

Chapter 2

Malingering: Definitional and Conceptual Ambiguities and Prevalence or Base Rates

2.1 Introduction

This chapter presents different approaches to the definition of malingering, such as the psychiatric and legal. It builds on the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision; American Psychiatric Association 2000) and DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; American Psychiatric Association 2013) approach that involves both conscious, overt malingering and gross exaggeration for external incentives, such as financial gain. Malingering should be attributed only when the evidence is incontrovertible. Psychological approaches are described that have conflated exaggeration, in general, with frank malingering. Other psychological approaches are presented that adhere to the traditional approach of pairing only gross exaggerations with outright malingering.

The chapter also considers the base rate of malingering, or its prevalence, in psychological/psychiatric injury populations, such as forensic disability claimants. The definitional and conceptual ambiguities and problems that have been described interfere with obtaining accurate estimates of the prevalence of malingering, feigning, exaggeration, and related response biases. Multiple studies and recent reviews on the prevalence of malingering in the forensic disability and related context refer to the percentage of up to 50 % or so (although others tend to the other extreme of little malingering in such cases). However, the percentage might be this high because exaggeration and malingering are categorized together in the research on the topic. A more balanced view would consider these aspects of response bias as separate, or at least exclude minimal exaggeration or exaggeration that is not gross from any general definition of malingering.

Moreover, in adopting such a strategy, not only the research on prevalence or base rate would be improved but also in practice the definition and its application in assessment would be tightened. However, even if there would be less cases of malingering attribution that would obtain with a tighter definition, the astute assessor still can arrive at useful conclusions on doubtful cases for court purposes. When evaluatee presentation and performance indicates noted degrees of noncredible

feigning in forensic disability and related mental health assessment cases in which there is insufficient evidence to attribute malingering, *per se*, the chapter indicates that there still would be room for the astute evaluator to indicate in ways helpful to court the presence of noncredible, feigned performance and presentation.

In reviewing the literature, the chapter presents some major instruments used in the field, such as symptom validity and personality tests [e.g., Test of Memory Malingering (TOMM); Tombaugh 1996; Minnesota Multiphasic Personality Inventory, Second Edition, Restructured Form (MMPI-2-RF); Ben-Porath and Tellegen 2008/2011]. Moreover, the chapter introduces major extant “diagnostic” systems or models in use related to the detection of malingering and related response biases, such as the MND (Malingered Neurocognitive Dysfunction) and the MPRD (Malingered Pain-Related Disability) models of Slick et al. (1999), and Bianchini et al. (2005), respectively.

Table of Terms and Sources

Abbreviation	Name	Source(s)
A-Test	A-Test	Chafetz (2008)
CARB	Computerized Assessment of Response Bias Test	Allen et al. (1997), Conder et al. (1992)
CVLT	California Verbal Learning Test	Delis et al. (1987)
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition	American Psychiatric Association (1994)
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision	American Psychiatric Association (2000)
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition	American Psychiatric Association (2013)
F	Infrequency Scale	Butcher et al. (1989)
FBS	Symptom Validity Scale (originally called Fake Bad Scale)	Ben-Porath and Tellegen (2008/2011), Lees-Haley et al. (1991)
Fp(-r)	Infrequent Psychopathology Responses	Ben-Porath and Tellegen (2008/2011)
F-PR-D	Feigned Pain-Related Disability/Dysfunction	Young (2014); present work
F-r	Infrequent Responses	Ben-Porath and Tellegen (2008/2011)
Fs	Infrequent Somatic Responses	Ben-Porath and Tellegen (2008/2011)
LMT	Letter Memory Test	Inman et al. (1998)
M-FAST	Miller Forensic Assessment of Symptoms Test	Miller (2001)
MMPI-2	Minnesota Multiphasic Personality Inventory, Second Edition	Butcher et al. (1989, 2001)
MMPI-2-RF	Minnesota Multiphasic Personality Inventory, Second Edition, Restructured Form	Ben-Porath and Tellegen (2008/2011)
MND	Malingered Neurocognitive Dysfunction	Slick et al. (1999)
MPRD	Malingered Pain-Related Disability	Bianchini et al. (2005)
MSVT	Medical Symptom Validity Test	Green (2004)
PDRT	Portland Digit Recognition Test	Binder (1993), Binder and Willis (1991)

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Abbreviation	Name	Source(s)
-r	Revised (e.g., FBS-r)	Ben-Porath and Tellegen (2008/2011)
RC	Restructured Clinical Scales	Ben-Porath and Tellegen (2008/2011)
RDS	Reliable Digit Span	Greiffenstein et al. (1994)
SIMS	Structured Inventory of Malingering Symptomology	Widows and Smith (2005)
SIRS	Structured Interview of Reported Symptoms	Rogers et al. (1992)
TOMM	Test of Memory Malingering	Tombaugh (1996)
VSVT	Victoria Symptom Validity Test	Slick et al. (1997/2005)
WAIS-III	Wechsler Adult Intelligence Scale, Third Edition	Wechsler (1997)
WMT	Word Memory Test	Green (2005)

2.2 Conceptual and Definitional Ambiguities

2.2.1 Introduction

Mental health professionals need to conduct comprehensive, impartial, and scientifically-informed evaluations in forensic disability and related contexts in order to both (a) ascertain the credibility of the presenting symptoms and performances and (b) arrive at valid and supported conclusions, for example, about diagnosis, prognosis, disability status, and treatment recommendations. Psychologists are particularly well-suited for this task given their expertise in psychological tests, including those that can help attribute the presence of malingering and related motivations to an acceptable degree of certainty for court and related purposes. Psychiatrists have an important role to play, as well, in these types of assessments, and their focus on inconsistencies and discrepancies in patient presentation, self-report, documentation, collateral informants and information, and so on, has played a central role in this field.

Malingering is a relevant consideration when making a number of important clinical and/or forensic decisions, such as whether to pursue medical intervention in the former setting or whether to award tort damages or worker compensation benefits in the latter setting. However, the valid assessment of malingering is a notoriously complicated problem that continues to elicit heated debate about issues among forensic psychologists, clinical psychologists, rehabilitation and trauma psychologists, occupational psychologists, personality psychologists, health psychologists, and other mental health professionals, as well as scholars of law, the court, and jurisprudence. In particular, there is no clear consensus on the definition of malingering nor its criteria and there are disparate base rate or prevalence estimates that confound reliable and valid research and assessment in the field.

Psychiatric/psychological injuries refer to psychiatric or psychological conditions associated with an event at claim, such as posttraumatic stress disorder (PTSD), pain disorder (chronic), and mild traumatic brain injury (MTBI). The diagnosis of a

psychiatric/psychological injury might lead to a lawsuit in tort action or other legal-related venues, for example, in worker compensation and disability insurance cases. Typically, the precipitating event is a negligent action, such as conducting a vehicle negligently in a motor vehicle accident (MVA).

Without careful definition of terms and elucidation of ambiguities in the field, a comprehensive, scientifically-informed literature review cannot be undertaken. Therefore, a primary goal of this chapter in this part of the book is to disambiguate the terms in the field related to malingering and related response styles and biases. This will help lead to better surveys than have been undertaken to date so that the normative base rate of malingering and related response biases can be ascertained in populations relevant to work in the area of psychiatric/psychological injury. The chapter does not include a comprehensive review of all the literature on base rates of malingering and related response biases, but does review much of the most recent literature and select examples in past literature to make the points raised. Clear inconsistencies in basic concepts and criteria related to malingering exist and need to be clarified to prepare for better research than has been conducted to date. For example, the Mittenberg et al. (2002) survey is highly influential but contains some inconsistencies that will be clarified.

