

Lying in the medicolegal field: Malingering and psychodiagnostic assessment

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Abstract

The simulation of mental illness, so-called “Malingering”, is a very difficult phenomenon for professionals to identify when making an assessment, especially in the medicolegal and forensic psychology and psychiatry fields. When malingering, the subject implements strategies that mimic the symptoms related to a possible psychiatric disease, with the aim of misleading the operator. It is necessary, therefore, to elicit a complete medical history and make a close clinical examination and, especially, to be able to rely on appropriate diagnostic tools. Another important aspect, in the legal medicine, and forensic psychology and psychiatry fields, is the opposite strategy, namely that of dissimulating, or masking, a disease.

Several diagnostic tools that the professional clinician can employ to identify dissembling strategies are considered in this article, namely the MMPI- 2, PAI, M- Fast, the SIRS and, finally, the SIMS. *Clin Ter 2019; 170(2):e134-141. doi: 10.7417/CT.2019.2123*

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Introduction

The simulation of mental disease, so-called Malingering, is an area that arouses considerable controversy among scholars and operators in the medicolegal and forensic fields, as regards both the correct definition and the identification of this behavior in general for medicolegal and forensic purposes.

From the adaptive standpoint, dissembling is defined as “an instinct and a means of preservation of the individual and the species”, or “an adaptive response to adverse circumstances”(1).

In 1980, the American Psychiatric Association issued an official definition in the Diagnostic And Statistical Ma-

nual for Mental Disorders (DSM-III), according to which dissembling is not a mental disorder but rather a condition with clear psychological implications, to which close clinical attention must therefore be devoted.

By the time the fifth edition of DSM was published, dissembling was defined as: the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives like the wish to avoid military service, or job tasks, or to obtain financial compensation, to evade penal trials or to obtain drugs. In some circumstances dissembling may be an adaptive behavior, as can occur, for example, when prisoners of war feign to be affected by a disease (2).

Already in the Diagnostic And Statistical Manual for Mental Disorders (DSM-III), a series of symptoms were listed which, if present, should raise the ‘strong’ suspicion that the subject is lying:

- the symptoms are present in a medicolegal context;
- there is a marked discrepancy between the reported stress and impairments complained of by the subject and the objective clinical and examination findings;
- a lack of collaboration is observed during the diagnostic assessment, as also of compliance to the prescribed therapeutic regimen;
- an Antisocial Personality Disorder is noted.

This list was drawn up to support those called upon to make an assessment both in purely clinical contexts and in medicolegal and forensic psychology or psychiatry settings, including use by clinicians asked to make a medicolegal assessment of suspected malingering (3).

When analyzing the issue of malingering, it is important also to refer to the opposite phenomenon when, again in a medicolegal context, subjects dissimulate their condition, disguising it in order to mask a true medical or psychiatric problem. There are many reasons that can lead a subject to lie, such as to obtain a given certificate, keep or obtain a particular job, obtain more advantageous conditions when stipulating an insurance policy, or gain some medicolegal advantage in the social security field (4).

Dissembling behaviors in the medicolegal setting: malingering and dissimulating

Many professionals operating in both the clinical and the medicolegal fields have observed that feigning symptoms, or malingering, is not always a behavior motivated by a wish to gain some advantage, and it is not possible to exclude the possibility that the dissembling behavior is adopted to safeguard the subject's own psychological integrity.

Three conceptual models can be identified: the *pathogenic model*, in which dissembling is considered as a symptom of the mental disease, that then degenerates to a psychosis; the *criminological model*, in which the dissembling is not a disease but an attempt to fake or exaggerate physical or mental symptoms in order to gain some advantage; the *adaptation model*, in which the dissembling is interpreted as an adaptive mode employed when facing a trial or cross-examination; in clinical practice, this is very rarely observed.

