



Malingering Posttraumatic Stress Disorder in Open-Ended and Directive Formats

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Abstract

This study attempted to identify symptom-reporting patterns in people who were malingering posttraumatic stress disorder (PTSD). Thirty participants comprised treatment-seeking patients with posttraumatic stress disorder (PTSD) and non-PTSD participants instructed to malingering PTSD. Participants were required to describe their symptoms during an open-ended interview and subsequently were administered a directive interview based on the Clinician Administered PTSD Scale (CAPS). Audiotaped responses were independently rated for symptom endorsement. Malingerers reported emotional numbing less often than genuine PTSD participants during the open-ended format. Both malingerers and genuine PTSD participants reported a range of symptoms more often on the CAPS than during open-ended interviewing. Malingerers increased symptom reporting of physiological reactivity, social detachment, and irritability during the directive format more than genuine participants. These findings suggest that changes in symptom reporting in open-ended and directive formats may be useful in discriminating between malingered and genuine PTSD.

Keywords: Malingering; Posttraumatic Stress Disorder; PTSD

INTRODUCTION

The inclusion of a precipitating stressor as part of the definition of posttraumatic stress disorder (PTSD) inherently links the observed symptoms to a causal event. This relationship between traumatic event and the subsequent psychiatric symptoms has made PTSD highly amenable to both compensation and criminal claims (Pitman, Sparr, Saunders, & McFarlane, 1996). Resnick (1997) cites a study in which 40% of claimants as a result of PTSD showed no actual disability). The prevalence of PTSD claims in litigation has increased the need for accurate means to discriminate between genuine and feigned presentations of PTSD. The accurate assessment of genuine PTSD can be difficult because diagnosis relies heavily on self-report of

subjective symptoms (Resnick, 1997). Moreover, growing awareness of PTSD symptoms allows people to approach the task of malingering with knowledge about expected PTSD symptoms (Lees-Haley, 1992). The possibility of feigning PTSD is further increased by the common practice of inquiring about PTSD symptoms with directive questions that can cue the respondent to the expected response (Neal, 1994). The difficulty of discriminating between genuine and malingered PTSD is heightened by reports that genuine PTSD is often associated with over-reporting of symptoms (Hyer, Fallon, Harrison, & Boudewyns, 1987). Considering the significant medical, financial and legal implications of mistakenly identifying genuine

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or malingered PTSD (Resnick, 1997), there is a need for more empirically-derived guidance to identify malingerers.

Individuals can fake PTSD symptoms in clinical interviews and self-report symptom inventories with considerable proficiency (Freuh & Kinder, 1994; Liljequist, Kinder, & Schinka, 1998; for a review, see Gurriel & Fremouw, 2003). Some commentators have proposed that it is useful to distinguish between salient symptoms that may be more susceptible to successful malingering, and subtle symptoms that malingerers are less likely to report (Bryant, 2003; Rogers, 1997). Bryant and Harvey (1998) required treatment-seeking PTSD participants and malingerers to listen to a sound effect of a crashing car, and then report their cognitive and affective responses to this stimulus. Whereas malingerers were able to mimic PTSD participants' reports of imagery, involuntariness, belief in the reality of the memory, and affect, malingerers reported distracting themselves from their memories less than genuine PTSD participants. This pattern suggests that malingerers may be less able to mimic symptoms that are subtle or require subjective experience of the reaction.

This study investigates PTSD symptom reporting in malingerers in open-ended and directive formats. This study assessed individuals who (a) trauma survivors who presented with genuine PTSD and (b) control participants who were instructed to feign PTSD. Participants were initially asked to nominate all their problems in response to open-ended questions, and then were administered directive questions about PTSD symptoms. We hypothesized that malingerers would increase symptom reporting in the directive format, relative to the open-ended format, more than genuine PTSD participants.

METHOD

Participants

Davis (1994) asserts, in his review of empathy The PTSD group comprised 15 (5 males, 10 females) participants of mean age 32.06 years ($SD = 11.78$) who were referred to the Westmead Hospital PTSD Unit for treatment following a nonsexual assault. Exclusion criteria included (a) poor English proficiency, (b) concurrent psychiatric diagnosis, (c) aged less than 16 years or older than 65 years, (d) evidence of traumatic brain injury, and (e) outstanding compensation issues. Participants were allocated to the PTSD group if they met sufficient criteria for PTSD diagnosis based on the Clinician

Administered PTSD Scale (CAPS; Blake, Weathers, Nagy, Kaloupek, Gusman, Charney, & Keane, 1995). PTSD diagnosis was made on the 1-2 scoring criteria for the CAPS to determine if a symptom was endorsed (Weathers, Ruscio, & Keane, 1999). Malingering participants were 15 (6 males, 9 females) undergraduate psychology students of mean age 25.14 years ($SD = 9.45$) who participated in the study in return for research credit. Genuine and malingering participants did not differ in terms of age, $t(28) = 1.77$, ns.