The chapter describes other examples in the most current literature in the field that include some inconsistencies beyond their good work (e.g., Frederick 2012; Miller et al. 2011). The adversarial (plaintiff/defense) divide that marks the field makes it difficult to avoid some inconsistencies both in practice and research. However, the dispassionate, balanced view that is adopted in the present chapter leads to solutions with respect to these inconsistencies [For further argument about the effect of the adversarial system on the field, see Young 2010].

2.2.2 Different Approaches to the Same Terms

Carone and Bush (2013a) focused on symptom validity, assessment, and malingering in MTBI. In Carone and Bush (2013b), they offered an excellent, historical perspective on the topic. They noted cases of malingering in the bible, and noted that early books on the topic appeared in the nineteenth century and early twentieth century (Gavin 1843; King 1906). In the modern era, Rogers (2008) book is considered the classic text. Carone and Bush reviewed how the definition of and approach to malingering has changed over different editions of the psychiatric manual, the DSM. The most recent versions are the DSM-5 (Diagnostic Statistical Manual of Mental Disorders, Fifth Edition; American Psychiatric Association 2013) and the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision; American Psychiatric Association 1994, 2000). Moreover, the term malingering is defined or approached differently in psychology, psychiatry, and law.

For psychiatrists, malingering involves the “intentional production of false or grossly exaggerated physical or psychological symptoms” that derives from “motivation by external incentives,” for example, for obtaining financial compensation (in the DSM-IV-TR, DSM-5).

However, the American Psychological Association's dictionary of psychological terms does not reference exaggeration in its definition of malingering (VandenBos 2007). For this psychological dictionary, malingering is the deliberate feigning of an illness or disability that is motivated to achieve a particular specific external factor or outcome (e.g., financial gain obtained by faking physical illness).

As for a legal definition, similarly, Black's law dictionary (Garner 2009) provides a definition that includes feigning for external incentives, such as disability benefits, but does not include an exaggeration component ("to feign illness or disability," [for example, to initiate receiving or] "to continue receiving disability benefits").

The court expects mental health professionals to use the DSM-IV-TR as the basis for diagnosis. However, the DSM's approach to malingering is quite criticized with respect to its criteria (e.g., Berry and Nelson 2010), and often alternative approaches are used in psychiatric/psychological evaluations to rule it in or out (e.g., Rogers and Granacher 2011).

The DSM-IV-TR and DSM-5 suggest that any combination of four factors is indicative of possible malingering: (a) the referral context is medicolegal; (b) the objective findings are "markedly" discrepant with the evaluatee's claimed "stress or disability;" (c) the evaluatee exhibits a lack of cooperation with the assessment procedure or with suggested treatments; and (d) he or she is diagnosed with antisocial personality disorder. For the DSM, malingering should be "strongly suspected" if any combination of these factors is present.

However, the first factor automatically and erroneously brands all evaluatees in forensic disability examinations as possible malingerers; the second and third factors might reflect the confrontational nature of the examinations; and the fourth factor suffers from the inclusion fallacy mentioned for the first factor. For reasons like this, workers such as Boone (2011a) have indicated that the DSM-IV-TR has not been found to be accurate with respect to malingering.

What about regular dictionary definitions of malingering? Merriam-Webster's includes an exaggeration component but without specifying degree, such as is the case for the DSM's adjective of "grossly" exaggerating (definition: to pretend or exaggerate incapacity or illness, e.g., to avoid work; Mish 2003).

Miller et al. (2011) have presented differential definitions of terms related to malingering. *Fabrication* refers to fraudulently presenting in a wholesale invention symptoms or impairments that are present as being the result of an injury. In *exaggeration*, the evaluatee represents true symptoms or impairments caused by an injury as worse relative to their actual condition. The authors added that in clinical and forensic evaluatees exaggeration probably is the most common "form of malingering". Note that in this approach even the mildest of exaggerations can be used to index malingering, which is inconsistent with the DSM approach. *Extension* is another type of fraudulent claim: symptoms or impairments caused by an injury have recovered or improved, but they are claimed to continue at the level of the initial injury or to even have worsened over time. Finally, in *misattribution*, symptoms that preceded, postdated, or are otherwise unrelated to an injury are fraudulently attributed to it.

Kane and Dvoskin (2011) have an equilibrated approach to the relationship of exaggeration and malingering. For them, exaggeration concerns a "relatively mild

overstatement” of injury sequelae and, furthermore, it might be either within or outside of conscious awareness. In contrast, for Kane and Dvoskin, feigning, as defined by Rogers (2008), refers to deliberate fabrication or gross exaggeration of psychological or physical symptoms. Moreover, use of the term is generic, and does not connote any assumption about its underlying goal. For Kane and Dvoskin, the DSM-IV-TR approach to defining malingering is the appropriate one [intentional production of false/grossly exaggerated symptoms, motivated by external incentives ... (American Psychiatric Association 2000)]. In terms of malingering attribution, absent direct proof, with appropriate assessment, a “strong inferential statement” can be made about the likelihood of its presence. Note that, as with most workers in the field, although Kane and Dvoskin accept the legitimacy of the definition of malingering in the DSM-IV-TR, they do not endorse as useful the four DSM-IV criteria of malingering.

Despite the difficulties in assessing underlying motivations, the terms involved in malingering and related biases can be defined. Warren (2011) noted that in primary gain, which is an internalized motivation, symptoms create relief and help avoid an unconscious, internal conflict, for example, by providing an acceptable excuse to avoid a situation. Primary gain is different from secondary gain, for which the motivation is conscious and externally-based and it is related to obtaining or to avoiding something knowingly and willingly. For Warren, symptom exaggeration is also a conscious act. She related it to malingering by indicating that it can be a component of it, but that this does not mean that the presence of exaggeration automatically means that malingering is taking place. For example, a person might exaggerate to obtain help. Warren’s (2011) approach is consistent with that of Kane and Dvoskin (2011).

Ruff and Jamora (2008) presented a figure that captures well the relationship between malingering and other response biases in relation to hypothesized conscious and unconscious process (see Fig. 2.1). In addition, they introduced the important variable of socio-cultural context. Assessments of psychological injuries need to consider age, gender, and socio-cultural variations and factors. Also, see the description by Slick and Sherman (2013) in Chap. 16 on terminology related to primary and secondary gain, volition, and effort.

