

MALINGERING PSYCHOLOGICAL SYMPTOMS:
AN EMPIRICAL REVIEW

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This review summarizes the current literature on the assessment and measurement, foundations of behavior, treatment/management options, ethical and professional issues, research challenges and future needs, and cultural considerations regarding malingering psychological symptoms.

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Abstract

Malingering is defined as the intentional production of false or grossly exaggerated physical or psychological symptoms in order to gain some external incentive (American Psychiatric Association, 2000). In this paper, the focus is on malingering psychological symptoms only. While malingering is not recognized as a mental illness in the DSM-IV-TR, it is something that warrants clinical attention and is of growing concern, due to its possible negative consequences, including misdiagnosis and inappropriate treatment with adverse side effects. Malingering is best detected using any combination of the following: clinical interview and observation, screening measures (e.g., M-Test, SIMS, ADI, M-FAST), and/or more comprehensive measures available for the assessment of malingering (e.g., PAI, MMPI-2, SIRS). There are various models and motives that have been used to explain malingering behavior, but the general consensus is that there is no simple way to explain what type of individual is more likely to malingering and why. Because malingering is not a mental illness, clinical treatment is more likely to entail management and prevention of malingering, as opposed to providing treatment specifically designed for such behaviors. There are many ethical and professional issues that also must be addressed when considering a diagnosis of malingering, such as the possibility of misdiagnosis or stigma. There has been a recent influx of research regarding the assessment and measurement of malingering, but there is much research still needed, especially in areas such as accurate prevalence rates and cultural considerations.

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MALINGERING PSYCHOLOGICAL SYMPTOMS:

AN EMPIRICAL REVIEW

A 58 year-old Caucasian male presents to the Emergency Department at a metropolitan hospital complaining of increasing feelings of depression and suicidal ideation. This patient is well known to hospital staff due to several previous admissions. He is also known to not have a stable living residence, often reporting staying with “friends” or at motels. Currently, he reports hearing voices telling him he is worthless and that he should jump off a bridge onto a nearby expressway. The patient also reports having been off his medication for nearly a month, not having much of an appetite over the last 2 weeks, and having a difficult time falling and staying asleep most nights. He reports that he cannot contract for safety at this time. His toxicology screening is positive for cocaine, opiates, and marijuana. Upon admission to the behavioral health floor, the patient is irritable and demanding. The patient reports being annoyed with the admission process and is demanding that he be given snacks and simply be allowed to go to his room without answering any of the assessment questions.

During his stay on the behavioral health unit, the patient refuses to attend or participate in groups but is seen up and about in the dayroom watching television and playing cards with peers during times that there are no groups being provided. The patient is selective with his medication and is at the nurses’ station seeking PRN medication for “anxiety” every few hours. He is often demanding and becomes very upset if his demands are not met or if limits are set with him. When meeting with his doctor, the patient continues to complain of feeling depressed with fleeting suicidal thoughts and poor appetite. Shortly after the doctor leaves the patient can be seen joking

with peers and staff and is constantly seeking snacks outside of meal/snack times. The patient is also overheard saying, “I am glad I have never had to deal with hearing voices” after a psychotic patient that was responding to internal stimuli walked past him in the hallway. While socializing with peers, the patient is also overheard describing a situation he was involved in prior to admission where he was supposed to get into legal trouble after breaking a window at a local pharmacy when he was told he was not able to refill a prescription of narcotic medication. He states that, luckily, he was able to avoid legal trouble by admitting himself into the hospital. When the patient is confronted by staff regarding the differences between his reported complaints and the observations made on the unit, the patient either denies making such statements or becomes very defensive and irritable, stating that he will be reporting staff for not supporting him during his state of depression.

Assessment and Measurement

Although malingering is not considered a mental disorder, it is recognized by *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) as something that warrants clinical attention. Malingering is defined 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” (American Psychiatric Association, 2000, p. 739). In addition to this definition, the DSM-IV-TR also provides additional factors that should lead professionals to strongly suspect the use of malingering. These factors are as follows: (1) an individual is presenting with symptoms within a medicolegal context, (2) there are marked discrepancies between the person’s subjective account of

stress/disability and objective findings, (3) the individual is uncooperative during evaluation or non-compliant with the prescribed treatment regimen, (4) there is a presence of Antisocial Personality Disorder.

It is important to note the differences between malingering and similar disorders found within the DSM-IV-TR. For instance, Factitious Disorder and malingering only differ in that the motivation for symptom production in Factitious Disorder is the internal incentive of assuming the sick role, with an absence of external incentives altogether. The general behaviors of individuals that are malingering and those with factitious disorders are often impossible to differentiate (Rogers, Bagby, & Dickens, 1992), making it very important to thoroughly assess what incentives are being sought with the production of an individual's symptoms. Also, malingering differs from Conversion Disorder and the other Somatoform Disorders due to the intentional production of symptoms present and, again, because of the external incentives sought after in malingering (American Psychiatric Association, 2000).

Although malingering may be easy to define, its detection and diagnosis in clinical practice is not as simple. Professionals almost always need to consider outside data in addition to the basic clinical interview in order to reliably detect and diagnose malingering (Resnick & Knoll, 2005). In fact, Rogers and Vitacco (2002) warn against solely using the additional factors of "strongly suspected" malingering laid out by the DSM-IV-TR as a detection strategy, as doing so can result in a misclassification rate of over 80%. For instance, Resnick and Zuchowski (2007) note that in a criminal justice setting, an individual may begin the assessment with three out of four of the above-stated factors simply because of the setting itself. Therefore, it is imperative that one or more of the valid, structured measurement techniques designed specifically for malingering detection, as well as multiple sources of independent data, be used in

order to more accurately confirm or disconfirm cases of malingering (Vitacco, 2008). Beyond the general clinical interview, there are several screening measures, structured interviews, and psychometric tests available for use in detecting malingering of mental illness. Because it is so important to use multiple sources of assessment, it is up to the professional to decide which to use and in what combination based upon the symptoms presented and the needs of each case.

Clinical Interview

If possible, Resnick and Knoll (2005) recommend first reviewing any available collateral information from friends, family, previous medical or insurance records, or police reports before the interview begins. As is recommended with most clinical assessments, professionals are advised to start off asking open-ended questions so that patients are able to explain symptoms in their own words. Also important is allowing the individual to tell his or her story with few interruptions and by avoiding leading questions that may give clues to specific symptoms that make up certain diagnoses. It is also recommended that if malingering is suspected, the interview should take a prolonged period of time because fatigue may decrease an individual's ability to maintain faked symptoms (Chesterman, Terbeck, & Vaughan, 2008; Resnick & Knoll, 2005). Resnick (1997) recommends that a 24-hour inpatient observation might be useful in difficult instances when possible, especially where malingering is highly suspected.

Resnick and Knoll (2005) report that during the clinical interview professionals need to keep an eye out for certain red flags that may indicate the possibility of malingering. Individuals that are malingering may report rare or improbable symptoms that even severely mentally ill patients almost never report (Rogers, 2008). The interviewer might even consider asking individuals about improbable symptoms to see if they endorse them. Examples may include visual hallucinations of giants or seeing the words spelled out when a person is talking to them

(Miller, 2001). Other things to look for are any internal or external inconsistencies in the individual's reports. Examples of internal inconsistencies include providing a clear and articulate report of being confused or providing conflicting stories regarding one's own history. Examples of external inconsistencies include differences between reported and observed symptoms or differences between reported symptoms and how a genuine symptom typically presents. For example, individuals experiencing genuine visual hallucinations typically report these hallucinations are seen in color (Resnick & Knoll, 2005). Therefore, if an individual reports seeing things in black and white, the clinician may want to investigate this further. Overall, being aware of symptoms and how they typically present themselves is very important for professionals in the detection of possible malingering within the initial clinical interview.

