

MALINGERING

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Malingering is almost always a rule-out in any forensic evaluation. The adversarial process and the high stakes involved in criminal proceedings may affect the likelihood that an individual will distort his or her symptom presentation. In cases where a forensic evaluation is sought, the defendant may be feigning illness to gain admission to a psychiatric hospital, to reduce culpability with an insanity defense, or to seek a more lenient sentence.

Self-report information is an important aspect of any psychological evaluation. Mental health professionals often proceed on the assumption that clients will provide an honest and complete description of their symptoms. However, this sort of forthrightness cannot be taken for granted when a referral takes place in a forensic context. Distortions in a client's presentation may compromise the accuracy of the psychological evaluation (Rogers, 1997). Assessment of malingering in a forensic setting is crucial; in fact failure to examine patterns of dissimulation can render an assessment deficient (Bordini, Chaknis, Ekman-Turner, & Perna, 2002).

THE DEFINITION OF MALINGERING

The American Psychiatric Association (2000) has defined malingering as “the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives...” (p.739). The DSM-IV-TR fails to provide more specific criteria because it does not recognize malingering as a psychiatric diagnosis, but rather as a “condition that may be a focus of clinical attention” (APA, 2000, p.739). In the assessment of malingering both the client's volition and the presence of external motivation must be examined. The DSM provides a list of situations in which malingering should be strongly suspected, but

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supplies no information about detection strategies to guide clinicians in their work. For instance, a medicolegal context for the evaluation is one situation in which malingering should be considered.

Levels of Malingering

Malingering is not an all-or-nothing phenomenon; it exists on several levels. The person who is exaggerating genuine symptoms in an attempt to create the appearance of a more severe form of psychopathology represents one level. Another level of malingering involves an examinee who uses deceit to extend legitimate symptoms back to the time of the criminal activity in order to reduce culpability. Lastly there are individuals who completely fabricate symptoms for the sole purpose of receiving an external incentive.

Malingering and Reliability

The difference between malingering and simple unreliable reporting is a matter of the individual's intent. Malingering, by definition, is deliberate. Both degree of intentionality and distortion should be considered when labeling a potential malingerer. Where intentionality is in doubt, the examinee may be classified as unreliable. The information provided may be inaccurate and not present a valid portrait of the individual's condition, but that is not due to purposeful distortion. As the evidence for dishonest responding increases, so might the level of malingering from suspected to definite. This classification system provides clinicians with an opportunity to examine their degree of certainty (Rogers, 1997).

Malingering and Mental Illness

Malingering and mental illness are not mutually exclusive phenomena. An individual might experience depressive symptoms, but feel pressure to exaggerate those symptoms in order to reduce criminal responsibility. Some of the more effective malingerers are those who have experienced or are experiencing actual symptoms. Clinicians should be willing to admit that

malingering and mental disorders may co-exist and some malingers are simply embellishing symptoms of genuine psychopathology (Rogers & Bender, 2003).

Malingering and Factitious Disorders

The concept of malingering may be confused with other disorders, such as Somatoform and Factitious disorders. Therefore, several diagnostic distinctions must be outlined for clarity. The main difference between malingering and the Somatoform disorders is motivation. Where the feigning of a mental illness or a cognitive deficit is due to a conscious effort, it can be referred to as malingering, whereas Somatoform disorders are motivated by unconscious or involuntary processes. Factitious disorders can also be distinguished from malingering in that there are no external incentives present. The malingered presentation extends beyond the patient role and is understandable in light of the individual's circumstances (Rogers, 1997).

Prevalence

The prevalence of malingering is unknown and difficult to determine. In a sample of insanity defendants deemed sane, Rogers (1986) estimated that 4.5% were definite malingers and approximately 20% were suspected of malingering. More recently, estimates of malingering in forensic populations reach 17% (Rogers, Sewell, Morey, & Ustad, 1996). The accuracy of such estimates is questionable because successful malingers, by definition, are not detected and thus not included.

THE LABEL AND ITS CONSEQUENCES

Probative Versus Prejudicial

Courts can exclude relevant evidence if its probative value is substantially outweighed by the danger of unfair prejudice. Use of the term "malingering" can be highly prejudicial. The stigma attached to the term far exceeds that of phrases such as "unreliable information" or "inaccurate picture." Decision makers can be easily biased by a conclusion that the examinee is faking a mental disorder by manipulation or lying about symptoms to avoid punishment. A clinician must be very careful in applying the term

because adverse outcomes, such as denial of treatment or offense enhancement, may ensue. The use of a stringent threshold is advised to reduce the rate of false positives.

