THE WETC PSYCHOLOGY NEWSLETTER

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"Find the Truth, Tell the Story"

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Detecting Malingering in Psych Cases

According to the DSM-IV-TR, Malingering (V65.2) is **not** a psychological disorder but a "condition" that may be a focus of a psychologist's or a psychiatrist's "clinical attention." The DSM-IV-TR goes on to say that malingering is the intentional production of false or grossly exaggerated symptoms or complaints that is motivated by a variety of external incentives such as avoiding undesirable duties or obligations, punishment for crimes and obtaining financial compensation through the legal system. In personal injury and workers' compensation litigation one encounters faking or malingering as the production of symptoms or complaints to obtain unwarranted compensation of one form or another, usually money.

In clinical practice and in a legal context when not referring to the DSM-IV-TR condition defined as Malingering, the behavior of individuals who are not responding honestly during a psychological evaluation are often described as "malingering," "faking," over-reporting, exaggerating, or attempting to simulate symptoms of a psychological disorder. However, a rose by any other name is still a rose!

It is virtually universally accepted that the first issue that must be addressed by any medical-legal evaluator is the examinee's credibility. In this regard, the most significant question that must be asked is, "If the complaints made by the plaintiff or applicant are accepted at face value, to what extent are they an honest accounting of their true psychological condition and to what extent are they a product of faking?"

Clues that a person may be trying to fake a mental disorder can be observed in a number of ways. On occasion, individuals may present with some extremely bizarre complaints that they think are indicative of being mentally ill or "crazy." They may talk about seeing or hearing things or having hallucinations. However, they just don't jibe with the hallucinations of truly mentally ill individuals. In medical-legal cases faked claims of hallucinations are extremely rare.

Generally malingering or faking should strongly be suspected when the examinee complains about dysfunctions that are highly discrepant from the doctor's observations. Every competent psychological evaluation includes a Mental Status Examination. A Mental Status Examination produces a set of observation of the examinee that are made by the doctor during a face-to-face interview using a relatively standard set of examining techniques that yield data that can be presented to the court. During a Mental Status Examination the doctor will measure the patient's memory, concentration ability, judgment and insight. A "clue" to faking occurs when the patient complaints of memory dysfunction but the doctor's multiple measurements reveals no such inability, but a normal performance for the claimant's demographics.

Another clue that a person may be faking occurs when they appear extremely vague or evasive in describing their history or present with highly internally inconsistent accountings of that history during the clinical interview. For example, people who are clinically depressed do not usually provide histories such as, "I don't know doc, I just don't feel right." In fact, truly depressed people most frequently come right out and describe their feelings of hopelessness, helplessness, guilt etc.

Yet another telltale sign of faking occurs when the claimant's accountings are highly discrepant from their medical records. Such individuals often describe their

physical complaints in ways that are completely in conflict with the records of orthopedists and/or neurologists.

Additionally, sub rosa videos often reveal faking that may not be evident during a clinical interview. Consider the patient who reportedly has injured their back and tells the interviewing psychologist or psychiatrist that they spend all of their time at home, in bed, in terrific pain, mostly crying but they do not know I have seen videotape of them cleaning out their garage and lifting extremely heavy objects without any apparent difficulty or help from others.

All of the above are evidence of faking or malingering but the mental health professional's principal method for determining credibility is the objective psychological testing data. Specifically, psychological testing data is the only information collected by the examiner that is open to public inspection and can be presented to the court in an objective and generally numerical fashion. There are only a few tests that can generate meaningful objective scores that can be presented to the court that speak directly to the patient's honesty. The most frequently used, and from most perspectives, the most valid and reliable instrument is the Minnesota Multiphasic Personality Inventory (MMPI). The version used by most mental health professionals is the second edition of this test that is called the MMPI-2.

There are multiple measurements or scales on the MMPI-2 that tell the examiner if the patient if faking. Specifically, there are the F Scale, the Lie (L) Scale, the K Scale, the F(b) Scale, the F(p) Scale and the Revised Dissimulation Scale. Scores on the MMPI-2 are presented in the form of what are called T-Scores. T-Scores can vary from 0 to over 100, depending on the scale, with a T-Score of 65 or greater being significant or interpretable.

For example, a T-Score of 65 or greater on the F Scale is indicative of faking although it could conceivably be indicative of a psychotic disorder but the doctor would have no trouble detecting a psychosis since they typically present with overt signs of hallucinations or delusions.

So with all these scales for measuring faking, on how many of the scales does the claimant have to get a T-Score over 65 to conclude they are faking? The analogous question in oncology would be "How many cancer cells does a pathologist have to see before diagnosing cancer?" Just one! Perhaps the most interesting aspect of the MMPI-2 validity scales is what a score less than 65 means. Quite clearly, it does not mean you're **not** faking or telling the truth. It just means that you weren't found to be lying. There are no truthfulness scales on the MMPI-2, just scales that show that you were faking or malingering.

In passing, I would like to comment on Malingering and the DSM-5. In this regard, Malingering is found and defined in the much-maligned DSM-5 on pages 726 and 727 in the same way it is described in the DSM-IV-TR. However, in the DSM-5 it is buried in a section called Nonadherence to Medical Treatment and if you try to find the term Malingering in the Index or the table of Contents, it simply is not there. It appears that the authors of the DSM-5 wished to downplay the existence of Malingering, a conclusion consistent with the statement that appears on page 25 that the DSM-5 was not designed to meet the "technical needs of the courts and legal profession." In fact, the DSM-5 has been met with worldwide disapproval that in large part has been provided by Dr. Allen Frances, a psychiatrist and a professor at Duke University, who as the chairperson of the DSM-IV and DSM-IV-TR Task Force was in charge of producing both of those diagnostic manuals; Dr. Thomas Insel, the psychiatrist who served as head of the National Institute of Mental Health who wrote that the DSM-5's weakness is "its lack of validity;" and the decision of the Center for Medicare and Medicaid Services (CMS) that requires all healthcare providers covered by HIPAA to use the International Classification of Disease (the ICD-10), not the DSM-5.

In conclusion, if you are an experienced attorney or an insurance adjuster you most likely can "smell out" those cases in which the claimant is "faking" or "malingering." However, no offense intended but you most probably do not have enough knowledge to interpret the testing scores that demonstrate its presence. That's where I come in. Give me a call at 310-444-3154 and I'll be happy to go over the report with you and tell you what the doctor's data really demonstrate. Perhaps most importantly, you can count on there being absolutely no charge for the phone consultation. I simply love doing it!

This is the one hundred fifty-first of a series of monthly newsletters aimed at providing information about pre-deposition/pre-trial consultations, 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, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.