attention should not have above average memory; a patient with WAIS Digit Span at level characteristic of dementia should have above average Vocabulary, etc.
  - **Test performance and suspected etiology of dysfunction**
    - E.g., significant memory impairment with mild TBI

Determing Neurocognitive Malingering Using Standard Test Measures (Larrabee, 2012)

- Inconsistencies between:
  - **Test performance and medical documents**
    - E.g., performance consistent with prolonged LOC in patient with mild TBI with no LOC
  - **Test performance and behavioral presentation**
    - E.g., failure on measures of recent and remote memory contracted with ability to report accurate clinical history or current medication

Malingering of Psychopathology

- Feigned issues with mental health issues
  - Psychosis
  - PTSD
  - ADHD
  - Depression
  - Etc.

Strategies for Detecting Malingered Mental D/O's (Rogers, 2008)

- Detection strategies for feigned mental illness form two general categories
  - **Unlikely Presentations**
    - Presence of unusual or atypical characteristics not generally observed in normative samples
  - **Amplified Presentations**
    - Evaluation of frequency and intensity of characteristics generally observed in normative samples

Unlikely Presentation

(Rogers, 2008)

- **Symptom Exaggeration**
  - SIMS (Widows & Smith, 2005)
    - Psychosis
    - Affective Disorders
- **Rare Symptom Endorsement**
  - symptoms (<0.5%)
    - SIRS-2 RS (rare symptoms) scale
    - MMPI-2 Fp (F-psychiatric) scale (best single scale)
      - Elevated F and Fb scores could signify malingering, random responding, or serious mental disturbances
    - PAI NIM (neg, impression management) scale
    - M-FAST UH (unusual hallucinations) scale

Unlikely Presentation

(Rogers, 2008)

- **Quasi-rare symptoms**
  - Infrequent, but could be genuine
    - MMPI-2 F scale and Fb scale
- **Improbable Symptoms**
  - Extreme variant of rare symptoms
    - SIRS-2 IA (improbably and absurd symptoms) scale
    - MCMI-III Validity Index

Unlikely Presentation

(Rogers, 2008)

- **Unlikely Symptom Combinations**
  - Common symptoms which rarely occur together
    - SIRS-2 SC (symptom combination) scale
    - M-FAST RC (rare combinations) scale
- **Spurious patterns of psychopathology**
  - Extensive elaboration of symptoms combinations
    - PAI MAL (Malingering Index) and Rogers Discriminant Function (RDF) Unlikely Symptom Combinations

Amplified Presentation

(Rogers, 2008)

- **Indiscriminant symptom endorsement**
  - Endorse large number of symptoms
    - SIRS-2 SEL (Symptoms Selectivity) scale
    - SADS SEL scale
- **Symptom severity**
  - Endorse wide range of symptoms as extreme and unbearable
    - SIRS-2 SEV (Symptom Severity) scale
    - MMPI-2 LW (Lachar-Wrobel Critical Items) scale
    - M-FAST EX (Extreme Symptomatology) scale

Amplified Presentation

(Rogers, 2008)

- **Obvious symptoms**
  - Endorse common or prominent symptoms vs. subtle symptoms
    - SIRS-2 BL (Blatant Symptoms) scale
    - MMPI-2 O-S (Obvious-Subtle Difference) scale
- **Reported vs. observed symptoms**
  - Discrepancies between the two
    - SIRS-2 RO (Reported vs. Observed) scale
    - M-FAST RO scale

Amplified Presentation

(Rogers, 2008)

- **Erroneous stereotypes**
  - Endorse characteristics commonly associated with mental disorders
    - MMPI-2 Ds (Dissimulation) scale
    - PSI EPS (Erroneous Psychiatric Stereotype) scale

Psychotic disorders

- Key Features
  - **Hallucinations**
    - Auditory
    - Visual
    - Gustatory
    - Olfactory
    - Tactile
  - **Delusions**
    - Erotomanic
    - Grandiose
    - Jealous
    - Persecutory
    - Somatic
    - Mixed

Psychosis (Rogers, 2008)

- Hallucinations: the creation of new non-existent stimuli
- Illusions: the misinterpretation of actual stimuli
  - E.g., your face melting in mirror
- Hallucinations ≠ always psychosis (Lindal et al., 2014)
  - 10-15% of the general population have hallucinations (APA, 2013)
  - 14-18% have visual hallucinations
  - Most people see a vision of deceased relative or a stranger
  - 4x more likely in women