Screening Measurements

The use of malingering-specific self-report screenings is an effective way of deciding whether or not to proceed in further assessment of malingering, as these measures can usually be administered in 15 minutes or less (Rogers, 2008). Professionals must take into account several factors when deciding which screening measurement to begin with. These factors include the condition or symptoms presented, the setting in which it will be given, and the administration method (i.e., self-report, interview-based, multi-method) (Smith, 2008). Some of the screenings that have shown potential in recent research include the M-Test (Beaber, Marston, Michelli, & Mills, 1985), Structured Inventory of Malingered Symptomatology (SIMS; Widows & Smith, 2005), Assessment of Depression Inventory (ADI; Mogge & LePage, 2004), and Miller Forensic Assessment of Symptoms Test (M-FAST; Miller, 2001).

The M-Test (Beaber et al., 1985) is a self-report true/false screening measure originally designed to detect malingering of schizophrenia. This measure is comprised of 33 items divided

into 3 scales. The Confusion scale assesses general comprehension first, with 8 items that reflect beliefs and attitudes not associated with mental illness at all. The S-scale is comprised of 10 items assessing actual symptoms associated with Schizophrenia. The M-scale is made up of 15 items assessing fake symptoms not associated with Schizophrenia. Initial research (Beaber et al., 1985) reported that the M-Test correctly screened 87.3% of individuals with genuine schizophrenia and 78.2% of malingering individuals. Since then, the M-Test has been utilized in both known-groups and simulation studies yielding markedly varied sensitivity results in accurately differentiating between genuine schizophrenia and malingering (Smith, 2008). Also, some research indicates that genuine patients with severe psychopathology and impairment may yield results similar to that of someone malingering schizophrenic symptoms (Hankins, Barnard, & Robbins, 1993; Schretlen, Neal, & Lesikar, 2000). Variability has also been seen in the research literature regarding race, gender, and education level (Gillis, Rogers, & Bagby, 1991; Heinze, 2003; Schretlen et al., 2000), thus indicating that further research should focus on possible confounding factors in these areas. Smith (2008) notes that even with these potential issues with external validity, the M-test remains an important screening measure for use with malingering schizophrenic symptoms. It has demonstrated acceptable internal reliability and consistency in the exploration of its psychometric characteristics, and an abundance of research continues to support the use of this test in select clinical and forensic settings (Smith, 2008).

The Structured Inventory of Malingered Symptomatology (SIMS; Widows & Smith, 2005) is a self-administered screening tool comprised of 75 true-false items. The SIMS was designed to screen for malingering across a variety of clinical and forensic settings, and it typically takes about 15 minutes to complete. This screening measure is comprised of 5 scales with 15 questions for each. The scales are meant to assess affective disorders, amnesic disorders,

low intelligence, neurological impairment, and psychosis. The original research indicated that the SIMS total score approach (looking at the total score as opposed to each subscale individually) accurately identified 95.6% of the individuals simulating psychopathology and 87.9% of the individuals answering genuinely. Later research also yielded promising results in differentiating genuine versus feigned responses, but more research is needed utilizing clinical comparison samples to strengthen these findings (Smith, 2008). Overall, the SIMS has demonstrated effectiveness in known-groups designs with both male and female patients (Alwes, Clark, Berry, & Granacher, 2008). Smith (2008) also notes that research supports the effectiveness of the SIMS across cultures and languages, and it has a low reading level, making it available to a wider range of individuals overall.

The Assessment of Depression Inventory (ADI; Mogge & LePage, 2004) is a self-administered, 39-item screening tool designed to assess depressive symptoms in an individual. The first subscale assesses genuine depression symptoms. The other two subscales are used to detect feigning, random, and unreliable responding. Based on a 4-point Likert scale (answering *never, sometimes, often, or always*), individuals specify the frequency with which they have experienced each item within the previous 2 weeks. This screening measure has yielded promising results in detecting individuals simulating depressive symptoms. Another strength of this screening measure is the low reading level needed to complete the task. Further research is needed in order to provide more support for the use of the ADI in clinical and forensic settings (Smith, 2008).

The Miller Forensic Assessment of Symptoms Test (M-FAST; Miller, 2001) is a brief structured interview designed to screen for malingering. The M-FAST is modeled after the Structured Interview of Reported Symptoms (SIRS; Rogers, Bagby, & Dickens, 1992), a well-

validated clinical interview used in the detection of malingering. The M-FAST is comprised of 25 items divided among 7 scales that measure differences between subjective symptoms and observed presentation, rare symptom combinations, excessive reporting, atypical symptoms, suggestibility, negative image, and unusual symptom course. The response structure varies for the items present on this screening measure. There are 15 true/false questions, 5 Likert-scale frequency questions (i.e., *never, sometimes, always*), 2 yes-or-no questions, and 3 items that compare the individual's response with observations made by the interviewer (Smith, 2008). The M-FAST takes approximately 10-15 minutes to administer. The M-FAST scales demonstrate overall satisfactory reliability and high discrimination between genuine responders and individuals that are malingering (Vitacco et al., 2008). Research also indicates that the M-FAST demonstrates reasonable validity and high correlation with both the SIRS and the MMPI (Jackson, Rogers, & Sewell, 2005; Miller, 2004). Strong evidence of construct validity of the M-FAST has also been seen in recent research (Vitacco et al., 2008). Though the M-FAST has mostly been validated and used in forensic settings, research indicates it will likely be as efficacious in other settings as well (Smith, 2008).

Comprehensive Measurements

As noted earlier, the use of more than one measure is needed for the most accurate assessment of malingering. Therefore, if a professional believes that an individual is malingering based on clinical observation or one of the above-noted screening measures, he/she may want to investigate further using a more exhaustive detection measure. Most notably, there are two widely used psychometric tests used for this purpose (PAI, MMPI-2), as well as a specialized structured interview designed specifically to detect malingering of mental illness (SIRS).

The Personality Assessment Inventory (PAI; Morey, 1991) is a 344-item, self-report personality measure designed to assess psychopathology and significant personality characteristics for an individual. There are three measures within the PAI that are used for the detection of overreporting psychopathology. The first is the Negative Impression scale (NIM), which is comprised of PAI items that are rarely reported in the community and clinical normative samples (Morey, 1996). As seen with the M-test, though, Morey (2007) cautions that individuals with more severe psychopathology tend to yield elevated NIM scores as well, thus limiting its effectiveness in detecting overreporting of symptoms (Hawes & Boccaccini, 2009). The other two scales used in the detection of overreporting were designed to identify PAI profile characteristics that suggest the use of malingering. The Malingering Index (MAL) is modeled after characteristics often associated with an attempt to fake mental illness (Morey, 1996). The Rogers Discriminant Function (RDF) is based on a weighted combination of 20 PAI scale scores and a constant value (Rogers, Sewell, Morey, & Ustad, 1996). The idea behind the RDF is that individuals attempting to fake mental illness symptoms have a difficult time producing PAI profile characteristics consistent with individuals that present with a genuine mental illness (Hawes & Boccaccini, 2009). The use of these scales in detecting malingering has produced mixed research results, especially with great variability seen with the RDF scale. Rogers (2008) proposes that this variability may be due to potential influences from study design characteristics not utilizing enough real-world comparisons. Hawes and Boccaccini (2009) conducted a meta-analysis of the current PAI/Malingering research and found that the PAI measures compare favorably with the MMPI-2 in detecting malingering. These researchers also propose that the variability observed is more of a characteristic of malingering research in general, as opposed to

being a characteristic of the PAI measures. Further research is still needed to assess whether or not the PAI would be very useful in clinically detecting malingering.