2.2.3 *Comment*

Unless there is scientific, conceptual, or pragmatic reason for changing the DSM-IV-TR (2000); DSM-5 (2013) approach to defining malingering, that approach should remain as the only one in use in the field. Nevertheless, the DSM-IV-TR approach to defining malingering can be qualified to separate its two major components. That is, its definition includes both (a) overt, outright, frank, and conscious, intentional fabrication, feigning, or dissimulation of symptoms, disorders, disabilities, or functional impairments for external incentives such as financial gain, and for which there is incontrovertible, indisputable, or compelling evidence, and (b) conscious, intentional gross exaggerations of symptoms, disorders, disabilities, or functional impairments that clearly are greater than the moderate level for the same external

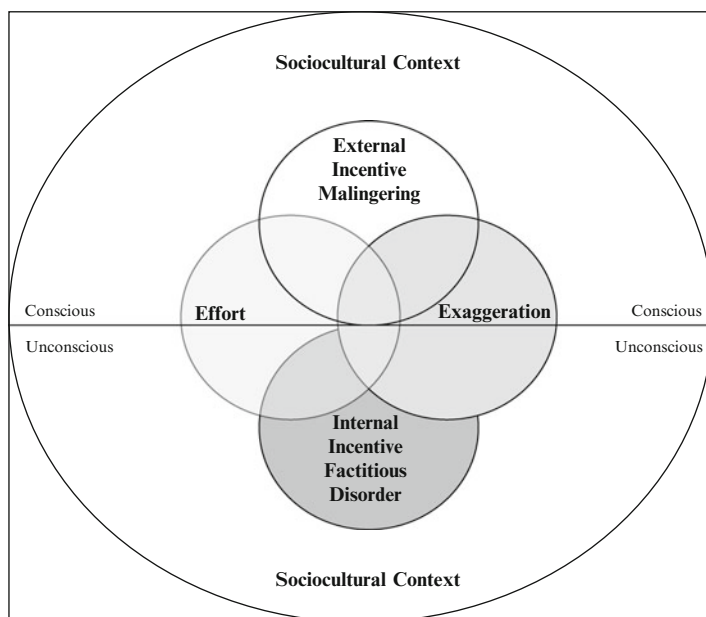


Fig. 2.1 Symptom invalidity model

The figure organizes the DSM categories on one axis and symptom invalidity on another, while indicating the variable of sociocultural context. Malingering, exaggeration, and poor effort are hard to differentiate and they overlap. Malingering takes place for conscious reasons, whereas factitious disorder develops for unconscious ones. Exaggeration and poor effort might take place for either conscious or unconscious reasons

Abbreviation. DSM Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 2000)

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incentives, and for which there is incontrovertible, indisputable, or compelling evidence. Later Part II of the book, I revisit the definition of malingering, questioning several facets of its received definition in the DSM approach.

2.3 Recent Literature on Malingering and Related Response Biases

2.3.1 Inconsistent Conceptualizations

In the following, I focus on some inconsistencies with respect to how malingering is treated in several recent chapters in books that will be read widely and influence practitioners. In particular, the works of Miller et al. (2011) and Frederick (2012)

are reviewed. Then, I analyze the widely-cited survey of Mittenberg et al. (2002) on the prevalence of malingering and related motivations in assessments in forensic disability and related contexts concerning psychiatric/psychological injuries.

IMEs. In Miller et al. (2011), two inconsistencies are evident. First, the position of Miller et al. (2011) that exaggeration is part of malingering represents a view that is inconsistent with the predominant DSM view. Malingering should include only gross exaggerations and not unqualified exaggeration because, by definition, the latter's motivational base might not be known, and the degree involved might be mild.

Second, Miller et al. (2011) noted correctly that an IME (independent medical examination) is not truly "independent." They specified that mental health professionals might undertake IMEs for either the plaintiff or the defense side in a personal injury case. They referred to arriving at objective conclusions in the case at hand. This approach is the one to which all evaluators should adhere no matter what the referral source.

However, the authors added that the "job" of an IME assessor is to conduct an assessment of the plaintiff for the purpose of attempting "to refute the plaintiff expert's claims" about the injury at issue or its relationship to the event in dispute, or both (p. 279). They added that this "typically" requires that the evaluator should adopt an "adversarial" role with respect to the evaluatee.

If Miller et al. are referring to the fact that a good portion of evaluatees in forensic disability and related assessments express problematic presentations and performances of one type or another, their wary approach about conducting assessments in this context is fully warranted. However, if they mean otherwise, such as evaluators needing to advocate for the positions of the referral source, their opinion is inconsistent with prevailing professional education, training, and practice. This latter conclusion about the role of IME assessors with respect to psychological and psychiatric injuries appears inconsistent with the middle-of-the-road, balanced, impartial perspective needed in assessment for forensic disability and related assessments and for court and court-related matters.

Definition. Frederick (2012) has written a chapter on malingering, cooperation, and effort for the edited volume by Faust (2012), which is the most recent edition of Ziskin's classic work on testimony and court. He began the chapter by indicating that malingerers will either fabricate their impairments or disability or they will "exaggerate" the degree of their impairment or disability. No qualifier is given about the degree of exaggeration needed to constitute malingering. Later in his chapter, Frederick indicated that elevation on scales related to exaggeration "generally" are "better explained" as exaggeration that is aimed at "proving" an impairment [symptom, disability] for "some secondary gain" (p. 238).

Frederick (2012) referred to Rogers' (1990) classic model that malingering is adaptive behavior and can be readily, routinely, or often anticipated or expected in adversarial examinations evaluations. According to this adaptational model, malingering in these evaluations takes place not because the evaluatees are "bad," but because deception of perceived enemies is appropriate. In my reading between the lines, the Rogers model opens the gate for ascribing the motivation of malingering

to evaluatees in civil proceedings because it minimizes the stigma or pejorative connotation associated with the term.

Frederick (2012) reviewed the literature on the prevalence of malingering, in particular, and he cited the study on its prevalence by Mittenberg et al. (2002). They surveyed practitioners about their approaches to the matter in over 30,000 cases of neuropsychological assessment that took place in the prior year. Other articles cited in the Frederick review did not give percentages higher than 35 % for malingering. Nevertheless, Frederick (2012) concluded that the prevalence rate of malingering based on the literature review is “probably not more than 50 %–60 %.”

However, in describing Mittenberg et al. (2002), Boone (2011a) added the rate at issue and can be up to 41 % for cases of mTBI. The goal of the survey was to seek the estimated rate of “feigned cognitive impairment.” For the different civil cases of personal injury, disability, fibromyalgia/chronic fatigue, chronic pain, and neurotoxic cases, the percentages did range up to 35 %. In contrast, she cited Boone et al. (1995), who found that in the worker compensation context, feigned cognitive deficits in stress claims are as low as 15–17 %. Therefore, in reading these sources, I was confused both about the base rate of malingering or feigning in the various forensic disability and related contexts and the actual base rate reported in Mittenberg et al. (2002).

Base rate. Reference to the actual research conducted by Mittenberg et al. (2002) revealed several inconsistencies. First, in the survey, the definitions of malingering and exaggeration were not provided to the respondents. Moreover, not only was malingering conflated with exaggeration in the study but also exaggeration was not specified for severity. In addition, by capitalizing together the terms malingering and exaggeration, the specific question in the survey accentuated that exaggeration and malingering are considered as a unified concept. That is, the base rate or prevalence of putative malingering or feigning that derived from the Mittenberg et al. survey might have included cases of the simplest of exaggeration and not just ones of overt malingering. Finally, the survey involved questions about “probable” exaggeration or malingering, so that inconclusive cases of exaggeration might have been included with malingering even when it was not definitely suspected in the estimates of the latter’s prevalence. Finally, note that the survey title included: probable symptom exaggeration *and* malingering, but the particular question on the topic used in the survey included the word “or” rather than “and,” adding to the confusions for any survey respondent and readers of the research.