Genuine Psychosis

(Resnick & Knoll, 2005)

- *Genuine Hallucinations*
  - Hallucinations are often associated with delusions (88%)
  - Intermittent NOT continuous
  - Hallucinations can be interrupted by activity
  - Patients can be aware their hallucinations are not real
  - Look for subtle symptoms of psychosis:
    - Derailment, word salad, neologisms, loose associations - more difficult to fake

Auditory Hallucinations (Larøi, 2012)

- Most common type of Hallucination
- Hearing your name is the most common AH
- Childhood onset (tween years vs. adulthood)
- Attributable to sprits or angels
- Tend to be clear vs. vague (7%)
- Typically heard outside of head (88%) NOT inside
  - ***R/O patient is not mistaking their internal thoughts for AH – more common in low-functioning populations***

Auditory Hallucinations (Larøi, 2012)

- Voices are often intermittent
- Commands are *not* always obeyed
  - Usually commands to hurt/kill themselves
- Voices may ask questions (33%; Leudar et al., 1997)
  - Asks about behaviors not facts
    - E.g., Why are you smoking
- Insults from voices are usually gender based (Nayani & David, 1996)
  - Women = promiscuous
  - Men = homosexuality

Auditory Hallucinations (Larøi, 2012)

- Voices may talk to each other
- Voices may be benevolent (angels, God)
  - Patient may want to hear these
- Voices may be malevolent (demon, ghost)
  - Patient will seek to avoid hearing these
- Voices may talk with each other or provide commentary

Auditory Hallucinations (Farhall et al., 2007)

- **Strategies used to reduce AH**
  - Talking to others
  - Extra Medication(s)
  - Humming
  - Listening to Music
  - Telling the voices to stop or go away
  - Sleeping
  - Prayer

Malingered Auditory Hallucinations (Spitzer, 1992)

- **Emphasize positive symptoms of the d/o**
  - Hallucinations
  - Delusions
- **Negative symptoms are infrequent or absent**
  - Blunted affect
  - Poverty of speech & thought
  - Apathy
  - Anhedonia
  - Catatonia
    - It is very difficult to keep up these presentations for prolonged periods, therefore observation over multiple hours may be helpful in determining the presence of malingering

Malingered Auditory Hallucinations (Pollock, 1998; Spitzer, 1992)

- **Describe AH as:**
  - More frightening
  - More abusive
  - More controlling
  - More distressing
  - Less predictable
- **Delusions start/stop**
  - True delusion are consistent and typically lessen over time
- **Obey all commands**
- **Constant AH**

Alcohol Induced Psychotic Disorders (Rogers & Bender, 2018)

- AIPD
  - Delusions and/or hallucinations due to Substance Intoxication or Withdrawal
    - Symptoms usually remit without treatment in a matter of days to weeks
    - Hallucinations are often frightening
    - AH most common

Visual Hallucinations (Rogers, 2008)

- **Less frequent than auditory AH**
- Initial response is typically fear
- More common in *Organic Brain Syndrome* (Mott, Small, & Anderson, 1965)
- VH are usually humanoid (Gaunlett & Kulper, 2003)
- Unformed hallucinations may be more suggestive of a *Neurologic Disease or Eye Pathology* (Goodwin, Alderson, & Rosenthal, 1971)

Visual Hallucinations (Rogers, 2008)

- **Normal sized people, in full color** (Goodwin et al., 1971)
  - Animals/objects less frequent (Gaunlett & Kulper, 2003)
- **VH come and go**
  - Not constant and usually go away in the dark or when eyes are closed
  - Except drug induced VH

Visual Hallucinations (Rogers, 2008)

- **Lilliputian VH – little people** (Benke, 2006; Cohen, Alfonso, & Haque, 1994)
  - Likely due to Alcohol or other substance intoxication
  - Atropine Effect
  - Peduncular (Charles Bonnet Syndrome – neurologic syndrome)
- **50% with Schizophrenia see a phenomenon** (Lindal et al., 1994)
  - Mist/Fog
  - Light
  - People

Malingered Visual Hallucinations

(Rogers, 2008)

- VH is the most common symptom reported by malingers
- They have no strategies to lessen hallucinations
- VH are unlikely
  - E.g., miniature pink dinosaur
  - E.g., in black and white

Gustatory Hallucinations (Rogers & Bender, 2018)

