
CURRENT OPINION

Evaluating Malingering in Contested Injury or Illness

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■ **Abstract:** An interdisciplinary task force of physicians and neuropsychologists with advanced training in impairment and disability assessment provided a review of the literature on malingering in chronic pain, medical disorders, and mental/cognitive disorders. Our review suggests that treating health care providers often do not consider malingering, even in cases of delayed recovery involving work injuries or other personal injuries, where there may be a significant incentive to feign or embellish symptoms or delay recovery. This report discusses the implications of this issue and offers recommendations to evaluating physicians and other health care professionals. ■

Key Words: malingering, disability evaluation

INTRODUCTION

Malingering

The concept of malingering dates back to antiquity. Even in biblical times, individuals feigned illness in

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order to avoid execution. Throughout the years, malingering has been utilized as a way to avoid military service, work, school, unpleasant responsibilities, etc. According to Sari and Spires,¹ Bleuler first conceptualized malingering as a mental illness, a notion that gained prominence during World War II.

The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* describes malingering as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs” (p. 739).² The *DSM-IV-TR* provides four criteria for meeting the definition:

1. Medical/legal context (referred by an attorney): This usually involves litigation. A person claims to have been injured with someone else at fault and now wants to be compensated for the injury. Faking or exaggerating an illness or injury is determined to have a secondary gain, as there is no reason to malingering without an incentive.
2. Marked discrepancy between claimed disability and objective findings: Because the illness or injury is fabricated, exaggerated, or embellished,

the patient or claimant* may not have objective findings of the alleged illness or injury.

Symptom exaggeration (which can be a conscious or unconscious process) related to a mental disorder may produce "nonorganic" findings on examination and may make the individual appear to be bizarre or suspect. Other emotional conditions to consider prior to the classification of malingering, according to the *DSM-IV-TR*, are factitious disorder, somatization disorder, conversion disorder, and pain disorder associated with psychological factors.

3. Lack of cooperation with testing or treatment: An individual who is malingering may avoid objective diagnostic evaluations or therapeutic interventions, especially if those are likely to confirm the discrepancy between subjective complaints and (lack of) objective findings.
4. Antisocial personality disorder: These individuals exhibit, or their records reflect, a deviation from the social norms or unlawful behavior; they are at least 18 years of age, developed a conduct disorder with onset before age 15, and have a family history of a triad of antisocial personality disorder, substance disorders, and somatization. The history may indicate: behaviors that were grounds for arrests; deceitfulness such as lying, developing aliases, and misrepresentation; or self- or other-directed violence, impulsivity, disregard for safety, irresponsibility, failure to work, lack of remorse, stealing, etc.

According to the *DSM-IV-TR*, probable malingering exists when two or more of the four criteria are met. However, other emotional disorders (as stated above) can be mistaken for malingering.

One tends to suspect malingering when an individual presents in a medicolegal context exhibiting disabling symptoms that are blatantly exaggerated, inconsistent with anatomic or physiologic mechanisms, and unaccompanied by appropriate objective evidence of impairment. However, in many instances the presentation is not straightforward. In such situations, malingering can go on for considerable periods of time before the clinician even considers it as a diagnostic possibility. This is particularly the case when malingering develops or progresses over time in response to situational incentives

in individuals who are psychologically and/or environmentally prone to this behavior.

Because the *DSM-IV-TR* defines malingering not as attributable to a mental disorder but rather as the intentional production of false or grossly exaggerated physical or psychological symptoms, malingering implies conscious deception. Persons usually malingering psychosis for one of the following five reasons:

1. To avoid criminal punishment by feigning incompetence to stand trial or insanity at the time of the crime, or to mitigate sentencing.
2. To avoid induction into the military, undesirable military assignments, or combat.
3. To receive financial gain from social security disability, veterans benefits, workers' compensation, or personal injury damages.
4. For substance abusers/criminals, to obtain drugs or to be transferred to a psychiatric hospital where they perceive they will have an easier stay, or have a greater opportunity to escape.
5. To obtain social services or free room and board, or to avoid criminal charges (p. 48).³

In a classic study, Rosenhan⁴ evaluated eight individuals (without apparent psychiatric disorder) who presented themselves for admission into a psychiatric hospital alleging that they heard atypical voices. All were admitted and stopped reporting symptoms once they were admitted. All were diagnosed as having schizophrenia and remained hospitalized from 9 to 52 days. The study concluded that mental health professionals were unable to distinguish normality from mental illness, especially regarding feigned psychosis.

