

CASEINPOINT

MALINGERING MEDICAL PRESENTATIONS:

Separating the Real from the Malingered, and Fact from Fiction

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Few topics generate as much interest, emotion, misunderstanding and mislabeling among adjusters and case managers as malingering. Simply put, malingering is a minefield.

On the one hand, if a claimant is malingering, this is morally and legally “wrong.” Most of us would agree that the malingerer should be exposed, the money recovered and an example should be made so that others who might be tempted to cheat the system are made to realize that there are serious consequences for fraud. On the other hand, a call on malingering is almost never clear-cut and it will often pit adjuster against treater (particularly mental health treaters and primary care physicians). Further, a wrong call has the potential to open a bad faith lawsuit against the insurer, and possibly against the adjuster personally. So treading carefully is really important here, perhaps more so than with any other “diagnosis.”

Malingering did not originate with insurance coverage and is not specific to insurance – the idea has been around for a while. In the Old Testament, King David fakes insanity to escape from an enemy. A couple of thousand years ago the legendary Roman physician Galen reported two cases which he felt were malingering. One patient supposedly faked colic to avoid a public meeting, while the other faked an injured knee to avoid going on a trip. While one might justifiably wonder about diagnostic accuracy in Roman times, the point is not that Galen was correct on the diagnosis, it is the simple awareness that some people would feign illness. Examples of malingering abound in our own lives and history, from the child who puts the thermometer under a lamp while Mom is looking the other way to avoid going to school (as in the movie “E.T.”), to draftees in the Vietnam era drinking tons of sugary drinks in an attempt to fake diabetes at army physical exams to avoid conscription, to criminals faking insanity to avoid prosecution. Though not always the case, in our industry, the reason is most likely money.

The essence of malingering is “faking,” i.e. consciously fabricating or exaggerating the symptoms of mental or physical disorders. Malingering is, in fact, recognized in the diagnostic manual used by psychologists and psychiatrists, the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Revised*. Malingering is a V-code (i.e., it is not considered a “disorder”) and is found in the chapter entitled “Other Conditions That May Be a Focus of Clinical Attention.” DSM-IV defines malingering in this way:

“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.”

The key aspects of this definition are: (1) that production of the symptoms be intentional and (2) that there be clearly identifiable external incentives. Determining the presence of external incentives is usually fairly straightforward – the criterion of intentionality that is so difficult to establish. Indeed, it has been commented with respect to malingering that no syndrome is as easy to define, and yet, as difficult to diagnose.

Conscious or Unconscious Motivation

The key to malingering is intentionality. The malingerer is out-and-out lying. What makes intentionality so difficult to nail down is that psychologists and psychiatrists differentiate between conscious and unconscious motivation. To establish malingering, the motivation must be conscious meaning the claimant must willfully be manufacturing or exaggerating his or her symptoms. With unconscious motivation, one could argue that the person is kidding himself and that the lie to others is an unintentional side effect, but knowing full well what you are doing is far from out-and-out lying.

Skeptical adjustors and others may scoff at the notion of unconscious motivation, but consider this situation, in which we have all found ourselves. You have been invited to a social function that you would really prefer to avoid. That morning, you awaken with a back ache. Be honest, now: are you not more aware of your back pain than if you were looking forward to the party? It’s not just a matter of using the back ache as an excuse, it actually hurts more, doesn’t it?

Expand this example a bit by raising the pain level, by having a clearly identifiable cause on which the pain can be blamed (you slipped in the shower as you bent down to pick up the soap) and by increasing the value of the motivator, and you have yourself a perfect example of how unconscious motivation can enhance and maintain physical symptoms.

If you are still skeptical, consider hypnosis as a tool for tapping into unconscious motivations. If you took an introductory psychology course, you will have read (and you may even have seen a demonstration) about how, under hypnosis, many people can be made to experience temporary paralysis in a

limb, numbness, pain, mutism, blindness, loss of memory and even visual hallucinations. Subjects in hypnosis experiments and demonstrations are not faking and they invariably walk away with a vastly enhanced respect for the complexities of the human mind. You may have seen stage hypnotists produce the same phenomena. What the skilled hypnotist can do easily, the person's own mind can do far more skillfully still and without awareness of how and why it is doing it.