- **Other types of hallucinations are rarer than AH and VH**
- **Gustatory hallucinations**
  - Typically bad tastes
  - May be indicative of:
    - A seizure d/o (Hausser-Hauw, & Bancaud, 1987)
    - Effect of drug/medication (O'Connor & Mastaglia, 2014)
    - Intracranial Colloid Cyst (Fuller & Perry, 2010)

Olfactory Hallucinations (Rogers & Bender, 2018)

- **Phantosmia**
  - Typically malodorus
  - May be indicative of:
    - Cerebral ischemia (Beume, Klinger, Reinhard, & Niesen, 2015)
    - Epilepsy (Beume et al., 2015)
    - Parkinson's disease (Tousi & Frankel, 2004)

Tactile Hallucinations (Rogers & Bender, 2018)

- **Tactile hallucinations**
  - *Typically associated with substance use*
    - Methamphetamine
    - Cocaine
  - More rare, but occurs in Schizophrenia d/o
  - May be indicative of:
    - Parkinson's disease (Fénelon, Thobois, Bonnet, Broussolle, & Tison, 2002).
    - Delirium tremens (ETOH; Platz, Oberlaender, & Seidel, 1995)

Delusions (Rogers & Bender, 2018)

- Often associated with hallucinations
  - E.g., a depressed person will hear negative A*H*
- Complex delusions consistent with behavior and IQ of patient
  - Do NOT have abrupt onset or termination
  - Usually not bizarre content, and if it is behavior is usually disorganized
  - Patient is NOT eager to discuss delusions
- Paranoid delusions
  - Patients may barricade themselves in their room
  - Carry a weapon
  - Ask police for protection
  - Move residences

Malingered Psychosis (Jaffee, & Sharma, 1998)

- Will give evasive answers
- State "I don't know" frequently
- No preservations
- Absence of negative symmptoms
- May pretend to also have cognitive deficits

Detecting Malingered PTSD

(Resnick et al., 2008)

- A clinical model to identify malingered PTSD
  - Understandable motive to malinger PTSD
  - At least two of the following criteria:
    - Irregular employment or job satisfaction
    - Prior claims for injuries
    - Capacity for recreation, but not work
    - No nightmares or, if nightmares, exact repetition of the civilian trauma
    - Antisocial personality traits (not applicable to criminal-forensic cases)
    - Evasiveness or contradictions
    - Non cooperation in the evaluation
- PAI may be a useful measurement (Wooley & Rogers, 2015)

Detecting Malingered ADHD

(Cook et al., 2018)

- Use of the Conners' Adult ADHD Rating Scales (CAARS)
- Three groups:
  - Best effort (*N = 44)*
  - *Malingering ADHD for the purposes of* receiving stimulant medication (*N = 36)*
  - *Malingering ADHD for the* purposes of receiving extra time accommodations (*N = 43)*
- Results:
  - All malingers scored higher than controls on all CAARS subscales and the Infrequency Index (CII)
  - However, those malingering for extra time accommodations were more difficult to detect than those malingering for medication.

Detecting Malingered ADHD

(Jasinski et al., 2011)

- Review of symptom validity measures
  - Test of Memory Malingering (TOMM)
  - Letter Memory Test (LMT)
  - Digit Memory Test (DMT)
  - Nonverbal Medical Symptom Validity Test (NV-MSVT
  - b Test
- Results:
  - Comparison as a group with failure of 2+ of the measures resulted in a sensitivity of. 475 and a specificity of 1.00.

Detecting Malingered Depression

(Mogge & LePage, 2004)

- Assessment Depression Inventory (ADI)
  - ADI Dep scale is highly correlated with the BDI-II
  - ADI Fg (feigning scale) was able to discriminate between honest and dishonest respondents
  - Recommended >9 cut-off score for Fg (Clegg, Fremouw, & Mogge, 2009)
- MMPI-2 F and Fb scales (Bagby, Nicholson, Buis, & Bacchiochi, 2000)

Feigning Medical Issues

- Feigned medical issues
  - Pain
  - Disorders
  - Diseases
  - Etc.