The Costs of Successful Malingering

There are costs associated with successful malingering. False claims that are undetected have societal consequences such as increased insurance premiums and diversion of funds from the truly deserving to the undeserving (Bordini et al., 2002). Additionally, where malingerers are not properly identified, the administration of justice will be hampered. Charges might be dismissed and malingerers will achieve their secondary gain by avoiding prison for treatment-based rehabilitation (Frederick, Crosby, & Wynkoop, 2000).

The Inpatient Option

Intensive observation is often the best method to rule out malingering, especially with a defendant who is uncooperative or not communicative at all. In a number of forensic contexts the option of an extended inpatient assessment is available. For example, if a defendant is initially found incompetent to stand trial, the law allows for commitment to a hospital to restore competence. If not already incarcerated, this does result in the temporary loss of the examinee's liberty. However, it also allows for around-the-clock observation by trained mental health personnel. Under such circumstances, it becomes extremely difficult – even for the most adept malingerer – to maintain a consistent symptom pattern. Where an outpatient evaluation has been conducted and malingering is suspected but the evaluator remains uncertain, giving the individual the benefit of the doubt and recommending inpatient treatment /evaluation may be the most appropriate option.

Legal Standards

Although the evaluation of malingering occurs in many forensic cases, it is not addressed specifically in statute. In terms of case law, *United States v. Greer* (1998), a federal case decided by the Fifth Circuit Court of Appeals, emphasizes the importance

of malingering assessment in court. After a number of mental health evaluations (including one 4-month inpatient evaluation), the trial court found that Mr. Greer was competent to stand trial and had been malingering his claimed mental condition. Testimony by expert witnesses included an explanation of forced choice testing and conclusions drawn from extensive behavioral observation. The defendant was later found guilty of kidnapping and sentenced for his crime. The court then extended his sentence by 25 months for obstruction of justice based upon his egregious malingering behavior. In doing so, the court compared his feigning symptoms of mental illness to a situation where someone provides a false handwriting sample. On appeal, the Fifth Circuit Court of Appeals affirmed the trial court's actions and denied the defendant's claim that his malingering had simply been manifestation of his personality disorder. The U. S. Supreme Court later denied certiorari on the case. Therefore, the decision stands.

COLLATERAL INFORMATION IS CRITICAL

Where self-report information is suspect, it is crucial that an evaluator seek alternate sources of information. Key sources of information might include, but are not limited to:

- school transcripts
- mental health treatment and evaluation records
- medical records
- arrest records
- correctional records (particularly those relating to grievances and disciplinary infractions)
- interviews with people who have had contact with the defendant

Collateral information allows the evaluator to check for consistency of symptoms and look for contradictions in the examinee's self-report. Reviewing various records and obtaining several points of view facilitates the examination of patterns of behavior. It is important to have sufficient data in order to

evaluate the veracity of purported symptoms and/or deficits. Gross discrepancies between reported and observed behavior may make surprising sense when viewed in context.

FUNCTIONAL MALINGERING

Functional malingering refers to fabricating a positive symptom or symptoms one really does not experience. This would typically occur if someone were attempting to feign a psychotic disorder. For example, such a person might claim to hear voices or see visions or endorse strange or bizarre beliefs.

Signs of Potential Malingering During an Interview

Phillip Resnick has written extensively about symptom presentations that may be indicative of malingering. In addition to his own observations he has gathered a large body of empirical data. Some of his findings are presented below. It must be remembered however that the identification of one or more symptoms that correlate with malingering does not prove the person is, in fact, feigning or exaggerating. Such a conclusion requires corroborating evidence from a number of sources. It is always possible that symptoms frequently displayed by malingerers may be genuine in a particular individual.

Bona-fide hallucinations

According to Resnick (1997a), malingered psychosis typically looks different from the authentic disorder. Genuine hallucinations usually:

- Are ego dystonic. Psychotic patients report that their hallucinations are distressing.
- Are intermittent rather than continuous (Goodwin, Alderson, & Rosenthal, 1971).
- Are perceived as originating outside of the head.
- Do not awaken the patient from sleep.
- If visual, have color, normal-sized people and are not overly dramatic. They also do not change when eyes are closed.