The validity scales of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Greene, 1991) are also widely researched and utilized in the detection of suspected malingering mental illness (Chesterman, Terbeck, & Vaughan, 2008). The MMPI-2 is a self-administered psychometric test comprised of 567 true/false items. Some of the scales of the MMPI-2 have been found to be useful in assessing the validity of the test-taker's attitude, including attempts to exaggerate symptoms. Singh, Avasthi, and Grover (2007) recommend using the triad of a low L scale, high F scale (often, $T > 99$), and low K scale indicates malingering. Other research recommends looking at the five malingering detection scales of the MMPI, which are as follows: (1) rare versus common symptoms, (2) severity of different symptoms, (3) obvious versus subtle symptoms, (4) selectivity of symptoms reported, and (5) incorrect stereotypical "knowledge" of illnesses (Raine, 2009). The first and fifth scales are shown to be the most effective in detecting malingering (Rogers, Sewell, Martin, & Vitacco, 2003) due to a malingerer's tendency toward reporting a wide assortment of extreme symptoms that most genuine patients would not (Gassen, Pietz, Spray, & Denney, 2007), and the inability to differentiate true symptoms from erroneous beliefs about mental illness (Rogers et al., 2003). Even those two scales fail to detect 5-15% of attempts at malingering, though, due to individuals being able to avoid detection when they have high intelligence and background knowledge of mental illness and the test measure itself (Pelfrey, 2004). Although the MMPI-2 is not foolproof, it is still the most widely researched and well-validated comprehensive psychological measure used in the detection of malingering, and thus it is widely used and preferred by psychologists in this regard (Greene, 2008).

The Structured Interview of Reported Symptoms (SIRS; Rogers et al., 1992) is a widely accepted, well-validated structured interview designed to detect malingering of mental illness. The SIRS typically takes about 45-60 minutes to administer and is comprised of 172 items divided among 8 primary scales assessing rare symptoms, improbable and absurd symptoms, symptom combinations, blatant symptoms, subtle symptoms, symptom severity, symptom selectivity, and reported versus observed symptoms. Each scale provides four categorizations: honest, indeterminate, probable faking, and definite faking. The scales have shown good internal ($\alpha = .86$) and exceptional interrater ($r = .96$) reliabilities on average (Vitacco et al., 2008). The SIRS is used in both clinical and forensic practice and has become the gold standard for use in research on malingering, as it is currently the most empirically validated measure specifically designed to detect malingering (Rogers, 2008). Research shows the SIRS demonstrates high rates of accuracy in both simulation studies and real-world applications (Lewis, Simcox, & Berry, 2002). The SIRS does have its limitations though, such as the length of time it takes to administer (Clegg, Fremouw, & Mogge, 2009). The SIRS also requires the use of an interviewer and his/her clinical judgment, and thus allows for the possibility of human subjectivity and error (McCusker, Moran, Serfrass, & Peterson, 2003). Even so, Rogers (2008) states, "In terms of its conceptualization, reliability, and validity, the SIRS should be considered the strongest measure of feigned mental disorders" (p. 321).

Foundations of Behavior

Explanatory Models of Malingering

Rogers, Salekin, Sewell, Goldstein, and Leonard (1998) describe three models that have been proposed over the years to help explain the core motivation behind why an individual would malingering mental illness: the pathogenic model, the criminological model, and the

adaptational model. The pathogenic model, which was most popular during the height of psychoanalytic influence in the early 20th century (Resnick & Knoll, 2008), proposed malingering as a mental illness. The main belief behind this model is that malingering stems from a psychopathological condition in which the individual is actually experiencing difficulty coping with an existing underlying mental illness (Kucharski et al., 2006). In other words, the individual ineffectually attempts to take control over his or her genuine impairment by voluntarily producing symptoms. According to this model, as the individual's mental state deteriorates the individual is then less able to control the fabricated symptoms and the mental illness becomes genuine. Rogers and colleagues and Resnick and Knoll (2008) note that there is very little empirical research supporting this model. In fact, malingerers' symptoms tend to disappear, instead of worsen, once the external incentive has been gained or eliminated (Resnick & Knoll, 2008). Although the pathogenic model is no longer accepted as a viable explanation (Vitacco & Rogers, 2005), it is important to review this model in order to understand how the view of malingering has evolved over time (McDermott et al., 2008).

The second explanatory model described by Rogers and colleagues (1998) is the criminological model, which is consistent with the DSM-IV-TR (American Psychiatric Association, 2000) description of malingering. The criminological model proposes that malingering is an antisocial act often committed by an antisocial person (Rogers, 2008). As noted earlier, the DSM-IV-TR proposes four additional factors to use in the assessment of malingering, all of which seem to align with antisocial behaviors and attitudes (Vitacco & Rogers, 2005). This model assumes that the malingerer is essentially a "bad" and deceptive individual (McDermott et al., 2008) who engages in "bad" and deceptive behaviors. Within the DSM-IV-TR's description of malingering, included are the following four factors that indicate a

high likelihood of malingering: (1) an individual presenting with symptoms within a medicolegal context, (2) marked discrepancies between the person's subjective account of stress/disability and objective findings, (3) an individual who is uncooperative during evaluation or non-compliant with the prescribed treatment regimen, (4) the presence of Antisocial Personality Disorder. As mentioned earlier, these additional factors have received negative attention from researchers (Resnick & Zuchowski, 2007; Rogers & Vitacco, 2002) due to the high rate of misclassification and the biases and cynicism they may create within certain settings (i.e., forensic and correctional settings). Vitacco and Rogers (2005) warn that using the criminological model to explain malingering behavior may lead to clinicians assuming that an individual seen in a correctional setting is being deceptive, and this could negatively influence the assessment process. Although this model has received criticism, it still holds some merit in the clinical field, and, at times, the criminological model does appear to be the best fit in describing the motives of some individuals that malingering mental illness (Rogers & Cruise, 2000; Vitacco & Rogers, 2005).

Rogers and Cavanaugh (1983) developed the adaptational model due to their belief that all motives behind malingering could not be defined so simply by labeling the individual and his or her actions as being "mad" or "bad." This model proposes that the malingerer performs a cost-benefit analysis of his or her choices and then decides that malingering is the best choice available (Rogers et al., 1998). The important features of this model are that the individual views his or her current situation as unfavorable or unpleasant, believes there is something to gain by malingering, and doesn't see another, more effective way of achieving his or her goal (Kucharski et al., 2006). This model seeks to remove the negative connotations associated with malingering and provide an explanation for this behavior based on the individual's need for adapting in order to better survive adverse conditions. Even the DSM-IV-TR does allow for this as a possible

explanation for malingering behavior, through the inclusion of the following statement, “Under some circumstances, Malingering may represent adaptive behavior – for example, feigning illness while a captive of the enemy during wartime” (American Psychiatric Association, 2000, p. 739). Vitacco and Rogers (2005) report that there has been empirical support for using the adaptational model as an alternative to the criminological model. For example, Rogers and Vitacco (2002) report finding some inmates who were willing to admit fabricating symptoms in order to gain access to the correctional mental health unit, due to the more calm, non-violent nature when compared to the regular prison environment.

General Motivations for Malingering Behavior

The two main motivations in malingering mental illness are to evade difficult situations or punishments (i.e., avoiding pain) and receive compensation or medication (i.e., seeking pleasure) (Resnick & Knoll, 2005, 2008). Common examples of the former include avoiding arrest, prosecution, or enlistment in the military. Common examples of the latter include acquiring controlled substances, a place to stay (i.e., inpatient psychiatric ward), or social security disability benefits. Naturally, the basis of the motivation depends on the person’s circumstance and environment. For example, someone facing legal charges may be trying to avoid jail time, whereas a person already in jail might malingering in order to receive better living conditions or prescription medication (Resnick & Knoll, 2008). Individuals being seen in the emergency room are typically seeking medication and shelter, whereas someone being seen in a clinic or office might be seeking some sort of compensation.

