

Malingering of Psychiatric Problems, Brain Damage, Chronic Pain, and Controversial Syndromes in a Personal Injury Context

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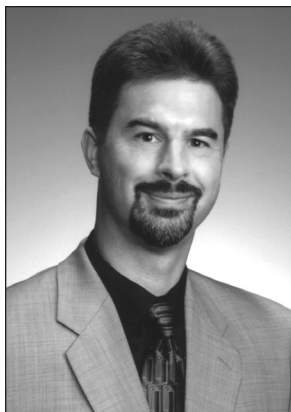
I. INTRODUCTION

Malingering is defined as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives . . .” by the American Psychiatric Association (APA).¹ The APA’s Diagnostic and Statistical Manual further states that, “Malingering should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role.”² Treating clinicians, however, may not know that a patient has such motivations since a patient may not disclose a pending lawsuit. Moreover, in treatment settings, few clinicians have reason to suspect feigned symptoms and few have sufficient training or tools to assess the problem. Not surprisingly, they rarely find it.³

¹ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS IV 739 (4th ed.1994) [hereinafter DSM-IV].

² *Id.* at 467.

³ Edward J. Hickling et al., *Detection of Malingered MVA Related Posttraumatic Stress Disorder: An Investigation of the Ability to Detect Professional Actors by Experienced Clinicians, Psychological Tests, and Psychophysiological Assessment*, 2 J. FORENSIC PSYCHOL. PRAC. 33 (2002); J. Gordon, R. Sanson-Fisher & N.A. Sanders, *Identification of Simulated Patients by Interns in a Casualty Setting*, 22 MED. EDUC. 533 (1988).



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Treatment providers tend to trust their patients. Often, there is no reason for them to do otherwise. A recent survey⁴ tellingly quoted the responses of several pain experts:

“I believe pain is what the person says it is.”

“If he says he is suffering, then he is suffering.”

“Pain is a subjective experience. Experts in pain are taught to believe the patient’s reports. Diagnostic tests are not as useful for pain conditions as other medical problems.”

Two writers, after examining a number of Post Traumatic Stress Disorder (PTSD) claimants who had been held hostage for three hours, stated that, “the victims involved in this incident appear to have been genuine, honest people They were largely a law-abiding group who had previously shown respect for, and trust in, authority.”⁵ Despite the fact that

⁴ Marcus T. Boccaccini et al., *Evaluating the Validity of Pain Complaints in Personal Injury Cases: Assessment Approaches of Forensic and Pain Specialists*, 6 J. FORENSIC PSYCHOL. PRAC. 51 (forthcoming).

⁵ Oscar E. Daly & Timothy G. Johnston, *The Derryhirk Inn Incident: The Psychological Sequelae*, 15 J. TRAUMATIC STRESS 461, 463 (2002).

all were involved in litigation, no assessment of malingering was deemed necessary. The reliance on a claimant's apparent good character is probably ill-founded. A survey of university students, presumably also without significant criminal histories, found that forty-eight percent indicated they would fake symptoms following an accident to recover more money in a personal injury lawsuit.⁶

Treatment providers sometimes have been very reluctant to acknowledge the possibility of faking or exaggeration, even with those patients involved in litigation. A recent authoritative work on chronic pain contains no chapter on malingering or exaggeration.⁷ When the *Clinical Journal of Pain* published a recent special issue on malingering in pain patients, several contributors opined that malingering is infrequent in pain populations, although one grudgingly admitted that rates *may* be higher in litigating populations.⁸ By contrast, a recent survey of psychologists who evaluate pain patients involved in litigation estimated that approximately thirty percent were engaging in exaggeration or malingering.⁹ While some researchers have investigated techniques to detect malingering, treatment issues remain the primary concern (with a dash of advocacy as reflected in their characterization): "Despite the sometimes pressing need to acquire assessment data from the *victim*, the ultimate issue is the *victim's* continuing well-being and the importance of avoiding any further harm."¹⁰

In contrast to treating professionals, forensic psychologists consider malingering assessment a crucial element of their craft and routinely test for it. Because this situation potentially places the examiner in opposition to the examinee's interests, evaluation in forensic settings is viewed as a professional specialty that is incompatible with providing treatment.¹¹ Other differences between forensic evaluators (who may be clinical, forensic, or clinical neuropsychologists) and treating clinicians are summarized in Table 1 (adapted from S.A. Greenberg & D. W. Shuman, 1997).¹²

⁶ Grant L. Iverson, *A Comment on the Willingness of People to Malingering Following Motor Vehicle or Work-Related Injuries*, J. COGNITIVE REHAB., May/June 1996, at 10.

⁷ HANDBOOK OF PAIN ASSESSMENT (Dennis C. Turk & Ronald Melzack eds., 2d ed. 2001).

⁸ Mark Sullivan, *Exaggerated Pain: By What Standard?*, 20 CLINICAL J. PAIN 433 (2004).

⁹ Wiley Mittenberg et al., *Base Rates of Malingering and Symptom Exaggeration*, 24 J. CLINICAL & EXPERIMENTAL NEUROPSYCHOL. 1094 (2002).

¹⁰ JOHN BRIERE, PSYCHOLOGICAL ASSESSMENT OF ADULT POSTTRAUMATIC STATES 59 (American Psychological Association 2002) (emphasis added).

¹¹ Stuart A. Greenberg & Daniel W. Shuman, *Irreconcilable Conflict between Therapeutic and Forensic Roles*, 28 J. PROF. PSYCHOL.: RES. & PRAC. 50 (1997).

¹² *Id.*

Table 1
Differences between Treatment and Forensic Roles in Psychology

	Therapists	Forensic Examiners
The Client Identified	Patient	Attorney or the Court
Goals	Provide treatment and support	Objectively evaluate a defendant or claimant
Data	Accept what the client says	Corroborate or refute examinee's statements with collateral information
Emphasis	Treatment; "helping"	Assessment of psycho-legal issue at stake
Trust	Assume basic honesty of patient	Do not blindly trust any source
Accountability	Anticipate little challenge to conclusions, diagnoses	Anticipate cross-examination, consider alternative hypotheses, explanations
Privilege	Governed by therapist-client privilege	Governed by attorney-client privilege, if any
Knowledge of legal issues	May be unaware of legal standards or rules of evidence	Familiar with case law governing the issue to be addressed, (i.e., <i>Daubert</i> and Federal Rules of Evidence standards)
Attitude	Avoid court appearances	Accept legal proceedings as part of the work; develop testimony skills

This article will review issues pertaining to malingering psychiatric and cognitive impairment in a personal injury context. As such, it will discuss the techniques available and examine syndromes where defense counsel frequently may face psychiatric faking or exaggeration: head injury, PTSD, depression, chronic pain, and controversial diagnoses.

II. ASSESSING FOR MALINGERING

Before proceeding, it is important to understand that not all dramatization or even intentional failure necessarily qualifies as malingering. *Factitious disorder* involves the intentional production of symptoms, but only for the purpose of being treated as a sick person – not external incentives as in malingering. However, the diagnoses are not mutually exclusive. For example, a man who fears losing his wife might exaggerate his health problems in order to gain her sympathy. If this continues over time, his wife may press him to apply for disability or to litigate in order to compensate for loss of income. In such a case, the husband may have no interest in the financial outcome, but he may fear exposure to his wife.

