

# Assessment of Malingering: Pathways Through Conundrums and Complications

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# Pre Test

# Pre-Test: Questions & Answers

1. We have some excellent tests that assess malingering
  - \_\_\_\_\_
2. Inconsistency can be an indicator of malingering
  - \_\_\_\_\_
3. Deception is evidence of malingering
  - \_\_\_\_\_
4. All FAIs that assess response style have laser sharp cut scores and classifications
  - \_\_\_\_\_

# Pre-Test: Questions & Answers

5. Malingering occurs at a stable base rate
  - \_\_\_\_\_
6. A relevant FAI is always sufficient to rule in malingering
  - \_\_\_\_\_
7. Malingering is always an antisocial act by an antisocial individual
  - \_\_\_\_\_

# Pre-Test: Questions & Answers

8. Malingering is a static response style, i.e. once a malingerer, always a malingerer
  - \_\_\_\_\_
9. A good clinical interview is always sufficient to rule in malingering
  - \_\_\_\_\_
10. It's perfectly fine to use social media as collateral in malingering assessments
  - \_\_\_\_\_

# Base Rates of Malingering

- Vary depending on the samples used
- Forensic evaluations: 8% of defendants were identified as malingering in one study (Cornell & Hawk, 1989)
- Survey of forensic psychologists: 15.7% of forensic evaluatees were classified as malingerers (Rogers, Sewell, and Goldstein, 1994)
- Jail inmates referred for mental health services: 20% of participants were found to be feigning mental illness (Rogers, Ustad, & Salekin, 1998)

# Survey of the American Board of Clinical Neuropsychology (Mittenberg et al., 2002)

- Estimates were based on 33,531 annual cases involved in personal injury, (n = 6,371), disability (n = 3,688), criminal (n = 1,341), or medical (n = 22,131) matters
- Base rates did not differ among geographic regions or practice settings
- 29% of personal injury, 30% of disability, 19% of criminal, and 8% of medical cases involved probable malingering and symptom exaggeration

# Base Rates of Malingering

- Large scale surveys of more than 500 forensic experts (Rogers, et al., 1994; Rogers, et al., 1998) suggest that malingering is not rare in either forensic or clinical settings
- Rogers (2008): the assessment process itself can affect base rate:
  1. When malingering measures used with all referrals, base rate = 10-30%, even in forensic settings
  2. When M-FAST used as a screen, base rate may exceed 50%

# Malingering in DSM-5

1. the intentional production of false or grossly exaggerated physical or psychological symptoms

**AND**

2. motivated by external incentives, such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs
- Coded as a V-code: V65.2

# Malingering (Frederick, 2013)

- Intentional presentation of false mental state
- Production of false symptoms
- Exaggeration of true symptoms
- Suppression of true abilities
- To avoid undesired consequences
- To obtain desired goals

# When to Assess for Malingering

- Rogers (2008): when these circumstances apply:
  1. Atypical presentation of symptoms
  2. Unusually high number of unusual or obvious symptoms
  3. Nonselective endorsement of symptoms
  4. Discrepancies between reported and documented history of mental illness
- Why not note presence/absence of evidence for malingering in every evaluation?

# Common Motives in Malingering

(Resnick & Knoll, 2005)

<u>Motives</u>	<u>Examples</u>
To Avoid Something Unpleasant	Arrest
	Criminal prosecution
	Conscription into the military
To Obtain Something Desired	Controlled substances
	Free room and board
	Worker's compensation/disability benefits from alleged psychological injury

# External Incentive: Models of Gain

(Warren, 2011)

1. Primary gain: an internalized motivation in which symptoms create relief and help avoid an unconscious, internal conflict, for example, by providing an acceptable excuse to avoid a situation
2. Secondary gain: the motivation is conscious and externally-based, and it is related to obtaining or to avoiding something knowingly and willingly

# Possible External Incentives

1. Food
2. Shelter
3. Medications
4. Transfer from jail to hospital
5. Avoidance of work, school, military duty, unwanted obligations
6. Avoid criminal prosecution: IST, NGRI
7. Financial gain
  - a. Civil damages for physical/psychological injury
  - b. Social security disability benefits, worker's compensation

# Making Inferences about Possible External Incentives

1. Inferences are interpretations derived from data
  - ✓ Example: *"The person has no mental health history and is claiming atypical symptoms. Feigning is suspected."*
2. How do we know about suspected external incentive?  
Ask!
  - ✓ Example: *"What do you hope to get out of this evaluation or being here today?"*