- Are coped with best through activity. Genuine patients stop auditory hallucinations by getting involved in activities with other people.
- Give clear, brief messages. An auditory hallucination conveying a set of complicated instructions would be very atypical.
- Are not all-powerful. For example, in the case of command hallucinations, it would be very unusual for a person to report always having to follow the commands.

Bona-fide delusions

Research indicates that genuine delusions have the following characteristics:

- Do not have sudden onset. Delusional schemes develop and dissolve gradually. Unaware of this theme, potential malingerers may report a sudden onset of their mental illness or a sudden cessation of symptoms.
- Are in many ways consistent with past patterns of behavior. Persons with fixed delusions often have a history of behaving in ways that make no sense or are openly self-defeating unless considered within the context of the delusion.
- Are not quickly volunteered or obsessively discussed. Whereas malingerers are often eager to tell mental health professionals about their delusional beliefs and prone to remind the clinician about them, persons with genuine delusions are usually more reticent.
- Are usually accompanied by thought disorder, if bizarre in content. If the only apparent symptom is a bizarre delusion, malingering should be investigated.

Bona-fide PTSD

Less research has been done on the malingering of Posttraumatic Stress Disorder than on other areas of functional malingering. Much of the research has focused on combat veterans, but may be applicable to those who have experienced other horrific events. From the data available, Resnick (1997b)

concluded that clients feigning Posttraumatic Stress Disorder are more likely to exaggerate current symptoms or dishonestly extend genuine symptoms to the time of criminal action rather than completely to fabricate a list of symptoms. Some symptoms of PTSD, often presented differently by people who are exaggerating the condition, include:

- Denial of emotions or emotional numbing is common. Persons who are attempting to feign PTSD may claim to experience or present with extremely intense emotions.
- Often downplay symptoms. Clients who suffer from PTSD are reluctant to talk about their traumatic experiences. Malingerers, on the other hand, may take every opportunity to recount their supposed trauma in excessive detail.

Bona-fide depression

- Is evident is the client's facial expression. Malingered depression often lacks the typical furrowed brow.
- Involves cognitive slowing, whereas a potential malingerer will often forget to change their rate of speech.

Typical characteristics of malingering

The overall presentation of malingering is often characterized by:

- Answers becoming less psychotic with fatigue. Resnick (1997a) warns that simulators become increasingly normal as time goes by. This is one reason to schedule lengthy interviews when malingering is suspected.
- Endorsement of positive rather than negative symptoms. Delusions and hallucinations can be fabricated, but catatonic behavior or flat or inappropriate affect is rarely simulated.
- Over-playing and reminding. Malingerers are more likely to call attention to their delusions (Cornell & Hawk, 1989).

- Aberrations in content rather than form of thought. The disorganized speech, loose associations, and flight of ideas that characterize thought disorder are nearly impossible to fake throughout a lengthy interview.
- Approximate answers.
- Positive response to suggested symptoms. Malingerers are more likely to be suggestible when they believe that endorsing a symptom will increase the appearance of psychopathology. For example, in *U.S. v. Greer*, the defendant stopped urinating outside of his cell in favor of defecating inside the cell after being told that this would convince his doctors that he was incompetent.
- A conglomerate of symptoms not consistent with any mental illness. Malingerers tend to endorse many symptoms indiscriminately. The belief is that more symptoms will be construed as a more severe disorder.

Detection strategies (Rogers, 1997)

Richard Rogers has been conducting and publishing extensive research on strategies to detect malingering for the past two decades. He incorporated the principal strategies into a formal test instrument, the *Structured Interview of Reported Symptoms (SIRS)*, which is commercially available. Even if the SIRS is not employed as part of an evaluation, the individual strategies can be very helpful in gathering evidence.

Rare Symptoms

Endorsement of symptoms infrequently seen in a clinical population is a common technique used to distinguish malingerers from genuine patients. This is one of the most robust detection strategies.

Indiscriminant symptom endorsement

When given the opportunity, malingerers tend to endorse a wide variety of symptoms. They do not respond selectively, but endorse a large proportion of symptoms. The over-endorsement of symptoms continues to be a hallmark of malingering (Rogers, 1997). Those who endorse global psychopathological symptoms

are easier to identify as malingerers than those feigning specific symptoms with a diagnosis in mind (Berry, Baer, & Harris, 1991).