Strategies for Detecting Malingered Medical Impairment (Rogers, 2008)

- Detection strategies for feigned cognitive impairment form two general categories
  - **Unlikely Presentations**
    - Presence of unusual or atypical characteristics not generally observed in normative samples
  - **Amplified Presentations**
    - Evaluation of frequency and intensity of characteristics generally observed in normative samples

Unlikely Presentations (Rogers, 2008)

- **Rare medical complaints**
  - MMPI-2 FBS (Fake Based Scale/Symptoms Validity Scale) and Fs (Infrequent Somatic) Complaints scale
  - Toronto Interview for Posttraumatic Symptoms (TIPS) RS (Rare Symptom) scale
  - LAQ Rare Items
- **Improbable medical complaints**
  - TIPS Implausibility (IMP) scale, LAQ Nonsense Items
- **Symptom combinations**
  - LAQ Unusual Pairings scale
  - TIPS Symptom Association (SA) scale

Amplified Presentations (Rogers, 2008)

- **Indiscriminant endorsement of health problems**
  - LAQ Physical Complaints
  - PSI HPO (Health Problem Overstatement) scale
- **Intensity of medical complaints**
  - MSPQ, BHI-2 Self-Disclosure Scale, NSI
- **Reported vs. observed symptoms**
  - Consistency score between Pain Rating Scale (PRS) and Pain Behavior Checklist (PBC)

How to Assess Malingering

- Testing
  - Direct measures
  - Indirect measures
- Interview
- Collateral Information

Malingering Assessments

(Rogers, 2008)

- **Direct**
  - **Psychotic and Mood Symptoms**
    - Structured Interview of Reported Symptoms – 2nd edition (SIRS2)
    - Miller Forensic Assessment of Symptoms Test (M-FAST)
  - **Cognitive Impairment**
    - Rey fifteen item test (Rey-15)
    - Test of Memory Malingering (TOMM)
    - Victoria Symptom Validity Test (VSVT)

Malingering Assessments cont.

(Rogers, 2008)

- **Indirect**
  - **Objective Personality Assessments**
    - Minnesota Multiphasic Personality Inventory – 2nd edition (MMPI -2)
    - Personality Assessment Inventory (PAI)
  - **Projective Tests**
    - Rorschach
  - **Must have multiple indicators of symptoms exaggeration or performance invalidity**

Reliability and Validity of Measures

- Reliability
  - I.e., consistency - can the same results be obtained if one person takes the same test several times
- Validity
  - Is it measuring what it is intended to measure
- Where to find information on this for specific measurements
  - Yearbook of Mental Measurements
  - Recent Academic Articles
    - Databases, online journals, etc.

Interviewing (Rogers, 2008)

- Review collateral information *before* the interview
- Use open-ended questions
- Do not list symptoms, make them explain
- Ask about improbable symptoms to see if they will be endorsed
- Listen for any inconsistencies
- Use quotes
- Keep your suspicions of malingering to yourself so as not to make the patient defensive or on guard
- Prolong the interview – malingering is hard to keep up for long
- Only confront patient with inconsistencies at the end of the interview in a non-judgmental manner – allow them to save face

Malingerers… (Rogers, 2008)

- Have inadequate knowledge of the mental d/o they are faking
- Believe the more bizarre their behavior, the more convincing they will be.
- May believe more is better
  - E.g., present as psychotic and intellectually impaired

Malingerers…cont. (Rogers, 2008)

- **Verbal**
  - Will give clear and articulate descriptions of symptoms
  - Gives vague answers
    - "I don't know"
  - Repeat/answer questions slowly
  - Recount events exactly (scripted)
  - Eager to discuss symptoms
  - Blames symptoms
  - Speak in a higher voice
  - Add a lot of extra unnecessary details in their responses
  - Use passive rather than active verb forms
  - May use phrases such as "To be honest" or "Honestly"

Malingerers…cont. (Rogers, 2008)

- **Non-Verbal**
  - Words don't match behavior (E.g., report problems with memory, but able to recall your name, medications, medication schedule, schedule, staff names, test instructions, etc.)
  - Over/Under acting
  - Attempt to control interview
  - Subtle symptoms are not presented
  - Blink more frequently

Collateral Information

- Official Records
- Unofficial Documents
- Relevant Individuals
  - Teachers
  - Families
  - Co-workers
  - Neighbors
  - Correctional Officers
  - Facility staff, nurses and medical providers

Remember

- **Malingering cannot be assessed using one tool**
- **Malingering is a diagnosis of exclusion**
- **Thoroughly consider all differential diagnoses before concluding a person is malingering**
- **Look for other explanations for poor performance on measures**
  - E.g., poor performance on the TOMM is often seen in persons with severe depression due to lack of motivation and attention

Remember

- **Inconsistencies and poor test performance can also be related to secondary factors outside an individuals conscious intent or control**
  - E.g., depression, lack of sleep, visual and auditory impairment, anxiety, medical problems, prescriptions, conversion disorder, factitious and somatization disorders, etc.