The Mittenberg et al. publication constitutes a classic study that is cited frequently, and it was used as a general pre-conference reading for the American Academy of Clinical Neuropsychology Consensus Conference Statement on effort, response bias, and malingering (Heilbronner et al. 2009). It reinforced the conference’s impression that “non-credible somatic disability presentation shows base rates of 30–40 % in secondary gain contexts (Mittenberg et al. 2002) similar to those reported for non-credible cognitive performance disability” (p. 1108). Therefore, Heilbronner et al. (2009) arrived at conclusions on base rates about somatic disability partly based on the Mittenberg et al. study that included in its base rate estimates possibly the mildest of exaggerations, conflating its estimate of

base rate for malingering. Given these inconsistencies in Mittenberg et al., reference to it in Heilbronner et al. does not provide sufficient evidence to support their contention that non-credible somatic and cognitive performance disability presentations are as high as 40 %.

To conclude his chapter, Frederick (2012) returned to the argument raised at its outset that malingering “represents” an “obstruction of justice” that is liable to “criminal penalties” (e.g., *United States v. Greer* 1998). In making this claim about the behavior of plaintiffs in cases of personal injury, there are important implications both for the court to consider and that evaluators need to take into account. First, if there is no incontrovertible evidence of malingering, evaluators who arrive at a conclusion about the presence of malingering based on either problematic test results or inconsistencies in the data gathered, or both, are making serious allegations about the plaintiff of a criminal nature that might be overstepping their professional and ethical boundaries and competencies. Moreover, because they are stepping into the criminal arena in making the accusation, the degree of certainty about the evidence used to arrive at the conclusion changes to the stricter and more rigorous criteria expected in criminal cases. In civil cases, the evidence proffered in support of a conclusion only has to be at the level of “more likely than not,” or at a level of 50 % degree of certainty (or more). But for criminal matters, the level of certainty for conclusions must meet higher standards – the accused is considered innocent until clearly proven guilty “beyond a reasonable doubt.”

Therefore, the question arises whether in forensic disability and related contexts the civil test of evidence being “more likely than not” is a sufficient basis for attributing malingering. The evidence should be incontrovertible in this regard, and not merely suggested as possible or probable according to some test results or file inconsistencies/discrepancies. It would be more prudent in such cases to word conclusions in terms of generic feigning or the like.

Note that the argument that conclusions about malingering are criminal allegations is opposite to the one by Rogers that malingering is adaptive and therefore not as pejorative an attribution as one would think. By conflating malingering in the civil arena with criminal intent as well as including exaggeration as part of malingering, Frederick (2012) might be lowering the bar for its attribution too low and raising the bar for its implications when attributed too high.

As indicated, there are solutions to the quagmire that can be used. By using terms such as “total lack of credibility” instead of malingering itself when the reliable data gathered in an evaluation do not warrant the attribution of malingering, the court [and evaluatee] would be better cases with incontrovertible evidence for served. In this manner, malingering would become a term reserved exclusively for its valid attribution.

2.3.2 Consistencies

Boone. In the context of differentially diagnosing malingering versus somatoform disorder and factitious disorder, Boone (2011a) examined the psychological testing needed to infer an attribution of malingering. She referred to recommended practice

by Bush et al. (2005) and by the American Board of Clinical Neuropsychology (2007). She cited research that failure on two or more tests of effort can best discriminate between credible and non-credible populations (e.g., Victor et al. 2009). Boone added that although failure on two or more tests of effort represents an appropriate criterion for distinguishing credibility, the more there are “failed indicators,” the more confidence one can have in conclusions – with four, if not five test failures considered giving the opportunity for perfect specificity or incontrovertible evidence. Once an evaluatee reaches this level of test failure, the evaluator needs to determine whether the evaluatee had engaged in either conscious or non-conscious fabrication of symptoms. She concluded that available assessment techniques “do not distinguish” between the two types of conclusions. She added that the “gold standard” for identifying malingering of symptoms has been performance on forced-choice symptom validity tests (SVT) that is “significantly below chance.” Yet, Boone (2011a) added that test-takers on such tests who are hypnotized and, therefore, whose behavior does not appear to be under conscious control, obtain scores below the 50 % level of success when they are instructed to display memory impairment (Spanos et al. 1990).

Although I agree that below-chance forced-choice testing performance is the best evidence available from testing about malingering, there are other factors to consider. It is fair to say that no test result on one test by itself, without considering the full reliable data set gathered in an evaluation, can be considered incontrovertible or gold-standard evidence of malingering. Moreover, failure to meet threshold or cut-scores on multiple SVTs narrows the nature of conclusions possible in an evaluation. However, it is notable that Boone underscored that multiple SVT failure refers to four to five such failures, rather than two of them.

Boone (2011a) concluded that the differential diagnosis of malingering versus factitious disorder or somatoform disorder is at present one of “art” and requires supplementary information about what evaluatees believe with respect to the reality of their symptoms. Moreover, evaluatees might express simultaneously both conscious and non-conscious symptom fabrication and, also, to different degrees rather than as absolute, all-or-none categories.

Note that Boone introduced the inclusion of “art” in the process of ruling in or out malingering and related biases, and referred to the process involved as “differential diagnosis.” First, it is worth reminding that malingering is not a diagnosis, per se, but a class of behaviors that is given a V-code, according to the DSM-IV-TR. Second, in the scientific approach needed for conducting forensic mental health assessments (Heilbrun et al. 2009), the use of qualitative and idiographic data gathered from interviews of evaluatees does not mean that “art” rather than science is being used. A scientific approach in this type of assessment means that (a) all the relevant data are gathered in a comprehensive manner, including from testing and interviews, (b) all possible hypotheses are considered for the conclusions, and (c) the final conclusions arrived at are supported by both the evidence gathered and the state-of-the-art science in the literature that is applicable to the case at hand. This understanding of the scientific nature of mental health assessments does not rule out the steps described by Boone (2011a) in gathering qualitative data, but

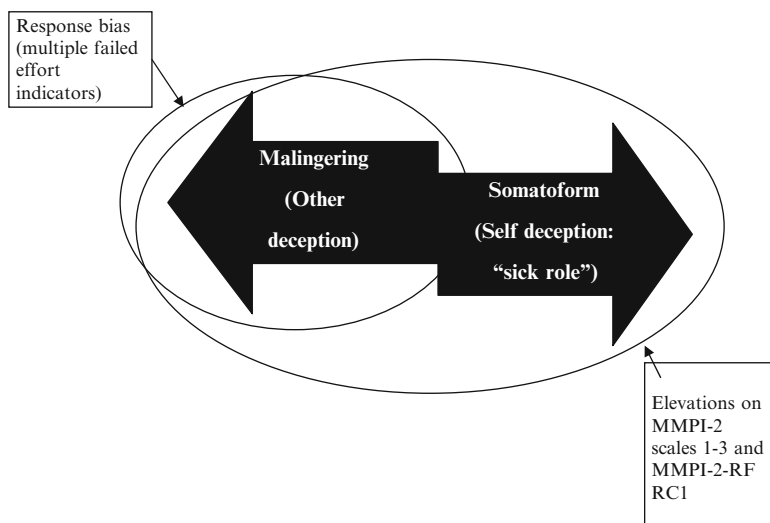


Fig. 2.2 Illustration for a conceptualization of somatoform disorders and malingering
The figure relates malingering and somatoform disorders to deception (other-deception for malingering, self-deception for somatoform disorder). Testing can help differentiate them, e.g., the MMPI test family

Abbreviations. *MMPI-2* Minnesota Multiphasic Personality Disorder, Second Edition (Butcher et al. 1989, 2001), *MMPI-2-RF RC* Minnesota Multiphasic Personality Disorder, Second Edition, Restructured Form, Restructured Clinical Scales (Ben-Porath and Tellegen 2008/2011)

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simply asks us to be careful in how it is described. That being said, in the present book, for heuristic reasons, I do refer at times to the detection of malingering as a diagnosis.

