

# Should Malingering Matter to Speech Language Pathologists?

Suzanne Hungerford & Nancy Bassendowski

Plattsburgh State University of New York, Department of Communication Disorders and Sciences

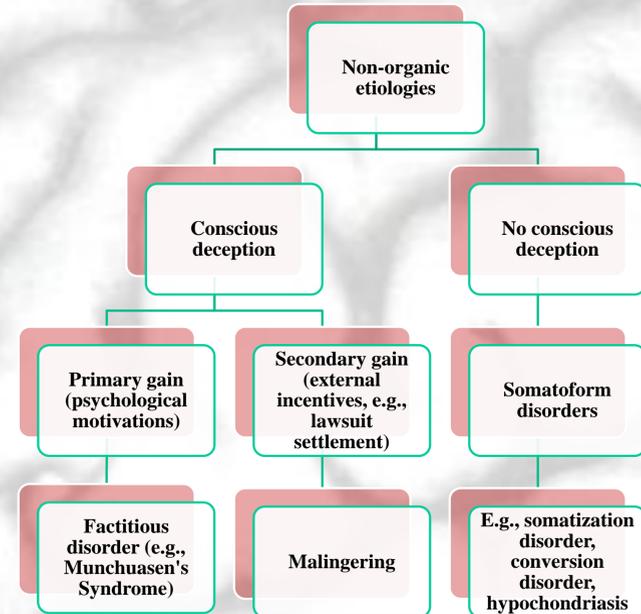
## Introduction

- Malingering is the intentional feigning or exaggeration of disorders for the purpose of secondary gain, such as obtaining an insurance settlement, getting disability payments, or avoiding criminal prosecution (American Psychiatric Association [DSM-IV-TR], 2000).
- Malingering constitutes fraud and places unnecessary burdens on the healthcare system.
- Malingering can involve somatic disorders (e.g., back or swallowing pain) or psychological or neurocognitive disorders (e.g., including mental illness, memory impairment, or communication disorder).
- “Malingering by Proxy” is also recognized by some researchers (Feldman, 2004).
- Malingered cognitive or communication impairment is an important consideration in assessment – particularly in cases where litigation, benefit eligibility, or expert legal testimony of the SLP is involved.
- Rogers (2008) maintained that malingering is often not considered as a diagnostic possibility because clinicians believe its occurrence is very rare, when in fact, malingering is not rare in either clinical or forensic settings (e.g., litigation).
- Research shows that is easy for untrained persons to report typical symptoms of brain injury and to perform on neuropsychological tests like patients with moderate to severe TBI (Meyer, 2007).
- It has been estimated that 39% of individuals with mild head injury may feign symptoms (Mittenberg, Patton, Canyock, & Condit, 2002).
- In Kane’s (2008) review, it was determined that in forensic contexts, estimates of malingering range from 8% to 41%. Kane also reported that “as many as 20% of students seeking ADHD evaluation were probably exaggerating symptoms or malingering” (p. 7).

## Documented Malingering of Communication, Cognitive, and Swallowing Disorders

-  Mutism, dysphonia, dysphagia, breathing disorders, and deafness <sup>1</sup>
-  Dysphagia and odynophagia (painful swallow) <sup>2</sup>
-  Stuttering <sup>3</sup>
-  Neologisms and incoherent speech <sup>4</sup>
-  Slurred speech and “prominent tongue protrusion” <sup>5</sup>
-  “Severe [speaking] effort and tension ... marked hesitations, and forceful articulation,” anomia, abnormalities of syntax, reading difficulty, and other receptive and expressive language difficulties <sup>6</sup>
-  Neurocognitive dysfunctions typically associated with brain injury <sup>7</sup>
-  Learning disorders and attention deficit hyperactivity disorder (ADHD) <sup>8</sup>

## Differentiating Non-Organic Disorders



## Hallmarks of Malingering

- The “presence of substantial external incentive” (pending lawsuit, lawyer referral, seeking disability benefits, etc.);
- Difference between claimed stress and observed findings;
- Says tests are “too hard;” may be vague or evasive;
- May fail very easy or practice items on a test;
- Perform recognition memory tests at levels less than chance;
- Inconsistent symptoms or performance across similar trials;
- Lack of cooperation during assessment or failure to follow through on therapy recommendations;
- Inquiring about or suggesting unlikely symptoms often results in client saying he/she has those symptoms;
- Antisocial personality disorder or histrionic personality disorder;
- Neuropsychological evidence conflicts with reported symptoms.

