

A Systematic Approach to the Detection of False PTSD

Mikel Matto, MD, Dale E. McNiel, PhD, and Renée L. Binder, MD

Posttraumatic stress disorder (PTSD) can occur after a traumatic experience and can cause severe symptoms that interfere with a person's psychological, physical, interpersonal, occupational, and social functioning. It is important to accurately identify genuine cases of PTSD and, as part of the differential diagnosis, to rule out instances of false PTSD. False PTSD diagnoses can adversely affect treatment planning, resource management, and research. The subjective nature of stressors, stereotypic presentation of symptoms, wealth of resources detailing how to malingering PTSD, and the high stakes for individuals involved in criminal, civil, and disability evaluations create challenges for making an accurate diagnosis. This article presents a systematic approach to help clinicians and forensic evaluators distinguish genuine PTSD from false variants of the disorder. It describes the types of false PTSD to be considered as alternative diagnoses, including malingering PTSD (for external gain, such as receiving a disability pension or evading criminal consequences), factitious PTSD (for internal gain, such as assuming the victim or hero/veteran role), and misattributed PTSD (legitimate psychopathology misdiagnosed as PTSD). The authors describe clinical features and psychological testing that may be leveraged to aid in reaching a more valid diagnosis.

J Am Acad Psychiatry Law 47:325–34, 2019. DOI:10.29158/JAAPL.003853-19

Posttraumatic stress disorder (PTSD) is a serious condition that is associated with high levels of social, occupational, and physical disability, as well as considerable economic costs and high levels of medical utilization.¹ Service members are returning to their communities from the wars in Iraq and Afghanistan with symptoms of psychiatric disorders, including PTSD. Survivors of sexual assault on college campuses share their experiences with increasing openness, and some report severe psychological sequelae after their trauma. In short, PTSD is a growing problem that the mental health field continues to study for predisposing factors, mitigation strategies, and the development of more effective treatments. To do so effectively, great care needs to be taken to distinguish between genuine and false cases of PTSD.

Trauma is used frequently as the basis for civil suits involving mild to severe injuries. It is also used in criminal cases to minimize responsibility or mitigate sentencing. PTSD can also be alleged as the basis for

financial incentives such as those related to disability. Forensic evaluators are often called upon to help distinguish between genuine and false PTSD. This article describes a detailed approach designed to help with these evaluations and to assist treating clinicians and PTSD researchers.

Despite its apparent ubiquity, PTSD is not the expected outcome from trauma exposure. The National Comorbidity Survey demonstrated that although 61 percent of men and 51 percent of women were exposed to a traumatic experience at some point in their lives, the lifetime prevalence of PTSD was 8 percent and 20 percent, respectively.² Experiencing symptoms after a trauma (e.g., intrusive thoughts, nightmares, insomnia, avoidance of reminders of the event, exaggerated negative beliefs, irritability, and hypervigilance that do not spontaneously resolve within months after trauma) is the exception to the norm. Such symptoms become less exceptional, however, as cumulative trauma burden increases.

After being described by various terms throughout each of the country's wars, bearing names like "soldier's heart," "shell shock," "combat neurosis," and "battle fatigue," PTSD formally entered the psychiatric lexicon in 1980 with the publication of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III). Because of the subjective nature of the symptoms in the diagnostic criteria,

Published online June 10, 2019.

Dr. Matto is Assistant Clinical Professor of Psychiatry, Dr. McNiel is Professor of Clinical Psychology, and Dr. Binder is Professor of Psychiatry in the Department of Psychiatry, University of California, San Francisco. This article was presented, in part, at the 47th annual meeting of the American Academy of Psychiatry and the Law, October 27–30, 2016, in Portland, Oregon. Address correspondence to: Mikel Matto, MD, UCSF Department of Psychiatry, 401 Parnassus Ave., Box 0984, San Francisco, CA 94143. E-mail: mikel.matto@ucsf.edu.

clinicians have always relied heavily on patient report. This reliance has increased in recent years by the gradual broadening of the definition of what constitutes a traumatic stressor, which changed in 1994 with the publication of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) from an objective standard (an event that would be distressing to anyone) to a subjective one (an event the individual found distressing).³ In 2013, with the publication of Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the diagnosis no longer requires a reaction at the time to include “fear, helplessness, or horror.” The PTSD criteria for what constitutes trauma and how a patient reacts to it have become more inclusive over time.

Patients may have conscious and unconscious motivations to feign a diagnosis of PTSD. These can include legal (e.g., reducing or avoiding criminal liability), personal (e.g., justifying relationship strife and occupational problems), financial (e.g., acquiring money from civil lawsuits, disability, and veteran pensions), shelter (e.g., securing inpatient or ER admission), and social (e.g., gaining sympathy or respect from peers). Clinicians may be reluctant to question the validity of self-reported trauma and related symptoms. They may worry about loss of rapport, stigmatizing patients, and the moral responsibility to veterans or patients as victims deserving additional services.⁴

The importance of an accurate PTSD diagnosis is critical on both individual and community levels. For the individual, accurate identification of true PTSD is important so that appropriate treatment can be provided. On the other hand, patients may be given inappropriate or even harmful treatment for non-present PTSD, and suspicion of feigning during treatment can have negative impacts on rapport.⁵ An inaccurate PTSD diagnosis also often obscures a legitimate alternate diagnosis that is left untreated. On a community level, the availability of clinical resources to treat PTSD is limited, and efforts to treat misdiagnosed PTSD deprive others in need of treatment. Inappropriate diagnosis also leads to inaccuracies in medical research because these cases would not be expected to respond to PTSD treatment. Many researchers are emphasizing the importance of ruling out suspected malingered PTSD from clinical trials to more reliably measure the effectiveness of PTSD treatment.⁵⁻⁷