Characteristics of Malingering

Malingering mental illness is not a rare phenomenon in either clinical or forensic contexts, although its prevalence does vary depending on the population in question

(McDermott, et al., 2008). Yates, Nordquist, and Schultz-Ross (1996) found that 13% of patients being seen in a metropolitan emergency room were strongly suspected or considered to be malingering their reported symptoms of mental illness. Rogers, Sewell, and Goldstein (1994) estimated the occurrence of malingering at 16% for forensic patients and 7% of non-forensic patients. Raine (2009) states that research suggests that prevalence rates of malingering in the general population are estimated at about 3% in males and 1% in females. Still, others insist that true prevalence cannot be thoroughly assessed due to underreporting, difficulties in accurate assessment, and a variety of other factors (Rogers, 2008). It has been proposed that the prevalence of malingering mental illness will likely continue to grow as well, due to decreases in state facilities designated for housing and mental health treatment, as well as the increased need for government assistance/funding (Chesterman, Terbeck, & Vaughan, 2008).

It is very important to note that an individual that is malingering may very well present with an actual mental illness, as the two are not mutually exclusive (Conroy & Kwartner, 2006). As the DSM-IV-TR definition notes, malingering is either intentionally producing or greatly exaggerating symptoms (American Psychiatric Association, 2000). Resnick and Knoll (2005) note three patterns of malingering to help understand this further: (1) pure malingering, (2) partial malingering, and (3) false imputation. Pure malingering occurs when an individual completely fabricates a mental illness he or she does not have. Partial malingering occurs when an individual knowingly exaggerates real symptoms he or she experiences. For example, a homeless individual with a history of schizophrenia may exaggerate command hallucinations of suicide in order to be admitted to a hospital for a safe, warm place to stay. Another example of partial malingering would include an individual that has a substance abuse disorder but fabricates another set of symptoms for another disorder in order to gain some external incentive. For

instance, an individual with a substance abuse disorder may fabricate symptoms of depression or psychosis to gain admission to a mental health unit for shelter or because he or she knows certain medications (i.e., narcotic painkillers) cannot be obtained while on a detox unit. False imputation occurs when an individual attributes actual symptoms to a cause he or she knows has nothing to do with the symptoms. An example of this would be if an individual who already had a long-standing history of Major Depression later attributed its onset to a more recent work accident in order to receive more money for disability or workman's compensation. Of these, partial malingering is the most common (Kleinman & Stewart, 2004), and pure malingering is not as common (Trimble, 1981). Partial malingering and false imputation are often the most difficult to detect because these individuals have experienced genuine symptoms and may be better able to report them accurately (Hall & Hall, 2006).

While there has been a resurgence of research involving malingering in the last 20-30 years (e.g., Pankratz, 1998; Halligan, Bass, & Oakley, 2003; Morgan & Sweet, 2009; Rogers, 2008), most of the focus has been on the detection and assessment of malingering (Chesterman, Terbeck, & Vaughan, 2008) and not as much on the characteristics of the "typical malingerer." Hall and Hall (2006) mention that there has been research supporting the idea that malingerers often present with Axis II traits or some kind of Personality Disorder. They also note that malingerers often have a history of at least one of the following: legal issues; behavior problems in school, work, or the military; sporadic employment and attendance issues at work; alcoholism or substance use; and very few financial responsibilities. Swanson (1985) reports that malingerers may also have a tendency to move around a lot, in both residence and work. Rogers (2008) stresses that malingering is more of a situational occurrence as opposed to a stable trait

that someone possesses. In fact, most of the time malingering appears to be aimed at a specific goal in a certain context and doesn't always lead to a chronic habit.

As mentioned earlier, the DSM-IV-TR, and subsequently many clinicians, associate malingering with Antisocial Personality Disorder and antisocial traits. While this has become a common assumption surrounding malingering, there is very little research support for a strong relationship between the two (Resnick & Zuchowski, 2007). For instance, Rogers (1990) found that Antisocial Personality Disorder was found in similar proportions of individuals found to be malingering and those who were not malingering (20.8% and 17.7% respectively). Also, many studies have found very little evidence that individuals with Antisocial Personality Disorder are more likely to malingering or that they are better able to malingering successfully (Kucharski et al., 2006; McDermott & Sokolov, 2009; Poythress, Edens, & Watkins, 2001). Although most of the research lacks clear, strong evidence, Resnick and Zuchowski (2007) note that there may still be a relationship between APD (or other psychopathic disorders) and malingering, reporting that the difficulties in researching malingering (i.e., using subjects instructed to simulate malingering as opposed to subjects of genuine malingerers) in general may affect previous findings. Either way, it is important to avoid jumping to conclusions and assuming an individual is malingering solely based on his or her personality characteristics or legal past.

Applications to Therapy

Because malingering is not considered a clinical mental illness in the DSM-IV-TR, not much empirical research has focused on finding therapeutic approaches to use in the management of malingering. In fact the inclusion of the factor "non-compliance with the prescribed treatment regimen" (American Psychiatric Association, 2000, p. 739) in the DSM-IV-TR definition of malingering would have some believe that this individual may not even

continue treatment beyond the time needed to achieve the external incentive being sought. Also adding to this idea are Greene (1988, 2008) and Hale and colleagues (1988) noting that malingering individuals tend to terminate treatment after only a few sessions, if they even return after the initial session. Once the individual has gained the desired external incentive, it is unlikely that he or she will continue with any kind of treatment.

Still, the little research that does exist in this area suggests that if a person is strongly suspected of malingering following a thorough assessment process, it is very important that the professional attempt to get the individual involved in some sort of therapeutic intervention. Also, as mentioned earlier, partial malingering is most common form of malingering, where an individual who already has a pre-existing mental illness exaggerates his or her symptoms for external gain. Therefore, an individual who is malingering may benefit from treatment to address the genuine mental illness as well, if the individual was willing to continue with some type of therapy. Along with this, Walters (2006) notes the importance of addressing the issues that may exist behind the malingering (i.e., poverty, homelessness, impending criminal charges) even in the case of pure malingering, where there is no genuine mental illness present. Therefore, it is important for the clinician to understand the motivation behind why the individual is choosing to mangle so that the intervention may be tailored to suit the needs and circumstances of the client. According to Pankratz (1998), it is the patient's treatment plan that actually requires attention through intervention, rather than the exaggerated symptoms themselves. Therefore, the general course of "treatment" for malingering is not usually going to look like that of someone suffering from a genuine mental illness. Instead the "treatment" is more of a set of "management" techniques aimed at avoiding any future use of malingering for the given

individual. Walters (2006) proposes three intervention tactics that have been found to be useful with the management of malingering: confrontation, support, and alternative options.

Confrontation

Confronting an individual suspected of malingering is not something clinicians are typically comfortable doing, especially due to the negative connotation associated with the term “confrontation” (Pankratz, 1998). Even so, this can be an important first step in the management and treatment of malingering. This technique allows the clinician to communicate to the patient that malingering behavior is not acceptable and presents the opportunity for the individual to take responsibility for this behavior. Instead of looking at confrontation as such an uncomfortable, conflict-ridden situation, Pankratz suggests reframing it as “the process of presenting the information you have and its implications” (p. 223). Frederick and Towers (2002) discuss a case study in which confronting a suspected malingerer with assessment results that suggested malingering led to valid results upon re-assessment of the individual. Many researchers emphasize confronting, while also allowing the individual the opportunity to “save face,” as an important course to follow (Pankratz, 1998; Resnick & Knoll, 2005; Frederick & Towers, 2002). Avoiding direct accusatory statements, and instead opting for statements such as “You haven’t told me the whole truth” or “The kind of symptoms provided are not consistent with any known mental illness” are suggested in order to more effectively confront an individual suspected of malingering (Inbau & Reid, 1967). It might be useful to ask the individual to clarify inconsistent responses as a form of confrontation, as this may be a more safe, comfortable approach for the clinician (Resnick & Knoll, 2005). Confronting the individual may serve as an important step in forming a strong therapeutic relationship, as it may lead him or her to respect the clinician’s competence and ability to detect his or her deceptiveness. Even if the individual refuses to admit

to malingering, confrontation itself can lead to an improved therapeutic relationship (Reich & Gottfried, 1983; Walters, 2006). Of course, clinicians do need to be aware that the individual may react unfavorably, by becoming defensive, angry, or continuing to deny malingering (McDermott et al., 2008). Resnick and Knoll (2005) advise that in a situation in which the clinician is confronting an individual with a known history of aggression and/or violence, adequate security measures should be taken into consideration before the confrontation takes place (i.e., security personnel present).

