Clinical and Conceptual Problems in the Attribution of Malingering in Forensic Evaluations

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The authors review clinical and conceptual errors that contribute to false attributions of malingering in forensic evaluations. Unlike the mental disorders, malingering is not defined by a set of (relatively) enduring symptoms or traits; rather, it is an intentional, externally motivated, and context-specific form of behavior. Despite this general knowledge, attributions of malingering are often made by using assessment tools that may detect feigning but cannot be relied upon to determine incentive and volition or consciousness (defining characteristics of malingering). In addition, forensic evaluators may overlook the possibility that feigning is a function of true pathology, as in Ganser syndrome or the factitious disorders, or that a seemingly malingered presentation is due to symptoms of an underlying disorder, such as dissociative identity disorder (DID). Other factors that set the stage for false positives, such as pressure on forensic specialists to identify malingering at all costs, failure to consider the base rate problem, and cultural variables, are also reviewed.

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The assessment of malingering in a forensic context is beset by a variety of clinical and conceptual difficulties that are often overlooked by forensic specialists who are called upon to make such determinations. These difficulties include problems associated with conceptualizing malingering as a psychiatric diagnosis, problems in evaluating truthfulness in general, the inadequacy of methods designed for evaluation of personality traits in assessing a volitional behavior that is highly state and context dependent, complexities introduced by such syndromes as the factitious disorders and the Ganser syndrome, problems in establishing base rates for malingering in different clinical/forensic settings, ethics-related problems associated with rates of misclassification, and problems arising from clinician and interactional variables that affect the forensic psychological assessment. Because forensic specialists often fail to recognize these and other complexities in the assessment of malingering, such assessments are often inadequate and impressionistic and in rare cases amount to little more than a reflection of the clinician's negative countertransference and/or negative moral evaluation of the individual being assessed.

In a previous publication,[1] we have discussed the complexities associated with distinguishing malingering from various pseudodementing and pseudopsychotic conditions, including Ganser syndrome and related hysterical and dissociative states. Our experience on a busy metropolitan forensic psychiatry service was that individuals undergoing forensic examinations were often said to be malingering by clinicians who not only failed to consider the possibility of factitious disorders and Ganser syndrome, but who were also unaware of the complex conceptual questions that underlie the malingering attribution. Indeed, even those authorities (e.g. Meyer and Deitsch[2]) who author professional articles on the detection or diagnosis of malingering frequently simply list signs and symptoms and fail to include a consideration of the many clinical, conceptual, and statistical complexities associated with the attribution of malingering in a clinical or forensic psychological context.

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Malingering as a Diagnosis

It is important first to recognize that the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) clas-

sifies malingering with a V-code (V65.2), thus indicating that it is not a mental disorder but rather one of the "additional conditions that may be a focus of clinical attention" (Ref. 3, p 739). Unlike schizophrenia or depression, which are (relatively) enduring conditions that befall a patient and cannot simply be willed away, malingering is by definition the result of a consciously motivated decision on the part of a subject at a given time. The determination of malingering is thus very different from other types of psychological assessments and, in effect, amounts to a determination of whether a particular individual is intentionally lying by falsely claiming that he or she is experiencing certain symptoms.

A major rationale for enumerating signs and symptoms and constructing tests for malingering rests on the misleading assumption that malingering is a diagnosis. If one were to see malingering for what it is (i.e., intentional lying), one would have as much (or as little) rationale for constructing tests to ascertain it as the judiciary has for constructing tests to ascertain the truthfulness of witnesses. At best, our tests can tell us that what we are seeing is unlikely to be, for example, schizophrenia or a true neuropsychological deficit, but such tests cannot tell us that the individual before us is intentionally lying (i.e., malingering), because tests cannot ascertain the motive or intention behind an individual's presentation or test performance, and motive is the essential component of malingering. As will be discussed, this is not simply an academic or philosophical question, but rather there are several conditions that can present as a malingered test performance in a subject who is either not lying or who, for other reasons, we would not classify as malingering.