On a national level, the financial need for accurate PTSD diagnosis is critical. Between 1999 and 2004, PTSD disability payments increased 149 percent (up to \$4.3 billion) versus an increase of 42 percent for all other disability payments. The number of veterans receiving Veterans Affairs (VA) disability for PTSD rose 80 percent (versus 12% for other disabilities) during that time. By 2010, the number of veterans receiving PTSD disability had risen by 222 percent compared with 1999.⁸⁻¹⁰ By 2013, 6.8 percent of all veterans receiving any VA disability payments were receiving compensation for PTSD, and 34.9 percent of veterans receiving disability payments for mental health reasons, such as PTSD, received compensation at a 70 percent or higher disability rating (compared with 3.8% receiving ratings at this level for all other conditions).¹¹ Data have also demonstrated that service-connected veterans reported increasingly worsening symptoms of PTSD until reaching 100 percent disability, followed by an 82 percent decrease in their use of VA mental health services (without a change in their use of VA medical services).^{8,12} PTSD is now the most prevalent service-connected mental disorder and the third most prevalent service-connected disability for veterans receiving pension benefits.¹³ Whether this rapid rise in the number and severity of PTSD claims is due to the diagnostic criteria changes in DSM, the nature of the combat during Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) (e.g., high comorbidity of traumatic brain injuries, increased rates of multiple amputations, etc.), the trauma burden of recent veterans, or increased rates of feigned PTSD is unclear at this time, but it warrants consideration.

How frequently are cases of PTSD feigned? Prevalence of general malingering is largely a matter of context. Base rates are estimated at 15.7 percent for forensic evaluations versus 7.4 percent for non-forensic evaluations.¹⁴ In the criminal justice system, malingering estimates for competency to stand trial evaluations vary between 8 percent and 17.4 percent, and malingering in requests for psychological services in the correctional setting is estimated to be 45 to 56 percent.¹⁵ Malingering is estimated to occur in 20 to 30 percent of personal injury claims for PTSD and at least 20 percent of compensation- and pension-seeking combat veterans.^{9,16,17}

Given the level of PTSD awareness in popular culture and the attraction the diagnosis may hold for some patients, it is important that clinicians, re-

Table 1 Data Domains to Consider in the Evaluation of False PTSD

Domain	Analysis to Include
Work	Performance appraisals and disciplinary actions
School	Grades, evaluations, test scores, and correspondence
Friends and family	Interviews that can corroborate symptoms, particularly ones the evaluatee may be unaware of (e.g., movement while sleeping or dissociation episodes). Caution is warranted in interpretation of these data because close friends or family may have a vested interest in the outcome of the evaluation.
Police	Arrest records, police reports, or witness statements concerning criminality or past trauma
Correctional	Any custody records of the evaluatee's observed behaviors and activities while incarcerated
Military	The DD-214 (certificate of release or discharge from active duty that lists awards that pertain to actions, wounds, and deployments), evaluations, and disciplinary actions. Given that these records can be forged, evaluators may consider ordering them directly from the National Personnel Records Center online via a SF-180 request form.
Courts	Depositions or transcripts of civil, criminal, or administrative hearings
Medical/psychiatric	Past psychiatric and medical evaluations, diagnoses, and treatment. Medical records warrant careful review because non-mental health care providers often do not describe mental health concerns unless they are a chief complaint.

From References 4, 5, 9, 18, 19.

searchers, and forensic evaluators consider a methodical approach to facilitate diagnostic accuracy by arriving at a determination of PTSD after considering and ruling out alternatives resembling PTSD (i.e., false PTSD).

Steps to Evaluate False PTSD

The five steps to properly evaluate false PTSD are listed here and discussed in the following sections:

- Review collateral information and relevant records.
- Conduct the evaluation.
- Consider misattributed PTSD.
- Consider malingered or factitious PTSD.
- Consider performing psychological testing.

Collateral Information and Records

The most accepted way to confirm volitionally produced PTSD is to compare the patient's subjective report with outside evidence. For single-session evaluations, it is desirable to collect and review collateral information prior to the evaluation. This can facilitate consideration of the consistency between information derived from the interview (including signs, symptoms, and described cross-domain functionality) with pertinent documentation in multiple domains, as listed in Table 1.

The Evaluation

Further relevant information can be gathered from behavioral observations prior to the formal be-

ginning of the evaluation session. Observation of an evaluatee's interaction with his or her environment can be useful (e.g., waiting room seating selection, demonstration of irritability with paperwork or delays, eye contact or behavior with patients or staff). Discussion prior to the perceived initiation of the formal evaluation interview can yield information that is helpful for determining potential PTSD symptom clusters. Casual questions about things like traffic, sporting events, or hobbies can help reveal the presence or absence of triggers for road rage, avoidance symptoms, and level and ubiquity of impairment, respectively.

Interviewing an evaluatee in the presence of others can be problematic.^{4,5} A third party can potentially taint the evaluation through interruptions or unsolicited input and can affect the responses of the evaluatee. Given that PTSD often presents in ways similar to portrayals in film and television, particular care needs to be taken to use open-ended and non-leading questions. This gives evaluatees the ability to report genuine symptoms in their own words and provides more opportunity for suspected malingerers to contradict themselves.^{18,20,21}

Whereas a structured interview format is helpful in research settings, it can be problematic in forensic evaluations by suggesting possible symptoms that an evaluatee may readily endorse due to demand characteristics of the setting. Instead, eliciting more detail about each symptom and evaluating each of the criteria for the PTSD diagnosis in DSM-5 helps determine whether the PTSD diagnosis is genuine.