Obvious symptoms

Those symptoms that are clearly indicative of mental illness are more often endorsed than those that might not be so obviously associated with psychopathology.

Improbable symptoms

When an examinee endorses symptoms that have a fantastic or outrageous quality the credibility of their report should be questioned.

Extreme or unusual severity

Even severely impaired patients experience only a discrete number of symptoms as intolerable. Malingerers are often unable to estimate how many severe symptoms should be reported or endorsed. They also tend to report that most of their symptoms are extremely severe.

Unlikely symptom combinations

Unless the malingerer has advanced knowledge of psychopathology, s/he would probably be unaware of the fact that some symptoms that are common alone are not found together.

Erroneous stereotypes

If an examinee subscribes to common misconceptions of mental illness and the associated symptoms, malingering may be suspected. For example, a person relying on stereotypes might describe his schizophrenic condition as “having two personalities.”

Reported versus observed symptoms

Potential malingerers often report symptoms that do not correspond with their actual behavior. An evaluator should be aware of any inconsistencies between self-report and either clinical observation or observations from the record. Marked discrepancies may be useful in the detection of malingering. One downfall of this detection strategy is that sometimes genuine patients lack insight into their symptoms.

TRADITIONAL PSYCHOLOGICAL TESTS USED TO DETECT MALINGERING

Minnesota Multiphasic Personality Inventory-2

The MMPI-2 (Butcher, Williams, Graham, Tellegen, & Kaemmer, 1989) is the most widely used and researched multi-scale measure of psychopathology. A thorough review of the MMPI-2 malingering literature is beyond the scope of this chapter (see Greene, 1997; Rogers & Bender, 2003; Rogers, Sewell, & Salekin, 1994). Professionals who are trained in MMPI-2 interpretation however can utilize the validity indicators, particularly the family of F scales (F, Fb, Fp), to generate hypotheses regarding the potential for dissimulation. Consistency scales (VRIN and TRIN) can be helpful in separating random responding and reading problems from other types of invalid profiles.

Personality Assessment Inventory

The PAI (Morey, 1991) is a psychometrically sound multi-scale inventory with increasing applicability in clinical and forensic contexts. The Negative Impression Scale (NIM) is used to identify possible malingering and the exaggeration of psychopathology by assessing infrequently-endorsed symptoms and items associated with an unfavorable impression.

Specialized Malingering Assessment

A number of forensic instruments have been developed in recent years specifically to aid in identifying functional malingering. Only the most widely used instruments will be discussed in detail. The reader is referred to the Appendix following this article for a description of additional tools.

The *Structured Interview of Reported Symptoms (SIRS)* is a 172-item instrument designed to assess a wide range of psychopathology (Rogers, Bagby, & Dickens, 1992). This generalized measure of feigning mental illness includes eight primary scales and five supplementary scales. The eight primary scales correspond almost perfectly with the detection strategies mentioned previously. Endorsement of symptoms that are rarely

seen in psychiatric populations, infrequently occur together, are absurd, or are obvious signs of mental disorder are taken into account. Scores from the primary scales are classified into one of four categories: honest responding, indeterminate, probable feigning, and definite feigning. The SIRS was normed to minimize false positives, therefore it does not necessarily rule malingering out.

COGNITIVE MALINGERING

Cognitive malingering refers to feigning a deficit, pretending to be less intelligent or less able than one actually is. Typical examples include someone attempting to appear to have mental retardation or a significant brain injury or severe memory problems. In this effort, an examinee engages in sub-optimal effort. Their mission is twofold: (a) trying to convince the evaluator that they are putting forth a sincere effort and (b) providing evidence that their decreased performance or failure is due to brain insults.

Traditional Psychological Tests

IQ testing -One element of any assessment where mental retardation is suspected is some test of cognitive functioning. There are a number of well-validated instruments available (e.g., the WAIS-III) for this purpose. For the most part, however, no measures of response style are embedded in them. Although it is very difficult to over-achieve on such a test, it is quite easy to under-achieve by simply giving incorrect answers or saying "I don't know." A careful review of the individual's adaptive functioning can be critical when malingering is suspected. If the person is feigning deficits, there are likely to be marked inconsistencies between test scores and previous levels of functioning. In such cases, it is important to study the person's behavior prior to the current legal entanglement. If the person has been incarcerated for a number of years, records relating to grievances filed and participation in disciplinary proceedings can prove very illuminating. If the evaluator wishes to use a specific instrument to measure adaptive functioning, several are available.