Diagnosis

- Terms for overstated pathology:
  - **Malingering**
    - Must meet DSM-5 criteria
  - **Factitious presentations**
    - Intention production of feigning of symptoms motivated by the desire to assume a sick role
  - **Feigning**
    - The deliberate fabrication or gross exaggeration of symptoms without any assumptions about goals
- Terms which lack well-defined and validated descriptions:
  - ***Suboptimal effort***
  - ***Over-reporting***
  - ***Secondary gain***

Diagnosis cont.

- Nonspecific terms for response styles which explain an individuals' response styles without any assumption about intent:
  - ***Unreliability***
    - questions the accuracy of reported information, useful in cases of conflicting clinical data
  - ***Nondisclosure***
    - withholding of information
  - ***Self-disclosure***
    - how much individuals reveal about themselves; high self-disclosure of lack there of
  - ***Deception***
    - attempt by individuals to distort or misrepresent
  - ***Dissimilation***
    - a general term to describe an individual who is deliberately distorting or misrepresenting psychological symptoms

Rey 15 & RAVLT Example

(Otto, DeMier, & Boccaccini, 2014, p. 240)

On the Rey-15-Item Test, Mr. Xx recalled only three items. Even people with severe cognitive and psychotic conditions consistently perform much better than this. The Rey Auditory Verbal Learning Test; RAVLT) requires an individual to learn a list of words. Mr. Xx recalled no works on the first trial and at the end of five trials, he recalled four words; even people with legitimate impairment generally recall more words. Additionally, it is noteworthy that Mr. Xx "recalled" numerous words that were not on the list, but were similar to words on the list. For example, he recalled "doom" instead of "drum" and "certain" instead of "curtain." It could be argued that such a response style requires an even higher level of sophistication, because the subject would have recall the accurate words and search his vocabulary for similar words.

VIP Example

(Otto, DeMier, & Boccaccini, 2014, p. 241)

The VIP is a measure of response style with verbal and nonverbal portions. Each test item has two response choices. Mr. Xx consistently missed the easier items on the test, but his performance actually improved as test items became more difficult. This indicated that he suppressed his abilities when he could discern the correct response, but as items became more difficult, he performed at a level equal to chance. In other words, when he knew the correct answer, he chose the wrong one, but when the items became too difficult, he performed near chance.

M-Fast Example

The Miller Forensic Assessment of Symptoms (M-FAST) is a measure shown to be a valid and effective tool for screening psychiatric malingering in criminal forensic and psychiatric inpatient settings. Mr. Xx's score suggests an exaggeration of psychopathology as his self-report is mildly inconsistent with his observed behavior. Elevations suggest he endorsed symptom combinations that are both unlikely and inconsistent with common mood and psychotic disorders. His endorsements are indicative of an atypical presentation of hallucinations and a tendency to endorse severe, unusual psychotic symptoms. Elevations further demonstrate he reported an unusual course of illness that is inconsistent with the course of most psychiatric disorders recognized in clinical practice.

SIRS-2 Example

The Structured Interview of Reported Symptoms (SIRS-2) is a comprehensive structured interview, designed to assess for feigned mental disorders, by discriminating between response styles associated with feigning and genuine responding. The SIRS-2 is based on empirically validated decision rules to identify inconsistent and other problematic response styles that have implications for clinical and forensic considerations. The SIRS-2 was administered in order to assess the validity of findings from the CAPS-5 and other assessments. The interview was provided in accordance with standardized administration and scoring procedures and the SIRS-2 was administered after the follow-up clinical interview and assessments, per guidelines.

SIRS-2 Example Cont.

Mr. Xx obtained no scale score elevations on the primary scales that would suggest probable or definite feigning. His protocol indicated that his responses were genuine and there was no evidence of defensiveness, feigned cognitive impairment, or inconsistent responding. Mr. Xx endorsed an expected level of reported symptoms, which is highly consistent with genuine responding.

Overall, Mr. Xx's profile evidenced a clear pattern of scores that is strongly characteristic of an individual with a genuine disorder who is making no efforts to overstate his symptoms. According to the SIRS-2, his results are classified as Genuine Responding, with a greater than 90% accuracy.