Exposure (Criterion A)

As mentioned above, the definition of what constitutes “exposure” and “trauma” in PTSD have changed over the years. The Criterion A specification in DSM-III that characterized the index trauma as “outside the range of usual human experience” (Ref. 22, p 236) and one that would “evoke significant symptoms of distress in almost everyone” (Ref. 22, p 238) was eliminated in DSM-IV after epidemiologic surveys used examples from lists of qualifying traumatic events and determined that clinical judgment about the stress resulting from specific traumatic events for a typical person was not a feasible standard.³ DSM-IV also included language in Criterion A1 indicating that the event could be “witnessed” or the individual “confronted with” the trauma,²³ explicitly incorporating a class of traumatic experiences that, prior to this, had been the subject of debate. One study found that this change increased the number of traumatic events meeting the exposure criteria by 59 percent, with a corresponding 38 percent increase in the number of people meeting PTSD diagnostic criteria.³ DSM-5 criteria serve to limit the indirect exposure described in DSM-IV by requiring “learning that the traumatic event(s) occurred to a close family member or close friend” for an event in which the “actual or threatened death was violent or accidental (Ref. 1, p 271) and specifically excluding witnessing events through media (such as television, movies, or video games) unless the exposure is work related.^{1,24} The Criterion A2 requirement that individuals respond to the traumatic event with “intense fear, helplessness, or horror” (Ref. 23, p 467) was removed entirely in DSM-5, making a PTSD diagnosis more applicable to individuals whose background and training might preclude them from expressing such a response in the moment, such as first responders and military service members. The forensic evaluator’s determination of a Criterion A-qualifying traumatic event is critical to distinguish PTSD from an adjustment disorder with similar PTSD-like symptoms. With changes that will potentially serve to both increase inclusion (lack of emotional reaction requirement) and decrease inclusion (“learned-about” trauma limited to family or close friend suffering violent or accidental threats or trauma), it is unclear at this time how the changes between DSM-IV and DSM-5 will affect prevalence.

Finally, when determining whether an evaluatee’s described traumatic event satisfies Criterion A, it is

important to consider this event in the context of the individual’s overall trauma history. While a subject may focus on a single recent event of modest intensity, the literature suggests that there is a cumulative burden of trauma with increased prevalence, symptom complexity, and functional impairment of PTSD and other psychopathologies that correlate to the number of childhood and adult trauma exposures (including combat deployments, sexual assault, and other traumatic experiences).^{25–27}

Intrusion Symptoms (Criterion B)

Dreams and flashbacks are often viewed by the layperson as the hallmark of PTSD, and these symptoms are often predominant in feigned PTSD. The forensically-oriented PTSD literature contains the following descriptions of ways to assist in determining the likelihood that intrusion symptoms are legitimate. It is particularly helpful to validate these symptoms with third parties and collateral, when possible.

Individuals with PTSD related to combat or rape are believed to more likely have repetitive dreams of discrete content from the traumatic event itself, whereas other sufferers of PTSD typically have more thematic types of content during nightmares.^{9,18,28–31} Emotions experienced during nightmares are often representative of emotions experienced at the time of trauma. For example, nightmares related to civilian trauma, such as rape, often consist of feelings of anxiety and helplessness, versus nightmares related to combat trauma, which more frequently have predominant themes of horror, grief, hostility, or rage.^{18,28} PTSD nightmares are almost always accompanied by either sudden awakenings or notable body movement while asleep, a fact that should be apparent to bedmates.^{4,18,30,32}

Although individuals experiencing flashbacks re-experience perceptual and emotional details, feigning evaluatees may underappreciate that flashbacks are more likely to include auditory and olfactory components (compared with nightmares, which are often purely visual) and not understand that during flashbacks individuals also experience and remember portions or the entirety of their actions.^{18,33}

Avoidance (Criterion C)

Whereas DSM-IV employed one criterion consisting of avoidance (C1–C2) and numbing (C3–C7), DSM-5 separated them into symptoms of “persistent avoidance of stimuli associated with the traumatic event(s)” (Criterion C) and “negative al-

terations in cognitions and mood associated with the traumatic event(s)” (Criterion D) (Ref. 1, p 271). This change was made in the setting of factor analysis, which suggests that avoidance and numbing symptoms were distinct entities originating from separate mechanisms and having different clinical associations with other psychopathologies.^{34–37} A study indicated that when avoidance was created as the standalone Criterion C in DSM-5, this change reduced classification of PTSD cases when compared with DSM-IV criteria by 22 percent and 26 percent at 3 months and 12 months after trauma, respectively,³⁴ with many of the re-classified cases instead likely attributable to major depressive disorder.

While intrusion symptoms are often understood and appreciated by individuals feigning PTSD, the importance of avoidance in the diagnosis and presentation of PTSD is often undervalued; this is particularly relevant with avoidance now being a required component of PTSD diagnosis. When evaluatees are familiar with the concept of PTSD avoidance, it may be literal (e.g., avoiding movies about the wars in Afghanistan and Iraq) rather than the subtler symbolic associations (e.g., avoiding gas stations due to the smell of oil triggering memories of the patrols in trucks while deployed). As with other aspects of detection of false PTSD, it is important to consider whether underreporting is an overlooked feigned symptom or a component of underreporting of all PTSD and other mental health symptoms due to an emphasis on resiliency stemming from a military background or other elements of an evaluatee’s culture.