Assessment of Malingering as Lie Detection

Results from a recent meta-analysis call into question the ability of psychologists to detect intentional lying. Of 193 studies correlating one's profession with the ability to detect deception in artificial situations, it was found that psychologists are only slightly more accurate in deception detection than are student research participants (62% accuracy compared with 54%, respectively).[4] Although the studies included in the meta-analysis were evaluating deception in general and not specifically malingering, the study raises the question of whether psychologists have any particular expertise in lie detection in individuals who claim to suffer from depression, hear voices, or have certain delusional beliefs, given that psychologists have no special expertise in assessing lying in other contexts (and are generally not permitted to testify about a defendant's or other individual's truthfulness in a court of law). One answer to this question is that psychologists have no particular expertise in detecting lying and truthfulness, but presumably have clinical knowledge (e.g., about the usual symptoms of depression or how people with true schizophrenia tend to respond to certain test items) that enables them to apply commonly used criteria for truthfulness (e.g., consistency and plausibility) in a psychological context. The important point to remember, however, is that, in attributing malingering to an individual, we are not making a diagnosis but are instead saying that the individual is intentionally lying, and our capacity to do so is subject to all of the vagaries associated with lie detection in general. It is subject to a few other complicating factors as well.

As we have indicated, malingering, unlike the disorders described in the DSM-IV-TR, does not represent a set of enduring characteristics. Rather, it is the product of context. A person with schizophrenia presumably has schizophrenia in any situation, and while context may affect his or her presentation and symptoms, certain enduring traits remain. With respect to malingering, an individual's volitional feigning of a mental illness can change from setting to setting, and, as will be discussed below, can be strongly affected by the clinician's attitude toward and interaction with the patient. As such, malingering is better understood as a function of an individual's incentives and circumstances rather than as arising from his or her individual psychology or diagnosis.[2,5]

Since malingering is not a syndrome, it has no specifiable inclusion and exclusion criteria and is fundamentally different from other clinical assessments. Although assessment measures such as the Structured Interview of Reported Symptoms (SIRS) are used to detect feigning, DeClue[6] warned that such measures do not identify an individual's motivation for feigning and therefore can never be used in isolation to detect malingering. Thus, when psychologists make judgments about malingering they are venturing outside the normal bounds of the science of psychology and are actually making a judgment about an individual's motives, intentions, and behav-

ior. To the extent that psychologists make such judgments, they must utilize the same principles that are utilized in daily life or in a court of law; the examinee's conduct must be placed within the broadest motivational and psychological context possible, with an awareness that a broader context may ultimately reveal an initial judgment to have been in error. Clinicians who fail to gather data by using a variety of assessment methods beyond testing, such as unstructured interviews, behavioral observations, collateral reports, and review of historical records, run a high risk of false-positive attributions.[6] An anecdotal example that readily comes to mind is a patient whose behavior was deemed as obvious feigning of amnesia symptoms and who was labeled an outright malingerer until records from a previous hospitalization revealed a history of paranoia and similar amnestic behavior motivated by a paranoid desire not to reveal anything to the doctors, who he believed were government spies.

Consciousness, Volition, and Intention

Placing an examinee's behavior in the broadest possible context is not always the rule in clinical assessment. In making diagnoses, the field of vision is often narrowed to reflect only behavioral observations. Unlike DSM-IV-TR diagnoses, for which the clinician classifies syndromes on the basis of a patient's symptoms, behaviors, or reactions to treatment, the attribution of malingering involves an inference of an interviewee's consciousness and volition. To diagnose schizophrenia, a clinician need not infer that the individual is aware that he is psychotic, nor must the clinician (unless seeking to exclude malingering) make any inference at all that the individual's behavior is or is not volitional. In fact, many psychologists regard consciousness and volition to be nonscientific, obscure concepts and prefer to exclude them from any scientific description of the mind. While judgments about intentionality and awareness are made in the courtroom and daily life, it is unclear that psychology or psychiatry has any sound theoretical or empirical basis for making such judgments. Psychologists can contribute data that add to the behavioral and situational context in which such judgments are made, but the judgment itself is not a scientific one. In view of the deterministic presumptions of natural science, the idea that there is a scientific test or technique that penetrates the question of free will may well be a contradiction in terms.

