

SYMPTOM EXAGGERATION

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DEFINITIONS

DSMV

Malingering

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.

Malingering

- **Malingering should be strongly suspected if any combination of the following is noted:**
 1. **Medicolegal context of presentation (e.g. the individual is referred by an attorney to the clinician for examination, or the individual self-refers while litigation or criminal charges are pending.)**
 2. **Marked discrepancy between the individual's claimed stress or disability and the objective findings and observations.**
 3. **Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regiment.**
 4. **The presence of antisocial personality disorder.**

Malingering

- Malingering differs from factitious disorder in that the motivation for the symptom production in malingering is an **external incentive**, whereas in factitious disorder external incentives are absent.
- Malingering is differentiated from conversion disorder and somatic symptom-related mental disorders by the **intentional production** of symptoms and by the **obvious external incentives** associated with it.
- Definite evidence of feigning (such as clear evidence that loss of function is present during the examination but not at home) would suggest a diagnosis for factitious disorder if the individual's apparent aim is to assume the sick role, or malingering if it is to obtain an incentive, such as money.

Performance Characteristics

Malingering-Lezak 2012

- **Symptoms and complaints that far exceed expectations of cause by an injury or illness**
- **Inconsistency in performance levels on testing**
- **Inconsistency between patient's report of disability and performance levels**
- **When a disability would be advantageous-secondary gain**

Malingering Criteria Checklist

Slick, Sherman & Iverson (1999)

- A. Presence of a substantial external incentive**
- B. Evidence from neuropsychological testing**
 - 1. Definite negative response bias (below chance on a forced choice measure of cognitive function)**
 - 2. Probable response bias on a validity test**
 - 3. Discrepancies between test data and known patterns of brain functioning**

Malingering Criteria Checklist Slick, Sherman & Iverson (1999)

- B. Evidence from neuropsychological testing**
 - 3. Discrepancy between test data and observed behavior**
 - 4. Discrepancy between test data and reliable collateral report**
 - 5. Discrepancy between test data and documented background history**

Malingering Criteria Checklist

Slick, Sherman & Iverson (1999)

C. Evidence from self-report

- 1. Self-reported history discrepancy with documented history**
- 2. Self-reported symptom discrepancy with known patterns of brain functioning**
- 3. Self reported symptom discrepancy with behavioral observations**

Malingering Criteria Checklist

Slick, Sherman & Iverson (1999)

C. Evidence from self-report (cont'd)

4. Self-reported symptom discrepancy with reports from close informants

5. Evidence of exaggerated or fabricated psychological dysfunction

D. Behaviors meeting criteria from groups B or C not full accounted for by psychiatric, neurologic, or developmental factors

Examples.....

- **Symptoms and complaints that far exceed expectations of cause by an injury or illness**
 - **Person with a concussion event without LOC, abnormal CT/MRI findings**
 - **Complaints of severe memory loss for new events**
 - **Claim loss of memory for all past events**
 - **Can't recall personal information like age, DOB**

Examples.....

- **Inconsistency in performance levels on testing**
 - **Very low test performance on a simple test but adequate performance on more complex task in the same type of task or cognitive domain**
 - **Poor performance on memory but good performance on attention**
 - **Wide variance in test performance across and within domains**

Examples.....

- **Inconsistency between patient's report of disability and performance levels**
 - **Evidences severe impairment on test profile but able to drive, manage finances, care for home and children without help or reported major problems.**
 - **Reports that they are very slow, dizzy and forgetful but disagree that they should stop driving saying it does not effect their driving ability.**

Secondary Gain

- **Financial benefits of disability of illness or injury related to job, military service or accident**
- **Indirect emotional and social rewards or illness, injury or disability**

Types of Malingering?

- In Lezak, note that in 1962 Lipman conjectured types as
 - Invention- complete feigning of symptoms where none exist
 - Perseveration- symptoms were initially present but have resolved
 - Exaggeration- magnification of genuine symptoms
 - Transference- genuine symptoms not due to the particular injury in question

Types of Malingering?

