THE WETC PSYCHOLOGY NEWSLETTER

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February, 2012
Volume 1, Issue 37

Malingering (V65.2)

There are many ways of referring to applicants and plaintiffs who seem to be making more of their symptoms or complaints than can be found upon objective review. In psychiatric and psychological medical-legal cases, patients frequently are said to be "embellishing" their complaints, "exaggerating," "over-reporting symptoms," or "attempting to simulate symptoms." Most often, these conclusions are drawn when a person makes complaints that are very unlikely to be true, but nevertheless possible. One example of this is when an applicant tells the doctor that for the last month they have only slept four hours a night, despite the fact that they are bright-eyed and bushy tailed. Another example of this is when objective psychological testing data can provide data indicating that the person most likely is not being honest and straightforward on the psychological tests but attempting to simulate symptoms.

Experience has taught me that a relatively large number of individuals will behave in this manner in the course of a psychological examination. In fact, the number may be so large, perhaps even a majority, that by a purely statistical definition, one might consider it quite normal to over-emphasize one's symptoms or a disability. However, in 26 years of doing forensic psychological evaluations, I can recall specifying Malingering (V65.2) on only two occasions. This is because there is a difference between laying it on a little thickly, over-reporting a complaint or symptom, exaggerating or embellishing something that is really wrong, attempting to simulate symptoms on a battery of tests, and outright Malingering as that concept is defined by the DSM-IV-TR.

"Unless an examiner can obtain some objective findings that are clearly inconsistent with the person's claimed disability or symptoms, it is not reasonable to specify Malingering, and the most that can be said is that there is some evidence of over-reporting, embellishment, exaggeration or perhaps an attempt to simulate symptoms on the psychological testing."

According to the DSM-IV-TR, Malingering (V65.2) is specified correctly when an individual has intentionally produced false or grossly exaggerated signs and/or symptoms of a physical and/or psychological nature, and that deliberate misrepresentation is motivated by external incentives such as obtaining financial compensation, avoiding work, or evading military duty. The DSM-IV-TR goes on to say that Malingering should be strongly suspected if there is a combination of any of the following:

A. An attorney refers the individual for an evaluation and/or treatment.
B. There is a marked discrepancy between the individual's claimed stress or disability and the objective findings.
C. There is a lack of cooperation with the evaluator's procedures and/or the treatment prescribed.
D. The individual presents with an Antisocial Personality Disorder.

Where is the line between laying it on thickly and Malingering? Well, let's take a look at what the DSM-IV-TR says and then we'll look at how a psychological evaluation is conducted and what data can be generated that speaks directly to the points of Malingering.

As you can see above, in order to conclude that an individual is Malingering it is necessary to determine that the individual has "intentionally produced false or grossly exaggerated signs and/or symptoms of a physical and/or psychological nature." A key word here is "intentionally." What information does a psychologist or a psychiatrist have to have in order to conclude that the behavior was intentional? Using a number of dictionaries, it seems that the word "intentional" implies that something is done by conscious design or purpose, involves a knowing attempt to defraud, is done deliberately, is planned and premeditated and is willful. Taking all of this into consideration, it is reasonable to conclude that one of the requirements of Malingering is that the person doing the "faking" has consciously designed or planned to produce false or grossly exaggerated signs or symptoms, knows that what they are doing is an attempt to defraud, and is doing so deliberately, willfully and premeditatedly. Let's consider what data an examiner needs to draw the conclusion that the person was consciously "faking" when the examiner has no direct access to a person's consciousness?

To take just one example, one disorder that is sometimes diagnosed in psychological cases is Primary Insomnia (307.42). In this disorder, the person exhibits difficulty in initiating and/or in maintaining sleep and/or experiencing nonrestorative sleep for one month or longer. In order to diagnose this disorder correctly the individual must complain of difficulty initiating and/or maintaining sleep and/or having nonrestorative sleep that has been present for at least a month. There must also be clinically significant distress and/or impairment in social and/or occupational and/or some other important area of functioning. In taking an individual's history it is normal procedure to ask them questions about their past and current sleeping habits. For example, one way of determining if there is difficulty sleeping is to find out how much a person is sleeping. Another way of determining if there is difficulty initiating sleep is to get some history on how long it took the person to fall asleep in the past, say before they were injured, and how long it now takes them to fall asleep. Another source of information is to find out if they are having difficulty maintaining sleep by asking things like how many times they awoke in the middle of the night before they were injured, and how many times they currently wake up. This is typically followed up by asking the person how long it takes them to get back to sleep once they have woken up in the middle of the night.

Now here comes the kicker! Almost regardless of what the person says, is there any way of determining if they are telling the truth? If they are consciously and deliberately faking, how could the interviewer know? Further, if a person says they are sleeping four hours a night and they seem quite awake and alert during the interview process and throughout a full day evaluation that includes a battery of psychological tests as well as a face-to-face interview, how could the examiner possibly know for sure if they are exaggerating or telling the truth? Moreover, if the examiner thinks they are exaggerating, embellishing or over-reporting, how can they know that they are doing it "intentionally" and that they are not reporting what they really believe to be true? The simple answer is that we can't!