Negative Cognitions and Mood (Criterion D)

Changes to DSM-5 added new symptoms to represent a broad range of disturbances in PTSD, including “persistent and exaggerated negative beliefs or expectations about oneself, others, or the world” (Criterion D2), “persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others” (Criterion D3), and “persistent negative emotional state” (Criterion D4) (Ref. 1, p 272). Studies have demonstrated that these symptom clusters are predictive of later development of PTSD and are well represented in validated civilian and combat PTSD.^{24,38–40} The challenge for evaluators is to distinguish PTSD-related negative alterations in cognitions and mood (such as survivor guilt, a sense of foreshortened future, and feelings of de-

tachment) from the negative alterations in cognition and mood that can result from similar features in depression. Two other symptoms in this PTSD criterion (i.e., inability to recall important aspects of trauma and reckless or self-destructive behavior) may be presented by individuals feigning PTSD due to the potential for these symptoms to reduce or mitigate legal responsibility. These two symptoms, however, represent the least commonly endorsed symptoms seen in individuals with PTSD per DSM-5,^{24,38} and in a large-scale study of active duty military service members, risky behavior was moderately associated with anxiety and depression but only mildly associated with PTSD.⁴¹

Arousal and Reactivity (Criterion E)

Similar to intrusion symptoms, hypervigilance and exaggerated startle response are well known to individuals with even a minimal understanding of PTSD. Care needs to be taken to compare collateral sources and third-party reports of observed behavior with the presentation of the evaluatee during the interview (e.g., an evaluatee sitting with his back to the door of a busy hallway exhibiting discomfort or exaggerated response to unexpected noise that is consistent with claims). As is described in more detail in the testing section below, there is a dearth of instruments to quantitatively detect physiological changes in individuals with PTSD without prohibitive false-positive and false-negative rates that render these tests unsuitable for most forensic evaluations.¹⁸

Duration and Impairment (Criteria F and G)

Two separate studies evaluated cases of emotional reactions to non-traumatic events that met PTSD criteria for intrusion, avoidance/numbing, and arousal symptoms. When the duration and impairment criteria were applied, the PTSD rate decreased from 20 percent to 3 percent.⁴² The subject needs to demonstrate clinically significant distress or impairment in work, relationships, and other major activities of daily life for more than one month to be accurately characterized as PTSD. This requires attention to whether reduction in function is limited to areas of unpleasant duties or impacts domains of life that would be otherwise pleasurable.

Consider Misattributed PTSD

After a thorough review of symptoms, accurate evaluation of potential PTSD can be facilitated by a consideration of a broad differential diagnosis to rule out non-PTSD psychopathology. Techniques vary,

but using a simple acronym (i.e., STAMP) can be helpful in clinical encounters to ensure the consideration of multiple diagnostic possibilities:

S – Substance

T – Trauma

A – Anxiety

M – Mood / Medications / Medical

P – Psychosis / Personality

Cases in which the suspected PTSD is due to psychopathology from another etiology is a form of misattributed PTSD due to misdiagnosis. Experiences of irritability, insomnia, poor concentration, and stress intolerance may be a result of persistent postconcussive syndrome from a traumatic brain injury. Anxiety disorders may be the cause of hyperarousal and non-trauma-focused avoidance symptoms. Affect dysregulation and impaired behavioral control may be due to underlying personality disorders. Depressive disorders may be responsible for symptoms of negative beliefs, guilt, and persistent negative affect. Given that a traumatic event is a discrete and often life-changing experience for an individual, survivors may be more likely to assign symptoms of psychopathology to the trauma itself rather than to recognize that these symptoms predated it.²⁴ Even in cases in which PTSD is genuine, it is still important to screen for missed diagnoses. PTSD is rarely seen as a stand-alone disorder. In one large study of outpatients with a principal PTSD diagnosis, 92 percent had another active psychiatric diagnosis,⁴³ and the National Comorbidity Survey showed that 59 percent of men and 44 percent of women diagnosed with PTSD had three or more other psychiatric diagnoses.² Clinicians may attribute symptoms to PTSD that are instead related to unrecognized comorbidities such as depression, anxiety, or personality disorder. These comorbidities are particularly important to recognize in cases in which PTSD is being utilized for purposes of criminal responsibility, civil liability, or pension or disability. Misattributed PTSD is likely to produce substandard responses to treatment due to non-evidence-based interventions (in the case of misdiagnosis) or incomplete interventions (in the case of missed diagnosis).

Consider Malingered or Factitious PTSD

The next step is to determine whether observed PTSD-like symptoms are being volitionally produced. Patients feigning symptoms of PTSD will of-

ten give vague or non-specific answers to direct questions and will provide stereotypic or dramatic, heroic, or cinematic symptom depiction. It is important to determine if this is due to symptom avoidance, mistrust of the clinician, or exaggeration compensating for memory impairment.^{4,5,9,18,28,44} Patients attempting to portray PTSD often underestimate the body movement that typically occurs with PTSD nightmares, overestimate the frequency of flashbacks, and underappreciate the dissociative quality that typically accompanies them.^{4,18}

Although there is a wealth of clinical lore regarding features of volitionally produced symptoms of PTSD, caution is warranted because much of it represents an accumulation of anecdotal evidence rather than the results of formal studies. Further, many such generalizations (e.g., “Real combat veterans are reluctant to talk about their combat.”) are culturally biased and may be out of date. While the generalization of the stoic World War II veterans reluctant to discuss their experiences may have had some validity at a point in time, it is difficult to apply this convincingly (without further study) to an Iraq or Afghanistan veteran who grew up with social media without further study. Rogers and Schuman describe six indications for feigned symptoms: rare symptoms, improbable or absurd responses, indiscriminate symptom endorsement, unlikely symptom combinations, contradictory symptoms, and symptom severity.^{45,46}

