

6. Pope, M., Anderson, G., Frymoyer, J., and Chaffin, D. (Eds.), *Occupational Low Back Pain: Assessment, Treatment and Prevention*. Mosby Year Book, St. Louis, 1991.
7. Cailliet, R., *Head and Face Pain Syndromes*. Rene Cailliet Pain Series, Edition 1, FA Davis Co, Philadelphia, 1992.
8. Cailliet, R., *Neck and Arm Pain*. Rene Cailliet Pain Series, Edition 3, FA Davis Co, Philadelphia, 1991.
9. Cailliet, R., *Lower Pain and Disability*. Rene Cailliet Pain Series, Edition 3, FA Davis Co, Philadelphia, 1992.
10. Cailliet, R., *Shoulder Pain Syndrome*. Rene Cailliet Pain Series, Edition 3, FA Davis Co, Philadelphia, 1991.
11. Cailliet, R., *Low Back Pain Syndrome*. Rene Cailliet Pain Series, Edition 4, FA Davis Co, Philadelphia, 1988.
12. Cailliet, R., *Hand Pain and Impairment*. Rene Cailliet Pain Series, Edition 4, FA Davis Co, Philadelphia, 1994.
13. Sella, G.E., Dubbert and New Technologies: An Independent Medical Examiner's View, Parts 1 & 2, *Forensic Examiner: The Official Journal of the American College of Forensic Examiners*, Vol. 6 & 8, Nos. 5, 6, 7 & 8, May/June & July/August 1997.
14. AMA Guides to Evaluation of Permanent Impairment, 4th Edition, 1993.
15. Sella, G.E., *Neuromuscular Testing with S-EMG*. GENMED Publishing, Martins Ferry, OH, 1995.
16. Sella, G.E., The Utilization of S-EMG in Neuromuscular Rehabilitation, Proceedings: 9th European Congress of Clinical Neurophysiology, Ljubljana, Slovenia, June 4-7, 1998, pp. 375-359, Mondazzi Editor, International Proceedings Division.
17. Sella, G.E., *Guidelines for Neuro-muscular Resuscitation: The Electromyographic Approach*. GENMED Publishing, Martins Ferry, OH, 2000.
18. Fischer, A.A., New developments in diagnosis of myofascial pain and fibromyalgia. *Phys Med Rehabil Clin North America* 1977;8:1-21.
19. Fischer, A.A., Application of pressure algometry in manual medicine. *J. Manual Medicine*, 1990;5:145-150.
20. Fischer, A.A., Clinical use of tissue compliance meters for documentation of soft tissue pathology. *Clin J Pain* 1997;3:23-30.
21. Fischer, A.A., Quantitative and objective documentation of soft tissue abnormalities: Pressure algometry and tissue compliance recording. *Spinal Manipulation*, Summer 1994;1-4.
22. Fischer, A.A., Pressure algometry over normal muscles. Standard values, validity and reproducibility of pressure threshold. *Pain* 1987;30:115-126.
23. Fischer, A.A., Pressure threshold measurement for diagnosis of myofascial pain and evaluation of treatment results. *Clin J Pain* 1987;2:207-214.
24. Fischer, A.A., Diagnosis and management of chronic pain in physical medicine and rehabilitation. In *Current Therapy in Physiatry*, edited by Ruskin AP, Philadelphia, 1984, WB Saunders, 123-145.
25. Fischer, A.A., New approaches in treatment of myofascial pain. *Phys Med Rehabil Clin North America* 1977;8:153-169.
26. Fischer, A.A., Muscle tone in normal persons measured by tissue compliance. *J of Neurological & Orthopaedic Medicine & Surgery* 1987;8:227-233.
27. Sella, G.E., *Muscular Dynamics: Electromyographic Assessment of Energy and Motion*, GENMED Publishing, Martins Ferry, OH, 2000.
28. Gerbaud, J.J., *Documentation of Joint Motion*, Revised 3rd edition, Portland, OR, Oregon Medical Association, 1992.
29. Sella, G.E., *Muscles in Motion: The S-EMG of the Range of Motion of the Human Body*, GENMED Publishing, Martins Ferry, OH, 1993.
30. Hagberg, M., Electromyographic signs of shoulder muscle fatigue in two elevated arm positions. *Am J Phys Med* 1981;60:111-121.
31. Sella, G.E., S-EMG Utilization in Low Back Pain Investigation and Rehabilitation. *Kinesiotherapy Scientifique*, p. 35, No. 383, Paris, France, November 1998.
32. Sella, G.E., Internal Consistency, Reproducibility and Reliability of S-EMG Testing. *Europa MedicoPhysica*, March 2000, Vol. 36, No. 1, pp. 31-38.
33. Sella, G.E., Surface Electromyography Testing: Sensitivity, Specificity, Positive and Negative Predictive Values. *Europa Medico-physica*, December 2000.
34. Anchor, K., Felicetti, T.C., eds. *Disability Analysis In Practice*. Kendall/Hunt Publishing Co, Dubuque, Iowa, 1999, Chapter 15, pp 279-314.
35. Sella, G.E., S-EMG assessment. In Yao-Ping Zheng and Shu-Qiao Yao, *The Practice of Biofeedback*, Chapter IV, High Education Press in P.R. China, July 2001.
36. Basmajian, J.V., and DeLuca, C.J., *Muscles Alive, Their Functions Revealed by Electromyography*, 5th Edition, Baltimore, Williams & Wilkins, 1985.
37. Sella, G.E., *Graphics of Motion: The Electromyography of Muscular Dynamics*. GENMED Publishing, Martins Ferry, OH, 2000.
38. Kumar, S., Mital, A., *Electromyography in Ergonomics*. Taylor & Francis, 1996.

LLOYD I. CRIFE, PhD

## MALADY VERSUS MALINGERING: A TRICKY ENDEAVOR

Private Practice  
Carlsborg, Washington

Reprint requests to:  
Lloyd I. Crife, PhD  
P.O. Box 250  
Carlsborg, WA 98324

They only are deceived who willingly  
deceive themselves.

—James of Scotland

Diagnosticians are challenged by patients whose reported problems are difficult to verify objectively. These patients present with disorders that lack definitive research and objective medical tests. The diagnosis of the disorder relies heavily upon accurate patient symptom reporting. Examples of these types of disorders are headaches, chronic pain syndromes, concussions, chronic fatigue syndrome, and fibromyalgia. Medical-legal and compensation issues are often involved.

Confronted by these types of cases, the medical diagnostician typically obtains a history and reports of symptoms from the patient and significant others. This is followed by appropriate medical tests that are usually negative. After exhausting the available avenues of objective medical exploration, there is consideration of psychological conditions such as somatoform disorders (unconscious psychological causes). When medical-legal compensation issues are involved, there may be suspicions of secondary gain. In some cases, malingerer (conscious deliberate feigning of illness for monetary rewards) is considered.

Following the negative medical findings, the patient is usually referred to a psychiatrist or psychologist for evaluation. The psychiatric evaluation involves medical records review and an interview of the patient. Significant others may be interviewed. A diagnostic conclusion is formed and a report issued.

In addition to the procedures used in the psychiatric evaluation, a psychological evaluation includes the administration of a battery of standardized tests. The battery of tests usually includes cognitive performance tests and psychological symptom inventories. Tests of effort and motivation are often included to identify questionable effort, poor motivation, deception, and malingering. Often the patient is found by the psychiatrist or psychologist to have a psychological problem such as depression or a somatoform disorder. If the patient performs poorly on effort tests and monetary compensation issues are involved, it is concluded that the patient is of questionable motivation, driven by secondary gains and possibly malingering.

Following the psychological consultation, the referring medical diagnostician receives a report of the psychological findings and determines whether any interventions or treatments are necessary. The patient is often either directly or indirectly placated or rejected by the physician. If litigation or other compensation is involved, the medical findings are used to complicate litigation or to deny benefits.