- Larrabee (2005) 3 patterns
- False or exaggerated reporting of symptoms
- Intentionally poor performance on NP tests
- A combination of symptom exaggeration and intentional performance deficit.
- Note: a person can intentionally give poor performance on several or one test

Differential diagnosis of Malingering

Heilbronner et al (2009)

- **A clinical process that:**
 - Requires careful analysis on the part of the examiner
 - Is based on objective criteria
 - Incorporates indicators that have established classification accuracy
 - Combines clinical judgment with the results of scientifically validated measures in this process (p. 1, 099)
 - In Lezak (2012) pg 833

Assessment Considerations

- **Validity measures are similar to other tests yet readily answered by individuals with all but severe cognitive deficits**
- **Look to injury characteristics as to severity of injury. Neuropsychological test findings often reveal a pattern reflective of severity of injury.**
 - **Severe impairment on NP tests is not unexpected after a major TBI with extended LOC, evidence of significant internal injury in the brain (major bleed, multiple bleeds, extensive swelling, e.g.)**
 - **NP evaluation 3 months after a concussion does not evidence severe impairment**

Symptom Validity Measures

- **Embedded tests that are sensitive to bias**
 - **Forced choice on a list learning task**
 - **Fine Motor Speed typically does not reveal significant impairment in milder injury (apart from a significant hand injury/problem)**
 - **Reliable Digit Span**
 - **Validity indices in MMPI and PAI**

Response Validity on Established Tests

- **Inconsistent performance, bizarre and unusual responses**
- **Performance below usual range for persons who have the reported symptoms on a known neurological basis**
 - E.g., mTBI patient with lower memory scores than someone with documented significant brain injury
- **Absence of practice effect on repeat testing where it would be expected**
- **Unaccountable highs and lows**
- **Wide variation in intratest response patterns**



Symptom Validity Measures Frequently Used

- **Test of Memory Malingering**
- **Word Memory Test**
- **Green's Nonverbal Medical Symptom Validity Test**
- **Validity Indicator Profile**
- **21 Item Test, Rey 15 Item Test**
- **Victoria Symptom Validity Test**
- **Supported by research comparing performance of individuals of different ages, types of injury/disease and often, a group of those who were asked to give poor effort.**

Valid Test Performance

Lezak 2012

- 1. Evidence of consistency in the history or examination**
- 2. Likelihood that the set of symptoms and neuropsychological test profile –including validity measures- makes sense**
- 3. Understanding the patients present situation, personal/social history and emotional predispositions**
- 4. Emotional reactions to their symptoms and complaints**

**Do not use ONE measure as a
malingering screen given that no
one measure provides 100%
sensitivity
Lezak (2012)**

Incidence

Lezak 2012

- **Locke et al (2008)-22% of treatment seeking patients with TBI and not in litigation performed below cut off on TOMM (pg 832)**

False Positives

From Heilbronner (2008)

- **Palmer et al (1998) 132 health adults**
 - **73% had 1 or more scores at or below the 10th %ile**
 - **37% had 1 or more scores at or below 2 standard deviations below the mean**
- **If set criterion of deficit at 1 Standard Deviation below the mean, we accept a priori that 16% of healthy adults will score in this impaired range on any give test, without actually having an acquired deficit.**
- **If we use normative data not corrected for education, people with low education are statistically more likely to be labeled as having acquired deficits when they do not while those with university degrees are statistically more likely to be labeled as not having deficits when they do**

Challenges to Interpretation

Lezak 2012

- **Difficulty identifying malingering or response bias in review of NP data alone**
- **Confirmatory bias and attribution error resulting in under reporting or over diagnosis of malingering**
- **Tendency of examiners to overestimate their capacity to identify malingerers when they feel they have established rapport with the patient**
- **The above recommends including direct and embedded measures or response bias**
- **No single measure has sufficient sensitivity and specificity**

Longitudinal Study on Symptom Reporting and Compensation Seeking

Paniak et al (2002)

- Compensation seeking does not appear associated with brain injury severity within an MTBI group.
- None of the injury related variables of time to first memory, retrograde amnesia, time to return of continuous memory, or length of confusion postinjury was indicative of increased compensation seeking
- Only variable positively predictive of compensation seeking was prescription of postinjury analgesic, neurological, and/or psychopharmacological medication at baseline.
- Study results indicate that compensation seeking is associated with much greater symptom report, and that this association persists across time.