SIRS-2 Example: (Otto, DeMier, & Boccaccini, 2014, p. 241)

Mr. Xx was administered the SIRS-2, a measure designed to assess the response styles associated with feigning and genuine responding. According to the normative data on that instrument, one or more elevations in the "definite range" or three or more elevations in the "probable range" are considered indicative or malingering. Mr. Xx obtained scores in the "definite range" on two scales, and he obtained scores in the "probable range" on four additional scales. He reported symptoms which were qualitatively and quantitively for more extreme than symptoms reported by individuals with genuine mental illness.

Written Report Example

PSYCHIATRIC HISTORY:

According to Mr. Xx, he received inpatient treatment between 2000 and 2007 while in prison, indicating he "ended up in a safety cell" every time he was arrested on a violation because, "I would tell them I didn't feel right; tell them I felt like hurting myself." He then stated, "I hear voices." He reported he received mental health treatment at the Correctional Clinical Case Management System (CCCMS); this is the lowest level of mental health care in California Department of Corrections (CDCR). He listed his previous diagnoses, given while in prison, as attention-deficit hyperactivity disorder, paranoid schizophrenia, and fear of spiders.

He endorsed symptoms of depressed mood, sadness, and hopelessness in the past 30 days, stating, "I don't think they are gonna let me out; kind of hopeless about that." He endorsed feelings of anxiety in the past 30 days, stating, "because of messy inmates who throw water on me." He endorsed problems understanding and concentrating in the past 30 days, indicating he struggled with short-term memory and concentration. Furthermore, Mr. Xx endorsed symptoms of hallucinations in the past 30 days. When asked for further detail, he indicated his hallucinations began around the age of 12, when he believed someone was following him.

Written Report Example Cont.

Recently, his hallucinations have included seeing people move out of the corner of his eye, but when he looks at the person, they are not moving. He also reported hearing voices for the last year and a half explaining the voice used to repeat everything he was thinking. He stated "it repeats it" and "it lies a lot." The voice would tell Mr. Xx, "There's somebody over there," though no one was there. At one point in the interview, Mr. Xx explained he also hears a girl screaming.

Mr. Xx indicated experiencing serious thoughts of suicide in the past 30 days, reporting he was "suicidal because people were trying to get into my things and I wanted to move." He told jail staff he felt like he was going to hurt himself. As mentioned previously, Mr. Xx reported attempting suicide seven to eight times. He displayed his wrist pointing to areas where he stated he cut himself. When asked whether he needed medical attention after these attempts, he explained the prison medical unit bandaged his arms after these attempts and stitches were not necessary.

Written Report Example Cont.

Mr. Xx indicated experiencing serious thoughts of suicide in the past 30 days, reporting he was "suicidal because people were trying to get into my things and I wanted to move." He told jail staff he felt like he was going to hurt himself. As mentioned previously, Mr. Xx reported attempting suicide seven to eight times. He displayed his wrist pointing to areas where he stated he cut himself. When asked whether he needed medical attention after these attempts, he explained the prison medical unit bandaged his arms after these attempts and stitches were not necessary.

He explained one incident when he cut his wrists while a staff member was passing out medication. He stated he walked up to the cell door and showed the staff he cut his wrists. He explained he was hearing voices and wanted them to stop stating, "They were kind of telling me to do it." He reported he went to the hospital twice after cutting his wrists while not incarcerated, but could not remember any details about these events. He explained he was kept for two to three weeks last year, but could not remember the name of this hospital. When asked about the stay, he reported he was in counseling all day, participating in individual therapy, group therapy and activity groups.

Written Report Example Cont.

According to the Competency Evaluation report dated xx/xx/2015, Mr. Xx reported experiencing hallucinations continuously since the summer of 2013. He reportedly stated that gangs and child molesters were "trying to get me" and characterized himself as the anti-Christ. The evaluator noted that Mr. Xx alleged the devil "sometimes holds me down by demons." Mr. Xx told the evaluator demons control his heartbeat and sometimes convince him to do things which he does not want to do. He stated demons have "latched onto" him through magazines at least once. He reported seeing a demon which lacked a neck and had fangs like a vampire. The evaluator indicated that Mr. Xx stated he was able to see butterflies and the holes on dartboards, which are located in the mountains, from the valley floor.