The attribution of malingering has historically been made with regard to patients whose symptoms do not correspond to the prevailing medical nosology. We often hear that malingering should be diagnosed when an individual's symptoms correspond to no known illness. One problem with this approach is that what is regarded as pathologic in clinical psychology and psychiatry is continually evolving. At one point many individuals who would currently receive a diagnosis of psychosomatic (somatoform), hysterical, and post-traumatic disorders were deemed malingerers. The shifting boundary between malingering and genuine illness is today evident in the controversy over the diagnosis of dissociative identity (multiple personality) disorder. Kluft pointed out that individuals with dissociative identity disorder (DID) may exhibit many of the signs generally considered indicative of malingering and noted that "malingering and factitious augmentations may accompany legitimate DID" (Ref. 7, p 79). In addition, as Brown[8] observes, the development of odd physical symptoms without known organic pathology is rather common among patients and often is a function of unconscious and semiconscious processes such as conversion, somatization, distortions of perception and awareness, reactions to trauma, and negative affective states.

Hysteria and Dissociation

There is a strong tendency on the part of forensic psychologists and psychiatrists to ignore the possibility of hysteria and dissociation and to label individuals with these syndromes as malingerers. There are several factors that contribute to this tendency. First, there is a desire to avoid the conceptual problems associated with hysteria and dissociation (i.e., the attribution of unconscious defensive processes and/or a splitting in consciousness—problems that, in their reverse form, persist in the assessment of malingering). Second, there is a resistance to the notions of hysteria and dissociation themselves. Kluft[7] noted that many clinicians are skeptical about dissociative processes and favor other diagnoses even in the presence of strong evidence of a dissociative disorder. In a study of Australian clinician attitudes toward dissociative disorders, Leonard and colleagues[9] found that nearly half of those surveyed doubted the legitimacy of patient diagnoses of dissociative disorder.

Of the 55 DID patients included in the study, 80 percent reported encountering antagonistic or skeptical clinicians, and 64 percent reported suffering adverse consequences due to delays of 3 to 10 years in receiving an accurate diagnosis of DID. A reason for this type of resistance may be that, as Freud pointed out long ago, these phenomena show us that "the ego is not master in its own house" (Ref. 10, p 143) and that, even among psychologists, this idea is very unsettling. By labeling patients/evaluees with hysteria as malingerers, we avoid the inevitable conclusion that unconscious processes can and do dominate consciousness and will.

Perhaps more important, hysteria and dissociation render problematic any effort to detect malingering on the exclusive basis of signs, symptoms, and test performance, as these syndromes introduce the possibility that an apparently malingered symptom or test performance is the result of an unconsciously determined distortion. The difficulty here is identical with the problem that conversion hysteria introduced into general medicine, where physicians frustrated by such patients' presentations were forced to conclude that an impossible symptom that appeared to be feigned may well be the result of a psychopathological process.

The resistance to hysteria, dissociation, and unconscious mental processes is magnified among forensic specialists, who are typically either skeptical of these ideas or reluctant to introduce them into a legal context. Since the advent of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III), there has been what Wilson describes as the "narrowing of psychiatry's clinical gaze" (Ref. 11, p 399) and an increasing focus on the observable aspects of symptoms and behavior at the expense of a weakening of the concept of the unconscious. One might therefore be inclined to ask about the implications for the concept of malingering when we reintroduce the notion of the unconscious into forensic psychology.

Factitious Disorders and the Ganser Syndrome

As we argued in a previous publication,[1] while the malingerer knowingly produces false symptoms on the basis of a motive that is known to and adopted by him or her, in the factitious disorders, symptoms are volitionally produced for a reason that lies outside the subject's conscious awareness. Finally, in the Ganser syndrome, the subject is both unaware of the motive for producing pseudodementia or pseudopsychotic symptoms and unaware that he or she is producing such symptoms, as the entire process lies outside of consciousness. When one accepts the idea that pseudosymptoms can be produced unconsciously as the result of a second-tier psychological diagnosis such as factitious disorder or Ganser syndrome, the whole rationale for detecting malingering on the basis of inconsistency and absurdity and especially for devising psychological tests (such as the MMPI-2 and the SIRS) for detecting malingering becomes highly questionable. As we have pointed out,[12] there is little if any difference between the conscious and unconscious feigner on the level of symptoms and test responses. (Indeed, it is our experience that those with Ganser syndrome and factitious disorder often score higher on so-called scales of malingering than do actual malingerers.)