To conclude presentation of the Boone (2011a) work, I present her model of the relationship between malingering and somatization (see Fig. 2.2). It illustrates her theme that evaluatees might exaggerate symptoms not only because of engaging in malingering and related response biases, that is, for external incentives, but also for other incentives, or internal ones, such as adopting the sick role, as happens in somatization. Moreover, it indicates that the family of MMPI personality tests can be used to indicate the presence of somatoform disorders via certain clinical patterns distinct from results deriving from tests' validity/effort scales. These themes in Boone are ones that I have incorporated in my own approach in the present book.

Rogers. Rogers and Granacher (2011) provided a review of the conceptualization and the assessment of malingering. They referred to the DSM-IV-TR approach and specified that the component of gross exaggeration in the definition of malingering is unlikely to involve "minor or isolated amplifications of symptoms." This is consistent with the present view that the DSM approach to defining malingering as involving only gross exaggerations is a valid one. Similarly, Rogers and Granacher

(2011) also addressed pitfalls in assessments. They introduced the useful concept of “construct drift,” or that the term malingering is broadening in definition from more conservative approaches, such as that of the DSM.

Rogers and Granacher (2011) added that the concept of secondary gain cannot be measured directly and should never be used in assessments. The authors considered the concepts of overreporting and inadequate effort as vague. However, to me, overreporting appears a neutral term that accurately reflects the exaggerations in data that could be gathered in an assessment, although I would agree that use of the term “inadequate effort” might be vague for some assessments. They also argued that malingering should not be determined just on the basis of test data, which is a constant theme in the literature. In assessments, inconsistencies in the data gathered have been considered as important in deciding upon the presence of malingering, but in actuality the authors opined that they “are ineffective for the assessment of malingering” (p. 663). Note that, in contrast, the approach that I take is that compelling, gross, incontrovertible, substantial, or marked inconsistencies, in particular, might be quite revealing toward attributing malingering or related motivations.

Rogers and Granacher (2011) described detection strategies of possible malingering and feigning. These include use of: (a) rare symptoms; (b) symptom combinations; (c) indiscriminant symptom endorsement; (d) symptom severity; (e) magnitude of error; (f) violation of learning principles; (g) floor effect; and (h) use of SVTs. They described selected measures of feigned mental disorders, such as the MMPI-2 and the MMPI-2-RF. The MMPIs include evaluatee validity scales or family scales. Rogers and Granacher noted that the initial research for those of the MMPI-2-RF has produced “promising yet disparate results.” Therefore, according to Rogers and Granacher, the research has not yet justified using them in forensic cases in which malingering is suspected (Rogers et al. 2011; Sellbom et al. 2010). [However, see below for a description of recent research that is validating the use of the MMPI-2-RF in psychiatric/psychological injury contexts.]

Consensus Statement. The American Academy of Clinical Neuropsychology Consensus on the neuropsychological assessment of effort, response bias, and malingering (Heilbronner et al. 2009) stated that intentional exaggeration could be considered as evidence to support the diagnosis of malingering. No justification is provided for deviating from the DSM-IV-TR standard of having only gross exaggerations as indicative of malingering. This illustrates the concept of “construct drift” that Rogers and Granacher (2011) had described.

The committee noted that, unlike the case for Rogers and Granacher, the “term secondary gain” can be used in an assessment but should be limited to the context of the assessment and should never be used as a synonym for malingering. This raises the important point that assessments in the forensic disability and related contexts should address malingering and related motivations, but prudently, a point with which I agree. The committee noted that the best way to assess malingering is by ruling out intentions related to other possible conditions. However, on the one hand, I would add that there might be incontrovertible evidence for malingering and, on the other hand, intent is hard to assess with accuracy. Nevertheless, I agree

with Heilbronner et al. that malingering should be addressed in evaluations, in contrast to those who argue that such types of conclusions should be left to the province of the court or trier of fact. I add that a set of test data by itself, or inconsistencies/discrepancies, as well, or both, might rule in malingering to the needed level of certainty, everything else being considered and equal in the case at hand.

Others. Sollman and Berry (2011) took a more sanguine approach to describing the research by Mittenberg et al. (2002). They noted that the evidence of base rates for “suboptimal effort” in clinical practice is equal to or greater than 40 % in some settings, and they cited Mittenberg et al. as one authority. By using a more generic or global term than of malingering (suboptimal effort), Sollman and Berry afforded the possibility that such terms might involve even mild exaggeration. Their estimate that the percentage might be even higher than 40 % for the base rate of suboptimal effort makes sense if one includes all types of suboptimal effort and reasons for them.

In this regard, Merckelbach et al. (2011) demonstrated in analogue studies with undergraduate students that conscious feigning eventually could be forgotten and lead to symptom conviction and somatoform disorders. Further, Merckelbach and Merten (2012) elaborated a cognitive dissonance model of malingering. Conscious other-deception could turn into unconscious self-deception. The malingered symptoms become internalized and considered subjectively as genuine. The deceivers lose perspective on the origins of their fabrications, being convinced of their reality (e.g., Von Hippel and Trivers 2011). Or, also from a cognitive dissonance perspective, medically unexplained symptoms (MUS) might develop for reasons other than self-deception, such as escalating ambiguous or minor symptoms into more serious ones by anxiety and over-focus on them (e.g., Brown 2004; Suls and Howren 2012).

Therefore, to conclude, the work of Merckelbach and colleagues suggests that, on the one hand, malingering might be masked with time and, on the other hand, malingering, itself, is not the only way that evaluatee validity can be compromised. This fits my emphasis that referring to lack of credibility should be used when the data in an assessment does not warrant a direct conclusion of malingering. Using the language of a lack of credibility should be sufficient for many court purposes. In Chap. 5, consistent with Merckelbach and colleagues, I refer to the process of conscious malingering leading to unconscious symptom conviction and symptom propagation.

2.3.3 *Comment*

This review of definitions and concepts related to malingering has indicated that there is no clear consensus on what it involves. The most striking difficulty relates to whether exaggeration should be included as a component of malingering and, if so, what degree of exaggeration constitutes an index of malingering. Another problem relates to the suggested prevalence or base rate of malingering, which has been estimated as well over 50 % in some forensic contexts, such as those related to

psychiatric/psychological injury. Indeed, Larrabee et al. (2009) have argued that the standard base rate in the field should be acknowledged as 40 % plus or minus 10. Further, Larrabee (2007) agreed with Mittenberg et al. that in neuropsychological evaluations in which there is persistent neuropsychological deficit in cases of MTBI, the malingering rate might be as high as 88 %!