For those who interface with the forensic world, the model of main interest is that of simulating a disease to evade a penal trial.(3)

Instead, in the civil law field, malingering can be adopted to gain various advantages or concessions, such as a certificate of biological injury of a psychological nature, ascribable to various geneses or dynamics, to obtain a pension, or to gain a favorable evaluation of the injury, etc. etc. The hypothesis that the patient is trying to fake a health condition can very easily induce a conflict situation and so harm the doctor-patient, -psychologist or -medical examiner relationship. This situation generates the innumerable difficulties that are encountered, in both the medicolegal and the psychiatric fields, when needing to differentiate between a feigned and a genuine disease.(5) In fact, in many studies it has been shown that the highest number of cases of dissembling occurs in penitentiaries where subjects deprived of their freedom deliberately and in full awareness fake the symptoms of a disease in order to obtain some benefit (e.g. to gain a transfer to another institution, to house arrest, recognition of partial or total mental infirmity at the moment of the crime, or of a state of health incompatible with the jail regimen, or even just a transfer from one cell to another, minor financial benefits or a job in the institution or outside, etc..) (4).

Those who are lying are identifiable as individuals who refer single symptoms with no relevant associations, and no correlations with a true disease picture. A subject who intends to fake a health condition may experience the feigned disease symptoms(6) but those simulating a disease are not coherent and tend to attract the examiner's attention by referring the loss of coherent ideas and knowledge, space-time disorientation and forgetfulness (2-5).

However, the examiner who deals with subjects that could be potential malingerers must not rule out the possibility that the subject really does have a genuine mental disease of psychiatric-psychological-criminological concern, due to detainment in a correctional institute and the loss of personal freedom. There can be a series of clues that can help the clinician to distinguish malingerers from subjects genuinely affected by a disease, who will, instead, attempt to disguise and mask their true problems. If patients decide to dissimulate, they experience the symptoms but try to

mask them, whereas the malingerer describes individual symptoms with no links to others and lacking any disease correlations: they lack coherency and constancy. They tend to try and attract the examiner's attention by referring reduced intellectual or sensorial powers, the loss of ideas and knowledge, and time-space disorientation. They can also report hallucinations and delusions, defining them using the appropriate terminology; the content of their delusions and hallucinations is generally bizarre and infantile (4,6).

In the light of the above, it is important to be able to recognize and distinguish dissembling from similar mental disorders reported in the DSM 5, that include the Factitious Disorder and the Conversion Disorder.

The Factitious disorder is subdivided into Factitious Disorder **imposed on self**, and **imposed on another**.

The former is characterized by deliberately feigning physical or psychological signs or symptoms, or the self-induction of an accident or a disease, associated with ascertained lying. Such people present themselves to others as ill, handicapped or wounded. The dissembling behavior is evident and manifests even in the absence of any external benefit. Such behavior is not better explained by any other mental disturbances like delusional or psychotic disorders.

The factitious disorder imposed on another is characterized by falsifying physical or psychological signs or symptoms, or inducing an accident or disease in another person, associated with ascertained deceit. The subject presents the other person (victim) to others as ill, handicapped or wounded (3).

The differentiation between dissembling and factitious disorders lies in the reasons underlying the faking of symptoms. In factitious disorders there is no external advantage or incentive that induces the subject to fake the role of a patient/carer.

However, the general behavior of malingerers and those suffering from a factitious disorder is sometimes very difficult, if not impossible, to differentiate. For this reason it is essential to pay close attention to evaluating what might be possible motives prompting subjects to feign disease symptoms.

Another disorder that requires differential diagnosis is the *Conversion Disorder*, whose diagnostic criteria include "one or more symptoms of altered voluntary or sensory motor function; the clinical results prove the incompatibility between the symptom and the known neurological or medical conditions; the symptom or deficit is not better explained by any other medical or mental disorder; the symptom or deficit causes clinically significant distress or impaired functioning in the social, employment or other important settings, or requires medical assessment" (3).

Another element that is important in medicolegal contexts, but is sometimes somewhat neglected by clinicians, is the already mentioned phenomenon of Dissimulating or masking a real disease.

