

Detection and management of malingering in people presenting for treatment of posttraumatic stress disorder: Methods, obstacles, and recommendations

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Abstract

Malingering of symptoms of posttraumatic stress disorder (PTSD) has become a growing concern, particularly in healthcare and other settings in which the diagnosis is associated with financial incentives such as disability benefits. Although there is a steadily increasing body of research on methods for detecting PTSD malingering, little has been written on the assessment and practical management of malingering in treatment settings. The present article addresses this important issue, including a review of the methods, obstacles, and possible solutions for assessing PTSD malingering, along with suggestions for managing cases in which malingering is strongly suspected.

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Posttraumatic stress disorder (PTSD) arises after exposure to a traumatic stressor. That is, following exposure to a situation or event that is, or is perceived to be, threatening to the safety or physical integrity of oneself or others. PTSD symptoms include reexperiencing of the trauma (e.g., recurrent and intrusive thoughts, distressing dreams), avoidance and emotional numbing (e.g., avoidance of reminders of the traumatic event, restricted range of affect), and hyperarousal (e.g., exaggerated startle response) ([American Psychiatric Association \[APA\], 2000](#)). In other words, to diagnose PTSD these symptoms must persist for at least one month and must be associated with significant distress or impairment in functioning.

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Traumatic events are common, yet PTSD is comparatively rare. Estimates indicate that 40–60% of community adults have been exposed to trauma (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Yehuda & Wong, 2001), whereas the lifetime prevalence of PTSD is 8% (APA, 2000). Vulnerability factors, such as particular learning experiences or genetic factors, likely influence the person's risk of meeting criteria for PTSD after exposure to a trauma (Stein, Jang, Taylor, Vernon, & Livesley, 2002).

In order to diagnose PTSD according to the DSM-IV-TR, malingering needs to be ruled out (APA, 2000). Malingering is the intentional production of false or grossly exaggerated symptoms, motivated by external incentives. There are three recognized forms of malingering: (1) *pure malingering*—complete fabrication of symptoms, along with the possible fabrication of traumatic experiences; (2) *partial malingering*—gross exaggeration of existing symptoms or reporting of remitted symptoms as ongoing, along with the possible exaggeration of aversive experiences; and (3) *false imputation*—intentional and false attribution of symptoms to a traumatic event (Resnick, 1997). Malingering is less likely to occur in children than adults. However, parents may coach a child to report symptoms that the child does not have, or to exaggerate complaints (Lubit, Hartwell, van Gorp, & Eth, 2002). Coaching similarly can occur in adults, as illustrated by cases in which attorneys have coached their clients to report symptoms (Aronson, Rosenwald, & Rosen, 2001; Youngjohn, 1995).

There are several reasons why a person might malingering PTSD, with the most obvious being financial incentives. A survivor of a work-related accident or road traffic collision might malingering PTSD in order to obtain a large workers' compensation or insurance settlement, or a military veteran might malingering PTSD in order to obtain government disability benefits. In forensic settings, PTSD might be malingering in order to avoid criminal responsibility (as part of the "not guilty by reason of insanity" defense). There are additional, more easily overlooked, reasons why a person might malingering PTSD. Some patients malingering PTSD in order to justify their level of functioning to others, such as a history of failed relationships, poor occupational functioning, or legal problems (Lacoursiere, 1993). In such cases the person may feign PTSD in order to "save face" (e.g., "It's not my fault—I'm not to blame—it's all due to what happened back in 'Nam"). In some cases the primary motive for feigning combat-related PTSD may be to impress the general public or to gain the attention and respect of fellow veterans (Lacoursiere, 1993). Such patients may exaggerate or fabricate how they survived extreme conditions or even performed heroically under severe stress. Here, the fabrication of PTSD symptoms serves to underscore the dramatic nature of their traumatic experiences.

The purpose of this article is to consider the prevalence and importance of PTSD malingering, and to discuss methods, obstacles, and possible solutions for identifying and managing malingering in patients seeking treatment for PTSD in clinical settings. To our knowledge, very little has been previously written on how to manage patients who are malingering PTSD, aside from confronting the patient and terminating treatment. No empirical studies have been published on how to best manage PTSD malingering. In this article we offer some suggestions and consider some important directions for future investigation.

1. Prevalence of PTSD malingering

Most of the relevant research on PTSD malingering has regarded malingering as a monolithic construct, rather than distinguishing among the three forms mentioned earlier. In such studies PTSD malingering is estimated to occur in at least 20–30% of personal injury claimants

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