conversion disorders offered by Teasell and Shapiro (this volume) suggests that feedback for conversion disorders should correspond to subsequent treatment by being less psychoeducational and more behavioral in focus, laying the foundation for the particular behavioral techniques that are part of the program.[4] In their "strategic-behavioral" approach, used to treat chronic conversion disorder, the treatment strategy hinges on a "double-bind" intervention, which involves a measure of pretext on the part of clinicians. As such, treatment contains a paradoxical component, and in-depth explanations of psychophysiologic interactions are not as prominent. Knowledge of the treatment modality to be employed is crucial in ensuring that feedback does not later serve as a detriment to treatment. Whatever treatment modalities are employed, all include the often-cited prerequisites for psychotherapeutic improvement, consisting of a credible rationale and a believable ritual.[1]

The feedback session ends with an eye toward treatment options, allowing the patient time for questions or comments. Some patients with somatoform disorders may be very sensitive to being dismissed or instructed without being given an opportunity to speak or ask questions. An open, non-confrontational attitude by the clinician, with appropriate empathy reflected in nonverbal cues, will help inoculate patients against possible negative emotional reactions to feedback. In the end, feedback is usually meant to instill in patients a greater appreciation of psychophysiologic interactions, sowing seeds for the extension of such themes in the context of ongoing psychological treatment.

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APPENDIX A. Survey of Indicators Suggestive of Non-organic Presentations and Somatic, Psychological, and Cognitive Response Biases

Pain Assessment Measures with Built In Response Bias Indicators	
Pain Assessment Battery (PAB)—Research Edition: Proposed clinical hypothesis procedure for evaluating response bias	I. Symptom Magnification Frequency (SMF) > 40% II. Extreme Beliefs Frequency (EBF) > 35% III. Four other "validity" indicators (i.e., alienation, rating percent of max, % extreme ratings (2 scales)
Millon Behavioral Health Inventory (MBHI)	Elevations on 3 validity scales
Hendler (i.e., Mensana Clinic) Back Pain Test	Scores of 21–31 (Exaggerating) Scores > 31 (Primary psychological influence)
Medical Indicators	
Hoover's test	Test for malingered lower extremity weakness associated with normal crossed extensor response
Astasia abasia	"Drunken type" gait with near-falls but no actual falls to ground
Non-organic sensory loss	Patchy sensory loss, midline sensory loss, large scotoma in visual field, tunnel vision
Non-organic upper extremity drift	Long tract involvement results in pronator type drift Proximal shoulder girdle weakness and malingering typically present with downward drift while in supination
Stenger's test	Test for malingered hearing loss during audiologic evaluation
Gait discrepancies when observed versus not observed	If organic, should be consistent regardless of whether observed or not
Gait discrepancies relative to direction of requested ambulation	Gait for a patient with hemiparesis should present similarly in all directions; malingerers do not as a rule practice a feigned gait in all directions
Forearm pronation, hand clasping and forearm supination test for digit/finger sensory loss	Malingered finger sensory loss is difficult to maintain in this perceptually confusing, intertwined hand/finger position
Pain versus temperature discrepancies	Due to the fact that both sensory modalities run in the spinothalamic tract, they should be found to be commensurately impaired contralateral to the side of the CNS lesion
Lack of atrophy in a chronically paretic/paralytic limb	Lack of atrophy in a paralyzed/paretic limb suggests the limb is being used or is getting regular electrical stimulation to maintain mass
Diminishes under influence of sodium amytal, hypnosis or lack of observation	All these observations are most consistent with non-organic presentations including consideration of malingering or conversion disorder
Incongruence between neuroanatomical imaging and neurologic examination	Lack of any static imaging findings on brain CT or MRI in the presence of a dense motor or sensory deficit suggests non-organicity
Arm drop test	An aware patient malingering profound alteration in consciousness or significant arm paresis will not let their own hand when held over their head, drop onto their face
Presence of ipsilateral findings when implied neuroanatomy would dictate contralateral findings	An examinee claiming severe right brain damage who claims right eye blindness and right-sided weakness and sensory loss