Neuropsychological Testing

Persons suspected of suffering from brain damage are often referred for neuropsychological testing. Whereas a neurological evaluation can establish that a particular area of the brain has incurred damage, it often cannot translate those findings into specific functional abilities or deficits. Neuropsychological testing requires special training and skills. The research literature has raised questions about the ability of even highly trained professionals to detect malingering (Faust, Hart, & Guilmette, 1988; Faust, Hart, Guilmette, & Asher, 1988). However, the literature in this area has continued to expand (Reynolds, 1998) and additional tools have been added to the neuropsychologist's armamentarium.

Detection Strategies

Rogers, Harrell, and Liff (1993) identified specialized detection strategies utilized to assess the malingering of neuropsychological impairment. These strategies can be divided into two categories: excessive impairment and unexpected patterns. Excessive impairment can be seen where an examinee fails easy items, as assessed by floor effects, or scored below chance, as in symptom validity testing. Unexpected patterns, such as similar scores on easy and difficult tasks, can be assessed by a performance curve or by examining the magnitude of error on forced-choice formats.

A listing and explanation of specific malingering assessment instruments is included in the Appendix that follows this article. However, it is important to keep in mind that an invalid profile on any measure of malingering does not rule out malingering. Techniques are generally developed to minimize false positives, so that an individual truly attempting to be honest is not inadvertently identified as a malingerer.

Symptom Validity Testing (SVT)

SVT involves the use of two alternatives forced-choice testing. This is a simple strategy based in binomial distribution theory. A patient with a legitimate impairment who cannot discriminate between the two stimuli presented should perform at

chance levels over many trials. Malingerers are likely to select the wrong response deliberately and thus perform significantly below chance (Rogers et al., 1993). This provides evidence of exaggerated impairment because malingerers know the correct answer and decide not to choose it. Although the SVT technique is most useful in identifying extreme forms of malingering, clinicians can be confident in their conclusions about cognitive feigning using this technique because even patients with severe cognitive impairments are capable of performing at chance levels.

The Portland Digit Recognition Test (PDRT; Binder, 1990) is an example of a forced-choice procedure in which below-chance performance is assessed. This 72 item digit recognition test involves the presentation of a 5-digit number, followed by distracter, after which the individual is asked to pick the previously presented number from two alternatives. It is highly likely that someone whose profile indicates malingering is actually feigning. However, the PDRT also yields a large number of false negatives (Rogers & Bender, 2003).

For the ambitious evaluator, it is also possible to adapt the SVT technique to a particular person and situation. For example, it has been used to examine suspicious complaints of amnesia. This was done by simply constructing a two-alternative test based on what is known about the actual events (Frederick, Carter, & Powel, 1995).

The Floor Effect

This detection strategy is based on the assumption that even severe brain trauma patients are able to answer simple questions about themselves (What is your name?) or make easy comparisons (Which is taller, a child or a giraffe?). Failure on these simple questions is an effective indicator of malingering because even grossly impaired individuals are successful in answering them. Rey's 15-Item Test is a quick screening device (Lezak, 1995) that utilizes the floor effect to distinguish cognitive malingerers from genuine organic patients. This simple short-term memory task is presented to a potential malingerer as a difficult task by stressing the number of items to be recalled. The items in this task were

selected specifically for the ease with which they can be grouped and remembered, (Lezak, 1995). Ethical questions arise when clinicians use this kind of deceit in clinical testing. Floor effect data should be used cautiously because coaching can increase a malingeringer's ability to foil this detection strategy (Rogers & Bender, 2003).

Performance Curve Analysis

This detection strategy relies on the presentation of a range of items from relatively easy to very difficult, with the assumption that honest responders should answer the easy questions correctly but fall to chance performance on difficult items. Malingeringers, however, may not always consider item difficulty when deciding which questions to fail. Therefore, malingeringers are expected to perform poorly on easy items (where they know the right answer and intentionally fail to choose it) and to approach chance as the items increase in difficulty (where they do not know the right answer and may choose it inadvertently). When plotted on a graph, the classic malingeringer's curve will be the mirror image of the honest responder's.