If the symptoms appear to be feigned, clinicians need to consider the type of motivation behind it. Feigned symptoms are often assumed to represent malingering, which is described in DSM-5 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” (Ref. 1, p 726). Examples of external motivations that can be present in malingered PTSD include acquiring VA disability pension, military medical retirement, or state disability; obtaining financial rewards through civil damages; securing housing through veteran- or PTSD-specific programming; obtaining drugs or medications such as benzodiazepines, sedatives, or medical marijuana; gaining workplace accommodations; and avoiding criminal responsibility through not guilty by reason of insanity defense, unconscious defense, self-defense, or mitigating circumstances.^{4,5,44,47}

Feigned PTSD is not necessarily a complete manufacturing of symptoms, and it is valuable to consider malingering patterns as described by Resnick: pure malingering is when the person feigns non-existing symptoms, partial malingering is when the person consciously exaggerates existing symptoms, and false imputation is when the individual consciously attributes existing symptoms to a cause not responsible for the symptoms (e.g., an individual with longstanding anxiety disorder intentionally attributes these symptoms to a later accident for the sake of a civil lawsuit).¹⁹ The motivation for malingering may be influenced by third parties, such as when patients are encouraged by legal representation to present for treatment for the sake of gaining a diagnostic report to bolster their case or for prolonged care to demonstrate refractory psychopathology to increase a potential financial settlement.⁹

When patients appear to consciously produce symptoms in the absence of external gain, a form of “factitious PTSD” is a potential diagnosis. Whereas a diagnostic criterion of factitious disorder in DSM-IV was “the motivation for the behavior is to assume the sick role” (Ref. 23, p 517), DSM-5 does not require this distinction and only requires that the subject’s “deceptive behavior is evident even in the absence of obvious external rewards” (Ref. 1, p 325). In this rarely discussed form of feigned PTSD, patients may fabricate symptoms for the sake of the potential benefits that the community and society give to individuals who are in the sick role.⁴⁸ This can be further amplified for individuals in the victim role (e.g., motor vehicle accidents, rape, assault) or the hero role (e.g., combat veterans). This phenomenon has been repeatedly observed in veterans presenting with feigned symptoms of PTSD in which a review of collateral information demonstrated that the described traumas did not occur and there is no obvious external gain.^{49–51} Similar cases of factitious PTSD have been described in civilian counterparts in claims of abuse and abductions.⁵² Explanations have been posed that patients may desire to take on this patient or victim role to transform their identity and cultivate desired relationships.⁵³ PTSD can be used as a way to gain recognition, respect, and appreciation from peers, loved ones, and society at large. It can also be used as an explanation or rationalization for failures in interpersonal relationships, professional obligations, or sobriety. In a large study of VA dis-

ability claimants for PTSD in the Midwest over one year, 74 percent agreed both that the service connection for PTSD was important because “it will show the government acknowledges how I was affected by my military experience” and “it will show that there is a reason for my problems” (Ref. 54, p 2138). With increased destigmatization of PTSD and the cultural cachet of the survivor designation, PTSD is a more attractive diagnosis than substance use disorder, anxiety, or depression. While the Stolen Valor Act of 2013⁵⁵ (a revised version of the 2005 law of the same name⁵⁶ determined by *United States v. Alvarez*⁵⁷ to be an infringement on the First Amendment) made it a crime for individuals to claim to have received valor awards by the military only if done so for the sake of external gain, there are still many websites that detail cases of men and women falsely claiming war veteran and PTSD status only for other reasons. Factitious PTSD and seeking internal gain is a consideration for clinicians noting feigned symptoms when there is no obvious material reward.

Psychological Testing

Although listed last here, formal psychological testing to distinguish genuine PTSD from the variants of false PTSD may be employed at any point in the forensic evaluation and, in fact, may be a critical part of the evaluation. In one study, 86 percent of college students without specific training and without clinical evidence of PTSD were able to successfully meet criteria for PTSD by using a symptom checklist.⁵⁸ Although a comprehensive review of psychological tests that can assist in evaluation for false PTSD is beyond the scope of this article, some examples will be described.

One initial approach is to use a screening test such as the Miller-Forensic Assessment of Symptoms (M-FAST).⁵⁹ This 25-question instrument requires 5–10 minutes to complete. Studies have demonstrated identification of 78 percent of subjects who have been instructed to malingering.⁶⁰ It is commonly used to identify individuals who score above a cutoff suggesting malingering and are then referred for more intensive testing. As is true for any forensic determination, the determination of feigned PTSD should not rely on any single measure.⁶¹

Self-report symptom checklists such as the PTSD Checklist for DSM-5 or PCL-5⁶² can be problematic due to the potential for over-reported or feigned symptoms but can be helpful if the evaluator uses

them cautiously to contrast the results with observed signs or symptoms during the interview or via collateral. The Clinician-Administered PTSD Scale (CAPS)⁶³ is a structured interview developed by the Department of Veterans Affairs that includes 17 items rated on a scale of 0–4 points and takes approximately one hour to complete. While widely used in research settings, the measure has the potential to be exploited by evaluatees feigning symptoms. Although the measure permits the evaluator to note items of “questionable validity,” the accuracy of the clinician ratings in detecting exaggerated or invalid symptom endorsement has not been demonstrated empirically.^{16,64}

The Structured Interview of Reported Symptoms-2 (SIRS-2)⁶⁵ requires 30–45 minutes to complete and is widely used to assess malingering in general and in PTSD specifically. It includes a variety of strategies to detect feigning, such as questions about highly unusual symptoms or atypical symptom pairing.⁹ It has been used in inpatient, correctional, and forensic populations with high accuracy.⁴ The tool uses eight primary and five supplementary scales to detect 13 response styles that have been associated with feigned symptoms.⁴⁵ One study tested subjects coached with PTSD diagnostic criteria, and the results indicated that the RS, IA, SC, BL, SU, SEL, SEV, and RO scales of the SIRS discriminated legitimate patients from coached subjects.^{64,66}