Two other diagnostic possibilities include *conversion disorder* and *somatoform disorder*. In conversion disorder, it is thought that the symptom is produced unconsciously as part of a hysterical personality style to cope with a psychological conflict. However, this proposition has never been rigorously tested and it is quite possible that even such personalities are aware of their exaggerations. In somatoform disorder, the symptoms are believed to be part of a neurotic personality style that indirectly expresses needs for nurturance through bodily complaints. Thus, the desired reward is attention or sympathy from family members, friends, or medical staff. An alternative, less psychodynamic explanation is that such persons are biologically disposed to experience more negative emotions and negative bodily sensations than most people. People who are neurotic tend to be relatively dissatisfied with their health, as well as their employment or marriage.¹³ They may well experience more unpleasant bodily sensations than most people, particularly as they approach middle age – or they may just complain more than others.

Thorough assessment of malingering usually will involve multiple interviews with the claimant (as opposed to “patient”), review of previous medical and psychiatric records, interviews of family members and collaterals with no apparent loyalty to the examinee (e.g., ex-wife, ex-employer), and specialized psychological testing. Observations beyond the examination room also can be very revealing. Although family members can be very useful, the possibility of collusion with the plaintiff must be considered, and family members almost always should be interviewed separately from each other and the claimant.

Two types of testing are likely to be useful in a personal injury context. These include self-report tests of symptom exaggeration and performance tests of intentional poor performance or incomplete effort.

¹³ ROBERT R. McCRAE & PAUL T. COSTA, JR., *PERSONALITY IN ADULTHOOD* (2d ed. 2002).

A. *Self-Report Tests of Symptom Exaggeration*

Tests such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) ask hundreds of questions about psychiatric symptoms and problems. The test itself has a number of embedded indices of response consistency and bias. There are scales that are quite sensitive to some forms of both faking good (denying any faults or problems) and faking bad (exaggerating or faking symptoms). Some of these indices are automatically scored by the primary software vendor, but some are not. The classic “fake bad” scale is the Infrequency (F) scale, consisting of items that are rarely endorsed by people without psychiatric illness. It contains some items suggestive of psychosis, but also contains many items that are just odd and not closely associated with any clinical syndrome. Although there is ample evidence that persons who feign psychosis score much higher than both normals and psychiatric patients, various studies on the F scale recommend widely varying cut-scores to separate honest responders from malingerers. This is problematic, as is the fact that the F scale contains many items that are reflective of true mental illness. The Infrequency-Psychopathology (Fp) scale was created to overcome these limitations. It has produced consistent cut-scores across studies and has demonstrated effectiveness at distinguishing true from feigned depression as well.¹⁴

Personal injury claimants often report memory and bodily symptoms to a greater degree than severe psychiatric problems. Those who exaggerate tend to maintain the same pattern but to produce more elevated MMPI-2 profiles in general.¹⁵ A number of studies have examined the ability of various MMPI-2 scales to distinguish legitimate from feigned brain injuries, chronic pain, and PTSD. The results indicate that the best-established traditional validity indexes (F, F-K, Fp) are not very sensitive to exaggeration of these conditions. This may be because the indexes mostly contain items suggesting psychosis or extreme deviance, neither of which a litigating plaintiff wants to portray. A more desirable presentation is that of a good, upstanding person who has suffered a very bad injury. One such “aftermarket” index, the Fake Bad Scale (FBS), was developed specifically for personal injury claimants and has shown considerable success in distinguishing feigned head injuries,¹⁶ chronic pain,¹⁷

¹⁴ Richard Rogers et al., *Detection of Feigned Mental Disorders: A Meta-Analysis of the MMPI-2 and Malingering*, 10 *ASSESSMENT* 160 (2003).

¹⁵ *Id.*

¹⁶ Scott R. Ross et al., *Detecting Incomplete Effort on the MMPI-2: An Examination of the Fake-Bad Scale in Mild Head Injury*, 26 *J. CLINICAL & EXPERIMENTAL NEUROPSYCHOL.* 115 (2004); Chantel S. Dearth et al., *Detection of Feigned Head Injury Symptoms on the MMPI-2 in Head Injured Patient and Community Controls*, 20 *ARCHIVES CLINICAL NEUROPSYCHOL.* 95 (2005); M. Frank Greiffenstein et al., *The Fake Bad Scale in Atypical and Severe Closed Head Injury Litigants*, 58 *J. CLINICAL PSYCHOL.* 1591 (2002).

¹⁷ Glenn J. Larrabee, *Exaggerated Pain Report in Litigants with Malingered Neurocognitive Dysfunction*, 17 *CLINICAL NEUROPSYCHOLOGIST* 395 (2003) [*hereinafter Exaggerated Pain Report*]; Glenn J. Larrabee, *Somatic Malingering on the MMPI and MMPI-2 in Personal Injury Litigants*, 12 *CLINICAL NEUROPSYCHOLOGIST* 179 (1998); John E. Meyers et al., *A Validity Index for the MMPI-2*, 17 *ARCHIVES CLINICAL NEUROPSYCHOL.* 157 (2002).

mixed personal injury claimants,¹⁸ and (in some studies) PTSD.¹⁹ While the FBS scale has engendered some recent controversy,²⁰ there are many published studies and a recent meta-analysis that support its validity and use in forensic settings.²¹

Several other MMPI-2 indices have been shown useful. These include the Ds scale (and its short form, Dsr), which assess erroneous stereotypes of neurotic mental illness, and the Ego Strength scale, which reflects emotional stability and resilience. While the Ego Strength scale and the traditional validity scales are scored by the primary software vendor for the MMPI-2, the FBS and Ds/Dsr are not. Thorough assessment of symptom over-reporting in conditions such as head injury, PTSD, and chronic pain requires use of these specialized MMPI-2 scales in addition to F, F-K, and Fp. An examiner should not conclude that an MMPI-2 is “valid” in a personal injury setting simply because the traditional validity indicators are not elevated. In fact, one could argue that the examiner should never make such a statement since it is possible that successful coaching might result in an inaccurate presentation that escapes detection on any of the validity indices.

¹⁸ William T. Tsushima & Vincent G. Tsushima, *Comparison of the Fake Bad Scale and Other MMPI-2 Validity Scales with Personal Injury Litigants*, 8 *ASSESSMENT* 205 (2001); Glenn J. Larrabee, *Detection of Symptom Exaggeration with MMPI-2 in Litigants with Malingered Neurocognitive Dysfunction*, 17 *CLINICAL NEUROPSYCHOLOGIST* 54 (2003); Glenn J. Larrabee, *Exaggerated MMPI-2 Symptom Report in Personal Injury Litigants with Malingered Neurocognitive Deficit*, 18 *ARCHIVES CLINICAL NEUROPSYCHOL.* 673 (2003).

¹⁹ M. Frank Greiffenstein et al., *The Fake Bad Scale and MMPI-2 F-Family in Detection of Implausible Psychological Trauma Claims*, 18 *CLINICAL NEUROPSYCHOLOGIST* 573 (2004); Paul R. Lees-Haley, *Efficacy of MMPI-2 and MCMI-II Modifier Scales for Detecting Spurious PTSD Claims: F, F-K, Fake Bad Scale, Ego Strength, Subtle-Obvious Subscales, DIS, and DEB*, 48 *J. CLINICAL PSYCHOL.* 681 (1992).