Support

According to Walters (2006), support from the clinician is just as important as confrontation in the management of malingering behaviors. Just as with any other individual seeking treatment, the malingering individual is likely to benefit from having the clinician listen to the underlying issues and concerns that have led him or her to malingering in the first place. Clinician support can help the individual explore the reasoning behind his or her malingering behavior and deal with these more appropriately. This is likely to assist with the third intervention proposed by Walters, alternative options.

Alternative Options

As the adaptational model of malingering would suggest, malingering individuals are engaging in these behaviors in order to adapt to some sort of adverse situation (Rogers & Cavanaugh, 1983). Therefore, Walters (2006) proposes that it is important to provide these individuals with alternative ways to adapt in these kinds of situations. The hope is that in the future the individual will no longer turn to malingering and will instead utilize more functional, effective ways of coping with adversity. Cognitive-behavioral treatments focused on encouraging and improving problem solving, goal setting, and coping skills may be especially

helpful in this regard. Other intervention strategies may prove useful depending upon the situation behind the malingering. For example, an individual found to be malingering in order to avoid work might find vocational counseling in which alternative options for future work are addressed useful.

Management of Pure Malingering

As mentioned earlier, the above management/treatment techniques might prove most useful in cases of partial malingering and false imputation, as they involve an underlying mental illness that might justify continued treatment. In cases of pure malingering, where an individual is completely fabricating symptoms, the course of “treatment” is likely to differ slightly, as there would be no real need or justification for further treatment of symptoms. As mentioned earlier, though, Pankratz (1998) points out the need for managing malingering to fix the individual’s “treatment plan” so that he or she is less likely to turn to malingering in the future. Therefore, a brief, possibly even one-time, intervention strategy attempting to confront the individual and provide alternative options for future use would likely be ideal. For example, if an individual is found to be completely malingering psychiatric symptoms inside a hospital emergency department the attending physician or crisis worker might be able to intervene using confrontation, support, and alternative options right then and there in order to avoid an unnecessary admission to the psychiatric unit. “An ounce of intervention in the emergency department can be worth a pound of effort in the hospital and resources spent preventing unnecessary admissions will be cost effective” (Pankratz, 1998, p. 215). Therefore, emergency department staff might find it useful to confront the individual, while still being supportive, and offering referrals to community resources that might offer what the individual might actually

need (e.g., financial assistance, shelter) at the time. The same might be useful in an outpatient setting where an individual might be found to be malingering completely.

Other Proposed Interventions

Chase, Shea, and Dougherty (1984) proposed that short-term paradoxical interventions could be of use in working with psychiatrically hospitalized inmates presenting with mental illness symptoms. In cases of malingering individuals, using defiance-based paradoxical treatments is the primary suggestion. Defiance-based treatments assume that the individual will likely oppose any treatment intervention, and therefore the individual's resistance is used as a primary motivator for change. Some successful treatment techniques used in this setting have been that of restraining, reframing, and positioning techniques. In "restraining" techniques, clinicians suggest that the individual cannot or should not change his or her behaviors or symptoms quickly. Using "reframing" techniques, the clinician presents the symptom as something unacceptable to the client. Finally in the "positioning" technique, the therapist takes on a position opposite to what the individual is likely to expect. Often, changes following these techniques are observed to be quick and long-term. These techniques are very effective in correctional settings because they play into many typical characteristics of inmates, such as opposition, hostility toward authority, resistance, and the desire to conquer others. Chase and colleagues also suggest that these interventions would likely assist in avoiding power struggles typically involved with inmates in traditional treatment approaches. They do warn, though, that these paradoxical approaches are not appropriate for everyone and can actually cause harm in some cases. Although this might be the case with individuals presented with genuine mental illness, the authors propose that malingering individuals are typically good candidates that have been known to benefit from such approaches.

Han (1997) proposed and implemented a social rehabilitation program for known malingerers in a prison in China that yielded promising results. This intervention involved not only the individuals that were previously found to be malingering but also the communities in which they were being released into upon leaving prison. Dubbed the Comprehensive Management of Ex-Prisoners (CME), this intervention is based on a cognitive/social approach. First, it employs the use of confronting the individuals with assessment evidence that indicated a suspicion of malingering. The individuals were then forced to consider other alternatives for their malingering behavior, and the help of doctors and (when possible) family members were enlisted in order to instill these new attitudes and ideas. The support from family and the prison doctors was found to be very useful. The prisoners also engaged in various training courses to help obtain various occupational skills. Finally, they received “pre-release education” which was an intensive program designed to help individuals avoid future “relapse,” tailored to the individuals based on malingering background. Upon release, the prisoners were to have the opportunity to work in various places in the community (i.e., factories, farms). The results suggested success on an individual level, with no further instances of malingering. Although these results are promising, it was observed that the community was not always supportive in accommodating the released prisoners (i.e., business owners mistreating or not maintaining contracts, parole officers not maintaining appropriate contact).

It is important to note that the two strategies described above have only been used and proved successful within prison/forensic settings. Therefore more research is needed to decide whether or not these interventions can be applied in other, general clinical settings.

Beyond Clinical Intervention

Although there are clinical interventions that appear useful in the management of malingering, it must be noted that outside of the realm of treatment, there may be other consequences for this type of behavior. Some circumstances may warrant action from an institution or the legal system. For example, some facilities may enforce certain restrictions or penalties due to the incidence of malingering, such as being moved from a mental health ward back into the general prison system, or even adding time to an individual's sentence. Also, for cases pending in federal court, the individual found to be malingering might receive enhanced sentencing.

As was the case with assessment and measurement and understanding the nature of malingering behavior, it is important to take into consideration many different factors when deciding which course of treatment to follow in the management of malingering. First, the clinician needs to address the suspicion of malingering with the individual and then assess the reasoning behind these behaviors. After understanding more about this aspect, the individual must decide whether or not he or she would even like to continue with a course of treatment to address these underlying issues. The clinician must also decide which form of therapeutic intervention would be most effective in treating this individual, given his or her needs and goals. Finally, the possible consequences for such behavior must be recognized and dealt with accordingly.

Case Study: Comprehensive Management of Ex-Prisoners (CME) Example

A 32 year-old inmate at a correctional facility reports experiencing a variety of psychiatric symptoms, including increased depression and suicidal, as well as homicidal ideation. The inmate reports feeling it would be best if he were transferred to the psychiatric ward in the

prison in order to avoid hurting himself or others. The inmate also had a history of using malingering as a coping skill prior to entering prison, often in and out of several hospitals and clinics seeking pain medication, shelter, and government assistance funding. Upon a more thorough assessment of his current situation, the results indicated a strong suspicion of malingering. The inmate was confronted with these assessment results first. At first the inmate became defensive, but after talking with the mental health professional he finally admitted to malingering in order to gain access to the less violent, less restrictive environment provided by the psychiatric ward. The professional and other prison authorities forced the inmate to propose alternative behaviors that would be more socially acceptable both while in the prison system and upon release to avoid other instances of malingering outside of prison. The inmate continued to meet with the mental health professional and a doctor in order to maintain these more socially acceptable behaviors and ideas. As the inmate's release date neared, his mother and father also became involved in the process, as the inmate was planning to return to their home. The inmate was also involved with training courses to increase skills and abilities related to factory work, as there was a factory in the community that had agreed to hire this inmate upon release. Finally, he was involved with social skills, problem-solving, and various other coping skill programs to enhance his ability to cope with adversity in more effective, healthier ways instead of turning to the use of malingering and deception when faced with potential problems. Upon his release, the inmate moved back home with his mother and father and began working at the local factory. Through follow-up with the inmate, his parents, his boss, and his parole officer six months later, it was found that the inmate did not have any further instances of malingering or major behavioral concerns since his release.