Malingering is distinct from factitious disorder. In factitious disorder, maintaining the symptoms is not motivated by external gain, but rather by internal emotional and psychological issues, causing the claimant to maintain a "sick role."

Rogers³ criticized *DSM-IV*⁵ screening indices for malingering and found the criteria to be overly moralistic and empirically lacking. He found that use of two or more of the *DSM-IV* indicators of malingering correctly classified only two-thirds of malingers. Moreover, for every malingeringer who was correctly classified, four actual claimants were misclassified. Rogers views malingering within the context of an adaptation model: "Would-be malingeringers engage in a cost-benefit analysis when confronted with an assessment they perceive as indifferent, if not inimical to their needs. Malingering is more likely

*Throughout this article the word *patient* is used when it is assumed that the interaction with the individual is in a clinical context, and *claimant* or *evaluate* when referring to a medical-legal/forensic context.

to occur when 1) the context of the evaluation is perceived as adversarial, 2) the personal stakes are very high, and 3) no other alternatives appear to be viable" (p. 8).³

Prior to recent studies on litigating and benefit-seeking chronic pain claimants, relatively few claimants with pain or medical problems were thought to be malingering. Some individuals are passive, dependent, and emotionally needy, and look to their health care provider for comfort and emotional support. For them, illness was felt to involve primary gain. In the majority of claimants, emotional and psychological manifestations and illness behaviors were felt to occur as part of a conditioned process, not motivated by personal gain or conscious attempts to defraud.^{6,7} Most illness involves some secondary gains (not to be confused with malingering), such as avoiding certain activities and receiving increased attention. Other individuals manage to cope with life's demands until faced with an illness or injury, at which point they have difficulty resuming their baseline functioning, leading to delayed recovery and prolonged disability. Detailed assessment may reveal a characteristic developmental history and past psychosocial history notable for many unmet emotional needs, psychosocial traumas, physical/sexual abuse, and hyper-responsibility at an early age.⁸ The ongoing symptoms seem to be their way of saying, "now it is my turn to be taken care of."⁹ These individuals do not plan their suffering, and they are not considered to be malingering, even though their ongoing suffering and illness behavior may not correspond to a disease. Without appropriate treatment, some continue in the sick role indefinitely.¹⁰

While secondary gain can be based upon monetary issues, and may be associated with malingering, the assumption that this is always the case often does a disservice to the claimants receiving disability payments, who, when resistant to returning to work, can have unfounded suspicions cast on the legitimacy of complaints and symptoms. In fact, legitimate concerns and fears may be interfering with their return to work. The courts and media have drawn attention to fraudulent cases by showing surveillance video of workers who are collecting disability payments for injuries and are seen on film doing strenuous physical activities. But this is more the exception than the rule. Boden¹¹ estimated that at most, 3% of injured workers in the United States fall into this category.

Table 1 summarizes prevalence rates for feigned mental disorders, cognitive impairments, and chronic pain.

Fishbain et al.³³ indicated that malingering occurred in 1.25% to 10.4% of chronic pain claimants. More

recent research has suggested a much higher incidence of malingering of chronic pain, or cognitive or emotional symptoms secondary to chronic pain, in litigating and benefit-seeking claimants. Larrabee^{36,37} and Meyers et al.³⁵ indicated a 36% base rate for malingering in chronic pain claimants. Gervais et al.³⁸ found that 50% of compensation-seeking chronic pain claimants failed symptom validity tests (the Computerized Assessment of Response Bias [CARB] and the Word Memory Test), and that when warned that poor test performance would cast doubt on their claimed impairment, they had a drop in failure rate to 6%. This clearly indicates the presence of conscious symptom distortion and lack of full effort in this problematic group of claimants. Gervais et al.³⁴ also found that 0% of rheumatoid arthritis patients and nondisability-seeking fibromyalgia claimants failed the above symptom validity tests, compared with 30% of fibromyalgia claimants seeking disability. Converging newer literature suggests the need to consider a possible 30% to 40% incidence of malingering of pain, emotional, and/or cognitive symptoms secondary to pain in litigating and benefit-seeking claimants. Mittenberg et al.³⁹ indicate a 38.61% malingering base rate for fibromyalgia and a 33.51% malingering base rate for chronic pain or somatoform disorders. Available studies agree that in chronic pain populations not seeking compensation, rates of malingering are low.