The basic thesis of this chapter is that the diagnostic process with these challenging patients is in general a complicated interpersonal relationship, but it is further complicated and challenged when medical-legal situations are involved. It is especially challenged when the doctor is working for defense counsel or insurance companies. A third entity is imposed on the relationship, and the examination is mandated. This places a heavy strain on the relationship and the purpose of a good diagnostic evaluation is potentially thwarted. This endeavor is a tricky business fraught with problematic assumptions and potential pitfalls. In these situations, it is often difficult to know who is deceiving whom and who is being deceived.

To better understand these issues, this chapter discusses the general process of the diagnostic evaluation, the interpersonal doctor-patient relationship, the limits and hazards of detecting deception, the problems with psychological assessment procedures, and the complexities of the medical-legal diagnostic relationship. Underlying assumptions, misconceptions, and pitfalls are discussed. Suggested guidelines for more effective diagnostic relationships in complicated cases are presented.

## THE DIAGNOSTIC RELATIONSHIP

The only way to make a man trustworthy is to trust him.

—Henry Lewis Stimson

The doctor-patient relationship is now briefly discussed to help understand how the relationship is complicated when trying to determine the presence or absence of a somatoform disorder or malingering. For the reader who wants more understanding of the general dynamics of the doctor-patient relationship, several references are provided.<sup>30,34,35,36,30,32,33</sup>

Medical diagnosis is an interpersonal process involving two or more persons, the doctor, the patient, and others (e.g., referral source, a funding source, significant others). As in all interpersonal relationships, the diagnostic relationship involves a collaborative effort with roles and responsibilities for all the players to ensure the successful accomplishment of goals. Although not usually explicit, the goal is an accurate diagnosis that leads to effective treatment.

The primary role of the doctor is to apply professional training, knowledge, and experience to collect patient information and formulate an accurate diagnosis and treatment plan to ameliorate disease and suffering. The primary role of the patient is cooperation with the diagnostic endeavor and treatment compliance.

Fundamental to the relationship is mutual respect and trust. Patients need to believe and trust that they will be understood and treated professionally and compassionately. They are in a vulnerable position with a powerful authority figure. The diagnostician needs to trust the patient's report of problems, because diagnosis of a disease involves an understanding of the type of problems (symptoms), their onset, and course. Every pathology has a predictable onset, pattern, and course of symptoms. Knowing the history of the problem and its development is essential. The major source of this history is the patient. The doctor needs to trust the patient's report.

Medical disorders that have clear-cut objective technological diagnostic procedures depend less upon the patient's report. Trust in the patient's report is especially important in diagnosing disorders that have few, if any, objective tests. Such disorders rely heavily upon the patient's report of symptoms and place a heavy demand on the doctor's judgment (e.g., headaches, chronic pain syndromes, concussions, chronic fatigue syndrome, fibromyalgia).

The basic vehicle for developing and maintaining a relationship of respect and trust is communication. The communication skills of listening, talking openly, negotiating, and contracting plans of action are important for all concerned in the diagnostic relationship. This ensures successful accomplishment of the intended goals of accurate diagnosis and effective treatment.

The diagnostic relationship is intrinsically a powerful authority relationship. The patient is in a vulnerable and dependent position. The patient feels out of control with both his or her problems and with the doctor-patient relationship. The patient views the doctor as someone who knows the cause of the problem and can provide a cure. The patient is in a one-down position and at the mercy of the doctor. The doctor is invested in playing the role of a competent problem solver and healer. Out of necessity, the doctor has to take charge and manage the situation. Ideally, the doctor and patient will work together toward a better balance of power and responsibility.

Different patients respond differently to the doctor-patient authority relationship based upon their early life experiences with parental authority figures. Depending on their early treatment by parents, they learn a style of relating to persons in power and control. Some learn to listen, comply, and cooperate. Others learn to be skeptical, resistant, and even rebellious. Some develop an independent approach (Tell me what to do) in dealing with authority, while others develop an independent stance (Don't tell me what to do). Whatever the learned habits of relating to authority, patients bring these habits to the doctor-patient relationship. They also bring the attitudes and beliefs they have learned from home and culture about doctors. These attitudes span the gamut from over-idealized to over-demonized.

This is not a one-sided issue. Both the doctor and the patient bring to the relationship a particular psychological and interpersonal style, attitudes, and beliefs based upon their individual life histories and experiences. These styles interact consciously and unconsciously to influence and shape the dynamics and behaviors of the relationship.

Dr. Harry Stack Sullivan,<sup>34</sup> the late noted analyst, contributed significantly to our understanding of interpersonal relationships and their impact upon the development of a person's psychology. He coined a term "interpersonal pull" that helps understand how two or more persons affect each other in a relationship. Interpersonal pull refers to the fact that when two persons encounter each other, they tend to consciously and unconsciously pull responses from each other based upon their early

history that shapes their psychological and social dynamics. For example, if a person has learned a psychosocial dynamic of dependency, they tend in an authority relationship to pull dominance and control. On the other hand, a dominating person tends to pull submission and dependence from another person. This pull happens whether or not the persons are aware of it. Interpersonal pull between two persons is a very complex dynamic involving multiple pulls at conscious and unconscious levels.

The concept of interpersonal pull is important in understanding the dynamics of the doctor-patient relationship. Both the doctor and the patient are continually pulling conscious and unconscious responses from each other. The patient, operating from an often unrealistic expectation that the doctor has almost magical powers to diagnose problems and cure, is idolizing the doctor and pressuring him or her to deliver the magic. This stance fosters a mistaken belief that the patient is helpless and cannot be an active participant in the process. This places a heavy demand on the doctor to produce a successful outcome regardless of the complexity of the case. The patient's behavior pulls egotistic grandiosity from the doctor that puts pressure on him or her to be a messianic rescuer regardless of the complexity of the case. All of this is a setup for potential disappointment, frustration, projection, and blame. In power relationships, when unrealistic expectations are shattered, all involved tend to blame each other. Usually the weaker person in the relationship, the patient, receives the greater blame and ultimately loses.

Another significant factor impacting upon the diagnostic relationship is the referral source. Patients are either referred by themselves or others, but most often by others. When patients are self-referred, they usually enter the relationship with a positive expectation and commitment. They have chosen to be there and believe in the possibility of good results. This inspires trustworthiness, cooperativeness, and compliance. If the patient is referred by someone who trusts and believes in the doctor's professional skills, there is a higher probability that the patient has been prepared to enter the relationship with positive expectations and commitment. If the patient is referred by someone they do not trust (e.g., an agency, insurance company, or defense attorney), they are forced into the situation and enter the relationship with doubts, suspicions, and distrust. They come with a negative expectation for the outcome. This sets the stage for significant interpersonal resistance. Even before the doctor and the patient have physically met each other, the door to open-honest communication and a cooperative effort is closed. If the doctor enters the relationship with a distant demeanor suspicious of the patient's motivations, resistance from the patient is fueled. In this context, the possibility of developing mutual respect is seriously retarded. This tainted climate hampers the possibility of successfully accomplishing the purpose of the diagnostic process.

In general when patients enter the doctor-patient relationship because they want to be there, and have a belief that the doctor is dedicated to understanding and helping, there is a greater probability they will have a positive attitude about the relationship and cooperate. They trust and believe in the doctor. They will communicate more openly and honestly, and be cooperative and committed to the process. This creates the climate for the growth of a successful working relationship. Likewise, when doctors enter the doctor-patient relationship wanting to be there and have positive attitudes of trust in the patient, they communicate more effectively, involve the patient in the process, and are more committed. This mutual respect increases the probability of a positive working relationship that results in successful diagnosis and effective treatment.

## PATIENT REPORTS

Attentive history-taking does more than add details. It is the most important aspect of doctoring. While obtaining a history takes time, no time is more productively spent. Ultimately it lays the foundation for a human relationship between patient and doctor based on mutual respect. The time invested is but a small sacrifice for curing as well as healing.

