

A Clinical Approach to Evaluating Malingering in Forensic Neuropsychological Evaluations'

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The detection of malingering of psychopathology and neuropsychological impairment has become an issue of increasing concern to clinicians. This paper provides a process-oriented overview of the clinical assessment of malingering, based on the findings in the published literature. Included is a review of the terminology used to describe malingering, models of when and how to assess for malingering, and possible detection strategies for the clinician to use. Limitations in the literature as well as to conclusions that may be reached are discussed. While the issue of malingering is fraught with controversy, clinicians should be aware of and utilize a combination of techniques to rule out a suspicion of malingering.

Key Words: Clinical neuropsychology, forensic, assessment, malingering

Aproximación Clínica para Valorar la Simulación en la Evaluación Neuropsicológica Forense

La detección de la simulación de daños neuropsicológicos y psicopatológicos se ha convertido en un aspecto de creciente interés para los clínicos. Este artículo aporta una revisión orientada en el proceso de la evaluación clínica de la simulación, basada en los resultados de la literatura. Se incluye una revisión de la terminología usada para describir la simulación, modelos de cuándo y cómo evaluarla y las posibles estrategias para su detección. También se discuten las limitaciones y las conclusiones alcanzadas.

Palabras clave: Neuropsicología clínica, forense, evaluación, simulación.

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The concept of malingering has been around long before modern times. There are both mythological and biblical references to malingering (Zielinski, 1994), while in the second century B.C. persons were noted to feign disability in order to take advantage of relief facilities (Nies & Sweet, 1994). It was not until the middle of this century, however, that the term “malingering” was coined to describe soldiers who feigned illness to avoid military duty (Nies & Sweet, 1994). Later definitions of malingering have expanded the concept beyond the military realm, and have included the feigning of psychological as well as physical illness. The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994) defines malingering as, “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives, such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs” (p. 683). Others find it is more useful to differentiate types of malingering along a continuum, as individuals may vary on several dimensions including degree of intentionality, degree of distortion, and motivation to malingering (Lipman, 1962; Travin & Potter, 1984; Ustad & Rogers, 1996). For instance, Lipman proposed four types of malingering: (a) invention – the patient has no symptoms, but fraudulently represents that he has, (b) perseveration – genuine symptoms that were formerly present have ceased, but are alleged to continue, (c) exaggeration – the patient represents symptoms as worse than they are, and (d) transference – genuine symptoms are fraudulently attributed to a particular injury. (To avoid confusion with the psychoanalytic concept of transference, we prefer to refer to this last type of malingering as misattribution/attribution error). Still others have argued against the term entirely, calling it a weak diagnosis serving only to justify denial of treatment and benefits (Erickson in Pankratz & Erickson, 1990).

This controversy does not end with the diagnosis. There is considerable debate in the literature as to which clinical and psychometric methods are most reliable and valid in detecting malingering. There are significant limitations in the literature stemming from problems inherent in the research design. One way that malingering has been researched is through simulation designs, in which normal, non-patient groups are asked to feign symptoms. They are then compared to either other normal subjects who are instructed to perform honestly, or with a comparison group of either brain-injured or mentally impaired subjects who are also instructed to answer honestly. This

approach has been criticized for its unknown generalizability to individuals who malingers in real-world settings (Rogers, Harrell & Liff, 1993). A second limitation to this approach is that it is subject to what Rogers and Cavanaugh (1983) call the "simulation-malingering paradox"; which occurs when one asks subjects to comply with directions to fake. Another approach to researching malingering utilizes known-group designs. In these studies, actual malingerers, as identified by clinicians not involved with the research, are compared with actual patients on standardized measures (Rogers et al., 1993). The main drawback of this approach is the difficulty in establishing an accurate classification of malingerers. Indeed, there is considerable debate over the ability of clinicians to detect malingering, particularly when based on subjective methods (Faust, 1995; Faust, Hart, & Guilmette 1988; Faust, Hart, Guilmette & Arkes, 1988; McCaffrey & Lynch, 1992; Trueblood & Binder, 1997). It is not the intent of this paper to review or critically evaluate this literature. Interested readers should consult recent reviews by Franzen, Iverson & McCracken, (1990); Haines & Norris (1995); Nies & Sweet (1994); and Rogers et al., (1993). Rather, this paper will present a process-oriented overview of the clinical assessment of malingering. We begin with an overview of terminology used to describe dissimulation, or the distortion or misrepresentation of psychological symptoms. We then discuss models of when to assess for malingering, followed by strategies for detecting feigned psychopathology and feigned neuropsychological deficits.