Ethical and Professional Issues

Many clinicians are hesitant to label an individual as a malingerer, even when evidence strongly supports it (Yates, Nordquist, & Schultz-Ross, 1996). Often times professionals fear they will be sued or face retaliation from the patient. They may also worry about possible effects that may occur for someone diagnosed with malingering, such as future denial of necessary care, stigma, and legal sanctions (Kropp & Rogers, 1993). Even when taking these negative possibilities into consideration, clinicians have an ethical obligation to thoroughly assess for malingering in situations where its likelihood is increased. Examples of these situations include someone seeking an external gain via treatment, such as a letter for disability benefits, or an individual pleading insanity for a court case. Also included are situations in which an individual presents with symptoms that appear exaggerated when compared to the norm or when symptoms do not seem to fit within a specific diagnosis (LoPiccolo, Goodkin, & Baldewicz, 1999). Several of the General Principles and Ethical Standards provided by the American Psychological Association (APA) Ethics Code (2002) can be used to make sure one is appropriately assessing and diagnosing malingering (Seward and Connor, 2008).

Standard 2 (Competence) states that mental health professionals must provide services only within their boundaries of competence and must work to develop and maintain competence within the psychological field (APA, 2002). Professionals trained more than a decade ago may not have a complete understanding of the current research on the assessment and measurement of malingering, as it has become more of a focus since that time (Seward & Connor, 2008). Even so, with the obligation to maintain competence and keep up with current research literature, any lack of training and education on the subject is no excuse. Another issue that falls under this standard is a clinician's ability to differentiate between malingering and the presentation of an

actual mental illness. Therefore, keeping up with the current literature, as well as being familiar with typical symptom presentations and how they manifest in individuals, is imperative for maintaining competence in this area. Along with this, clinicians must be able to differentiate between individuals that are malingering and those that are simply non-compliant or treatment-resistant individuals presenting with a genuine mental illness. Pankratz (1998) notes that individuals who consistently distort, manufacture, or withhold information are more likely to be malingering, when compared with those simply having difficulty with compliance. Keeping up with continuing education and up-to-date research literature is a must in this area. Also important is that clinicians recognize their limits of competence, referring patients elsewhere as needed when dealing with questionable situations.

Principle A of the Ethical Guidelines, Beneficence and Nonmalficence, states that mental health professionals are not to inflict any harm on the clientele with whom they work (APA, 2002). Therefore, clinicians are expected to provide treatments that avoid and minimize harm as much as possible. Providing unnecessary treatment to an individual strongly suspected of or proven to be malingering can be potentially quite harmful to that client (Seward & Connor, 2008). For example, treating someone with psychotropic medication who does not genuinely need it and exposing them to possible adverse side effects is unacceptable, especially since such effects can lead to permanent damage.

Seward and Connor (2008) also note that the label of malingering may lead to stigmatization. Labeling someone as a malingerer is often synonymous with calling him or her a fraud, and this could have significant consequences in the individual's future. This label may be misused by others in the future in the form of denying future insurance claims, and it could bias future treatment from others even when the individual legitimately needs care and services. Even

so, if someone is malingering it needs to be appropriately addressed and documented. As Seward and Connor also note, avoiding this diagnosis based on the fear of negative consequences and stigma that could result from a malingering label is no more justified than it would be to avoid a diagnosis of Schizophrenia for the same reasoning.

Clinicians may also fear that the label of malingering will pose a threat to the therapeutic relationship (Seward & Connor, 2008). Ironically, some patients who malingering actually form close relationships with their therapists (Pankratz, 1998). The therapist, who may be searching for why an individual's symptoms don't match up, may create a fabricated "truth" to explain the patient's condition that helps avoid any responsibility for the patient to work toward change. It is important that clinicians avoid such behavior so they do not enable the malingering behavior or enter into unnecessary treatment with the patient. Some therapists also worry that any doubt they have about a patient's story may be damaging in and of itself (Early, 1984; Pankratz & Sparr, 1984). Some even have difficulty coming to terms with the idea that their patients would intentionally deceive them. Collecting supplemental information from third-party individuals and reviewing compliance history may be even more important due to these instances, in order to assist the clinician with gaining a more objective point of view and come to terms with any doubts he or she may be having (Pankratz, 1998). As noted earlier, and also important for clinicians to remember, is that oftentimes confronting an individual about the suspicion of malingering may actually improve the therapeutic relationship, as it implies therapist competence (Reich, Gottfried, 1983; Walters, 2006).

Principle C (Integrity) states, "Psychologists seek to promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology. They do not steal, cheat, or engage in fraud, subterfuge, or intentional misrepresentation of fact" (APA, 2002, p. 3). Seward

and Connor (2008) note that some may argue that using validity tests in the assessment of malingering without explaining their purpose could be viewed as deceptive practice by the clinician. As long as it is done in such a way that the individual is given the opportunity to do well and deny any deficit, Gutierrez and Gur (1998) were told by a university Biomedical Ethics Center that “deceiving” someone suspected of malingering might actually be ethical. It is suggested that the examinee be encouraged to provide a “good and honest effort,” but the examinee should not be informed that symptom validity assessment techniques will be used, as this may lead to the examinee being more prepared to skillfully fake impairment (Youngjohn, Lees-Haley, & Binder, 1999). Therefore, the clinician should make a statement to indicate that full cooperation and good effort is necessary for an accurate assessment. Requesting an agreement from the patient to provide both of these is both ethically responsible and minimally informative to an examinee that is potentially malingering (Seward & Connor, 2008).

Principle E (Respect for People’s Rights and Dignity) states, “Psychologists respect the dignity and worth of all people” (APA, 2002, p. 3). Therefore, clinicians are expected to respect all individuals they meet in practice and are not to disrespect or hold resentment toward a client suspected or found to be malingering. Clinicians are expected to maintain objectivity, professionalism, and ethics as dictated by the profession and demanded by the mental health field (Seward & Connor, 2008). This principle means that clinicians need to be cautious and avoid denying future services to someone simply based on a previous diagnosis or suspicion of malingering.

Also important is that clinicians do not allow their personal beliefs to get in the way of assessing for malingering or providing necessary treatment. For example, if a clinician is

assessing someone that could potentially receive a death penalty sentencing, he or she cannot let his or her personal beliefs on the matter get in the way of fair and appropriate assessment.

Finally, there are many individuals who believe that malingering is a “victimless crime,” but in reality it has many societal and personal effects and costs that need to be taken into account (Seward & Connor, 2008). Chafetz and Abrahams (2005) note evidence of malingering in 76% of adult claims and 67% of child claims for Social Security Disability Income (SSDI) in the state of Louisiana in 2004. Also in 2004, SSDI paid out about \$80.3 billion. If prevalence rates across the nation are similar to those in Louisiana, the cost of malingering would be billions of dollars each year for the already struggling Social Security Administration (Seward & Connor, 2008). Also, the costs inflicted on taxpayers for legal proceedings, medications, and a variety of other costs accrued by malingerers are important to keep in mind. Moreover, it is much more difficult for individuals with genuine mental illnesses to receive appropriate treatment and funding assistance when they are being provided to those who do not necessarily need them.

The Coalition Against Insurance Fraud (CAIF) estimated that in 1995 the total cost of insurance fraud in the United States was \$85.3 billion, the vast majority of which stemmed from health insurance claims (LoPiccolo, Goodkin, & Baldewicz, 1999). From 1994 to 1995 the cost of false health insurance claims rose 10.3% from \$53.6 billion to \$59.1 billion. This increase resulted in a cost of \$1,050 in health insurance premiums, increased taxes, and increased goods and services for the average American family, up from \$945 in 1994. LoPiccolo, Goodkin, and Baldewicz note that this was occurring during a time that all other forms of insurance (auto, homeowners, etc.) remained stable overall. Due to this, many insurance companies have now implemented special units specifically used to manage difficult and fraudulent claims (Pankratz, 1998). One example is the Critical Claims Unit (CCU) established by an Oregon public workers’

compensation company. Claims adjusters refer suspicious claims to the CCU, and they utilize greater expertise in investigating these potentially fraudulent claims. The CCU has helped decrease insurance rates for businesses in the state of Oregon. Administrative programs such as these may be essential in the management of problematic and deceptive patients. They are cost effective for managed care programs, especially in instances where patients have access to multiple facilities or providers. These units can also be useful in assisting busy clinicians that may have a difficult time with or lack the expertise necessary to make decisions with serious legal and/or ethical implications (Pankratz, 1998).