—Bernard Lown

Different patients have different reporting styles. The particular reporting style is determined by a combination of the person's psychological, interpersonal, and cultural dynamics learned early in their lives. There are many reporting styles, but they basically fall into three categories: minimized, exaggerated, and balanced. Some patients are quiet, reserved, and constrained. They tend to under-report and minimize problems. Others are talkative, outgoing, or even effusive. They often mix a lot of emotion into their thinking and expression. They tend to over-report and maximize problems. Some persons exaggerate their reports. Others give very balanced reports, neither minimizing or exaggerating. It is important to understand that these styles of reporting exist and are not particularly right or wrong. The reporting style should not be confused with the issue of veracity or deception. The reporting style pulls various responses from the doctor. Some styles tend to pull accepting responses, while others pull pejorative and even rejecting responses.

When patients report problems and symptoms to a doctor, there are several possibilities regarding the veracity of their reports. The report may be accurate or inaccurate, or some mix of the two. Inaccurate reporting can be the result of misperception, lack of awareness, or prevarication. Inaccurate reporting can be consciously or unconsciously controlled.

If the report is accurate, it is useful and there is of course no problem trusting and using the information in the diagnostic process. If the report is inaccurate, the information is not useful and can be misleading. The doctor ideally needs to know what is true and not be misled into believing something that is false and confusing to the diagnosis. If the doctor perceives that the report is inaccurate, a cloud of suspicion quickly develops over the doctor-patient relationship, further complicating trust.

Reported symptoms and the correlation with a particular disorder require that the doctor have a thorough knowledge and experience with the disorder in question. It is difficult if not impossible to find and diagnose a disorder if you don't know what you are looking for. It is easy to be misled and deceived in trying to diagnose problems that are not understood. The greatest insurance against being deceived by a counterfeit in the diagnostic process is knowing what the genuine looks like.

It is important to realize there are three distinct disease-reporting possibilities when diagnosing a disorder:

- The patient has the disorder and is accurately reporting the problems.
- The patient has the disorder and is inaccurately reporting problems.
- The patient doesn't have the disorder and is inaccurately reporting problems.

Inaccurate reporting by a patient does not automatically connote conscious or unconscious intent. Nor does it necessarily mean that the patient is manipulating the situation for some type of gain. It is important to know that malingering persons can also have medical disorders. The presence of one does not exclude the other.

history that shapes their psychological and social dynamics. For example, if a person has learned a psychosocial dynamic of dependency, they tend in an authority relationship to pull dominance and control. On the other hand, a dominating person tends to pull submission and dependence from another person. This pull happens whether or not the persons are aware of it. Interpersonal pull between two persons is a very complex dynamic involving multiple pulls at conscious and unconscious levels.

The concept of interpersonal pull is important in understanding the dynamics of the doctor-patient relationship. Both the doctor and the patient are continually pulling conscious and unconscious responses from each other. The patient, operating from an often unrealistic expectation that the doctor has almost magical powers to diagnose problems and cure, is idolizing the doctor and pressuring him or her to deliver the magic. This stance fosters a mistaken belief that the patient is helpless and cannot be an active participant in the process. This places a heavy demand on the doctor to produce a successful outcome regardless of the complexity of the case. The patient's behavior pulls egotistic grandiosity from the doctor that puts pressure on him or her to be a messianic rescuer regardless of the complexity of the case. All of this is a setup for potential disappointment, frustration, projection, and blame. In power relationships, when unrealistic expectations are shattered, all involved tend to blame each other. Usually the weaker person in the relationship, the patient, receives the greater blame and ultimately loses.

Another significant factor impacting upon the diagnostic relationship is the referral source. Patients are either referred by themselves or others, but most often by others. When patients are self-referred, they usually enter the relationship with a positive expectation and commitment. They have chosen to be there and believe in the possibility of good results. This inspires trustworthiness, cooperativeness, and compliance. If the patient is referred by someone who trusts and believes in the doctor's professional skills, there is a higher probability that the patient has been prepared to enter the relationship with positive expectations and commitment. If the patient is referred by someone they do not trust (e.g., an agency, insurance company, or defense attorney), they are forced into the situation and enter the relationship with doubts, suspicions, and distrust. They come with a negative expectation for the outcome. This sets the stage for significant interpersonal resistance. Even before the doctor and the patient have physically met each other, the door to open-honest communication and a cooperative effort is closed. If the doctor enters the relationship with a distant demeanor suspicious of the patient's motivations, resistance from the patient is fueled. In this context, the possibility of developing mutual respect is seriously retarded. This tainted climate hampers the possibility of successfully accomplishing the purpose of the diagnostic process.

In general when patients enter the doctor-patient relationship because they want to be there, and have a belief that the doctor is dedicated to understanding and helping, there is a greater probability they will have a positive attitude about the relationship and cooperate. They trust and believe in the doctor. They will communicate more openly and honestly, and be cooperative and committed to the process. This creates the climate for the growth of a successful working relationship. Likewise, when doctors enter the doctor-patient relationship wanting to be there and have positive attitudes of trust in the patient, they communicate more effectively, involve the patient in the process, and are more committed. This mutual respect increases the probability of a positive working relationship that results in successful diagnosis and effective treatment.

## PATIENT REPORTS

Attentive history-taking does more than add details. It is the most important aspect of doctoring. While obtaining a history takes time, no time is more productively spent. Ultimately it lays the foundation for a human relationship between patient and doctor based on mutual respect. The time invested is but a small sacrifice for curing as well as healing.

—Bernard Lown

Different patients have different reporting styles. The particular reporting style is determined by a combination of the person's psychological, interpersonal, and cultural dynamics learned early in their lives. There are many reporting styles, but they basically fall into three categories: minimized, exaggerated, and balanced. Some patients are quiet, reserved, and constrained. They tend to under-report and minimize problems. Others are talkative, outgoing, or even effusive. They often mix a lot of emotion into their thinking and expression. They tend to over-report and maximize problems. Some persons exaggerate their reports. Others give very balanced reports, neither minimizing or exaggerating. It is important to understand that these styles of reporting exist and are not particularly right or wrong. The reporting style should not be confused with the issue of veracity or deception. The reporting style pulls various responses from the doctor. Some styles tend to pull accepting responses, while others pull pejorative and even rejecting responses.

When patients report problems and symptoms to a doctor, there are several possibilities regarding the veracity of their reports. The report may be accurate or inaccurate, or some mix of the two. Inaccurate reporting can be the result of misperception, lack of awareness, or prevarication. Inaccurate reporting can be consciously or unconsciously controlled.

If the report is accurate, it is useful and there is of course no problem trusting and using the information in the diagnostic process. If the report is inaccurate, the information is not useful and can be misleading. The doctor ideally needs to know what is true and not be misled into believing something that is false and confusing to the diagnosis. If the doctor perceives that the report is inaccurate, a cloud of suspicion quickly develops over the doctor-patient relationship, further complicating trust.

Reported symptoms and the correlation with a particular disorder require that the doctor have a thorough knowledge and experience with the disorder in question. It is difficult if not impossible to find and diagnose a disorder if you don't know what you are looking for. It is easy to be misled and deceived in trying to diagnose problems that are not understood. The greatest insurance against being deceived by a counterfeiter in the diagnostic process is knowing what the genuine looks like. It is important to realize there are three distinct disease-reporting possibilities when diagnosing a disorder:

- The patient has the disorder and is accurately reporting the problems.
- The patient does not have the disorder and is inaccurately reporting problems.

Inaccurate reporting by a patient does not automatically connote conscious or unconscious intent. Nor does it necessarily mean that the patient is manipulating the situation for some type of gain. It is important to know that malingerers persons can also have medical disorders. The presence of one does not exclude the other.

## REFERRALS FOR PSYCHOLOGICAL EVALUATION

Formerly, when religion was strong and science weak, men mistook magic for medicine; now, when science is strong and religion weak, men mistake medicine for magic.

