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Assessing malingered posttraumatic stress disorder: A critical review

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Abstract

This article is a critical examination of the current state of the literature regarding the assessment of malingered posttraumatic stress disorder (PTSD). First, published empirical studies that examine the assessment of malingering in PTSD claimants using the American Psychiatric Association's *Diagnostic and Statistical Manual* criteria are summarized. Next, conceptual and methodological strengths, weakness, and limitations of existing research are outlined. Currently, there is no method or single instrument that is universally recognized as being the best tool to detect malingering in PTSD claimants. Lastly, recommendations for future investigations are provided.

Keywords: Malingering; Posttraumatic stress; Posttraumatic stress disorder; Faking

1. Introduction

During the past 20 years, research regarding the ability to detect malingering, the feigning of symptoms for secondary gain, in posttraumatic stress disorder (PTSD) claimants has grown rapidly. PTSD is an anxiety disorder resultant from exposure to a traumatic event (American Psychiatric Association [APA], 1994). It is a diagnosis particularly vulnerable to malingering because it is characterized by a number of subjective symptoms and is commonly associated

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with reinforcing financial and personal gains (e.g., disability benefits). PTSD is also characterized by a variable symptom profile and is highly comorbid with a variety of clinical and personality disorders, making detection of malingering a challenging endeavor. This article is a critical review of published empirical literature pertaining to the assessment of malingered PTSD.

1.1. Overview and assessment of malingering

Malingering is defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV; APA, 1994) as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives. . ." (p. 683). Inclusion of a motivational specifier distinguishes malingering from factitious disorder and other forms of dissimulation because it requires that an individual be conscious of his/her intentionally deceitful attempt to achieve secondary gain in the form of external incentives (APA, 1994; Cunnien, 1997; Franzen, Iverson, & McCracken, 1990; Nies & Sweet, 1994).

Resnick (1997) described three distinct types of malingering: (a) "pure malingering," or complete fabrication of symptomatology, (b) "partial malingering," in which existing symptoms are overreported or remitted symptoms are reported as ongoing, and (c) "false imputation," where symptoms are intentionally misattributed to a traumatic event. Any of the three may potentially be found in cases of malingered PTSD (Hall & Poirier, 2001). Rogers' (1997) adaptational model of malingering is most applicable to PTSD cases (Koch, Shercliffe, Federoff, Iverson, & Taylor, 1999; Resnick, 1997). This model describes the feigning of psychological symptoms as the result of a cost–benefit analysis in a situation where there is "substantial personal investment." Rogers and others (e.g., McGuire, 1999) support this model because it is minimally pejorative.

Exact prevalence rates for malingering are currently nonexistent. This is largely because practitioners are so conditioned to accept client reports as being ingenuous that they fail to scrutinize the accuracy of the report and, consequently, do not formally assess for malingering (e.g., Cunnien, 1997). Rogers (1997) found that estimates of malingering from nonforensic evaluators are currently absent. This is important since figures from forensic evaluators may be spuriously inflated relative to those in nonforensic settings given the adversarial nature of such evaluations (e.g., Hickling, Taylor, Blanchard, & Devineni, 1999). Clinicians may be apprehensive to include malingering indices in their assessment batteries because they are intimidated by legal consequences or confrontation with potentially dangerous clients (Resnick, 1997). Furthermore, the relative infrequency of malingering assessment may result from the lack of a universally recognized "gold standard" instrument (Koch et al., 1999; McGuire, 1999; Rose, Hall, Szalda-Petree, & Bach, 1998).

When malingering is assessed, prevalence rates vary considerably. In a survey of forensic evaluators, base rates of malingering were estimated to be 15.7% for forensic clients and 7.4% in nonforensic evaluations (Rogers, Sewell, & Goldstein, 1994). Estimates of malingering psychological symptoms following personal injury are reported to range from 1% to over 50% (Hickling et al., 1999; Resnick, 1997). Lees-Haley (1997) found that as many as 20–