## Detecting Malingering

- Potential for bias of malingering detection due to reliance on clinical judgment (Halligan, Bass, & Oakley, 2003).
- Individuals who are malingering may research evaluation methods and malingering detection strategies. Therefore, techniques devised to detect malingering should be complex and/or multi-pronged (Neudecker & Skeel, 2009).
- The majority of malingering detection strategies utilize the floor effect which means that a low performance on specific test items is rare and usually reflects the individual intentionally scoring poorly (Neudecker & Skeel, 2009).
- As well, the test items should increase in difficulty level. For individuals who are not feigning difficulty, they will require more time to respond to test items as the level of difficulty increases. However, individuals who are malingering will require less response time (Neudecker & Skeel, 2009).
- On assessment tests where there are parallel forms (such as the *Peabody Picture Vocabulary Test (PPVT)*), administer both forms with a short delay to compare the results. Individuals who are malingering will have a very difficult time obtaining similar scores on both forms (Hall & Poirier, 2001).
- Symptoms are not resolved with treatment when they are deliberately demonstrated. These symptoms may be exaggerated (Babbitt & Gross, 2002).
- Some tests available to SLPs have inconsistency measures (*CVLT II, BRIEF*). Psychologists and neuropsychologists are more familiar with tests of malingering, and consultation may be indicated: Malingering detection tests include: *Test of Memory Malingering (TOMM)*, *Rey 15 Item, Recognition Memory Test*, *Word Memory Test*, *Validity Indicator Profile*, *Computerized Assessment of Response Bias*, *Portland Digit Recognition Test*, *Victoria Symptom Validity Test*, and *Digit Memory Test* (Slick et al., 2004).
- **Caution: NO MALINGERING TEST HAS PERFECT SPECIFICITY or SENSITIVITY.**

## Summary and Implications

- Ross et al. (2006) stated that “the assessment of malingering seems almost a preoccupation among neuropsychologists” (p. 798), yet the speech-language pathology literature related to malingering is very scant (Abudarham & White, 2001). There is ample evidence, however, that speech, language, swallowing, and cognitive disorders are sometimes malingered.
- In 2005, ASHA published a position statement indicating that SLPs have a role in the assessment and management of individuals with communication disorders associated with cognitive impairment, making malingered neurocognitive disorders a concern for SLPs.
- **Food for thought:**
  - “Because malingering for the purpose of compensation constitutes criminal behavior, document the diagnosis meticulously. When in doubt, assuming that the patient is not malingering is a better course of action.” (<http://emedicine.medscape.com/article/293206-print>)
  - Singh et al. (2007) caution against confronting the malingeringer directly in order to avoid hostile reactions or lawsuits against the practitioner. They instead recommend stating that the objective findings do not meet the criteria for a diagnosis.
  - When confronted with evidence of malingering, most neuropsychologists handling medicolegal cases state in the report something like “the test results were invalid [or] inconsistent with the severity of the injury or indicative of exaggeration” (Slick et al., 2004, p. 470).
- Malingered disorders can cause frustration for the clinician, and malingered disorders have economic and legal implications for the society at large (Vaiman, Shoval, & Gavriel, 2009).
- **Malingering should matter to SLPs.**

<sup>1</sup> Granacher and Berry (2008 ); <sup>2</sup> Vaiman, Shoval, & Gavriel (2009); <sup>3</sup> Seery (2005) <sup>4</sup> Cornell & Hawk (1989); <sup>5</sup> Babin & Gross (2002, p. 8); <sup>6</sup> Abudarham & White (2001, p. 60); <sup>7</sup> e.g., Babin & Gross (2002); <sup>8</sup> Harrison, Edwards, & Parker (2007); Alfano & Boone (2007); Kane (2008).