It is thus little wonder that those who have devised scales for measuring malingering have either ignored or criticized the factitious and Ganser diagnoses. For example, Rogers and colleagues[13] noted that the factitious disorders are empirically unsubstantiated, in that they do not have clear inclusion, exclusion, and outcome criteria. In addition, they noted that the motivation for a factitious presentation may be unknown and that these symptoms may represent the prodromal stage of another disorder. It should be noted, however, that these same arguments can be made with respect to the attribution of malingering as well. As will be discussed later, there is no known base rate for malingering. Malingering is not defined by any set of criteria, nor does it have a predictable course. The motivation for it may not be known to the clinician. Finally, it may take place in the context of or serve as a mask for genuine pathology.

Of note, Rogers and colleagues[14] actually reported that tests for malingering, such as the Structured Interview of Reported Symptoms (SIRS), the Personality Assessment Inventory (PAI), and the Structured Inventory of Malingered Symptomatology (SIMS), fail to distinguish factitious and hysterical pathology from malingering. They even used this observation as part of an argument for questioning the legitimacy of the factitious diagnosis and to suggest the term be replaced by "feigning."[15] Rather than concluding that the SIRS, PAI, and SIMS are simply not sensitive or applicable to the diagnosis of factitious disorders, they prefer to legislate it out of existence and

define malingering/feigning in a manner that accords with the findings of a single test. This logic may explain why Rogers and colleagues[16] translated evidence of the utility of the SIRS in detecting feigning as evidence of its utility in detecting malingering. A tendency to lump factitious disorders and malingering into a general category of "feigning" and a bias against the possibility of a factitious disorder may have serious consequences for individuals struggling with this often overlooked condition. Gregory and Jindal[17] noted that individuals with factitious disorders may be especially fearful of abandonment and highly sensitive to rejection. Confronting such individuals, who commonly have comorbid Axis I and Axis II diagnoses, with accusations of feigning can potentially exacerbate symptoms and increase risk of self-harm.

The Assumption of a Rational, Willing Subject

The ascription of malingering rests, in part, on the assumption of the unity of the willing subject. It assumes that an individual of clear mind and unity of purpose consciously acts on the basis of certain motives to achieve a given end. This is the same, albeit unarticulated, assumption that is made by the law in its attribution of criminal responsibility. What is not clear, however, is whether this assumption has any valid application in psychology.

From a philosophical point of view, the assumption of rational volition raises the thorny question of determinism versus free will, but a more interesting and relevant objection is made by those dynamic psychologists who question the unity of the ego or self. For them, while it is theoretically possible for an individual to act in a conflict-free unitary manner, actual individuals act not only on the basis of conscious motivation but also in response to a host of motives, affects, and ideas of which they are partially or completely unaware.

While dynamic psychologists have questioned the assumption of a unitary, rational ego as it is applied to so-called normal subjects, the application of this notion to a forensic psychological population (i.e., to individuals who typically have histories of trauma and abuse and who are currently under the stresses of criminal charges and incarceration) is even more problematic. Behavior simulating the ideal of a unified willing subject can probably be approximated in an experiment with college students who are instructed to simulate mental illness, because such individuals are placed in a highly structured and artificial context in which they can act in a manner that is relatively divorced from their personal history and psychodynamics. That subjects who are asked to malinger in the context of such experiments (which serve as the basis for much research on malingering) follow the experimenter's instructions should not lead us to the conclusion that these subjects accurately model the thought processes and behaviors of actual criminal defendants, who, as Delain et al.[18] point out, are certainly not cooperating with examiners' instructions.

Malingering, Genuine Pathology, Acquiescence, and Cultural Difference

An attribution of malingering implies that because an individual has feigned symptoms of a mental illness, he or she is free of psychopathology. Such an assumption is not necessarily accurate. In fact, the individual's pathology may be fueling the malingering. For example, manic patients are often prompted by illness to lie, and the lying does not negate the reality of an individual's manic symptoms. When we become convinced that an individual has feigned certain psychiatric symptoms, it behooves us not only to consider whether he or she has done so in response to unconscious processes but also whether such apparent feigning is the result of a genuine mental disorder unrelated to the presented symptoms. Iverson and Binder[19] warned that individuals with depression who exhibit cognitive slowing and poor memory or who present with numerous somatic complaints and exaggerated health concerns may be wrongly perceived as malingering. Individuals with post-traumatic stress disorder (PTSD) may also be erroneously identified as malingerers. Limited or inconsistent memory recall, irritability and lack of cooperation, poor test performance and concentration, and delayed symptom onset—all legitimate characteristics of PTSD—are frequently considered red flags for malingering.[20] In fact, previously accepted cutoff scores on the Atypical Response Scale of the Trauma Symptom Inventory (TSI), a scale used to identify individuals who are malingering PTSD, were recently found to cause a substantial number of false-positive attributions.[21]