Dissimulating means hiding or voluntarily refraining from informing about a disease known to exist. A dissimulator is really ill but in particular circumstances tends to conceal the disease; when this is of a psychiatric nature, the subject hides the symptoms and signs and pretends to be disease-free. The subject is well aware of the true situation but denies it, and mentally manipulates the truth, replacing

it with contrary information: such dissimulation can be seen as a way of adapting to the world (7).

Usually the causes of the dissimulation are intrinsic to the disease, and partly organized in the patient's relational context. Variables that must be present for the case to be recognized as malingering, such as a wish to cheat the system, pretended psychopathic disorders and an external advantage, seem to work in the opposite way in dissimulators, who simulate a state of wellbeing. Interests in disguising or concealing a disability or imperfection include many different scenarios:

- to gain a certificate (e.g. a permit to carry a weapon, to drive, to undergo a sex change, to be certified able to do a certain job, to bring up a family, to adopt a child);
- to get or keep a job, career advancement or a licence;
- to stipulate a more advantageous insurance policy, if the disease would make it more costly or even impossible;
- in various medicolegal assessments, for insurance purposes, or to evade interdiction, certified inability or support administration.

In such cases the subjects undergoing clinical assessment are particularly motivated to obtain the health or legal advantage and so very unlikely to be truthful about previous psychic or behavioral disturbances (8,9).

Psychodiagnostic assessment to identify malingering and dissimulation in the medicolegal setting

In the forensic context, identifying Malingering or Dissimulation is not easy because the psychiatrist or psychologist faces a situation unlike the one s/he most commonly deals with. Professionals needing to make such diagnoses are very aware of the need to increase their level of understanding of the subject, referring to external data and adding them to those resulting from the visit in order to gain a reliable identification of the malingered behavior (10). It is important to associate the general structured visit with other screening and psychometric tests that can support the identification. The professional will decide which tools are best suited to the case, and what combination, on the basis of the symptoms presented and the particular needs observed in each case.

The psychodiagnostic tools tailored to the Italian scenario that have been shown to be most valid and reliable in the detection of malingering or dissembling are of two types: *multiscale questionnaires* like the Minnesota Multiphasic Personality Inventory (MMPI-2) and the Personality Assessment Inventory (PAI); *structured interviews* like the Structured Interview of Reported Symptoms (SIRS) and the Structured Inventory of Malingered Symptomatology (SIMS), considered one of the most reliable tools (10).

One of the commonly used tools in these cases is the above-mentioned Minnesota Multiphasic Personality Inventory-2. This is a self-report tool consisting of 567 items designed to measure the presence and degree of a psychopathic disease. It is recognized as the objective personality test most widely employed in forensic evaluations because vast research has confirmed its capacity to pinpoint biased answers, thanks to the validity scale (11).

The test features four types of scale, namely *validity scales*, *content scales*, *basic clinical scales* and *supplementary scales*.

The validity scales include:

- a) scale **L**, *lying*, referred to some forms of behavior that for almost all people are demonstrably true or false;
- b) scale **F**, *frequency*, indicates the possibility that the symptoms are being exaggerated, that may occur by chance, due to malingering or to a wish to be anticonformist. It indicates the moment when the subject starts to answer without paying attention to the question, due to fatigue or disinterest;
- c) scale **K**, *correction*, that indicates a defensive attitude or a tendency to wish to hide problems.

Various configurations of these scales have been studied to manage the resulting impressions, both positive and negative. Further research using this tool has led to the development of many other validity scales, such as:

- scale VRIN, *variable response inconsistency*, that pinpoints a tendency to give incoherent answers and project a poorly credible self image;
- scale TRIN, *true response inconsistency*, that assesses similar tendencies to the above VRIN scale;
- scale Fb, *F bad*, when the subject is 'faking bad' in the last half of the test;
- scale Fp, *frequency of psychopathy*, rarely endorsed in psychopathic patients.

These provide an efficient measurement of two types of malingering: feigning severe psychopathic disease (like psychosis) and feigning somatic/ neurocognitive symptoms. Severe psychopathic disease is often identified as a pattern in the scale F family, that is also often associated with feigned psychopathy. Faking somatic and/or neurocognitive symptoms is often observed in Civil Law cases, and this has therefore fueled the need to develop other validity scales, including the Fake Bad Scale (FBS), that measures "feigning somatic disease", although its use has generated some argument as to whether it is admissible in Court (12).

