

The Behavioral Characteristics of "Simulated" Aphasia

John P. Porec
Bruce E. Porch

Veterans Administration Hospital
Albuquerque, New Mexico

Malingering as defined by Horenstein "is a condition in which the patient is deliberately and consciously feigning illness for purposes of his own. It can be recognized only upon the patient's admission and requires no neurologic treatment" (Horenstein 1976). In this definition we might ask what is the meaning of "It can be recognized only upon the patient's admission"? Does it mean we can't rehabilitate the patient until he comes to grips with the problem? Or does it mean we as a profession can't correctly diagnose the problem unless the patient admits to it? This problem of separating aphasia from a non-aphasia condition is one which is now arising in many diagnostic centers around the country. All of us in our practices have seen patients who exhibit "unusual" behaviors and often we are called upon as professionals to put a "label" on these patients.

The research undertaken in this paper asks, "Is it possible to differentiate aphasia from non-aphasia behaviorally, and if you can, how well will the testimony stand up in court". In 1975, Rada, Porch and Kellner wrote that the speech pathologist is the appropriate expert medical witness in the case involving aphasia. As this view becomes more widespread and as the legal profession begins to tap this new source of expertise, the speech pathologist is going to be called upon more and more to make exact decisions about the nature and extent of brain involvement. As Dr. Porch discussed yesterday, the field of forensic aphasiology is here and professionally we must answer the call.

In a project recently completed at the Albuquerque VA Hospital, we carried out a series of studies in an attempt to generate some objective answers for these questions. In this study we tested 25 graduate students in speech pathology and five bartenders using the Porch Index of Communicative Ability (Porch 1967). All of the subjects were given the same instructions in which we basically asked them to pretend they were aphasic and that they should attempt to simulate communicative disorders resulting from brain damage. All of the subjects were rated according to their knowledge of aphasia and the amount of contact they had had with true aphasic patients. The statistical results from the study are beyond the scope of this paper and are being presented elsewhere. The question we wish to raise here is whether or not there are distinctive patterns of response or some type of aberrant behavior which the clinician can detect which separate true aphasia from simulated aphasia.

During our study of simulated aphasia we looked at behavior in several ways. We not only looked at the test results themselves but we also made notations about the types of behavior the subjects exhibited and contrasted these two with true aphasic behaviors. We also questioned the subjects after the fact as to the type of strategies they were using and what went through their minds as they were performing the act of simulating aphasia.

Before we enter into the discussion of these analyses I would like to show you some brief samples of behavior on tape and see if you could be confident in differentiating which of these patients are aphasic and which is

merely simulating aphasia. Try to determine which strategy the subject was using and what other non-aphasic behavior you became aware of as the test progresses.

-----Video Tape Examples of Simulated Aphasia-----

If we examine the graphic responses of non-aphasic subjects, we see much the same strategy that we noted on the gestural and verbal responses. At times, the simulated aphasia is quite apparent, especially when the subject overdoes a certain strategy. However, there are many graphic subtests which are not readily distinguishable from those of a true brain damaged patient.

Discussion

In a paper we presented at the International Neuropsychological meeting in February (Porch, Friden, Porec 1977), we reported that there was very little difference between the profiles of speech pathologists versus bartenders in simulating aphasia. However, when one looks at the actual behavior of these subjects, it is frequently possible to see some minor differences in levels of sophistication in the task.

As mentioned earlier we asked each of the subjects to discuss their strategies that they used in simulating aphasia. First of all very few subjects made any attempts at simulating an anterior lesion since feigning hemiplegia and elevated reflexes is very difficult to do. None of the subjects tried to be anarthric or severely apraxic and almost without exception were what might best be described as conduction aphasia or mild Wernicke type patients. Subjects adopted the following strategies:

1. Simulated "Posterior" Type Aphasia
2. "Memory" Problems
3. Anomia
4. Latencies and Slowness
5. Awkwardness and Mild Coordination Problems
7. Illiteracy
8. Thought of a Patient and Tried to Simulate Him

As you saw in the tapes, attempts to simulate memory problems and anomias were very common and are often associated by the layman with brain dysfunction. These "memory" problems produce the fourth item on the list, latencies and slowness in performance. Most of the subjects reported that they had used delays and hesitations as part of their strategy.