Tell me "when I'm not touching" responses	An examinee with claimed sensory loss who endorses that he does not feel you touch him when you ask him to tell you "if you do not feel this"
Lack of shoe wear in presence of gait disturbance	An examinee with claimed longer term gait deviation due to orthopedic or neurologic causes should demonstrate commensurate wear on shoes (if worn with any frequency)
Calluses on hands in "totally disabled" examinee	An examinee who is unable to work should not present with signs of ongoing evidence of physical labor
Assistive device "wear and tear" signs	In any examinee using assistive devices for any period of time, e.g., cane, crutches, there should be commensurate wear on the device consistent with their claimed impairment and disability
Mankopf's maneuver	Increase in heart rate commensurate with nociceptive stimulation during exam (there is some controversy on whether this always occurs)
Lack of atrophy in a limb that is claimed to be significantly impaired	If side to side measurements and/or inspection do not bear out atrophy, consider other causes aside from one being claimed
Sudden motor give-away or ratchitiness on manual strength testing	Considered to normally be a sign of incomplete effort or symptom exaggeration
Weakness on manual muscle testing without commensurate asymmetry of DTRs or muscle bulk	Suggests simulated muscle weakness if longstanding
Toe test for simulated low back pain	Flexion of hip and knee with movement only of toes should not produce an increase in low back pain
Magnuson's test	Have examinee point to area several times over period of examination; inconsistencies suggest increased potential for non-organicity
Delayed response sign	Pain reaction temporally delayed relative to application of perceived nociceptive stimulus
Wrist drop test	In an examinee with claimed wrist extensor loss, have them pronate forearm, extend elbow and flex shoulder...if on making a fist in this position they also extend wrist, non-organicity should be suspected
Object drop test	Examinee claims inability to bend down yet does so to pick up a light object "inadvertently" dropped by examiner
Hip adductor test	Test for claimed paralysis of lower extremity, similar to Hoover's test yet looks for crossed adductor response
Disparity between tested range of motion and observed range of motion of any joint	When ROM under testing is significantly disparate (e.g., less) from observed, spontaneous ROM suspect functional contributors
Straight leg raise (SLR) disparities dependent on examinee positioning	Differences in SLR between sitting, standing, and/or bending may suggest a functional overlay to low back complaints
Grip strength testing via dynamometer	Three repetitions at any given setting should not vary more than 20% and/or bell-shaped curve should be generated if all 5 psoitions are tested
Sensory "flip" test	Sensory findings should be the same if testing upper extremity in supination or pronation or lower extremity in internal versus external rotation. Differences may suggest a functional overlay