The Response Bias Scale (RBS), that was empirically developed by testing the approval of items by individuals who had passed or failed the cognitive validity test symptoms. Moreover, researchers claim that this scale helps to improve the precision of the F and FBS scales (11).

An exemplary case study reported by Duncan et al in 2010, that was important for its contribution to detecting dissembling, involved the use of the MMPI-2 test formula RF. In this study it was expected that the F-r and FP-r scales would more likely be able to differentiate the group of simulators from the non simulators, because the former are better able to detect unlikely somatic and neurocognitive responses.

The participants in the study were recruited from Federal Court archives, and included a total of 155 subjects who had been judged able to stand trial, or else penally liable. Each of them was administered both the SIRS and the MMPI-2, for the psychodiagnostic assessment (11). The study had excluded all those subjects who had provided a large quantity of responses that were impossible to score (e.g. I can't answer), who gave incoherent responses (that were attributable the incoherence variable in the VRIN response),

or were continually indiscriminate (being attributable the incoherence variable in the 'true' response) on the MMPI-2 validity scale.

The sample was thus reduced to 125 subjects, mean age 36.7 years, with medium level education, and of variable ethnic origin: Caucasian 51.8%, Afroamerican 44%, Hispanic 3.5% and the remainder of other ethnic origin. Of this sample, 64% referred that they had already undergone previous mental health treatment and 38% had a history of at least one psychiatric ward admission. About 84% of the patients confessed that they indulged in substance abuse and about 94% had a record of a previous sentence.

The SIRS was used as the external criterion to determine what group they belonged to, simulators vs non simulators. A cut-off validated in different forensic populations was applied. This led to the classification of 27 subjects as malingers, and the remaining 98 as non malingers. In addition, the SIRS indicated eight subjects as *probable* malingers. The participants had been chosen from State archives rather than randomly from the population purely for reasons of convenience.

For each subject the Federal Court had stipulated a psychological assessment. All the information on previous psychiatric ward admissions was collected through preliminary reports, documents presented at ward admission and clinical interviews. All the psychological assessments had been made by a forensic examiner who took into account the subjects' ability to collaborate.

The research showed that, as expected, including the F-r and FP-r scales in the MMPI-2 was the best way to differentiate malingers from non malingers, as demonstrated by the SIRS. These results are comparable to those obtained in the study made by Rogers and collaborators, suggesting that these scales are rightly reputed the best for differentiating malinging and non malinging. Instead, the other scales applied to detect vitiated responses, namely the FS and FBS-r, did not elicit a favorable validity judgment; this was a good thing bearing in mind the different significance of these scales.

Logistic regression analysis of the F-r and FP-r scales showed that they have a mutual predictive utility, as both scales add something unique when differentiating malinging from non malinging. A further potential benefit of this discovery is that these scales detect different response strategies, the scale F-r being more concentrated on detecting rare symptoms in genuine mental diseases, whereas the scale FP-r is focused on slightly less rare symptoms. In the forensic criminology setting it seems that these strategies are complementary, as potential criminals are seen to be less accurate and sophisticated when describing their symptoms. Despite the excellent results gained with the F-r scale, it is necessary to use great caution when assessing slightly less rare symptoms because they are not always rare in some clinical populations.

The aim of the investigation was to determine the validity of the scales in the tool used to detect malinging. It was concluded that the scales designed to assess malinging are recognized as able to differentiate malinging from non malinging, with small variations in differences.

Another tool used to detect Malinging is the Personality Assessment Inventory (PAI), a self-report questionnaire that includes 344 items designed to assess psychopathy in general (13). Like in the MMPI, also in the PAI the introduction of validity scales to assess dissembling responses was a critical component in its development. The original validity scales included: incoherence (a pair of items of similar content), infrequency (expected responses to the items are given in the same way by both populations, clinical and non clinical), a negative impression of handling of the questionnaire (claiming bizarre or improbable symptoms), a positive impression of handling (very rarely given for both interviews, clinical and non, but often seen in those attempting to present themselves in a good light). A supplementary validity scale, of a defensive nature, was later added to assess underestimation.