The Minnesota Multiphasic Personal Inventory-2 (MMPI-2)⁶⁷ is a self-report multi-scale personality inventory that is reported by multiple studies to have high sensitivity for identifying malingered PTSD.⁴⁷ In early studies of the MMPI, more than 90 percent of subjects attempting to malingering PTSD were correctly identified using the F and PK scales, leading to a recommendation that examiners use cutoff scores of $T > 88$ and $T > 30$, respectively.^{47,68,69} More recent studies of the MMPI-2 found that the strongest predictors of malingering in civilian samples were the Fp, F-K, and O-S scales, whereas the strongest predictor in a veteran study was the F-K scale, closely followed by the F, Ds₂, F-F_B, O-S, and OT fake-bad scales.^{47,70–72} Although the F scale is the most effective at detecting malingered psychopathology in general, it has not been shown to be one of the best MMPI-2 predictors for malingered PTSD. A specific Infrequency-Posttraumatic Stress Disorder scale (Fptsd) was developed to assist with

feigned PTSD detection. Results appear to indicate that the Fptsd scale was more effective at predicting malingering using combat PTSD patients, whereas Fp was most useful with civilian PTSD patients.^{72–74}

The Personality Assessment Inventory (PAI)⁷⁵ is a widely used multi-scale inventory that includes validity scales to assess response style and scales that assess symptoms related to PTSD. The Negative Impression (NIM) scale, Negative Distortion Scale (NDS), and Malingering Index (MAL) are validity scales that are reported to be useful in differentiating genuine from feigned PTSD.^{61,76}

Other domains of testing show promise but have not reached a level of acceptance required for forensic purposes. Psychophysiological testing is occasionally used and has variable admissibility in court.⁴ Testing can include measurements such as blood pressure, heart rate, temperature, forehead electromyography, and galvanic skin response after exposure to sudden loud noises or via script-driven imagery. At this time, there is a lack of consistent criteria for identifying feigned PTSD on the basis of psychophysiological testing, although the approach may be promising.¹⁸ There has also been growing research in the diagnostic use of hormones and neurotransmitters (including cortisol, cortisol-releasing factor, neuropeptide Y, and norepinephrine), but current findings cannot be used reliably to diagnose PTSD or to rule out feigned PTSD.^{18,64} Neuroimaging has also been utilized to identify increased or signature brain activity associated with lying, particularly the orbito-frontal/ventrolateral prefrontal cortex, dorsolateral prefrontal cortex, anterior cingulate cortex, and thalamus,⁷⁷ but these are areas of research and are not used clinically at this time.

Conclusion

A methodical approach can help clinicians and forensic evaluators rule out several types of false PTSD prior to arriving at an accurate diagnosis of genuine PTSD. Consideration of the data described in this paper can help ensure that more valid research occurs and that clinical and financial resources are allocated to individuals with genuine PTSD, while evaluatees presenting with false PTSD can be approached intentionally, compassionately, and tactfully.