He alternately stated he is sometimes and always able to hear others' unspoken thoughts. He told the evaluator that others can always hear his thoughts. Mr. Xx indicated others can insert thoughts in his head and remove them through his ears. He reportedly portrayed himself as capable of facilitating world peace, if afforded the opportunity. The evaluator explained that Mr. Xx reported auditory hallucinations, stating they were calling his name during the course of the evaluation. The evaluator noted that when Mr. Xx was asked whether drinking root beer floats decreases the frequency of his auditory hallucinations, Mr. Xx stated ice cream does. The evaluator noted Mr. Xx's thought processes were not reflective of incoherence, tangentiality, circumstantiality, disorganization, perseveration, loose associations, or other abnormalities. The evaluator found Mr. Xx to be competent to stand trial and listed diagnoses as: antisocial personality disorder, cannabis use disorder, amphetamine use disorder (possible), and malingering (possible).

Written Report Example Cont.

MENTAL STATUS EXAMINATION/BEHAVIORAL OBSERVATIONS:

Mr. Xx was interviewed at the XX County Jail, in XX, California. Mr. Xx is a 37-year-old, right-handed Hispanic/Native American male, who appeared his stated age. Wearing a jail-issued jumpsuit, Mr. Xx appeared adequately groomed with shoulder length curly brown hair, a beard and mustache. Per the police report dated 04/02/2015, Mr. Xx is five feet nine inches and 150 pounds. He presented as euthymic and his mood was consistent with affect. Mr. Xx was cooperative, maintaining good eye contact and his attention and concentration were good. Throughout the entirety of the evaluation, his stream of mental activity was normal and short and long-term memory appeared to be intact. Mr. Xx's association of thought was logical and goal-directed. He displayed an appropriate quantity of speech, with a normal velocity and an adequate use of vocabulary. He displayed poor insight as evidenced by his report of the arresting incident and his description of his symptomology. He displayed poor judgment as evidenced by his continued substance use despite his legal problems. Mr. Xx reported a history of auditory hallucinations, although he did not appear to be responding to internal or external stimuli during this evaluation. He endorsed suicidal ideation reporting "seven to eight" previous attempts; however, these reports appear to have been suicidal gestures, aimed at getting attention and medical treatment while incarcerated. He denied current suicidal and homicidal ideation.

Mr. Xx completed the methods of evaluation over one session. During this session he was oriented to time, person, place, and situation. His score on the Mini Mental Status Exam (MMSE), a formal mental status exam, indicated mild cognitive impairment. Specifically, he struggled with delayed recall and mathematical calculation.

Written Report Example

(Otto, DeMier, & Boccaccini, 2014, p. 237-238)

When asked about potential psychotic symptoms, Mr. Xx described symptoms that would be very unusual if they were genuine. He reported both auditory and visual hallucinations. Mr. Xx reported experiencing auditory hallucinations with which he can converse; some command hallucinations were also reported. He stated the voices emanated from inside his hea, he hears them continuously, and he has developed no mechanisms for coping with them. He reported visual hallucinations in the form of a "little girl" and "blue people" who sit and motion for him to follow them. He asserted that he experienced hallucinations when not under the influence of substances. He stated that his fingernails gave him special strength. Diagnostic following the interview was that Mr. Xx was malingering.

During the August 6 meeting, Mr. Xx recalled much of the information I had provided him on July 29. He asked numerous reasonable questions about his commitment, and hew as attentive to the responses. The following week, he became angry with me, but his anger appeared contrived. He suggested that I was completing a "fraudulent report." He also stated that "Mike" told him not to talk to me. He explained that "Mike" is "my voice that talks to me and tells me what to do and I have to do it."

On his living unit, he did not display behaviors consistent with the presence of a mental illness. Both treatment staff and security staff on that unit reported no behaviors suggestive of genuine illness. Rather, they described Mr. Xx as a "bully" who taunted mentally ill patients. On August 28, the defendant was asked co comply with a tuberculin skin test. He stated, "I'm not crazy like those other guys. I know I had a test in May." The records confirmed that he had indeed been tested in a county jail. His statement was noteworthy both for his denial of mental illness and for his keen awareness of time (which stood in contrast to his earlier contention that he could not estimate the date).

Written Report Example Cont.