More recently, two further scales have shown encouraging results in assessing malinging:

- the Malinging Index, constructed on the basis of a typical profile often associated with malinging psychiatric symptoms (14).
- the Rogers Discriminant Function, constructed on the basis of 3 research groups: a clinical group (patients with schizophrenia, depression and generalized anxiety disorders) and non clinical participants classified as ingenuous or false (15).

The results of discriminant analyses showed that the weighted mean of the combination of scales yielded a 92% success rate (accuracy of detection of malinging).(11)

The PAI is gaining a wide consensus in forensic practice but it has been less studied in terms of diagnostic accuracy in assessing malinging as compared to the MMPI-2. (15) Much of the research made to assess the diagnostic accuracy of both tools employed dissembling models that potentially suffer from internal validity bias, posing the risk of being unable to generalize the findings to the real forensic setting.

In one research study, Roger et. al included a control group of clinical subjects, and found that genuine patients but not malingers could be well assessed, with a cut off of 9 for the NIM scale (15).

In another study, conducted by Liljequist and collaborators, it was also shown that those who feign post traumatic stress disorder (PTSD) obtained high scores for the NIM scale (16), while other studies obtained the same score or a score of 8 and a 75% classification rate of those feigning PTSD (17).

Roger et al analyzed the Rogers Discriminant Function scale, composed of a series of scales and subscales with T scores, that discriminate malingers from genuine patients. The research conducted on this type of scales provided useful information about how generalizable they are in forensic practice (15).

Studies of the Malinging Index demonstrated a certain level of accuracy in discriminating subjects who had been asked to feign a psychiatric disorder, but had a poor performance in individuating those feigning PTSD, and so showed its poor reliability in generalizing results in the forensic context.

To assess the diagnostic accuracy of the validity scales of the PAI- NIM, RDF and MAL- as malingering indexes, a study was made of two groups of criminal suspects for which the Judge had requested assessment of the ability to stand trial, the degree of penal liability and, finally, suggestions or recommendations as regards the sentence. The suspects were classified empirically as malingers, not on the basis of the SIRS scores.

In a study made by L. T.Kucharski and collaborators of Correctional Institute subjects, the PAI resulted a reliable tool for detecting malingering, especially thanks to the application of the clinical scale NIM, that is less defined than the others. This suggests that caution should be used, and several different diagnostic tools applied to guarantee a more accurate assessment (18).

Another tool we have analyzed is the Miller Forensic Assessment of Symptom Test (M-FAST)(19), consisting of a structured interview including 25 items, developed as a screening tool to detect faking of mental disease. The main use of this tool is to gain further confirmation in individuals already judged to be "likely malingers" using other tools, or to exclude faking in individuals judged to be "in good faith", and so in need of support (20).

The items in this tool have been built on the basis of clinical constructs, behaviors and strategies described in literature, previously reported to help to detect faking strategies from those responding in good faith (Miller, 2001). The results and total score point to seven strategies, shown to be the most commonly employed by malingers(18):

reported vs observed (RO)
extreme symptomatology (ES)
rare combinations (RC)
unusual hallucinations (UH)
unusual symptom course (USC)
negative image (NI)
suggestibility (S)

Given the potential consequences to alter a person's life of an assessment including the M-FAST, it is essential to carry out further research to confirm the results obtained. (20) An important aspect of the utility of the M-FAST that has not yet been evaluated is to understand what basic rates the tool employs to define malingering.

Most tools investigated for their power to distinguish malingering have been evaluated on the basis of their power not only to detect faking psychopathy in general, but also faking specific disorders. This diagnostic power is highly important in such a tool, especially in light of the fact that most individuals present with different symptoms in the various fields of forensic assessment. For example, feigning psychosis can be frequent in the penal setting, whereas feigning affective disorders or PTSD is more frequent in civil law contexts (21).