Procedure

Each session was conducted by one of two clinical psychologists. Following informed consent that included recognition by participants that the session would be audiotaped, the following instructions were given to malingerers:

“This experiment is interested in finding out how well people can fake a particular psychiatric disorder. Specifically, we are interested in posttraumatic stress disorder. I don't know what you know about this condition, but it is a disorder that some people suffer after a threatening experience. What I want you to do today is to imagine that you are the victim of a nonsexual assault. You may invent an imaginary assault scenario if you wish. Imagine that you have been assaulted in a nonsexual way, and assume that this happened a few months ago. Your task today is to put yourself in the shoes of someone who has posttraumatic stress disorder and I want you to respond in exactly the way that you would if you wanted someone to believe that you actually had posttraumatic stress disorder because of this assault. To do this, you are to use whatever you know about posttraumatic stress disorder, or how you imagine posttraumatic stress disorder would affect someone. This is a difficult task, but one in which subjects have shown surprising insight. I'm going to give you about five minutes to imagine what it is like to have posttraumatic stress disorder. Try to think of all the sorts of things you might experience and stretch your imagination”.

Participants were provided with five minutes to consider their simulation and then given the following instruction:

“Now, remembering that you are now acting as someone who has posttraumatic stress disorder, I want you to answer these questions”

Following this, the procedure was the same for PTSD and simulating participants. Phase 1 comprised a series of open-ended questions. Participants were initially asked, “First of all, describe to me all the symptoms and problems you experience at the moment?” An example was requested for each problem to clarify the specific nature of the reported problem. Phase 1 then encouraged participants to provide as much detail as possible about their symptoms by providing prompts without cueing about specific symptoms. Specifically, participants were given the following prompts, (a) “Now think carefully, are there any other problems or difficulties that you have?”, (b) “Have you noticed any changes in how you feel emotionally?”, (c) “Have you noticed any changes in how you feel physically?”; and (d) “Have you noticed any changes in your daily routine or activities?”. Following this open-ended inquiry, Phase 2 comprised administering all participants the CAPS. The CAPS is a structured diagnostic interview that directly inquires about the frequency and intensity of the 17 PTSD symptoms described by DSM-IV. The session was then terminated.

Data Coding

Responses in the open-ended interview were categorized according to whether respondents mentioned the presence of any of the 17 PTSD symptoms described by DSM-IV. The presence of each symptom was categorized from responses on the CAPS by defining symptom endorsement as a frequency score of at least 1 and an intensity score of at least 2 (Blake et al., 1995). A second independent rater categorized 20% of Phase 1 responses and displayed strong agreement with the identification of symptoms categorized by the initial rater (Kappa value range: .80 - .94).

Symptom Reporting Styles

Table 1 presents the proportions of participants reporting each symptom in the open-ended and directive formats. Multiple chi-square analyses were conducted for each symptom in the open-ended and directive phases. A Bonferroni adjustment was made to allow for the multiple comparisons and the alpha rate was set at .01. During the open-ended interview, fewer malingerers than genuine participants reported intrusive memories, avoidance of thoughts, and emotional numbing. There were no significant differences between groups on the CAPS responses.