²⁰ Jim N. Butcher et al., *The Construct Validity of the Lees-Haley Fake Bad Scale (FBS): Does the Scale Measure Somatic Malingering and Feigned Emotional Stress?*, 18 *ARCHIVES CLINICAL NEUROPSYCHOL.* 473 (2003); Paul R. Lees-Haley & David D. Fox, *Commentary on Butcher, Arbisi and McNulty (2003) on the Fake Bad Scale*, 19 *ARCHIVES CLINICAL NEUROPSYCHOL.* 333 (2004); Kevin W. Greve, *Response to Butcher et al., The Construct Validity of the Lees-Haley Fake Bad Scale*, 19 *ARCHIVES CLINICAL NEUROPSYCHOL.* 337 (2004); Paul A. Arbisi & James N. Butcher, *Failure of the FBS to Predict Malingering of Somatic Symptoms: Response to Critiques by Greve and Bianchini and Lees-Haley and Fox*, 19 *ARCHIVES CLINICAL NEUROPSYCHOL.* 341 (2004).

²¹ Lees-Haley & Fox, *supra* note 20. See also Nathaniel W. Nelson, Jerry J. Sweet, & George J. Demakis, *Meta-Analysis of the MMPI-2 Fake Bad Scale: Utility in Forensic Practice*, 20 *CLINICAL NEUROPSYCHOLOGIST* 39-58 (2006).

Table 2
Some Major MMPI-2 Indexes Used to Detect Malingering

Index	Description	Typical Cut-Score
F	(Infrequency Scale). Items that are rarely endorsed by “normal” people who are not psychiatric patients. May be elevated by careless responding or intentional faking of psychiatric disorder, especially psychosis.	> 80
F(b)	Same as F scale, but designed for items on the back side of the answer sheet. Helps identify protocols where the subject loses interest mid-way and randomly completes the remaining test.	> 80
F(p)	Items that are rarely endorsed by psychiatric patients – a more specific version of F; includes fewer legitimate symptoms of psychiatric illness than F.	> 75
K	A measure of defensiveness; possibly more stable and enduring than L (not due to impression management). It is inversely related to malingering.	< 35
F-K	The raw score of K subtracted from the raw score of F.	> 5 R
O-S	The sum of “obvious” items (“I hear voices”) minus the sum of subtle items (“I think Washington was greater than Lincoln”).	> 140
Ds /Dsr	(Dissimulation Scale and its short form). Items that reflect erroneous stereotypes of neuroticism (vs. serious mental illness).	>35 R > 70 T
Es	(Ego Strength). Low scores indicate that the subject reported he/she lacks emotional stability and resilience. Very low scores suggest exaggeration.	< 20
FBS	(Fake Bad Scale). Designed to identify faking in personal injury claimants; its items include reports of bodily complaints combined with a portrayal of oneself as an honest and virtuous person.	> 20-27 R
MVI	(Meyer’s Validity Index). An index created by assigning 1 or 2 points to indications on seven other indices, such as F, FBS, and Ds.	> 5 R
RBS	(Response Bias Scale). Created by identifying items that correlate with failure on the Word Memory Test.	> 21 R

Scores in this table are T scores (Mean = 50, SD =10), unless otherwise noted (“R” – raw score). Most cut-scores in this table are taken from Greve, 2005. Some authors utilize considerably higher cut-scores, especially for the F scales.

Other instruments that are useful for evaluating over-reporting or exaggeration in other contexts include the Structured Inventory of Reported Symptoms and the Miller Forensic Assessment of Symptoms Test (both structured interviews) as well as the Personality Assessment Inventory. However, all of these instruments were developed and validated primarily to detect feigned psychosis and not the kinds of complaints typical of personal injury plaintiffs. At this point, the MMPI-2 has no real rivals for detecting over-reporting of symptoms in personal injury settings, except for patients with chronic pain cases.²²

B. *Performance Tests of Suboptimal Effort/Motivated Failure*

The second type of testing involves assessing the effort expended on tasks which require the examinee to solve a mental problem, remember information, or exhibit a competence. Neuropsychological and intelligence tests assume that the test-taker puts forth his or her best effort. This assumption is highly suspect in situations where a criminal defendant may be found eligible for the death penalty or a civil plaintiff may be ineligible for compensation as a result of good performance on a test. There has been a virtual explosion of interest and development of tests designed to detect inadequate effort or intentional failure. Most are moderately sensitive (they will detect most though not all feigners) but highly specific (few if any legitimate patients will fail them). For this reason, using at least two and preferably three effort tests is recommended.²³ However, two recent tests have shown perfect sensitivity and specificity in published studies. This is truly a milestone. Nonetheless, given the possibility of coaching by plaintiffs’ attorneys²⁴ as the specific tests become better known, it is also prudent to utilize malingering indices that are embedded within traditional tests, such as the WAIS-III. Several such indices have been cross-validated and demonstrate accuracy of classification in the seventy-five to eighty-five percent range.²⁵

²² See Section F., *infra*.

²³ National Academy of Neuropsychology Policy & Planning Committee (2005), *Symptom Validity Assessment: Practice Issues and Medical Necessity*, 20 ARCHIVES CLINICAL NEUROPSYCHOL. 419 (2005); John E. Meyers & Marie E. Volbracht, *A Validation of Multiple Malingering Detection Methods in a Large Clinical Sample*, 18 ARCHIVES CLINICAL NEUROPSYCHOL. 261 (2003); Glenn J. Larabee, *Detection of Malingering Using Atypical Performance Patterns on Standard Neuropsychological Tests*, 17 CLINICAL NEUROPSYCHOLOGIST 410 (2003); Chad D. Vickery et al., *Head Injury and the Ability to Feign Neuropsychological Deficits*, 19 ARCHIVES CLINICAL NEUROPSYCHOL. 37 (2004).

²⁴ Martha W. Wetter & Susan K. Corrigan, *Providing Information to Clients about Psychological Tests: A Survey of Attorneys’ and Law Students’ Attitudes*, 26 PROF. PSYCHOL.: RES. & PRAC. 474 (1995).

²⁵ Kevin W. Greve et al., *Detecting Malingered Performance on the Wechsler Adult Intelligence Scale: Validation of Mittenberg’s Approach in Traumatic Brain Injury*, 18 ARCHIVES CLINICAL NEUROPSYCHOL. 245 (2003).

Since specific information about detecting poor effort could greatly facilitate coaching if it fell into the wrong hands, this article will not provide such material and will otherwise provide only selected references. As an alternative, the article will familiarize the reader with some of the factors that should be considered when reviewing a psychological or neuropsychological report. It also will provide guidelines for selecting an appropriate expert, suggesting questions to pose at the outset before retaining such an expert as well.

There currently are a number of specialized, well-researched tests designed to detect effort or intentional failure. Some of the best validated instruments include the Test of Memory Malingering, the Word Memory Test, the Computerized Assessment of Response Bias, the Portland Digit Recognition Test, and the Victoria Symptom Validity Test. Aside from head injury, patients with many conditions (depression, chronic fatigue, chronic pain, fibromyalgia) complain of cognitive symptoms, especially poor memory and concentration. They also show substantial rates of apparent malingering on effort tests when assessed in the context of litigation (see Table 3). For these reasons, effort tests should be included in any evaluation of memory or cognitive complaints or when test results are used to make such claims.

