Educational

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

W0012

The Importance of Secondary Gain - a Missing Story

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

Disclosure: No significant relationships.
Keywords: Secondary Gain

W0010

A Lowlands Perspective on Exaggeration and Feigned Symptoms

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

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Keywords: Symptom validity; Performance validity; Feigning; Symptom Exaggeration

W0011

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

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

Disclosure: No significant relationships.
Keywords: performance validity; symptom validity; malingering; pain

W0012

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

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

the participants qualified for embitterment disorder and 93% for PCS. In conclusion, clinicians' diagnoses of depression seem frequently erroneous. The reasons are improper assessment of the diagnostic criteria, confusion of depression with bereavement or embitterment and a failure to assess for response bias.

Disclosure: No significant relationships.
Keywords: Major depression; diagnostic accuracy; embitterment; response bias

Clinical/Therapeutic

Minding the Gap, How to Provide Adequate Psychiatric Treatment for Adolescents and Emerging Adults

W0013

'Maisons Des Adolescents', Youth Mental Health in France

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Since 1999, more than 100 "Maisons des Adolescents" (MDAs) - "House of Adolescents" - have been developed in France. These integrated youth-friendly facilities enabled young persons to gain access to specific care. The various medical programs of MDAs depend on the priorities of local communities rather than on official regulations. Most MDAs offer the following essential services: a "Health and Prevention Space" open daily; multidisciplinary consultations; consult liaison for youths hospitalized in medical units; a home visiting service; outpatient clinic including art workshops; refresher courses for school work; peer and parent support groups. The MDAs from the start addressed an age group (young people aged 11-21 years) rather than an illness. They thus provide primary prevention for young persons according to the World Health Organization definition of health as "a state of complete physical, mental and social well-being." The success of the MDA network is already widely acknowledged by users, professionals, and policymakers.

Disclosure: No significant relationships.
Keywords: integrated youth health care services; Maison des Adolescents; mental health; transition

W0014

Alcohol Use in Adolescence: Transition from Use to Abuse

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Understanding the factors that play a role in the initiation of alcohol use and the subsequent transition to later alcohol abuse adolescence is of paramount importance from the context of developing better-targeted types of secondary ("pro-active") prevention interventions (Hendriks VM, Dom G., 2021). Peer and family influences together with temperament traits have been suggested to be of cardinal importance regarding the initiation of alcohol use. In addition to these factors neurobiological and genetic factors play a major role in the risk of developing alcohol abuse upon initiation. The presentation will highlight the different psychological, neurobiological, and social factors underlying the risk of the transition to abuse and dependence in adolescence. In addition, examples of targeted prevention interventions will be highlighted.

Disclosure: No significant relationships.
Keywords: Transition; alcohol; abuse; adolescent

Assessment and Treatment of Cognitive Impairment in Schizophrenia

W0015

Cognitive and Social Cognitive Impairment and their Impact on Real-Life Functioning and Quality of life.

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Cognitive and social cognitive impairments are a central feature of schizophrenia and are known to significantly affect real-life functioning [1]. These impairments include deficits in memory, language function and executive function, as well as in processing speed and attention. In the domains of social cognition, face perception [2], voice perception, mentalizing and emotion regulation have been described to be affected. All deficits, cognitive and social-cognitive, can persist during symptomatic remission. Social cognition is a partial mediator between neurocognition and functional outcome. Recent research has demonstrated that neurocognition affects functional capacity and that social cognition affects community functioning [3]. The impact of cognition on quality of life (QOL) was shown in a large meta-analytic study, in which a moderate correlation of verbal ability and processing speed with subjective quality of life was found [4]. A network analysis showed that functional capacity and everyday life skills were the most central and highly interconnected nodes in the network. Functional capacity bridged cognition with everyday life skills, the everyday life skills node was linked to disorganization and expressive deficits [5]. Deficits in neurocognition and social cognition play a pivotal role as enduring impairment after clinical remission and as a critical rate-limiting factor in functional recovery. [1] Green et al. Schizophr Bull. 2000; 26(1): 119-136 [2] Sachs et al. Schizophr Res. 2004; 68(1):27-35 [3] Bechi et al. Psychiatry Res. 2017; 251:118-124 [4] Tolman & Kurtz Schizophr Bull. 2012; 272:419-424 [5] Galderisi et al. JAMA Psychiatry. 2018; 75(4):396-404

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Keywords: Quality of Life; cognition; functional outcome; schizophrénia