The Validity Indicator Profile (VIP; Frederick, 1997) utilizes the forced-choice technique with performance curve analysis. The VIP is a measure of response validity that assesses both verbal and nonverbal abilities. It classifies profiles as either valid or invalid. Invalid profiles can then be divided into three categories: (a) careless, poor effort but motivated to do well (b) irrelevant or random responding, motivation to perform poorly but with low effort to do so (c) malingering, high effort when motivated to perform poorly (Frederick & Crosby, 2000).

Atypical Performance

Similar to the rare symptoms detection strategy of functional malingering, atypical performance signals potential malingering when one's cognitive performance mirrors a profile that rarely occurs in patients with genuine cognitive impairment. The observation of inconsistent results between or within measures also belongs in this category. However, there is very little empirical evidence to support the use of this detection strategy. In fact,

inconsistency of presentation is common in severe brain-injuries (Pankrantz, 1988). Although inconsistency on neuropsychological tests may not be considered a reliable technique alone, this kind of discrepancy should not be ignored. Further investigation may be warranted.

COACHING

In recent years, the concept of coaching has emerged as a potential problem in assessing the veracity of individuals' self reports. Does instruction increase the likelihood that a malingerer will escape detection? There are two types of coaching techniques that have been studied: (a) Education about common symptoms of psychopathology and neuropsychological impairment and (b) Education on psychological detection strategies.

The current literature reveals that increased knowledge of psychopathology does not seem to enhance malingering skills. Bury and Bagby (2002) found that informing participants about the symptoms of the disorder to be feigned (PTSD) did not reduce the likelihood of being detected on the MMPI-2. In addition, the authors believe that this information hinders the participants' ability to malingering the disorder effectively because they cannot inhibit the urge to over-endorse symptoms. However, increased knowledge of detection techniques can enhance malingering skills. Participants who were given information about the MMPI-2 validity scales were successful in evading detection as malingerers (Bury & Bagby, 2002).

When examining the effects of coaching on neuropsychological tests, it seems that instruction on symptomatology and detection strategies lead to successful malingering. Rose, Hall, Szalda-Petree, and Bach (1998) coached participants to malingering cognitive impairments by providing basic information about the effects of head injury and a strategy to evade detection ("major exaggerations, such as remembering absolutely nothing, are easy to detect"). The participants in the coached malingering group were better able to escape detection than those that were not provided with additional instruction.

Information about the symptoms of psychopathology are now widely available. Potential malingerers have access to a variety of sources to obtain the information needed to feign mental illness or cognitive impairment. The popular media, including magazines, talk shows, and television commercials advertising antidepressants, provide ample opportunity to collect data about frequent symptoms. Other resources are exposure to family members with prior experience and the use of the Internet. Attorneys have also been known to research information about psychological testing and validity scales to share with clients before an assessment (Bury & Bagby, 2002).

ETHICAL CONCERNS

The assessment of malingering begs the question: “To what extent do mental health professionals have an ethical obligation to inform examinees about efforts to detect malingering?” Is it unethical to mislead an examinee in an attempt to assess effort? The answers to these questions remain a controversy. Ethical guidelines for both forensic psychiatry and forensic psychology stress the importance of honestly explaining the evaluation to the person to be assessed. Persons being evaluated have the right to know the purpose of the assessment. The controversial aspect of the assessment of malingering is how much deception is employed. Some (McCann, 1998, Rogers & Bender, 2003) argue that, in order to serve as objective evaluators, clinicians must be forthcoming with examinees about the purpose of the assessment and the intended use of the findings. This includes informing the examinee that the veracity of his/her claims will be examined. Others view this degree of honesty as a problem in that it provides the examinee with an opportunity to filter self-reports and contaminate the assessment.

Some aspects of the forensic assessment serve multiple purposes and can be so explained. On the one hand, for example, conducting an interview, reviewing records, or administering an MMPI-2 is not done solely to unmask malingerers. On the other hand, some tests and techniques for detecting invalid responding serve no other purpose. The SIRS, for example, is not a general personality test. Yet to inform the individual that a particular test

is being given to see if they are feigning or exaggerating problems would likely invalidate the procedure.

Each evaluator must determine the appropriate level of detail in which an evaluation or technique is explained. However, in light of the serious consequences that might attach to a finding of malingering (e.g., *United States v. Greer*, 1998), some warning might be considered.