Research Challenges and Needs

Malingering mental illness is a phenomenon that has been around since ancient times. In Homer's "Odyssey" Ulysses feigned mental illness in order to avoid taking part in the Trojan War. Examples of malingering can also be seen in the Bible's account of King David, as well as many other literary works, such as Shakespeare's Hamlet and King Lear. Though malingering has been recognized as occurring for quite some time, it was not until the 19th century that clinicians began focusing on how to detect feigned psychosis. Even so, during this time the general consensus of psychiatrists was to simply use observation as an assessment technique. Oftentimes clinicians were advised to look for discrepancies between the way the individual presents him or herself and known characteristics of mental illness, namely looking for exaggerated behavior or symptoms from several different mental illnesses (Chesterman, Terbeck, & Vaughan 2008). Ray (1838) and Taylor (1865) suggested observing for extended periods of time, examining a patient's writings, and using anesthetics or sedatives to assess for malingering. Periodic descriptions of malingering behaviors can be seen throughout later decades as well, but

it was not until the late 1980's that there was another increase in interest and research on malingering (Chesterman et al., 2008).

The father of forensic medicine, Paolo Zacchias (1584-1659), commented that insanity is one of the easiest diseases to fake but is also one of the most difficult to detect (Chesterman, Terbeck, & Vaughan, 2008). Rosenhan's (1973) study supports the idea that mental health clinicians often have difficulty simply observing whether or not patients are malingering. In this study 8 individuals, including a housewife, a painter, psychiatrist, psychology student, pediatrician, and 3 psychologists, were admitted to psychiatric hospitals under the façade of auditory hallucinations. Their claims of hearing voices were ceased upon admission. Their length of stay in the hospital varied from 9 to 52 days, and they were each diagnosed with schizophrenia. The fact that these individuals were able to be admitted and remain in the hospital without the staff detecting that the initial symptoms were faked is alarming and definitely helped clinicians recognize the need for better malingering assessment measures. As discussed at length earlier, many new screening and assessment measures have come out of the resurgence of malingering research. Although there has been an influx of research on the topic, there is still much more needed, especially because of the many challenges that come along with studying malingering.

One of the biggest challenges present in malingering research is differentiating between malingering and other deception-centered conditions, such as Factitious Disorder. Although it is easy to define the differences, often the behaviors exhibited for both conditions are very similar. Therefore, in research it is necessary to assess for the motive behind the deceptive behavior in order to make sure the correct condition is being studied. Such an assessment can be very difficult though, especially if the external incentive is not obvious or the individual is not

forthcoming with such information. A similar challenge is that sometimes individuals who have severe psychopathology may have answers that parallel that of a malingerer, so this makes it difficult to differentiate the two in certain situations (Rogers, 2008).

Also, individuals who are using deception are not likely going to admit to this behavior, as they are attempting to avoid any negative repercussions that might come along with it. While malingering individuals are not necessarily pathological liars, one can imagine they are not likely to confess that they are attempting to deceive the clinician, as they would then lose the external incentive they are seeking. This challenge affects all types of malingering research, from prevalence rates to assessment measure research, as actual malingerers will not likely be participating in research studies if they are not admitting to such behavior. Unfortunately this lack of admission and cooperation is one aspect that is out of the control of clinicians and researchers, but it is also something that is essential in research. It is especially necessary in malingering research, which is primarily dependent on self-report answers.

Another research challenge that is related to the abovementioned is the research designs used in malingering assessment studies. Most of the research in malingering assessment uses a simulation design, in which participants are randomly assigned to experimental (feigning) and control (honest answers) conditions. In order to assess for the difference between genuine and feigned mental illness, the experimental group is compared with a nonrandom clinical sample (Rogers, 2008). The problem with using a simulation design is that you cannot be sure that the individuals instructed to feign symptoms are answering similarly to those who actually malingering, especially since there are no external incentives or consequences present for the behavior. Therefore, the results of simulation designs are not the most generalizable to real-world situations. Another research design used in malingering assessment research is that of known-

groups comparisons. In this design, an expert places participants into the conditions based on their response style (honest, malingering, etc.). The downsides to this research design are that researchers have no control over the experimental assignment and it is dependent on the expert's ability to differentiate between malingering and non-malingering individuals (Rogers, 2008). Rogers (2008) notes "these two basic designs complement each other with their respective strengths" (p. 10), with simulation having strong internal validity and known-groups designs having strong external validity. It is ultimately up to the researcher(s) which design is more appropriate for the needs of the study.

As mentioned earlier, another challenge in malingering research is the description provided in the DSM-IV-TR. Unlike the Axis I and Axis II disorders, malingering does not have any sort of measurable, quantifiable descriptors that are often needed in research. It is difficult to study anything that cannot be measured or does not have a single operational definition. Also, as mentioned earlier, the overly broad factors in the DSM-IV-TR describe malingering as typically being carried out by an antisocial, uncooperative individual in legal trouble, which makes it difficult to accurately assess whether or not someone is truly malingering (McDermott et al., 2008). Even though these factors helped correctly identify about 65% of true malingerers in a study by Rogers (1990), only 20% of individuals meeting two out of the four factors were found to be truly malingering. Therefore, a more specific, measurable, and less stereotyped definition of malingering is needed for future research.

Finally, most of the current research on malingering focuses on validating assessment measures and less so on other areas related to the topic. One idea for future research includes looking into prevalence rates of malingering among various population/cultural groups. Also important is developing a way to identify how much prior knowledge individuals have about

feigned or genuine mental illness, as well as the various assessment measures used. Assessing the relationship between the external incentive at stake and an individual's tendency to malingering is also something that would be important to examine. Finally, checking and updating the accuracy of the symptoms and discriminators used to differentiate between individuals with genuine mental illness and those that are malingering might be needed (Raine, 2009).

Cultural Considerations & Relevance to Special Populations

Cultural Considerations

Malingering is a phenomenon likely to occur across cultures and ethnic backgrounds, given that the motives behind such behavior (i.e., obtaining money, avoiding jail time) are temptations with universal appeal (Salazar, Lu, Wen, & Boone, 2007). Resnick and Knoll (2008) note that the occurrence of malingering is likely to have increased in recent years and will continue to do so, due to the state of the economy and the mental health field itself. For instance, the process of deinstitutionalizing individuals with severe mental illness did not go as planned, and many of these people ended up homeless or in jail (Mechanic & Aiken, 1987). Also notable has been the decrease in funding being provided across the United States for community mental health centers and social programs, leading to an increased lack of treatment availability outside the hospital setting (National Alliance on Mental Illness, 2006). These issues combined have led to a greater possibility that individuals will exaggerate symptoms of mental illness for a place to stay or even simply to get necessary mental health treatment.

Although research interest in malingering has grown significantly in the United States over the last few decades, the same cannot necessarily be said about other countries. When Germany and the U.K. introduced social monetary benefits in the early 1900's, the medical profession was concerned with the possibility of increased cases of malingering. Even so,

Chesterman, Terbeck, and Vaughan (2009) point out that in Britain, malingering continues not to be much of a concern in modern psychiatry, with very little research literature available in the country. In Britain the pathogenic model of malingering continues to be popular, and therefore the idea of pure malingering is believed to be a rare occurrence (Chiswick & Dooley, 1995), which could explain the lack of psychological research in this area. There isn't much information available regarding which countries have a higher prevalence of malingering, but there is evidence of recent research in both the Netherlands and Czech Republic, where malingering appears to be of growing concern (Muntean, 2008; Oorsouw & Merckelbach, 2009).