—Thomas Szasz

When the patient continues to complain of problems and the direct examination of the patient along with medical tests is negative, a frustrating situation emerges. The doctor wants to be competent and succeed because this is his role. Reinforcement and satisfaction for the doctor occurs if the patient is found to have a real disease that has effective treatments. Diagnosticians do not like to be foiled in the problem-solving process. It is symbolic of weakness and a loss of control if the diagnosis is left hanging. Doctors do not like to say, "I don't know," and patients don't like to hear it. The psychological irritation of not knowing often leads to unnecessary tests and palliative treatments. In some cases, the doctor-patient relationship deteriorates into frustrations and projections upon the patient when the diagnosis is uncertain.

If the patient continues to complain of multiple symptoms after negative objective findings, it is common for the diagnostician to entertain the possibility of a functional psychiatric problem such as a somatoform disorder. If the person is involved in litigation or other financial compensations, the question of malingering is entertained. This typically results in a referral to a psychiatrist or psychologist for consultation. It is assumed that psychological consultants have methods of determining whether the patient has some type of somatoform disorder or is possibly malingering.

Patients in general do not like to be referred to psychiatrists or psychologists. They see this as a breach of trust. They feel rejected. From their perspective, the doctor is not believing them even though they know they are experiencing real problems. They are offended by what they perceive as the doctor's belief that "it is all in my head." Whether a reality or not, they perceive distrust and rejection. This tends to erode the doctor-patient relationship, and increases the chance that the patient will enter into the relationship with the consulting psychologist in a distrustful skeptical resistant state of mind. This poses significant challenges to developing a workable diagnostic relationship with the consultant.

Although it is not the focus of this chapter, an important question emerges that should be considered. Since it is assumed that the referral for a psychological consultation will rule in or out the diagnosis of a somatoform disorder, how dependable are these evaluations? In other words, how good are psychiatrists and psychologists in accurately diagnosing somatoform disorders?

The research regarding the validity and reliability of diagnosing somatoform disorders is limited.<sup>7</sup> The diagnostic process is one of exclusion rather than positive identification. If the patient has certain complaints and symptoms and the medical findings are negative, the person must have some type of somatization disorder. It is a diagnosis that depends heavily upon the experience, interpretation, and judgment of the examiner rather than positive medical tests. The diagnosis is vulnerable to the dynamics of the doctor-patient relationship. Arriving at the diagnosis of somatoform disorder is a challenging art. It is a precarious process that requires careful deliberation.<sup>17,33</sup> The cost of errors can be high. Many persons in the history of medicine have been initially diagnosed as somatizers to later discover they actually suffered from serious and even fatal medical diseases. On the other hand, many persons have also been declared to suffer from medical illnesses and given powerful treatments with negative side effects or fatalities when all they really needed was psychiatric

treatment. It is a serious matter to rule in or out the presence of medical disease versus somatizing. Better methods to make the discrimination are needed.

## CONCEPT OF SECONDARY GAIN

The concept of secondary gain has infiltrated the nomenclature of every medical specialty. Yet this concept is poorly defined, is subject to different interpretations by different clinicians, and is often abused in its application to patient care. In addition, there are questions about the scientific validity of this concept and whether it has actually been explored in scientific studies rather than in case reports.

—David Fishbain

The term "secondary gain" is frequently used by doctors in an attempt to explain why a person might have symptoms and problems associated with disorders whose causes are basically unknown but appear to be psychological. This term is commonly used when the patient is involved in some type of monetary compensation. It is assumed that the driving force behind the person's complaints and symptoms is some type of gain.

This concept has its origin in Freudian psychoanalytic theory where it was believed that when a person had some type of functional symptom (e.g., a paralyzed hand), the symptom was serving some unconscious internal psychological purpose to control anxiety. A conversion disorder was diagnosed. The unconscious benefits for having the symptom were labeled "primary gains." The symptom might also be serving some purpose of reducing stress and anxiety in the person's external interpersonal world. These benefits were labeled "secondary gains." Over time, the idea of gains changed with less emphasis placed on primary gains and an expanded emphasis put on secondary gains. Now if a person has some type of disorder that is more difficult to diagnose with objective medical tests (e.g., chronic pain, mild head injury) and personal injury litigation or workers compensation is involved, the doctors involved are quick to entertain the idea of secondary gain as an explanation of why the problem persists and is resistant to treatment. The label of secondary gain is now also associated with conscious attempts to reap benefits such as malingering, whereas originally it was more associated with unconscious mental operations in neurotic persons.

The concept of secondary gain is overworked, abused, and fraught with problems.<sup>9,10,13,18,21</sup> A basic flaw in the concept is the failure to appreciate what a patient is losing by having the disorder. What are the secondary losses? Patients often have much more to lose by having their problems than they will ever gain by having them. The losses can be many. Examples include: loss of earnings; economic hardships; loss of a meaningful life; loss of hobbies and diversions; loss of marital and family roles; loss of sexual intimacy; the stigma of being weak and impaired; loss of self-esteem; loss of social involvement. Rarely do the financial gains from litigation and workers compensation outweigh such losses.

## DETECTING DECEPTION

The human ability to detect lies is less developed than our skill to deceive. A few persons do seem to have unusual abilities to catch lies, but the majority of so-called experts at lie detection are, in fact, deceiving themselves about their abilities. We are at great risk when we are too trusting and willing to believe such experts.

—Charles V. Ford

How good are psychiatrists and psychologists at detecting deception and malingering? The answer is simple. They are not very good.

Ford reports that most people can only detect deceit a little above the chance level.<sup>11</sup> Ekman and O'Sullivan's research found that only 12% of psychiatrists had better than normal skills at detecting lies.<sup>6</sup> Ford states, "Most people—including psychiatrists—who regard themselves as experts at catching lies, are, in fact, deceiving themselves." Whether or not doctors can learn more effective deception detection skills is uncertain, but merits further research.<sup>5,6,11,12,36</sup>

The technology for detecting deception in the psychological examination is limited. Psychiatrists mainly rely upon records review and the interviews. They look for unusual and improbable observed and reported symptoms. They also look for inconsistencies and contradictions. They check to see if the reported problems fit with what has been previously reported to other doctors. There is little research as to effectiveness of this process. The process is highly dependent upon the subjective interpretation of the examiner and is strongly affected by whatever knowledge, experience, or biases the doctor has about a particular disorder.

If the doctor believes that a disorder doesn't exist or that it only exists in the imagination of the patient and other doctors, it will never be seen and diagnosed. For example, if a doctor believes that chronic fatigue syndrome is only a fantasy and primarily a psychosomatic manifestation even if the patient has the disorder and is suffering from a real disease, it will be seen as a somatoform disorder. Diagnosticians cannot diagnose what they don't know or believe.

The evaluation process for detecting malingering in psychological evaluations utilizes multiple methods. The clinical psychologist or neuropsychologist also looks for unusual or exaggerated symptoms trying to determine if the reported problems fit the disorder in question. In addition to the interview, the psychologist uses standardized tests to study cognition and psychological symptoms. These tests are checked to see if they make sense relative to the possible disorder. Consideration is given to whether or not there is an unexpected extremely poor general level of performance on tests. Both within test and between test comparisons are made to find signs or inconsistencies that might indicate deception. Specific tests of effort and motivation are used to try and determine how diligently the patient has performed. Test-retest comparisons are made if there is testing from previous evaluations. Based upon the results of all these methods, the psychologist interprets the results and forms an opinion regarding the presence or absence of malingering.

How effective is the multiple method process in identifying malingerers? The answer is not complete. Research in this area is very difficult. One of the main difficulties is finding criterion groups of true malingerers to make comparisons with non-malingering medical patients. Simulated malingerers have usually been used rather than using real identified malingerers. Another shortcoming is that most of the research has been done with specific tests rather than using a multiple method process.