Miller⁴⁰ was one of the first authors to calculate that compensation benefits of much greater than 50% of wages led to an increased number of days of the disability claim by persons who were insured. According to Loeser et al.,⁷ not all of the reviewed studies on back pain were fully consistent, and not all of the studies showed any effect. The best available literature suggests that a 10% increase in workers' compensation benefits produces a 10% to 11% increase in the number of claims and a 2% to 11% increase in the average duration of claims. This translates into an average increase of 2 to 5 days off work because of back pain. These effects are similar for other injuries such as fractures and for other subjective complaints such as soft tissue injuries. It should be noted that secondary gains might be balanced by secondary losses.⁶

Nagi and Hadley⁴¹ showed that 82% of disabled people in the United States were financially worse off than when they were working, 17% had little change, and only 1.5% were better off. The trend had not changed by the 1990s. Few people on disability benefits are better off than when they were working. Half of the disabled persons receiving compensation benefits receive

Table 1. Prevalence Rates for Feigned Mental Disorders, Cognitive Impairments, and Chronic Pain

Feigned mental disorders		
Keiser 1968 ¹²	Post-traumatic stress disorder	1%
Miller and Cartlidge 1972 ¹³	Post-traumatic stress disorder	50%
Henderson 1986 ¹⁴	Post-traumatic stress disorder	50%
Rogers 1986 ¹⁵	Total likely malingering insanity plea and judged sane	24.5%
	Definite malingering	4.5%
	Probable malingering	20%
Rogers 1990 ¹⁶	Malingering in correctional population	5-50%
Rogers et al. 1994 ¹⁷	Forensic cases	15.7%
	Nonforensic cases	7.4%
Schretlen et al. 2000 ¹⁸	Criminal defendants	11.3%
Feigned cognitive impairments		
Hopwood and Snell 1933 ¹⁹		
	Malingered amnesia	22%
	Definite malingering	14%
	Probable malingering	8%
Kiersch 1962 ²⁰	Malingered amnesia detected by hypnosis and amytal interview	41%
	Self-admitted malingered amnesia	25%
Heaton et al. 1978 ²¹		64%
Heilbrun et al. 1990 ²²	Malingered neuropsychological impairment	67%
Youngjohn 1991 ²³	Malingered neuropsychological impairment in workers' compensation claimants	47%
Binder 1993 ²⁴	Malingered neuropsychological impairment	18-33%
Trueblood and Schmidt 1993 ²⁵	Malingered neuropsychological impairment	7.5-15.7%
Frederick et al. 1994 ²⁶	Malingered neuropsychological impairment	10-25%
Rogers et al. 1994 ¹⁷	Forensic	15.7%
	Nonforensic	7.4%
Greiffenstein et al. 1994 ²⁷	Malingered deficits in personal injury litigants	60-64%
Guilmette et al. 1994 ²⁸	Social security claimants	18%
Meyers and Diep 2000 ²⁹	Malingering of cognitive symptoms secondary to pain	
	Litigating	29%
	Nonlitigating	0%
Meyers and Volbrecht 2003 ³⁰	Malingered neuropsychological impairment	15-20%
Feigned chronic pain		
Leavitt and Sweet 1986 ³¹		
		5-20%
Kay and Morris-Jones by Video Surveillance 1998 ³²		
		20%
Fishbain et al. 1999 ³³		
		1.25-10.04%
Gervais et al. 2001 ³⁴		
	Chronic pain from fibromyalgia	
	Applying for disability	44%
	Already on disability	23%
Meyers et al. 2002 ³⁵	Litigating	36%
	Nonlitigating	0%
Larrabee 2003 ³⁶	Several study average	40%

less than 50% of their prior net earnings, and only one in eight receives more than 80%.⁴² Only 5% of persons with back pain were financially better off than when they were working. These individuals were very few in number and were generally part-time or very poorly paid workers whose wages were so low that they gave little financial incentive to work at all. The overall social picture shows that the vast majority of people off work with back pain are much worse off financially in many ways. Disability compensation income or other sickness benefits are a very inadequate replacement of prior working income.