References

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, DC: American Psychiatric Association, 2013
2. Kessler RC, Sonnega A, Bromet E, *et al*: Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry* 52:1048–60, 1995
3. Breslau N, Kessler RC: The stressor criterion in DSM-IV post-traumatic stress disorder: an empirical investigation. *Biol Psychiatry* 50:699–704, 2001
4. Knoll J, Resnick PJ: The detection of malingered post-traumatic stress disorder. *Psychiatr Clin North Am* 29:629–47, 2006
5. Ali S, Jabeen S, Alam F: Multimodal approach to identifying malingered posttraumatic stress disorder: a review. *Innov Clin Neurosci* 12:12–20, 2015
6. Charney DS, Davidson JRT, Friedman M, *et al*: A consensus meeting on effective research practice in PTSD. *CNS Spectrums* 3:6–10, 1998
7. Rosen GM: DSM’s cautionary guideline to rule out malingering can protect the PTSD data base. *J Anxiety Disord* 20:530–5, 2006
8. Review of State Variances in VA Disability Compensation Payments (Report #05-00765-137). Washington, DC: Department of Veterans Affairs Office of Inspector General, 2005
9. Taylor S, Frueh BC, Asmundson GJ: Detection and management of malingering in people presenting for treatment of posttraumatic stress disorder: methods, obstacles, and recommendations. *J Anxiety Disord* 21:22–41, 2007
10. Marx BPH, Holowka DW: PTSD disability assessment. *PTSD Res Q* 22:1–6, 2011
11. McNally RJ, Frueh BC: Why are Iraq and Afghanistan War veterans seeking PTSD disability compensation at unprecedented rates? *J Anxiety Disord* 27:520–6, 2013
12. Frueh BC, Grubaugh AL, Elhai JD, Buckley TC: US Department of Veterans Affairs disability policies for posttraumatic stress disorder: administrative trends and implications for treatment, rehabilitation, and research. *Am J Public Health* 97:2143–5, 2007
13. 2015 Annual Benefits Report (Compensation). Available at: <https://www.benefits.va.gov/REPORTS/abr/ABR-Compensation-FY15-05092016.pdf>. Accessed January 22, 2018
14. Rogers R, Sewell KW, Goldstein A: Explanatory models of malingering: a prototypical analysis. *Law & Hum Behav* 18:543–52, 1994
15. McDermott BE, Dualan IV, Scott CL: Malingering in the correctional system: does incentive affect prevalence? *Int J L & Psychiatry* 36:287–92, 2013
16. Frueh BC, Hamner MB, Cahill SP, *et al*: Apparent symptom overreporting in combat veterans evaluated for PTSD. *Clin Psychol Rev* 20:853–85, 2000
17. Lees-Haley PR: MMPI-2 base rates for 492 personal injury plaintiffs: implications and challenges for forensic assessment. *J Clin Psychol* 53:745–55, 1997
18. Hall RC, Hall RC: Malingering of PTSD: forensic and diagnostic considerations, characteristics of malingerers and clinical presentations. *Gen Hosp Psychiatry* 28:525–35, 2006
19. Resnick PJ, West S, Payne JW: Malingering of posttraumatic disorders, in *Clinical Assessment of Malingering and Deception*, Third Edition. Edited by Rogers R. New York: Guilford Press, 2008, pp 109–27
20. Resnick PJ: The detection of malingered psychosis. *Psychiatr Clin North Am* 22:159–72, 1999
21. Wiley SD: Deception and detection in psychiatric diagnosis. *Psychiatr Clin North Am* 21:869–93, 1998
22. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington, DC: American Psychiatric Association, 1980
23. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association, 2000
24. Zoellner LA, Bedard-Gilligan MA, Jun JJ, *et al*: The evolving construct of posttraumatic stress disorder (PTSD): DSM-5 criteria changes and legal implications. *Psychol Inj Law* 6:277–289, 2013
25. Karam EG, Friedman MJ, Hill ED, *et al*: Cumulative traumas and risk thresholds: 12-month PTSD in the World Mental Health (WMH) surveys. *Depress Anxiety* 31:130–42, 2014
26. Cloitre M, Stolbach BC, Herman JL, *et al*: A developmental approach to complex PTSD: childhood and adult cumulative trauma as predictors of symptom complexity. *J Trauma Stress* 22:399–408, 2009
27. Kline A, Falca-Dodson M, Sussner B, *et al*: Effects of repeated deployment to Iraq and Afghanistan on the health of New Jersey Army National Guard troops: implications for military readiness. *Am J Public Health* 100:276–83, 2010
28. Resnick PJ: Malingering of posttraumatic psychiatric disorders. *J Pract Psychiatry Behav Health* 4:329–339, 1998
29. Ross RJ, Ball WA, Sullivan KA, Caroff SN: Sleep disturbance as the hallmark of posttraumatic stress disorder. *Am J Psychiatry* 146:697–707, 1989
30. Van der Kolk B, Blitz R, Burr W, *et al*: Nightmares and trauma: a comparison of nightmares after combat with lifelong nightmares in veterans. *Am J Psychiatry* 141:187–90, 1984
31. Schreuder, BJ, Kleijn WC, Rooijmans HG: Nocturnal re-experiencing more than forty years after war trauma. *J Trauma Stress* 13:453–63, 2000
32. Zervas IM, Soldatos CR: Nightmares: personality dimensions and psychopathological attributes. *Int Rev Psychiatry* 17:271–6, 2005
33. Geraerts E, Kozarić-Kovačić D, Merckelbach H, *et al*: Traumatic memories of war veterans: not so special after all. *Conscious Cogn* 16:170–7, 2007
34. Forbes D, Fletcher S, Lockwood E, *et al*: Requiring both avoidance and emotional numbing in DSM-V PTSD: will it help? *J Affect Disord* 130:483–6, 2011
35. Naifeh JA, Elhai JD, Kashdan TB, *et al*: The PTSD symptom scale’s latent structure: an examination of trauma-exposed medical patients. *J Anxiety Disord* 22:1355–68, 2008
36. Palmieri PA, Weathers FW, Difeo J, *et al*: Confirmatory factor analysis of the PTSD Checklist and the Clinician-Administered PTSD Scale in disaster workers exposed to the World Trade Center Ground Zero. *J Abnorm Psychol* 116:329–41, 2007
37. Simms, LJ, Watson D, Doebbeling BN: Confirmatory factor analyses of posttraumatic stress symptoms in deployed and non-deployed veterans of the Gulf War. *J Abnorm Psychol* 111:637–47, 2002
38. Miller MW, Wolf EJ, Kilpatrick D, *et al*: The prevalence and latent structure of proposed DSM-5 posttraumatic stress disorder symptoms in US national and veteran samples. *Psychol Trauma* 5:501–12, 2013
39. Foa E, Ehlers A, Clark DM, *et al*: The Posttraumatic Cognitions Inventory (PTCI): development and validation. *Psychological Assessment* 11:303–14, 1999
40. Dunmore E, Clark DM, Ehlers A: A prospective investigation of the role of cognitive factors in persistent posttraumatic stress disorder (PTSD) after physical or sexual assault. *Behav Res Ther* 39:1063–84, 2001