Neuropsychologists have a special interest in studying test taking effort and motivation, because neuropsychologists make inferences about the condition and integrity of a person's brain system on the basis of test performances. They study test score performances to determine whether or not the person has brain dysfunction and what brain functions are involved. For the neuropsychological evaluation process to result in a valid and reliable deduction of brain condition, neuropsychologists have to gain the full cooperation of the patient. They have to ultimately trust that the patient has given his or her best and maximum performance on the tests. If there is any question about full cooperation and best effort, it is not possible to rely

upon the test data. Conclusions about the neurobehavioral condition of the brain system hinges on this best effort. If there is any question in the mind of the neuropsychologist that a maximum effort has occurred, it is not possible to know whether the person has or doesn't have any neurobehavioral problem. The inference of brain condition teeters on the assurance of the patient's best effort.

Bianchini, Mathias, and Greve state it succinctly: "At the heart of the issue of motivation lies the question, 'is the patient intentionally performing below their true capacity?' Only after this question has been answered is one free to interpret the remainder of test results with any confidence."<sup>1</sup> This necessity of trusting that the patient has given best effort has motivated neuropsychologists to develop a variety of tests to explore patient cooperation and effort.

One type of test procedure commonly used to check for best effort is called symptom validity testing. These are purported tasks that persons with or without brain dysfunction typically have little difficulty performing at or above chance levels. An example is the Portland Digit Recognition Test (PDRT). With this task, patients are instructed that their memory is going to be tested. They are asked to remember a five-digit number that is read to them. After they hear the number, they are to count backwards from a number by 3s until the examiner shows them a card with two five-digit numbers on it. One of the numbers is the one they were previously told to remember. They are then asked to identify the correct number. After they respond, they are then told they did okay (whether they did or not) and the test goes on in this manner with different intervals of delay between the hearing of the number and the showing of the card with two choices.

An assumption underlying the PDRT is that if the patient just guessed, they would get 50 percent or more of the items correct by chance alone. If the performance falls at or below the chance level, the person is judged to be deliberately giving a poor effort. It is assumed that such a poor effort is deliberate and probably linked to surreptitious motives such as malingering. This has been taken a step further by generating cutoff scores that are considerably higher than chance based upon limited research of small groups of normal and brain-impaired subjects. Using these cutoffs, if the patient scores lower than the cutoff score, the question of poor effort and malingering is raised.

How good is this type of effort testing in determining effort and motivation? A recent critical review of symptom validity testing by Bianchini, Mathias, and Greve indicates varying rates of classification sensitivity and specificity depending upon the particular procedure.<sup>1</sup> They discuss the methodological weaknesses and challenges that include apparent difficulty and task transparency, sample selection, cutting schemes, sensitivity versus specificity, and predictive value. They conclude that these measures may prove useful, but they need further work to ensure that they meet adequate legal standards of evidence. Another review focusing on mild head injury patients and malingering concludes that single tests are limited and it is better to rely upon multiple methods.<sup>17</sup>

A basic assumption underlying symptom validity testing of motivation is the belief that if someone scored at or below chance they have to be deliberating trying to do poorly. The premise is that there are two items on the recognition card, the person has a 50 percent chance of getting the right answer. To test this idea, 12 persons were presented the PDRT cards alone and told that one of the numbers was the correct one. Without any other information, they were to select one of the numbers. They were given 36 trials without any feedback. In a sample of 12 persons, 3 subjects obtained scores at or below the chance level. In other words, when persons just

guess at the two words, they can in fact score at or below the chance level. One cannot assume that humans guess randomly. The notion that a person would score at or above chance level if they just guessed is not true with a low number of trials. Even if the choice was made only 36 times with a coin flip, the distribution would not always fall at the 50 percent level.

Another assumption is that if a person performed at the 50 percent or lower level on these tasks, they are deliberately feigning or malingering. A poor effort on a task is not necessarily indicative of malingering. If a patient simply shuts down on a task and guesses, they may score at or below chance. There are probably many reasons other than malingering that can result in a person shutting down and not performing at maximum effort. These include: illness, pain, fatigue, avoidance of concentrating, frustration with the doctor-patient relationship, psychological defenses, unhappiness with the evaluation situation, depression, and brain dysfunction itself. To conclude that poor performance on a task of effort excludes the presence of a genuine medical condition and is solid evidence of malingering is a biased leap of faith not supported by either the facts or common sense.

Rogers, a leading researcher on malingering, argues that the use of uncooperativeness in either evaluation or treatment as a sign of malingering is a problematic concept and endeavor.<sup>31</sup> Rogers states:

The use of uncooperativeness as a factor in establishing malingering is counterintuitive and theoretically bankrupt. It is roughly analogous to the sociological construct of "blaming the victim"...in which implicit blame is levied on uninterested and disinterested psychiatric patients. Many patients are either unable or unwilling to participate actively in their assessment and subsequent treatment. Imagine for the moment the implications of using uncooperativeness as a factor. First, all involuntary patients would need to be considered because, by definition, they are uncooperative with their prescribed treatment. Second, among psychiatric patients, approximately 20%...deny or minimize their psychopathology; paradoxically, these "uncooperative" patients would also be considered for malingering. Third, some illnesses such as substance abuse and eating disorders involve poor compliance and cooperation and would also have to be considered. Taken to its logical end, even patients with well-established Axis I disorders, namely schizophrenic and bipolar disorders, would need to be reevaluated each time they had a substantial lapse in taking their prescribed medication. Simply put, uncooperativeness is an overly inclusive, imprecise, and unworkable concept. Furthermore, there is no empirical evidence to support the use of uncooperativeness as a discriminating variable between bona fide patients and their malingering counterparts. (p. 185.)

All a neuropsychologist can safely say if a person does poorly on effort tests is that something has interfered with the patient's full effort. What that something is cannot be divined from a weak performance on an effort test.

Poor effort on tests should raise questions about the doctor-patient relationship. Something has significantly interfered with the doctor and patient developing a trusting working relationship. When this happens, the doctor should do everything possible to remedy the situation and get the cooperation of the patient. If full cooperation cannot be obtained during that session, testing should await a better day. It is the doctor's job to orchestrate the matter. Test results tainted by poor effort cannot be reliably used to determine if there is or isn't the presence of brain impairment or other medical disorder. The diagnosis has to await a workable diagnostic relationship when full effort occurs from all the participants.

When psychologists observe poor effort from a patient, they should basically say, "I don't know whether or not the patient has a neurobehavioral problem. I only

know that for some reason, I didn't gain full cooperation of the patient during the session."

Another problem with the psychological examination for somatoform and malingering is the use of psychological inventories. Most psychological and neuropsychological batteries include giving the patient a psychological symptom inventory. The most common inventory is the Minnesota Multiphasic Personality Inventory (MMPI). If the patient elevates on scales 1, 2, and 3 of the MMPI with scales 1 and 3 more elevated than scale 1, the psychologist sees this as the "Psychosomatic Y" and usually decides there is significant somatizing. This bolsters the conclusion that the patient probably has a somatoform disorder, is hyper-focused upon symptoms, exaggerating, and possibly malingering.

This use of the MMPI is problematic and potentially misleading. The ability of the MMPI to discriminate the presence or absence of somatoform disorders or malingering is not reliably established. Additionally, there are many items on the MMPI that patients with bona fide medical conditions, especially neurological conditions, endorse because of their medical condition<sup>34</sup> and not because they are somatizing. The endorsement of these symptoms inflates the profile and misleads the uninformed psychologist into a psychiatric interpretation of the test results, although there may in fact be no psychiatric condition present. Unfortunately, the test results produce a scientific looking graph that gives the illusion of objectivity and science causing psychologists and referral doctors to assume that the interpretations are valid. This is misleading. It can have unfortunate and even devastating effects upon the diagnosis and treatment of suffering patients.