Financial incentives can modify people's behavior in certain situations. Once back injuries occur, better compensation benefits tend to increase the number and duration of claims.⁴² However, studies differ as to whether

compensation benefits increase the reported severity of back pain. The amount of compensation benefits is only one factor in maintaining an ongoing sick role. Socio-economic issues affect workers' compensation claims, including work demands/environment, job satisfaction, availability of modified work, income generated, job security, advancement/career potential, pension, natural job attrition, job availability, and compensation.⁴²

Rohling and Binder,⁴³ in a well-designed meta-analysis of 32 studies encompassing 3802 chronic pain claimants and 3849 control claimants, showed that claimants receiving compensation consistently reported more pain, although the difference was small, approximately 6%. They also concluded that the outcomes of conservative treatment, back surgery, and chronic pain rehabilitation programs are consistently poorer in com-

pensation claimants. Receiving compensation benefits delayed clinical recovery. Studies show that work-related injury and compensation lead to more prolonged disability, even when one considers job demands. Findings also suggested that, in the absence of compensation, there would be a 24% reduction in disability with consequent return to work. Studies also suggest that compensation claimants are more depressed.⁴³ It should be noted that the vast majority of compensation claimants (75–90%) respond well to treatment, recover from injury or illness, and return to work. Social factors tend to be less important with individuals who suffer severe physical injuries. Those with less-severe injuries, higher education, higher income, greater lost income, and more independence seem to have a higher motivation to return to work.⁴³

MALINGERING AND THE PRIMARY CARE PHYSICIAN

Initial Presentation

Malingering can be a single action, such as “false imputation,” in which an individual falsely claims that a given medical problem is due to a particular injury or event. This is often seen in claims that involve motor vehicle accidents, workers’ compensation, or other liability claims, but can also occur when a person becomes disabled due to a medical condition that predated a newly acquired short- or long-term disability policy. The rationale is to obtain coverage or remuneration for conditions that otherwise would not be compensable.

Many primary care physicians do not concern themselves with issues regarding causation and apportionment, as they are generally not related to their primary responsibility of providing patient care. Additionally, focusing on these issues may pose an ethical dilemma, as it could conflict with their usual role as a patient advocate. However, physicians who see the claimant later in treatment often rely on these early treatment records as the basis for assessing a causal relationship between an incident, injury, or illness and resulting medical or psychiatric complaints. Therefore, it may be difficult for later physicians to accurately interpret the earlier reports, as the claimant’s subjective complaints may have been accepted as fact in the history without any attempt to verify the alleged facts.

Regardless of the “usual” standard of care, physicians who manage work-injured patients or those with other personal injuries are advised to take a comprehensive history, including past medical/psychosocial history

and mechanism of injury. To assess a causal relationship, one should assess areas such as temporal relationship and biological plausibility. The existence of a causal relationship should be assumed only in those situations in which the mechanism of injury and temporal factors are clearly supportive.