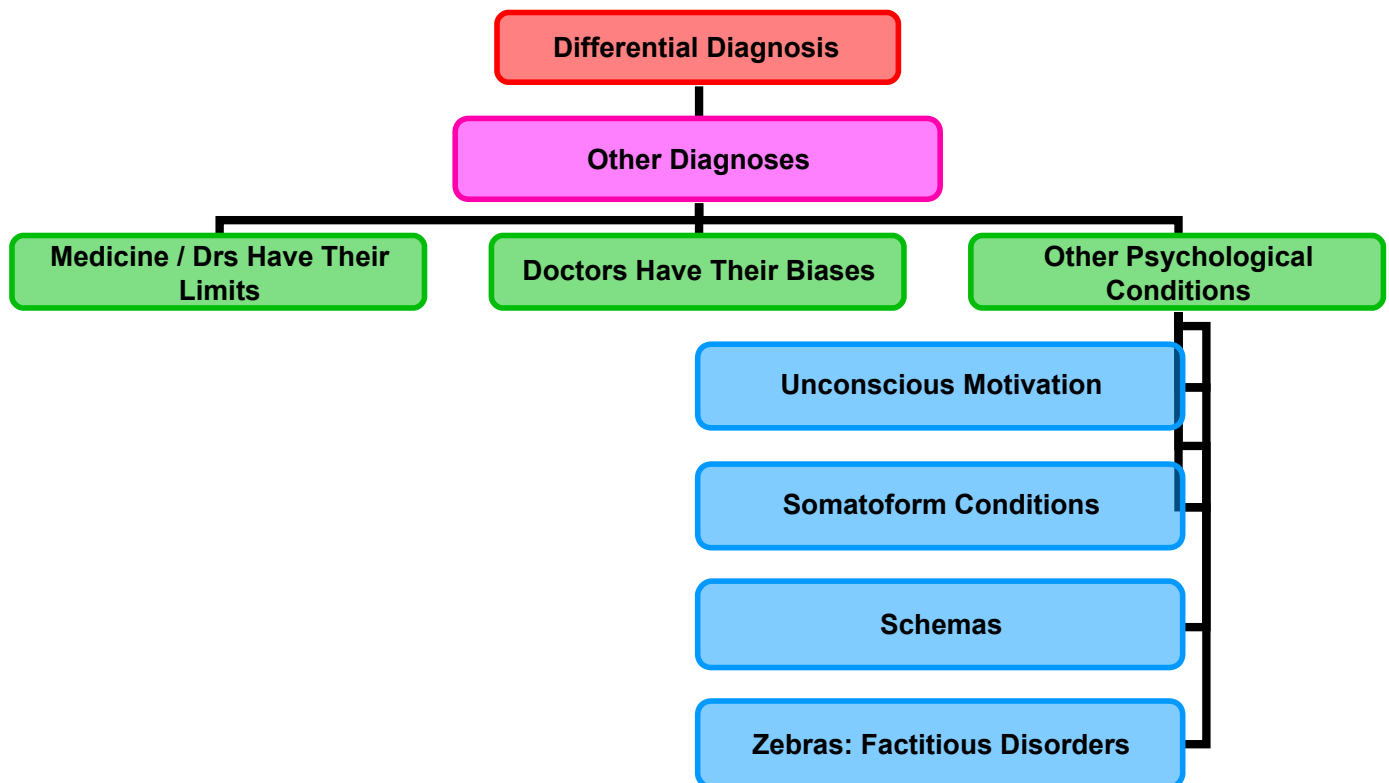
What sorts of symptoms can be produced and maintained through a mechanism of unconscious motivation? In principle, any number of sensory or motor problems and even disorders of consciousness, such as pseudo-seizures that mimic epileptic seizures. The literature can readily document many cases of paralysis, blindness, tunnel vision, anosmia (loss of the sense of smell), loss of sensation in various parts of the body, even pseudocyesis (false pregnancy) and, of course, pain that is either focused on particular areas of the body or generalized.

To understand why the mind would want to suffer the agony of pain or paralysis, sometimes for a lifetime, we must consider the question of what constitutes unconscious motivation. To most adjusters, the primary motivator is money and, indeed, we have no doubt that money is the motivator in almost all cas-

es of malingering involving the insurance industry. But when it comes to unconscious motivation, money is often only distantly relevant, if at all. From a strictly monetary point of view, people almost always make less money on benefits than when they were working. What is more relevant are factors such as whether the claimant enjoyed her or his job, the relationship with the spouse and the children, and unmet emotional needs often stemming from childhood. More about this below.

Differential Diagnosis For Malingering

Let's consider the differential diagnosis for malingering. Before labelling someone a malingerer, you must consider what else it could be. Malingering is almost always a diagnosis by exclusion. Unless you have a video of the claimant who had always shown up for appointments walking with two canes, dancing the night away at a club while bragging to his buddies that he is milking the system, the conclusion that we are dealing with malingering is going to depend on eliminating all the other possibilities – so that malingering is the only one left standing that fits the data. Let's work our way through the Differential Diagnosis Tree.



Other Physical Diagnoses. The obvious differential diagnosis for malingering is some other diagnosis, either physical (left and center green boxes in the chart above) or psychological (right green box and lower blue boxes). If there is another physical diagnosis, one possibility is that it could have been missed. How could that be? Possibly the doctor missed it (remember why we get second opinions) or medicine itself may not yet have the tools (diagnostic and/or theoretical) to recognize the symptoms as a new condition.