# Is Clinical Judgment about Malingering Enough?

- Not always
- Utilizing **DSM criteria** can result in high false-positive rates → suspect it when there is: 1) marked discrepancy between claimed distress/disability & objective findings; 2) lack of cooperation during evaluation or treatment; 3) medicolegal context of presentation; 4) APD
- The empirical literature indicates that objective assessment instruments are more accurate than clinical judgment alone (Miller, 2005; Rogers, 1984; Ziskin, 1984)

# Are Objective Assessment Tools Enough?

- Not always
- The SIRS-2 Decision Model produces 5 different classifications:
  1. Feigning
  2. Indeterminate - Evaluate
  3. Indeterminate - General
  4. Disengagement: Indeterminate - Evaluate
  5. Genuine
- Clinical interview/review of collateral helps settle 2-4

# Clinical and Conceptual Errors Leading to False Attribution of Malingering (Drob et al., 2009)

1. The base rate problem - malingering is by definition volitional, so the base rate will vary across settings, depending on the defendant's perception of the cost/benefit ratio of attempting to feign mental illness
  - As base rates fall, false positives rise
2. Misclassification - consequences of being wrong are serious:
  - In court - proceeding legally as competent and/or sane when neither are accurate
  - Outside of court - loss of benefits, exclusion from services

## Clinical and Conceptual Errors Leading to False Attribution of Malingering (Drob et al., 2009)

3. Implicit forensic bias?: In a subspecialty that prides itself on tough-mindedness and savvy, the successful malingerer makes the forensic examiner feel like a naïve fool
  - a. built-in motive for forensic examiners to set the standard for detecting malingering at a low level
  - b. to avoid being fooled, the forensic examiner may assume anyone suspected of manipulation to be a malingerer
  - c. students quickly learn that it is more respectable to over identify than to under identify malingering

# What We Are up Against

Results of Google Searches: How to Fool  
Psychologists/Psychiatrists

# How to Fool Psychiatrists

from Yahoo! Answers

- *"Choose a mental disorder of your own choosing and study everything you can about this disorder (i.e. symptoms, behavior resulting from the disorder, etc.)"*
- *Also, look up the disorder in the DSM-IV-TR. Figure out how you can exhibit the minimum criteria needed to be diagnosed with your chosen disorder*
- *Practice, practice, practice. Take an acting class if you can*
- *Mental Health Practitioners cannot truly know what you are thinking. They can only gauge things about you by what you give them via speaking and body behavior."*

# How to Fool Psychologists

from Yahoo! Answers

- *"Psychologists tend to pick up on patterns when a person is evaluated. If they can see that they have answered all the questions like a 'normal' person would, then there will be some eyebrows raised. Most people have at least some personality flaws and a flawless evaluation means they were probably trying too hard to look normal."*
- *"Most psychological evaluations have what is called a 'bogus pipeline' within the actual evaluation. These questions are strategically placed within the evaluation to alert the forensic psychologist of any inconsistencies."*

# Common Mistakes in the Assessment of Malingering

1. Relying solely upon self-report
2. Not making use of available collateral data
3. Relying solely upon a forensic assessment instrument such as the M-FAST or SIRS-2
4. Not considering inconsistencies:
  - a. Current presentation compared to known phenomenology of claimed symptoms
  - b. Current presentation against the backdrop of known history
5. Confusing pleasant cooperation with forthright honesty

# How To Avoid Common Mistakes

1. Careful evaluation of claimed symptoms
2. Use forensic assessment instruments as needed
3. Obtain and consider relevant collateral information
  - a. Multiple sources if available
  - b. Diagnostically-informed interviews
  - c. Consideration of possible bias
4. Review obtained data for consistencies
5. Explain inconsistencies
6. If cannot resolve inconsistencies to the point of reasonable certainty → 20 day observation

# Strategies for Avoiding Common Mistakes

# **#1. Carefully Evaluate Claimed Symptoms**

# Evaluation of Claimed Symptoms

- McCarthy-Jones, S., & Resnick, P. (2014). Listening to voices: The use of phenomenology to differentiate malingered from genuine auditory verbal hallucinations. *International Journal of Law and Psychiatry*, 37, 183–189
- McCarthy-Jones, S., Trauer, T., Mackinnon, A., Sims, E., Thomas, N., & Copolov, D., (2014). A New Phenomenological Survey of Auditory Hallucinations: Evidence for Subtypes and Implications for Theory and Practice. *Schizophrenia Bulletin*, Vol. 40, No. 1, 225–235