A Systematic Approach to Detect False PTSD

41. Thomsen CJ, Stander VA, McWhorter SK, *et al*: Effects of combat deployment on risky and self-destructive behavior among active duty military personnel. *J Psychiatr Res* 45:1321–31, 2011
42. Boals A, Hathaway LM: The importance of the DSM-IV E and F criteria in self-report assessments of PTSD. *J Anxiety Disord* 24: 161–6, 2010
43. Brown TA, Campbell LA, Lehman CL, *et al*: Current and lifetime comorbidity of the DSM-IV anxiety and mood disorders in a large clinical sample. *J Abnorm Psychol* 110:585–99, 2001
44. Berger O, McNiel DE, Binder RL: PTSD as a criminal defense: a review of case law. *J Am Acad Psychiatry Law* 40:509–21, 2012
45. McCullumsmith CB, Ford CV: Simulated illness: the factitious disorders and malingering. *Psychiatr Clin N Am* 34:621–41, 2011
46. Rogers R, Shuman DW: The mental state at the time of the offense measure: its validation and admissibility under Daubert. *J Am Acad Psychiatry Law* 28:23–8, 2000
47. Guriel J, Fremouw W: Assessing malingered posttraumatic stress disorder: a critical review. *Clin Psychol Rev* 23:881–904, 2003
48. Bass C, Halligan P: Factitious disorders and malingering: challenges for clinical assessment and management. *Lancet* 383:1422–32, 2014
49. Sparr L, Pankratz L: Factitious posttraumatic stress disorder. *Am J Psychiatry* 140:1016–19, 1983
50. Lynn EJ, Belza M: Factitious posttraumatic stress disorder: the veteran who never got to Vietnam. *Hosp. Comm Psychiatry* 35: 697–701, 1984
51. Hamilton J: Pseudo-posttraumatic stress disorder. *Mil Med* 150: 353–6, 1985
52. Rosen GM, Taylor S: Pseudo-PTSD. *J Anxiety Disord* 21:201–10, 2007
53. Baumeister RF, Sommer KL: Patterns in the bizarre: common themes in satanic ritual abuse, sexual masochism, UFO abductions, factitious illness, and extreme love. *J Soc Clin Psychol* 16: 213–23, 1997
54. Sayer NA, Spont M, Nelson D: Veterans seeking disability benefits for post-traumatic stress disorder: who applies and the self-reported meaning of disability compensation. *Soc Sci Med* 58: 2133–43, 2004
55. 18 U.S.C. § 704 (2013)
56. 18 U.S.C. § 704 (2006), invalidated by *United States v. Alvarez*, 567 U.S. 709 (2012)
57. *United States v. Alvarez*, 567 U.S. 709 (2012)
58. Lees-Haley PR, Dunn JT: The ability of naive subjects to report symptoms of mild brain injury, post-traumatic stress disorder, major depression, and generalized anxiety disorder. *J Clin Psychol* 50:252–6, 1994
59. Miller HA: *Miller Forensic Assessment of Symptoms Test (M-FAST)*. Lutz, FL: Psychological Assessment Resources, 2001
60. Messer JM, Fremouw WJ: Detecting malingered posttraumatic stress disorder using the Morel Emotional Numbing Test-Revised (MENT-R) and the Miller Forensic Assessment of Symptoms Test (M-FAST). *J Forensic Psychol Pract* 7:33–57, 2007
61. Wooley CN, Rogers R: The effectiveness of the personality assessment inventory with feigned PTSD: an initial investigation of Resnick's model of malingering. *Assessment* 22:449–58, 2015
62. Weathers FW, Litz BT, Keane TM, *et al*: The PTSD Checklist for DSM-5 (PCL-5) – Standard [Measurement instrument]. Available at: <http://www.ptsd.va.gov>. Accessed November 24, 2018
63. Weathers FW, Blake DD, Schnurr PP, *et al*: Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). US Department of Veterans Affairs. PTSD: National Center for PTSD [Measurement instrument]. Available at: <http://www.ptsd.va.gov>. Accessed November 24, 2018
64. Hall RC, Hall RC: Detection of malingered PTSD: an overview of clinical, psychometric, and physiological assessment: where do we stand? *J Forensic Sci* 52:717–25, 2007
65. Rogers R, Bagby RM, Dickens SE: *Structured Interview of Reported Symptoms (SIRS) and professional manual*. Odessa, FL: Psychological Assessment Resources, 2010
66. Rogers R, Kropp PR, Bagby RM, Dickens SE: Faking specific disorders: a study of the Structured Interview of Reported Symptoms (SIRS). *J Clin Psychol* 48:778, 1992
67. Butcher JN, Graham JR, Ben-Porath YS, *et al*: *MMPI-2: Manual for Administration and Scoring (revised)*. Minneapolis: University of Minnesota Press, 2001
68. Fairbank JA, McCaffrey RJ, Keane TM: Psychometric detection of fabricated symptoms of posttraumatic stress disorder. *Am J Psychiatry* 142:501–3, 1985
69. McCaffrey RJ, Bellamy-Campbell R: Psychometric detection of fabricated symptoms of combat-related post-traumatic stress disorder: a systematic replication. *J Clin Psychol* 45:76–9, 1989
70. Elhai JD, Frueh BC, Gold PB, *et al*: Clinical presentations of posttraumatic stress disorder across trauma populations: a comparison of MMPI-2 profiles of combat veterans and adult survivors of child sexual abuse. *J Nerv Ment Dis* 188:708–13, 2000
71. Elhai JD, Frueh BC: Subtypes of clinical presentations in malingerers of posttraumatic stress disorder: an MMPI-2 cluster analysis. *Assessment* 8:75–84, 2001
72. Elhai JD, Gold SN, Sellers AH, Dorfman WI: The detection of malingered posttraumatic stress disorder with MMPI-2 fake bad indices. *Assessment* 8:221–36, 2001
73. Elhai JD, Naifeh JA, Zucker IS, *et al*: Discriminating malingered from genuine civilian posttraumatic stress disorder: a validation of three MMPI-2 infrequency scales (F, Fp, and Fptsd). *Assessment* 11:139–44, 2004
74. Elhai JD, Ruggiero KJ, Frueh BC, *et al*: The Infrequency-Posttraumatic Stress Disorder scale (Fptsd) for the MMPI-2: development and initial validation with veterans presenting with combat-related PTSD. *J Pers Assess* 79:531–49, 2002
75. Morey LC: *The Personality Assessment Inventory (PAI): Professional Manual, 2nd Edition*. Lutz, FL: Psychological Assessment Resources, 2007
76. Boccacini MT, Hart JR: Response style on the Personality Assessment Inventory and other multiscale inventories, in *Clinical Assessment of Malingering and Deception, Fourth Edition*. Edited by Rogers R, Bender SD. New York: Guilford Press, 2018, pp. 280–300
77. Seron X: Lying in neuropsychology. *Neurophysiol Clin* 44:389–403, 2014