Table 3
Rate of Apparent Malingering in Various Diagnostic Groups in Litigation

Mild head injury	42%
Fibromyalgia or Chronic Fatigue Syndrome	39%
Pain/somatoform disorder	33%
Neurotoxic disorders	29%
Electrical injury	26%
Depressive Disorders	16%
Moderate & severe head injury	9%

Adapted from Mittenberg et al. (2002)²⁶

III. ASSESSING COMMON CLINICAL SYNDROMES FOR EXAGGERATION OR MALINGERING

A. *Traumatic Brain Injury*

Unlike the other conditions discussed below, cognitive deficits often are the primary claim for damages in alleged brain injury. Thorough neuropsychological assessment will

²⁶ Wiley Mittenberg et al., *Base Rates of Malingering and Symptom Exaggeration*, 24 J. CLINICAL EXPERIMENTAL & NEUROPSYCHOL. 1094 (2002).

likely be necessary, and this should always entail assessment of effort and intentional failure. The National Academy of Neuropsychology recently issued a formal policy statement that symptom validity (effort) testing is medically necessary for all neuropsychological evaluations.²⁷ Performance on neuropsychological measures of attention, memory, and other cognitive and motor functions depend greatly on the amount of effort expended; in the absence of demonstrated good effort, results may be meaningless or highly misleading.²⁸

There are two major types of brain injuries: closed head injuries, in which the skull is not breached, and open head injuries, such as those that accompany a gunshot wound to the head. Paradoxically, closed head injuries can be more serious because they typically affect larger portions of the brain. Because the brain is gelatinous and not securely attached to the skull, a motor vehicle accident or other sharp blow to the head can result in injuries throughout the brain as it literally bounces off the inside of the skull and shears neural connections to the spinal cord and lower brain centers. This article will focus primarily on closed head injuries.

Head injuries are classified in terms of their severity according to several factors. Among the most important are medical findings (CT, MRI scans); the length of any period of unconsciousness; the period of post-traumatic amnesia (period of memory loss following the injury); and the length of time after the injury until the patient is capable of following a verbal command. Increasingly, emergency rooms and hospitals formally record these observations in the form of a standardized scale such as the Glasgow Coma Scale. Mild head injuries are those that result in less than one-half hour of unconsciousness, a Glasgow Coma Scale score of thirteen to fifteen, and do not produce abnormal findings on the CAT or MRI scan. Since such claims often will be made in the absence of objective medical findings, and evidence of substantial rates of exaggeration or malingering exists in this population,²⁹ this article will further focus on mild head injuries.

Victims of head injuries often are reported to suffer from *Postconcussion Syndrome*. Its symptoms include memory difficulties, fatigue, headaches, confusion, difficulties multitasking, and depression. Not surprisingly, when such symptoms follow a head injury, they are often attributed to this cause. Recent research, however, finds that the level of postconcussion symptoms is not predicted by seriousness of head injury but by the patient's degree of depression.³⁰ In fact, the same group of symptoms appear in a number of ill-defined and

²⁷ National Academy of Neuropsychology Policy and Planning Committee, *supra* note 23.

²⁸ Paul Green et al., *Effort Has a Greater Effect on Test Scores than Brain Injury in Compensation Claimants*, 15 *BRAIN INJURY* 1045 (2001); Paul Green et al., *The Word Memory Test and the Validity of Neuropsychological Test Scores*, 2 *J. FORENSIC NEUROPSYCHOL.* 97 (2002).

²⁹ Mittenberg et al., *supra* note 26.

³⁰ John Gunstad & Julie A. Suhr, "Expectation as Etiology" versus "The Good Old Days": *Postconcussion Syndrome Symptom Reporting in Athletes, Headache Sufferers, and Depressed Individuals*, 7 *J. INT'L NEUROPSYCHOL. SOC'Y* 323 (2001); John Gunstad & Julie A. Suhr, *Factors in Postconcussion Syndrome Symptom Report*, 19 *ARCHIVES CLINICAL NEUROPSYCHOL.* 391 (2004).

controversial disorders.³¹ Symptoms such as reported memory problems and others associated with postconcussion syndrome are not specific to any particular disorder and have little or no diagnostic value.

In the overwhelming majority of cases, the expected outcome from a mild traumatic brain injury (with no abnormality on medical tests or subsequent complication) is complete recovery within three months.³² Although there have been some reports of persisting deficits in concentration or memory past this time, such deficits disappear when patients who fail effort tests are excluded from the group.³³ Psychologists have only recently taken full account of how malingering or exaggeration may have contaminated previous conclusions about the course of recovery from head injury. If one-third of such patients are malingering, this could easily result in the false conclusion that persisting deficits are common.

Among the most important pieces of data in assessing head injury are the emergency room records. These should indicate observations of the patient in the immediate aftermath of the injury. By definition, if the patient is alert, responsive, and not confused within the first half hour; does not show a skull fracture or abnormal CAT or MRI; and does not experience a subsequent complication such as a hematoma, the head injury is mild and full recovery to previous levels of functioning is expected. It is not uncommon for those who exaggerate or malingering to misreport their level of impairment during the first few days or weeks following the injury. And although this paper will focus on mild traumatic head injury (MTBI), it should be noted that even some patients suffering moderate and severe injuries may exaggerate or fake, as several recent case studies have demonstrated.³⁴

The amount of impairment from a head injury should be proportionate to its severity: a mild head injury should produce mild deficits (if any); a severe injury, more significant ones. In the absence of a subsequent complication, the expected recovery course from a head injury is one of progressive improvement – impairment should be worst immediately after the injury and improvement should be fairly steady. This does not apply, of course, if a patient subsequently develops a hematoma (blood mass), and may not apply if depression complicates the picture. In the latter case, of course, the deficits observed should not be attributed to brain damage.

³¹ Laurence M. Binder, *Forensic Assessment of Medically Unexplained Symptoms*, in FORENSIC NEUROPSYCHOLOGY: A SCIENTIFIC APPROACH 298 (Glenn J. Larrabee ed., 2005).

³² David J. Schretlen & Anne M. Shapiro, *A Quantitative Review of the Effects of Traumatic Brain Injury on Cognitive Functioning*, 15 INT'L REV. PSYCHIATRY 341 (2003); Laurence Binder et al., *A Review of Mild Head Trauma Part 1: Meta-analytic Review of Neuropsychological Studies*, 19 J. CLINICAL & EXPERIMENTAL NEUROPSYCHOL. 421 (1997); Sureyya S. Dikman et al., *Neuropsychological Outcome at 1-year Post Head Injury*, 9 NEUROPSYCHOLOGY 80 (1995).

³³ Green et al., *supra* note 28.

³⁴ Kevin J. Bianchini et al., *Definite Malingered Neurocognitive Dysfunction in Moderate/Severe Traumatic Brain Injury*, 17 CLINICAL NEUROPSYCHOLOGIST 574 (2003).

There are numerous validated techniques to assess the genuineness of a head injury claimant's presentation. Typically, neuropsychological testing will be the major focus of a psychologist's evaluation in a head injury case. Neuropsychological testing involves assessment of intellectual, motor, and cognitive functions such as attention, memory, and perception. A typical assessment may take more than twelve hours and involve many tests, some of which have dozens of individual indices. There is increasing evidence that, when formally evaluated, patterns of performance within tests can identify those who exaggerate or fake with moderately high levels of sensitivity and specificity. Specific indices have been identified and cross-validated for the Wechsler Adult Intelligence Scale-III and the California Verbal Learning Test, two very popular neuropsychological instruments. Sometimes a patient will provide highly unusual responses that can serve as red flags of atypical performance. Such indicators have been identified for the popular Trail Making Test and the Wechsler Memory Scale-III. These anomalies are highly specific (highly diagnostic of faking when they occur), but are produced by relatively few malingerers. Thus, they have low sensitivity. Relying on only one or a few such indicators will fail to identify many of those who do not exert their best effort.

If multiple evaluations have occurred, comparisons between the two or more evaluations can be highly informative. Formal research using both test scores and item responses, compared across the two administrations, has displayed perfect classification in one study — something rarely achieved in psychological research.