# More Recent Findings about Hallucinations: A Brief Summary

(McCarthy-Jones & Resnick 2014; McCarthy-Jones et al., 2014)

*Every malingerer is an actor portraying an illness, and the more you know about the illness, the more you can ask questions that the malingerer will not know.” (Resnick, 2015)*

# Factors about Auditory Hallucinations No Longer Supported as Signs of Malingering

1. Vague or inaudible - mumbling is commonly heard, but rare to hear only mumbling
2. Location
  - a. inside or outside of the head should not be used as a single indicator of malingering
    - ✓ 34% only inside, 28% only outside, 38% both
    - ✓ If the voices are only experienced inside one's head there will not be "attending behavior"
  - b. Left ear or right ear
    - ✓ fairly evenly split and may shift over time

# Non-Psychotic Auditory Hallucinations

(Resnick 2015)

1. Typically have childhood onset (mean age = 12 in non-psychosis, 21 in psychosis)
2. Make sense of the experience by attributing the voices to angels or spirits (in psychosis attributed to people)
3. Content does not tend to be demeaning, critical, or pejorative
4. Tends not to cause distress (in psychosis genuine auditory hallucinations typically lead to distress)

# Non-Psychotic Visual Hallucinations

(Resnick 2015)

1. Occurs in 14 to 18% of the population
2. Most often of a deceased relative or stranger
3. Women are 4x more likely than men to see a dead relative, men more likely to see a stranger
  - ✓ Women grieve, men replace
4. In non-psychotics, a human figure is most commonly seen (in a psychotic group, 50% see a visual phenomenon such as an unusual light or a silhouette, 50% see a human figure)

## Factors about Visual Hallucinations Not Supported as Signs of Malingering (Resnick 2015)

1. Shadows – may reflect an illusion (a misperception) rather than an actual hallucination
2. Ghosts – consider cultural/familial issues

# #2. Use Forensic Assessment Instruments

# Decision Theory

- Classifies an outcome as either positive or a negative
  1. True Positive: malingering identified and confirmed
  2. False Positive: malingering identified but not confirmed
  3. True Negative: malingering not identified and not confirmed
  4. False Negative: malingering not identified but confirmed

# Decision Theory: Classifications

	Actually Malingering	Actually Non-Malingering	
Assessed as Malingering	True positive	False Positive	<b>Positive Predictive Value</b>
Assessed as not Malingering	False Negative	True Negative	<b>Negative Predictive Value</b>
	<b>Sensitivity</b>	<b>Specificity</b>	

# Decision Theory: Computing Classifications

- Sensitivity = proportion of individuals with X that are correctly classified as having X (true positives/true positives + false negatives)
- Specificity = proportion of individuals without X that are correctly classified as not having X (true negatives/true negative + false positive)
- Positive Predictive Value = proportion of individuals who test positive for X who actually have X (true positive/true positive + false positive)
- Negative Predictive Value = proportion of individuals who test negative for X who actually do not have X (true negative/true negative + false negative)

# FAIs for Malingering

## OPTIONS:

1. SIRS-2
2. M-FAST
3. PAI
4. MMPI-2-RF
5. VIP
6. TOMM
7. ATP section of ECST-R
8. Forced Choice Recognition Test

## CONSIDERATIONS:

1. Balance between specificity and sensitivity
  - SIRS-2 sensitivity = .80 (or is it? - Tarescavage & Glassmire, 2016)
2. Enough data points for #8

# #3. Gather Relevant Collateral Information

Assemble Pieces of the Puzzle

# Why Collateral Information?

(Goldstein et al., 2003; Heilbrun et al., 2015)

- Specialty Guidelines: use a variety of independent data sources
- The defendant's self-report is one pathway to establishing relevant base of data
- Limitations of the defendant's self-report:
  1. Memory errors
  2. Rationalization & other defense mechanisms
  3. Malingering or other response style
  4. Exaggeration
  5. Influence of symptoms

# Collateral Information

(Heilbrun, Warren, Picarello, 2003)

- Describing sources requested and obtained helps deflect criticism about bias or inadequate base of data
- Helps distinguish claimed from actual functioning
- Problems with non-professional 3<sup>rd</sup> party sources
  1. Bias
  2. Suggestible
  3. Uninformed
  4. Lacking in specific & relevant knowledge
  5. Unable to recall specific & relevant knowledge

# Collateral Information: Problems & Strategies

(Heilbrun, Warren, Picarello, 2003, p. 82)