Another disturbing diagnostic error in psychological evaluations with these patients is the linking of past behaviors or disorders to current symptoms as an explanation of the cause. For example, a patient may present following a concussion with persistent cognitive problems involving complex attention (multi-tasking) and short-term memory. The psychologist examines the patient and finds some mild decreased performance on neuropsychological measures, but the MMPI profile is highly elevated. It is also discovered that the patient has some prior to head injury history of some type of depression several years ago that required treatment with antidepressants. The psychological examiner concludes that the patient's current mild poor neuropsychological test performance is somehow due to the previous history of depression rather than the head trauma. The results of the MMPI are used to reinforce the notion of the presence of some type of psychiatric problem involving depression and somatizing. The fact that the patient did not have the reported symptoms at the time of the depression, the symptoms only emerged after the mild head injury, and there is no correlation whatsoever between neuropsychological test performances and the MMPI scales is ignored and discounted. This post-hoc correlation of present problems to some past disorder is a significant logical error. It is made even though there is nothing in the test data itself that can make that connection. The connection is a subjective conclusion on the part of the psychologist rather than the result of any objective scientific exercise. It is a biased leap of belief. It is often a blaming of the past for things more obviously and logically linked to the present.

While a referral for psychological consultation by a well-trained and experienced psychiatrist or psychologist aware of the limitations of the technology is often useful in the diagnostic process of ruling in or out somatizing disorders or malingering, doctors utilizing these consultants need to be aware of the inherent limitations and problems. These examinations use methods that depend heavily upon interpretation by the examiner. They are not of the same validity or reliability usually expected

from other medical consultations. They should be used, but with an understanding of their limitations. They should not be seen as an opportunity to defer diagnostic responsibility in complicated cases. The information garnered from them should be carefully considered in making the best possible diagnostic decisions.

### THE MEDICAL-LEGAL DIAGNOSTIC RELATIONSHIP

It is an equal failing to trust everybody, and to trust nobody.

—English Proverb

Medical-legal diagnostic evaluations pose unique challenges to the doctor-patient relationship. This is especially a challenge when the patient is referred by a defense attorney, an insurance company, or a workers compensation agency for a misnamed IME (independent medical evaluation). The term IME is deceptive. It implies that somehow all previous evaluations have lacked objectivity and are tainted by subjectivity. In reality, the IME is plagued by biases, subjectivity, and relationship problems. The IME is better labeled a DOE or AOE (defense attorney or agency ordered evaluation).

The IME relationship begins shrouded in bias and distrust. The doctor and patient are suspicious of each other's motives from the start and cocked to find faults with each other. The patient often feels threatened and knows that the doctor has been selected by the referral source to skeptically scrutinize his case, question his veracity, and err in favor of the referral source. Financial support is often at stake. If the doctor walks into this stressed relationship aloof and distant, there will be a bias of not listening to the "subjective complaints" of the patient and only considering "objective findings." In this atmosphere, the diagnosis of a disorder that relies strongly on an understanding and appreciation of reported symptoms is improbable. The patient is more likely to be accused of secondary gains, somatizing, and malingering.

All of this undermines mutual respect and trust that are vital to a working cooperative relationship. Both the doctor and the patient enter the relationship in a resistant interpersonal mode that makes it impossible to communicate and work together to accomplish the necessary goals of accurate diagnosis and effective treatment. There is a high probability that the relationship will fail.

It takes exceptional communication skills and dedication on the part of the diagnostician in these situations to work through these barriers and create a climate of trust and openness that leads to a working relationship. It is rare that doctors can work through all these forces. The doctor inadvertently elicits defensive responses from the patient. If the patient has an interpersonal style that is contrary in authority relationships and is suspicious, there will be limited communication. If the disorder in question is one that has few technical methods of diagnosis and needs to rely more upon reported symptoms, there is a high probability that the patient will be seen as uncooperative, exaggerating, somatizing, and possibly malingering.

The problems generally associated with psychological evaluations are greatly magnified in defense-oriented examinations. The interview often takes the form of interrogation and a search for details to indict and discredit the patient rather than understand the patient's history and perception of her problems. A cold clinical stance with the patient interferes with developing the working relationship necessary for effective test administration. The testing includes tactics designed to try and catch the person rather than carefully study the condition. The patient's defenses and resistances are elicited. During performance testing, she may be so stressed and frustrated with the situation that she shuts down. This often results in poor performance

on effort tests. A tedious psychological symptom inventory like the MMPI (566 statements) is given to the person, which further stresses them. Even if patients are honest about their symptoms, a profile is generated that is used against them. The results of this type of evaluation process is interpreted by the examiner as indicative of somatizing and possible malingering. Rather than the examiner being aware that there never was an essential working rapport developed with the patient, and that he cannot reliably conclude whether or not the patient does or doesn't have a disorder, the examiner engages in a self-deception that reinforces the preconceived notion that the patient is self-deluded, has suspicious motives, and is somatizing or malingering. Both the doctor's and patient's preconceived notions and self-deceptions of distrust are deeply reinforced.

### CASE EXAMPLE

The following case illustrates some of the diagnostic challenges previously discussed.

The patient is a 58-year-old, married, white female referred by a neurologist for a neuropsychological evaluation. The purpose of the referral was to differentiate between true medical complaints and somatization. The patient reported a plethora of symptoms that included: kidney pain relieved by urination, excessive night sweats, general weakness, lethargy, confusion, alterations of consciousness, anxiety, irritability, and agitation. The medical doctors involved considered numerous diagnoses (e.g., Parkinson's disease, Wilson's disease, Alzheimer's, ALS, tumor, seizure disorder, multiple sclerosis) and pursued a variety of medical test procedures to rule in and out these disorders. There was consideration of a somatoform disorder, and the patient was referred for neuropsychological evaluation.

The neuropsychologist developed a good working rapport and was able to obtain a good history and understanding of the patient. The patient cooperated and gave good effort on tests, producing valid test results. The results of neuropsychological testing revealed a full scale intelligence of 79 (8 percentile) compared with the general population) with a verbal intelligence of 84 (14 percentile) and a performance intelligence of 77 (6 percentile). Overall performance on neuropsychological tests indicated slowed processing rate and a general decrement of brain functioning. The trail making test part B required 275 seconds. Finger tapping test scores were very low (right dominant hand = 28 taps per 10 second interval; left hand = 21 taps per interval). The Halstead Impairment Index was 0.9 (90 percent of the tests outside of normal cutoff scores). The neuropsychological deficit scale was in the moderate range of impairment. It was concluded that the test results indicated a general decrement of functioning consistent with a generalized dementia.

Results of the MMPI-2 indicated significant elevations and a 312 code type profile. Figure 1 shows the profile pattern with the "psycho-somatic V"

If the neuropsychologist depended heavily upon common clinical psychology interpretations of this profile or computer-generated reports, somatizing would have been postulated and the diagnosis of a somatoform disorder promoted. For example, Grahnam,<sup>14</sup> a noted MMPI scholar, suggests the following interpretation of this profile:

This configuration, in which scales 1 and 3 often are significantly higher than 2, has been referred to as the "conversion valley." Persons with this code type may show classic conversion symptoms, and diagnoses of conversion disorder or somatoform pain disorder are common. Stress is often converted into physical symptoms. Persons with this code use denial and repression excessively, they lack insight into the causes of their symptoms, and they resist psychological explanations of their problems. Although these



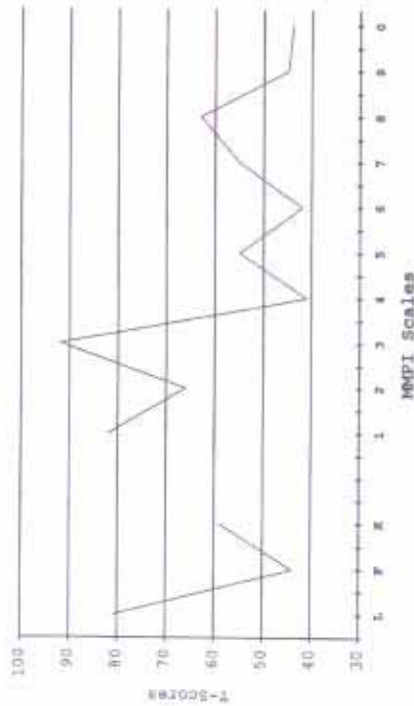


FIGURE 1. MMPI-2 profile.

individuals tend to be rather sociable, they tend to be passive-dependent in relationships. It is important for them to be liked and approved of by others, and their behavior typically is conforming and conventional. (p. 103.)