RESULTS

Table 1

Table 1
Proportions of Participants Reporting PTSD Symptoms

Symptom	Open-Ended Format			CAPS			Increased Reporting		
	Malingerer	PTSD	χ^2	Malingerer	PTSD	χ^2	Malingerer	PTSD	χ^2
Intrusive memories	13%	60%	7.03*	87%	100%	2.14	73%	40%	3.39
Nightmares	40%	67%	2.14	100%	100%	na	60%	33%	2.14
Flashbacks	20%	13%	0.24	47%	27%	1.29	27%	13%	0.83
Psychological reactivity	33%	13%	1.68	87%	47%	5.40	53%	47%	2.14
Physiological reactivity	40%	47%	0.14	93%	80%	1.15	100%	67%	6.00*
Avoid thoughts	0%	33%	6.0	100%	100%	na	20%	47%	4.66
Avoid activities/situations	80%	40%	5.0	80%	87%	0.24	47%	20%	2.40
Amnesia	0%	0%	na	47%	20%	2.40	80%	53%	2.40
Diminished interest	20%	33%	0.68	100%	87%	2.14	40%	20%	2.80
Social detachment	40%	60%	1.20	73%	80%	0.19	93%	20%	16.42*
Emotional numbing	7%	53%	7.78*	100%	73%	4.62	33%	60%	2.14
Foreshortened future	0%	13%	2.14	33%	73%	4.82	47%	33%	3.33
Insomnia	47%	60%	0.54	80%	93%	1.15	27%	13%	0.83
Irritability	67%	73%	0.16	93%	87%	0.37	74%	40%	7.92*
Concentration deficit	27%	33%	0.16	87%	73%	0.83	47%	20%	2.40
Hypervigilance	47%	60%	0.54	93%	80%	1.15	53%	53%	0.00
Startle response	33%	27%	0.16	87%	80%	0.24	53%	40%	1.35

Note. * Chisquare = $p < .01$.

To index the increase of symptom reporting from the open-ended to directive formats, we calculated the number of participants who increased endorsement of each symptom from Phase 1 to Phase 2 (see Table 1). Multiple chi-square analyses were conducted for each symptom. It is worthwhile noting that the proportion of participants who increased their reported symptoms across formats does not equate to the difference between those who reported symptoms in open-ended and directive formats because different participants endorsed symptoms in different formats. Further, some participants reported a symptom in the open-ended format but not in the directive format. Malingers significantly increased their reports in the directive interview relative to the open-ended interview in terms of physiological reactivity, social detachment, and irritability.

DISCUSSION

Malingers did not report emotional numbing during open-ended interview as much as genuine PTSD participants. This finding is consistent with Rogers' (1997) hypothesis that individuals who mangle posttraumatic stress will be less likely to report negative or subtle symptoms. The infrequent reporting of emotional numbing is also consistent with the finding of Bryant and Harvey (1998) that malingers are less likely to report symptoms that pertain more to the process of experience rather than the content of behaviors or images. In contrast, the finding that malingers were less likely to report intrusive memories in the open-ended format is inconsistent with the proposition that malingers are more likely to report positive symptoms (Fear, 1996).

There were global increases in reporting of symptoms in the directive format relative to the open-ended format. In terms of differential increases in symptom reporting between genuine and malingered participants, malingers increased reporting of physiological reactivity, social detachment, and irritability more than genuine participants. Pitman et al. (1996) suggest that reporting symptoms after being provided with cues in the absence of prior spontaneous reports of these symptoms may indicate malingering. The pattern in this study supports this approach. Caution is required in adopting this strategy, however, because many PTSD participants increased their symptom reporting in the directive format. People with PTSD can fail to report certain symptoms because of tendencies to avoid recognition of distressing symptoms (Schwartz & Kowlaski, 1991) or they do

not attribute problems to the traumatic experience that is the subject of the interview (Solomon & Canino, 1990). The current data suggest that directive questioning obtains greater symptom endorsement in both genuine and malingering respondents. This pattern notwithstanding, there appears to be a greater tendency for malingers to increase their reports of selective symptoms during directive questioning than during spontaneous reports.

We recognize a number of limitations with this study. First, our use of undergraduate participants may have limited the ability of our malingers to effectively feign PTSD. Use of trauma-exposed individuals who do not suffer PTSD may represent a more ecologically valid sample to study malingered PTSD. Second, previous malingering studies have been criticized because they do not sufficiently motivate malingers to feign the designated disorder (Rogers, Ornduff, & Sewell, 1993). Providing participants with incentives to mangle successfully may enhance the performance of malingers. Third, providing malingers with coaching about malingering PTSD would also increase the generalizability of findings. Fourth, the experimenters who interviewed participants were not blind to group status, and it is possible that interviewer bias influenced responses. The legal and clinical implications of incorrectly evaluating the genuineness of a person claiming to have PTSD necessitate strong empirical support for the procedures used to delineate feigned and genuine PTSD. The current results point to the need for more research into differential symptom reporting in open-ended and directive formats in assessing trauma survivors.

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