Although most tests employed to assess brain damage are performance-based measures, there is an increasing role for self-report inventories such as the MMPI-2. Although the traditional validity indices have poor sensitivity when usual cut-scores (which were developed for detecting feigned psychosis) are used, they can perform respectfully when cut-scores derived in personal injury settings are implemented.³⁵ The FBS scale has been the subject of nearly a dozen studies with generally positive results, and some have found it to be the best response bias scale for head injury claimants.³⁶ Several studies also have found the Dsr scale to be quite useful.³⁷

³⁵ Kevin W. Greve et al., *Sensitivity and Specificity of MMPI-2 Validity Scales and Indicators to Malingered Neurocognitive Dysfunction in Traumatic Brain Injury*, 20 *CLINICAL NEUROPSYCHOLOGIST* (forthcoming).

³⁶ Larrabee, *supra* note 18; Griffenstein et al., *supra* note 19; Ross et al., *supra* note 16.

³⁷ Greve, et al., *supra* note 25; Dearth et al., *supra* note 16; Larrabee, *supra* note 18.

B. PTSD

When introduced in the Diagnostic and Statistical Manual-III (DSM-III) in 1980, a diagnosis of PTSD required a stressor that was life-threatening, beyond ordinary human experience, and likely to evoke significant distress in nearly everyone. In DSM-IV, the criteria were modified to include someone “who experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others [if] the person’s response involved intense fear, helplessness, or horror.”³⁸ Originally proposed in the Vietnam era to cover combat veterans,³⁹ “criterion creep” had led to suits alleging PTSD due to sexual harassment or exposure to repeated foul language at work – and the latter was successful to the tune of \$21 million.⁴⁰ Despite an enthusiastic embrace by “traumatologists,” more scholarly professionals have emphasized the political origins of the diagnosis and numerous facts and findings that contradict the clinicians’ assumptions.⁴¹

Published estimates of malingering rates following personal injury vary from one to over fifty percent.⁴² Following the Vietnam War, the government printed flyers to help veterans recognize characteristic symptoms and prompt them to apply for allocated benefits. Among the symptoms of PTSD intended for listing was “survivor’s guilt.” However, a printing error in one region resulted in a number of veterans who showed up to file their claims carrying their “survivor’s *quilt*.” Some veterans claiming PTSD have been found never to have experienced combat or, in some cases, never even to have been in the armed services.⁴³

Almost from the beginning, observers have commented on the tendency of PTSD patients to produce evaluated scores on MMPI validity indices. At first, many viewed this as a function of the severity of the disorder and the variety of its symptoms. Over time, however, others commented that the extremely pathological test scores observed were inconsistent with the

³⁸ DSM-IV, *supra* note 1, at 467.

³⁹ Ben Shepard, *Risk Factors and PTSD: A Historian’s Perspective*, in POSTTRAUMATIC STRESS DISORDER: ISSUES AND CONTROVERSIES 39 (G. M. Rosen ed. 2004); D. Christopher Frueh et al., *Unresolved Issues in the Assessment of Trauma Exposure and Posttraumatic Reactions*, at 63.

⁴⁰ Richard J. McNally, *Conceptual Problems with the DSM-IV Criteria for Posttraumatic Stress Disorder*, in POSTTRAUMATIC STRESS DISORDER: ISSUES AND CONTROVERSIES 1 (G. M. Rosen ed. 2004).

⁴¹ *Id.*

⁴² Jennifer Gurriel & William Fremouw, *Assessing Malingered Posttraumatic Stress Disorder: A Critical Review*, 23 CLINICAL PSYCHOL. REV. 881 (2003).

⁴³ Richard J. McNally, *Progress and Controversy in the Study of Posttraumatic Stress Disorder*, 54 ANN. REV. PSYCHOL. 229 (2003); B. Christopher Frueh et al., *Apparent Symptom Overreporting in Combat Veterans Evaluated for PTSD*, 20 CLINICAL PSYCHOL. REV. 853 (2000); Jeannine; Monnier, Todd B Kashdan, Julie A Sauvageot, Mark B Hamner, B. G. Burkett, & George W. Arana, *Documented Combat Exposure of US Veterans Seeking Treatment for Combat-Related Post-Traumatic Stress Disorder*, 186 BRIT. J. PSYCHIATRY 467-72 (2005).

outpatient status of most PTSD patients, and that the disability rate far exceeded that seen in previous wars or tragedies.⁴⁴ In the *Aleutian Enterprise* sinking, eighty-six percent of survivors reported PTSD symptoms, far exceeding the more typical figures of twenty-five to forty percent in similar tragedies. Post-litigation interviews with these claimants, however, found that most had communicated with other claimants and were coached by attorneys.⁴⁵

A distinct literature has developed for survivors of motor vehicle accidents.⁴⁶ Like many treating clinicians, these authors appear overly trusting about their patients' honesty: they discount MMPI-2 findings believing they may falsely label their patients as exaggerating and do not collect medical records—although they advise others to do so.⁴⁷

The literature on PTSD may be badly compromised by the failure of researchers to rigorously screen for malingering among presenting patients.⁴⁸ This failure potentially contaminates much of what is known about the disorder. For example, one correlate of PTSD is antisocial personality disorder, which denotes a personality style marked by deception, exploitation, and substance abuse. Authors often refer to antisocial behavior and drug use as a consequence of PTSD without making any serious attempt to determine if such traits were present before the alleged injury. Further, antisocial personality disorder is one of four DSM-IV indicators of potential malingering. The failure to consider malingering has resulted in a published recommendation that journal editors demand disclosure of the litigation status of study participants, and that those with incentives to exaggerate be identified and (at a minimum) analyzed separately from those without such motivations.⁴⁹ Some general indicators of possible PTSD malingering are listed in Table 3. With the exception of “unvarying, repetitive dreams,” these apply to other disorders as well.

⁴⁴ *Id.*

⁴⁵ Gerald M. Rosen, *The Aleutian Enterprise Sinking and Posttraumatic Stress Disorder: Misdiagnosis in Clinical and Forensic Settings*, 26 PROF. PSYCHOL.: RES. & PRAC. 82 (1995).

⁴⁶ EDWARD B. BLANCHARD & EDWARD J. HICKLING, *AFTER THE CRASH: PSYCHOLOGICAL ASSESSMENT AND TREATMENT OF SURVIVORS OF MOTOR VEHICLE ACCIDENTS* (2d ed. 2004).

⁴⁷ *Id.*

⁴⁸ Gerald M. Rosen, *Malingering and the PTSD Data Base*, in *POSTTRAUMATIC STRESS DISORDER: ISSUES AND CONTROVERSIES* 85 (G. M. Rosen ed. 2004); Gerald M. Rosen, *Litigation and Reported Rates of Posttraumatic Stress Disorder*, 36 PERSONALITY & INDIVIDUAL DIFFERENCES 1291 (2004); McNally, *supra* note 43, at 225.

⁴⁹ Gerald M. Rosen, *Litigation and Reported Rates of Posttraumatic Stress Disorder*, *supra* note 48.