Studies made to evaluate the Miller Forensic Assessment of Symptom Test (M- FAST) used to detect malingers have underlined that it is able to identify at least 2/3 of malingers in the specific condition. One case study was conducted by Guy L. S., M.A, Kwartner P. P., M.A., Holly A. Miller, to gain more information about the psychometric properties of the tool and make a detailed analysis of the error rates associated with it as a function of the different reference rates and cut-off scores for each diagnostic category (22). It

was the first investigation of the diagnostic capacity of the M-FAST to detect fake psychotic and affective symptoms, attempting to distinguish between malingers and subjects really affected by the disorders. Four disorders in particular were contemplated: schizophrenia, major depressive disorder, bipolar disorder and PTSD, chosen in view of their ample presence in the population of subjects affected by mental disorders and also because there has been a documented increase in the attempts to fake these disorders in certain forensic settings (23).

The research compared two groups:

- 1) **simulators**: university students enrolled in courses of Psychology and Law at South West University, USA;
- 2) **clinical subjects**: a control group of clinical patients (n= 142), composed of forensic psychiatry patients judged unable to stand trial, psychiatric inpatients, prison inmates undergoing psychiatric support, and subjects of recognized incapacity attending outpatients psychiatric services.

To prevent the M-FAST scores from differing significantly among the 4 clinical groups, they were analyzed as a single clinical group. In addition, to exclude simulators, the control group was analyzed by groups of psychiatrists or psychologists, that based their diagnoses on tests or clinical interviews, eliminating the possibility of dissembling.

The group of simulators was further subdivided into the 4 diagnostic groups. After close analysis of the instructions, the M-FAST tool was administered, and at the end they completed the post- test questionnaire.

To make sure the results were not affected by lack of attention or understanding of the instructions, only those protocols that included answers to the handling control questions were kept. In this way, of the 226 simulators, 36 were excluded a priori because they had failed to answer one or more questions. Most of the subjects excluded belonged to the group that had been asked to feign Post Traumatic Stress Disorder (PTSD). The remainder were uniformly distributed among the other disorders.

The primary aim of the study was to assess the psychometric powers of the tool. Taking into account the whole sample, the total M-FAST score showed an excellent internal density. The mean correlation among items was a little less satisfactory. Of the 4 scales making up the tool, the Rare Combination (RC) scale was the one that demonstrated the most robust psychometric properties; instead, the correlations among items were relatively low in all the diagnostic combinations in both groups.

The second aim was to indicate the error rates linked to the tool.

The positive and negative predictive power of faking disease is indicated by the positivity or negativity of the score compared to the cut-off. Sensitivity was calculated on the basis of the percentage of individuals correctly labeled as simulators, while specificity was referred to the percentage of subjects correctly recognized to have a genuine disease. The data demonstrated a good percentage of success and satisfactory specificity and sensitivity rates expected from the cut-off scores for all the diagnostic conditions. Thus, the analysis underlined the utility of the M-FAST tool for use with the different diagnostic conditions.

In short, the results of this study showed that the M-FAST is a tool that can cast light on those faking a disease. The study had focused in particular on some specific mental diseases. In fact, those asked to feign the different conditions had significantly higher scores than the control group, that consisted of subjects with a genuine mental disorder. One scale in particular, the *rare combinations*, was able to make a significant differentiation between the fakers and the clinical subjects, independently of the disease in question. Instead, the discriminatory capacity of the other scales was found to be variable: the unusual symptom course (USC) scale, negative image (NI) scale, suggestibility (S) scale, composed of a single element, did not show a good discriminatory capacity. From the psychometric standpoint this underlines the need to apply each item, and eliminate incomplete elements. Therefore, a poor specificity in diagnosing a disorder is explained, if the faker wishes to feign depression, for example, by the fact that the test will be more concentrated on the mood scales and this will annul its validity. Moreover, owing to the structure of the tool, only the total score of all the scales, not the single scores of the different scales, can be considered reliable in differentiating fakers from genuine clinical subjects.