On this last point, you may not be aware that quite a number of Freud's patients who were diagnosed with psychiatric conditions at the time turned out, decades later and after much progress in neurology, to have had neurological conditions. Neurologists (and Freud was a neurologist) did not have a sufficient knowledge base in those days to make the (ultimately) correct diagnoses. Similarly, until a few years ago, multiple sclerosis (MS) was strictly a diagnosis by exclusion but, with the advent of better MRIs and better knowledge about the disease process, MS can now often be identified positively from the scans. Unfortunately, in decades past many MS patients, in all probability, were misdiagnosed as psychosomatic cases or even malingerers. What can look like absolute lunacy or malingering sometimes turns out to have a completely rational explanation. Here is a documented case published in the *American Journal of Psychiatry* that can serve as an object lesson:

A 35-year-old war veteran with depression and headaches complained of hearing voices and music in his head. Strangely, the symptom was relieved only if he lay on his back on the floor of his garage. One day, one of the psychiatrists noticed that his voices and music seemed to match the 560 kHz AM broadcast band on the local radio station. It turns out he was receiving radio signals via shrapnel fragments in his left parietal lobe.

Another possible reason for the doctor having missed the diagnosis is that the doctor, out of "bias," may refuse to recognize a particular diagnostic entity. This may seem like a strange thing to say, but bear in mind that science, of which medicine is a part, is always a work in progress, hopefully getting closer and closer to some ultimate truth. Consequently, at any given time, there are facts, theories and techniques in the following categories: (A) Well-established and considered unassailable; (B) Others that are experimental or hypothetical and that may

(or may not) eventually make it into the first category; and (C) All the rest, that are unknowns.

At one time, the notion that Aspirin can prevent heart attacks if taken prophylactically was in category C, i.e., not even considered. At some point, the possibility moved into category B, with some physicians taking this idea seriously enough to recommend that their patients take Aspirin daily ("you have nothing to lose") and others scoffing at the whole notion. Eventually, after proper studies had been done, the notion moved into category A and became dogma. To take another example near and dear to many insurers, some physicians believe that the diagnoses of chronic fatigue syndrome and fibromyalgia reflect a single condition and that this condition is psychological. Others believe they have found biochemical markers of two different physical conditions, and that these reflect "real" physical disease entities. These conditions therefore fall into category B – we're not sure yet about these conditions, but some physicians take one view, and others a very different view.

And so, a patient with a good deal of undefined pain, fatigue, and other amorphous symptoms may receive different diagnoses depending on the diagnosing physician. In contrast, a patient with the clear-cut symptoms of a heart attack would hopefully receive the same diagnosis regardless of which physician is seen in emergency (category A). For patients where malingering is a diagnostic possibility (obviously cases that are not clear-cut diagnostically), the possibility that there may be some other condition not yet recognized broadly and rejected by the diagnosing physician is one that should not be dismissed out of hand.

Psychological Conditions and Factors

If we can reasonably eliminate the possibilities that the doctors missed or refused to consider some physical condition, perhaps through secondary opinions, we are still not ready to jump to the conclusion that the patient is malingering. We must first take a long, hard look at psychological possibilities.

Is it possible that the patient's symptoms, while not directly physically caused, reflect the operation of unconscious motivation? If so, we need to do more than simply say that's possible, we need to identify likely candidates and a plausible mechanism which, in the workers' compensation world, is usually provided by an accident or injury. Let us have a look at a few typical examples.

One very common situation is that of the woman who is torn between her role as a mother and the family's need to have her provide some financial support. A whiplash injury can set the stage for the development of psychogenic pain. Maintaining a strong pain focus after the strictly physical problems are resolved allows her to solve the psychological conflict: she can stay home with the kids without feeling that she is letting the family down financially. After all, who could expect her to go to work when she is suffering excruciating pain?

Another typical case involves the man who, stemming perhaps from an abusive or otherwise dysfunctional childhood, has developed tremendous dependency needs that have gone unmet. This man may have been working at two jobs from the age of 13. Providentially, at age 40, an accident allows for these needs to be fulfilled at long last, as the spouse and children rally and start caring not only physically, but also emotionally, for the injured worker. Maintaining his symptoms allows him (unconsciously) to get his emotional needs met.

Yet another example is that of a man who has been experiencing a lot of conflicts with a new supervisor at work, but feels that he cannot leave his job because of his many years of seniority. Again, an accident-related injury can prove quite beneficial in solving his dilemma. He can now leave the frustrating work situation with his head held high.

In these and many other examples, maintaining the physical symptoms beyond healing of the strictly physical tissue damage is done automatically, without conscious intent. In all of these cases, we have now entered the very large grey area between genuineness and malingering: the person is definitely not faking, but the problems are definitely not simply physical.

As noted earlier, one might argue that the person is lying to himself or herself, but if you want to take that tack, an awful lot of our behaviors fall in that category, as most of us are not really aware of the motives for many of our actions, and we have an uncanny ability to rationalize our behavior every time we go astray. Not sure? Listen for a variation on one of the following self-serving rationales from the next politician, sports figure or entertainer who strays: "My marriage was not going well...I felt my spouse was not really understanding me...the pressure of the job...being away from home on the road so many nights...I had been drinking too much...my father left my mother when I was a child..."