Symptom Exaggeration

- Emotional response to injury/illness impact or effects of a neurological condition can lead to new symptoms or exacerbate existing ones.
- Neurogenic impairment can be superimposed on preexisting emotional disorders.
- Test performance can be lowered deliberately or by nonconscious psychological factors challenging the ability to distinguish between conscious feigning and nonconscious exaggeration

Symptom Exaggeration

- **Patients with genuine impairments who may try to minimize or ignore neuropsychological deficits in an attempt to appear psychologically normal or incentivized to ignore problems.**
- **Can lead to under-reporting of symptoms**
- **Faking good can be more of an issue with psychological adjustment assessment**

Somatic Symptom Disorder

- A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.**
- B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:**
 - 1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.**
 - 2. Persistently high level of anxiety about health or symptoms.**
 - 3. Excessive time and energy devoted to these symptoms or health concerns.**
- C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months)**

Illness Anxiety Disorder

- A. Preoccupation with having or acquiring a serious illness.**
- B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g. strong family history is present), the preoccupation is clearly excessive or disproportionate.**
- C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.**
- D. The individual performs excessive health-related behaviors (e.g. repeatedly checks his or her body for signs of illness) exhibits maladaptive avoidance (e.g. avoids doctor appointments and hospitals).**
- E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over the period of time.**
- F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.**

Conversion Disorder

(Formerly Neurological Symptom Disorder)

- A. One or more symptoms of altered voluntary motor or sensory function.**
- B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.**
- C. The symptom or deficit is not better explained by another medical or mental disorder.**
- D. The symptom of deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.**

Specify symptom type, specify w/o psychological stressor

Psychological Factors Affecting Other medical Conditions

- A. A medical symptom or condition (other than a mental disorder) is present.**
- B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:**
 - 1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.**
 - 2. The factors interfere with the treatment of the medical condition (e.g. poor adherence).**
 - 3. The factors constitute additional well-established health risks of the individual.**
 - 4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.**
- C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g. panic disorder, major depressive disorder, posttraumatic stress disorder)**

Factitious Disorder

Factitious Disorder Imposed on Self

- 1. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.**
- 2. The individual presents himself or herself to others as ill, impaired, or inured.**
- 3. The deceptive behavior is evidence even in the absence of obvious external rewards.**
- 4. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.**