Symptom Magnification

Matheson first described the concept of symptom magnification in 1988 as “a conscious or unconscious self-destructive, socially reinforced behavioral response pattern consisting of reports or displays of symptoms which function to control the life circumstances of the sufferer.” In essence, this is a learned behavior and not a *DSM-IV-R* or an *ICD-9* coded diagnosis. Technically, it is not a medical diagnosis. Matheson⁴⁴ describes three types of patients who magnify symptoms: refugee, game player, and identified patient. Hayes et al.,⁴⁵ building on the work of Tyndel and Tyndel⁴⁶ and Wilfling and Wing,⁴⁷ coined the diagnostic term “nomogenic disorder” to describe litigation- or compensation-seeking claimants showing symptom magnification. This describes an iatrogenic disorder in which law and its application through tort awards and workers’ compensation plays an etiologic role. In this model, pain and disability are caused and maintained by expectations of financial gain. They posit that using the diagnosis of a nomogenic disorder rather than malingering or a somatoform pain disorder gets around the problem of determining whether the malingering or magnifying behaviors are conscious (as in the malingering classification) or unconscious (as in the somatoform diagnosis), which is a very difficult differentiation to make empirically. They indicate that the behaviors of all claimants change compellingly in response to reinforcement. They conclude that whether the continuation or elaboration of pain disability behaviors is conscious or not, the treatment should be the same: removal of all social and financial reinforcers for pain disability behaviors.

Symptom magnification is said to be present when symptoms and/or disability are disproportionate to objective anatomical, physiological, or psychological findings. One should suspect symptom magnification when symptoms are vague, ill-defined, overdramatized, inconsistent, or not in conformity with expected signs and symptoms. It is also likely to be present when the results of physical and mental status examinations and other data are inconsistent with complaints.

According to Polatin et al.,⁴⁸ Mannion et al.,⁴⁹ and France et al.,⁵⁰ individuals with certain personality types

or psychiatric disorders have an increased prevalence of developing chronic pain and are more likely to exhibit symptom magnification. Dependency, passivity, and masochism are some of the personality characteristics seen in these claimants. They are often socially isolated, lonely, and have difficulty dealing with anger, hostility, and the communication of these feelings. Characteristically these claimants lack insight and often feel victimized. Preoccupation with, and virtual self-identification through, pain then becomes an important form of communication and gratification.⁵¹⁻⁵³

The presence of any one of the following should alert the physician to the possibility of symptom exaggeration, but no one of them should be used independently to assess malingering. The more of these that are present, the greater the likelihood of malingering. However, further studies must validate this linear relationship.

1. Unlikely symptoms, physical capacities, or clinical course:
 - Complaints grossly in excess of clinical findings
 - Inconsistency in symptom presentation
 - Bizarre or absurd symptoms
 - Atypical fluctuation in symptoms in response to external incentives;
 - Unusual symptomatic response to treatment that cannot otherwise be explained (eg, paradoxical response to medication);
 - Markedly discrepant capacity for work vs. recreation
 - Substantial noncompliance with evaluation or treatment
 - Compliance only with passive rather than active treatment (assuming that one rules out comorbid disorders, eg, depressed patients may "give up")
 - Refusal to undergo any invasive testing or treatments, regardless of potential benefit
2. Other psychosocial or environmental indicators of concern:
 - Prior "incapacitating" injuries
 - Overly idealized functioning before the trauma
 - Evasiveness
 - Antisocial personality traits
 - Unvarying, repetitive dreams (if post-traumatic stress)
 - Poor work record
 - History of dissatisfaction with job

- Poor relationship at work with employer, supervisor, or peers
- Economic downturn affecting workplace with concern about job loss
- Economic incentives (disability claim, tort action, motor vehicle accident, disability income from multiple sources, child-care issues)
- Multiple family members on disability or with pattern of personal injury claims/work-related injury claims
- Spouse on disability
- History of failure of symptom validity tests or Functional Capacity Exam validity measures

The History

Pain complaints as well as other medical or psychiatric symptoms should be assessed for consistency with the clinical examination, diagnostic test results, the alleged injury, resulting suffering, and objective impairment. Pain is subjective, cannot be disproved, and generally must be accepted as what a *credible* claimant says it is.

One should also question the claimant regarding self-care issues (activities of daily living vs. attendant care issues): Is the person independent with all self-care skills, or is/was attendant care required? Is there a discrepancy between the medical records, the evaluation, and the claimant's alleged activities of daily living and dependence on attendant care? Are there obvious findings on physical examination that bring the claimant's credibility into question (grease under the fingernails of a "disabled" mechanic, well-calloused feet in an individual who claims to be sedentary and on bed rest, etc.)?