If a plausible case can be made for the presence of unconscious motives maintaining the physical symptoms, we are in the domain of somatoform conditions, also known historically as psychosomatic disorders. The DSM-IV defines the field as follows:

The common feature of the somatoform disorders is the presence of physical symptoms that suggest a general medical condition (hence, the term somatoform) and are not fully explained by a general medical condition, by the direct effects of a substance or by another mental disorder, e.g., panic disorder. The symptoms must cause significant distress or impairment in social, occupational or other areas of functioning. In contrast to factitious disorders and malingering, the physical symptoms are not intentional, i.e., under voluntary control.

There are subdivisions within the somatoform disorders category. For our purposes, in focusing on workers' compensation cases and medical presentations, we note that from a diagnostic point of view, a distinction is made between disorders where the focus is sensory-motor and conditions where the focus is pain. When the feature of the disorder is an alteration or loss of physical functioning that suggests a physical disorder (sensory or motor), but that is apparently an expression of a psychological conflict or need, the diagnosis is conversion disorder, e.g., conversion blindness or paralysis. When the essential feature is a preoccupation with pain in the absence of adequate physical findings to account for the pain or its intensity, the diagnosis is pain disorder, which is also known as psychogenic or somatoform pain disorder and more commonly as chronic pain syndrome. There are other categories and interested readers

should consult the DSM. In addition, conditions such as depression can also exacerbate the perception of pain and other physical symptoms.

It is important to point out that traditionally the psychological mechanisms underlying somatoform disorders have been assumed to be emotional, i.e., that the physical symptoms provide for some sort of emotional need for the patient. However, the tendency in the literature more recently has been to focus on the behavior (pain behavior, sick behavior, etc.) and more or less ignore the why's of the behavior. In part, this is a reflection of a move away from a historical emphasis on unobservable constructs not really amenable to observation or subject to falsification that psychiatry and psychology had inherited from psychoanalysis, but in part, this also reflects the increasing importance given to cognitive (conscious) processes.

This brings us to the concept of schema. If you have followed the discussion so far, you might be thinking that people with physical symptoms either (a) have something physically wrong with them, (b) are psychologically maladapted, or (c) are out-and-out faking/malingering. Let us carve out yet another little piece of the pie. Studies have shown that a substantial proportion of pain patients with no diagnosable organic disease nonetheless show no evident psychopathology.

A schema is essentially a higher order abstraction or a person's understanding of something. For example, most of us have a schema about how automobiles work and so, when you find yourself stuck on the side of a highway calling for a towtruck, you will usually provide a "naïve" hypothesis about what is wrong with the car derived from your understanding of what makes a car function and break down. Similarly, we all have schemas about disease. Your mother might have told you never to go near someone with a cold, that chicken soup is good medicine for a cold, that a shot of brandy is good when you're sick because the alcohol kills the germs. From these or other similar wives tales (and many other sources) we build our understanding of disease. All you need to do is talk to a few patients about what ails them to realize that some of their ideas are dead wrong, even wacky, and yet they believe and act on these ideas – sometimes even when their actions completely contradict expert medical opinion and advice.

For example, a workers' compensation claimant with degenerative disc disease, based in part on how horrible that label sounds and on his experiences and family history, may come to believe that his back (discs) are gradually dissolving (degenerating), such that in fairly short order he will end up in a

wheelchair, and that nothing can be done about it. (He recalls that his father spent his last few years in a wheelchair from back problems.) A number of studies have shown that you can measure the accuracy of these schemas, and it turns out that the accuracy of patients' schemas often predicts compliance with treatment and return to work (RTW) much better than either medical variables or measures of psychopathology. This makes intuitive sense. If you believe that your back is slowly dissolving as a function of age, it might follow, according to this logic, that using the back muscles and discs more, as in exercise, might accelerate the ageing/dissolving process and, if your belief is strong enough, nothing the "insurance doctors" will tell you will dissuade you.

On the other hand, if you understand the medical model as explained to you by the medical personnel, it might follow that exercise would strengthen the back muscles and thereby provide better support for discs that are losing their elasticity, and so you would be more inclined to follow the prescribed exercise regimen. Beliefs can drive behavior; behavior then drives outcomes. In one widely cited study of workers' compensation back pain patients published in the journal *Spine*, schema accuracy was not only the best predictor of RTW, it was the only predictor that was replicated in two separate samples, outperforming both orthopaedic evaluations and MMPI measures of psychopathology: 94 percent of patients with a good understanding of their condition returned to work versus only 33 percent of those with a poor understanding of their condition.

These findings on the importance of illness schemas for prognosis obviously point to the importance of patient education (instead of psychotherapy) for rehabilitation with these sorts of folks. But they also raise a fundamental question: If the patient absolutely believes that he is sick and getting worse and uses the "understanding" he derives from his schema of the condition to look for more evidence of his illness – which can be found readily given the vast array of ambiguous physiological signs and symptoms available to all of us at any point in time – is he actually malingering? One might argue that he is lying to himself, but if so, it is only because he does not, or refuses to, recognize the medical truth. If he is lying, he does so based on his own ignorance, not malevolence, and with no intention to deceive. So here also, we are not dealing with malingering but with another slice of the grey area between genuineness and malingering.