However, the neuropsychologist involved was aware that the MMPI-2 profile can be falsely elevated because of endorsement of symptoms related to medical neurologic disorder. An analysis of the CNS<sup>4</sup> (Cripe Neurologic Symptom) items revealed that the patient endorsed 48 of these items, indicating problems that included attention/mental control, emotion control, fatigue and decreased energy, general cognition, headaches, memory, motor operations, pain, sleep disturbance, and sensory operations. These of course were problems that the patient was reporting in interviews in the climate of a positive trusting doctor-patient relationship.

Considering the CNS items and using a neuropsychology profile for clinical settings developed by Greene,<sup>13</sup> the neuropsychologist compared the patient's CNS item pattern with a large group of psychiatric patients and found that the pattern was not consistent with a somatization disorder, but more consistent with patients experiencing neurologic symptoms. Rather than declaring the patient a somatizer driven by secondary gain, it was concluded that the patient was not somatizing and probably had some type of medical condition causing neuropsychological impairment. Further medical evaluation was recommended.

Further medical evaluation revealed elevated glucose, significantly low sodium, and low chloride levels. The patient was eventually diagnosed to have type II diabetes and fibromyalgia. With appropriate medications, the patient's neuropsychological symptoms resolved. A re-evaluation about a year later indicated improved neurobehavioral functioning and significantly decreased elevations on the MMPI-2.

If this patient had been referred to a neuropsychologist who did not develop a working rapport, was skeptical of reported problems, disbelieved the positive neuropsychological test results, and relied heavily upon a cookbook interpretation of the MMPI-2, this patient would have been referred back to the referring doctor with the label of somatoform disorder. If legal monetary matters had been involved, the idea of secondary gains and even possible malingering would have been entertained. Fortunately, the patient was seen by a neuropsychologist who believes in the importance

of a trusting doctor-patient relationship, listening to the patient, using the best possible technology, interpreting all the information obtained in a balanced manner, and understanding the limits of the methods. An accurate diagnosis and useful treatment followed.

## GUIDELINES

Care more for the individual patient than for the special features of the disease.

—Sir William Osler

Although the diagnostic relationship in challenging cases has potential pitfalls, it is possible to develop a positive working relationship with the patient and accomplish the intended goals of diagnosis and treatment. The following guidelines are presented with the intent of helping the reader think about the doctor-patient relationship and improve the diagnostic process with patients suspected of having somatoform disorders and possible malingering.

- Become a student of the doctor-patient relationship. Devote some time to reading and thinking about it. Lowy has written a very readable and enlightening book on the subject.<sup>24</sup> Reading about interpersonal-group process and communication skills in general is useful.<sup>25,26,29</sup> If you only read one book in your lifetime on the subject of relationships, read Dale Carnegie's *How to Win Friends and Influence People*.<sup>2</sup>
- Work on becoming more aware of your own interpersonal style and its impact upon the patient, your diagnoses, and treatment. This is not easily done alone and usually requires individual and group therapy experiences to learn what your style is and how it impacts on others.
- Try to become aware of your own biases and how they impact upon your diagnostic work.
- Work on developing effective communication skills. Again, this is difficult to do without deliberate group training experiences, but such training is available.
- Approach each patient in a trusting and open-minded manner. If you enter the relationship in a spirit of distrust, you will probably pull it from the patient and thwart the diagnostic process.
- Take time to interview and listen to the patient.
- Don't see the interview as an interrogation of the patient to try and find malingering. Besides collecting information, the purpose of the interview is to foster trust and cooperation. The interview is not a criminal investigation or indictment. If you behave like an interrogator, you will probably pull defensive uncooperative behavior from the patient, which will sabotage the goals of the diagnostic process.
- Learn to say "I don't know" without putting yourself or the patient down. If the medical tests are negative and you can't come up with the diagnosis, don't project or dump on yourself or the patient. Despite technological advances, there are still many unknowns and mysteries in medicine.
- Don't treat symptoms or disorders that you cannot diagnose. Treatments can be worse than the disorder, especially if the disorder doesn't exist.
- Don't assume that a suffering patient whose diagnosis is unclear is necessarily driven by "secondary gains." Carefully consider all the losses the person is experiencing before deciding that the scale tips in the direction of gains.
- Don't believe that psychological consultants have magic techniques to ferret out the presence or absence of somatoform disorders or malingering. They

can be useful to the diagnostic process, but their methods have limits. They rely heavily upon subjective educated interpretations.

- Choose psychiatric and psychological consultants who are well trained and experienced to understand the complex interactions of disease and mind. Become aware of their work, how they do it, and how balanced they are in their conclusions. You can usually tell by their reports whether or not they understand the patient and are not driven by extreme biases.
- Prepare patients for the referral to a psychological consultant by directly discussing the matter with them. Try to allay their fears and build a positive expectation for the evaluation. Let them know that you are not deserting them, but want to better understand their problems and how best to treat and manage them.
- Don't use the diagnosis of somatoform disorder as an excuse to get rid of the patient. Persons with these disorders can benefit from the primary physician remaining involved in their care by monitoring their medical status, listening and giving psychological support. Ford offers some practical suggestions for working with these patients.<sup>12</sup>
- Be aware of the challenges in developing a positive doctor-patient relationship when the referral sources are defense attorneys, insurance companies, or agencies. Put extra effort into developing trust and cooperation with these patients. Don't do anything differently than you would for any other patient.
- Don't waste much time looking for malingerers. Remember that we aren't very good at identifying them. It is not worth tarnishing many doctor-patient relationships with distrust, for the pursuit of a few deceivers. It is better to be deceived by a few than to harm many.

## CONCLUSION

In the final analysis, it is not lying but mutually reinforced self-deception that poses the greatest danger to the individual, society, and humanity.

—Charles Ford

The doctor-patient relationship is important to a good diagnosis. It is especially critical when the technology for determining the presence of a disorder is limited and there is a strong need to depend upon the patient's report of problems. If technology is plentiful and correlates of the disease process are definitive, the doctor-patient relationship is important but less demanding. However, when the disorder lacks definitive diagnostic technology and depends upon the subjective reports and interpretations of the doctor, a healthy doctor-patient relationship is essential.

For the diagnostic relationship to work, there must be mutual trust and respect facilitated by effective communication. Both the doctor and patient pull from each other various conscious and unconscious responses based upon their interpersonal habits, styles, attitudes, and beliefs. If the doctor and patient approach the relationship with suspicion and distrust, the process is jeopardized. If this distrust flourishes, the doctor and patient will behave in ways that diminish or destroy the possibility of accurate diagnosis and effective treatment.

Referrals for psychological evaluation are especially delicate because the patient feels misunderstood and rejected. In general, psychological consultants face significant hurdles in developing productive trusting relationships. Medical-legal referrals are particularly problematic. Unless the consultant is careful and puts extra

effort into developing a working rapport with the patient, the consultant's psychology and methodology will pull defensive resistant responses from the patient. This increases the likelihood of confused information in interviews and poor performances on psychological tests. This poor effort can be misinterpreted as the fault of the patient. A pejorative mislabeling potentially harms and seldom leads to anything productive in the way of treatment or management.

The diagnostician who gets caught up in the pursuit of malingering is misdirected from developing healthy relationships that accomplish the intended goals of diagnosis and treatment. This endeavor misplaces energy into a potentially deceptive enterprise that can actually create the malingering problem. This is a tricky matter often confusing who is the deceiver and who is the deceived.

Doctors are better advised to put their energies into the development of positive diagnostic relationships rather than play policemen trying to catch a few persons who are deliberately trying to deceive. Malingering is more a legal matter than a disease matter. Psychology researchers can better spend their time by studying the doctor-patient relationship, how to measure and improve it, rather than expending undue effort trying to develop flimsy entrapments to catch a few malingerers. An editor of a major neuropsychology journal recently said, "I think I have seen more articles on the subject of malingering come across my desk than there are malingerers in the world." It is far more challenging, rewarding, and certainly more useful for clinicians and researchers to focus their dedicated efforts in the direction of understanding the complex interaction of a person's psychological style with disease or trauma.