A greater validity was found in identifying subjects faking schizophrenia, because of the test structure itself, that is more focused on psychotic and affective symptoms. Moreover, it was found that generally fakers have less knowledge of schizophrenia than of depression and so are less able to be convincing. The results suggest that close attention must be paid to identifying PTSD, because although some of the subjects had positive scores at the M-FAST, some of them did not pass the post-test screening for understanding of the stimuli.

In conclusion, it can be stated that this study confirmed the validity of the M-FAST tool for identifying and discriminating between fakers and subjects with a genuine mental disorder, but underlined the importance of proceeding toward the diagnosis with caution if the identification of dissembling of a specific disease is based exclusively on single scales (24).

Another tool in the armamentarium of the professional engaged in assessing malingering is the Structured Interview of Reported Symptoms (SIRS), (25) constructed by Rogers in 1986. It was developed to assess a vast range of strategies that can be employed to identify malingering. It is a structured interview composed of 172 items, that takes about 30-40 minutes to administer. It contains 8 scales (25):

1. rare symptom
2. symptom combinations,
3. improbable or absurd symptoms,
4. blatant symptoms,
5. subtle symptoms,
6. severity of symptoms,
7. selectivity of symptoms,
8. reported vs. observed symptoms.

Apart from these eight main scales, a further 5 subscales can be distinguished:

1. direct appraisal of honesty,
2. defensive symptoms,
3. overly specific symptoms.

4. symptom onset and resolution,
5. inconsistency of symptoms.

These supplementary scales are used only if the subject being interviewed does not propose a sufficient quantity of symptoms to be diagnosable as a faker. The responses to the scales are defined as: *honest, indeterminate, probable or definite*.

An individual is accused of feigning psychiatric symptoms if her/his scores are correlated with at least one primary scale in the *definite* category, or if the scores are correlated with three or more subscales in the *probable* category. (25) The SIRS has been shown to be a valid and reliable method for individuating malingerers, with a low frequency of false positive rates. As compared to other psychological personality tests, that take longer to administer, as well as to manage the scoring, this tool is quick and easy to apply, and especially has the advantage of showing a high correlation with the situation in the forensic setting, having been created specifically in this field of work in order to identify malingerers (26).

A research study was conducted at the University of California, on a sample of jail inmates in the county of Sacramento, to determine the tool's validity in assessing malingering. Nearly 400 jail inmates were assessed for the need to receive assistance services. Before undergoing the test, they were asked to attend a brief interview to institute a clinical relationship and collect data on their psychiatric history. Then the SIRS was administered and a brief report was prepared and inserted in the criminal's files. Of a sample of 161 inmates, 66.5 % were found to have values ascribable to the SIRS scales. There were no particular differences in race or gender in the sample (27).

When all the scales were combined, it was found that most of the malingerers were within the probable or definite range. However, 12% of the subjects figuring as likely malingerers in the subscales were then judged to belong to the honest group (27).

The results obtained administering the SIRS suggest that malingering is more common in correctional institutes than it is thought to be. The point of major interest in the percent identification rates, that provide information on the accuracy of the tool, is that they are much higher than the positive rates proposed in the manual.

The limit of the study is that it was not possible to definitely distinguish malingerers from non malingerers, unlike in those studies set up to examine subjects who have been instructed to simulate malingering (27).

The last tool examined in our analysis is the Structured Inventory of Malingered Symptomatology (SIMS), that has been introduced in Italy more recently. It is designed to identify feigning of psychiatric symptoms (e.g. depression or psychosis) and/or cognitive deficiencies (e.g. low intelligence and memory deficiencies) (28,29).

It includes five scales, plus one referred to the total score:

1. ***Psychosis (P) Scale***, that assesses to what extent the subject refers unusual or bizarre symptoms, that are not typical in psychiatric patients;
2. ***Neurological Injury (NI) Scale***, that assesses to what extent the subject refers illogical or decidedly atypical neurological symptoms;

3. *Amnesic Disorders (AM) Scale*, that assesses to what extent the subject refers memory disorders that are not compatible with the cerebral injury or dysfunction observed;
4. *Low Intelligence (LI) Scale*, that assesses to what extent the subject invents and/or exaggerates intellectual deficiencies by pretending a poor performance for simple general knowledge items;
5. *Affective Disorders (AF) Scale*, that assesses to what extent the subject refers atypical symptoms of depression or anxiety.