To return to the DSM-IV definition for malingering, there is no intentional production of false or grossly exaggerated physical or psychological symptoms, and there is no external motivation

such as is found in malingering in terms of external incentives like avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution or obtaining drugs. Therefore, this is not malingering.

There is one more branch to be eliminated on the Differential Diagnosis before concluding a diagnosis of malingering. This is considered “zebra” in medical parlance in that it is rare – but as we all know, rare is not nonexistent. The term zebra derives from a humorous definition for a neurologist which capitalizes on the neurologist’s reputed fascination with unusual diagnoses: a neurologist is someone who, upon hearing hoofsteps, immediately thinks “zebra”. This is a most unusual condition also known as factitious disorder. The DSM defines it as follows:

Factitious disorders are characterized by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role... factitious disorders are distinguished from acts of malingering. In malingering, the individual produces the symptoms intentionally, but has a goal that is obviously recognizable when the environmental circumstances are known... in factitious disorder, the motivation is a psychological need to assume the sick role, as evidenced by an absence of external incentives for the behavior... a definition of a factitious disorder always implies psychopathology.

In other words, individuals with factitious disorder are fakers. They lie consciously about having pain and/or physical or psychological symptoms and may take drugs or otherwise go to great lengths to induce such symptoms in themselves artificially. They may go through many medical examinations, hospitalizations and may undergo repeated exploratory and other surgeries for relief of these “symptoms.” But the goal is not to defraud, the goal is some pathological benefit that they derive from playing the patient role. Note that the television show *60 Minutes* and others in recent years have focused some attention on a subset of the disorder known as munchausen by proxy or factitious disorder by proxy, whereby a parent (almost always the mother) deliberately causes injury or illness to another person (her child), usually to gain attention or some other benefit. The motivation is to assume the sick role by proxy. It should be obvious that this constitutes child abuse. Per the DSM, factitious disorder always implies psychopathology.

Having made our way through the Differential Diagnosis, there is a legal issue that needs disposed. Many cases initially thought of as malingering may, upon further and more thorough evaluation, end up being classified as psychological cases in one form or another – and therefore not malingering. Nonetheless, many of those cases may not qualify for workers’ compensation benefits because of state laws and regulations that limit compensable injuries to strictly physical ones. But at least, if the claim is to be denied, it should be denied based on the correct diagnosis and rationale. By doing so, it should decrease the likelihood of the insurer (and possibly the adjuster) being dragged into a bad faith lawsuit.

The Problem Of Detection

If nothing else, the above should make clear that picking out a malingerer is not a simple matter (again, with the exception of the “disabled” claimant caught on film dancing the night away and bragging to his friends.) And yet, understandably, there is a great hunger in the workers’ compensation field for some “test” that can easily sift the wheat from the chaff. This has led to a vast number of postings, papers and opinions. A recent Google search for “malingering and workers’ compensation” yielded 26,000 entries; however, a thorough discussion of the topic – see Rogers, 2008 – required 526 pages to properly cover the topic.

A quick stroll through these 26,000 entries reveals an awful lot of heat but very little light, with most entries consisting of opinions to the effect that malingering is everywhere or a non-problem concocted by insurance companies, that attorneys encourage cheating or that lawyers are essential to keeping insurance companies honest, etc. These opinions are not particularly useful, as they are not empirically based. A more formal review by the California Commission on Health and Safety and Workers’ Compensation (2001) summarized the current state of ignorance as to real numbers as follows:

There is no generally accepted method or standard for measuring the extent of workers’ compensation fraud in California. As a consequence, there are widely divergent opinions about the size of the problem and the relative importance of the issue... those who describe fraud broadly and believe that a sizable amount of fraud goes unreported claim that workers’ compensation fraud is a major prob-

lem. For example, the Los Angeles District Attorney (LA DA) cites a 1993 “Little Hoover Commission” report that reportedly concluded that (1) 30 percent of system costs, or \$3 billion a year, are wasted in fraud, (2) 20-30 percent of employee claims are fraudulent and (3) businesses are twice as likely to commit fraud than are injured workers. On the other hand, those who doubt that fraud is that prevalent or substantial point to the relatively small number of cases in which it is prosecuted. In that regard, California Applicants’ Attorneys Association (CAAA) refers to statistics indicating that in 1998, there were 358 fraud arrests, three-quarters of which were injured workers, and that amounted to “less than one-tenth of 1 percent of claims.” In addition, CAAA has submitted a 1998 article prepared by the Labor Research Association that refers to a 1997 study by the Wisconsin Division of Workers’ Compensation which concluded that, “There is no evidence that criminally prosecutable fraud is more than one percent of all reported claims in Wisconsin, a far cry from the 20-30 percent estimates thrown about elsewhere.”

The reality, of course, is that no one knows what the real numbers are. Malingers who are receiving benefits are not likely to come forward to confess. On the other hand, those injured workers who are wrongly identified as malingers may well sue and end up being included in opinion pieces as supporting the argument that attorneys encourage cheating.