Response Styles

In order to assess for malingering, it is important to understand both the concept of malingering and the terminology surrounding it. While the bulk of the experimental literature focuses on the detection of malingering, Rogers (1997b) argues that the examinee's "response style" has important clinical relevance. Rogers (1984, 1997b) delineates six response styles of dissimulation. *Malingering* refers to the conscious fabrication or gross exaggeration of physical and psychological symptoms for an external goal. *Defensiveness*, the opposite of malingering, refers to the conscious denial or minimization of physical or and/or psychological symptoms. *Irrelevant responding* occurs when the individual fails to engage in the assessment process, thus the responses are not related to the content of clinical inquiry.

Random responding is a type of irrelevant responding in which a random pattern of responses can be identified. *Honest responding* occurs when the individual is sincere in their attempts to be accurate in his or her responses, and *hybrid responding* can be a combination of any of the previous styles.

Differentiating between and/or among the various types of response styles is not merely an academic exercise. The response style of the examinee is of particular importance when there is a strong motivation to feign (Ustad & Rogers, 1996). As such, differentiation becomes a key factor in addressing the disposition of an examinee, as well as in diagnosing and making treatment recommendations (Rogers, 1988). Rogers further proposes gradations of malingering and defensiveness ranging from mild to severe. While these gradations have not been tested widely in populations with mental illness or suspected malingerers, they have been studied in forensic populations (Rogers, 1984). This research suggests that clinicians are able to make reliable discriminations of the gradations of malingering (Rogers, 1997b). Again, these distinctions could have important implications in assessment, diagnosis, and treatment of patients.

Explanatory Models of Malingering

Another issue that has far reaching implications for clinical practice involves the possible motivations of examinees. Rogers, Bagby & Dickens (1992) argue that regardless of one's theoretical orientation, the evaluation of a person's motivation is critical to the evaluation of malingering in the forensic context. Many researchers have developed threshold models or rules of thumb to follow to determine when to assess for malingering (Brandt, 1988; Franzen et al., 1990; Pankratz & Binder, 1997; Ruff, Wylie & Tennant, 1993). Implicit in these models are assumptions about the possible motivation of the examinee. A useful framework for examining these assumptions and motivations are three explanatory models of malingering proposed by Rogers (1997b), the pathogenic model, the criminological model, and the adaptational model.

Pathogenic Model

In the pathogenic model, the motivation of the malingerer is presumed to be a mental disorder. The examinee is presumed to create symptoms and

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portray them as genuine in an attempt to gain control over actual emerging symptoms. As the mental disorder worsens, the examinee is presumed to lose control over the simulated symptoms (Rogers, 1997b). In recent decades, however, this model has fallen out of favor for two significant reasons. First, many malingerers have not shown this hypothesized deterioration. Second, a shift in the perceptions of malingering has occurred. As a result of Miller's (1961) work on accident neurosis, there has been a shift towards considering an economically based motivation for malingering. Moreover, external motives for malingering have often been identified (Ustad & Rogers, 1996). In addition, improvements in the mental health system have negated the previous assumption that one would have to be "crazy" to want to appear mentally ill. This has led to increasing concerns that criminal defendants might try to avoid punishment by feigning mental illness (Rogers, 1990, 1997b).

Criminological Model

Such concerns led to the development of the criminological model (Rogers, 1997b; Ustad & Rogers, 1996). This view is epitomized in the DSM-IV (American Psychiatric Association, 1994) model, which indicates that, "malingering should be strongly suspected if there is a medico-legal context to the presentation, the person is referred by an attorney to the clinician for examination, there is a marked discrepancy between the person's claimed stress or disability and the objective findings, there is lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen, or there is the presence of Antisocial Personality disorder" (p.683). Thus, according to Rogers (1990), the theme to this model is "badness". "A bad person (with Antisocial Personality Disorder), in bad circumstances (legal difficulty), is performing badly (uncooperative)" (p.7, Rogers, 1997b).