Finally, there is the Total Scale, that is the sum of the scores of all the scales and reflects the general level of faking. In total, the scales include 75 items.

Once the total score has been calculated from the scores of each single scale, they are compared with the pre-established cut-offs, positioned under the raw scores, in order to assess the probability that the subject is malingering or not, and so orient investigations toward more accurate assessments (28,29).

The tool was validated by administering the questionnaire during laboratory workshops in three different experimental conditions: the first group was asked to answer the questionnaire honestly, according to their true feelings about the items; before undergoing the test, the second and third groups underwent a training session about two forms of psychopathy, namely affective disorders and psychosis, that they were asked to feign.

After the training the subjects underwent the test. None of the completed questionnaires was excluded, because they had all been correctly filled out, or at any rate a sufficient number of valid responses had been given.

A first analysis demonstrated a good reliability for the three samples, whereas the coherence was slightly penalized due to the small number of items, but was anyway found to be good in the experimental groups and nearly optimal in the control group. To distinguish the scores of the honest from the faked responses, analysis of variance (ANOVA) was performed, that revealed significant differences among the groups. ANOVA was also employed to assess differences in the single scales, and again demonstrated a good power to discriminate the different disorders in the different conditions. This meant that each scale presented a good distribution of fakers and non, in accordance with the experimental expectations. In particular, the AF and LI scales individuated 100% of the fakers in the respective samples. Finally, the sensitivity of the single scales in identifying malingerers was found to be inferior to that of the total scale. For this reason, it seems wise to use the total score as the overall indicator of malingering, and the single scales as indicators of the chosen area of malingering (30).

Conclusions

In the forensic or medicolegal settings, tools allowing an assessment of dissembling in the form of accentuation or minimization of mental disease, attitudes adopted for defensive or instrumental purposes and that could invalidate the assessment, undoubtedly offer a significant contribution to

obtaining more reliable, credible results in such circumstances. Above all in the medicolegal field, the issue of obtaining valid results is essential (31-33).

In fact, in the forensic and medicolegal contexts what the subject refers (symptoms or problems described) is not only used to infer a disease or physical/social disability, but also to ascertain the clinical credibility of the source. In a sense, the symptoms are divorced from their natural context (the disease) and acquire a new aspect, that of revealing the clinical credibility of the subject presenting them. An awareness of this situation, although apparently a given, should never be taken for granted, and the potentially distorting role played by the contextual situation should never be underestimated in the medicolegal setting. It is reasonable to believe, in fact, that a large part of those patients genuinely affected by a mental disease is in any case in possession of sufficient cognitive capacities to understand what is at stake in the medicolegal assessment, and so to exaggerate their symptoms, invent others, or on the contrary, endeavor to hide them, in order to gain the relative advantages in question. Exploring the proportion of malingering/dissembling due to the setting could further refine the accuracy of assessments made in legal and forensic settings.

It is for this reason that we must always stress the fact that assessments in forensic and medicolegal settings are made in completely different settings that are never directly assimilable to the clinical setting. The attempt to simply transpose clinical knowledge to the legal field poses one of the greatest threats to the overall quality of medicolegal assessments (34-38).

In conclusion, in relation to psychodiagnostic assessments of subjects in settings where it is more probable that they will dissemble, feigning illness or, on the contrary, good health, it was stated already more than a decade ago that *"undoubtedly the assessment approach offered by psychodiagnostic tests is more scientific than what can be elicited with the clinical interview. Indeed, a test is a "controlled experiment" which attempts to reduce to a minimum the confounding variables, and in which the data are collected according to a standardized method, to ensure the maximum reproducibility and reliability. It must nevertheless be borne in mind that such tests are designed to respond to specific clinical and research demands, and so their value when applied in the forensic context is quite different from the value they may have in experimental or purely clinical contexts"* (39-44).

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