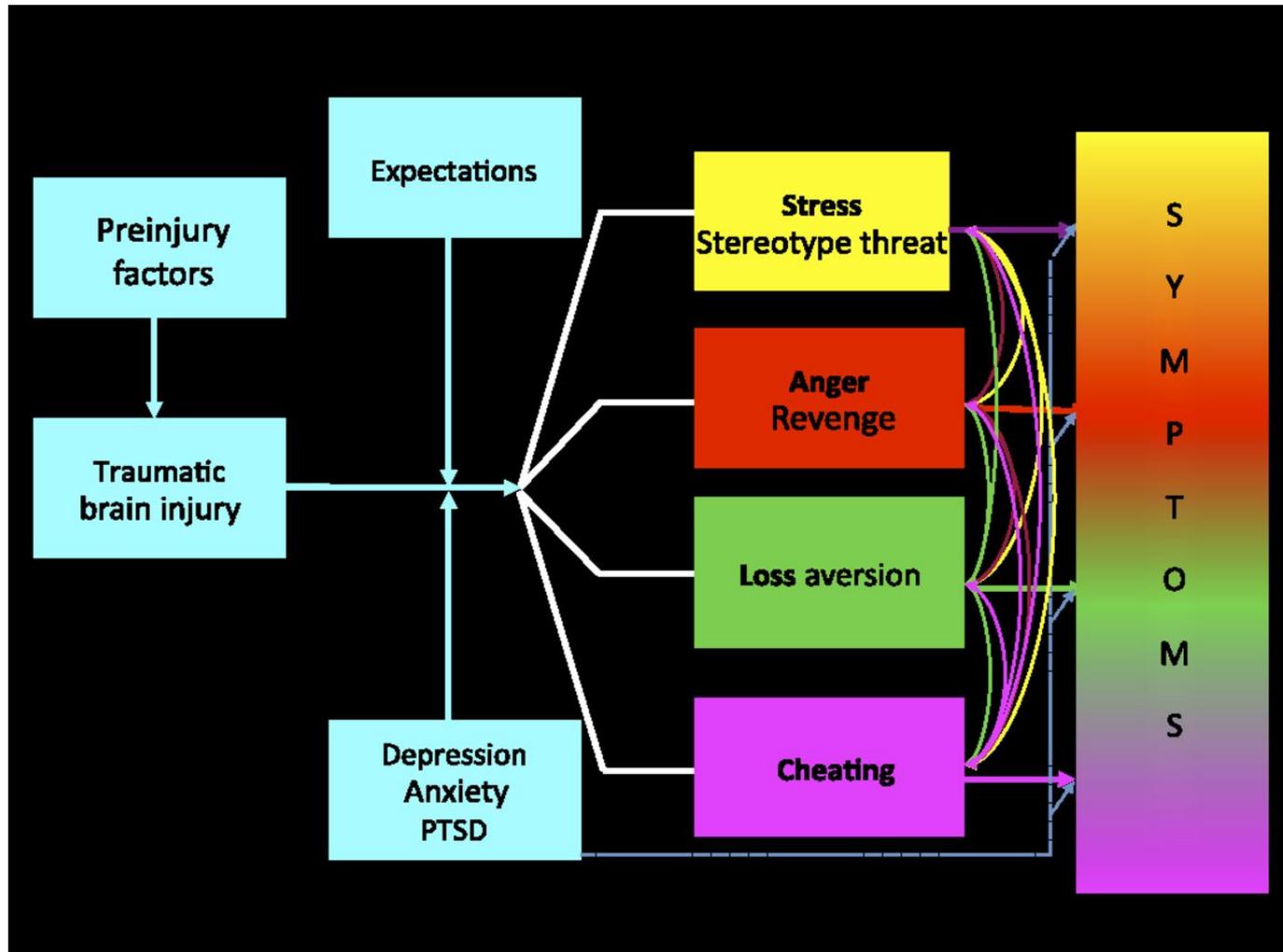
Factitious Disorder

Factitious Disorder Imposed on Another (Previously Factitious Disorder by Proxy)

- A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
- B. The individual presents another individual (victim) to others as ill, impaired or injured.
- C. The deceptive behavior is evident even in the absence of obvious external rewards.
- D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

- **Cognitive Underperformance and Symptom Over-Reporting in a Mixed Psychiatric Sample.** Dandachi-FitzGerald^{et} al (2011), Our findings indicate that underperformance and over-reporting are loosely coupled dimensions and that particularly over-reporting is intimately linked to heightened SCL-90 scores.

A model for understanding the interactions of multiple factors in their contribution to symptoms after brain injury.



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Caution-Lezak 2012

- **“As with many aspect of test interpretation, findings on measures designed to assess performance validity and response bias should not be interpreted outside the context of clinical history and other measure of cognitive function.” (pg 833)**
- **Failure to take into account contributions to test performance of demographic variables such as low education and advanced age may lead to erroneous interpretation**

References

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