Essentially, with most complaints or, as they are sometimes called, symptoms, the examiner, on listening to the history, cannot possibly have data indicating that what they are being told is false and that the falsehood is being perpetrated with a conscious design or purpose, involves a knowing attempt to defraud, is done deliberately, and is planned, premeditated and willful.

As noted in the DSM-IV-TR, Malingering should be strongly suspected if an attorney refers the individual for an evaluation and/or treatment, which is always the case in a medical-legal examination, and if there is either a marked discrepancy between the individual's claimed stress or disability and the objective findings or a lack of cooperation with the evaluator's procedures and/or the treatment prescribed.

The key here is the concepts of a "marked discrepancy between the person's claims and the objective findings" and/or a lack of cooperation with the evaluator's procedures. I think I can eliminate the notion of a lack of cooperation, since I don't ever remember evaluating a person who wasn't cooperative. If you ask nicely and are not antagonistic, virtually everyone undergoing a psychological evaluation is cooperative. In fact, I think you really have to go out of your way to make someone uncooperative. That brings us down to "objective findings." With sleep, a psychological evaluator can have no objective findings that will

conflict with the person's claims. Even if they have had a sleep study that shows no problems, that hasn't eliminated the possibility that the one-night study is not characteristic of what typically occurs. Given just the above, almost regardless of what happens during the clinical interview and the rest of the psychological evaluation, it is almost impossible to specify Malingering.

Having made the above point, let's switch gears and talk about depression. Assuming that an individual presents with some objective measures of depression, if they tell me they are depressed 24 hours a day, 7 days a week, 52 weeks a year, as long as I find some evidence of a clinical depression, what objective findings can I possibly have that will conflict with that history? Answer: Nothing! I could go on, but you see the point.

Now let's get to the two cases of Malingering in my past. I think you'll agree that they are out of the ordinary. The first involved a man who reportedly had a legitimate back injury at work. When I first saw him he was walking into my office with the assistance of two arm crutches. He looked to be in excruciating pain as he very slowly and seemingly tortuously walked from my front door to the interview room. On entering my office he made a great production of sitting down while exuding multiple moans and groans. Thereafter, he started telling me in detail, not only how much he hurt physically, but how depressed he was, how little energy and interest he had in life and that all he could do all day long, every day, was sit on his couch and watch television. He then went on to tell me how his wife had to help him go to the bathroom and bring him all his meals. What this poor man did not know was that prior to his coming into my office, he had been the subject of sub rosa videotaping that showed him not only cleaning out his garage without assistance, crutches or apparent pain, but depicted him actually lifting a 4-drawer dresser by wrapping his arms completely around it, picking it up and walking it into his driveway. All of the time he was doing this he was quite clearly actively engaged in his cleaning and took time to have a warm, friendly and apparently outgoing conversation with what appeared to be a neighbor or a friend who dropped by.

The second case involved a reasonably well-educated woman who also claimed to be depressed and who seemed incapable of even a minimal level of cognitive functioning. When asked to perform a series of the simplest mental arithmetic problems, such as multiplying 3 by 4, she failed miserably. Unfortunately for her, she was not very psychologically sophisticated in psychological testing as she completed an I.Q. test before the interview and scored above average, a testimony to her pride, but also a fatal error with regard to attempting to look dysfunctional to the examiner, since her performance on the I.Q. test was completely inconsistent with her arithmetic performance during the clinical interview and very clearly indicated that she was deliberately failing the mental arithmetic problems. In her case there seemed to be no reasonable alternative but to conclude that she was deliberately or intentionally producing false or grossly exaggerated signs of psychological dysfunction, i.e., Malingering.

So that's why Malingering is hard to specify. Unless an examiner can obtain some objective findings that are clearly inconsistent with the person's claimed disability or symptoms, it is not reasonable to specify Malingering, and the most that can be said is that there is some evidence of over-reporting, embellishment, exaggeration or perhaps an attempt to simulate symptoms on the psychological testing.

This is the thirty-seventh of a series of monthly newsletters aimed at providing information about psychological evaluations and treatment that may be of interest to attorneys and insurance adjusters working in the areas of workers' compensation and personal injury. If you have not received some or all of our past newsletters listed on the next page, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.

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June, 2009 - Subjectively Interpreted Projective Psychological Tests

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September, 2009 - Compulsive Computer Use Disorder

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December, 2009 - Psychological Factors Affecting Medical Condition

January, 2010 - Pain Disorders

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March, 2010 - Drugs: Use, Abuse and Dependence

April, 2010 - Common Flaws In Psych Reports #3

May, 2010 - "Impossible" MMPI-2 scores and their consequences for litigation

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