Pinch test for low back pain	Pinching the lumbar fat pad should not reproduce pain due to axial structure involvement; if test is positive, suspect a functional overlay
Personality Instruments with Built-in Response Bias Designs	
Personality Assessment Inventory (PAI)	• Inconsistency (INC), Infrequency (INF), Positive Impression Management (PIM), and Negative Impression Management (NIM) scales • 8 score patterns thought to comprise a "Malingering Index" (Morey, 1996) • > 2 patterns malingering suspected • > 4 patterns likely malingering
Minnesota Multiphasic Personality Inventory (MMPI-2)	• Validity indices (L, F, Fb, Fp, Ds, K, VRIN, TRIN), F-K (Gough, 1954) • The Fake Bad Scale (Lees-Haley, 1991) • Compare subtle to obvious items Rogers et al (1994)—cutoff scores: Liberal: 1. F-Scale raw score > 23 2. F-Scale T-Score > 81 3. F-K Index > 10 4. Obvious—subtle score > 83 Conservative: 1. F-scale raw > 30 2. F-K index > 25 Obvious—subtle score > 190
Other Domain Specific Measures with Built-in Response Bias Designs	
Trauma Symptom Inventory (TSI)	3 Validity Scales (Response Level, Atypical, Inconsistent
Qualitative Variables in Assessing Response Bias	
Time/Response Latency Comparisons Across Similar Tasks	Inconsistencies across tasks
Performance on Easy Tasks Presented as Hard	Low scores or unusual errors
Remote Memory Report	Difficulties, especially if < recent memory, or severely impaired in absence of gross amnesia
Personal Information	Very poor personal information in absence of gross amnesia
Comparison Between Test Performance and Behavioral Observations	Discrepancies
Inconsistencies in History and/or Complaints, Performance	Inconsistencies across time, setting, interviewer, etc.
Comparisons for Inconsistencies Within Testing Session (Quantitative and Qualitative):	• A. Within Tasks (e.g., Easy vs. Hard Items) • B. Between Tasks (e.g., Easy vs. Hard) • C. Across Repetitions of same/parallel tasks (R/O fatigue) • D. Across similar tasks under different motivational sets
Comparisons Across Testing Sessions (Qualitative, Quantitative)	Poorer/inconsistent performance on re-testing
Symptom Self Report: Complaints	High frequency, severity of complaints and higher frequency, severity versus significant other report or other collaborative report
Main and Spanswick, 1995	• Failure to comply with reasonable treatment • Report of severe pain with no associated psychological effects • Marked inconsistencies in effects of pain on general activities

	• Poor work record and history of persistent appeals against awards • Previous litigation
Symptom Self Report: Early/Acute vs. Late/Chronic Symptom Complaint	Early symptoms reported late or acute symptoms reported as chronic
Response to Typically Helpful Pain Interventions	1. Failure to show any pain relief to at least one of the following: biofeedback, hypnosis, mild analgesics, psychotherapy, relaxation exercises, heat and ice, mild exercise 2. Failure to show any pain relief in response to TENS
Genuine vs. Malingered PTSD (Resnick, 1995)	Stress initiator minimized vs. emphasized; Blame self vs. other: Helpless vs. grandiose dreams; Deny vs. emphasize emotional impact; Reluctant vs. easy memory elicitation; Specific vs. general guilt; More vs. less stress associated environmental avoidance; Helpless vs. directed anger.
Assessment of Cognitive Effort: Performance Patterns on Existing Psychological/Neuropsychological Tests	
Full Scale IQ	Low (vs. expected, estimated, etc.)
Arithmetic and Orientation scale Performance	"Near-miss" (Ganser errors)
WMS-R Malingering Index: Attention/Concentration Index versus Memory Index	Attention-Concentration Index Score < General Memory Index (AC-GMI)
Grip Strength	Unusually low w/o gross motor deficit
Recognition memory (Cal. Verbal Learning Test -CVLT)	< 13
Rey Complex Figure and Recognition Trial	Atypical Recognition Errors (>=2); Recognition Failure Errors
Haltstead or Luria Nebraska Neuropsychological Battery Formulas	See formulas
Word Stem Priming Task Performance	Poor or unusual performance
Specific Cognitive Effort/Response Bias Measures	
Word Memory Test (WMT)	< 50%, chance responding
Test of Memory Malingering (TOMM)	< 50% chance level responding
Dot Counting Test (DCT)	Correct/incorrect responses; time on group vs. ungrouped
Computer Assessment of Response Bias (CARB)	< 89% raises suspicion
Rey Memory for 15 Items Test (MFIT)	Lezak (1983), < 3 complete sets, < 9 items
Symptom Validity Testing (SVT)	< 50% chance level responding
Word Completion Memory Test (WCMT); Any implicit memory word stem priming task	R< 9 or Inclusion < 15; poor or unusual performance
Validity Indicator Profile	< 50% chance level responding or below cutoff
Portland Digit Recognition Test	< 50% chance level responding or below cutoff
Pritchard Tests of Neuropsychological Malingering	< 50% chance level responding or below cutoff
Rey Memory for 15 Items Test (MFIT)	< 3 complete sets, < 9 items

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