Problem	Strategy
Reluctance	<ol style="list-style-type: none"><li>1. Notification of purpose</li><li>2. Cannot use unattributed sources</li></ol>
Bias	<ol style="list-style-type: none"><li>1. Count on it!</li><li>2. "What do you think should happen?"</li><li>3. Multiple sources</li></ol>
Reporting Irrelevancies	<ol style="list-style-type: none"><li>1. Start with broad questions<ul style="list-style-type: none"><li>• "What was she doing?"</li></ul></li><li>2. Next focus on specific symptoms &amp; behaviors</li><li>3. Do not elicit conclusions<ul style="list-style-type: none"><li>• "Was she psychotic?"</li></ul></li></ol>

# Collateral Information: Problems & Strategies

(Heilbrun, Warren, Picarello, 2003, p. 82)

Problem	Strategy
Suggestibility	<ol style="list-style-type: none"><li>1. Start with broad questions</li><li>2. Next focus on specific symptoms &amp; behaviors</li><li>3. Compare #1 and #2</li></ol>
Memory	<ol style="list-style-type: none"><li>1. Move from broad to specific</li><li>2. Provide specific information<ul style="list-style-type: none"><li>• Date</li><li>• Location</li></ul></li></ol>

# Should We Obtain Jail Phone Calls?

- Routinely, perhaps not, but when there are indications of malingering, why not?
- A recent case:
  1. Examiner suspects malingering, asks prosecutor if there were any recorded jail phone calls that could be reviewed
  2. Prosecutor produces audio recording of several calls, one revealed the defendant talking to his girlfriend about how he was faking it (he said he thought the examiner "fell for it"), and coaching her on what to tell the examiner when called

# #4. Review Data for Consistencies

# The Hallmark = Inconsistency

(Resnick & Knoll, 2005)

<u>Internal Inconsistencies</u>	
Examinee reports confusion and lack of understanding	Examinee's self-report is well-organized and logical
Examinee describes current psychotic symptoms	Examinee has no known history of the reported symptoms

# The Hallmark = Inconsistency

(Resnick & Knoll, 2005)

<u>External Inconsistencies</u>	
Reported Symptoms	Observed Symptoms
Reported Symptoms	Observed Functioning/Behavior
Reported Symptoms	Genuine Symptoms
Reported Symptom Clusters	Genuine Symptom Clusters

# The Hallmark = Inconsistency

(Resnick & Knoll, 2005)

## External Inconsistencies

Known Past Functioning

Reported Decline in  
Functioning In Absence of  
Plausible Explanation for  
Decline

Reported Symptoms

Forensic Assessment  
Instrument or Psychological  
Testing Results

# Social Media: Fair Game as Collateral In Forensic Evaluations?

# Social Media: A Clinical Perspective

(Clinton et al., 2010)

- **Six Questions to Ask before Searching Social Media**
  1. Why do I want to conduct this search?
  2. Would my search advance or compromise treatment?
  3. Should I obtain informed consent from the patient?
  4. Should I share the search results with the patient?
  5. Should I document the search findings in the health-care record?
  6. How do I monitor my motivations and the ongoing risk– benefit profile of searching?
    - Does my boss know?

# Social Media: A Forensic Perspective

(Pirelli et al., 2016)

- Not much literature on professional use of internet as part of forensic mental health assessment
- Forensic psychiatry is ahead of forensic psychology in considering the complexities in this area
- When conducting forensic evaluations, psychologists are obligated to comply with the EPPCC, and although the APA considers all of its published guidelines to be aspirational, psychologists should act in ways consistent with them

# Social Media: A Forensic Perspective

(Pirelli et al., 2016)

1. Forensic practitioners who use internet data should conceptualize them as a type of collateral information
  - a. Even examinees' own words from blogs or other online postings should not be considered self-report data in the context of a forensic assessment
  - b. Evaluators must consider the source of the data, their characteristics (e.g., the date and context in which something was written), and, ultimately, the convergence or divergence with other available data

# Social Media: A Forensic Perspective

(Pirelli et al., 2016)

2. Although searching for/using internet-based data is not prohibited by the EPPCC or SGFP, forensic practitioners should consider conducting internet searches on a case-by-case basis, weighing the potential utility versus the potentially prejudicial effects of such data
  - a. No current standards or guidelines can be interpreted as prohibiting examiners from seeking such data, but nor can any be interpreted as requiring such data to be collected

# Social Media: A Forensic Perspective

(Pirelli et al., 2016; Recupero, 2008; 2010)