Table 3
Indications of Possible PTSD Malingering

Poor work record
Prior incapacitating injuries
Discrepant capacity for work and recreation
Unvarying, repetitive dreams
Antisocial personality traits
Overidealized functioning before the trauma
Evasiveness
Inconsistency in symptom presentation ⁵⁰

Some PTSD experts built their reputations by developing checklists or interview schedules to identify PTSD patients and to help them fully describe their experiences and symptoms. This focus on “finding” the disorder has helped create a culture in which the validity of PTSD reports is largely assumed. The program for the 20th annual meeting of the International Society for Traumatic Stress Studies makes no mention of malingering in any of its dozens of trauma symposia. One researcher reported that his efforts to develop a measure of PTSD malingering were met with hostility by one PTSD pioneer.⁵¹

C. *Assessment of Malingering in PTSD*

Most PTSD diagnostic interviews and self-report scales represent straightforward queries about symptoms and allow motivated persons to present themselves as having the requisite symptoms to meet the diagnostic criteria.⁵² Few instruments have any means to detect exaggeration or unreliable responding. One such interview schedule, the *Clinician Administered PTSD Scale*, has a consistency scale to assess unreliable responding, but the only study that examined its utility found it completely ineffective at identifying exaggeration.⁵³ The

⁵⁰ Philip J. Resnick, *Guidelines for Evaluation of Malingering in PTSD*, in POSTTRAUMATIC STRESS DISORDER IN LITIGATION 194 (R.I. Simon ed. 2003).

⁵¹ Personal Communication from Kenneth R. Morel (on file with the author) (2004).

⁵² C. Burges & T. M. McMillan, *The Ability of Naïve Participants to Report Symptoms of Post-traumatic Stress Disorder*, 40 BRIT. J. CLINICAL PSYCHOL. 209 (2001); Edward J. Hickling et al., *Detection of Malingered MVA Related Posttraumatic Stress Disorder: An Investigation of the Ability of Professional Actors by Experienced Clinicians, Psychological Tests and Psychological Assessment*, 2 J. FORENSIC PSYCHOL. PRAC. 33 (2002).

⁵³ Hickling, et al., *supra* note 52, at 42.

Atypical Responding Scale on the *Trauma Symptom Inventory*, a self-report inventory, has shown only mixed results.⁵⁴

The MMPI-2 has two scales, PS and PK, which are designed to assess PTSD symptoms. These scales, however, appear highly sensitive to general distress and are not specific to PTSD.⁵⁵ More useful are the MMPI-2 validity scales, which are capable of distinguishing malingerers from those with genuine PTSD. Although several studies found the Fp scale to be the most effective scale and the FBS scale to be ineffective,⁵⁶ these studies had serious design flaws: they compared students asked to simulate PTSD with claimants or veterans (who are eligible for permanent disability and have a very high incidence of malingering⁵⁷) diagnosed with PTSD – but the claimants were not assessed for malingering! The effectiveness of Fp with better-designed studies is mixed,⁵⁸ with one such study showing FBS to be the only valid indicator.⁵⁹ Another found both traditional indices and FBS to effectively separate simulators or pseudo-PTSD patients (those claiming PTSD symptoms but lacking a qualifying stressor).⁶⁰ Lastly, although knowledge of PTSD symptoms may help a claimant present a convincing facade in a face-to-face interview or on self-report scales, such knowledge does not help feigners evade detection on the MMPI-2 validity scales.⁶¹

Another test, specifically developed to distinguish feigned PTSD, is the *Morel Emotional Numbing Test* (MENT). Norms are available for legitimate PTSD patients (and other

⁵⁴ John F. Edens et al., *Susceptibility of the Trauma Symptom Inventory to Malingering*, 71 J. PERSONALITY ASSESSMENT 379 (1998); Gerald M. Rosen et al., *The Risk of False Positives When Using ATR Cut-Scores to Detect Malingered Posttraumatic Reaction on the Trauma Symptom Inventory (TSI)*, 86 J. PERSONALITY ASSESSMENT 329 (2006); Jennifer Guriel et al., *Impact of Coaching on Malingered Posttraumatic Stress Symptoms on the M-FAST and the TSI*, 4 J. FORENSIC PSYCHOL. PRAC. 37 (2004).

⁵⁵ Susanne Scheibe et al., *Assessing Posttraumatic Disorder with the MMPI-2 in a Sample of Workplace Accident Victims*, 13 PSYCHOL. ASSESSMENT 369 (2001).

⁵⁶ Jon D. Elhai et al., *The Detection of Malingered Posttraumatic Stress Disorder with MMPI-2 Fake Bad Indices*, 8 ASSESSMENT 221 (2001); Jon D. Elhai et al., *Cross-Validation of the MMPI-2 in Detecting Malingered Posttraumatic Stress Disorder*, 75 J. PERSONALITY ASSESSMENT 449 (2000); Alison S. Bury & R. Michael Bagby, *The Detection of Feigned Uncoached Posttraumatic Stress Disorder with the MMPI-2 in a Sample of Workplace Accident Victims*, 14 PSYCHOL. ASSESSMENT 472 (2002).

⁵⁷ B. Christopher Freuh et al., *Apparent Symptom Overreporting in Combat Veterans Evaluated for PTSD*, 20 CLINICAL PSYCHOL. REV. 853 (2000).

⁵⁸ M. Frank Greiffenstein et al., *The Fake Bad Scale and MMPI-2 F-Family in Detection of Implausible Psychological Trauma Claims*, 18 CLINICAL NEUROPSYCHOLOGIST 573 (2004).

⁵⁹ *Id.*

⁶⁰ Lees-Haley, *supra* note 19.

⁶¹ Martha W. Wetter et al., *MMPI-2 Profiles of Motivated Fakers Given Specific Symptom Information: A Comparison of Matched Patients*, 5 PSYCHOL. ASSESSMENT 317 (1993); Gina L. Walters & James R. Clopton, *Effect of Symptom Information and Validity Scale Information on the Malingering of Depression on the MMPI-2*, 75 J. PERSONALITY ASSESSMENT 183 (2000).

psychiatric groups) and for patients identified as probably exaggerating. None of the former group failed the MENT, as opposed to eighty percent of the latter group.⁶²

Because complaints of memory and concentration problems are common in PTSD,⁶³ despite few demonstrated cognitive impairments,⁶⁴ failure on effort tests (such as the TOMM, WMT) can provide strong evidence of malingering. Poor performance on these cognitive tests requires intentional failure or poor effort (except in cases of retardation or dementia), which is distinct from over-reporting or exaggeration. Thus, failure cannot be explained by the claim that dramatization is essential to PTSD.

D. *Who Develops PTSD; In Whom Does It Persist?*

Significant literature exists regarding the factors associated with developing PTSD following exposure to trauma. A recent meta-analysis of seventy-seven studies found that previous psychiatric history, childhood abuse, and family psychiatric history were consistently associated with developing PTSD. Less consistent predictors included gender, race, age, education, previous trauma, and general childhood adversity.⁶⁵ Another review reported lower intelligence, neuroticism, negativistic personality traits, and dissociation surrounding the trauma as predictors of subsequent PTSD diagnosis.⁶⁶ Thus, the data suggest that people who later report symptoms of PTSD are often vulnerable individuals who show neurotic tendencies *before* the index accident/trauma. Preexisting anxiety, depression and dissatisfaction, which might be exacerbated following the trauma, gradually abate to baseline levels of functioning – but still are (mis)interpreted as PTSD.

Follow-up studies of those initially diagnosed with PTSD show that sixty percent continue to report significant symptoms at six months. The most reliable predictor may be dissociation at the time of the trauma and PTSD-like symptoms in the immediate aftermath. Acute Stress Disorder (ASD) entails the same symptoms as PTSD but does not require the one-month delay between the traumatic event and the diagnosis. Not surprisingly, the presence of such symptoms before one month predicts the presence of such symptoms after one month.

⁶² Kenneth R. Morel, *Development and Preliminary Validation of a Forced-Choice Test of Response Bias for Posttraumatic Stress Disorder*, 70 J. PERSONALITY ASSESSMENT 299 (1998).