(Otto, DeMier, & Boccaccini, 2014, p. 239-240)

Mental Status:

At the time of discharge, Mr. Xx remained alert and aware of his surroundings. He recognized he was in a secure hospital for evaluation. Over time, he became less and less cooperative whit the evaluation. He maintained that he was charged with driving without a license; he denied his actual charge when it was mentioned. Nevertheless, I believe he is well aware of his charges. He has maintained that he was confused about the purpose for his admission, but his complaint was not perceived to be genuine, because at various points he accurately recalled that I would be preparing a report for the court.

No deficits in attention or concentration were noted at the conclusion of the evaluation. As discussed above, he appeared to be malingering memory deficits, but observation of his functional abilities reflected no evidence of memory impairment. According to a psychiatric nurse, he read multiple books and discussed then intelligently.

Although Mr. Xx reported both auditory and visual hallucinations, his descriptions of those experiences were not credible. There were no behavioral indications he hallucinated during the present evaluation and there was no evidence of any impairment in his contact with reality. He spoke with a normal rate and tone. His speck was clear, coherent, logical, and goal-directed. He voiced suspicions of the legal system, but these beliefs seemed to reflect cynicism rather than any delusional process…

Diagnostic Example

Mr. Xx currently meets criteria for Stimulant Use Disorder, severe, as he endorses a maladaptive pattern of use over the last 20 years. He reported recurrent use resulting in a failure to fulfill major role obligations at work, continued use despite having persistent or recurrent interpersonal problems exacerbated by the substance, and continued use in the face of legal issues.

While Mr. Xx reported auditory and visual hallucinations, further testing as well as behavioral observation during testing indicates Mr. Xx is likely feigning symptoms of psychosis. His symptom report was inconsistent throughout the interview sessions, and his symptoms were atypical, over-exaggerated, and inconsistent with his presentation and history. Mr. Xx did not appear to be responding to internal or external stimuli during testing and was able to attend appropriately throughout the interview and assessment. He appeared to put in less effort as demonstrated by testing to assess for effort and motivation, and thus his cognitive and academic skill assessments are of questionable validity.

Additionally, a mood disorder diagnosis is not being provided, even though Mr. Xx reported periods of depression lasting several weeks with symptoms including loss of interest in pleasurable things, fatigue and loss of energy, feelings of worthlessness, diminished ability to think and concentrate as well as recurrent thoughts of death. Consistent with his over-exaggeration and over-reporting of symptoms for a psychotic disorder, Mr. Xx was unable to describe his specific symptoms, endorsing all symptoms. With regard to his self-described suicide attempts, these behaviors appear to be a form of manipulation to achieve attention and medication rather than genuine suicide attempts. Therefore, Mr. Xx meets criteria based on the psychological interview, testing data, and behavioral observations for Malingering.

Clinical Formulation Example

(Otto, DeMier, & Boccaccini, 2014, p. 241-242)

It is clear that Mr. Xx is malingering. Compelling evidence indicated that Mr. Xx is malingering symptoms of mental illness with the hope that this will have a positive impact on his legal case. Several factors support this conclusion. First, his clinical presentation was disingenuous. His descriptions of symptoms of mental illness were unsophisticated and reflected a lack of understanding of those illnesses. The descriptions of symptoms were not credible, and some were absurd. Second, there were clear differences between his speech and demeanor when speaking to me and his speech and demeanor when speaking to others. Third, psychological testing offered strong support that he is malingering.

Authors continued to summarize and explain disingenuous clinical presentation and different presentations in different situations.

Ethical Issues

- Rosenhan's (1973) study on simulated psychosis.
  - Eight volunteers
    - psychology student, three psychologists, pediatrician, psychiatrist, painter, and housewife
  - Gained admission to psychiatric hospitals by claiming that they were "hearing voices"
  - Voices stopped on admission
  - Pseudopatients were diagnosed as schizophrenic
  - Stayed hospitalized between 7 and 52 days

Ethical Issues Continued

- Stigma of labeling
  - Future interactions with
    - Law Enforcement / Courts
    - Medical Doctors
    - Psychologists
- Incorrect diagnosis
  - Outcome to client in current case
  - Broken trust in the field of psychology

Legal Issues

- Issues with the case at hand
  - Outcome
    - Incarceration
    - Money
    - Mental or physical health
- Malpractice (Weiss & Van, 2017)
  - Board complaints
  - Civil suits – defamation (liable and/or slander)
    - NOT covered under most insurances

Discussion & Case Examples

- Discussion
- Case Examples
- Q & A

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