Part of the problem is definition. If one uses the “official” definition provided in DSM-IV, then the proportion of malingers is probably small. But bear in mind that evaluating whether claimants meet this definition requires a fairly extensive Differential Diagnosis process, as described earlier. Many adjusters, however, operate with a simplistic dichotomy whereby symptoms are either “real,” i.e., supported by the physical evidence (and usually as evaluated by insurance-friendly IME physicians) or “fake,” i.e., not supported by the physical evidence. With this

latter, much looser, definition, which would include all the psychological conditions enumerated above, the proportion of malingers would be considerably higher and inflated by a lot of cases that are not genuine malingers.

There have been two general approaches to detection. The first, overused by insurers, has been to try to “unmask” malingers by having them surveilled unobtrusively. There are a number of problems with that approach, not the least of which include identifying the correct person and making sure the whole neighborhood has not figured out why a surveillance van is parked inside the community. A van with a driver inside that suddenly appears and parks for several days in front of a neighbor’s house often draws attention, particularly in close-knit communities. Beyond these logistical issues, much of the “evidence” gathered by surveillance is not useful to the Differential Diagnosis process. There are thousands of hours of video gathered every year showing people walking down their driveways to pick up their mail and then going back inside, which is only relevant if the claim is that the person cannot walk at all.

As an alternative strategy, since the psychological piece is so important to understanding symptoms and disability, some have suggested that psychological tests should be able to detect the genuine claimants from the malingers. On this point, a lot of attention has focused on the Minnesota Multiphasic Personality Inventory (MMPI). This is a personality test consisting of 567 true or false questions that has been around for decades. (It has undergone revisions and improvements over the years.) The test measures various aspects of personality, including the tendency to somatize. Many clinical and research scales can be derived from all these items, including the so-called “Lie Scale” and the “Fake Bad Scale.” Due to the use of the short-cut labels that have become attached to those (and other) scales, many have assumed that they are actually measuring lying or faking badly; however, in actuality, what they measure is a response set. For example, the L scale was constructed to detect a deliberate and rather unsophisticated attempt on the part of the person taking the test to present him or herself in a favorable light. High L scores can be obtained by denying peccadilloes of which all of us have been guilty at one time or another, in an apparent attempt to put oneself in a better light (hence, the presumption of lying). However, there are reasons other than malingering why a person might obtain a high score on the L scale, and smart malingers might be able to “see through” the test, particularly now with information available on the Internet. There are usually a lot of things other than the accident going on in peoples’ lives, and they may have reasons to be secretive on psychological tests other than an at-

tempt at symptom fabrication. Moreover, this scale is impacted by English proficiency and education: less well educated, lower IQ, less sophisticated people from lower socioeconomic classes tend to get higher scores on the L scale. Even to the extent that one would accept the L scale as a measure of actual “lying,” this would relate specifically to lying on the MMPI, not cheating on one’s spouse or lying about one’s back pain or anything else. It would be silly to assume that someone who is lying to make himself look better than he is on a psychological test would necessarily be lying about everything else in his life. To use the L scale (or any other similar scale) as conclusive of malingering is a major overreach – and yet people do exactly that. We actually had a case a few years ago of an orthopaedic surgeon complain at a multidisciplinary conference that he had found the L scale of the MMPI useless in helping him determine which of his patients were good vs. bad surgery candidates.

It is, in any case, extremely dangerous to come to diagnostic conclusions about a specific patient on the basis of probabilistic evidence. Even if 75 percent of people with elevated L scales should turn out to be malingerers if they have a workers’ compensation claim, that still leaves an awful lot of uncertainty with respect to a specific claimant. Similarly, if 75 percent of patients with elevated scores on a test turn out to have cancer, would you start chemotherapy based only on the finding that you fall in that 75 percent?

The reality is that there is no psychological trick test that will reveal the malingerer beyond any doubt, and anyone who tells you any differently is attempting to trick you. However, there are factors that increase the likelihood that a particular complaint is fabricated.

So, How Can You Pick Them Out?

While it is important to recognize that many cases will fall in the grey area, the fact remains that there are cases of conscious fabrication of symptoms. How can you go about differentiating between conscious and unconscious motivation and unmasking the true malingerer?

The DSM-IV does provide some hints as to when malingering should be suspected.