Complicating the problem further is the possibility that an individual who appears to be malingering is actually engaging in *pseudologia fantastica* or patho-

logical lying, an internally motivated form of lying that may be caused by fixation at a developmental stage when denial of reality and use of fantasy are adaptive. Although the role of volition in such pathological lying is controversial, some believe the behavior is unconscious, uncontrollable, and indicative of poor reality testing.[22]

A related problem arises in examinees whose limited intelligence or personality characteristics cause them to appear to be feigning on standard malingering indices. For example, Pollock[23] has shown that scores on the validity scales of the MMPI-2 and certain scales of the Structured Interview of Reported Symptoms (SIRS) are influenced by such variables as acquiescent responding, low intelligence, and interrogative suggestibility, thus yielding a high rate of false-positive attributions in the use of these scales for the detection of malingering.

Research is also needed to determine how cultural and language differences affect performance on indices used to detect malingering[20] and how clinicians' perceptions of the likelihood of malingering may be affected by racial or cultural variables. Reliance on unusual symptoms that do not fit into known diagnostic categories as an indicator of malingering may also be problematic when assessing culturally diverse populations. Though the DSM-IV-TR[3] now includes a glossary of culture-bound syndromes, clinicians may not be completely familiar with these syndromes, and the listings in the glossary are not exhaustive.

The major point with regard to each of these cases is that an approach to malingering that is overly reliant on signs, symptoms, and/or test scores and that fails to consider the causes or motives behind them (including the presentation of factitious disorders) is likely to yield misleading conclusions.

Content Validity of the Malingering Construct

Apart from the considerations discussed thus far, the problem of the content validity of the malingering construct is likely to confound any attempt to attribute malingering by means of a test or battery of tests. Because malingering is highly state and context dependent and is not an enduring condition, it is not possible to confirm an attribution of malingering independently, and independent confirmation is necessary for establishing the content validity of the malingering construct. We can say, for example, that a test for the early detection of a particular medical illness is 80 or 90 percent accurate because we ultimately know for sure who actually becomes ill. However, with regard to malingering, our only confirmatory criteria are the judgments of experienced clinicians[24] or perhaps adjudication in a court of law.[25] This problem, of course, is present in all psychiatric diagnoses, where the ultimate criterion for the validity of a given test is either another test or the judgment of experts. However, the problem is particularly acute with malingering because, in contrast to diagnoses such as depression or schizophrenia, the field has not specified, and perhaps cannot, clear-cut inclusion and exclusion criteria for malingering (or any other volitional act). Even in cases in which feigning is fairly well established through testing or other means, the presence of malingering is always based on idiosyncratic interpretations of available information and is therefore debatable.[6] There is no litmus test for whether someone is malingering, and in many cases in which forensic experts differ regarding malingering, they continue to do so even after a judge or jury has rendered a verdict that for legal (but not scientific) purposes answers the question. Although clinicians tend to have strongly held views about the presence of malingering, a recent meta-analysis of 58 studies supported previous findings that confidence in one's ability to detect deception and the actual accuracy of detection do not correlate highly.[4]

Malingering and the Base Rate Problem

A further problem with the attribution of malingering, one that has only recently come to be adequately recognized, relates to specifying the base rate for malingering in any given context.[26–28] The base rate for malingering becomes an important consideration when one recognizes that a test or procedure that is reasonably or even highly effective in a context in which a target disorder or behavior is common can become highly unreliable in a context in which that disorder or behavior is uncommon.[29] It is helpful to explain this with an example. Assume that one has a test that detects malingering with 90 percent accuracy. Such a test correctly classifies 9 of 10 malingerers and incorrectly classifies as malingering only 1 of 10 nonmalingerers. Assume that the test is administered to 1000 individuals, 500 of whom are malingering and 500 of whom are genuinely ill. The base rate for malingering would be 50 percent. We would