This view has dominated much of the clinical literature that has offered guidelines to clinicians as to when to assess for malingering. For instance, Pankratz (1988) suggests that one consider malingering if the patient is involved in litigation or criminal proceedings, could receive obvious secondary gains from having a deficit, or has a history of malingering or factitious disorder. The first criterion of Brandt's (1988) threshold model of malingered amnesia is whether there are criminal charges pending. There are,

however, several limitations to this criminological model. Rogers (1997b) argues that, while many persons evaluated in forensic settings are not voluntary, one cannot assume that they are likely to malingering. Instead, they may engage in a variety of response styles. For instance, sex offenders and persons involved in custody battles are unlikely to exaggerate symptoms. In mild closed head injury due to motor vehicle accident, litigation is quite common, so the medicolegal context may not be a particularly unique indicator of malingering (Ruff et al., 1993). A second problem with this model is the notion of "uncooperativeness" as a criterion for malingering. Persons with schizophrenia are often non-compliant with their treatment, while persons with eating disorders or substance abuse problems are often uncooperative with ongoing assessments (Rogers, 1997b). Non-compliance with treatment could result from denial of problems rather than malingering (Ruff et al., 1993). Ruff et al. also point out that lack of cooperation may be due to distractibility and attentional fluctuations, which often result from minor traumatic brain injury. Conversely, malingerers may often appear highly cooperative (Rogers, 1990; Ustad & Rogers, 1996). A final problem is the criterion of subjective claims being discrepant with objective findings. Clinicians must be careful in what they assume to be objective findings. As Ruff et al. remind us, results of psychometric tests are subjective, since the patient is in control of their response. In most cases of mild traumatic brain injury there are no objective findings; however, to date, this is due to the limits in neuroimaging techniques, not necessarily an absence of real damage (Ruff et al., 1993).

Adaptational Model

The adaptational model (Rogers, 1990) proposes that potential malingering examinees engage in a cost-benefit analysis when confronted with an assessment that they perceive to be at odds with their own needs. Rogers (1997b) argues that the likelihood of guardedness or malingering increases, "when the context of the evaluation is perceived as adversarial, the personal stakes are very high, and no other alternatives appear to be viable" (p.8). Initial studies of these models (Rogers, Sewell & Goldstein, 1994) suggest that forensic psychologists consider the characteristics associated with the adaptational model to be of greater importance than those associated with the pathogenic or criminological model when assessing mentally disordered offenders. This model provides a framework for the clinician to assess the examinee's motivation to malingering by exploring how adversarial they perceive

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the relationship to be, what the client's objectives are, and if the examinee perceives any alternatives to meeting these objectives (Rogers, 1997b).

Numerous authors have detailed instances in which an individual might attempt to malingering (Adelman & Howard, 1984; Franzen et al., 1990; Haines & Norris 1995; Rogers, 1997b, Ustad & Rogers, 1996). In criminal forensic settings, individuals may attempt to malingering for several reasons, including postponement of legal proceedings, avoiding incarceration, or for obtaining valuable amenities while incarcerated (Ustad & Rogers, 1996). Thus, clinicians should remain vigilant when working in the legal realm (Adelman & Howard, 1984). In civil forensic settings, individuals may attempt to malingering in order to secure financial compensation, avoid obligation, gain sympathy, or obtain social support (Ustad & Rogers, 1996). The general consensus in the literature is that the possibility of malingering should be considered in any situation in which the client may benefit from appearing mentally ill or cognitively impaired (Franzen et al., 1990; Haines & Norris 1995; Wasyliw & Golden 1985).

Detection Strategies for Psychological Disorders

Once one has established the criteria of when to assess, the next issue becomes how to assess. Malingering has typically fallen in to two different categories; fabrication of psychopathology and feigned neuropsychological deficit. As the goals of malingerers differ (i.e., which symptoms they are feigning), so do their attempts to achieve their objectives, and thus so must our detection strategies (Rogers 1997c).

