Educational

Trans-National Perspectives on Exaggeration: Misassessment, Misdiagnosis, and Missed Opportunities

W0009

The Importance of Secondary Gain - a Missing Story

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There is a wealth of data to tell us that, when it comes to illness, not all is as it seems. Research into hidden agendas of patients [1]drives home the point that a substantial portion of patients (up to 42%) have covert motives for obtaining secondary gains associated with their patient status (e.g., financial support, help or attention from others, stimulant medication, work or study related privileges, or evasion of responsibilities. Less than 10% shared their expectations with the psychiatrist. The Accident Compensation Scheme in New Zealand, , reported a prevalence of symptom exaggeration of 20-50%. In 2017 a disorder struck in Sweden. It struck whose families had failed their last appeal for asylum. The previously unknown 'catatonia' has many of the characteristics of a culture bound syndrome – giving voice to the voiceless/powerless. Researchers from Ireland studied the motivations of people with factitious disorder. A desire for affection was the most commonly mentioned reason for fabricating illness and as a coping mechanism for threatening life events. The analysis showed that motivation was conscious. Bianchini et al have reported on the Financial Incentive Effect. Perhaps counterintuitively one of the most important points they make is that the presence of a financial incentive is associated with worse outcomes. They found that factors othere than the injury itself control for the probabilities of return to work. How can we determine what is real? [1] Van Egmond, J., Kummeling, I., & Balkom, T. A. (2005). Secondary gain as hidden motive for getting psychiatric treatment. European Psychiatry, 20(5-6), 416-421.

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W0010

A Lowlands Perspective on Exaggeration and Feigned Symptoms

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Some patients present symptoms in an exaggerated manner [1,2]. This behavior can be assessed with specialized tests: Symptom validity tests (SVTs) to measure overreporting of symptoms, and performance validity tests (PVTs) to measure underperformance on cognitive tests. But what does it mean when patients fail on multiple SVTs and/or PVTs? Does it reflect malingering; i.e. grossly exaggerating or feigning symptoms to gain an external benefit? Could it be seen as a plea for help in some cases? Or could pain, fatigue or cognitive impairment be underlying reasons for the validity test failures? In this presentation some credible and non-credible explanations for failing on validity tests will be discussed. A tentative framework that might aid in conceptualizing poor symptom validity will be presented. References [1] Dandachi-FitzGerald, B., Merckelbach, H., Bošković, I., & Jelicic, M. (2020). Do you know people who feign? Proxy respondents about feigned symptoms. Psychological Injury and Law, 13, 225–234. [2] Merckelbach, H., Dandachi-FitzGerald, B., van Helvoort, D., Jelicic, M., & Otgaar, H. (2019). When patients overreport symptoms: More than just malingering. Current Directions in Psychological Science, 28, 321–326.

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W0011

A UK Perspective on Pain and Atypical Performance - When the Maths doesn't Add up!

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This presentation provides an overview of factors that can cause symptom exaggeration and/or fabrication in chronic pain. It will explore how symptom and performance validity tests can be applied to chronic pain in the context of a malingering framework and the problems of implementing this in the UK through a case example.

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Keywords: performance validity; symptom validity; malingering; pain

W0012

The validity of clinicians' diagnoses: Is it bread and butter?

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Major depression has become one of the most frequent diagnoses in Germany. It is also quite prominent in cases referred for medicolegal assessment in insurance, compensation or disability claims. This report evaluates the validity of clinicians' diagnoses of major depression in a sample of claimants. In 2015, n = 127 consecutive cases were examined for medicolegal assessment. All had been diagnosed with major depression by clinicians. All testees underwent a psychiatric interview, a physical examination, they answered questionnaires for depressive symptoms according to DSM-5, embitterment disorder, post-concussion syndrome (PCS) and unspecific somatic complaints. Performance and symptom validity tests were administered. Only 31% of the sample fulfilled the diagnostic criteria for DSM-5 major depression according to self-report, while none did so according to psychiatric assessment. Negative response bias was found in 64% of cases, feigned neurologic symptoms in 22%. Symptom exaggeration was indiscriminate rather than depression-specific. By self-report (i.e. symptom endorsement in questionnaires), 64% of