expect the test to identify correctly 450 of the 500 malingerers, and to classify incorrectly only 50 of the 500 nonmalingerers (i.e., those with genuine mental illness) as malingering. Let's leave aside the fact that no such (90% accurate) procedure for the detection of malingering currently exists and also the question of the acceptability of misclassifying even 50 of 500 mentally ill defendants as malingerers and turn our attention to a hypothetical situation in which the base rate for malingering is much lower, say only 10 percent. In such a case, for every 1000 defendants only 100 are malingering and 900 are genuinely ill. In this situation our test would correctly identify 90 of the 100 malingerers and would incorrectly identify as malingering 90 (10%) of the 900 nonmalingerers. In other words the test would identify 180 subjects as malingering, half of whom are genuinely ill. If the base rate for malingering is even lower than 10 percent, our 90-percent-accurate test would actually misclassify more mentally ill patients as malingerers than it would correctly classify those who are actually malingering.

Since malingering, unlike psychiatric disorders, is by definition a volitional act, the rate at which individuals malinger is likely to vary from setting to setting, depending on, among other things, the defendant's perception of the cost/benefit ratio of attempting to feign mental illness. Institutions and individual doctors have reputations in the jails and prisons, and inmates may be either encouraged or discouraged to feign symptoms in a particular setting or with a particular examiner. Mittenberg and colleagues[30] surveyed neuropsychologists on rates of suspected malingering in their practices and found some variability related to referral sources. Specifically, individuals referred by defense attorneys in civil matters and by prosecutors in criminal matters were more likely to be identified as probable malingers. Overall, respondents reported that they suspected malingering in 29 percent of personal injury, 30 percent of disability, 19 percent of criminal, and 8 percent of medical cases. Other researchers have found a similar degree of variability in reported cases of possible and definite malingering among surveyed neuropsychologists. Estimated base rates ranged from less than 5 percent to more than 30 percent of individuals seen over the course of one year.[31]

A cutoff score (i.e., the F-scale of the MMPI-2) that may be useful in the assessment of malingering in one context, may lead to highly misleading results in another where the base rate for malingering is much higher or lower than the first. For example, Graham and colleagues[32] recommended a cutoff score of 18 on the MMPI-2 F-scale when making assessments in a normal population, but a cutoff score of 27 for men and 29 for women when conducting assessments in a psychiatric setting. However, not all normal or psychiatric settings are alike, leading to the unwieldy conclusion that cutoff scores should vary from setting to setting and possibly also from clinician to clinician.

The Ethics of Misclassification

Even assuming a high base rate for malingering (as high as 50%) and procedures with 90 percent accuracy, as we noted above, we would still misclassify 50 of 500 or 10 percent of genuinely mentally ill defendants as malingerers. Given that attributions of malingering are often made in legal contexts, one could question whether misclassifying, for example, 10 percent of potential insanity acquittees as malingering, and therefore guilty, is an acceptable outcome. One might ask if it is acceptable to find 10 of 100 innocent defendants guilty. Of course the problem becomes far more acute once the base rate for malingering drops below 50 percent; and if it reaches 10 percent our 90-percent-accurate procedures might actually lead to a finding of guilty for fully half the innocent defendants. At a base rate below 10 percent, more than half of potential insanity acquittees would be misclassified. This possibility should alarm us, given that various studies have found the rate of malingering to be less than 10 percent of both insanity[33] and pretrial evaluees.[34]

In a broader context, possible consequences of the misclassification of malingering outside of the courts include loss of employment benefits or disability income, exclusion from social services programs or remedial education, unemployment, and denial of needed medical or psychological treatment.[20]

Clinician and Interactional Variables in the Assessment of Malingering

As we have noted, there is considerable variability in the frequency with which individual clinicians detect malingering in their patients. Slick and colleagues[31] found that surveyed neuropsychologists also varied on the combination of assessment meth-

ods they typically used to detect malingering. This supports our own experience that clinicians each have their personal equation that influences their attribution of malingering in certain types of patients in a variety of contexts. In a typical forensic setting, there is considerable pressure on the forensic evaluator to identify malingering, or more important, to avoid being fooled by a malingerer. Malingerers are the bad apples of forensic psychiatry and psychology, the manipulators whose very *modus operandi* is to deceive the forensic specialist and undermine his or her work. The successful malingerer, in effect, renders the forensic specialist impotent.