## REFERENCES

1. Bianchini, K.J., Mathias, C.W. and Greve, K.W. (2001). Symptom validity testing: A critical review. *The Clinical Neuropsychologist*, 15, 1, 19-45.
2. Carnegie, D. (1982). *How to win friends and influence people*. New York: Simon & Schuster.
3. Cripe, L.I. (1999). Using the mmpi with mild traumatic brain injured patients. Chapter 13 in *Evaluation and Treatment of Mild Traumatic Brain Injury*, N.R. Varney and R.J. Roberts (Eds.), Mahwah, NJ: Lawrence Erlbaum, 291-314.
4. Cripe, L.I. (1996). The mmpi in neuropsychological assessment: A murky measure. *Applied Neuropsychology*, 3, 4, 97-103.
5. Ekman, P. (1992). *Telling lies: Clues to deceit in the marketplace, politics, and marriage*. New York: W.W. Norton & Company.
6. Ekman, P. and O'Sullivan, M. (1991). Who can catch a liar? *American Psychologist*, 46, 913-920.
7. Fink, P. (1996). Somatization: Beyond symptom count. *Journal of Psychosomatic Research*, 40, 1, 7-10.
8. Fishbain, D.A., Rosomoff, H.L., Cutler, R.B., and Rosomoff, R.S. (1999). Chronic pain disability exaggeration/malingering and submaximal effort research. *The Clinical Journal of Pain*, 15, 4, 244-274.
9. Fishbain, D.A., Rosomoff, H.L., Cutler, R.B., and Rosomoff, R.S. (1995). Secondary gain concept: A review of the scientific evidence. *The Clinical Journal of Pain*, 11, 1, 6-21.
10. Fishbain, D.A. (1994). Secondary gain concept: Definition problems and its abuse in medical practice. *American Physical Society Journal*, 3, 4, 264-273.
11. Ford, C.V. (1996). *Lies! Lies! Lies! The psychology of deceit*. Washington, D.C.: American Psychiatric Press.
12. Ford, C.V. (1986). The somatizing disorders. *Psychosomatics*, 27, 5, 327-337.
13. Gallagher, R.M. (1994). Secondary gain in pain medicine: Let us stick with biobehavioral data. *American Physical Society Journal*, 3, 4, 274-278.
14. Graham, J.R. (1990). *MMPI-2: Assessing personality and psychopathology*. New York: Oxford University Press.
15. Greene, R.L. (2000). *The MMPI-2: An interpretative manual*. Boston: Allyn & Bacon.
16. Hart, K.J. (1995). The assessment of malingering in neuropsychological evaluations: Research-based concepts and methods for consultants. *Consulting Psychology Journal: Practice and Research*, 47, 4, 246-254.

17. Hayes, J.S., Hilsabeck, R.C., and Gouvier, W.D. (1999). Malingering traumatic brain injury: Current issues and caveats in assessment and classification. Chapter 12 in *Evaluation and Treatment of Mild Traumatic Brain Injury*. N.R. Vurney and R.J. Roberts (Eds.), Mahwah, NJ: Lawrence Erlbaum, 249-290.
18. King, S.A. (1994). Concept of secondary gain: How valid is it? *American Physical Society Journal*, 3, 4, 279-281.
19. Kirmayer, L.J., Robbins, J.M., and Paris, J. (1994). Somatoform disorders: Personality and the social matrix of somatic distress. *Journal of Abnormal Psychology*, 103, 1, 125-136.
20. Korsch, B.M. (1998). *The intelligent patients guide to the doctor-patient relationship*. New York: Oxford University Press.
21. Lurie, R.G. (1994). Advantages of illness. *American Physical Society Journal*, 3, 4, 282-284.
22. Lewis, M., and Saarni, C. (1993). *Lying and deception in everyday life*. New York: Guilford Press.
23. Lofricolo, C.J., Goodkin, K., and Balteswicz, T.T. (1999). Current issues in the diagnosis and management of malingering. *Annals of Medicine* (England), 31, 3, 166-174.
24. Lowy, B. (1996). *The art of healing*. New York: Houghton Mifflin Company.
25. Luft, J. (1970). Group processes: An introduction to group dynamics, second edition. Palo Alto, California: National Press.
26. Luft, J. (1969). *Of human interaction*. Palo Alto, California: National Press.
27. McBeath, J.G. (2000). Labeling of postconcussion patients as malingering and litigious: A common practice in need of criticism. *Headache*, 609-610.
28. Meyer, R.G., and Deitsch, S.M. (1995). The assessment of malingering in psychodiagnostic evaluations: Research-based concepts and methods for consultants. *Consulting Psychology Journal: Practice and Research*, 47, 4, 234-245.
29. Narciesto, J., and Burkett, D. (1994). *Relating redefined: Discovering the new "Language" for communicating*. San Antonio, Texas: Reiman-Wright Publishing.
30. Ong, L.M.L., de Haes, J.C.J.M., Hoos, A.M., and Lammes, F.B. (1995). Doctor patient communication: A review of the literature. *Social Science & Medicine*, 40, 7, 903-918.
31. Rogers, R. (1990). *Models of feigned mental illness. Professional Psychology: Research and Practice*, 21, 3, 182-188.
32. Rotter, D.J., and Hull, J.A. (1992). *Doctors talking with patients/patients talking with doctors*. Westport, Connecticut: Auburn House.
33. Stimmert, J.L. (1987). The functional somatic symptom. *Psychiatric Clinics of North America*, 10, 1, 19-33.
34. Sullivan, H.S. (1953). *The interpersonal theory of psychiatry*. New York: Norton.
35. Tombs, K. (1992). *The meaning of illness: A phenomenological account of the different perspectives of physician and patient*. Dordrecht, Netherlands: Kluwer Academic Publishers.
36. Walters, S. B. (2000). *The truth about lying: How to spot a lie and protect yourself from deception*. Naperville, Illinois: Sourcebooks, Inc.

ROBERT RUCHINSKAS, PsyD  
IAN MAITIN, MD

## THE DETECTION OF EXAGGERATED SENSORY SYMPTOMS

From Department of Physical Medicine and Rehabilitation Temple University School of Medicine Philadelphia, Pennsylvania

Reprint requests to: Robert Ruchinskas, PsyD Dept. of Physical Medicine and Rehabilitation Temple University Hospital 3401 N. Broad Street Philadelphia, PA 19140

A well-known study of the early 1980s posited that over \$20 billion were spent in the investigation and treatment of symptoms that appeared to be without a specific identified disease, a dollar amount that has surely risen over time.<sup>3</sup> It is known that individuals with extensive medical utilization also often have high lifetime prevalence of co-morbid psychiatric disorders, e.g., depression, anxiety, somatization, and other somatoform disorders including conversion.<sup>9</sup> Thus, while rates vary according to setting and criteria, it has been estimated that between .2 and 20 percent of medical patients evidence symptoms that are either exaggerated or have a psychiatric etiology.<sup>2,6</sup> While some argue that the rate of misdiagnosis has decreased over time through the use of improved technology (e.g., MRI to diagnose multiple sclerosis),<sup>18</sup> there still remains a significant chance of encountering these patients in everyday practice.

The *Diagnostic and Statistical Manual of Psychiatric Disorders* (DSM-IV)<sup>1</sup> defines a group of somatoform disorders that include somatization, conversion, and pain disorders, along with hypochondriasis. The common features of these disorders are the unconscious physical expression of underlying psychologic distress. Factitious disorders, on the other hand, represent a conscious effort to create symptoms to obtain the "sick role," while malingering implies the above symptoms to attain an external benefit—compensation, disability, etc. The presence of concurrent psychiatric conditions such as depression or a personality disorder (along with low education and recent stressful life events) has been