Rogers (1997a) proposes four detection strategies for feigned psychopathology that have been cross-validated across both simulation and known-groups research designs, and both psychometric and interview-based methods of assessment. These are composed of *rare symptoms*, *indiscriminant symptom endorsement*, *obvious symptoms*, and *improbable symptoms*. In the first, the patient is seen to over-endorse symptoms and associated features that occur only occasionally in patients with actual mental disorders. In utilizing this technique, a clinician must have a working knowledge of base-rates of symptoms of mental disorders (Gouvier, Hayes, & Smiraldo, 1998; Hayes, Hilsabeck, & Gouvier, 1999; McCaffrey, Williams,

Fisher, & Laing, 1993). This strategy has been validated with the F, Fb and Fp scales of the Minnesota Multiphasic Personality Inventory (MMPI-2, Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) and the RS scale of the Structured Interview of Reported Symptoms (SIRS, Rogers, Bagby, & Dickens, 1992; see also Rogers, 1997d; Rogers et al., 1993; Rogers, Kropp, Bagby, & Dickens, 1992). In the second strategy, the patient is seen to simply overendorse symptoms. Thus, if a patient endorses over two-thirds of a large array of physical and psychological features, either in an unstructured interview or on psychometric measures, the clinician should suspect feigning (Rogers, 1990, 1997d). In the third strategy, a person may be suspected of malingering if they endorse a higher proportion of symptoms that are obvious indicators of severe psychopathology than expected in actual clinical populations. Again, sufficient knowledge of base rates of symptoms in these disorders is required in using this strategy. In the last strategy, a subject may be suspected of malingering if they report highly unusual or preposterous symptoms. Since these absurd details are often offered in response to questions in clinical interviews, the clinician may need to insert questions in the interview specifically to elicit such symptoms (Rogers, 1997d). Two other strategies which nearly meet the above mentioned criteria, but require additional validation, are symptom combination and symptoms of extreme severity (Rogers, 1997a).

Detection Strategies for Neuropsychological Disorders

In a similar way, researchers have identified six detection strategies that form the basis for the most systematic approaches to the assessment of feigning on neuropsychological measures (Franzen et al., 1990; Haines & Norris 1995; Rogers et al., 1993). The first strategy is referred to as the floor effect. In this strategy, the individual is failing at tasks on which even grossly impaired persons are likely to succeed. An example of such tasks would include knowledge of basic personal history, such as date of birth. Some measures used expressly for the purpose of assessing this effect include the Wiggins and Brandt Personal History Interview (Brandt, 1988; Wiggins & Brandt, 1988) and the Rey 15-item Memory Test (see Lezak, 1995). A second detection strategy is the performance curve method. This is based on number of easy items failed and difficult items passed. It is assumed that most patients will perform better on easier items and worse on more difficult items. If a patient performs in the opposite direction, feigning should be suspected. A

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third strategy is referred to as magnitude of error. Some have suggested that malingering can be detected by the type of wrong answer given (Bash & Alpert, 1980). For instance, if a client is giving Ganser-like responses, or "near misses", malingering may be suspected. There are also some suggestions that a qualitative difference in wrong responses might

discriminate malingerers from others (Rogers et al., 1993). A fourth strategy is referred to as symptom validity testing. In this strategy, a client is asked to complete forced choice tasks. A performance that is below chance is seen as an indicator of malingering. Later improvements of this method include procedures that take into account simple and difficult items (Binder, 1992; Hiscock & Hiscock, 1989), use more than two alternatives (Rogers, 1987), and examine performance across time (Iverson, Franzen, & McCracken, 1991). A fifth strategy is that of atypical presentation. In this strategy, inconsistent or atypical performances, or large variations in test performance on either tests of similar abilities or readministrations of the same tests, are seen as indications of malingering (Rogers et al., 1993). However, clinicians must use caution when applying this approach. Pankratz (1988) reported that inconsistency of symptoms as well as presentations were common in brain-injured patients. Ruff, et al. (1993) warn against overinterpreting inconsistencies as malingering because neuropathology, psychopathology, fatigue, and the like may result in fluctuating performance. Additionally, they point out that differences in mode of presentation of the task may have an effect. Others have suggested that "cognitive deterioration" occurring on repeat testing when there is no evidence of brain injury may indicate feigning (Rogers et al., 1993). The last strategy for the assessment of feigning cognitive deficits involves associated psychological sequelae. In this strategy, clients who endorse a high number of psychological symptoms or atypical attitudes towards their deficit are seen as possible malingerers.