Before estimates of base rate or prevalence of malingering in the forensic disability and related context can be considered this high, replication is needed. Moreover, careful analysis of terms and research might reveal a pattern different than those published. Moreover, addressing the inconsistencies in terminology and methods in the research might further lessen the estimates.

That being said, problematic presentations and performances of a type less prejudicial than malingering might be as widespread as the research suggests. For example, definite and probable response bias as opposed to malingering, per se, might be quite elevated. Terminology and research in the field needs an integrated schema of concepts, terms, and conditions for their attribution, such as I attempt to provide in the present work. It is important to note that diagnostic accuracy can be improved by having scientifically-validated knowledge of the prevalence of a psychiatric/psychological condition. However, it can become problematic when the prevalence estimates are inaccurate, especially if wildly so, due to inconsistencies in terminology and methods in the research.

Mittenberg et al. (2002) explained that the likelihood that a diagnosis is accurate is when the ratio of its base rate to the probability of not having the diagnosis exceeds the ratio of false to true positives for a given method (as per Meehl and Rosen 1955). Therefore, considering the estimates of prevalence of malingering in the literature cited by Mittenberg et al., according to them, in an MTBI case, the likelihood that a correct evaluation of “probable malingering” is higher when the test used in the assessment produces less than 39 % false positive outcomes and, conversely, more than 61 % true positive outcomes. For the test used to have diagnostic utility, it should yield a positive predictive value or accuracy (the proportion of accurate to total positive diagnoses) exceeding the proportion of the relevant population not having the diagnosis involved (i.e., above 61 %).

This psychometric logic indicates the reason that the percentage of 40 ± 10 for the base rate or prevalence of malingering in MTBI cases appears a benchmark that workers in the field are striving to reach. The closer the figure reaches 50 %, the easier it is to work with in establishing a test’s predictive utility in diagnosing malingering. However, if the percentage is appreciably lower, such as less than 10 %, the test will err toward classifying non-malingers as malingerers, which is clearly unacceptable. In this field, test constructors take care to avoid such mislabeling because of their unfair consequences, and they adopt conservative cut-offs. However, the more the base rate is toward 50 %, the less likely extreme conservative cut scores are needed.

Moreover, if the 50 % or so percentage estimates for the base rate of malingering were accurate and valid, this figure would indicate to individual evaluators that, for a particular evaluatee, it is more likely than not before the person even begins the assessment that a conclusion of malingering to the assessment at hand is quite possible if not likely.

However, (a) if the basic definition of malingering is unclear, (b) if intent is hard to assess, (c) if the assessment instruments themselves have disparate even if relevant findings, and so on, any definitive estimate about the prevalence of malingering is premature. These and related arguments reinforce the conclusion that evaluators should be using alternative language to malingering to indicate doubt about the demonstrated veracity or truth-value of an evaluatee's symptom presentation and performance (such as generic terms related to credibility, feigning, dissimulation, unfavorable self-presentation, etc.), except in cases with incontrovertible evidence.

The latter conclusion appears appropriate scientifically but it presents practical drawbacks in the field of psychiatric/psychological injury. If psychiatric/psychological evaluators are constrained in arriving at conclusions about malingering, stakeholders/institutions, such as the court and the third parties involved, might object or find that psychiatric/psychological testimony does not help as much as it should and even might be superfluous. Without a diagnosis of malingering itself, cases might not be won outright in court and, moreover, from their perspective, financial settlements or court-imposed compensation might be higher than should be the case.

That being said, absent incontrovertible evidence of malingering, mental health professionals, including psychiatrists and psychologists, should argue that the alternative ways of indicating doubt about the honesty of an examinee's symptom presentation (e.g., feigning, non-credible) is the most accurate possible in the circumstances and should be sufficient to satisfy court and related requirements. That is, given absent evidence of malingering, in most cases involving doubt about credibility in forensic and related determinations of disability due to psychiatric/psychological injury, mental health evaluators should indicate that they have provided sufficient evidence in their assessments related to response bias and to presentation and performance feigning/dissimulation, in general, but the evidence cannot address the presence or absence of malingering itself, so that conclusions related to but without over mention of malingering are best in the circumstances.

It is better that psychology and psychologists lobby for changes to tort thresholds, disability policies, and the like, related to malingering and the need of its imputation instead of forcing its methods and procedures to yield conclusions that malingering is present when the evidence does not support such conclusions. Moreover, astute stakeholders and attorneys who are presented with cases described in terms such as noncredible and feigning could argue that these terms could be taken to infer malingering-type motivations, which might play better in court and related venues. Of course, plaintiff might argue otherwise, but in such cases mental health professionals would be correctly left out of the legal fray and triers of fact would be left to decide on the issue. Furthermore, when a conclusion of malingering proffered to court or related venues (a) goes beyond the data gathered for a particular case, (b) goes beyond the applicable science, and (c) goes beyond the boundaries of professional regulations and competencies, the evaluator's practice might face close scrutiny by regulatory bodies.

To conclude, given the difficulties encountered in defining malingering and related terms and in determining its base rate or prevalence in forensic disability and related contexts, when evaluatee presentation and performance casts notable doubt on

evaluee credibility, evaluators might be limited to using alternative terms other than malingering, itself, in order to express that doubt. The credibility of an evaluatee's symptom presentation and performance could be described using language that, if phrased correctly, can be as equally effective as using the "M" word, but without the baggage that opens the conclusions to the assessment to the type of criticisms being made in the present work. Using the term "feigning" and referring to a clear lack of "credibility" in the presentation and performance of the evaluatee should be sufficient to alert the court or trier of fact about the problematic veracity in the facts presented in the case at hand. Casting the net wider than this by attributing malingering even when unwarranted by the data at hand might lead to unexpected and quite negative practice outcomes.

2.4 Research on Prevalence of Malingering and Related Response Biases

2.4.1 Malingering Minimized

Gold and Shuman (2009) described in depth psychiatric assessment in the disability context. They devoted little space to the topic of malingering. They cited Tisza et al. (2003) as indicting that malingering was less common than exaggeration in evaluations in this setting. Reference to Tisza et al. (2003) reveals they cited an article by Eliashof and Steltzer (2003) indicating that malingering is likely "rare" among disability claimants. Other psychiatrists, such as Resnick, refer to psychological research in their publications and have a different perspective.

Soliman and Resnick (2010) presented the standard psychiatric perspective on evaluating feigning, and focused on malingering or feigned cognitive incompetence in adjudicative evaluations (the competence to stand trial). They suggested a step-wise approach, starting with clinical suspicion. In the next step of actually determining the presence of malingering, they included the use of psychological tests along with the assessment interview. The evaluator should then proceed to determine the presence of feigned cognitive incompetence. Some of the strategies and tests to use are psychological in nature, such as using Rogers and Correa's (2008) strategies for detecting feigned cognitive impairment, and also administering tests, such as personality inventories (e.g., the MMPI-2) and SVTs (e.g., the SIRS, Structured Interview of Reported Symptoms, Rogers et al. 1992). Note that psychiatrists need to be trained on using tests such as these before administering them to evaluatees (Dattilio et al. 2011).