MALINGERING SHOULD BE STRONGLY SUSPECTED IF ANY COMBINATION OF THE FOLLOWING IS NOTED:

1. *Medicolegal context of presentation.*

2. *Marked discrepancy between the person’s claimed stress or disability and the objective findings.*
3. *Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen.*
4. *The presence of antisocial personality disorder.*

However, these “hints” are really of limited value. Let’s look at the reasons why: (1) Hiring an attorney may be an attempt by a malingerer to obfuscate and hide behind the lawyer, but many people hire attorneys because the insurance company seems to be giving them the run-around and others have a policy of always being represented when dealing with large institutions to avoid being taken advantage of; (2) There may be a discrepancy between the person’s symptoms and what the orthopaedist thinks they should be because the claimant is faking, but the doctor may not be on his game the day he sees the claimant, he may not be that good a doctor and may have missed something, or medicine may be missing something (see our earlier discussion); (3) The claimant may not be very cooperative with evaluations and prescribed treatment out of a desire to dissimulate, maybe because he just “doesn’t believe in doctors” or because his wife, who is a nurse’s aide and his own personal medical authority, told him the treatment plan made no sense to her; and (4) As for the presence of an antisocial personality disorder (people with this disorder are often referred to as psychopaths or sociopaths), remember that folks in prison, even if guilty as sin of the crimes with which they are accused, sometimes do get sick, they develop cancer and they die of heart attacks. So, these hints are just that – hints that should lead to suspicion. Taken individually, they are by no means conclusive.

At the end of the day, the unmasking of a malingerer will almost always be done on the basis of converging lines of evidence, i.e., that all the different lines of evidence points to fraud.

Beyond the “hints” provided by the DSM is performance on a variety of psychological tests. For example, a high L score on the MMPI, while by no means diagnostic on its own as discussed above, should increase suspiciousness. Similarly, one of the most common complaints following motor vehicle and workers’ compensation accidents is a disturbance in memory functions. In some cases memory disturbances are the product of organic brain damage, but in most cases they derive from anxiety or depression. However, memory complaints may also be used as part of the symptom picture presented by the malingerer in an attempt to suggest brain damage. Psychological

tests such as the California Verbal Learning Test can be useful in identifying response patterns that simply do not fit with a typical diagnosis of brain dysfunction, anxiety or depression, and that suggest symptom fabrication. The WAIS-III (Wechsler Adult Intelligence Scale) can be similarly useful in identifying unusual response patterns in cognitive functioning generally. Moreover, neuropsychologists often administer tests which can be performed well by persons with brain injuries to detect suspected malingerers, who perform more poorly on these tests than patients with actual brain damage. The Test of Memory Malingering (TOMM) and the Rey Fifteen Item Test (FIT) are two such tests that are used extensively for this purpose. When used with caution and due concern for false positives, psychological tests such as these can be very useful.

Other factors that have been found or are believed by mental health specialists to be correlated with malingering include:

CLAIMANT BEHAVIORS

- Dramatic or atypical presentation.
- Patient relates events too fantastic to be believed (a.k.a. pseudologia fantastica).
- Vague and inconsistent details, although possibly plausible on the surface.
- Admission circumstances that do not conform to an identifiable medical or mental disorder.
- Presentation in the emergency department during times when obtaining old medical records is hampered or when experienced staff are less likely to be present (e.g., holidays, late Friday afternoons).

REPORTED SYMPTOMS

- Rare or bizarre symptoms.
- Symptoms worsen over time.
- Symptoms begin after a latency period.
- Multiple symptoms.
- Few symptoms volunteered initially.
- Never reported it to anyone else.

MEDICAL PRESENTATION

- Knowledge of textbook descriptions of illness.
- An unusual grasp of medical terminology.
- Symptoms or behaviors only present when the patient is being observed.
- Fluctuating clinical course, including rapid development of complications or a new pathology if the initial workup findings prove negative.
- Controlling, hostile, angry, disruptive or attention-seeking behavior with medical personnel or during hospitalization.
- History of substance abuse, especially of prescribed analgesics and sedatives.

INCONSISTENCIES

- Between self-report and abilities.
- Between self-report and testing.
- Between self-report and medical record.
- Between self-report and family interview.

Conclusions

In sum, short of “hard evidence” such as a video of the allegedly bedridden claimant boogeying the night away, what eventually allows us to unmask the malingerer is the weight of the evidence. Unmasking a malingerer is a bit like convicting a criminal in a court of law. If the murder weapon belongs to the accused and the accused is an unsavory character with the motive and the opportunity, then conviction is easy. If the claimant yields a test profile that is suggestive of malingering, there is a history of dishonest acts and there is supportable motive (e.g., impending loss of job) and opportunity (an accident-related “injury” with minimal physical findings), then the diagnosis of malingering becomes reasonably straightforward.

The diagnostician’s task of diagnosis can be facilitated by giving him or her all the relevant information. Go back and review the DSM-IV criteria and the “hints” outlined above: any information about any of these, such as the claimant’s poor cooperation with treatment or significant discrepancies between the claimed level of disability and physical findings, is potentially important. So is any information on possible external incentives for symptom fabrication, such as information about forthcoming

ing lay-offs at the claimant's place of employment or tax returns showing that the claimant did not in fact earn what he claims to have earned. Any information bearing on intentionality should also be considered relevant.

Armed with all the relevant information, the diagnostician will then be in a position to go through the Differential Diagnosis, administer the most relevant tests and then interpret them in a way that is most diagnostically appropriate. Given solid evidential grounds, a competent physician or psychologist should not shy away from a diagnosis of malingering. Conversely, given similar evidence, competent adjusters should not shy away from acknowledging mechanisms other than malingering in cases where symptomatology is in excess of physical findings. As noted earlier, if the claim is to be denied, it should be denied based on the correct diagnosis and rationale.