⁶³ Neena Sachinvala et al., *Memory, Attention, Function, and Mood among Patients with Chronic Post-traumatic Stress Disorder*, 188 J. NERVOUS & MENTAL DISEASE 818 (2000).

⁶⁴ Elizabeth W. Twamley et al., *Neuropsychological Function in College Students with and without Post-traumatic Stress Disorder*, 126 PSYCHIATRY RES. 265 (2004).

⁶⁵ Chris R. Brewin et al., *Meta-analysis of Risk Factors for Posttraumatic Stress Disorder in Trauma-Exposed Adults*, 68 J. CONSULTING & CLINICAL PSYCHOL. 748 (2000).

⁶⁶ McNally, *supra* note 43.

E. *Depression*

Malingered depression presents some of the same problems as PTSD: the symptoms are familiar and widely disseminated, there are no definitive medical or psychological tests, and the diagnosis typically depends largely on self-report. Some depressed persons obtain elevated scores on some standard validity scales like the MMPI-2 F scale. The MMPI-2's newer, special malingering scales, particularly F(p) and Ds (Dissimulation), appear to be effective and produce reasonably high correct classification (seventy-five to eighty-five percent) rates in classifying legitimate and feigned depression.⁶⁷ A newly-developed scale, Md (Malingered Depression), appears to provide some additional discrimination when feigners have been coached about the content of depression scales and the validity indicators used to detect exaggeration.⁶⁸ It is clear, however, that coaching about validity scales does reduce their effectiveness.

Persons who are depressed often complain about memory problems and difficulty concentrating. Nonetheless, they typically perform normally on formal memory tests,⁶⁹ unless there is evidence of poor effort.⁷⁰ Thus, as with PTSD, failure on effort tests like the TOMM or WMT can provide potentially powerful corroborating evidence of intentional failure.

F. *Chronic Pain*

Pain that is unresponsive to pain management techniques is another frequent cause of claims. As with mild brain injury, such complaints may lack objective medical findings to corroborate them. Although there are several standardized questionnaires to assess pain and its impact on functioning, only some assist in assessing whether reports of pain are exaggerated.⁷¹

Chronic pain patients often report depression, and treatment with antidepressants often helps with both mood symptoms and physical discomfort. On the MMPI-2, such patients have a prototypical profile which is distinguishable from those in litigation who are believed to be exaggerating based on other indicators. As with head injury and PTSD, some of the standard validity scales are not particularly good indicators, and supplemental scales should be examined. Based on a combination of six validity scales and the FBS, one index showed

⁶⁷ Rogers et al., *supra* note 14; Jarrod S. Steffan et al., *An MMPI-2 Scale to Detect Malingered Depression (Md Scale)*, 10 *ASSESSMENT* 382 (2003).

⁶⁸ Steffan et al., *supra* note 67.

⁶⁹ Ali H. Kizilbash et al., *The Effects of Depression and Anxiety on Memory Performance*, 17 *ARCHIVES CLINICAL NEUROPSYCHOL.* 57 (2002).

⁷⁰ Paul Green & Lyle M. Allen, *The Differential Effects of Depressive Symptoms on Self-Report and Performance Based Neurocognitive Measures in Patients Demonstrating Good Effort During Assessment*, 14 *ARCHIVES CLINICAL NEUROPSYCHOL.* 741 (1999).

⁷¹ Larrabee, *Exaggerated Pain Report*, *supra* note 17.

substantial differences between pain patients who were in litigation and those who were not. That index achieved greater separation between the groups than any of the individual scales included in the index.⁷² Several studies have reported good to excellent discrimination of exaggerators from legitimate patients on the basis of symptom profiles,⁷³ grip strength,⁷⁴ body extension,⁷⁵ and motor performance during neuropsychological testing.⁷⁶

Many chronic pain patients complain of memory problems and difficulty concentrating. Findings of impairment on neuropsychological tests have been somewhat inconsistent, however. As with mild head injury and depression, when patients showing good or poor effort on malingering tests are separated, few cognitive deficits are observed in the former group.⁷⁷ As with other disorders, effort testing should be routine.

Finally, there is at least one medical procedure designed to assess the validity of pain complaints. *Diagnostic blocks* involve the systematic administration of analgesics, injected into neurologically relevant sites, to map the enervation and the patient's verbal response to medication that should completely block the reported pain.⁷⁸ Because different formulations carry different expected periods of effectiveness, the patient's report can be compared with the expected pharmacological profile of the drug administered. Substantial mismatches suggest the possibility of false reporting. The rationale is that people cannot accurately report the presence or absence of pain if they do not legitimately feel it.

⁷² John E. Meyers et al., *A Validity Index for the MMPI-2*, 17 ARCHIVES CLINICAL NEUROPSYCHOL. 157 (2002).

⁷³ Larrabee, *Exaggerated Pain Report*, *supra* note 17.

⁷⁴ Gerald A. Smith et al., *Assessing Sincerity of Effort in Maximal Grip Strength Tests*, 68 AM J. PHYSICAL MED. & REHABILITATION 73 (1989); Somadepti N. Chengalur et al., *Assessing Sincerity of Effort in Maximal Grip Strength Tests*, 69 AM. J. PHYSICAL MED. & REHABILITATION 148 (1990).

⁷⁵ Zeevi Dvir, *The Measurement of Isokinetic Fingers Flexion Strength*, 12 CLINICAL BIOMECHANICS 473 (1997); Zeevi Dvir & Jennifer Keating, *Reproducibility and Validity of a New Test Protocol for Measuring Isokinetic Trunk Extension Strength*, 16 CLINICAL BIOMECHANICS 627 (2001); Zeevi Dvir & Jennifer Keating, *Trunk Extension Effort in Patients with Chronic Low Back Dysfunction*, 28 SPINE 685 (2003).

⁷⁶ Larrabee, *supra* note 18.

⁷⁷ Roger O. Gervais et al., *Effects of Coaching on Symptom Validity Testing in Chronic Pain Patients Presenting for Disability Assessment*, 2 J. FORENSIC NEUROPSYCHOL. 1 (2001).

⁷⁸ Nikolai Bogduk, *Diagnostic Blocks: A Truth Serum for Malingering*, 20 CLINICAL J. PAIN 409 (2004).

G. *Controversial Diagnoses*

There are a number of diagnoses, in addition to those already discussed, that share the following constellation of features:

- Vague, subjective symptoms
- Lack of objective laboratory findings
- Quasi-scientific explanations
- Mutual skepticism (physician/patient) with traditional medical practices
- Denial of psychiatric/stress contributors
- Subjective complaints that greatly exceed reliable laboratory findings
- High rate of failure on effort tests in claimants.

These include whiplash, fibromyalgia, non-epileptic seizures, Chronic Fatigue Syndrome, Multiple Chemical Sensitivities, Toxic Mold and Sick Building Syndrome, Silicon Breast Implant complaints, and Gulf War Syndrome.⁷⁹ Some have considered these to be masked psychiatric syndromes, while others have pointed to very high failure rates on effort tests when evaluations are conducted within the context of litigation. In all these conditions, subjective complaints include fatigue, depression, anxiety, pain or headache, poor memory and concentration, dizziness, and irritability. The overlap with Postconcussion Syndrome should be apparent, and the same issues apply.

Electrical injuries present many of the issues for mild traumatic brain injury, although there is speculation that the impairments produced may be more persistent or even progressive. As with brain injury, the absence of objective signs of physical injury, such as entry and exit wounds, is related to test indications of malingering.⁸⁰ A recent report found high rates of probable malingering using standard tests and criteria applied to head injury patients among eleven electrical injury patients referred for disability evaluation.⁸¹

Exposure to welding fumes and manganese also has been cited as a cause of neurological damage and, according to a recent article in *Science* magazine, “the number of claims could rival those for asbestos-related lung disease.”⁸² A recent neuropsychological investigation

⁷⁹ Binder, *supra* note 31.