In a subspecialty that prides itself on tough-mindedness and savvy, the successful malingerer makes the forensic psychologist feel like a naïve fool. Thus, there is a built-in motive for forensic psychologists and psychiatrists to set the standard for detecting malingering at a rather low level. To avoid being fooled, the clinician may assume anyone suspected of manipulation to be a malingerer, at nearly any cost. Over the years the senior author has continually observed that young forensic specialists are schooled in the signs of malingering, and they are deemed naïve for taking an individual at his word whom a more senior clinician suspects is malingering. Students quickly learn that it is safer (more respectable) to overdiagnose than to underdiagnose malingering, and there is a certain forensic pride that is achieved in ferreting out a malingerer by almost any means.

Fueling this didactic approach even further may be the common belief among clinicians in forensic settings that psychopaths are especially skilled at malingering. Thus, individuals assumed to have antisocial personality disorder (APD) and who do not score significantly high on indices used to detect malingering may still be suspected of malingering. The logic that one should suspect those with antisocial personalities of malingering was not supported in a study by Poythress et al.[35] who found that male prison inmates identified as having psychopathic traits were not more proficient in their ability to feign mental illness. Our view is that there is what amounts to a certain hysteria, at least in some quarters, in the manner and frequency with which malingering is diagnosed. For many, the malingerer is viewed as a threat to professional identity and must be identified and eliminated from the ranks of those who properly require mental health services. This attitude reflects what Rogers[5] has referred to as the puritanical model of feigned mental illness, a model that he even sees reflected in the DSM guidelines regarding suspected malingering. In particular, justification for the inclusion of "the presence of Antisocial Personality Disorder" (Ref. 3, p 739) as a risk factor for malingering is questionable, as the presence of APD does not preclude genuine mental illness.

The impact of approaching forensic evaluees under the assumption that they are probably malingering may actually create a self-fulfilling prophesy. By constantly being on guard so as not to be fooled by a malingerer, the evaluator develops a hypervigilant clinical stance that prevents him or her from relating to the individual being assessed. This hypervigilance does not go unobserved by the evaluee, who may react by becoming uncooperative. The clinician may then take this uncooperative attitude as verification of his initial suspicions of malingering. For instance, individuals with DID typically retract or deny previous reports of dissociative phenomena if they feel insecure with a clinician whom they may perceive to be doubtful or untrustworthy; consequently, the clinician is likely to feel even more justified in his or her skepticism.[7]

Malingering, rather than being an attribute of certain patients, is perhaps better conceptualized as a kind of interaction between patient and doctor, one that is as much a function of the doctor's attitudes and expectations as the patient's. Very often, an evaluee who appears to be an uncooperative manipulator with a hypervigilant clinician presents as traumatized, while the same patient presents as overwhelmed and depressed with a clinician who is open to hearing his or her pain. Of course, the hypervigilant clinician may interpret this behavior as one more instance of the malingerer's telling his sob story to deceive a naïve clinician. Rogers[5] suggested that such an attitude is tantamount to blaming the victim. Rather than taking a hypervigilant and punitive approach to evaluees suspected of feigning psychological symptoms, our personal and professional dignity is enhanced when we listen to individuals in a manner that might encourage honest disclosure and decrease manipulative behavior.[36] The major point is not only that what looks like malingering from one point of view looks like genuine illness from another, but also that the malingering behavior may very well be created (or eliminated) by the point of view of the clinician who is asked to identify it.

Conclusion

As we have described previously,[1] a more comprehensive, context-sensitive approach is needed to assess malingering and distinguish it from factitious disorders, Ganser syndrome, and related disorders. Given the base rate for malingering and the possibility of making a false-positive attribution, it is essential that the examinee's conduct be placed within the broadest motivational and psychological context possible. Further, given the problems associated with lie detection in forensic assessments (i.e., inadequate methods for the assessment of intentional lying and clinician and interactional variables that influence assessment), forensic evaluators should avoid taking a role themselves in making judgments and instead focus on contributing to much of the data that enter the legal system and add to the broader behavioral and situational context in which judgments are made.

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