Chafetz (2010) explained that in Social Security Administration (SSA) Disability benefit assessments (psychological consultative examinations) validity tests are not commonly used, nor are the constructs of symptom validity and malingering emphasized. However, he noted the value of evidence-based practice both for SSA policy

and medical consultants. Similarly, Evans (2011) and Worthen and Moering (2011) pointed out that Compensation and Pension (C & P) examinations at the Department of Veterans Affairs (VA) do not normally include the use of psychological tests that can help in detecting malingering. Even though best practice at the VA recommends use of the MMPI-2 and also research has revealed “high” base rates of exaggeration of PTSD, assessments rarely are comprehensive enough to detect response bias.

Chafetz et al. (2011) showed that of three groups of low-IQ claimants (disability from work, rehabilitation to return to work, individuals seeking reunification with their children), only the first group failed SVTs at a high rate. They attributed the group difference to differences in claimants’ intrinsic motivations. Moreover, the results suggest that failing SVTs does not reflect a low IQ, in particular. SVTs used in the study included the MSVT (Medical Symptom Validity Test), the RDS (Reliable Digit Span), and the A-Test (respectively, Green 2004; Greiffenstein et al. 1994; and Chafetz 2008).

However, it is noted that in these non-tort venues, the detection of malingering is not a priority. For example, in the military, there are political factors to consider. Nevertheless, practitioners such as Worthen and Moering and Chafetz realize the need for testing of malingered presentations. Worthen and Moering recommended use of tests such as the MMPI-2 and the SIRS.

2.4.2 *Malingering Maximized*

Reference to several of the more recent sources cited in the Mittenberg et al. (2002) article revealed that the percentages of malingering and related biases approached the 40 % level mentioned in the article. For example, Green et al. (2001) examined the relationship between failure on symptom validity testing and overall neuropsychological test battery mean in neurological patients, those with MTBI, and a miscellaneous group. They used the WMT (Word Memory Test), the CARB (Computerized Assessment of Response Bias Test), and the CVLT (California Verbal Learning Test) (Green 2005; Allen et al. 1997; Conder et al. 1992; and Delis et al. 1987 respectively). The failure rate on the SVT index used for purposes of establishing failure rate, the WMT, varied between 23 and 35 %.

Grote et al. (2000) used the VSVT (Victoria Symptom Validity Test; Slick et al. 1997/2005) to compare SVT performance in compensation-seeking (mostly TBI) and non-compensation seeking (intractable seizures) samples. For difficult memory items on the VSVT, the pass rate was 100 % for the former group but 58.5 % for the latter. That is, the failure rate using this test was in the 40 % range held as the norm by Mittenberg et al. (2002). Nevertheless, in both the Green et al. (2001) and Grote et al. (2000) studies, SVT failure rate was determined by using only one SVT test and not at the most stringent criteria.

Reference to recent research on the topic of base rate of malingering and related response biases involves research with better methodologies and it gives a mixed picture. Chafetz (2011) examined performance of social security disability claimants

using a score based on both embedded indicators of symptom validity and the RDS along with two other tests, the TOMM (Test of Memory Malingering; Tombaugh 1996) and the MSVT. Claimants were classified in the definite malingering group if they performed below chance on one SVT, and were classified as probable malingerers if they failed the A-Test and either the TOMM or the MSVT. Of 161 claimants in the sample, 38.5 % were classified as either probable or definite malingerers. However, examination of the breakdown of the two categories reveals that only 15 % were classified as definite malingerers ($n=24$). According to the author, there were no false positive errors in attributing malingering with three failed indicators from the scores used to develop a symptom validity index, consistent with the research of Victor et al. (2009) and of Larrabee (2003, 2008).

Greve et al. (2009) examined the prevalence of malingered disability in compensation-seeking chronic pain patients. They reviewed over 500 consecutive referrals to a private practice. They examined the battery of test scores and relevant clinical information according to the Slick et al. (1999) MND criteria, as well as a model derived from it for application to pain patients (MPRD, Malingered Pain-Related Disability; Bianchini et al. 2005). They noted that reliable empirical estimates of the base rates of malingered disability in pain patients have varied between 20 and 40 %, and the authors cited four studies to this effect. However, one of them is the survey authored by Mittenberg et al. (2002), which has the inconsistencies indicated in the present chapter.

In contrast to these various studies and reviews that suggest an elevated rate of malingering in the forensic disability and related context, Fishbain et al. (1999) provided an estimate as low as 1.25 % for malingered pain. However, Greve et al. (2009) undertook a recalculation of their data and arrived at a percentage of 23.5 %, aside from listing the study's methodological problems. In their research, Greve et al. undertook the first study of malingered disability in chronic pain patients (mostly back pain patients with no identifiable pathology related to their injuries) based on direct, individual evaluations using advanced psychometric indicators and formal diagnostic models.

The malingering indicators used in the study included all three major types of applicable measures – (a) indices from a personality inventory (MMPI-2); (b) stand-alone forced-choice symptom validity tests [the TOMM, the WMT, the PDRT (Portland Digit Recognition Test; Binder 1993; Binder and Willis 1991), the CARB] and (c) internal or embedded indicators taken from tests of cognitive ability [RDS and other WAIS-III intelligence test scores (Wechsler Adult Intelligence Scale, Third Edition; Wechsler 1997), and various CVLT scores; recognition hits, the Millis et al. (1995) formula, and the Millis and Volinsky (2001) linear shrinkage model].

The MPRD system is used to evaluate pain patients on five criteria; including presence of evidence from cognitive/perceptual (neuropsychological) testing and self-report (see Chap. 3). One method used only psychometric testing for determining the presence of MPRD whereas a second one included file inconsistencies (either two of them from their list or one compelling one for which two raters agreed). Patients were classified as probable or definite malingerers if they reached

either of the diagnostic systems' criteria (MND or MPRD). The authors also used a statistical estimation method using cut-offs associated with a specificity of approximately 95 % in TBI populations for the PDRT, TOMM, WAIS-III, and MMPI-2 (e.g., for F, FBS) and using modeling based on three prevalence estimates for malingering (20, 30, 40 %).

Of the 508 patients, up to 36 % were classified as probable or definite malingerers, with 10.4 % as definite malingerers. As for the statistical method of classifying malingering in these pain patients, the figure rose to as much as 40 %. Note that Greve et al. discussed their results in varied ways. On the one hand, they justified combining patients who reach probable and definite malingering criteria based on their scoring methods because in medico-legal terms the level of certainty needed for conclusions proffered to court is "more probable than not" or "to a reasonable degree of scientific certainty." However, the actual terminology is "more likely than not" and it is a worthy question to ask whether a diagnostic system that includes the adjective of "probable" actually meets the legal criterion of "more likely" [equal to or greater than 50 % probability, preponderance of the evidence]. The authors gave the results for the prevalence of malingering as between 20 and 50 %, depending on the type of analysis undertaken. However, according to the authors' own data, the estimate is more toward 10 %. Aside from the question of the base rate or prevalence of malingering ascertained in Greve et al., they discussed other matters that are consistent with my approach taken in this chapter, as presented in the following.

2.4.3 Malingering Balanced

Greve et al. (2009) indicated in the discussion of their results that "nearly half" the sample in the study showed some evidence of "symptom magnification," a term which is broader than malingering and includes symptom exaggeration. Moreover, they indicated that about one third of the sample met the criteria for "possible" MPRD. Furthermore, according to the authors, as much as two thirds of their sample showed "some form of exaggeration." Finally, the authors cautioned that "not all exaggeration reflects malingering" (p. 1124). Greve et al. appear to imply that workers in the field should be cautious about conflating exaggeration with malingering both in their research and in their individual assessments. These final conclusions are quite consistent with those of the present work that exaggeration is not synonymous with malingering. Indeed, the estimate that up to 2/3 of pain patients will show some form of exaggeration makes sense in light of my discussion of problematic presentation and performances in forensic disability and related determinations, in general. The question becomes to what degree and for what reasons.