⁸⁰ Kevin Bianchini et al., *Detection and Diagnosis of Malingering in Electrical Injury*, 20 ARCHIVES CLINICAL NEUROPSYCHOL. 365 (2005).

⁸¹ *Id.*

⁸² Jocelyn Kaiser, *Manganese: A High-Octane Dispute*, 300 SCIENCE 926, 927 (2003).

found evidence of significant impairment based on welding fume exposure.⁸³ However, this analysis and its conclusions were savaged in an article by malingering-savvy scholars, who pointed out huge differences between control and experimental groups on education, poor screening for malingering, and inconsistencies in the data, suggesting motivated failure.⁸⁴

IV. EVALUATING A REPORT

Psychological evaluations that are prepared for use in judicial proceedings are subject to the specialty guidelines for forensic psychologists.⁸⁵ Although the guidelines are aspirational and not binding on standards of practice, they do specify practical, reasonable expectations that may not be met in typical evaluations. Among the most important of these are that psychologists consider multiple, rival hypotheses to explain their data, and that the bases for their conclusions be adequately documented in the report. In other words, the examiner should consider other possible causes for deficits that are displayed or reported, including poor effort or previous injury or condition. Given this guideline, the statement in the DSM-IV about the need to rule out malingering in forensic contexts, and the National Academy of Neuropsychologists' position statement on effort testing, a case could be made that an examiner's failure to rigorously assess for malingering in a personal injury context is malpractice.

The report should identify tests or indices that were used to evaluate effort or symptom exaggeration, or alternately describe them in such a way that another examiner would know which technique was used. There should be a clear discussion of the level of effort expended, based on formal tests and indices, as well as the effect of any such problems on the test scores obtained in other areas. Statements that the examinee "appeared to put forth good effort" based on unaided observations are inadequate. Unfortunately, even when these issues are addressed appropriately, unfavorable findings are sometimes communicated indirectly. A recent survey of neuropsychological practices suggested that many practitioners are reluctant to diagnose malingering or to make strong statements on this topic.⁸⁶ In one recent case, the neuropsychologist possessed definitive evidence of malingering yet reported

⁸³ R. M. Bowler et al., *Neuropsychological Sequelae of Exposure to Welding Fumes in a Group of Occupationally Exposed Men*, 206 INT'L J. HYGENE & ENVTL. HEALTH 517 (2003).

⁸⁴ Paul T. Lees-Haley et al., *Methodological Problems in the Neuropsychological Assessment of Effects of Exposure to Welding Fumes and Manganese*, 18 CLINICAL NEUROPSYCHOLOGIST 449 (2004).

⁸⁵ Committee on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 LAW & HUMAN BEHAV. 655 (1991).

⁸⁶ Daniel J. Slick et al., *Detecting Malingering: A Survey of Experts' Practices*, 19 ARCHIVES CLINICAL NEUROPSYCHOL. 465 (2004).

his findings in this way: “Data therefore certainly suggest that either Mr. M is a severely demented individual or low in motivation, but such performance is rarely, if ever, obtained by persons suffering from mild to moderate head injury.”⁸⁷ The claimant obtained a score of three correct out of fifty on the Test of Memory Malinger. Someone who took the test blindfolded would be expected to score twenty-five (fifty percent of fifty items), plus or minus six, simply by guessing. A score of three is so far below chance that a blindfolded subject would have to take the test approximately fifty-four *billion* times to turn in a score this low. This information was not apparently understood by the referring physician, who wrote a report that helped the plaintiff to recover a multimillion dollar settlement. It did not help that, throughout the report, the neuropsychologist described “deficits” in motor, speech, and memory as if the question of poor effort did not exist.

Attorneys also may encounter neuropsychological reports that utilize no formal effort tests. Fortunately, many of the frequently-used tests have been studied for use in assessing exaggeration or faking. Researchers have identified patterns and individual responses that can be highly useful in this role. Often, such indices will not have been scored by the examining psychologist, but can be scored quickly and cost-effectively by a knowledgeable reviewer. Some of these indices have fairly good sensitivity and excellent specificity.

V. FINDING AN EXPERT

One might assume that finding a board certified expert in the area of claimed damages (e.g., pain medicine) is the logical choice. However, this makes a crucial assumption that is rarely true: expertise in treating a condition translates into expertise in distinguishing true and false presentations of that condition. In the context of litigation, this is perhaps the most important differential diagnosis. How can one identify such an expert? An expert’s publication history can be a guide, although many qualified experts may not publish. Furthermore, as seen in the discussion of PTSD, some experts who publish may have biases, employ poor designs and come to highly questionable conclusions. In addition to referrals from other attorneys, one might wish to post some of the following questions to potential experts:

⁸⁷ Quotation from report on a particular claimant in author’s possession.

- *What are some of the major goals of your assessment?* The expert should spontaneously state that assessment of effort or genuineness of the condition is one of the primary purposes of the assessment.
- *How common do you think malingering or exaggeration is in mild head injury/chronic pain patients who are involved in litigation?* The best estimates of these figures are about forty percent for the former and thirty percent for the latter. An answer significantly discrepant from this range should be cause for concern.
- *How do you assess the possibility of exaggeration or faking?* The expert's answer should clearly indicate that this is an area of expertise and that the expert competently uses multiple, sensitive, and established techniques. However, some experts may be reluctant to disclose their techniques, suspecting that the attorney may be misrepresenting his situation or interested in coaching a client.
- *Are the techniques you use widely accepted in your field? Will the techniques that you use pass a Daubert challenge?* The expert should have an understanding of the *Daubert* standards (if in a *Daubert* jurisdiction), and should be able to speak intelligently regarding the general acceptance, error rate, and other factors relevant to admissibility.

VI. CONCLUSION

Malingering and exaggeration are common among people who litigate for injuries involving mild head injury, chronic pain, and posttraumatic stress disorder. There also may be a substantial number of persons who sincerely experience symptoms but test negative on medical and psychological tests. Such people may mistakenly attribute symptoms and problems to an accident or incident. In such cases, assessment of Somatization and personality are likely to be important.

Any psychological reports that are submitted by the plaintiff should be reviewed by another qualified psychologist who is proficient in detecting malingering, poor effort and Somatization. Should an Independent Medical Examination (IME) be necessary, the same qualifications apply. One should not assume expertise in detection of malingering based on any specialty or formal credential. Although both forensic psychology and neuropsychology have developed measures of response style, there is a wide range of proficiency among practitioners—even board certification in either specialty is no guarantee. Armed with the information in this article and the sample questions noted above, however, attorneys should be able to evaluate candidates and decide upon the right expert for any given case.

Table 4
Report/Evaluation Features Important to Assessing Malingering or Poor Effort

1.	Explicit consideration and discussion of effort/malingering
2.	Listing of specific tests sensitive to effort
3.	Attempts to contact neutral or non-supportive sources of information
4.	Recognition that the patient, family members and treatment providers may be sympathetic, potentially biased, or possibly have deceived themselves
5.	Explicit consideration of alternative causes for the deficits observed; avoids use of phrases like “consistent with,” which imply consideration of only a single hypothesis
6.	Frank discussion of test results
7.	Avoid use of suggestive or conclusive language (i.e., “suffers from;” reporting patient statements, or those of any source, as conclusive facts)

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