Dreber and Johannesson (2008) found that men were more likely than women to lie for monetary gain. As mentioned earlier, research suggests that prevalence rates of malingering in the general population are estimated at about 3% in males and 1% in females (Raine, 2009), supporting this suggested gender difference. These authors also note that previous research (i.e., Gneezy, 2005) supports the idea that women are more likely to fake positive feelings, and therefore one might assume that women might be less likely to malingering based on these findings. More research is needed for gender differences, though, as the area of gender effects on malingering has gained very little empirical attention overall (Heard, 2010). It is difficult to study gender-malingering interactions because of research-related difficulties in this area alone, such as more males serving as participants in "known-groups" research designs due to their stronger presence in correctional and forensic settings, where such research tends to take place.

As far as other cultural considerations, not much research has been conducted regarding differences among various culture/race groups. In a study of worker's compensation applicants, DuAlba and Scott (1993) found evidence that Hispanic participants were no more likely to malingering than Caucasian participants. In this study it was also found that the Hispanic

participants were more likely to somaticize emotional symptoms, instead complaining of physical symptoms. Therefore, it is possible that Hispanic individuals may malingering more from a physical standpoint than malingering mental illness. DuAlba and Scott note that there is a substantial amount of research indicating that cultural factors may influence individuals in Hispanic culture to somaticize under stress, and are more likely to mistake depression for physical ailments, fatigue, or feelings of nervousness (Escobar et al., 1987; Koss, 1990). Therefore, these individuals would be more likely to seek medical help when dealing with psychological problems. Also individuals within the Hispanic culture are more likely to seek out help from their family, the community, or the church, as they are part of a more collectivistic culture. Individuals from this culture may feel highly stigmatized reaching out to a mental health professional in dealing with mental health problems (American Psychiatric Association, 2007), so you may find it less likely that Hispanic individuals would be malingering psychiatric symptoms. Again, more research needs to be done in this area in order to understand any differences between culture groups.

Another important issue to consider in the assessment of malingering is the cultural validity of the screening and assessment measures used to detect the possibility of malingering. In comparing the results of European American and African American participants, the English-speaking version of the SIRS exhibits no significant differences due to race (Connell, 1991, cited in Rogers, 2008). More recent studies that have looked at the M-FAST have yielded results that indicate no significant differences due to race among Hispanic Americans, European Americans, and African Americans (Guy & Miller, 2004; Miller, 2005).

The MMPI-2 malingering scales have yielded a little more in the way of cultural validity research, when compared to the other malingering detection measures. For example, DuAlba and

Scott (1993) found no difference between the Hispanic and Caucasian participants in the dissimulation index of F-K. A couple of studies have found a difference when comparing Caucasian Americans and Chinese participants, as well as less acculturated Chinese Americans, with the latter two yielding significantly higher F-scale scores than the former (Cheung, Song, & Butcher, 1991; Sue, Keefe, Enomoto, Durvasula, & Chao, 1996). Sue and colleagues found no significant differences between more acculturated Chinese Americans and Caucasian college students, though. This coincides with Cheung, Song, and Butcher's theory that the elevated F scores were likely due to differences between Chinese and American cultural beliefs, values, and practice, rather than psychiatric deviance. Items that were endorsed most differently between the Chinese participants and American participants affecting the F-scale include religious items, sex items, and activity level, indicating that these may be areas of cultural difference (Cheung, Song, & Butcher, 1991). A recent study by Tsushima and Tsushima (2009) found no significant difference between Chinese and Caucasian Americans involved in civil lawsuits and disability claims when comparing their scores on all 5 validity scales, as well as any of the 10 clinical scales. Level of acculturation was not measured during this study. Again, the cultural validity of the various malingering assessment and measurement techniques is an area that needs to be investigated further, as the research available at the current time is scant (Rogers, 2008; Tsushima & Tsushima, 2009).

One very important aspect in all areas of therapy that also applies to cases of malingering is the cultural competency of the therapist. Westermeyer (1987) notes that misdiagnosis, overestimation, and neglect of true psychopathology are common issues when a clinician is of one culture and the patient another. This is due to the fact that the clinician may not completely understand cultural norms that may appear within the patient's presentation, thus leading to the

clinician making false assumptions and diagnosing incorrectly. The clinician needs to be able to differentiate between culturally normal behavior and abnormal symptoms in order to make an appropriate diagnosis (Witztum, Grinshpoon, Margolin, & Kron, 1996). The issue of cross-cultural misdiagnosis of ethnic minorities or individuals from different subcultures is more likely to occur in countries such as the United States, Great Britain, and Israel, as these countries have a large influx of immigrants (Witztum et al., 1996). Westermeyer questions whether or not Western clinicians are able to appropriately assess and diagnose individuals of different cultural backgrounds without a full understanding of their culture, and the accompanying values and behaviors. For example, the diagnosis of a psychotic disorder involves observing the individual's behaviors as deviating from the social norm. If a clinician does not understand the social norms of an individual's given culture, he/she runs the risk of misdiagnosing what is really going on. For example, if a patient presents with a culture-bound syndrome such as *ataque de nervios*, where an individual may present with very extreme anxiety and possibly suicidal gestures but then return to their normal state of functioning a short time later (APA, 2000), a clinician might assume the individual is malingering based on observing a sudden decrease of symptoms if he/she does not understand the nature of the syndrome.

Special Population Considerations

According to the definition presented in the DSM-IV-TR, malingering should be strongly suspected in instances where an antisocial individual involved in the legal system/prison culture is presenting with mental illness. Because of this description, a frequent misconception is that psychopaths or individuals with Antisocial Personality Disorder (APD) are more likely to malingering than individuals without APD. As mentioned earlier though, Resnick and Zuchowski (2007) report that the research does not necessarily support this idea (Poythress, Edens, &

Watkins, 2001; Kucharski et al., 2006). In a study of medico-legal evaluations, Rogers (1990) found that APD was found in 20.8% malingerers and 17.7% non-malingerers. Therefore, the research indicates that those with APD are not significantly more likely to mangle, thus providing another contradiction to the DSM-IV-TR definition.

Resnick and Zuchowski (2007) note that malingering does occur in medico-legal contexts more than other contexts, though, giving some truth to that factor included in the DSM-IV-TR definition. Again, though, the difficulty in assessing and researching malingering prevalence rates needs to be taken into consideration. Something else to take into consideration is the discrepancy that may occur between symptom presentations in the forensic system versus general public or workers' compensation situations. Swanson (1985) notes that malingering individuals involved in a worker's compensation case have a tendency to exhibit lower motivation, as the consequence or reward is not as life threatening or big as it is in forensic cases. Therefore, there are usually more cases of depression or amnesia in these situations than committable mental illness symptoms such as psychosis or suicidal ideation. Thus, the individual does not end up in the hospital but will receive the sought-after compensation. On the other hand, when it comes to people malingering in a legal context or for a larger incentive (i.e. shelter), it is more likely that an individual will feign more severe psychopathology, such as psychosis.

Conclusion

Although malingering is not considered a psychiatric diagnosis by the DSM-IV-TR, it is definitely something that warrants attention from mental health professionals. As seen throughout the current review of the literature, there are many negative consequences that can result from malingering behaviors, including potential adverse side effects from inappropriate treatment and several societal burdens and costs. With the empirically validated screening and

testing measures available today, clinicians should feel more comfortable in assessing cases of malingering without simply relying on clinical judgment from a single interview. Understanding what malingering may look like, how to utilize the assessment measures, and how to appropriately manage malingering behavior is imperative in maintaining compliance with the professional and ethical obligations mental health clinicians need to uphold in their practice. While there is still much more to explore in the area of malingering, the empirical research that exists at this point should be more than enough for clinicians to recognize the necessity of thoroughly assessing for malingering in situations and contexts in which its occurrence is more likely.

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