- b. Such data can provide a more complete picture of the examinee and inform judgments about response styles
- c. May help to confirm, corroborate, refute or elaborate on the psychiatrist's general impression of the person," and "digital evidence can be especially useful in assessments of impairment, credibility, and dangerousness or risk, particularly when the evaluatee is uncooperative or unreliable in the face-to-face psychiatric examination"

# Possible Complications

(Metzner and Ash, 2010)

- Meaning of the message may be difficult to understand (e.g., deciphering a text message)
- People present themselves on the internet differently than they do in face-to-face contexts, so interpretation is not always clear
- Possible generational differences about use of the internet – there may not be consensus of what constitutes “normal” internet use and communication



# Social Media: A Forensic Perspective

(Pirelli et al., 2016)

3. With rare exceptions, forensic practitioners who gather and/or rely on internet-based data (or anticipate such) should discuss this practice during the retention and notification processes
  - a. Explain to examinees the manner in which these data have been or will be collected, integrated, and disseminated
  - b. Make same disclosures to those who retain us
  - c. Don't if doing so poses safety concerns (e.g., the examinee is agitated and likely to be combative)

# Social Media: A Forensic Perspective

(Pirelli et al., 2016)

4. With rare exceptions, forensic practitioners should provide examinees with data points gathered via the internet and allow them to address such data
  - a. Allows examinees to challenge the content of what was yielded, or explain its context, which is critical to considering the weight the examiner should give it
  - b. If don't = vulnerable to cross examination especially if data reportedly an examinee's own words (e.g., "*Dr., you didn't even ask what she meant by that, did you?*")
  - c. Don't if doing so poses safety concerns

# Social Media: A Forensic Perspective

(Pirelli et al., 2016)

5. Forensic practitioners should be explicit about their use of and reliance upon any data gathered via the internet in their reports and testimony
  - a. EPPCC and SGFP both stress the importance identifying sources of information used and data considered (and whether the examinee was provided the opportunity to respond to such data)

# Social Media: Recommendations

1. If you plan on seeking out such data, note this in your notification statement
2. If you use such data, note them as a source of information and allow the examinee to respond to it
3. Be careful about your assumptions regarding accuracy of the information or what it means
  - a. A cautionary Facebook tale...
4. Your motive for seeking out such information should be the same as any other collateral: neutral and objective pursuit of data that may be relevant to the issue at hand

# #5. Explain Inconsistencies

# Explaining Inconsistencies

- Describe what they are
- Highlight different sources of information
- Note any concerns about reliability of such sources
- Who Do You Love?
  - ✓ Provide an analysis of why you do not find something credible (e.g., “*The defendant claimed to be hearing voices throughout the evaluation, but there were no behavioral indicators of hallucinations.*”)
  - ✓ Be careful with the keys to the kingdom

# A Case Vignette

# A Case Vignette

- **Charges** = Aggravated Burglary & Kidnapping
- **Alleged Offense** = bizarre quality
- Seen 3x
- **MSE**: disengaged
  - ✓ Almost no eye contact, sat hunched over with his head in his hand, very few verbal responses, lots of “I don’t know” and “I don’t remember,” shaking his head
  - ✓ Responsive to firm encouragement to continue
  - ✓ Convincing descriptions of many depressive sx
  - ✓ Reported hearing voices telling him he is worthless and that he should kill himself

# A Case Vignette

- **Hx:** no IP psych tx, one visit to Netcare for Opioid use
- **Appearance** = straight black hair covering face, multiple “satanic” tattoos, sharpened to-a-point fingernails
- **Collateral:**
  1. Jail staff = denied MH hx at intake; not on the mental health case load, but has used the call card system “quite a bit” with dental/medical concerns; no behavioral problems
  2. Parent = recent death of family member and a close friend after which he was more “sullen and introverted” but no behaviors indicative of hallucinations

# A Case Vignette

3. Former GF = rated his depression as a “7 or 8” after losses, but currently “2;” during visits he faces her and makes eye contact, has goals for the future; likes to make people laugh,” is trying to “make the best” of his current situation, and has made friends in jail; no recent significant changes in his appearance, speech, posture, or eye contact with her
- **Psych Testing:**
    1. MMPI-RF-2: invalid due to over-reporting
    2. ECSTR = on ATP, over-reporting on 4 of 4 subscales
    3. SIRS-2 = highly elevated pattern classified as Feigning

# Malingering Post Test – Name That Sign

# Questions?

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