It is also critical to ask about prior medical history. Individuals who allege injury may deny prior injuries to the parts in question that are later noted in other medical records. This raises a suspicion of malingering, as it is suggestive of conscious motivation to link prior conditions with the trauma for personal gain. (A possible exception would be the individual who sustained head trauma and has significant residual cognitive deficits, and whose failure to recall a past injury or past medical/psychiatric problem noted in the prior records is consistent with what would be expected based upon neuropsychological testing or clinical assessment.)

Another area to evaluate is the ability to drive and/or take public transportation in order to perform routine daily tasks; those who are able to do this generally should also have the independence to travel to and from

work. Also, if the claimant is using assistive devices, one should ascertain who prescribed them, why they were prescribed, and whether their current use provides any functional benefit.

The Physical Examination

The injured worker who embellishes his or her medical history, exaggerates pain drawings, or responds in a manner that is inconsistent with known pathophysiology, is a significant challenge to the clinician. Physicians should become adept at using established clinical maneuvers to assist in assessing for possible symptom embellishment. For example, a strongly positive supine straight leg-raising test without similar complaints in the seated position with the knee extended in a claimant with low back pain is an inconsistent response and indicates that nonphysiological factors may be playing a role in the claimant's responses. Another example would be a positive Hoover test. Neither is pathognomonic for malingering. However, these types of findings should be noted and the significance clarified as to whether they suggest dysfunctional pain behavior or conscious symptom embellishment/malingering. The more of these that are present, the more likely that symptom magnification should be considered. However, whether it is a conscious process or an unconsciously conditioned dysfunctional pain behavior may require further evaluation.

Examination of the claimant suspected of malingering should include observing the person moving about the room before, during, and after the examination. These movements should be consistent with limitations reported in the history, especially with regards to work activities. In taking the claimant's history, it is critical to obtain a detailed description of the initial injury or event and the subsequent clinical course. Any discrepancy between this information and that found in the actual medical record should be grounds for questioning the credibility of the claimant and considering the possibility of malingering.

It is important to distinguish maladaptive pain behaviors such as the claimant's inappropriately prolonged use of assistive devices (canes, crutches, braces, orthoses, cervical collars, lumbar supports, transcutaneous electrical nerve stimulation machines) from adaptive use of assistive devices that give therapeutic benefit. Malingerers may use these devices when they go for an evaluation in an attempt to impress the physician/evaluator with the extent of their suffering. Records from their treating physician/clinician should document that these appliances had been prescribed, as well as for how

long and when they were to be discontinued. The literature provides limited support for the use of orthotic devices, such as cervical collars and lumbosacral corsets, etc., in order to stabilize a body region. However, prolonged usage contributes to weakness and deconditioning (pp. 241–261).⁵⁴

With regards to systemic examination, musculoskeletal or neurological deficits should be consistent with underlying anatomic and/or physiologic processes. If not, this should be noted. An attempt should also be made to compare "involuntary" (spontaneous) actions with those made when the claimant is specifically asked to perform a given activity.

Diagnostic Testing and Treatment

The purpose of providing diagnostic evaluation of individuals who exhibit delayed recovery or symptoms disproportionate to objective findings is to reduce or eliminate the possibility of significant pathology and to assist us with treatment recommendations. Testing in this context can be therapeutic as well as diagnostic. Claimants who are symptom magnifying or malingering generally have a paucity of objective clinical findings. One should interpret diagnostic evaluation cautiously as, for example, imaging studies of the spine conducted in asymptomatic individuals showed that many subjects had abnormal (positive) findings without complaints of spinal pain.^{55–61} Positive findings on imaging studies must be correlated clinically to confirm that they are not just coincidental findings,^{55,56,60} as they may lead to unnecessary interventional procedures that contribute to iatrogenic impairment and disability.

Malingerers frequently attempt to continue prolonged use of passive modalities and, when they are involved in physical therapy or chiropractic care, the records may suggest submaximal effort, inconsistencies, or a lack of sustained progress. In those circumstances when a claimant repeatedly "fails" treatments or develops increased symptoms after treatment that should, at the very worst, have led to no benefit, one is obliged to reassess the treatment and carefully evaluate the claimant (and overall clinical situation) to see whether signs of malingering are present. Compliance with medications and with treatment (testing) recommendations is another factor to be concurrently evaluated.