These detection strategies, however, should serve as markers of malingering, not conclusive evidence in and of themselves. The clinical signs of malingering are best assessed through a combination of methods that include both structured and unstructured clinical interviews, psychometric testing, and ancillary sources (Bagby, Rogers, & 1994; Drob & Berger, 1987; Rogers, Sewell, & Goldstein, 1994). Seasoned clinicians will make their best judgments by obtaining a complete picture. This should be based on a thorough assessment of premorbid and current functioning, with information collected from as many sources as possible.

An essential component of the assessment is the determination of premorbid functioning. Individuals at risk for closed head injury, for instance, are more likely to engage in risky behavior, abuse substances, or come from socially and economically disadvantaged background, and thus may have impaired premorbid functioning (Haines & Norris 1995). The clinician must obtain an accurate picture of premorbid functioning to determine if there is an

appreciable loss of functioning, and probable reasons for such loss. A thorough investigation includes obtaining school, employment, and medical records, as well as evidence of any previous accident or arrest (Haines & Norris, 1995; Hayes, Hilsabeck & Gouvier, 1999). Zielinski (1994) warns that, in assessing premorbid functioning, the clinician is likely to encounter defensiveness, which may result in ascribing actual symptoms to the wrong etiology.

The next step is to obtain an accurate picture of the examinee's current functioning. The situational contexts in an individual's life can promote malingering efforts, thus the clinician must fully assess the client's medical status and possible life stresses, all of which may affect the current level of functioning (Pankratz & Erickson, 1990). For instance, physical and/or emotional problems may compound or impair cognitive functioning (Zielinski, 1994). Thus the clinician must obtain a thorough listing of comorbid symptoms and establish their interactions. Obtaining information from multiple sources, if possible, may be helpful as well. Family members and friends may observe the examinee in a variety of different settings, and they may report different symptomatology than does the examinee.

Psychometric test data should be interpreted in the context of ancillary behavioral observation during the test taking (Ruff et al., 1994). The clinician must be vigilant in observing subtle cues provided by the examinee at any time during contact with the clinician and note any discrepancies between observed behaviors and test performance. For instance, the examinee may correctly sign and date consent forms in the waiting room, but fail to produce such information as name and date on psychometric tests. Collateral information obtained from employers, family, and friends may also point out discrepancies. It may also be useful to periodically reevaluate and retest the examinee. As Zielinski (1994) points out, serial testing over time reduces the possibility that a malingering examinee can produce the same test pattern.

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However, the clinician must be aware of typical test-retest patterns and practice effects (McCaffrey, Duff, & Westervelt, 2000; McCaffrey, Duff, & Westervelt, 2000; McCaffrey & Westervelt, 1995). Additionally, since response styles may vary within and across settings, the clinician must determine the independence of data measures. Malingering on one measure does not necessarily mean that the client is malingering on all of them. (Ruff et al., 1993).

The clinician must determine the nature of any secondary gain, either directly or indirectly (Ruff et al., 1993). Again, this may be done by assessing the client or interviewing collateral informants. The clinician must be aware that as research on malingering has increased in the past decade, so have clients' and their attorney's knowledge of how clinicians assess for malingering (Coleman, Rapport, Millis, Ricker, & Farchione, 1998; Rapport, Farchione, Coleman, & Axelrod, 1998; Rose, Hall, & Szalda-Petree, 1998). In investigating the possibility of malingering, the clinician should investigate not only the client's knowledge of a particular disorder, but also his or her knowledge of particular tests (Rogers et al., 1993). Clinicians must be mindful of the fact that litigants may be provided information about specific psychological and neuropsychological tests (Hayes, Hilsabeck, & Gouvier, 1999). Indeed, it has been reported that some attorneys consider it "legal malpractice" not to prepare their client for a psychological or neuropsychological evaluation (Youngjohn, 1995).

The assessment of malingering has not been refined to an exact science. Perhaps it is due to the "nature of the beast." Absent any indisputable proof, such as the client performing an act he or she claimed to be unable to do, one can never know with absolute certainty the truth of another's dishonesty. Yet there are techniques, which if used in combination, may provide enough information to support a reasonable suspicion of malingering. A clinician must always be aware of the possibility that a client may not be presenting with full forthrightness, particularly if there are secondary, external gains to be had. Through judicious assessment of multiple sources of information, the clinician may be faced with the task of reconciling discrepant data. If the discrepant findings cannot be explained parsimoniously, then malingering should be suspected.

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