CONCLUSION

The assessment of malingering in a forensic context should be comprehensive and should never rely solely on a single measure due to the potential consequences associated with misclassification. In addition to the standard clinical interview, the acquisition of collateral information to verify the veracity of claims is essential. If a psychometric instrument is used, it is vital that forensic evaluators be familiar with the validity and reliability of the feigning measures they utilize, and apply them only to the intended population.

Although the research literature on malingering is ever expanding, our knowledge is still limited and conclusions should be drawn conservatively, remembering that evidence of exaggeration does not necessarily rule out a neurological or psychological condition. The intent of this chapter is only to provide a brief summary of evaluation techniques that are available. The following references will guide the interested practitioner to additional resources.

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Appendix

MALINGERING ASSESSMENT TOOLS

A. Structured Interview of Reported Symptoms (SIRS)

This was developed by Richard Rogers and his colleagues in 1992. It is a structured interview designed to assess functional malingering. It is very well researched and takes about 35-40 minutes to administer. It is designed to assess someone presenting psychotic-like symptoms as opposed to cognitive deficits.

Reference: Rogers, R. (Ed.) (1997). *Clinical assessment of malingering and deception*. New York: Guilford Press.

Source: Psychological Assessment Resources, Inc.
P.O. Box 998
Odessa, FL 33556

B. Miller Forensic Assessment of Symptoms Test (M-FAST)

This instrument was developed to function as a screening device for malingered mental illness. The M-FAST, which can be completed in 5-10 minutes, is a 25-item structured interview that yields a total score that corresponds with seven strategies identified as being commonly employed among malingerers.

Reference: Miller, H.A. (2001). *Miller-Forensic Assessment of Symptoms Test professional manual*. Odessa, FL: Psychological Assessment Resources.

Source: Psychological Assessment Resources, Inc.
P.O. Box 998
Odessa, FL 33556

C. Structured Inventory of Malingered Symptomology (SIMS)

This is a 75-item true-false test designed to detect the presence of malingering of specific neurological

conditions. It is recommended primarily as a screening device to determine if further assessment is warranted. Research data is still somewhat limited. The validation sample was primarily white females and did not employ an actual clinical population.

Reference: Smith, G.P. & Burger, G.K. (1997). Detection of malingering: Validation of the SIMS. *Bulletin of the American Academy of Psychiatry and the Law*, 25, 183-189.

D. Test of Malingered Memory (TOMM)

As the title suggests, this test was specifically designed to detect feigned memory impairment. It is a 50-item recognition test for adults. It relies on the premise that malingerers will score less than expected, but not necessarily below chance.

Reference: Tombaugh, T.M. (1997). The Test of Malingered Memory (TOMM): Normative data for cognitively intact and cognitively impaired individuals. *Psychological Assessment*, 9, 260-268.

Source: Psychological Assessment Resources, Inc.
P.O. Box 998
Odessa, FL 33556

E. Validity Indicator Profile (VIP)

This is a test designed to assess the malingering of cognitive deficits. It was developed by Richard Frederick and published in 1997. It is composed of a verbal subtest (78 items) and a nonverbal subtest (100 items). This test is based on performance curve analysis and yields profiles distinguishing between compliant, careless, irrelevant, and malingered response patterns.

Reference: Frederick, R.I., Crosby, R.D. (2000). Development and validation of the Validity Indicator Profile. *Law and Human Behavior, 24*, 59-82.

Source: National Computer Systems Assessments
5605 Green Circle Drive
Minnetonka, MN 55343

F. Portland Digit Recognition Test (PDRT)

The PDRT is a forced-choice procedure in which below chance performance is assessed. This 72 item digit recognition test involves the presentation of a 5-digit number, followed by distractor, after which the individual is asked to pick the previously presented number from two alternatives. It is highly likely that someone whose profile indicates malingering is actually feigning. However, the PDRT also yields a large number of false negatives.

Reference: Binder, L. (1993). Assessment of malingering after mild head trauma with the Portland Digit Recognition Test. *Journal of Clinical and Experimental Neuropsychology, 15*, 170-182.

G. Rey 15-item Memory Test

The Rey 15 item test is a screening device that utilizes the floor effect to distinguish cognitive malingerers from patients with genuine organic impairment. This simple short-term memory task is presented to a potential malingerer as a difficult task by stressing the number of items to be recalled. The items in this task were selected specifically for the ease with which they can be grouped and remembered, however.

Reference: Lezak, M.D. (1995). *Neuropsychological assessment* (3rd ed.). New York: Oxford.