Several subjects reported that they tried to be consistent with the pattern since they recognized that if there was a real brain damage that it would produce some constant effect. They seemed to sense that if they were inconsistent it would suggest malingering and therefore they used the strategy of consistency as much as possible. They were not always successful in doing this, however, and this was often evident in the next item, that of awkwardness and mild coordination problems. This characteristic, which some of them attempted, was difficult to maintain at a constant level throughout the test.

A few subjects simply tried to emulate an illiterate type of person and demonstrated what they thought were marked reading and writing difficulties. And, finally, some of the speech pathology students said that they just tried to think of a patient or a type of patient and tried to simulate him during the test.

K O T 9 7 U Z N
 Z L D 7 @ K
 9 @ A
 T L A
 7 0 7 T
 T 0 7 K @ 7
 9 @ A @ L i
 M D K @ Z
 T E Y
 T O M

Figure 1. An example of a non-aphasic subject overdoing letter reversals.

To examine these strategies more closely we see that none are readily unreasonable strategies and all of them are seen in the aphasic patient. Therefore, if the malingerer were successful in carrying out this plan, it is conceivable that he might fool the clinician into thinking that he is really aphasic. However, this strategy takes quite a bit of sophistication and it is probable that only the most experienced clinician would be successful in deceiving his colleagues.

APHASIA ?

Key in door lock
 hair comb the brush
 ci. smoke the
 teeth on the fr brus
 pencil paper
 buy the money
 pa
 eat the spoon too meat
~~sno~~ eat the
 make a fire ciqo.

Figure 2. A "simulated" subtest which approximates true aphasia.

What kind of things tend to give the "patient" away? (1) Subjects rarely attempted to simulate a hemiplegia, even though they had other signs of anterior lesions such as transitory dysarthrias and agrammaticisms. (2) Even though the patients were demonstrating posterior types of symptoms none of them seemed to recognize that hemianopia would be a normal accompaniment to that syndrome and therefore none of the patients neglected the objects on the right. (3) It was surprising how many times infantile responses would occur in the form of child-like behaviors and articulation patterns. Subjects also used semantically in-

fantile words and grammatical forms. Several of the subjects, and some actual non-organic cases, have talked about doing things or giving things to their mother. (4) One of the things that tends to be a giveaway with many of the subjects is their inconsistency in following through with behavior across subtests or within subtests. Some of the subjects might start off with memory problems and syntactic and semantic difficulties in the more difficult subtests and then as the subtests became very simple they seemed to have difficulty in thinking of what a patient might do. At this point some of them would start developing motoric and incoordination problems and have trouble remembering where the objects were on the table, and so on. (5) Inconsistencies and awkwardness alluded to earlier were seen in two different patterns. Some patients would start off with incoordination and then find that it was too difficult to maintain and would abandon it after a few subtests. Others would develop motoric problems when they couldn't think of anything else to do that was aberrant. (6) In many cases the non-aphasic subject would pick out a behavior that was truly aphasic-like in its character but they would overdo the symptom. A common example was on the overuse of letter reversals where, instead of doing it occasionally or on certain letters, they would write almost the entire page in reversed letters or inverted letters, the latter being extremely rare in aphasic patients. (7) The speech pathology students tended to show too much phonetic sophistication. They would almost write the graphic test in phonetic symbols such as writing knife "k-n-a-i-f". (8) It was interesting to note that when the examiner sat and waited out the whole 30 seconds for a response, that, whereas aphasic patients were still unable to respond at the end of that time, the nonorganic patient would feel too much time pressure and end up giving some kind of response. (9) And finally, it was not uncommon for subjects to have great difficulty remembering the common and frequently occurring words in language but substitute much rarer words in the language for the item.

Conclusion

What can we conclude from this study of aphasic behavior? First of all, some malingerers are poorer at simulating aphasia than others and these less adept actors would probably have difficulty in winning a lawsuit with their skills. However, many of the subjects, especially those family members of aphasic patients did an amazingly good job simulating aphasia and might be more successful in a court of law in winning their case. After looking at all of the data and the analysis of the behavior of the subjects, it is our conclusion that it is not the behavior that separates aphasics from non-aphasics but it is the pattern of scores across the whole battery of tests that is really discriminating of non-organicity.

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