Doing so is not only the right thing to do diagnostically and legally, it should also decrease the likelihood of the insurer, and possibly the adjuster, being dragged into a bad faith lawsuit.

Additional Readings

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington: American Psychiatric Association, 1994.

Boza RA, Liggett SB. Pseudohallucinations: radio reception through shrapnel fragments. *Am J Psychiatry* 1981; 138: 1263-4.

Halligan, P.W., Bass, C. and Oakley, D.A.. *Malingering and Illness Deception*. Oxford: Oxford University Press, 2003.

Lacroix, J. M. Assessing illness schemata in patient populations. In Skelton, J.A., and Croyle, R.T. (Eds), *Mental Representation in Health and Illness*. New York: Springer-Verlag, 1991.

McBirnie, Thomas J. Report on the Workers Compensation Anti-Fraud Program, California Commission on Health and Safety and Workers Compensation (2001). <http://www.dir.ca.gov/CHSWC/Finalfraudreport0801.html>

Rogers, Richard. *Clinical Assessment of malingering and deception*. New York: Guilford Press, 2008. (See particularly Chapter 9, on Feigned Medical Presentations).

Ziskin, J. and Faust, D. *Coping with Psychiatric and Psychological Testimony*, Fourth Edition. Marina del Rey: Law and Psychology Press, 1988. (see particularly Chapter 18 in Volume 2: Challenging the assessment of malingering or credibility.)

Separating the Real from the Malingered, and Fact from Fiction

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Please Circle the Correct Answer:

1. Malingering does not necessarily involve which of the following:

- A. False or greatly exaggerated symptoms
- B. The symptoms are produced intentionally
- C. The symptoms are produced in order to obtain external incentives
- D. These external incentives always involve money

2. Under hypnosis, many people can be made to experience temporary paralysis in a limb, numbness, pain, mutism, blindness, loss of memory, and even visual hallucinations. This is treated in the text as evidence for:

- A. The notion that anybody can become a malingerer
- B. The operation of unconscious motivation
- C. The unappreciated importance of hypnosis in our daily lives
- D. The relative unimportance of neurology in the understanding of workers' compensation injuries

3. Historically, malingering:

- A. Has been with us since ancient times
- B. Originated with the building of the railways and the beginnings of workers' compensation legislation

- C. Originated with Franklin D. Roosevelt's New Deal legislation
- D. Originated with Lyndon B. Johnson's Great Society legislation

4. Which of the following does not belong?

- A. Somatoform Disorder
- B. Conversion Disorder
- C. Schizophreniform Disorder
- D. Pain Disorder

5. Disorders characterized by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role:

- A. Somatoform Disorders
- B. Schizophreniform Disorders
- C. Conversion Disorders
- D. Factitious Disorders

6. A patient's internal model or understanding or abstraction of his/her medical condition may be called his/her:

- A. Zebra
- B. Schema
- C. Somatoform model
- D. Factitious model

7. The best summary of the evidence as to the proportion of malingerers in the workers' compensation system, according to the California Commission on Health and Safety and Workers' Compensation (2001):

- A. About 50% of claimants
- B. About 30% of claimants
- C. Less than 1% of claimants
- D. No one really knows

8. The text argues that the unmasking of a malingerer will almost always be done on the basis of what kind of evidence?

- A. The MMPI
- B. Psychological memory tests
- C. Converging lines of evidence
- D. Surveillance

9. Which of the following would not particularly increase one's suspiciousness about the possibility of malingering?

- A. A claimant with an unusual grasp of medical terminology
- B. A claimant whose symptoms emerged three months after the accident
- C. A claimant with a history of depression
- D. A claimant with a history of abuse of Percodan

10. Which of the following would not particularly increase one's suspiciousness about the possibility of malingering?

- A. Inconsistencies between the claimant's version of the accident and injuries and his family's
- B. A claimant whose symptoms have been getting worse over time
- C. A claimant who is controlling, hostile, angry, disruptive and attention-seeking
- D. A claimant who is a legal immigrant

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Instructions:

Using a scale of 1 to 5, with 1 being poor and 5 being excellent, please rate the following:

How well we:

Defined malingering	1	2	3	4	5
Describe two points that would demonstrate how malingering can be proven/documented	1	2	3	4	5
Differentiate between intentional and unconscious malingering	1	2	3	4	5
List three situations where malingering should be considered	1	2	3	4	5
Value of topics	1	2	3	4	5
Relevance to the practice	1	2	3	4	5
Quality of information	1	2	3	4	5

Please share one point you learned or were not aware of regarding malingering that you now have a clearer understanding after reading the supplement.

What practical takeaways did you gain from the supplement that you can incorporate into your practice?

Have you encountered a case where you suspected a patient may be malingering? Yes ____ No ____ . If yes, please share how you worked with the treating physician and adjuster to address the situation.

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