Evidence of potential malingering based upon the history, physical examination, level of disability, test results, and treatment response should prompt the primary care physician to refer the claimant for a consultation in order to substantiate and develop this

impression. It is important to do so before one definitively concludes that malingering is present.

Return to Work

With the exception of patients who have very severe psychiatric or cognitive disorders, it is rare for someone to be incapacitated to the point where he or she cannot do at least full-time sedentary work. It is highly unlikely for someone with this degree of incapacity to not have some evidence of an abnormal anatomic or physiologic process on diagnostic tests or the physical examination. When a claimant states, in the absence of clinical findings, that because of an injury he or she cannot return to any form of restricted duty (workers' compensation), or claims disability that is markedly in excess of (and inconsistent with) clinical evidence of impairment, the primary physician's role is *not* to accept these statements as valid in the absence of any substantive supportive evidence, but instead to question whether this appears credible. Because the evaluation is in a medical context, the question to be addressed is whether there is any medical basis to prevent or restrict the individual from returning to work if he or she chose to do so. If not, the physician should not support the request for disability.

Chronic Pain Syndromes

Patients with chronic pain syndromes often have subjective complaints markedly disproportionate to objective findings. It is estimated that of claimants with low back pain, approximately 85% cannot be given a definitive diagnosis because of the weak association of symptoms, pathological changes, and imaging studies (p. 257).^{54,62,63} "Chronic pain syndrome" is not a diagnosis but rather a descriptive term to indicate persistent complaints of pain, associated dysfunctional pain behaviors, self-limitations in activities of daily living, and associated global life disruption.⁶⁴ Nachemson⁶² and Rudy et al.⁶³ emphasize, however, that this does not represent malingering. Chronic pain syndromes involve learned, conditioned pain behaviors and disability behaviors. They can be part of a somatoform process or reflect other primary psychological diagnoses, and often involve significant somatization.⁹ Most often, the individual loses far more than he or she gains from the ongoing pain, associated disability, and life disruption. However, as is the case in claimants who are malingering, the evaluator may note many subjective complaints without objective findings, many emergency room visits with normal tests, complaints that the pain is constant or unbearable, total- or hemi-body pains, pain described

in elaborate and often dramatized terms, pain complaints progressively getting worse despite no evidence of increasing pathology, and other dysfunctional behaviors including drug seeking despite poor analgesic response, pain worsening when the claimant is advised to return to work, negative diagnostic testing, etc.

Malingers commonly have multiple subjective complaints without objective findings, or with findings that do not correlate with the subjective complaints. They may complain that their condition is progressively worsening and that no treatment is helping; the literature suggests^{10,65} that individuals who are malingering rarely seek second opinions or extensive diagnostic testing, because having these studies is not in the interest of supporting their malingering claim.

Herein is one of the characteristics distinguishing malingers from claimants who have chronic pain syndromes or somatoform disorders. The latter, too, may have subjective complaints disproportionate to objective findings. However, they often insist on further testing such as magnetic resonance imaging (MRI), computerized tomography scan, and electromyogram/NCV (nerve conduction velocity), and often believe that more diagnostic evaluation and interventional procedures can resolve their problem or at least better clarify the etiology. As noted previously, unless the potential benefits outweigh the risks and it is likely that the testing results would have an impact on the recommended treatment, the clinician should avoid the temptation for further testing. This is especially the case in claimants with chronic pain, as false-positive test results will only serve to reinforce their dysfunctional beliefs and fear-avoidance behaviors. The cautious clinician must be adept at distinguishing legitimate symptoms from somatization, unconscious mechanisms for symptom embellishment from malingering, and findings that are clinically significant from coincidental findings.⁹

Identification of Malingering

When all of the following are present, malingering can be considered as clearly present (see Cunnien⁶⁶):

1. Confirmation that psychological or physical symptoms are under voluntary control as manifested by one or more indicators:
 - Gross symptom production that is inconsistent with physiological or anatomical mechanisms
 - Unambiguous psychometric evidence of malingering or strong corroborative evidence of malingering