Wygant et al. (2011) examined the results of 251 individuals who had undergone compensation-seeking evaluations. The primary condition assessed was pain impairment (65 %), with head injury claimed in the remainder (four of these claimants presented with pain impairments, as well). A majority of the assessments were

conducted for the defense (57 %), with 40 % for the plaintiff (3 % were unknown). This archival study examined scores on both self-report measures and symptom validity tests/measures, focusing on the MMPI-2-RF and its family of over-reporting F tests, as well as the RDS, which was developed for the MMPI-2 but can be scored for the RF version, as well. The RF F-tests include four reduced versions of the MMPI-2 equivalents – the F-r, Fp-r, Fs, and FBS-r (Infrequent Responses, Infrequent Psychopathology Responses, Infrequent Somatic Responses, and Symptom Validity Scale, Revised, respectively).

Other tests/measures that had been administered included the self-reporting SIMS (Structured Inventory of Malingered Symptomology; Widows and Smith 2005), as well as the M-FAST (Miller Forensic Assessment of Symptoms Test; Miller 2001) and SIRS, which are two structured interview response bias measures. Finally, three symptom validity/tests measures were administered: the TOMM, VSVT, and LMT (Letter Memory Test; Inman et al. 1998).

Based on both performance on the various measures and file review for factors such as compelling inconsistencies, Wygant et al. (2011) applied both the MND and MPRD diagnostic systems to classify individuals in their sample as either: incentives only ($n=103$), possible malingering ($n=57$), probable malingering ($n=70$), and definite malingering ($n=21$). The authors did not calculate the percentages in the distribution of these four groups, but for the combined probable/definite malingering group, the total percentage is 30.7, which is consistent with prior estimates that malingering-related classifications should be in the 30–50 % range. However, the percentage of definite malingering was only 8 % in this study, which is consistent with other research that the figure for outright malingering should be about 10 %. About the remainder of the results, the various over-reporting measures distinguished the definite/probable malingering groups from the possible malingering/incentive only groups, especially for Fr and FBS.

Note that Wygant et al. did not undertake their study for the direct purpose of establishing malingering base rate or prevalence in relevant psychiatric/psychological injury populations, so their results are informative, and stand in contrast to higher percentages often cited in the literature, for example, the references to Mittenberg et al. (2002). The article reviewed next by Lee et al. (2012) also found results related to malingering base rates that run counter to the current emphasis on 40 % or so, and obtaining these results was not the primary objective of the study.

Lee et al. (2012) investigated gender differences on the FBS in claimants who had undergone non-neurological medico-legal disability assessments. Despite the presence of some gender differences in the results, the publisher-recommended cut scores (Ben-Porath et al. 2009) yielded classification accuracies that were similar for men and women. The results suggested that the FBS does not involve clinically meaningful gender bias in predicting SVT failure. Unreported findings with the FBS-r, part of the MMPI-2-RF, gave comparable results.

On the one hand, the results do not support criticisms of the FBS related to gender bias raised by Butcher et al. (2008) and Williams et al. (2009). On the other hand, the percentage of non-credible responders was calculated using the Slick et al. (1999) criteria as well as performance on SVTs (e.g., the WMT, the TOMM,

the CARB). The criteria for definite malingering involved scoring below chance on an SVT and, for probable malingering, it involved a below cut score on one or more SVTs. Of 1,209 patients who met inclusion criteria, over 30 % met the criteria for non-credible responders (definite, probable), but only 19 met the criteria for definite malingering. This works out to a percentage of about 1.5 %, which is the estimate of malingering provided in the much-criticized Fishbain et al. (1999) study for pain patients! These results were not the main ones to which the study was aimed, and I had to calculate the latter percentage myself. That such a low percentage is obtained in a study with a sample of disability claimants is telling, even if the overall percentage including definite and probable non-credible responders is over 30 %.

2.5 Chapter Conclusion

Rogers and Bender (2012) noted that although the base rates of malingering suggested by Mittenberg et al. (2002) and Larrabee (2003) “possibly” might be accurate (e.g., 38.5 % for mTBI, ± 40 %, respectively), the publications contain conceptual and methodological limitations. For example, in their survey of National Academy of Neuropsychology (NAN) members, of the respondents, Sharland and Gfeller (2007) found that the median for definite malingering was only 1 % (in their Table 3). Similarly, Slick et al. (2004) surveyed published researchers on malingering. Only 12.5 % rated the prevalence of the category “definite” malingering at 30 % or more. Also, Rogers and Bender (2012) noted that in Larrabee (2003) some of the research cited used “deficient” designs.

In addition, Rogers and Bender (2012) described that there are multiple possible reasons for incomplete/suboptimal effort in testing other than the reason of malingering. These include pain, depression, stress, and expectation of failure on the part of the evaluatee and reaction to evaluator factors. Also, Elhai et al. (2012) indicated that other evaluatee factors, such as being ill, poor sleep, and medication side effects, might be involved.

Clearly, establishing the actual base rate or prevalence of malingering and related response biases in psychiatric/psychological injury populations remains an outstanding issue in the field. Moreover, the estimates in the literature on the base rates applicable to forensic disability and related contexts is much less than the 40–50 % level (or more), often touted as the appropriate level in the literature. That being said, the estimates of problematic presentations and performances to lesser degrees than outright malingering might be this high, and malingering itself might be as high as 10–15 %, although other researchers might dispute this figure, with estimates as low as 1–2 %.

Aside from definitional issues related to the terms and the question of base rate/prevalence, the research varies in methods and scope. For example, the classification of definite malingering might be determined based on failure on one forced-choice measure or it might derive from considering a “diagnostic” system such as the Slick et al. MND model. Mild or minimal exaggeration might be conflated with

frank malingering and, moreover, classifications of probable compared to definite response biases usually are lumped together. Further, any response bias could be considered equivalent to malingering. Moreover, algorithms that integrate behavior on multiple symptom validity indicators suggest two to three failures on such tests but others indicate that four to five such failures are needed. Finally, perhaps the diagnostic systems and algorithms need revision before they are valid for individual assessments, as queried in the next chapter.

Just as the Slick et al. (1999) criteria for MND has the potential to become the gold standard in neuropsychological assessment in the psychiatric/psychological disability and related context, the same applies to the MPRD for pain-related disability assessments. However, just as Boone (2007, 2011b) has recommended that the MND diagnostic system should change its label to a more generic term involving non-credible presentation or feigning, instead of malingering, per se, I recommend that the MPRD criteria proposed by Bianchini et al. (2005) be given a more generic, non-credible label, such as “Feigned Pain-Related Disability” (“F-PR-D”). Moreover, neither the Bianchini et al. MPRD criteria nor the Slick et al. MND criteria should be considered “gold standard” until recommended changes are evaluated for their relevance. These types of issues might reveal the need for newer, integrated diagnostic systems on malingering and related response biases, such as I attempt to create in the next chapter.

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